Division of TennCare Eligibility Policy Consolidated

Eligibility Policy

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STATE RESIDENCE

Legal Authority: 42 CFR 435.403; TCA 71-5-120; TCA 40-38-601 *et seq.*; Tenn. Comp. R. & Regs 1200-13-20; 1360-11-01

1. Policy Statement

An individual must be a Tennessee resident to be eligible for TennCare Medicaid or CoverKids. An individual is considered a Tennessee resident if the individual attests to living in Tennessee, intends to reside in Tennessee and there is no information to indicate otherwise. Individuals will not be required to reside in Tennessee for a specific amount of time to claim residency. Individuals considered temporarily absent from Tennessee may retain their Tennessee residency under certain circumstances.

2. Residency

a. Non-Institutionalized Individuals under Age 21 who are not Emancipated or Married

For non-institutionalized individuals under age 21 who are not emancipated or married, and not receiving Title IV-E payments, the state of residence is:

i. The state in which the individual is living, with or without a fixed address; or
ii. The state in which the parent or caretaker resides.

b. Institutionalized Individuals under Age 21 who are not Emancipated or Married

For institutionalized individuals under age 21, who are not emancipated or married, and not receiving Title IV-E payments, the state of residence is:

i. The state in which the parent or legal guardian lives at the time of placement in an institution;
ii. The state in which the parent or legal guardian who files the application is currently living if the individual is institutionalized in that state; or
iii. The state in which the party who files the application lives, if the institutionalized individual has been abandoned by her parents and does not have a legal guardian.

c. Non- Institutionalized Individuals Age 21 and over, or under Age 21 and Emancipated or Married

For non-institutionalized individuals age 21 and over, or under age 21 who are emancipated or married, and capable of indicating intent, the state of residence is:

i. The state in which they are living and intend to reside with or without a fixed address; or

ii. Where the individuals live and entered with a job commitment or seeking employment, whether or not they are currently employed.

d. Non-Institutionalized Individuals over Age 21 who are not Capable of Stating Intent

For non-institutionalized individuals over 21 and not capable of stating intent, the state of residence is the state in which they live.

e. Individuals Receiving Federal Payments for Foster Care, Federal Payments for Adoption Assistance or State Supplementary Payments (SSP)

An individual of any age receiving federal payments for foster care or adoption assistance under Title IV-E of the Social Security Act is a resident of the state in which the child lives. An individual of any age receiving a SSP is a resident of the state paying the SSP.

f. Individuals Participating in the State's Safe at Home Address Confidentiality Program

Tennessee's Safe at Home Address Confidentiality Program protects the home, school or work address of a relocated victim of domestic abuse or other listed offenses by providing a substitute address for the participant to provide in lieu of a current home or mailing address.

Participation in the Safe at Home Address Confidentiality Program is determined solely by the Secretary of State. For an individual participating in the state's Safe at Home Address Confidentiality Program, the state of residence is determined and verified by the Secretary of State.

3. Incapable of Indicating Intent

An individual is considered incapable of indicating intent when tests, determined acceptable by the Department of Intellectual and Developmental Disabilities (DIDD), indicate an individual has an I.Q of 49 or less or a mental age of 7 or less. An individual is also considered incapable of indicating intent if found legally incompetent. Medical documentation from a physician, psychologist or other person licensed by the state in the field of intellectual disability may also be used if the documentation indicates that the individual is incapable of indicating intent.

4. Student

Individuals attending school out of state, but considered to be dependents of a Tennessee resident are temporarily absent while attending school. Individuals aged 18 to 22 attending school in Tennessee, but considered to be dependents of a non-Tennessee resident will not be considered a resident of Tennessee.

5. Temporary Absence

A temporary absence from Tennessee does not preclude continued eligibility if the individual indicates his intent to return to Tennessee once the purpose for the visit is accomplished when:

a. The absence is for a specific purpose such as a temporary work assignment, visit, hospitalization, participation in an educational or rehabilitation program not available in Tennessee; or
b. The absence is for children in treatment centers.

If an individual indicates that she is temporarily out of state, she must provide an anticipated date of return. The individual's temporary absence status will be assessed within 10 days of the individual's anticipated date of return.

If at any time during the absence the individual is determined no longer eligible for Medicaid or CoverKids benefits for any reason, the case must be closed. Application or receipt of Medicaid, CHIP or Advanced Premium Tax Credits (APTCs) in another state indicates intent to reside elsewhere and results in the loss of Tennessee residency. If a redetermination is required during the period of absence, follow renewal procedures and secure assistance from the other state as necessary.

6. Disputed Residency

An individual's physical location determines the state of residence if two or more states are unable to resolve what state is the state of residence.

7. Verification

An individual is considered a Tennessee resident if the individual attests to living in Tennessee, and intends to reside in the state. TennCare will conduct post-eligibility verification of state residency to ensure program integrity using national and state electronic verification sources. If an individual's state of residence is questionable, he will have 20 days to provide documentary evidence supporting his claim. Evidence of residency may include, but is not limited to the following:

a. A statement of intent to reside in Tennessee; and
b. A current Tennessee rent or mortgage receipt or utility bill in the adult applicant's name;
c. A current Tennessee motor vehicle driver's license or identification card issued by the Tennessee Department of Safety in the adult applicant's name;
d. A current Tennessee motor vehicle registration in the adult applicant's name;
e. A document showing that the adult applicant is employed in Tennessee;
f. A document showing that the adult applicant has registered with a public or private employment service in Tennessee;
g. Evidence that the adult applicant has enrolled the applicant's children in a school in Tennessee;
h. Evidence that the adult applicant is receiving public assistance in Tennessee;
i. Evidence of registration to vote in Tennessee;
j. Evidence of participation in the Safe at Home Address Confidentiality Program; or

k. Other evidence deemed sufficient by TennCare as proof of residency in Tennessee.

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CITIZENSHIP AND IMMIGRATION

Legal Authority: 42 CFR 435.406; 42 CFR 435.407; 42 CFR 435.956; 42 CFR 457.320; 8 USCA § 1431; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

In order to be eligible for TennCare Medicaid or CoverKids, an individual must be a:

a. United States (U.S.) citizen;
b. U.S. national; or
c. Qualified non-citizen who meets the eligibility conditions associated with specific immigration statuses. See the *Qualified Non-Citizens* policy.

Individuals declaring U.S. citizenship or immigration status must have such declarations verified by TennCare in order to receive TennCare Medicaid or CoverKids. Individuals who are not U.S. citizens, but have been granted the right to reside in the U.S. will have an immigration status. If TennCare is unable to verify a declaration of U.S. citizenship or immigration status using an electronic data source, the individual must provide satisfactory documentary evidence of citizenship or immigration.

Declarations of citizenship or immigration status must be made by either the individual, an adult member of the individual's household, an authorized representative, or if the individual is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status.

2. Definitions

a. **U.S. Citizen:** An individual who was born in:

- **i.** The U.S.;
- **ii.** Puerto Rico;
- **iii.** Guam;
- **iv.** The U.S. Virgin Islands; or
- **v.** The Commonwealth of the Northern Mariana Islands.

b. **U.S. National:** An individual who was born in the:

- **i.** American Samoa; or
- **ii.** Swains Island.

c. **Naturalized Citizen:** An individual who becomes a U.S. citizen after birth. Non-citizens do not automatically become citizens by marrying a U.S. citizen. Spouses, however, may apply for naturalization and, if eligible, become citizens through the court.

d. **Derived Citizen:** An individual who was adopted by or born abroad to at least one U.S. citizen parent. Citizenship may be conveyed to children through the naturalization of parents, to foreign-born children adopted by U.S. parents, or through birth abroad to at least one U.S. citizen parent.

e. **Child Citizenship Act of 2000:** According to the Child Citizenship Act of 2000, a child born outside of the U.S. to a citizen parent or adopted from abroad by a U.S. citizen parent automatically becomes a citizen of the U.S. when all of the following have been met on or after February 27, 2001:

i. At least one parent of the child is a U.S. citizen, whether by birth or naturalization;
ii. The child is under 18 years of age;
iii. The child is lawfully admitted for permanent residence to the U.S. and is residing in the legal and physical custody of the citizen parent. The child will have either a permanent resident card (i.e., green card) or an I-551 stamp on her passport. The child may or may not have a certificate of citizenship; and
iv. If adopted, the adoption is final.

f. **Qualified Non-Citizen:** An individual whose immigration status is included in one of the following groups (see *Qualified Non-Citizens* policy):

i. Qualified non-citizens, as defined by the Personal Responsibility and Work Opportunity Act of 1996 (8 USC 1641);
ii. Certain American Indians born outside of the U.S.; or
iii. Non-citizens granted a certain humanitarian immigration status.

3. Exempt Groups

TennCare accepts declarations of U.S. citizenship from the following individuals without verification:

a. Individuals receiving Supplemental Security Income (SSI) benefits;
b. Individuals entitled to or enrolled in any part of Medicare;
c. Individuals receiving Social Security benefits based on their disability;
d. Individuals to whom child welfare services are made available based on the child being in foster care, or receiving adoption assistance or foster care assistance; and
e. Newborns who are eligible for Medicaid on the basis of being born to a mother who was eligible for and receiving TennCare Medicaid at the time of birth. A newborn who is deemed eligible and enrolled in Medicaid is exempt from citizenship verification requirements for the rest of her life. This exemption applies to individuals enrolled as deemed newborns in other states.

Note: Pregnant women eligible for the CoverKids maternity benefits and pregnancy related services are not required to attest to citizenship or immigration status.

4. Verification of U.S. Citizenship and Immigration Status

a. Overview

Declarations of U.S. citizenship and immigration status must be accepted and then verified using an electronic data match with the Social Security Administration (SSA) or U.S. Department of Homeland Security. Federal law requires that the state first attempt to electronically verify citizenship and immigration status using the Federal Data Services Hub (the Hub). When unable to electronically verify citizenship or immigration status of an individual, the individual must provide satisfactory documentary evidence to TennCare.

Verification of U.S. citizenship is a one-time requirement. Once U.S. citizenship has been verified, it will be recorded in the individual's case and the state cannot request verification again, even if there is a break in coverage. Verification of immigration status is also a one-time requirement, unless the individual attests to, or TennCare receives information indicating, a change in status.

b. Electronic Verification of U.S. Citizenship and Immigration Status

i. Federal Data Services Hub

1. Applicant Attesting to U.S. Citizenship (Citizenship by Birth)

Confirmation of citizenship status by the SSA via the Hub is considered stand-alone evidence of citizenship. Applicants whose citizenship is confirmed via the Hub are not required to submit additional documentation of citizenship status.

2. Applicant Attesting to U.S. Citizenship (Naturalized and Derived Citizens)

Naturalized or derived citizens will have their citizenship status verified by the U.S. Department of Homeland Security via the Hub, if available. Applicants must provide their Alien Registration Number and information from their Naturalization Certificate or Certificate of Citizenship. Verification of citizenship status by the U.S. Department of Homeland Security via the Hub is considered stand-alone evidence of citizenship. Applicants whose citizenship is confirmed via the Hub are not required to submit additional documentation of citizenship status.

3. Applicant Attesting to Eligible Immigration Status

Applicants who are able to provide a U.S. Department of Homeland Security Alien Registration Number and/or other immigrant documentation numbers may have their immigration status verified by the U.S. Department of Homeland Security via the Hub. Electronic verification of immigration status by the U.S. Department of

Homeland Security is considered stand-alone evidence. Applicants whose immigration status is verified via the Hub are not required to submit additional information.

c. Documentary Evidence of Citizenship

When unable to verify citizenship or immigration status using electronic data sources, the individual must promptly provide satisfactory documentary evidence of citizenship status. Section 1903(x) of the Social Security Act requires that specific documentation be used to verify citizenship status, according to the reliability of the document (42 USC 1396b(x)).

Stand-alone evidence of citizenship is documentary evidence that must be accepted without any additional evidence of identity. If stand-alone evidence of citizenship cannot be provided, the second level of citizenship evidence must be accepted if the applicant also provides sufficient evidence of identity.

A photocopy, facsimile, scanned, or other copy of a document must be accepted to the same extent as an original document under this section, unless information on the submitted document is inconsistent with other information available or there is reason to question the validity of the document or information on the document.

i. Stand-alone Evidence of Citizenship

The following must be accepted as sufficient evidence of citizenship:

1. A U.S. passport, including a U.S. passport card issued by the U.S. Department of State, without regard to any expiration date as long as such passport or card was issued without limitation;
2. A Certificate of Naturalization;
3. A Certificate of U.S. Citizenship;
4. An enhanced driver's license issued by Michigan, Minnesota, New York, Vermont, or Washington;
5. A data match with the SSA; and
6. Documentary evidence issued by a federally recognized Indian Tribe, as published by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including Tribes located in a state that has an international border, which:

   a. Identifies the federally recognized Indian Tribe that issued the document;
   b. Identifies the individual by name; and
   c. Confirms the individual's membership, enrollment, or affiliation with the Tribe.

   Documents described in this subsection include, but are not limited to: a tribal enrollment card, Certificate of Degree of Indian Blood, Tribal Census Document, and documents on tribal letterhead, issued under the signature of the appropriate tribal official that provide the required information.

ii. Evidence of Citizenship

If an applicant does not provide stand-alone documentary evidence, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by acceptable evidence of identity:

1. 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 January 13, 1941), Guam, the Virgin Islands of the U.S., American Samoa, Swains Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (after November 4, 1986). The birth record document may be issued by a state, commonwealth, territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the CNMI before these areas became part of the U.S., the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:
- **a.** Puerto Rico:
  - **i.** Evidence of birth in Puerto Rico and the applicant's statement that he was residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941.
- **b.** Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):
  - **i.** Evidence of birth in the NMI, TTPI citizenship, and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986, (NMI local time) and the applicant's statement that he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);
  - **ii.** Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975, and the applicant's statement that he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);
  - **iii.** Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

2. A cross match with a state Vital Statistics agency documenting a record of birth;

3. A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.;

4. A Report of Birth Abroad of a U.S. Citizen;

5. A Certification of Birth in the U.S.;

6. A U.S. Citizen I.D. card;

7. A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency);

8. A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth;

9. Evidence of U.S. Civil Service employment before June 1, 1976;

10. U.S. Military Record showing a U.S. place of birth;

11. A data match with the SAVE program or any other process established by the U.S. Department of Homeland Security to verify that an individual is a citizen;

12. The following documentation demonstrating that a child meets the requirements of Section 101 of the Child Citizenship Act of 2000 as amended (8 USC 1431):

- **a.** The child's birth certificate or record;
- **b.** Marriage certificate of child's parents (if applicable);
- **c.** If the child's parents were married before their marriage to each other, proof of termination of any previous marriage of each parent (e.g., death certificate or divorce decree);
- **d.** Evidence of U.S. citizenship of parent, (i.e., birth certificate; naturalization certificate; FS-240, Report of Birth Abroad; a valid unexpired U.S. passport; or certificate of citizenship);
- **e.** If the child was born out of wedlock, documents verifying legitimation according to the laws of the child's residence or domicile or father's residence or domicile (if applicable);
- **f.** In case of divorce, legal separation, or adoption, documentation of legal custody;
- **g.** Copy of Permanent Resident Card/Alien Registration Receipt Card or other evidence of lawful permanent resident status (e.g. I-551 stamp in a valid foreign passport or Service-issued travel document);
- **h.** If adopted, a copy of the full, final adoption decree and, if the adoption was outside of the U.S. and the child immigrated as an IR-3 (orphan adopted abroad by U.S. citizen parent(s)), evidence that the foreign adoption is recognized by the state where the child is permanently residing; and
- **i.** Evidence of all legal name changes, if applicable, for the child and U.S. citizen parent;

13. Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth;

14. Life, health, or other insurance record that indicates a U.S. place of birth;

15. Official religious record recorded in the U.S. showing that birth occurred in the U.S.;

16. School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth;

17. Federal or state census record showing U.S. citizenship or a U.S. place of birth; and

18. If the applicant does not have one of the documents listed in 1-17 of this section, she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

iii. Evidence of Identity

1. TennCare must accept the following as proof of identity, provided such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

a. A driver's license issued by a state or territory;
b. A school identification card;
c. A voter's registration card;
d. A U.S. military card or draft record;
e. An identification card issued by the federal, state or local government;
f. A military dependent's identification card;
g. A U.S. Coast Guard Merchant Mariner card;
h. For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records; and
i. Two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees, and property deed or titles.

2. Finding of identity from a federal or state governmental agency. TennCare may accept as proof of identity a finding of identity from a federal agency or another state agency, including, but not limited to, a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

3. If the applicant does not have any documents listed in this section and identity is not verified by another agency, the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information. The affidavit does not have to be notarized.

iv. Verification of citizenship by a federal agency or another state

TennCare may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a federal agency or another state agency, if such verification was done on or after July 1, 2006.

v. Assistance with obtaining documentation

The state must provide assistance to applicants who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

d. Documentary Evidence of Immigration Status

When unable to verify immigration status using electronic data sources, the applicant must promptly provide satisfactory documentary evidence of immigration status. The United States

Citizenship and Immigration Services (USCIS) has several types of documents that a non-citizen might have to verify her status. These documents include, but are not limited to, the following:

- **i.** A Permanent Resident Card (I-551) or "Green Card" - Issued to eligible immigrants who enter the U.S. to permanently live;
- **ii.** A Permanent Resident Re-entry Permit (I-327) - Allows permanent residents to leave and re-enter the U.S.;
- **iii.** A Refugee Travel Document (I-571) - Issued to refugees and asylees for travel purposes;
- **iv.** A Temporary I-551 Stamp (on passport or I-94, I-94A) - A temporary I-551 stamp will have a handwritten or stamped issue date and a "valid until" date. Temporary I-551 stamps can be used to attest to permanent resident status;
- **v.** A foreign passport stamped by the U.S. Government indicating that the holder has been "Processed for I-551";
- **vi.** A machine readable immigrant visa (with temporary I-551 language) - Indicates permanent resident status;
- **vii.** An Arrival/Departure Record (I-94, I-94A) Form I-94 stamped with one of the following statuses: Asylee, Parolee or Parole, Refugee, Asylum, humanitarian parolee, or public interest parolee;
- **viii.** A court order stating that deportation has been withheld pursuant to Section 243(h) of the Immigration and Nationality Act (8 USC 1253);
- **ix.** A Notice of Action (I-797) - A form of communication from USCIS about immigration benefits;
- **x.** Document indicating membership in a federally recognized Indian tribe or American Indian born in Canada;
- **xi.** Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR); and
- **xii.** Office of Refugee Resettlement (ORR) eligibility letter (if under 18).

A non-citizen may contact USCIS or otherwise obtain the necessary verification.

5. Reasonable Opportunity for Verification of Citizenship and Immigration

a. Overview

When an applicant makes a declaration of U.S. citizenship or satisfactory immigration status and the applicant's citizenship or immigration status cannot be promptly verified using an electronic data source or acceptable documentary evidence, TennCare will grant the applicant a period of reasonable opportunity to secure valid verification. The Reasonable Opportunity Period (ROP) begins on the date of application and extends 90 days from the date the applicant receives notice of the reasonable opportunity. The date on which the applicant receives notice is considered to be 5 days after the date on the notice, unless the individual shows that he did not receive the notice within the 5-day period.

Current enrollees may be granted an ROP to secure documentary evidence of citizenship or satisfactory immigration status. An enrollee is not required to re-verify citizenship or immigration status unless he reports a change or TennCare becomes aware of a change in the individual's status, and the enrollee's citizenship or immigration status cannot be verified using an electronic data source or by acceptable documentary evidence. For current enrollees, the 90-day ROP will begin on the date that the enrollee receives notice of the ROP. The date on which the enrollee receives notice is considered to be 5 days after the date on the notice, unless the individual shows that he did not receive the notice within the 5-day period.

During the ROP, TennCare must accept a declaration of citizenship or immigration. TennCare must not delay, reduce, or terminate benefits for an applicant who is otherwise TennCare Medicaid- or CoverKids-eligible during this period.

If an applicant must provide information in addition to verification of citizenship, for example, verification of residence, she has 10 days from the day on which the notice is received to return the additional information. If verification of residence is provided within the 10 days, but verification of citizenship remains outstanding, a period of reasonable opportunity for verification of citizenship will be invoked.

b. Reasonable Opportunity Period

During the ROP, the state must assist the applicant with securing acceptable verification. This may include, but is not limited to:

- **i.** Assisting the individual in obtaining a Social Security Number;
- **ii.** Attempting to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and data from an electronic data source, and resubmit corrected information to the electronic data source;
- **iii.** Providing the individual with information on how to contact the source of the electronic data so that he can attempt to resolve such inconsistencies; and
- **iv.** Permitting the individual to provide other documentation of citizenship or immigration status, as listed in this section.

If satisfactory citizenship or immigration verification is received by the 90th day, the individual's eligibility will continue based on the initial application date and no additional action will be taken.

If citizenship or immigration verification is received during the 90-day ROP that shows that the individual is not a U.S. citizen or an eligible immigrant, eligibility may be terminated. If satisfactory citizenship or immigration verification is not received by the 90th day, eligibility will be terminated.

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QUALIFIED NON-CITIZENS

Legal Authority: 42 CFR 435.139; 42 CFR 435.406; 42 CFR 440.255; 42 CFR 457.320; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Non-citizen eligibility for TennCare Medicaid and CoverKids is limited to certain immigration statuses. In order to be eligible, an individual must be either:

a. A qualified non-citizen, as defined by Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 at 8 USC 1641;
b. An American Indian born outside of the U.S.; or
c. A non-citizen who has been granted a certain humanitarian status.

Ineligible non-citizens are potentially eligible for Emergency Medical Services (EMS) only. Ineligible non-citizens are not required to provide information regarding citizenship, immigration status or enumeration when applying for EMS.

2. Qualified Non-Citizen

The PRWORA created two categories of non-citizens for the purpose of public assistance eligibility: qualified and non-qualified (ineligible) non-citizens. A non-citizen's status is based on an individual's date of entry into the U.S. and their immigration status with the United States Citizenship and Immigration Services (USCIS).

A qualified non-citizen is an individual who belongs to one of several non-citizen categories, each of which is tied to a specific section of the Immigration and Nationality Act (INA) at 8 USC. 1101, *et seq*. Qualified non-citizens are potentially eligible for full TennCare Medicaid and CoverKids benefits just like U.S. citizens. However, certain categories of qualified non-citizens have periods of program ineligibility or time limits placed on eligibility.

Qualified non-citizens are:

a. Non-citizens lawfully admitted for permanent residence, a Lawful Permanent Resident (LPR), as an immigrant as defined in the INA (8 USC 1101);
b. Refugees admitted under Section 207 of the INA (8 USC 1157);
c. Asylees granted asylum under Section 208 of the INA (8 USC 1158);
d. Non-citizens paroled in the U.S. under Section 212(d)(5) of the INA (8 USC 1182(d)(5)) for a period of at least one year;
e. Non-citizens whose deportation is withheld under the INA (8 USC 1253 or 8 USC 1231(b)(3), as amended);
f. Battered immigrants and children who meet the conditions set forth in Section 431(c) of the PRWORA (8 USC 1641(c));

g. Cuban or Haitian entrants as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

h. Non-citizens granted conditional entry under the INA (8 USC 1153(a)(7)) in effect before April 1, 1980; and

i. Non-citizens who are victims of a severe form of trafficking or who have been granted nonimmigrant status under Section 101(a)(15)(T) of the INA or who have a pending application that sets forth a prima facie case for such nonimmigrant status.

j. Non-citizens who lawfully reside in the U.S. in accordance with the Compacts of Free Association (COFA) between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau

3. Other Eligible Immigration Statuses

The following immigration statuses are not statutorily defined as qualified non-citizens; however, these groups are generally treated like qualified non-citizens for eligibility purposes:

a. Non-citizens admitted as Amerasian immigrants under Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

b. Non-citizens who are members of a federally recognized Indian tribe as defined in the Indian Self-Determination and Education Assistance Act (25 USC 450(b)(e));

c. Non-citizens who are American Indians born in Canada to whom the INA (8 USC 1359) applies;

d. Afghan non-citizens granted Special Immigrant Status under Section 602(b) of the Afghan Allies Protection Act of 2009 as described in the INA (8 USC 1101(a)(27)); and

e. Iraqi non-citizens granted Special Immigration Status under the National Defense Authorization Act for Fiscal Year 2008 as described in the INA (8 USC 1101(a)(27)).

4. Ineligible Non-Citizens

Ineligible non-citizens are not eligible to receive full TennCare Medicaid or CoverKids benefits, but may be eligible to receive EMS.

Ineligible non-citizens include:

a. Undocumented Non-Citizens: Undocumented non-citizens are individuals who enter and reside in the U.S. without notification of or proper permission from the U.S. government.

b. Lawfully Present Non-Citizens: Lawfully present non-citizens are a specific group of non-citizens who are eligible to receive health insurance coverage through the Federally Facilitated Marketplace (FFM), but who are unable to receive TennCare Medicaid or CoverKids benefits.
Lawfully present non-citizens include:

i. Non-citizens paroled into the U.S. in accordance with 8 USC 1182(d)(5) for less than one year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

- **ii.** Non-citizens granted temporary resident status in accordance with 8 USC 1160 or 1255a;
- **iii.** Non-citizens granted Temporary Protected Status (TPS) in accordance with 8 USC 1254a and individuals with pending applications for TPS who have been granted employment authorization;
- **iv.** Non-citizens granted employment authorization under 8 CFR 274a.12(c);
- **v.** Family Unity beneficiaries in accordance with 8 USC 1182;
- **vi.** Non-citizens under Deferred Enforced Departure (DED) in accordance with a decision made by the President of the United States;
- **vii.** Non-citizens granted Deferred Action status;
- **viii.** Non-citizens granted an administrative stay of removal under 8 CFR 241;
- **ix.** Beneficiaries of approved visa petitions who have a pending application for adjustment of status;
- **x.** Individuals with a pending application for asylum under 8 USC 1158, or for withholding of removal under 8 USC 1231 or under the Convention Against Torture, who:
  1. Have been granted employment authorization; or
  2. Are under the age of 14 and have had an application pending for at least 180 days;
- **xi.** Non-citizens who have been granted withholding of removal under the Convention Against Torture (8 CFR 208.16);
- **xii.** Children who have a pending application for Special Immigrant Juvenile status as described in 8 USC 1101(a)(27)(J); and
- **xiii.** Non-citizens lawfully present in American Samoa under the immigration laws of American Samoa.

c. Non-Citizens Admitted for a Temporary Purpose

Some non-citizens are lawfully admitted to the U.S. for a temporary or specified period of time. They include foreign students, visitors, foreign government representatives on official business, crewmen on shore leave, treaty traders and investors and families, temporary workers, including agricultural contract workers, and members of the foreign press, radio, film and other media.

Examples of the types of documentation that a non-qualified or ineligible non-citizen may possess include:

- **i.** Form I-185, Canadian Border Crossing Card;
- **ii.** Form I-186, Mexican Border Crossing Card;
- **iii.** Form SW-434, Mexican Border Visitor’s Permit; and
- **iv.** Form I-95A, Crewman’s Landing Permit.

5. Five-Year Period of Ineligibility

The PRWORA established a five-year period of ineligibility for all federally funded benefits, including Medicaid and CoverKids, for certain qualified non-citizens entering the U.S. on or after August 22, 1996. The five-year period of ineligibility is not applied to qualified non-citizens admitted to the U.S. prior to August 22, 1996 who have been continuously present in the U.S. from the date of entry through the date the individual became a qualified non-citizen. An individual has been continuously present in the U.S. if the individual can demonstrate there has not been a single absence greater than 30 days or multiple absences totaling more than 90 days. Once the individual becomes a qualified non-citizen, absences from the U.S. do not impact the five-year period of ineligibility.

a. Non-Citizens Subject to the Five-Year Period of Ineligibility

The following qualified non-citizens are ineligible for TennCare Medicaid or CoverKids for a period of five years from the date they are granted qualified non-citizen status unless they meet an exception as described in 5.b.:

i. LPRs admitted under the INA, 8 USC 1101, *et seq*., after August 22, 1996;
ii. Non-citizens granted parole for at least one year under the INA (8 USC 1182(d)(5)); and
iii. Battered immigrants and children who meet the conditions set forth in Section 431(c) of the PRWORA.

A qualified non-citizen may apply for coverage once the five-year period of ineligibility expires. The five-year period of ineligibility expires on the five-year anniversary of the date the individual was granted a qualified status. Once the five-year bar expires, a qualified non-citizen may apply for benefits as if he was a U.S. citizen. No previous application is required. If the qualified non-citizen meets the technical and financial eligibility criteria for a TennCare Medicaid or CoverKids category and the five-year period of ineligibility has expired, he is eligible to receive coverage in the appropriate category as of the date of application.

A non-citizen granted parole for at least one year is considered a qualified non-citizen from the date he is granted parole. For non-citizens paroled in the U.S. for at least one year, the five-year period of ineligibility begins on the first day of the parole period.

Qualified non-citizens who are subject to the five-year bar are eligible to receive EMS and CoverKids Pregnant Woman during their period of ineligibility, if otherwise eligible.

b. Non-Citizens Exempt from the Five-Year Period of Ineligibility

The five year period of ineligibility does not apply to the following qualified non-citizens:

i. Non-citizens who are victims of a severe form of trafficking or who have been granted nonimmigrant status under Section 101(a)(15)(T) of the INA or who have a pending application that sets forth a prima facie case for such nonimmigrant status;
ii. LPRs who first entered the country under another exempt category (i.e., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or non-citizen whose deportation is being withheld and who later converted to LPR status);
iii. Non-citizens who are:
  1. Honorably discharged veterans;
  2. On active duty in the U.S. military; or

3. The spouses, the unmarried dependent children, or the unremarried surviving spouses of honorably discharged veterans or individuals on active duty in the U.S. military;

iv. Members of a federally recognized Indian tribe;

v. American Indians born in Canada to whom the INA (8 USC 1359) applies; and

vi. Non-citizens granted a specific humanitarian entrance status by the USCIS (8 U.S.C. 1612), including:
   1. Refugees and asylees;
   2. Cuban and Haitian entrants;
   3. Non-citizens whose deportation is being withheld;
   4. Amerasian immigrants; and
   5. Afghan and Iraqi non-citizens.

vii. Non-citizens who lawfully reside in the U.S. in accordance with the COFA between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau and whose immigration status is currently COFA Migrant. Once a COFA Migrant adjusts to an LPR status, the five-year period of ineligibility applies.

viii. Afghan individuals paroled into the United States between July 31, 2021 to September 30, 2022 are considered Qualified Non-Citizens to the same extent as refugees under section 207 of the Immigration and Nationality Act (8 U.S.C. 1157). They are exempt from the five-year period of ineligibility. Afghan Parolees are considered Qualified Non-Citizens until March 31, 2023 or until the end of their parole term, whichever is later. Individuals who are paroled after September 30, 2022 must either be the parent, legal guardian, spouse or child of an Afghan parolee to be considered Qualified Non-Citizens to the same extent as refugees under section 207 of the Immigration and Nationality Act (8 U.S.C. 1157).

Note: Non-citizens granted a specific humanitarian entrance status by the USCIS are exempt from the five-year bar for TennCare Medicaid and CoverKids eligibility, but they are subject to a seven-year eligibility time limit.

6. Seven-Year Eligibility Time Limit for Certain Non-Citizens

a. General Rule

Non-citizens admitted into the U.S. by the USCIS under a specific section of the INA identified below are qualified non-citizens and are potentially eligible for TennCare Medicaid and CoverKids for the first seven years after refugee, asylee, or other humanitarian status is granted.

b. Non-Citizens Subject to Seven-Year Eligibility Time Limit

Non-citizens granted a specific humanitarian status and subject to the seven-year eligibility time limit include:

i. Refugees admitted under Section 207 of the INA (8 USC 1157);

ii. Non-citizens granted asylum under Section 208 of the INA (8 USC 1158);

iii. Cuban-Haitian Entrant, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

iv. Non-citizens whose deportation is withheld under the INA (8 USC 1253) as in effect prior to April 1, 1997 or 8 USC 1231(b)(3), as amended;

v. Non-citizens admitted to the U.S. as an Amerasian Immigrant pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

vi. Afghan non-citizens granted Special Immigrant Status under Section 602(b) of the Afghan Allies Protection Act of 2009 as described in the INA (8 USC 1101(a)(27));

vii. Iraqi non-citizens granted Special Immigrant Status under the National Defense Authorization Act for Fiscal Year 2008 as described in the INA (8 USC 1101(a)(27)); and

viii. Spouses and unmarried children under age 21 of Afghan and Iraqi Special Immigrants who accompany or later join the Special Immigrant.

c. Expiration of Seven-Year Eligibility Time Limit

A non-citizen who is subject to the seven-year eligibility limit and does not have a change in immigration status or does not meet one of the exemptions listed in the following section will lose eligibility the first month after the seven-year anniversary date of entrance into the U.S. (or date that deportation was withheld under the INA (8 USC 1231 and 1253)).

d. Continuing Eligibility After the Seven-Year Eligibility Time Limit

A non-citizen who is subject to the seven-year eligibility time limit can remain eligible beyond the seven-year period if at the time of application or at any time during or after the seven-year period the USCIS determines that the non-citizen continues to be a qualified non-citizen and that she is one of the following:

i. An LPR; or

ii. An honorably discharged veteran, an active-duty member of the U.S. Armed Forces, or a spouse, an unmarried dependent child, or an unremarried surviving spouse of an honorably discharged veteran or active-duty member of the U.S. Armed Forces.

e. Adjustment to LPR Status within Seven-Year Eligibility Period

A qualified non-citizen subject to the seven-year eligibility time limit can adjust his status to LPR within the seven-year period. Non-citizens who adjust to LPR status within the seven-year period are not subject to the five-year bar and remain potentially eligible for benefits as an LPR beyond the seven-year period of eligibility.

7. Victims of Trafficking

The Trafficking Victims Protection Act (TVPA) of 2000 allows victims of human trafficking and non-citizens classified as nonimmigrants under Section 101(a)(15)(T) of the INA who are physically present in the U.S. to receive federally funded benefits and services to the same extent as refugees. Victims of human trafficking are non-citizens who are eligible to receive a special visa and benefits once they are identified.

a. Assistance Available to Victims of Human Trafficking

Adult victims of human trafficking who are certified by the U.S. Department of Health and Human Services (HHS) and are otherwise eligible may receive Medicaid in any Medicaid category available. Children under age 18 do not have to be certified by HHS to receive benefits. For an adult victim of trafficking to receive certification, she must:

- **i.** Be a victim of human trafficking as defined by the TVPA or a non-citizen classified as a nonimmigrant under Section 101(a)(15)(T) of the INA;
- **ii.** Be willing to assist with the investigation and prosecution of traffickers; and
- **iii.** Have completed a bona fide application for a T Visa that has not been denied, or have received continued presence status from the U.S. Department of Homeland Security.

b. The T Visa - Under the TVPA of 2000

The T Visa was established to allow victims of severe forms of trafficking to become temporary residents of the U.S. The Trafficking Victims Protection Act recognizes that returning victims to their country of origin is often not in the best interest of victims and those victims need the opportunity to rebuild their lives without the threat of deportation. After three years since the first date of admission as a T-1 nonimmigrant, a recipient of a T Visa may be eligible for permanent residence status if he:

- **i.** Is a person of good moral character;
- **ii.** Has complied with any reasonable request for assistance in the investigation during the three-year period; and
- **iii.** Will suffer extreme hardship if removed from this country.

c. The Certification Process

The certification process typically takes a few days after HHS is notified that a person has made a bona fide T Visa application or has been granted continued presence status (both of these actions are completed by the U.S. Department of Homeland Security). If the status of a person who has received HHS certification changes so that they are no longer eligible, HHS may be required to decertify that individual.

d. Verification of Victim Certification

A toll-free number can be used to verify victims of trafficking: 1-866-401-5510. Before victims can receive benefits, the Eligibility Specialist must call the toll-free trafficking victim verification line to verify the validity of the certification letter and to inform HHS that the individual has applied for program benefits.

8. Battered Immigrants and Children

a. Battered Immigrant Defined

Certain immigrants who have been subjected to battery or extreme cruelty in the U.S. by a family member with whom they reside are qualified non-citizens and are potentially eligible for TennCare Medicaid and CoverKids. The non-citizen must be either:

- **i.** The individual battered; or
- **ii.** The parent of a child who is battered; or
- **iii.** A child whose parent has been battered.

A family member includes a spouse, parent, or member of the spouse or parent's family residing in the same household.

If admitted to the U.S. on or after August 22, 1996, a battered immigrant and/or child is subject to the five-year period of ineligibility for TennCare Medicaid and CoverKids benefits. The five-year period of ineligibility begins on the date she obtains qualified non-citizen status.

b. Eligibility Conditions

In order to be considered as a qualified non-citizen and become potentially eligible for TennCare Medicaid (subject to five-year bar) or CoverKids (subject to five-year bar), a battered immigrant must meet all of the requirements provided below.

- **i.** The immigrant has been approved or has a pending petition which sets forth a prima facie case for:
  - **1.** Immigrant status as a battered spouse or child of a U.S. citizen or LPR (Form I-360);
  - **2.** Immediate Relative status (Form I-130);
  - **3.** Cancellation of removal pursuant to 8 U.S.C. 1229b(b)(2); or
  - **4.** Suspension of deportation and adjustment to LPR status;
- **ii.** The immigrant must show that there is a substantial connection between such battery or cruelty and the need for benefits; and
- **iii.** The immigrant must no longer be residing in the same household as the abuser.

Battered immigrants may be granted good cause for non-cooperation with child support when cooperation requires the involvement of the abuser.

9. American Indians

An Indian born in Canada who is at least one-half American Indian blood may enter and reside lawfully in the U.S., but this does not extend to the spouse or child of the Indian unless the child or spouse is also at least one-half American Indian. An Indian meeting the above criteria may be eligible for full TennCare Medicaid coverage if all other eligibility requirements are met.

The following documents may be used to verify an Indian is at least one-half American Indian blood:

i. Birth or baptismal certificate issued on reservation;
ii. Tribal record;
iii. Letter from the Canadian Department of Indian Affairs; or
iv. School records.

Document Title	Qualified Non-Citizens
First Published	12.03.2014

Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
08.01.2016	1-3.; 5.; 6.b.; 6.d.; 7.	Policy Statement; Qualified Non-Citizen; Other Eligible Immigration Statuses; Five-Year Period of Ineligibility; Non-Citizens Subject to 7-Year Eligibility Time Limit; Continuing Eligibility After the 7-Year Limit; Victims of Trafficking	1-2; 4-7	Policy Clarification	AJ
01.03.2018	1.; 3-5.; 7.; 9.	Policy Statement; Other Eligible Immigration Statuses; Ineligible Non-Citizens; Five Year Period of Ineligibility; Victims of Trafficking; American Indians	1-5; 7-9	Non-Substantive Change	JH
01.03.2018	2.; 8.	Qualified Non-Citizen; Battered Immigrants and Children	1-2; 8-9	Policy Clarification	JH
01.03.2018	6.	Seven Year Eligibility Time Limit for Certain Non-Citizens	5-7	Policy Change	JH
03.18.2019	5.a.	Legal Authority; Non-Citizens Subject to the Five-Year Period of Ineligibility	4	Policy Clarification	TB
10.01.2021	2.j.; 5.b.vii.	Qualified Non-Citizens; Non-Citizens Exempt from the Five-Year Period of Ineligibility	2, 5	Policy Change	KF
05.02.2022	5.b.vii; 6.	Qualified Non-Citizens; Non-Citizens Exempt from the Five-Year Period of Ineligibility	5	Policy Change	SA

ENUMERATION

Legal Authority: 42 CFR 435.910

1. Policy Statement

Enumeration is the procedure by which the Social Security Administration (SSA) assigns and verifies Social Security Numbers (SSNs). As a condition of eligibility for TennCare Medicaid and CoverKids, applicants who are eligible to receive an SSN must provide HCFA with:

- A valid SSN; or
- The SSN application date, if the individual's SSN is unknown or a number has never been issued.

Benefits will not be delayed or denied to otherwise eligible individuals pending issuance or verification of an SSN by the SSA.

By law, non-applicants are not required to provide their SSN. HCFA can request a non-applicant's SSN under the following conditions:

- When provision of the SSN is voluntary; and
- HCFA provides clear notice to the individual that provision of the non-applicant's SSN is voluntary and information about how the SSN will be used.

2. Notification of the Enumeration Requirement

Individuals will receive notification of the regulation requiring that they furnish an SSN when applying for TennCare Medicaid and CoverKids and how the SSN will be used. Individuals will be informed that:

- They are only required to furnish an SSN for the individuals in their household applying for benefits. Provision of a non-applicant's SSN is voluntary;
- Each applicant's SSN will be used to verify program eligibility, income and the amount of medical assistance payments received;
- This is a requirement of the state and federal government;
- Failure to furnish an SSN or proof that the individual has applied can result in that individual's ineligibility.

If an applicant does not have an SSN or the SSN is questionable, the agency will provide the individual with information about how to obtain an SSN through the SSA.

3. Children Less than 1 Year of Age

A newborn can be added to their mother's case without waiting for the enumeration process to conclude. In most situations, the enumeration process (completion of SS-5 application, which is the application for a Social Security card) now occurs for newborns at the hospital. Newborns must be enumerated by age one, or before they can be approved in another TennCare Medicaid or CoverKids category, whichever occurs first.

4. Refusal to Obtain as SSN

If an applicant fails or refuses to provide an SSN, then that individual is not eligible to receive benefits, unless he or she meets an exception or is a legal alien who is not eligible for an SSN.

a. Exceptions

i. Religious Objection

An applicant may refuse to obtain an SSN because of a well-established religious objection. A well-established religious objection means that the applicant:

- Is a member of a recognized religious sect or division of that sect; and
- Adheres to the teachings of the sect or division of that sect and for that reason is opposed to applying for or using an SSN.

HCFA will provide a Medicaid identification number to an applicant who refuses to obtain an SSN due to a well-established religious objection. The Medicaid identification number will not be able to be used for eligibility verification purposes.

5. Enumeration of Legal Immigrants

The Affordable Care Act amended the enumeration requirement for individuals who are not eligible for a regular SSN. Legal immigrants who are ineligible for a work-related or regular SSN are not required to obtain a non-work SSN for the purpose of TennCare Medicaid or CoverKids eligibility. The SSA will continue to issue SSNs for people who do have work authorization when an SSN is required to obtain other program benefits. However, a non-work SSN cannot be used to obtain data from other programs or agencies to verify eligibility for TennCare Medicaid or CoverKids.

Legal immigrants who are not eligible for a regular SSN must still meet the citizenship and immigration requirements, as well as all other conditions of eligibility, in order to receive TennCare Medicaid or CoverKids benefits.

6. Verification

a. Individuals With an SSN

SSNs will be verified by the SSA via the Federal Data Services Hub (the Hub). If the Hub is unavailable, the state will verify the SSN using the State Verification Exchange System (SVES) daily interface. If the Hub or another electronic data source, such as the State On-Line Query (SOLQ), is unable to verify an individual's SSN or validates the SSN as someone else's SSN, the state must first address any possible discrepancies with the SSN that was entered. If the individual's SSN cannot be verified, the state will notify the applicant and request a copy of the individual's Social Security card in order to verify the individual's SSN.

b. Individuals Without an SSN

Individuals who report not having an SSN, but who are eligible to obtain a work-related SSN must apply for an SSN prior to approval for TennCare Medicaid or CoverKids. Acceptable verification of an application for an SSN is a copy of Form SS-5.

c. Individuals Ineligible for a Work-Related SSN

If an individual attests that he or she is ineligible for a work-related SSN and the U.S. Department of Homeland Security has verified his or her immigration status, the Eligibility Specialist will make note of the exception in the individual's case record. Non-work SSNs should not be used when applying for TennCare Medicaid or CoverKids since these cannot be used for verification.

AGE

Legal Authority: 42 CFR 435.945; 42 CFR 435.952; 42 CFR 435.956

1. Policy Statement

In order to be eligible for TennCare Medicaid or CoverKids, an individual must meet the age requirement of the specific TennCare Medicaid or CoverKids category.

2. Verification

HCFA accepts self-attestation of the applicant's age, unless the HCFA has information that is not compatible with the attested information. If there is reason to believe that the attested age is incorrect, the state will attempt to verify the age of the individual using specific electronic data sources. If the individual's age is unable to be electronically verified, then acceptable documentary evidence of age must be provided.

a. Electronic Data Source

The following is a list of electronic data sources that may be used to verify the age of an applicant:

- Federal Data Services Hub (Hub);
- Social Security Administration interface; and
- Tennessee Vital Statistics.

b. Documentary Evidence

The following is a list of acceptable documentary evidence of age:

- A birth certificate;
- Birth verification;
- Census Bureau records;
- Immigration record;
- An insurance policy;
- A passport; and
- Proof of entitlement to Social Security benefits based on age.

If none of the examples of documentary evidence listed above can be provided, HCFA will accept a statement from the applicant which reasonably explains the discrepancy.

UNBORN STATUS

Legal Authority: 42 CFR 435.603; 42 CFR 435.956

1. Policy Statement

An unborn child is included in the household size of a pregnant woman when determining financial eligibility for TennCare Medicaid and CoverKids. An unborn child is not included in the household size when determining eligibility of family members of a pregnant woman, including the pregnant woman's spouse and other children in the household. When there is more than one fetus, each unborn child will be counted when determining the household size for the mother.

Unborn children are not eligible to receive TennCare Medicaid benefits. Once a child is born, he or she is eligible for benefits in the Deemed Newborn category up to age 1 from the date of birth as long as the mother was eligible for and receiving TennCare Medicaid at the time of the child's birth.

2. Verification

The State accepts self-attestation of pregnancy at application or as a reported change, unless the State has information that is not reasonably compatible with such attestation. If the state has information that is not reasonably compatible with an attested pregnancy, the state will contact the individual and may request written medical verification of the pregnancy.

Acceptable written medical verification of pregnancy has the following characteristics:

- Prepared and signed by medical personnel including but not limited to a physician, nurse, health clinic, or other medical paraprofessional; and
- The written verification bears a current date and includes at least an estimated date of delivery, if not a date of conception.
- If a woman attests that she is pregnant with multiple children, and the state has reason to believe that the woman has provided false information, then acceptable written medical verification of the pregnancy must also include confirmation of the number of fetuses.

COOPERATION WITH CHILD SUPPORT SERVICES

Legal Authority: 42 CFR 433.147

1. Policy Statement

To be eligible for TennCare Medicaid in the Caretaker Relative category, an individual must agree to cooperate with the state in establishing paternity of a child born out of wedlock and in obtaining medical support and payments for himself or herself and anyone for whom the individual can legally assign rights. Individuals who refuse to agree or fail to demonstrate cooperation with the state will no longer be eligible for TennCare Medicaid, unless the state has granted them good cause for failure to cooperate.

2. Definitions

Assignment of Rights: When an applicant or an authorized representative signs an application, he or she agrees to the following:

- His or her right to any medical support or payment for medical expenses is assigned or given to the state;
- The State may receive reimbursement from any third party for any medical expenditure made by HCFA on the enrollee's behalf; and
- The enrollee is required to return to the state any support or payments for medical expenses he or she received from a third party.

Cooperation with the State: The individual is required to provide the state any and all information necessary to establish paternity or obtain medical support or payment, if requested, unless good cause exists, and to attest to lack of information under penalty of perjury per 42 CFR 433.147(b)(3).

Medical Support: Medical support is financial support available to an individual for his or her medical expenses.

3. Exemptions from Cooperation Requirements

The following are exempt from child support cooperation requirements:

- Women eligible in the Pregnant Woman/Pregnancy MAGI category;
- A minor parent or caretaker who is eligible in a children's category;
- Single parent adoptions;
- The absent parent is deceased;
- A parent or caretaker whose only child receives Supplemental Security Income; and
- A parent or caretaker determined to have good cause for refusal to cooperate with Child Support Services.

4. Good Cause for Refusal or Failure to Cooperate with Child Support Services

Good cause can be granted for refusal or failure to cooperate with Child Support Services when the Department of Child Support Enforcement Services determines that cooperation is against the best interests of the child. Examples of when cooperation is not in the child's best interest include when:

- Cooperation may result in physical or serious emotional harm to the child; or
- Cooperation may result in physical or serious emotional harm to the caretaker; or
- A child was conceived as a result of incest or rape; or
- Adoption proceedings are pending for the child.

5. Refusal to Agree to Cooperate with Child Support Services

If an applicant refuses to agree to cooperate or an enrollee refuses to cooperate in establishing paternity or obtaining medical support and payments, the individual is not eligible for TennCare Medicaid and if enrolled, eligibility will be terminated.

6. Verification

Individuals are considered to be cooperating if, at the time of application, they agree to cooperate with Child Support Services.

DEATH

Legal Authority: 42 CFR 435.919; 42 CFR 431.213

1. Policy Statement

Eligibility for TennCare Medicaid and CoverKids will be terminated once an enrollee's death has been verified. Advance notice of action is not required if TennCare has factual information confirming the death of a beneficiary.

2. Verification

a. Notification of Death From the Enrollee's Family or Representative

If an enrollee's family member or representative reports an unverified date of death, verification of the death must be obtained. Verification can be obtained electronically by staff through Vital Statistics Inquiry or State On-Line Query Inquiry (SOLQi). When TennCare is unable to verify a date of death electronically, a hard copy of the obituary or death certificate, or a statement from a funeral home or medical provider is considered acceptable verification.

b. Notification of Death Through an Electronic Interface

TennCare accepts a date of death received electronically from Vital Statistics and such date will be applied systematically without requiring any additional verification. If the State receives a date of death through the State Verification and Exchange System (SVES), additional verification of death must be obtained. Additional verification can either be obtained electronically through Vital Statistics Inquiry or SOLQi. When additional verification is not available through Vital Statistics Inquiry or SOLQi, a hard copy of the obituary or death certificate or a statement from a funeral home or medical provider may be used as verification of death.

Document Title	Death
First Published	10.28.2014

Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
04.01.2015		Legal Authority	1	Policy Clarification	AF
04.01.2015	1.	Policy Statement	1	Policy Clarification	AF
03.18.2019	2.	Verification	1	Policy Clarification, Non-Substantive Change	AJ

OVERVIEW OF FINANCIAL ELIGIBILITY

1. Overview

The Affordable Care Act (ACA) requires that financial eligibility for certain TennCare Medicaid categories and CoverKids be determined using the Modified Adjusted Gross Income (MAGI) methodology. Implementation of the MAGI methodology eliminates former references to AFDC/TANF policies and procedures for the applicable MAGI categories. The MAGI methodology is based on federal tax rules for determining adjusted gross income.

In general, the MAGI methodology is defined by the following characteristics:

a. Financial eligibility is based on current monthly household income and Eligibility Determination Group (EDG) size;
b. Taxable income is countable income;
c. Non-taxable income is excluded income;
d. There is no asset or resource test;
e. There is a 5% disregard applied to income calculations when the disregard matters for determinations of eligibility; and
f. EDG size is determined by the principles of tax dependency.

2. Purpose

The ACA amended federal laws so that one eligibility determination methodology is used across all Insurance Affordability Programs: Medicaid, Children's Health Insurance Programs (CHIP), referred to as CoverKids in Tennessee, and the Advance Premium Tax Credits (APTC) offered through the state and federal Exchanges. Minor differences exist between the Medicaid/CHIP and the APTC MAGI methodologies, but in general, the methodologies yield similar outcomes when determining financial eligibility.

3. Federally-Required MAGI Eligibility Categories

The ACA requires that the MAGI methodology, as written in federal regulations, be applied to the following categories:

a. Child MAGI 0-1;
b. Child MAGI 1-5;
c. Child MAGI 6-18;
d. Caretaker Relative MAGI;
e. Presumptive Pregnancy;
f. Pregnancy MAGI;
g. Extended Medicaid;
h. Transitional Medicaid;
i. Hospital Presumptive Eligibility (HPE);

j. CoverKids Child; and

k. CoverKids Pregnant Woman.

Document Title	Overview of Financial Eligibility				
First Published	06.04.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	1.a.; 1.f.; 2; 3.a.-k.	Overview; Purpose; Federally-Required MAGI Eligibility Categories	1-2	Policy Clarification	JH

INCOME OVERVIEW

Legal Authority: 42 CFR 435.603; Tenn. Comp. R. & Regs. 1200-13-20

1. The MAGI Methodology and Insurance Affordability Programs

The Affordable Care Act (ACA) requires that financial eligibility for all insurance affordability programs be determined using the Modified Adjusted Gross Income (MAGI) methodology. This means that for certain Medicaid categories, the Children's Health Insurance Program (CHIP, or CoverKids in Tennessee) and the Advance Premium Tax Credits (APTCs) offered on the Exchange, household income determined using the MAGI methodology will apply across all three programs. The primary difference with income counting rules for the three programs is that Medicaid and CHIP determine eligibility based on monthly income, while the Exchange uses annual income to determine APTC eligibility.

MAGI methodology is based on federal tax rules. In general, when determining eligibility, taxable income is counted and non-taxable income is excluded. Expenses that are allowed under federal tax rules are allowed in Medicaid eligibility determinations. The MAGI methodology also eliminates the use of disregards based on household characteristics, e.g. the earned income disregard. A general 5% disregard of household income is permitted, but only if it impacts eligibility. See the *Expenses* and *The 5 Percent FPL Disregard for MAGI* policies.

2. General Income Types

Income types that are generally countable for TennCare Medicaid, TennCare Standard and CoverKids coincide with income types that are reported under the Income section on IRS Form 1040. Countable income under the MAGI methodology includes the following:

- **a.** Jobs (Wages, tips, etc.)
- **b.** Investment Income
- **c.** Alimony Received
- **d.** Self-employment
- **e.** Capital Gains
- **f.** IRA Distributions
- **g.** Pensions/Annuities
- **h.** Rental or Royalty Income
- **i.** Farming/Fishing Income
- **j.** Unemployment Compensation
- **k.** Social Security benefits
- **l.** Retirement
- **m.** Other income:
  - **i.** Canceled debts
  - **ii.** Court awards
  - **iii.** Jury Duty pay

iv. Cash Support
v. Gambling, prizes or awards

3. Exceptions

The MAGI methodology is used to determine income eligibility for all insurance affordability programs: Medicaid, CHIP (CoverKids) and the APTCs offered through the Exchange. The income counting rules are generally the same, except for 3 types of income (retained Medicaid policy):

a. Amounts received as lump sums are counted as income only in the month received;
b. Scholarships, awards or fellowship grants used for education purposes and not for living expenses are excluded from income; and
c. American Indian/Alaska native exceptions.

4. Medicaid Safe Harbor

Legal Authority: 42 CFR 435.603(i)

If an individual is determined financially ineligible for a MAGI TennCare Medicaid category, and is then determined to have household income below 100 percent FPL by the Federally Facilitated Marketplace (FFM), Medicaid financial eligibility will be determined in strict accordance with the income counting rules in the FFM.

Income determinations for Medicaid Safe Harbor individuals is accepted as determined by the FFM and TennCare Medicaid eligibility is granted as long as the individual meets all non-financial requirements.

5. Counting Income

Eligibility is determined based on monthly income. All income must be converted to a monthly figure. The following formulas are used to convert income to a monthly amount.

a. Hourly Work: Multiply the hourly wage by the number of hours the individual worked or is expected to work in a week to determine the weekly earnings figure.

b. Weekly Income: Multiply weekly income by 4.3333 to determine monthly income.

c. Bi-Weekly Income: Multiply the amount received every two weeks by 2.1666 to determine the monthly amount.

d. Semi-Monthly Income: Add the two semi-monthly amounts together to determine the monthly amount.

e. Annual Income: Divide the full amount of annual income by 12 to determine the average monthly amount.

6. Loss of Income

Self-attested loss of income is accepted, unless there is reason to suspect the income is still being received by the individual. See the *Verification* policy.

Document Title	Income Overview				
First Published	06.04.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	1.	The MAGI Methodology and Insurance Affordability Programs	1	Non-Substantive Change	RZ
03.18.2019	2.; 6.	General Income Types; Loss of Income	1; 3	Policy Clarification	RZ
05.01.2019	5.b.; 5.c.	Legal Authority; Counting Income	1-2	Policy Clarification	TN

ELIGIBILITY DETERMINATION GROUP FOR MAGI

Legal Authority: 42 CFR 435.603; 42 CFR 435.956

1. Policy Statement

Eligibility Determination Group (EDG) for TennCare Medicaid (Child, Pregnant Women and Caretaker Relative categories) and the CoverKids categories will be determined using the Modified Adjusted Gross Income (MAGI) methodology. MAGI EDG methodology is based on federal tax rules and the principles of tax dependency, however the MAGI rules apply to both applicants who expect to file taxes or be claimed as a tax dependent, and to those applicants who do not file taxes or are not claimed as tax dependents. Each applicant has her own EDG constructed under MAGI rules and it is permissible for applicants who live in the same household to have different EDG sizes.

MAGI EDG methodology allows for inclusion of individuals in an applicant's EDG who, under previous EDG rules, would have been excluded. Individuals who may be included in the applicant's EDG include: Supplemental Security Income (SSI) Recipients, IV-E Adoption Subsidy and Foster Care recipients, and individuals under the age of 19 who are legally married or have been emancipated.

2. Definitions

Custodial Parent and Non-Custodial Parent: The custodial parent and non-custodial parent are determined based on a court order, binding separation, divorce, or parenting plan establishing physical custody controls. The custodial parent, also known as the primary residential parent, is the parent with whom the child spends most nights.

Eligibility Determination Group Size (EDG): EDG size includes the number of persons counted as members of an individual's EDG based on the tax household or non-filer household rules. EDG size is a factor in determining what income standard is used.

Parent: Parent includes natural or biological, adopted or stepparents.

Sibling: Sibling includes natural or biological, adopted, half or stepsiblings.

Tax Dependent: Individuals for whom another person, the tax filer, claims a deduction for a personal exemption in a taxable year. For eligibility purposes, tax dependents are individuals who expect to be claimed as such by another tax payer for the taxable year in which an eligibility determination is made.

Tax Filer: An individual who expects to file a tax return for the taxable year in which an eligibility determination is made. A tax filer does not expect to be claimed as a tax dependent by another person.

Tax Household: Tax filer (includes married couples filing jointly) and all claimed dependents.

Tax Filing Threshold: An annual income amount set by the Internal Revenue Service (IRS) that determines whether an individual is required to file income taxes. The threshold varies by age, marital status and the number of tax dependents claimed.

Non-Filer: An individual who does not expect to file a tax return or be claimed as a tax dependent for the taxable year in which an eligibility determination is made.

3. Eligibility Determination Group

There are 2 sets of EDG rules under MAGI methodology. Tax filer rules are for applicants who file taxes or are claimed as tax dependents. Non-filer rules are for those applicants that do not file taxes, are not claimed as tax dependent, or meet a tax dependent exception.

NOTE: EDG is determined on an individual basis from the perspective of each individual. It is possible for household members to have different EDG sizes when determining eligibility. It is also worth noting that for individuals included in the EDG of his natural, adopted or step parents that do not meet the tax filing threshold should not have income included in EDG income whether or not the individual files a tax return.

4. Tax Filers

a. General Rule

For applicants who expect to file taxes, the EDG includes the tax filer and any dependents the tax filer expects to claim.

b. Tax Dependents

For applicants claimed as tax dependents, the EDG is the same as the tax filer claiming the tax dependent. Tax dependents may include individuals not otherwise eligible for TennCare Medicaid or CoverKids, and who are not applying for benefits. If a non-custodial parent claims a child as a dependent, the dependent child will be included in the non-custodial parent's EDG.

c. Spouses

Spouses who file joint taxes are both considered tax filers. For married couples who live together, each spouse will always be included in the other spouse's EDG, regardless of the couple's tax filing status. Spouses who expect to file joint taxes but live separately will be included in each other's EDG.

d. Tax Filer Household

The following would be included in the tax filer's household:

i. The tax filer;

ii. All individuals whom the tax filer expects to claim as a tax dependent;
iii. The tax filer's spouse if living in the household, regardless of whether the couple expects to file jointly or separately; and
iv. The tax filer's spouse, if not living in the home, when the couple expects to file jointly.

Reminder: The tax dependent's EDG is the same as the tax filer that claims the tax dependent.

e. Tax Dependent Exceptions

There are 3 exceptions to the general rule for applicants claimed as tax dependents. An applicant who meets any of the following is subject to the non-filer household rules:

i. The tax filer is someone other than the applicant's spouse, or natural, adopted or step parent;
ii. The applicant is under age 19, or 21 if a full-time student, and is claimed as a tax dependent by one parent, but her parents live together (and do not file a joint tax return); or
iii. The applicant is under age 19, or 21 if a full-time student, and expects to be claimed as a tax dependent by a non-custodial parent.

5. Non-Filers and Applicants Not Claimed as Tax Dependents

Applicants who do not expect to file taxes and are not claimed as tax dependents by another tax payer or applicants that meet one of the three tax dependent exceptions are subject to non-filer household rules.

For applicants subject to the non-filer household rules, the EDG includes the applicant and if living with the applicant:

a. The applicant's spouse;
b. The applicant's natural, adopted and stepchildren under age 19, or 21 if a full time student;
c. For applicants under age 19, or 21 if a full time student, the applicant's natural, adopted or step-parent; and
d. For applicants under age 19, or 21 if a full-time student, the applicant's natural, adoptive and stepsiblings who are under age 19, or 21 if a full-time student.

6. Pregnant Women

When determining EDG size for a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. When determining EDG size for other applicants in the household, the pregnant woman is counted as one person.

7. Joint Custody/Parenting Time

a. Joint Custody/Parenting Time

For the purpose of determining Medicaid eligibility, the custodial parent, often referred to as the primary residential parent in Tennessee, is established based on physical custody specified in a court order, binding separation, divorce, or parenting plan. If there is no court order or parenting plan, custody of a child born out of wedlock is with the mother. If there is a parenting plan, the primary residential parent is the parent with whom the child spends most nights.

b. Equally-Shared Joint Custody/Parenting Time

When an individual claims that equally-shared (50/50) joint physical and legal custody exists or provides a parenting plan that evenly divides the child(ren)'s living arrangement and parenting responsibilities, the parenting time situation must be carefully examined. Though a court order or parenting plan may evenly divide the care and control of the child(ren), the parents may not, in fact, be following the parenting plan.

In cases of alleged equal parenting time (50/50):

i. Both parents exercise parental guidance.

Parental guidance may include issues such as which parent takes children to and from school and/or day care, which parent does the school and/or daycare consider the responsible relative, who exercises responsibility for consenting to major medical treatment for the child, etc.

ii. Parents equally share physical custody.

If one parent has the child(ren) a majority of the time, this is not considered equally shared parenting time. Child(ren) must spend an equal amount of time living with each parent. The living arrangement may be based on days, weeks or months, but it must be equal (182.5 days per year with each parent) and parental functions of guidance and physical care cannot be substantially interrupted. (If equal time means 6 months at a time are spent with each parent, this will be considered extended visits. Eligibility for the parent ceases when the child is with the other parent.)

If it is determined that equal (50/50) parenting time exists, staff should contact the Member Services Eligibility Policy Unit for additional guidance on processing the case.

8. Verification

The State accepts self-attestation of EDG members, relationship between the EDG members, and tax filing intentions.

9. Eligibility Determination Group Procedures

When determining household size, an EDG must be constructed for each applicant in the household. The applicant's EDG is based on the tax filing status of the applicant.

a. Does the applicant expect to file taxes?

i. If No – Continue to 9.b.
ii. If Yes – Does the applicant expect to be claimed as a tax dependent by another person?

1. If No – The EDG is the same as the tax filer.
2. If Yes – Does the applicant meet any of the tax dependent exceptions listed in 4.e.?

   a. If No – The applicant's EDG is the same as the tax filer.
   b. If Yes – The applicant's EDG is based on non-filer rules.

b. Does the applicant expect to be claimed as a tax dependent?

i. If No – The applicant's EDG is based on non-filer rules.
ii. If Yes – Does the applicant meet any of the tax dependent exceptions listed in 4.e.?

1. If No – The applicant's EDG is the same as the tax filer.
2. If Yes – The applicant's EDG is based on non-filer rules.

10. Eligibility Determination Group Examples

a. Mary's Family

Mary (35), Mary's son Jeff (15) and Mary's daughter Kayla (12) live in the household. Mary claims all as tax dependents.

i. Mary's EDG

Does Mary expect to file taxes? Yes
Does Mary expect to be claimed as a tax dependent? No
Mary's EDG is her tax household: Mary, Jeff and Kayla (EDG= 3)

ii. Jeff's EDG

Does Jeff expect to file taxes? No
Does Jeff expect to be claimed as a tax dependent? Yes
Does Jeff meet any of the tax dependent exceptions? No
Jeff's EDG is same as the tax filer who claims him as a dependent: Mary, Jeff and Kayla (EDG= 3)

iii. Kayla's EDG

Does Kayla expect to file taxes? No
Does Kayla expect to be claimed as a tax dependent? Yes
Does Kayla meet any of the tax dependent exceptions? No
Kayla's EDG is the same as the tax filer who claims her as a dependent: Mary, Jeff and Kayla (EDG= 3)

b. John's Family

John (28), John's son Bill (8) and John's nephew Stephen (14) live in the household. John claims all as tax dependents.

i. John's EDG

Does John expect to file taxes? Yes
Does John expect to be claimed as a tax dependent? No
John's EDG is the tax household: John, Bill and Stephen (EDG= 3)

ii. Bill's EDG

Does Bill expect to file taxes? No
Does Bill expect to be claimed as a tax dependent? Yes
Does Bill meet any of the tax dependent exceptions? No
Bill's EDG is the same as the tax filer who claims him as a tax dependent: John, Bill and Stephen (EDG= 3)

iii. Stephen's EDG

Does Stephen expect to file taxes? No
Does Stephen expect to be claimed as a tax dependent? Yes
Does Stephen meet any of the tax dependent exceptions? Yes – Stephen expects to be claimed by someone other than a spouse or a natural, adopted or stepparent. Non-filer rules apply.
Stephen's EDG: Stephen (EDG= 1)

c. Rose's Family

Rose (51), Rose's daughter Stephanie (26) and Stephanie's daughter Jill (3) live in the household. Rose claims all as tax dependents.

i. Rose's EDG

Does Rose expect to file taxes? Yes
Does Rose expect to be claimed as a tax dependent? No
Rose's EDG is her tax household: Rose, Stephanie and Jill (EDG= 3)

ii. Stephanie's EDG

Does Stephanie expect to file taxes? No
Does Stephanie expect to be claimed as a tax dependent? Yes
Does Stephanie meet any of the tax dependent exceptions? No
Stephanie's EDG is the same as the tax filer who claims her as a dependent: Rose, Stephanie and Jill (EDG= 3)

iii. Jill's EDG

Does Jill expect to file taxes? No
Does Jill expect to be claimed as tax dependent? Yes
Does Jill meet any of the tax dependent exceptions? Yes – Jill is claimed as a tax dependent by someone other than a spouse or natural, adopted or stepparent. Non-filer rules apply.
Jill's EDG: Stephanie and Jill (EDG= 2)

d. Barbara's Family

Barbara (25), her son Alex (5) and her daughter Joy (1) live in the household. Barbara claims Joy as a tax dependent. Her son Alex is claimed as a tax dependent by his father (non-custodial).

i. Barbara's EDG

Does Barbara expect to file taxes? Yes
Does Barbara expect to be claimed as a tax dependent? No
Barbara's EDG is the same as her tax household: Barbara and Joy (EDG= 2)

ii. Alex's EDG

Does Alex expect to file taxes? No
Does Alex expect to be claimed as a tax dependent? Yes

Does Alex meet any of the tax dependent exceptions? Yes – Alex is claimed as a tax dependent by his father. Non-filer rules apply.
Alex's EDG: Barbara, Alex and Joy (EDG= 3)

iii. Joy's EDG

Does Joy expect to file taxes? No
Does Joy expect to be claimed as a tax dependent? Yes
Does Joy meet any of the tax dependent exceptions? No
Joy's EDG is the same as same as the tax filer who claims her as a dependent: Barbara and Joy (EDG= 2)

Note: If Alex's father applies for TennCare Medicaid, his EDG under the MAGI methodology will include himself, Alex and any other individuals he claims as tax dependents.

e. Joe's Family

Joe (42), his girlfriend Sarah (39), his son Damon (14), her daughter Kate (9), and their son Ben (6) live in the household. Joe and Sarah file taxes separately. Joe claims Damon and Ben as tax dependents, and Sarah claims Kate as a tax dependent.

i. Joe's EDG

Does Joe expect to file taxes? Yes
Does Joe expect to be claimed as a tax dependent? No
Joe's EDG is his tax household: Joe, Damon and Ben (EDG= 3)

ii. Sarah's EDG

Does Sarah expect to file taxes? Yes
Does Sarah expect to be claimed as a tax dependent? No
Sarah's EDG is her tax household: Sarah and Kate (EDG= 2)

iii. Damon's EDG

Does Damon expect to file taxes? No
Does Damon expect to be claimed as a tax dependent? Yes
Does Damon meet any of the tax dependent exceptions? No
Damon's EDG is the same as the tax filer who claims him as a dependent: Joe, Damon and Ben (EDG= 3)

iv. Kate's EDG

Does Kate expect to file taxes? No
Does Kate expect to be claimed as a tax dependent? Yes
Does Kate meet any of the tax dependent exceptions? No
Kate's EDG is the same as same as the tax filer who claims her as a dependent: Sarah and Kate (EDG= 2)

v. Ben's EDG

Does Ben expect to file taxes? No
Does Ben expect to be claimed as a tax dependent? Yes
Does Ben meet any of the tax dependent exceptions? Yes – Ben is claimed as a tax dependent by one parent (Kate) but he lives with both of his parents. Non-filer rules apply.
Ben's EDG: Joe, Sarah, Damon, Kate and Ben (EDG= 5)

f. Marcia's Family

Marcia (45), her husband George (50), her son Trent (16), his son Jack (22) and their daughter Beth (14) are in the household. Marcia files taxes and claims her son as a tax dependent. George files taxes and claims Jack and Beth as tax dependents.

i. Marcia's EDG

Does Marcia expect to file taxes? Yes
Does Marcia expect to be claimed as a tax dependent? No
Marcia's EDG is her tax household plus her spouse: Marcia, George and Trent (EDG= 3)

ii. George's EDG

Does George expect to file taxes? Yes
Does George expect to be claimed as a tax dependent? No
George's EDG is his tax household plus his spouse: Marcia, George, Jack and Beth (EDG= 4)

iii. Trent's EDG

Does Trent expect to file taxes? No
Does Trent expect to be claimed as a tax dependent? Yes
Does Trent meet any of the tax dependent exceptions? Yes. Trent is claimed as a tax dependent by one parent but he lives with both of his parents. Parent includes step-parent. Non-filer rules apply.

Trent's EDG is: Marcia, George, Beth and Trent (EDG= 4)

iv. Jack's EDG

Does Jack expect to file taxes? No
Does Jack expect to be claimed as a tax dependent? Yes
Does Jack meet any of the tax dependent exceptions? No – Jack is over the age of 21 and not subject to the tax dependent exceptions.
Jack's EDG is the same as the tax filer that claims him as a dependent: Marcia, George, Jack and Beth (EDG= 4)

v. Beth's EDG

Does Beth expect to file taxes? No
Does Beth expect to be claimed as a tax dependent? Yes
Does Beth meet any of the tax dependent exceptions? Yes – Beth is claimed as a tax dependent by one parent, but she lives with both parents. Non-filer rules apply.
Beth's EDG: Marcia, George, Trent and Beth (EDG= 4)

g. Julio's Family

Julio (27), his pregnant wife Gloria, expecting one baby, (24) and their daughter Anna (2) live in the household. Julio and Gloria file taxes and claim Anna as a tax dependent.

i. Julio's EDG

Does Julio expect to file taxes? Yes
Does Julio expect to be claimed as a tax dependent? No
Julio's EDG is the same as the tax household: Julio, Gloria and Anna (EDG= 3)

ii. Gloria's EDG

Does Gloria expect to file taxes? Yes
Does Gloria expect to be claimed as a tax dependent? No
Gloria's EDG is the tax household plus her unborn child: Julio, Gloria and Anna plus unborn child (EDG= 4)

iii. Anna's EDG

Does Anna expect to file taxes? No
Does Anna expect to be claimed as a tax dependent? Yes
Does Anna meet any of the tax dependent exceptions? No
Anna's EDG is the same as the tax household: Julio, Gloria and Anna (EDG= 3)

h. Carol's Family

Carol (34), her son Jake (8) and her daughter Alice (3) are in the household. Alice receives SSI benefits. Carol's income is low enough such that she does not file taxes.

i. Carol's EDG

Does Carol expect to file taxes? No
Does Carol expect to be claimed as a tax dependent? No
Carol's EDG: Carol, Jake and Alice (EDG= 3)

ii. Jake's EDG

Does Jake expect to file taxes? No
Does Jake expect to be claimed as a tax dependent? No
Jake's EDG: Carol, Jake and Alice (EDG= 3)

iii. Alice's EDG– Alice receives SSI so she would not receive benefits in a MAGI category. This is for illustrative purposes only.

Does Alice expect to file taxes? No
Does Alice expect to be claimed as a tax dependent? No
Alice's EDG: Carol, Jake and Alice (EDG= 3)

Document Title	Eligibility Determination Group for MAGI				
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Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	1.-4.; 4.d.ii.-iii.; 4.e.i.; 5.-6.; 7.b.i.-ii.; 8.-9.	Policy Statement; Definitions; Eligibility Determination Group; Tax Filers; Tax Dependent Exceptions; Non-Filers and Applicants Not Claimed as Tax Dependents; Pregnant Women, Equally-Shared Joint Custody/Parenting Time; Verification; Eligibility Determination Group Procedures	1-6	Policy Clarification	RZ

COUNTABLE AND EXCLUDED INCOME

Legal Authority: 26 USC 6409; 26 USC 36B(d)(2)(B); 42 CFR 435.603; 42 CFR 435.949; 42 CFR 435.952; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Income eligibility for certain TennCare Medicaid categories and CoverKids is determined using the Modified Adjusted Gross Income (MAGI) methodology. In general, countable income includes income types that are taxable under federal tax law and excluded income includes income types that are non–taxable.

2. MAGI Income Types

Countable income under the MAGI methodology is based on the taxable income types reported to the Internal Revenue Service (IRS) as part of an individual or household's income tax return. In an effort to simplify income reporting under the MAGI methodology, the Centers for Medicare & Medicaid Services (CMS) and the IRS identified the most often reported income types. The following income types are listed on the federal application: Jobs, Self-Employment, Rental or Royalty Income, Farming or Fishing Income, Social Security Benefits, Unemployment Insurance, Retirement, Pension, Capital Gains, Alimony, Investment (Interest) Income and Other Income (e.g. canceled debts, court awards, jury duty pay, cash support, gambling, prizes or awards).

3. Countable Income

a. Job

i. Wages

Wages includes all compensation from employment, and the term is generally defined to mean gross wages. Gross wages after pre-tax deductions are taken out by an individual's employer are countable. The pre-tax deductions may include funds for child care, health insurance or retirement plans that are not taxable.

An individual's pay stub may list his "federal taxable wages", which subtracts the pre-tax amounts from gross wages. If this amount is provided on a pay stub, the individual should report that number.

Wages are counted (considered available to the individual) at the earliest of the following:

1. When received or paid;
2. When credited to the individual's account; or
3. When set aside for the individual's use.

Deferred wage payment occurs when wages are paid at a time later than they normally would have been paid. If wage payments are deferred due to circumstances beyond the employee's control, consider the payment earned income when it is actually available to him. If payments are deferred at the employee's request, determine when the wages would normally have been paid and consider them earned income for that period.

ii. Bonus

Countable. A bonus is a one-time payment that an individual receives in addition to her normal job wage or salary.

iii. Commission

Countable. Income received by an individual for services performed. Commission income is often paid based on a percentage of a sale or a fixed amount per sale.

iv. Contractual

Countable. Income paid to an individual based on a contractual agreement. To calculate contractual income, average the full amount of income paid on a contractual basis over the number of months the contract covers.

v. Tips

Countable. Money and goods received for services performed by food servers, baggage handlers, hairdressers, and others. Tips go beyond the stated amount of the bill and are given voluntarily. All tip income is countable, even if it is not reported to the employer.

vi. Differential

Countable. Payment made to an individual by an employer for a period during which he is performing service in the uniformed services while on active duty for a period of more than 30 days. Payment represents all or a portion of the wages the individual would have received if he was performing services for the employer.

vii. Older Americans Act

Countable. Title V of the Older Americans Act of 1965 provides part-time jobs for unemployed low-income people age 55 and older who have poor employment prospects. This income type includes wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income.

viii. Sick/Disability Pay

Countable. Income an employee receives during a temporary absence from work due to an injury, sickness or disability. Sick/Disability pay is considered part of an individual's wages for tax purposes. Sick/Disability Pay received within the first 6 months of the individual being unable to work is earned income. Sick/Disability Pay received more than 6 months after the individual is unable to work is considered unearned income.

ix. In-Kind Wages

Countable. Non-cash compensation, including food or shelter, received by an individual for work performed in place of, or in addition to, wages, profit or payment in cash. The value of in-kind wages is determined by the current market value of the item minus the amount of the outstanding balance due on the item, if any.

x. In-Kind Not Food/Shelter

Countable. Clothing or other goods received by an individual for work performed in place of, or in addition to, wages, profit or payment in cash.

xi. Severance Pay

Countable. Severance pay is countable earned income in the month received.

xii. Census Wages

Countable. Income paid to an individual by the Census Bureau for temporary employment activities in connection with the full Census that occurs every 10 years.

b. Self-Employment

i. Net Earnings

Net earnings from self-employment are countable income when determining eligibility. Self-employment is the act of engaging in a trade or business. A trade or business is generally an activity carried on for a livelihood or in good faith to make a profit. Individuals may be contractors, franchise holders, owners, operators, partners, etc. An individual must meet all of the following criteria to be considered self-employed:

1. Earns income directly from the business or trade, not from wages or salary from an employer;
2. Responsible for the payment of their entire Social Security and federal withholding taxes;

3. Does not have an employee/employer relationship with another individual and the services performed cannot be controlled by an employer; and
4. Should file self-employment tax forms (Schedule F, C, C-EZ, SE, etc.).

ii. Allowable Deductions

Net income is the gross income from any trade or business minus allowable deductions for that trade or business. Allowable deductions include expenses paid to operate the business or participate in the trade, including:

1. Car and truck expenses;
2. Depreciation;
3. Employee wages and fringe benefits;
4. Property, liability or business interruption insurance;
5. Interest on business loans;
6. Legal and professional services;
7. Rent or lease of business property and utilities;
8. Commissions, taxes, licenses and fees;
9. Advertising;
10. Contract labor; and
11. Repairs and maintenance.

iii. Business Structures

There are different types of self-employment business structures. Some common structures include:

1. Sole Proprietorships: A self-employment business that is not incorporated and has one or two owners. A Limited Liability company (LLC) is not a sole proprietorship;
2. Independent Contractors: An individual who pays her own employment taxes and does not have an employee/employer relationship is considered self-employed, unless incorporated or an LLC; and
3. Sharecroppers: If a sharecropper pays the costs of doing business and receives a portion of the net income in exchange for her labor, she is considered self-employed, unless incorporated or an LLC.

If an individual is self-employed and has a partner or is a joint owner of a business, the individual’s self-employment net earnings will be based on her distributive share from the business.

iv. Federal Income Tax Return Forms

1. Net Earnings from Self-Employment (NESE)

Self-employed individuals report their NESE on the Schedule SE tax form. Other forms may be used to report income (Schedule C, Schedule F, etc.) but the amount listed on Schedule SE should be used to verify self-employment earnings whenever possible. The NESE is the gross income from any trade or business less allowable deductions for that trade or business. NESE also includes any profit or loss in partnership. For the purpose of determining eligibility, count the NESE on a taxable year basis and divide the total of these earnings equally among the months in the taxable year.

Verify net earnings from self-employment on Schedule SE. The amount of net earnings from self-employment that should be reported based on a Schedule SE may be found under line 4.c. of Part I. If line 4.c. shows a positive amount of less than $400, then line 3 is used even if the amount on line 3 is greater than $400.
Schedule SE may not be available or usable when:

a. An individual has started a new business and was not self-employed in the prior tax year; or
b. An individual has applied for or is receiving Title II (Social Security) benefits.

2. Schedule C

Used to report profit or loss from a Sole Proprietor business (general). Net profit or loss is listed on the Schedule C.

3. Schedule F

Used to report income and expenses from a farm operation. Net profit or loss is listed on the Schedule F.

4. Business Records

When a federal income tax return is not available, or the individual has made changes, stopped or added to the business, business records may be used to determine net earnings. When business records are used, use the individual’s gross income and allow the same deductions that are allowed by the IRS.

c. Rental or Royalty

i. Rental or Lease

Rental income is the amount an individual receives for use of his property after all property expenses are subtracted. Net rental income is countable when determining eligibility.

1. **Gross Rental Income:** All rental income that an individual collects for the use of his property is included in gross rental income.

2. **Rental Expenses:** Rental expenses that may be deducted from gross rental income include:

   a. Pre-rental expenses (expenses related to managing, conserving and maintaining rental property from the time property is available to rent);
   b. Advertising;
   c. Cleaning and maintenance;
   d. Utilities;
   e. Fire and liability insurance;
   f. Taxes;
   g. Interest;
   h. Commissions for the collection of rent;
   i. Ordinary and necessary travel and transportation; and
   j. Legal and other professional fees.

3. **Other considerations:** If an individual only rents part of his property, expenses must be divided between the part of the property that is used for rental purposes and the part of the property that is used for personal purposes. This also applies if an individual has any personal use of a dwelling unit, such as a vacation home, which he rents.

4. **Counting Rental Income:**

   a. Income Received on a Regular Basis.

   If an individual has a federal tax return available to verify the earnings from last year and the rental situation has not changed, prorate the reported annual profit over 12 months. Count the result as self-employment income, taking into account any changes for the prorated period. If this is the case, consider the individual self-employed. Rental income should be considered unearned income if the individual is not self-employed.

   If the individual does not have a federal tax return available from the previous year, determine the monthly income based on the rental/lease agreement in effect and any expenses the individual has paid or expects to pay in that month.

b. Income Received Annually or Infrequently.

If rental income is received on an annual or infrequent basis, prorate the annual amount including the anticipated changes over 12 months and count the monthly income as self-employment income.

5. Verification: If verification is required for rental income, request at least one of the following documents:

a. A copy of the rental or lease agreement in effect during the period under consideration;
b. A copy of the receipt the individual prepared upon receiving rental income; or
c. A copy of the previous year's federal income tax return.

ii. Royalties/Honoraria

Countable. Royalty income includes any payments an individual receives from a patent, copyright or any other natural resource owned by the individual.

Royalties are countable unearned income when the individual receives payment based on the use of a natural resource for which he owns the usage rights or the individual is not self-employed.

d. Farming/Fishing

Farming or fishing income may be considered self-employment income but should only be counted once.

i. Farming Income

Farming income is countable. Farming income is income received when an individual is in the business of farming if she cultivates, operates or manages a farm for profit, either as owner or tenant. A farm can include livestock, dairy, poultry, fish or fruit. It can also include plantations, ranches, ranges and orchards.

ii. Fishing Income

Fishing income is countable. Fishing income includes amounts an individual receives from catching, taking, harvesting, cultivating or farming fish, shellfish, crustacean, sponges, seaweeds or other aquatic forms of animal or vegetable life, as well as money from patronage dividends and fuel tax credits and refunds.

iii. Counting Farming or Fishing Income

1. Income Received on a Regular Basis

If an individual has a federal tax return available to verify the earnings from last year and the business model remains the same, prorate the reported annual profit over 12 months. Count the result as earned income, taking into account any changes for the prorated period.

If the individual does not have a federal tax return available from the previous year, determine the monthly income received and any expenses the individual has paid or expects to pay in that month.

2. Income Received Annually or Infrequently

If farming or fishing income is received on an annual or infrequent basis, prorate the annual amount with anticipated changes over 12 months and count the monthly income as earned income.

iv. Verification

If verification is required for farming or fishing income, request at least one of the following documents:

1. A copy of an agreement executed by the owner and the individual working the farm (the individual could be either the owner or the tenant);
2. A copy of the most recent profit or loss statement; or
3. A copy of the previous year's federal income tax return.

e. Social Security Benefits

Income received from Social Security disability, retirement or survivor's benefits each month is countable for individuals required to file taxes. Social Security is also countable for individuals when income other than Social Security is over the tax filing threshold. The individual must provide the amount of benefit prior to any deductions, such as Medicare premiums, income tax withholding, overpayments, child support or alimony.

Countable Social Security income types include:

i. Social Security Disability Benefit (SSDI); and
ii. Social Security Survivor or Retirement.

Note: This is not Supplemental Security Income (SSI). SSI is not countable income.

Income received from Social Security each month is not counted for tax dependents who are not required to file taxes. Social Security income is also not counted for children included in a natural or biological, adopted or stepparent's household when the child's income other than Social Security is under the tax filing threshold.

f. Railroad Retirement

Railroad Retirement Board benefits are paid in lieu of Social Security Retirement, Auxiliary or Disability to an individual based on earnings in the railroad industry. Railroad retirement benefits are countable unearned income in the month of receipt.

g. Unemployment Insurance

Count the full value of unemployment compensation benefits as available unearned income in the month of receipt. Unemployment compensation includes any amount received under an unemployment compensation law of the United States or a state.

If verification is required, verify the amount of unemployment benefits received with one of the following:

- **i.** Documentary evidence from the Tennessee Department of Labor and Workforce Development;
- **ii.** Access through data matches available through the Department of Labor – Unearned Income data source; or
- **iii.** Documentary evidence from the state of issuance showing unemployment benefits are from another state.

h. Retirement

Payments an individual receives from a retirement account may be countable depending on the type of account, how much was contributed to the account, and whether the amount contributed was already taxed.

For treatment of certain types of retirement accounts, see sections *3.n.vii* and *3.m.* in this policy.

i. Pension

A pension is generally a series of definitely determinable payments made to an individual after retiring from active employment. Pension payments are made regularly and are based on such factors as years of service and prior compensation. Pension payments are generally made to an individual after retiring from active employment.

Pension income may be countable depending on the type of pension account, how much was contributed to the pension account, and whether the amount contributed was already taxed.

The amount of distributions received from a pension account should be provided on the application, even if the individual is not retired.

j. Annuities

An annuity is a type of trust with periodic payments that are generated by a bank or insurance company from funds deposited by the individual either in a lump sum or installments to establish a source of income for a future period. Annuity income is subject to the same treatment as pension income for the MAGI categories.

The amount of distributions received from an annuity account should be provided on the application, even if the individual is not retired.

k. Capital Gains

Countable. A capital gain is income an individual receives when a capital asset is sold and an individual makes a profit. Capital assets include a home, household furnishings, and stocks and bonds held in a personal account. When a capital asset is sold, the difference between the amount paid for the asset and the amount it is sold for is a capital gain or capital loss.

l. Alimony

Alimony received is money paid to an individual from a spouse that the individual no longer lives with, or a former spouse, if part of a divorce agreement, separation agreement or court order. Alimony is countable income if the separation, divorce agreement, or court order was finalized on or before December 31, 2018. Alimony received as the result of separation, divorce agreement, or court order that was finalized on or after January 1, 2019 is excluded. Payments designated in the agreement or ordered as child support or as a non-taxable property settlement are not alimony.

m. Interest Income

Countable. Dividends and interest are returns on capital investments such as stocks, bonds, and savings accounts, including accrued interest on loans made by the individual.

Count income received on a monthly basis in the month the individual receives it, or the month it is available for his use. Convert interest payments received on other than a monthly basis to a monthly amount by prorating the payment over the accrued period.

Types of Interest Income:

i. **Stocks and Bonds:** Income that an individual receives from stocks, bonds or mutual funds that he owns are countable.
ii. **Certificate of Deposit:** The accrued interest, based on the individual's percentage of ownership, when the certificate of deposit has reached maturity is countable.

iii. **Checking Account:** The interest an individual receives on their checking account, based on percentage of ownership, is countable.

iv. **Life Insurance:** Interest income received as a result of life insurance proceeds is taxable income and countable for the purpose of determining eligibility.

v. **Retirement Account:** Interest income received on a traditional IRA is countable when received.

vi. **Savings Account:** The interest an individual receives based on the individual's percent of ownership of a savings account is countable.

vii. **Contract for Deed:** Income paid to an individual from the repayment of property debt is countable.

viii. **Promissory Note:** A promissory note is a promise in writing to pay an individual at a future date. Interest income an individual receives from a promissory note is countable.

n. Other Income

i. Canceled Debts

The amount of a debt that an individual is no longer required to pay, or that is forgiven, is countable as income in the month received. Student loan debt that is canceled or discharged under certain types of forgiveness programs, such as Public Service Loan Forgiveness (PSLF), Teacher Loan Forgiveness, or Perkins Loan Cancellation, is not countable. Student loan debt canceled or discharged due to the death or permanent and total disability of the student or school fraud or closure is not countable. Student loan debt canceled or discharged after December 31, 2020, and before January 1, 2026, for loans described in 26 U.S.C. § 108(f)(5)(A)-(D), including but not limited to those discharged under income-based repayment plans, is not countable.

ii. Cash Inheritance

The value of inherited cash is counted as income in the month of receipt.

iii. Cash Support

If an individual is claimed as a tax dependent by someone other than a spouse or parent, any cash support provided by the tax filer in excess of $30 a month is countable as income in the month received.

iv. Countable Unearned Income

1. Court awards

Settlement amounts that are received, either by compromise or judgment, may be countable income based on the item that the settlement replaces. The following settlements or awards are countable income:

a. Interest on any award;
b. Compensation for lost wages or lost profits in most cases;
c. Punitive damages;
d. Amounts received in settlement of pension rights (if the individual did not contribute to the plan);
e. Damages for patent or copyright infringement, breach of contract, or interference with business operations;
f. Back pay and damages for emotional distress received to satisfy a claim under Title VII of the Civil Rights Act of 1964; and
g. Attorney fees and costs where the underlying recovery is included in gross income.

Note: Compensatory damages for personal physical injury or sickness are not countable income.

v. Federal Emergency Management Agency (FEMA) Non Disaster or Emergency

FEMA funds made to a household to pay for rent, food and utility assistance when there is no major disaster or emergency declaration are countable income.

vi. Gambling, prizes or awards

Compensation received from gambling, prizes, or awards is countable. The way in which gambling, prizes, or awards are received impacts how the compensation is counted. Gambling, prizes and awards can be received in installments, a lump sum, or as a non-cash prize.

1. Installments

Monetary gambling winnings, including lottery winnings, which are received in installments are countable in the month received.

2. Lump sum

Monetary gambling or lottery winnings which are received as a lump sum are countable. The month in which the income is counted is dependent upon the total winnings and who in the Eligibility Determination Group (EDG) received the winnings.

a. Monetary gambling or lottery winnings is countable in the month received for all individuals in the EDG except for the individual who receives the winnings.
b. Monetary gambling or lottery winnings received in a lump sum for the individual who received the winnings should be counted as follows:

i. Winnings less than $80,000 are counted in the month received;

ii. Winnings of $80,000 but less than $90,000 are counted as income over two months, with an equal amount counted in each month; and

iii. For every additional $10,000, one month is added to the period over which the total winnings are divided in equal installments. The maximum period of time over which winnings may be counted is 120 months.

Example: Martha is pregnant and applies for Medicaid on February 7th. She purchases a lottery ticket on February 15th and wins a lump sum of $93,000. Since she received over $90,000 in winnings, her winnings will be counted over 3 months. Unearned income of $31,000 is countable in the February, March and April budgets.

3. Non-Cash Prizes

The fair market value of bonds, cars, houses or other noncash prizes won is countable income in the month received.

vii. Income Producing Resource

Income received from an income producing resource is countable in the month of receipt. Income producing resources include:

1. Contract for Deeds;
2. Promissory Notes;
3. Individual Retirement Account (IRA);
4. 401(k); and
5. Keogh Account.

viii. Jury Duty

Jury duty pay is countable income. Any jury duty pay that is turned over to the individual's employer may be excluded. Individuals must enter the amount of jury duty pay received. Reimbursements or allowances received separately from jury duty pay for travel to and from courthouse, or for meals and lodging, are excluded.

ix. Sheltered Workshop

Sheltered workshops provide employment opportunities for individuals with developmental, physical or mental impairment. Sheltered workshops prepare the individuals for gainful work and provide rehabilitation, work training, and life skills. Sheltered workshops are operated by certain non-profit organizations, or by state or local government institutions.

While training in a sheltered workshop, the income received is considered unearned and is excluded. If the individual continues to work in the sheltered workshop after training, income received is considered earned and is countable.

x. Care and Contribution In Exchange for a Transferred Asset

If an individual transferred an asset and part or all of the compensation he received included a provision for lifetime total care and support, the value of the care and support contribution is unearned income and is countable.

4. Excluded Income

The income types below are excluded when determining income eligibility under the MAGI methodology for TennCare Medicaid and CoverKids.

a. Achieving a Better Life Experience (ABLE)

ABLE accounts or 529A accounts are tax-advantaged savings accounts for individuals with disabilities that are established under a qualified ABLE program. The funds within an ABLE account are intended to cover the individual’s Qualified Disability Expenses (QDEs) related to her blindness or disability.

QDEs include, but are not limited to: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, funeral and burial expenses, and basic living expenses.

All contributions and ABLE account earnings in an ABLE account are excluded as income, except that contributions are not deducted from countable income of the individual making the contribution. Contributions to an ABLE account from a third party are not countable as income. This includes funds from a trust.

Distributions from an ABLE account are not income of the designated beneficiary in any month, regardless of whether the distribution is for non-housing QDEs or housing QDEs. Distributions which exceed the QDEs incurred by the account beneficiary in a taxable year are countable income.

b. Adoption Subsidies

Payments to an individual from state adoption assistance programs or Title IV-E funds for special needs children are excluded.

c. Child Support

A payment that is specifically designated as child support or treated as specifically designated as child support under a divorce or separation instrument is not alimony. The amount of child support may vary over time. Child support payments made to a child under court order are excluded.

d. Child Support Arrearage

Child support arrearages received, whether received on a regular monthly schedule or as a one-time payment are excluded.

e. Child Tax Credit

Child Tax Credit payments received either as monthly advance payments or a one-time refund are excluded.

f. Combat Pay

A combat zone is any area the President of the United States designates by Executive Order as an area in which the U.S. Armed Forces are engaging or have engaged in combat.

Payments made to an individual serving active duty in a combat zone are excluded entirely or in part depending on rank.

All combat pay is excluded for enlisted members, warrant officers, or commissioned warrant officers.

Combat pay is excluded for commissioned officers (other than commissioned warrant officers) up to the highest rate of enlisted pay plus imminent danger/hostile fire pay received for each month. For the 2016 tax year, the amount that may be excluded is $8,222.10 per month ($7997.10 for the highest enlisted pay + $225 for imminent danger pay).

g. Community Spouse Income Maintenance Allowance (CSIMA)/Dependent Income Maintenance Allowance (DIMA)

Excluded. If an individual has a spouse receiving Institutional Medicaid, the individual may receive a CSIMA. The CSIMA is an allocation of income intended to keep the spouse of an institutionalized individual residing in the community. If the individual is receiving a CSIMA and the spouse is not part of the individual's household when determining eligibility, the CSIMA is excluded.

If the individual is a dependent of someone receiving Institutional Medicaid, the individual may receive a DIMA. The DIMA is an allocation of income from an institutionalized individual to a dependent residing in the community intended to cover living costs. If the applicant is receiving the DIMA and the institutionalized individual is not part of her household, a DIMA is excluded.

h. Death Benefit

Excluded. A death benefit is received as the result of another's death. Examples of death benefits include:

- **i.** SSA lump sum death benefits;
- **ii.** Veterans Affairs (VA) death benefits;
- **iii.** Proceeds of life insurance policies received due to the death of the insured; and
- **iv.** Railroad Retirement lump sum death benefits.

Recurring survivor benefits such as those received under Social Security Title II, private pension programs, etc. are not death benefits.

i. Domestic Volunteers Act

Payments to volunteers from the following programs are excluded:

- **i.** Title II Retired Senior Volunteer Program;
- **ii.** Foster Grandparent Program; and
- **iii.** Title III Service Corps of Retired Executives, Senior Companion Program and Active Corps of Executives.

j. Earned Income Tax Credit (EITC)

Earned income tax credit payments received as advance payments or as refunds are excluded.

k. Gifts

Occasional monetary gifts to the household, such as money received as a birthday, anniversary, graduation or Christmas present, are excluded. Irregular or infrequent gifts received are excluded.

l. Income Not Pursued

Income not pursued includes payments for which an individual could apply on an ongoing or one-time basis that could include annuities, pensions, retirement benefits or disability benefits. These payments are excluded.

m. Military Allowances

Military allowances are cash payments made to service members and their families to compensate the service member, at least in part, for the expenses of housing, food, clothing, and special situations during periods of active-duty service. Examples include the basic allowance for housing (BAH) and the basic allowance for subsistence (BAS). Military allowances for food, clothing, housing, travel, and moving and other in-kind military benefits are excluded.

n. Payment from FEMA due to a Disaster or Emergency

FEMA payments issued as a result of a presidentially declared emergency or major disaster are excluded. Payments made by comparable disaster assistance programs by states, local governments and disaster assistance organizations are also excluded.

o. Parent Mentor Income

Parent Mentor Income is income received by a parent or guardian of a Medicaid or CHIP-eligible child who is trained to assist families with children who have no health insurance coverage with respect to improving the social determinants of the health of such children. These individuals provide education about health insurance coverage (including obtaining health insurance, eligibility criteria, and application and renewal processes), assist with the completion and submission of applications for health insurance, are a liaison between families and the State of Tennessee, provide guidance on identifying medical and dental homes and community pharmacies for children, and assistance and referrals to successfully address social determinants of children's health, including poverty, food insufficiency, and housing. Any nominal amount received by the parent or guardian as Parent Mentor Income is excluded.

p. Protective Payee

A Protective Payee is someone designated by the SSA to help a beneficiary manage his benefits. Funds received by a protective payee and used for the care and maintenance of a third party beneficiary (adult or child), who may or may not be part of the protective payee's household, are excluded.

q. Reimbursements

A reimbursement or other expense allowance arrangement is a system or plan that an employer uses to pay, substantiate, and recover the expenses, advances, reimbursements, and amounts charged to the employer for employee business expenses. Reimbursements are excluded income to the extent that they do not exceed actual expenses.

Examples of excluded reimbursements include:

i. Reimbursements for job or training-related expenses (travel, per diem, transportation);
ii. Reimbursements for out-of-pocket expenses of volunteers incurred during the course of volunteer work;
iii. Medical and dependent care reimbursements; and
iv. Non-taxable moving expenses.

r. Settlements and Restitution

Income received in compensation for personal physical injury or physical sickness, whether received as a lump sum or in installments, are excluded.

s. Social Services

Social Services payments, including governmental benefit programs that are based on need such as TANF, Food Stamps, payments made under Services to the Blind and Visually Impaired, Vocational Rehabilitation (VR), and other such programs are excluded.

t. Supplemental Security Income (SSI)

SSI is nontaxable and excluded from countable income.

u. Temporary Assistance for Needy Families (TANF) Allotment

In Tennessee, the TANF program is known as Families First. TANF Allotment is cash assistance provided to families with dependent children when at least one parent is incapacitated, unemployed, deceased, or absent from the home, and the family is unable to pay for essential living expenses. TANF Allotments are excluded from countable income.

v. Temporary Disability Insurance

Compensation received for loss of wages caused by temporary non-occupational disability is excluded. These are payments an individual does not receive from an employer. Payments received from an employer are considered Sick or Disability Pay.

w. Veterans Affairs Benefits

The following VA Benefits are excluded:

- **i.** VA Aid and Attendance Payment;
- **ii.** VA Apportioned;
- **iii.** VA Augmented Benefit;
- **iv.** VA Disability;
- **v.** VA Education Grant;
- **vi.** VA Pension; and
- **vii.** VA Survivor (DIC).

x. Workers Compensation

Payments an individual receives for occupational sickness or injury, and that are paid under a workers' compensation act or statute in the nature of the worker's compensation act, are excluded.

y. Education Income Not Work Study

Income received through federal student aid, such as grants and loans, except for income received through work study.

z. Work Study

Earned educational income directly contingent upon the individual attending an institution of higher education, including work study and stipends, is excluded.

aa. Workforce Innovation and Opportunity Act

The Workforce Innovation and Opportunity Act (WIOA) replaced the Workforce Investment Act of 1998. The WIOA funds a variety of programs designed to connect individuals with employment opportunities. Examples of WIOA programs include:

i. Adult Services Program
ii. Dislocated Workers Program
iii. Job Corps
iv. YouthBuild

Wages, incentives, and bonuses resulting from programs funded by the WIOA are considered countable income to the recipient. Income received in the form of supportive services, such as child care assistance, transportation, or job placement services, is not countable.

5. Medicaid Exceptions to the MAGI Methodology

MAGI-based income for TennCare Medicaid and CoverKids uses the same financial methodologies defined in section 36B(d)(2)(B) of the Code (which defines countable income as taxable income), with the following 3 exceptions:

a. Amounts received as lump sums are counted as income only in the month received;

b. Scholarships, awards or fellowship grants used for education purposes and not for living expenses are excluded; and

c. All of following American Indian/Alaska Native related income is excluded:

i. Distributions from Alaska Native Corporations and Settlement Trusts.
ii. Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior.

iii. Distributions and payments from rents, leases, rights of way, royalties, usage rights or natural resource extraction and harvest from:

1. Rights of ownership or possession in any lands described in paragraph (5)(c)(ii) of this section; or
2. Federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources.

iv. Distributions resulting from real property ownership interests related to natural resources and improvements:

1. Located on or near a reservation or within the most recent boundaries of a prior reservation; or

2. Resulting from the exercise of federally-protected rights relating to such real property ownership interests.

v. Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal law or custom.

vi. Student financial assistance provided under the Bureau of Indian Affairs education programs.

Document Title	Countable and Excluded Income				
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Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
07.05.2017	2.m.iii.; 2.n.	Medicaid Exceptions to the MAGI Methodology; Excluded Income	12-14	Policy Clarification	RH
03.18.2019	2.; 3.a.i-ii.; 3.a.iv.; 3.a.xi-xii.; 3.b.i-ii.; 3.c.i.; 3.d.i.; 3.e.; 3.l.; 3.n.viii.; 4.i.; 4.y.	MAGI Income Types; Wages; Bonus; Differential; In-Kind Not Food/Shelter; Severance Pay; Net Earnings; Allowable Deductions; Countable Income; Farming Income; Social Security; Alimony; Jury Duty; Earned Income Tax Credit (EITC); Work Study	1-5; 7-8; 10; 12; 15; 17	Non-Substantive Change	RZ
03.18.2019	3.a.viii.; 3.a.x.; 3.b.iii.; 3.c.i.4.; 3.c.i.5.ii.; 3.g.i.; 3.i.; 3.m.; 3.n.ii-iii.; 3.n.vii.; 3.n.ix-x.; 4.a.; 4.c-d.; 4.f-h.; 4.k.; 4.o-p.; 4.q.; 4.t.; 4.v.	Sick/Disability Pay; In-Kind Wages; Business Structures; Counting Rental Income; Royalties/Honoraria; Unemployment Insurance; Pension; Interest Income; Cash Inheritance; Cash Support; Income Producing Resource; Sheltered Workshop; Care and Contribution In Exchange for a Transferred Asset; Achieving a Better Life Experience (ABLE); Child Support; Child Support Arrearage; Community Spouse Income Maintenance Allowance (CSIMA)/Dependent Income Maintenance Allowance (DIMA); Death Benefit; Domestic Volunteers Act; Income Not Pursued; Rehabilitation;	3-4; 6-7; 9-17	Policy Clarification	RZ

		Reimbursements; Settlements and Restitution; Temporary Assistance for Needy Families (TANF) Allotment; Veterans Affairs Benefits			
03.18.2019	3.f.	Railroad Retirement	8 - 9	Policy Change	RZ
09.03.2019	3.a.xii; 4.q.; 4.y.	Legal Authority; Census Wages; Social Services; Workforce Investment and Opportunity Act	1; 3; 16; 18	Policy Clarification	TB
05.01.2020	3.l; 3.n.i;3.n. vi.; 4.n.; 4.p.iv	Alimony; Canceled Debts; Gambling, Prizes and Awards; Parent Mentor Income; Reimbursements	10-14;16-17	Policy Change	TN
11.01.2021	4.e.	Legal Authority; Child Tax Credit	15	Policy Clarification	MH
08.01.2022	3.b.iv.; 3.n.i.	Net Earnings from Self-Employment (NESE); Canceled Debts	5; 11	Policy Clarification	MH

EXPENSES

Legal Authority: 42 CFR 435.603; Public Law 115-97; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Individuals are allowed to deduct certain expenses from gross income when determining household income under the Modified Adjusted Gross Income (MAGI) methodology. The expenses allowed under the MAGI methodology correlate to the expenses or deductions permitted by the Internal Revenue Service (IRS) to determine an individual's adjusted gross income.

2. Expense Types

a. Legally Obligated Alimony: Alimony is a payment to or for a spouse or former spouse under a divorce or separation instrument. Alimony expenses do not include voluntary payments. The payment must be in cash, including checks and money orders, to be considered alimony. Alimony paid as a result of a divorce or separation agreement established prior to January 1, 2019 is an expense to the payer of the alimony and is allowed when alimony is paid during the month of application. In accordance with the Tax Cuts and Jobs Act of 2017, alimony paid as a result of a divorce or separation agreement established or modified on or after January 1, 2019 is not a deductible expense.

The following payments are not alimony: child support, noncash property settlements, and payments to keep up the payer's property.

b. Student Loan Interest Paid: The Student Loan Interest Paid expense refers to the amount of interest an individual pays out on a qualified student loan payment made during the month of application. Student loan interest includes both required and voluntary interest payments.

A qualified student loan is a loan that is taken out solely to pay qualified education expenses that are: for the individual, his spouse or a person who was a dependent when the individual took out the loan; paid or incurred within a reasonable period time before or after the loan was made; and for education provided during an academic period for an eligible student.

A qualified student loan is a loan that pays for the following items: tuition and fees; room and board; books, supplies and equipment; and other necessary expenses such as transportation.

c. Other As Defined By Policy: The Other As Defined By Policy expense refers to the following expenses as defined by the IRS. The descriptions included in this section are general descriptions. Applicable expenses are those expenses for the month of application. If an individual reports one of these expenses, notify the Member Services Eligibility Policy Unit.

i. Educator expenses: Eligible educators may deduct up to $250, if spent during the month an application for benefits is filed, for ordinary and necessary expenses paid in connection with books, supplies, equipment (including computer equipment, software and services) and other materials used in the classroom. An eligible educator is a kindergarten through grade 12 teacher, instructor, counselor, principal or aide who works in a school for at least 900 hours during a school year;

ii. Certain business expenses of reservists, performing artists and fee-based government officials;

iii. Health Savings Account (HSA) deductions: Contributions to an HSA, other than employer contributions, are a deductible expense;

iv. Moving expenses: A member of the U.S. Armed Forces, who is moving because of a permanent change of station, may deduct reasonable unreimbursed moving expenses for travel and moving household goods and personal effects. The cost of storing and insuring household goods and personal effects within any period of 30 consecutive days after the date the goods and personal effects are moved from the former home and before they are delivered to the new home may also be deducted;

v. Deductible part of self-employment tax;

vi. Self-employed health insurance deduction;

vii. Penalty on early withdrawal of savings;

viii. IRA deduction: In general, an individual can deduct the lesser of the contributions to his traditional IRA for the year; or the general limit. The general limit for 2019 is the lesser of $6,000 ($7,000 if you’re age 50 or older) or 100% of his compensation; or

ix. Tuition and fees: In general, tuition and fees for enrollment or attendance at an eligible postsecondary educational institution of up to $4,000, if spent during the month an application for benefits is filed, can be deducted for a student who is either the applicant, the applicant’s spouse or the applicant’s dependent; or

x. Domestic production activities deduction: A percentage deduction provided to certain small companies for production activities that are conducted in the United States.

Document Title	Expenses				
First Published	10.30.2014				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
05.01.2020		Legal Authority	1	Policy Clarification	TB
05.01.2020	2.a.; 2.c.	Legally Obligated Alimony; Other As Defined By Policy	1-2	Policy Change	TB

THE 5 PERCENT FEDERAL POVERTY LIMIT DISREGARD FOR MAGI

Legal Authority: 42 CFR 435.603; Tenn. Comp. R. & Regs. 1200-13-20

1. Overview

The Affordable Care Act (ACA) requires that financial eligibility for certain TennCare Medicaid and CoverKids categories be determined using the Modified Adjusted Gross Income (MAGI) methodology. The MAGI methodology eliminates all characteristic-specific income disregards, such as the earned income disregard, dependent care disregard or child support disregard. Instead, a 5% Federal Poverty Level (FPL) disregard will be applied to any individual in a MAGI TennCare Medicaid, TennCare Standard or CoverKids category when the disregard would make the individual eligible. These individuals are those whose household income is within 5 FPL percentage points of the highest income standard for which they can obtain TennCare Medicaid, TennCare Standard or CoverKids eligibility under MAGI-based income rules. The 5% FPL disregard does not apply to the TennCare Medicaid Medically Needy categories.

2. Policy Statement

A 5% FPL disregard is applied to applicants' household income in the TennCare Medicaid, TennCare Standard and CoverKids categories that use the MAGI methodology to determine financial eligibility. The 5% disregard does not apply to TennCare Medicaid Medically Needy categories.

Children and pregnant women whose household income is within 5 percentage points of a TennCare Medicaid or TennCare Standard category will receive the 5% disregard in order to be determined eligible for TennCare Medicaid or TennCare Standard rather than be determined eligible for CoverKids.

3. Application of the Disregard to TennCare Medicaid and TennCare Standard

The 5% FPL disregard is provided by converting 5% of the FPL to a dollar amount based on the Eligibility Determination Group (EDG) size. The dollar amount is subtracted from the applicant's/enrollee's household modified adjusted gross income.

Applicants whose household income is within the following ranges will be made eligible by applying the 5% FPL disregard:

a. Children Aged 0-1 Years Old: Household income is between 195% and 200% FPL;
b. Children Aged 1-5 Years Old: Household income is between 142% and 147% FPL;
c. Children Aged 6-18 Years Old: Household income is between 133% and 138% FPL;
d. Pregnant Women: Household income is between 195% and 200% FPL;
e. TennCare Standard Uninsured: Household income is between 211% and 216% FPL; and

f. Caretaker Relatives: The 5% disregard is the individual's Modified Adjusted Gross Income amount minus the actual dollar amount of 5% of 100% FPL for the appropriate household size.

4. Disregard Budget Examples

a. Example 1

A pregnant woman applies for TennCare Medicaid. She has no spouse or other children living in the home. The income standard for the Pregnancy MAGI category is $2,748 (195% FPL, EDG size of 2). The 5% FPL disregard equals $71 ($1,410 x 0.05 = $70.50 or $71). The applicant's monthly household modified adjusted gross income is $2,800. The applicant will receive the disregard, $2,800 - $71 = $2,729, making her eligible for the Pregnancy MAGI category.

b. Example 2

Mary and her two children Steven, age 4, and Carrie, age 9, apply for coverage. Mary is pregnant and expecting one baby. Mary pays taxes and claims Steven and Carrie as dependents. Since she is pregnant, Mary's EDG size is 4 and the two children's EDG sizes are 3. Mary earns $2,400 per month at her job. Mary is determined eligible in the Pregnancy MAGI category, Steven is determined eligible in the Child MAGI 1-5 category, but Carrie is ineligible for the Child MAGI 6-18 category because her income is over the income eligibility threshold. The 5% FPL disregard is applied to Carrie's household income, which brings her under the income eligibility threshold for the Child MAGI 6-18 category and she is determined eligible.

i. Mary: Income eligibility threshold in the Pregnancy MAGI category for EDG size of 4 = $4,185. Household income is $2,400 which is less than $4,185, so she is eligible.

ii. Steven: Income eligibility threshold in the Child MAGI 1-5 for EDG size 3 = $2,525. Household income is $2,400 which is less than $2,525, so he is eligible.

iii. Carrie: Income eligibility threshold in the Child MAGI 6-18 for EDG size 3 = $2,365. Household income is $2,400 which is greater than $2,365. Without the disregard, Carrie would be ineligible due to being over income. We determine the disregard amount by taking 5% of $1,778 (100% FPL for EDG size of 3), which is $88.90 or $89. The 5% disregard reduces her household income to $2,311 ($2,400 - $89). Her household income is now less than the income eligibility threshold, so she is determined eligible.

The above examples are current as of February 2019

5. Application of Disregard to CoverKids

Applicants whose household income is within the following ranges will be made income eligible for CoverKids by applying the 5% FPL disregard:

a. CoverKids Children: Household income is between 250% and 255% FPL, and
b. CoverKids Pregnant Woman: Household income is between 250% and 255% FPL.

Note: Pregnant women and children with income in the ranges described above for TennCare Medicaid categories will receive the 5% FPL disregard so that they are eligible for TennCare Medicaid, rather than being determined eligible for CoverKids.

Document Title	The 5 Percent Federal Poverty Limit Disregard For MAGI				
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Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.04.2016	3.	Application of the Disregard to TennCare Medicaid and TennCare Standard	1-2	Non-Substantive Change	AK
02.27.2017	3.	Application of the Disregard to TennCare Medicaid and TennCare Standard	1-2	Non-Substantive Change	RH
03.05.2018	3.	Application of the Disregard to TennCare Medicaid and TennCare Standard	1-2	Non-Substantive Change	TN
03.18.2019	3.; 4.; 5.	Application of the Disregard to TennCare Medicaid and TennCare Standard; Disregard Budget Examples; Application of Disregard to CoverKids	1-3	Non-Substantive Change	SN
03.18.2019		Legal Authority	1	Policy Clarification	TN

REASONABLE COMPATIBILITY AND VERIFICATION

Legal Authority: 42 CFR 435.948

1. Policy Statement

Eligibility determinations will be based, to the maximum extent possible, on self-attestation of income that is verified by information obtained from electronic data sources. When income information obtained through electronic data sources is reasonably compatible with an individual's attestation, the attestation is considered verified. Attestation and data sources are reasonably compatible when the difference or discrepancy between the two sources does not impact the eligibility of the application. If information is obtained through electronic data sources is not reasonably compatible with an individual's attestation, additional documentation may be required.

2. Reasonable Compatibility

The Affordable Care Act (ACA) requires states to accept self-attestation of income information when the individual's attestation and information obtained through an electronic data source are reasonably compatible. The reasonable compatibility test is only applied when an individual's attested income is below the income eligibility threshold, and information obtained through an electronic data source is above the income eligibility threshold. Table 1.1 *Reasonable Compatibility Test* illustrates when information is subject to the reasonable compatibility test, and when it is not.

Table 1.1 Reasonable Compatibility Test

Attested Income (including 5% disregard, if applicable)	Electronic Data Source	Outcome
Is below the income eligibility threshold	Is below the income eligibility threshold	Individual is financially eligible. The reasonable compatibility test is not required.
Is below the income eligibility threshold.	Is above the income eligibility threshold.	**Income is subject to reasonable compatibility test.**
Is below the income eligibility threshold.	Is not available	Request additional verification.
Is above the income eligibility threshold	Is above the income eligibility threshold	Individual is ineligible. The reasonable compatibility test is not required.
Is above the income eligibility threshold.	Is below the income eligibility threshold.	Attested income is used. The individual is ineligible. The reasonable compatibility test is not required.

Is above the income eligibility threshold.	Is not available.	Attested income is used. The individual is ineligible. The reasonable compatibility test is not required.

Reasonable Compatibility Calculation

a. Reasonable Compatibility Calculation with Reported Income from the Hub

Step 1: Individual has PASSED the Income Eligibility Determination.
Step 2: Modified Adjusted Gross Income (MAGI) from the Hub (converted to a monthly amount) is
available and:

- If the Hub value is less than the Category Income Standard, the individual is income-eligible and the reasonable compatibility test is NOT required.
- If the Hub value is greater than the Category Income Standard, the reasonable compatibility test is required. Continue to Step 3.

Step 3: Determine the Hub Reasonable Compatibility Maximum Amount:

MAGI from the Hub minus 10% of the MAGI from the Hub amount = the Hub Reasonable Compatibility Maximum

Step 4: Compare individual's attested income amount (prior to the 5% FPL disregard, if applied) to the Hub Reasonable Compatibility Maximum and:

- If the attested income is less than the Hub Reasonable Compatibility Amount, then income verification is required.
- If the attested income is greater than the Hub Reasonable Compatibility Amount, no verification is required and individual is considered to be income eligible.

Example: Mr. Jones is applying for coverage for himself, his wife and 2 children. Mr. Jones is the sole income earner and attests to earning $1,750 a month. The Caretaker Relative Income Standard for a family of 4 is $1,867, so Mr. Jones is income eligible for the Caretaker Relative category.

Income information from the Internal Revenue Service (IRS) is available from the Hub (MAGI from Hub), and it is reported that Mr. Jones' income on his last tax return was $1,900 per month. Given that the Hub data is greater than the Caretaker Relative Income Standard, the reasonable compatibility test is applied:

Attested Income: $1,750

Caretaker Relative Income Standard (household size of 4): $1,867
MAGI from Hub: $1,900

Hub Reasonable Compatibility Maximum: $1900 – (1900 x .10) = $1,710

Since Mr. Jones' attested income ($1,750) is GREATER THAN the Hub Reasonable Compatibility Maximum ($1,710). Attested income and income obtained from Hub are considered reasonably compatible and no further income verification is required.

b. Reasonable Compatibility Calculation with Reported Quarterly Wage Data

Quarterly Wage Data (QWD) will be subject to the reasonable compatibility test when there is no income information available from the Hub. The individual's attested income must still be less than the applicable category income standard, and QWD must be greater than the income standard before the Reasonable Compatibility is applied.

The reasonable compatibility test using QWD is calculated the same way as the reasonable compatibility testing using Hub data.

3. Verification

Income Type	Electronic Data Source	Paper Documentation
Wages	• IRS data from the Hub • Tennessee Department of Labor and Workforce Development (TDLWD) • Equifax/TALX data	• Pay stubs • Statement from employer • Signed statement for tips • Bank deposit slip • Statement from employer identifying an item paid in-kind, the date the in-kind wages were paid, any balance due on item
Self-Employment	• IRS data from the Hub	• Federal income tax return (Schedule SE) • Business Records • Individual's signed statement
Rental	• IRS data from the Hub	• Federal income tax return • Current Lease or Contract • Statement from renter including the amount and payment date of rental amount • Rent receipt indicating amount and payment date
Royalty	• IRS data from the Hub	• Written verification from the source of the royalty income

		• Business records • Bank deposit slip • Individual's signed statement
Farming or Fishing	• IRS data from the Hub	• Federal income tax return • Business Records • Bank deposit slips, receipts
Unemployment	• TDLWD	• Written verification from the TDLWD • Written verification from state of issuance if unemployment benefits are received from another state.
Retirement	• IRS data from the Hub • State On-Line Query System (SOLQ), if individual had previous SSI connection	• Written verification from the source of income • Copy of the most recent check and proof of deposit into the individual's bank account with date of deposit
Pension	• IRS Data from the Hub • SOLQ, if individual had previous Supplemental Security Income (SSI) connection	• Written verification from the source of income • Copy of the most recent check and proof of deposit into the individual's bank account with date of deposit
Social Security	• SOLQ	• Award letter from the Social Security Administration (SSA), Railroad Retirement Benefits
Capital Gains		• Receipt from sale • Sale agreement • Proof of deposit into the individual's bank account with amount and date of deposit
Investment Income	• IRS Data from the Hub	• Copy of the most recent check and date of deposit
Alimony Received	• IRS Data from the Hub	• Agreement awarding the individual alimony payments • Written statement from the individual paying the alimony and a copy of a recent alimony check or receipt
Cancelled Debts		• Signed statement from the individual who forgave the debt
Court Awards		• Court order or final judgment • Bank Statement
Jury Duty Pay		• Copy of check(s) received • Proof of deposit into the individual's

		bank account
Gambling, Prizes or Awards		• Award letter • Copy of the check • Contest advertisement • Income tax return for the year the prize/award was claimed

MEDICALLY NEEDY ELIGIBILITY DETERMINATION GROUP

Legal Authority: 42 CFR 435.301; 42 CFR 435.601; 42 CFR 435.602; 42 CFR 435.603; 45 CFR 233.20

1. Policy Statement

The Eligibility Determination Group (EDG) for Medically Needy categories is based on the methods of the former AFDC program. The EDG determines the income and resource standards used for an applicant's financial eligibility determination. Household income and resource inclusion for the EDG is governed by the principle of Financially Responsible Relatives (FRRs). Financial responsibility is limited to spouse to spouse and parent to child.

2. Definitions

Parents: Parents only include biological and adoptive parents.

Siblings: Siblings include biological, adopted, half or stepsiblings.

3. Child Medically Needy Eligibility Determination Group

For unmarried applicants, the EDG for Child Medically Needy includes the following individuals living in the home:

- **a.** The applicant;
- **b.** The applicant's children under 21;
- **c.** The applicant's unborn child(ren);
- **d.** The applicant's parents; and
- **e.** The applicant's siblings under 21 (including unborn children).

Parents of an emancipated minor are not included in the EDG.

For married applicants, the EDG for Child Medically Needy includes the following individuals living in the home:

- **a.** The applicant;
- **b.** The applicant's children under 21;
- **c.** The applicant's unborn child(ren); and
- **d.** The applicant's spouse (if under 21 and applying for medical assistance).

If the in-home spouse is not included in the EDG, the spouse's income and resources may be deemed to the applicant.

4. Qualified Pregnant Woman Medically Needy Eligibility Determination Group

The EDG for Qualified Pregnant Woman Medically Needy includes the following individuals living in the home:

a. The applicant;
b. The applicant’s unborn child(ren);
c. The applicant’s children under 21; and
d. The applicant’s spouse (if under 21 and applying for medical assistance).

If the in-home spouse is not included in the EDG, the spouse’s income and resources may be deemed to the applicant.

5. Financially Responsible Relative (FRR) Principle

The income and resources of a parent or spouse, FRR, living in the applicant’s household are considered available to the applicant. Income and resources of relatives other than a parent or spouse are not considered available to the applicant. Income and resources are not considered available when an FRR receives Families First, Supplemental Security Income (SSI) or needs-based Veterans Affairs (VA) Benefits.

a. Income and Resources of a Parent

The income and resources of the parents of a child under age 21 are considered available to the child in determining her financial eligibility when:

i. The child and parent(s) live together;
ii. The child is unmarried; and
iii. During the child’s temporary absence from the home.

Note: The child’s admission to a psychiatric facility is considered a temporary absence. Psychiatric care is not considered institutionalization for purposes of determining the under age 21 individual’s separation from her FRR.

b. Joint Custody/Parenting Time

For the purpose of determining Medicaid eligibility, the custodial parent, often referred to as the primary residential parent in Tennessee, is established based on physical custody specified in a court order, binding separation, divorce, or parenting plan. If there is no court order or parenting plan, custody of a child born out of wedlock is with the mother. If there is a parenting plan, the primary residential parent is the parent with whom the child spends most nights.

i. Equally-Shared Joint Custody/Parenting Time

When an individual claims that equally-shared (50/50) joint physical and legal custody exists or provides a parenting plan that evenly divides the child(ren)’s living arrangement and parenting responsibilities, the parenting time situation must be carefully examined. Though a court order or parenting plan may evenly divide the care and control of the child(ren), the parents may not, in fact, be following the parenting plan.

In cases of alleged equal parenting time (50/50):

1. Both parents exercise parental guidance.

Parental guidance may include issues such as which parent takes the children to and from school and/or daycare, which parent does the school and/or daycare consider the responsible relative, who exercises responsibility for consenting to major medical treatment for the child, etc.

2. Parents equally share physical custody.

If one parent has the child(ren) a majority of the time, this is not considered equally shared parenting time. Child(ren) must spend an equal amount of time living with each parent. The living arrangement may be based on days, weeks or months, but it must be equal (182.5 days per year with each parent) and parental functions of guidance and physical care cannot be substantially interrupted. (If equal time means 6 months at a time are spent with each parent, this will be considered extended visits.)

If it is determined that equal (50/50) parenting time exists, staff should contact the Member Services Eligibility Policy Unit for additional guidance on processing the case.

c. Income and Resources of a Spouse

Accept the individual’s attestation regarding his marital status if he is married, unmarried, or separated from his spouse, unless there is reason to doubt the self-attested information. The income and resources of the applicant’s spouse are considered available, whether or not they are actually contributed:

i. While the couple live together, including temporary absences; and
ii. During the first month of separation by one member’s admission to a medical institution, unless the couple had been living apart for at least 6 months prior to their separation.

Income and resources of the applicant’s spouse may be deemed to the applicant when the spouse is living in the household.

d. Spousal Income Deeming

Income deeming is the process of considering another person’s income to be available for meeting an individual’s basic needs of food and shelter. The income of a spouse who is not part of the EDG and is living in the home of an applicant may be deemed to the applying spouse. The following rules apply to the income deeming budget process:

i. If the deemed income amount is equal to or less than the MNIS for one, the deemed income is not included in the applicant’s budget.
ii. If the deemed income amount is greater than the MNIS for one, the deemed income is included in the applicant’s budget.

iii. If the spouse's income is deemed available, the income standard will be the MNIS for the EDG + 1.

e. Spouse Deeming Budget

Ms. Apple is a 20 year old woman applying for medical assistance. She has one child, age 3, from a previous marriage. She also has one child, age 1, with her current husband who is 24. Her husband earns $2,000 a month and has $1,600 in unearned monthly income. He is not applying for medical assistance. All 4 family members live together.

The Total Deemed Income is greater than $241, the MNIS for 1. Since the deemed income exceeds the MNIS for 1, the MNIS for 4 will be used for Ms. Apple's budget as her EDG includes her, the couple's common child, her own child, and an additional plus one. Also, the total deemed income will be counted in the budget.

Deemed Income Budget Calculation		
Net Countable Self-Employment Income		$ 0.00
Net Countable Earned Income	+	$ 2,000.00
Combined Earned/Self-Employment Income	=	$ 2,000.00
Irregular Earned Income Disregard ($30)	-	$ 0.00
Standard Work Expense Deduction ($90)	-	$ 90.00
Dependent Care Deduction (Up to $200 depending on age)	+	$ 0.00
Remaining Countable Earned/Self-Employment Amount	=	$ 1910.00
Net Countable Unearned Income	+	$ 1600.00
Irregular Unearned Income Disregard ($60)	-	$ 0.00
Child Support Disregard	-	$ 0.00
Total Countable Earned and Unearned Income	=	$ 3510.00
Child Support/Mandatory Expense	-	$ 0.00
Total Deemed Income	=	$ 3510.00
MNIS for 1		$ 241.00

Document Title	Medically Needy Eligibility Determination Group				
First Published	06.05.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	1.	Policy Statement	1	Policy Clarification	NF
03.18.2019	2.	Definitions	1	Non-Substantive Change	NF
03.18.2019	3.	Child Medically Needy Eligibility Determination Group	1	Policy Change	ME
03.18.2019	4.	Qualified Pregnant Woman Medically Needy Eligibility Determination Group	1-2	Policy Change	NF
03.18.2019	5.	Financially Responsible Relative (FRR) Principle	2-4	Policy Clarification	NF
03.18.2019	5.c.	Income and Resources of a Spouse	3	Non-Substantive Change	ME

MEDICALLY NEEDY COUNTABLE AND EXCLUDED INCOME

Legal Authority: 26 USC 6409; 45 CFR 233.20; State Plan, Supplement 8A to Attachment 2.6-A; Tenn. Comp. R. & Regs. 1200-13-20

The Medically Needy TennCare Medicaid categories are the only TennCare categories that continue to use the AFDC financial methodology. Additional descriptions about specific income types may be found in the MAGI and ABD income chapters, but the Medically Needy treatment of income types may differ in these policies and income treatment should be guided by this document.

Countable Earned Income	
Income Type	**Treatment**
Bonus	Count in the month received. A bonus is a one-time payment that an individual receives in addition to her normal wages or salary.
Commission	Count in the month received. Commission is income received by an individual for services performed. Commission income is often paid based on a percentage of a sale or a fixed amount per sale.
Contractual	Income paid to an individual based on a contractual agreement. To calculate contractual income, average the full amount of income paid over the number of months covered by the contract.
Differential	Count payment made to an individual by an employer for a period during which he is performing service in the uniformed services while on active duty for a period of more than 30 days.
Farming/Fishing	Earned income when individual materially participates in the production of income. Count in the month received. Farming or fishing income may be considered self-employment income, but should only be counted once. 1. **Farming Income** Farming income is income received when an individual is in the business of farming if she cultivates, operates or manages a farm for profit, either as owner or tenant. A farm can include livestock, dairy, poultry, fish or fruit. It can also include plantations, ranches, ranges and orchards. 2. **Fishing Income** Fishing income includes amounts an individual receives from catching, taking, harvesting, cultivating or farming fish, shellfish, crustaceans, sponges, seaweeds or other aquatic

	forms of animal or vegetable life, as well as money from patronage dividends and fuel tax credits and refunds.
In-Kind Not Food/Shelter	This includes clothing that is not considered part of an employee's wages.
In-Kind Wages	Non-cash compensation such as food, shelter, or other items received by an individual for work performed in place of, or in addition to, wages, profit or payment in cash. The value of in-kind wages is determined by the current market value of the item less any outstanding balance due on the item, if any. Countable when received, set aside for use or credited to an account.
Military Allowances	Cash allowances paid to active-duty service members and their families for housing, food, clothing and special circumstances count as earned income in the month of receipt. The basic allowance for subsistence (BAS), paid to military personnel to offset the cost of meals, counts as earned income. The basic allowance for housing (BAH) counts as earned income when the payment is made to military personnel living in private housing. When the BAH is paid to service members living on base or in privatized military housing and the allowance is paid and deducted from the service member's pay in the same month or paid directly to the housing contractor, the BAH is excluded.
Older Americans Act	Title V of the Older Americans Act of 1965 provides part-time jobs for unemployed low-income people age 55 and older who have poor employment prospects. Count only wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income.
Royalties/Honoraria	Royalties are countable earned income when they are either received as part of a trade or business or received by an individual in connection with any publication of his work. Royalties are counted as unearned income in all other situations. For example, an individual may receive payment for the use of a patent or natural resource that she owns. Honoraria are payment for services when fees are not legally or traditionally required. Honoraria are counted as earned income. For example, a professional who speaks at a meeting may receive an honorarium for her services and time.

Self-Employment	Count the annual net earnings from self-employment, and divide by the months in the taxable year. Self-employment is the act of engaging in a trade or business; which is an activity carried on for a livelihood or in good faith to make a profit. Individuals may be contractors, franchise holders, owners, operators, partners, etc. An individual must meet all of the following criteria to be considered self-employed: • Earns income directly from the business or trade, not from wages or salary from an employer; • Is responsible for the payment of their entire Social Security and federal withholding taxes; • Does not have an employee/employer relationship with another individual and the services performed cannot be controlled by an employer; and • Should file self-employment tax forms (Schedule F, C, C-EZ, SE, etc.). Net income is the gross income from any trade or business less allowable deductions for that trade or business. Allowable deductions include expenses paid to operate the business or participate in the trade, including: • Car and truck expenses; • Depreciation; • Employee wages and fringe benefits; • Property, liability or business interruption insurance; • Interest on loans for your business; • Legal and professional services; • Rent or lease of business property and utilities; • Commissions, taxes, licenses and fees; • Advertising; • Contract labor; and • Repairs and maintenance. There are different types of business structures referred to as self-employment. Some of the common structures include: • Sole Proprietorship: A self-employment business that is not incorporated and has one or two owners. A Limited Liability Company (LLC) is not a sole proprietorship. • Independent Contractor: An individual who pays his own employment taxes and does not have an employee/employer

	relationship is considered self-employed, unless incorporated or an LLC. Sharecropper: If a sharecropper pays the costs of doing business and receives a portion of the net income in exchange for her labor, she is considered self-employed, unless incorporated or an LLC. If an applicant is self-employed and has a partner or is a joint owner of a business, the applicant's self-employment net earnings will be based on his distributive share from the business.
Severance Pay	Severance pay is countable earned income in the month received.
Sheltered Workshop	Countable. Sheltered workshops provide employment opportunities for individuals with developmental, physical or mental impairment. Sheltered workshops prepare the individuals for gainful work and provide rehabilitation, work training and life skills. Sheltered workshops are operated by certain non-profit organizations, or by state or local government institutions.
Sick Pay/ Disability Pay	Countable. Sick or disability pay is a payment made to or on behalf of an employee by an employer or private third party for sickness or accident disability. Sick or disability pay is counted as earned income when it is received within 6 calendar months after the individual has stopped work. Sick or disability pay received more than 6 months after stopping work is counted as unearned income.
Tips	Countable.
Wages	Wages include all payment from employment, and the term is generally defined to mean gross wages. Gross wages are the total amount paid to the individual before deductions. Wages are counted at the earliest of the following: • When they are received or paid; • When they are credited to the individual's account; or • When they are set aside for the individual's use. Deferred wage payment occurs when wages are paid at a time later than the wages normally would have been paid. If wages are deferred at employee's request, count wages when they normally would have been received. If wages are deferred by the employer, count wages when they are received.
Workforce Innovation and Opportunity Act (WIOA)	The Workforce Innovation and Opportunity Act (WIOA) replaced the Workforce Investment Act of 1998. The WIOA funds a variety of programs designed to connect individuals with employment opportunities. Such programs include the Job Corps program,

	YouthBuild, and the Dislocated Workers Program. Payments received are considered countable income, unless for supportive services such as child care assistance, transportation, or job placement services.
Excluded Earned Income	
Income Type	**Treatment**
Census Wages	Wages paid to an individual by the Census Bureau for temporary employment activities in connection with the full Census that occurs every 10 years are excluded.
Child Tax Credit	Child Tax Credit payments received either as monthly advance payments or a one-time refund are excluded.
Combat Pay	Payments made to an individual serving active duty in a combat zone. These payments are excluded in the month of receipt. Any amount of the payment retained into the following month is countable resource unless otherwise excluded.
Domestic Volunteer Act	Payments to volunteers from the following programs are excluded: • Title II Retired Senior Volunteer Program; • Foster Grandparent Program; and • Title III Service Corps of Retired Executives, Senior Companion Program and Active Corps of Executives.
Earned Income Tax Credit (EITC)	Earned income tax credit payments received as advance payments or as refunds are excluded.
Infrequent or Irregular Income	Exclude up to $30 per calendar quarter of earned income that is received either irregularly or infrequently. In order to be excluded, the income need only be irregular or infrequent. Income is considered to be received irregularly if an individual cannot reasonably expect to receive it. Income is received infrequently if an individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the previous month or in the month following the month in which the money was received. A single source of earned income is an employer, trade or business.
Plan for Achieving Self-Support (PASS)	Excluded. Earnings received to fulfill a Plan to Achieve Self Support (PASS) Plan. PASS-enrolled individuals are SSI Medicaid recipients.
Volunteers In Service to America (VISTA) Payments	Excluded. Volunteers in Service to America under Title I of the Domestic Volunteer Services Act of 1973 (VISTA) payments are excluded.
Work Study	Excluded.

Countable Unearned Income	
Income Type	**Treatment**
Alimony	Countable. Payments an individual receives from a spouse he no longer lives with, or a former spouse, if paid as part of a divorce agreement, separation agreement or court order.
Annuities	Annuities are contracts or agreements that, in exchange for a lump sum payment or series of payments, provide income at regular intervals (i.e., monthly, quarterly, annually). Annuities establish a source of income for a future period, and are often used in retirement planning. Annuity payments count as unearned income the month received when the annuity is an excluded resource. See the *Countable and Excluded Resources for Medically Needy policy.*
Canceled Debts	The amount of a debt an individual is no longer required to pay or that is forgiven.
Capital Gains	Countable. Income an individual receives when a capital asset is sold and there is a profit from the sale. Count in the month received or when available for use.
Cash Inheritance	The value of inherited cash is counted as income in the month of receipt.
Cash Support	Regular cash contributions made directly to the individual are unearned income, unless excluded as irregular or infrequent income.
Child Support	Child support payments are countable unearned income to the child(ren) the payments are intended to support. If the support order does not indicate the amount per child, assume the amount received is equally distributed among all of the noncustodial parent's children for whom the payment is made. Child support received is subject to a $50 disregard.
Child Support Arrearage	Child support arrearages received on behalf of the applicant, whether received on a regular monthly schedule or as a one-time payment, are countable.
Community Spouse Income Maintenance Amount (CSIMA)/ Dependent Income Maintenance Amount (DIMA)	The CSIMA and/or DIMA is countable unearned income only when the institutionalized individual is not living in the same household as the community spouse or dependent.
Death Benefits	Unearned income when the total amount exceeds the expense of deceased person's last illness and burial costs.

Farming/Fishing	Farming or fishing income is countable when the individual does not materially participate in the production of income. Gross farm income is subject to deductions.
Federal Emergency Management Agency (FEMA) Payment Non Disaster or Emergency	FEMA payments made to a household when there is no major disaster or emergency declaration are countable in the month of receipt.
Gambling, Prizes and Awards	The value of a prize or award is unearned income in the month of receipt. A prize is something won in a contest, lottery or game of chance. If the individual is offered a choice between an in-kind prize or cash, the cash offered is counted as unearned income even if the individual chooses the in-kind item and regardless of the value of the in-kind item. An award is received as the result of a decision by a court, board of arbitration, etc. Secure from the applicant any of the following types of verification: • Award letter; • Copy of the check received; • Contest advertisement; or • Income tax return for the year the prize or award was claimed.
Gifts	Cash gifts are counted in whole in the month of receipt, unless excluded as infrequent or irregular income. The value of in-kind gifts is equal to the gift's CMV.
Income Producing Resource	Income earned off of an income-generating resource is counted or excluded based on the treatment of the resource. Income generating resources include: • Annuities; • Contract for Deeds; and • Promissory Notes. Income generated by a resource that is excluded is countable unearned income. Income generated by a resource that is countable is excluded as income.
Interest Income	Interest income and dividends are a return on a capital investment such as stocks, bonds, mutual funds or savings accounts. A cash gift or incentive payment to open an account is considered interest income.

	Interest income and dividends can be countable or excluded, depending on the treatment of the source of the interest or dividend. If the interest-bearing resource is counted, the interest income is excluded. If the interest-bearing resource is excluded, the interest income is counted, unless specifically excluded under federal statute. Interest bearing resources include the following: • Certificate of Deposit; • Checking Account; • Life insurance; • Mutual Funds; • Retirement account; • Savings account; and • Stocks and Bonds. If interest income is countable, count it at the earliest of the following: • Income is credited to an individual's account and is available for use; • Income is set aside for the individual's use; or • When the income is actually received by the individual.
Jury Duty	Count in the month received. Any jury duty pay that is turned over to an individual's employer is excluded.
Pension	If pension payments are made, count in the month received.
Railroad Retirement	Countable income in the month received.
Rental or Lease	Unearned income when the individual is not actively engaged in producing the income, or bears no responsibility in earning the income. Count the amount of income remaining after expenses related to maintaining the property are applied.
Sick Pay/Disability Pay	Unearned income when payments are being made 6 months or more after the individual stopped working.
Social Security Disability Benefit (SSDI)	Social Security Disability Insurance (SSDI) is received when an individual is under the full retirement age of 65, but has enough Social Security credits and a severe medical impairment that prevents her from working for a year or more, or could result in death. Social Security Disability benefits are countable unearned income in the month received.
Social Security Survivor or Retirement Benefit	Countable unearned income in the month of receipt. Social Security Retirement benefits are received once an individual reaches the full retirement age of 65 and has enough Social Security credits.

	Social Security Survivor's benefits are received by a surviving spouse, dependent child or parent who received more than half of his support from the deceased wage earner.
Temporary Disability Insurance	Compensation received for loss of wages caused by temporary non-occupational disability is countable. These are payments an individual does not receive from an employer.
Trusts	Money withdrawn from the body of a trust or interest/dividends accrued to the trust and paid to the individual is unearned income in the month of receipt.
Unemployment Insurance	Count the full value of unemployment compensation in the month of receipt.
VA Apportioned	An Apportioned benefit is a VA Payment made to a dependent spouse, child or parent not residing with the Veteran. The VA Apportioned amount is unearned income for the individual receiving the payment.
VA Disability	Countable. VA Disability is a benefit paid to Veterans with disabilities as a result of a disease or injury incurred or aggravated during active military service or that arose after service but is thought to be related to their service. The benefit is graduated according to the degree of the Veteran's disability on a scale from 10% to 100%.
VA Pension	Countable. VA Pension is the standard benefit received by a Veteran for wartime service which is based on financial need, not on a service-connected disability.
VA Survivor (DIC)	Countable. VA Dependency and Indemnity Compensation (DIC) is a benefit paid to eligible surviving dependents of service members who died while on duty or survivors of Veterans who died from their service-connected illness or injury. Parents' DIC is an income-based benefit for parents who were financially dependent on a service member or Veteran who died from a service-related cause. Parents' DIC is not subject to $20 disregard, as it is income based.
Workers' Compensation	Payments an individual receives for occupational sickness or injury, and paid under a workers' compensation act or statute in the nature of the worker's compensation act. Such payments are countable unearned income to the extent that they are not earmarked and used for the purpose for which the funds are paid (i.e., medical bills or legal expenses).

Excluded Unearned Income	
Income Type	**Treatment**
Achieving a Better Life Experience (ABLE)	ABLE accounts or 529A accounts are tax-advantaged savings accounts for individuals with disabilities that are established under a qualified ABLE program. The funds within an ABLE account are intended to cover the individual's Qualified Disability Expenses (QDEs) related to her blindness or disability. All contributions and earnings within a single ABLE account are excluded as income, except that contributions are not deducted from countable income of the individual making the contribution. Contributions made by an ABLE account owner from his own resources and contributions made by a third party, including a trust, are excluded as income. Distributions from an ABLE account are not considered income, but are a conversion of one resource to another. See the *Countable and Excluded Resources for Medically Needy Categories* policy.
Adoption Subsidies	Excluded. Payments to an individual from state adoption assistance programs or Title IV-E funds for special needs children.
Canceled Debts	Excluded. The amount of a debt an individual is no longer required to pay or that is forgiven.
Community Spouse Income Maintenance Amount (CSIMA)/ Dependent Income Maintenance Amount (DIMA)	If an applicant receives a Community Spouse Income Maintenance Allowance or Dependent Income Maintenance Allowance, and the institutionalized individual is living in the applicant's household, the CSIMA/DIMA is excluded.
Education Income Not Work Study	Exclude income received through Federal Student Aid, such as grants and loans, except for income received through Work Study programs. Includes: Pell Grant; SEOG Grant; National Direct Student Loan; Guaranteed Student Loan; State Student Initiative and any financial aid paid directly to the school and unavailable to the student.
Federal Emergency Management Agency (FEMA) Payment Disaster or Emergency	FEMA payments issued as a result of a presidentially declared emergency or major disaster are excluded. Payments made by comparable disaster assistance programs by states, local governments and disaster assistance organizations are also excluded.

Income Not Pursued	Excluded. Income not pursued includes payments for which an individual could apply on an ongoing or one-time basis and may include annuities, pensions, retirement benefits or disability benefits. Note: This may decrease household size for other individuals in the household and the applicant may be found not eligible due to failure to apply for other benefits.
Infrequent or Irregular Income	Exclude up to $30 per calendar quarter of unearned income that is received either irregularly or infrequently. In order to be excluded, the income need only be irregular or infrequent. Income is considered to be received irregularly if an individual cannot reasonably expect to receive it. Income is received infrequently if an individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the previous month or in the month following the month in which the money was received.
Long Term Care (LTC) Insurance Payout	Exclude payments from long term care insurance used for medical care.
Lump Sum	Lump Sum payments are excluded as income in the month of receipt if they are retained by the individual.
Protective Payee	Funds received by a protective payee (conservator, authorized representative or representative payee) and used for the care and maintenance of a third party beneficiary (adult or child) who may or may not be a member of the protective payee's household are excluded as income to the protective payee. Any part of the payment that is retained by the protective payee for his own use is countable income to the protective payee. Even if the protective payee retains a fee for their services, the entire payment issued to the beneficiary is countable income to the beneficiary.
Reimbursements	Excluded. Applies only to expenses an employee incurs in the performance of his or her duties for items other than normal living expenses.
Settlements and Restitutions	The following settlements and restitution payments are excluded as unearned income: • Agent Orange Settlement Payments (payments and interest are excluded); • Disaster Relief Assistance received under the Disaster Relief Act of 1974; • Distribution of perpetual judgment funds to Indian tribes under the following:

	- Indian Judgment Funds Distribution (P.L 93-134) - Black Feet and Gros Ventre Tribes (PL 92-254) - Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K; - Tribes of groups under PL 93-134; - Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL 94-433); and - Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under PL 94-114. - Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments (and interest from payments) made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products; - Filipino Veterans Compensation Fund Payments: Lump sum payments (and interest from payments) made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII; - Japanese-American and Aleutian Restitution Payments (and interest from payments); - Payments made to individuals because of their status as victims of Nazi persecutions (and interest from payments); - Payments to children born of Vietnam veterans diagnosed with spina bifida (and interest from payments); - Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (interest is not excluded); - Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act; and - State funds paid to crime victims.
Social Services	Any service (other than medical) which is intended to assist a handicapped or socially disadvantaged individual to function in society on a level comparable to that of an individual who does not have such a handicap or disadvantage. Cash received in conjunction with a social service is typically excluded unearned income. Social service programs include programs authorized under: - Title XX of the Social Security Act; - Title IV-B of the Act (Child Welfare);

	• Title V of the Act (Maternal and Child Health and Crippled Children's Services); and • The Rehabilitation Act of 1973 (including vocational rehabilitation services to individuals with disabilities).
Supplemental Security Income (SSI)	SSI is excluded unearned income.
Temporary Assistance for Needy Families (TANF) Allotment	Excluded. In Tennessee, the TANF program is referred to as Families First. TANF Allotment is cash assistance provided to families with dependent children when at least one parent is incapacitated, unemployed, deceased, or absent from the home.
VA Aid and Attendance Payment	Excluded. VA Aid and Attendance is compensation provided to a Veteran, her spouse, the surviving spouse, or the surviving parent based on the need of aid and attendance by another person. It cannot be received without some other form of VA payment.
VA Augmented Benefit	A VA Augmented Benefit is an increase in payment to the Veteran or his surviving spouse in order to provide for a dependent as defined by VA. An Augmented Benefit is unearned income to the dependent.
VA Education Grant	Excluded. A VA Education Grant is for a Veteran who is in an approved program and provides up to 36 months of education benefits. These benefits are intended to provide assistance as follows: • Tuition and fees; and • Annual books and supplies stipend. If the Veteran receives a stipend to assist with housing, it is countable unearned income.

Document Title	Medically Needy Countable and Excluded Income
First Published	06.05.2015

Revision History

Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
06.17.2016	Countable Earned Income; Countable Unearned Income	Bonus; Cash Support	1-2	Policy Clarification	NF
08.10. 2016	Excluded Unearned Income	ABLE Accounts	4	Policy Change	AJ
08.10.2016	Excluded Unearned Income	Census Payments	5	Policy Change	NF
11.01.2016	Excluded Unearned Income	Education Income Not Work Study; Work Study	5-6	Policy Clarification	NF
12.01.2016	Countable Earned Income; Excluded Earned Income	Earnings of a Part Time Student Employed Full Time; Earnings of a Student Who Does Not Attend School Part-Time While Working Full-Time	1; 4	Policy Clarification	RS
07.05.2017	Countable Earned Income	Military Allowances	1	Policy Clarification	RH
07.05.2017	Excluded Earned Income	Combat Pay	4	Policy Change	RH
03.18.2019	Countable Earned Income; Excluded Earned Income; Countable Unearned Income;	Bonus; Commission; Contractual; Farming/Fishing; In-Kind Wages; Older Americans Act; Royalties/Honoraria; Self-Employment; Sheltered Workshop; Sick Pay/Disability	1-13	Policy Clarification	ME

	Excluded Unearned Income	Pay; Tips; Wages; Work Study; Combat Pay; Domestic Volunteer Act; Earned Income Tax Credit (EITC); Infrequent or Irregular Income; Volunteers in Service to America (VISTA) Payments; Work Study; Alimony; Annuities; Cash Support; Child Support; Child Support Arrearage; CSIMA/DIMA; Farming/Fishing Federal Emergency Management Agency (FEMA) Payment Non Disaster or Emergency; Gambling; Prizes and Awards; Income Producing Resource; Interest Income; Social Security Disability Benefit (SSDI); Social Security Survivor or Retirement Benefit; Unemployment Insurance; VA Apportioned; VA Disability; VA Pension; VA Survivor (DIC); Workers' Compensation; Achieving a Better Life Experience (ABLE); Canceled Debts; Community Spouse Income Maintenance			

		Amount (CSIMA)/ Dependent Income Maintenance Amount (DIMA); Education Income Not Work Study; Federal Emergency Management Agency (FEMA) Payment Disaster or Emergency; Infrequent or Irregular Income; Income Not Pursued; Long Term Care (LTC) Insurance Payout; Protective Payee; Settlements and Restitutions; Social Services; Temporary Assistance for Needy Families (TANF) Allotment; VA Aid and Attendance; VA Augmented Benefit; VA Education Grant			
03.18.2019	Countable Earned Income; Countable Unearned Income	Severance Pay; Gambling, Prizes and Awards, Interest Income	4; 7-8	Non-Substantive Change	ME
03.18.2019	Countable Earned Income	Tips	4	Policy Change	TN
09.03.2019	Countable Earned Income; Excluded Earned Income	Legal Authority; Workforce Investment and Opportunity Act (WIOA); Census Wages	1; 4-5	Policy Clarification	TB/AJ
11.01.2021	Excluded Earned Income; Excluded Unearned Income	Legal Authority; Child Tax Credit; Lump Sum Payments	5; 8	Policy Clarification	MH

MEDICALLY NEEDY SPENDDOWN

Legal Authority: 42 CFR 435.4; 42 CFR 435.301; 42 CFR 435.308; 42 CFR 435.602; 42 CFR 435.603; 42 CFR 435.831

1. Policy Statement

Federal regulations provide that otherwise eligible individuals with net income greater than the Medically Needy Income Standard (MNIS) may achieve TennCare Medicaid eligibility if the applicant and her financially responsible relatives spend down the amount of the excess income on a monthly basis for medical expenses. Excess monthly income is the difference between total net income and the MNIS based on Eligibility Determination Group (EDG) size.

2. Spenddown Period

The spenddown period is the month of application and the 3 preceding months.

3. Incurred Medical Expenses

The following medical and remedial expenses may be used to satisfy the spenddown requirement:

a. Expenses incurred during the month of application, whether paid or unpaid;
b. Expenses paid during the month of application, regardless of when such bills were incurred (only count the portion paid); and
c. Expenses incurred during the 3 calendar months prior to the month of application, whether paid or unpaid.

4. Continuous Medically Needy Eligibility

Medically Needy enrollees must continue to meet the spenddown requirement at redetermination, if the EDG income remains over the MNIS. Current Medically Needy individuals may use the following medical and remedial expenses to meet a spenddown requirement:

a. Expenses incurred during the month of application, whether paid or unpaid;
b. Expenses paid during the month of application, regardless of when such bills were incurred (only count the portion paid);
c. Expenses incurred during the 3 calendar months prior to the date of application, whether paid or unpaid; and
d. Expenses incurred before the 3 calendar months prior to the month of application, only if:

  i. Payment is made on those expenses during the month of application, and only the amount paid during the month of application is counted; or
  ii. All of the following carry forward conditions are met:

1. The expenses were previously verified in order to meet spenddown criteria;
2. The individual has remained continuously eligible in a medically needy category since that time;
3. The individual has met a spenddown during each period of eligibility in order to qualify; and
4. The expenses remain unpaid and have not been written off by a provider.

Expenses paid during the 3 calendar months prior to the month of application will not be counted unless bills were also incurred during those calendar months.

5. Whose Expenses May be Counted

Medical expenses that are incurred or paid within the spenddown period for the following individuals may be used to meet the spenddown requirement:

a. The applicant;
b. Members of the applicant’s EDG;
c. The applicant’s FRRs or anyone for whom the applicant is financially responsible; and
d. Individuals not living in the home or eligible for inclusion if an EDG member or their FRR is legally obligated to pay their medical expenses. This could include old bills of a child now over the age of 21 or bills a parent is obligated to pay due to a child support order. This may also include medical bills of an individual who is now deceased.

6. Allowable Expenses

a. General Rule

Allowable medical and remedial expenses include verified expenses that are incurred within the spenddown period or payments made on medical bills during the application month regardless of when the bill was incurred. Allowable expenses are those for which the individual is still liable and that are:

i. For medical or remedial care, including over the counter;
ii. Verifiable and for which the individual provides substantiation;
iii. Incurred by the individual, a member of the individual’s EDG, or the individual’s FRR, or are the legal responsibility of the individual, her family or FRR and not subject to payment in full or part by a third party;
iv. Recognized under state law but not covered under the state’s TennCare Medicaid plan or waiver (continuously eligible individuals); and/or
v. Covered under TennCare Medicaid but incurred during the spenddown period (new applicants).

NOTE: Medical expenses that will be covered by TennCare Medicaid during an eligible period are not allowable expenses.

b. Allowable Medical Expenses

The following are types of medical expenses considered Allowable Medical Expenses for the Medically Needy categories:

i. **Acupuncture services**
ii. **Bed hold at a Long Term Care Facility (Medicaid rate)**
iii. **Dental expenses**
iv. **Doctor's fees -** Practitioners and others providing medical services, physicians, surgeons, dentists, optometrists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, and Christian Science providers.
v. **Drugs prescribed by a physician (prior to TennCare eligibility) -** Medicines and drugs prescribed by a doctor incurred prior to establishing TennCare Medicaid eligibility and which remained unpaid or paid in the month under consideration (i.e., spenddown month).
vi. **Guide dogs -** Guide dogs for the blind or deaf and the costs of their maintenance.
vii. **Hospital charges**
viii. **Medical care charges included in tuition costs -** Charges for medical care included in the tuition fee of a college or private school which is paid on a monthly basis, provided that a breakdown of the charges is included in the bill or is furnished separately by the institution.
ix. **Nursing home costs**
x. **Nursing services -** Nursing services include nursing care in an individual's home, if for the purpose of treatment or alleviation of a physical, mental, or emotional disorder and ordered by a provider acting within the provider's scope of practice. The care needed must be medical, e.g., administering medication or therapy. Cost of services solely domestic in nature, such as the preparation of meals and the performance of housework is not deductible.
xi. **Organ transplant expenses**
xii. **Prosthetic devices -** Artificial teeth, limbs, hearing aids and component parts, eyeglasses and crutches.
xiii. **Psychiatric care -** Psychiatric care primarily for alleviating a mental illness or defect; the cost of maintaining a mentally ill individual at a specially equipped medical center where the individual receives continual medical care.
xiv. **Special education for handicapped -** Special school for mentally or physically handicapped individuals if for the alleviation of handicap. Example: The costs of sending a blind child to school to learn Braille, or a deaf child to lip-reading classes, are medical expenses. The costs of meals and lodging, if supplied by the institution, and/or ordinary education furnished incidental to the special services are medical expenses.
xv. **Substance abuse treatment -** Treatment at a therapeutic center for drug addicts or alcoholics, including meals and lodging furnished as a necessary incident to the treatment.
xvi. **Transportation for medical/remedial purposes -** Transportation essential to medical care, e.g., bus, taxi, train, or plane fares, and 65.5 cents for each mile that the individual's car is used for medical purposes, in addition to parking fees and tolls.
xvii. **Over the counter (non-prescription) medicine -** Deduct up to $10 per month for over-the-counter (non-prescription) medicine without verification, using only the individual's statement. All of these expenses must be verified if the amount is more than $10 per month.

Expenses may be allowed if payment is made by a public program of a state or political subdivision that is other than a Medicaid program and there is a cost for the service. Free service to the public cannot be deducted.

Medical expenses related to maternity care (e.g., global fee) are considered incurred the month the physician presents a bill once services have begun (i.e., initial examination by the physician at a minimum). All other medical expenses are considered incurred the date the service is provided.

New bills, if incurred within the spenddown period, are deductible for the period in which they are incurred whether or not they have been paid with loan proceeds or a credit card. No carry forward expense will be allowed at the next spenddown review because the bill has been paid in full. The loan or credit card payments are not allowed as a medical expense at the next review.

If spenddown is not met by the medical bills presented at application or redetermination, the daily countable medical expenses incurred during the application month will be added until spenddown liability is reached. Use only the portion of the medical expense that is necessary to meet spenddown.

c. Non-Allowable Expenses

The following incurred expenses cannot be deducted from income in order to meet the spenddown requirement:

i. Expenses incurred prior to the individual becoming eligible for TennCare Medicaid or in a prior period for charges that have been written off as uncollectible or have been forgiven by the provider;

ii. Expenses that are covered by the State's TennCare Medicaid plan and are incurred during a period of eligibility:

1. Costs incurred during a period of TennCare eligibility due to co-pays or services not covered such as dental, hearing and eye care for adults are allowable as a medical expense.
2. Bills incurred during TennCare eligibility which are subject to TennCare reimbursement are not considered outstanding for subsequent spenddown periods even if not paid by TennCare.

d. Medical/Health Insurance Premiums

Health insurance premiums may be deducted as a spenddown expense only when payment is due, even if paid in another month. Premiums are deducted for health insurance that share the following characteristics:

i. It is reported to TennCare as a third party medical resource;
ii. Benefits are assignable and the eligible individual has agreed to assign them to the state; and
iii. The premiums are paid by the eligible individual, not a third party.

Note: The State pays the Medicare premiums for individuals eligible for SSI, Pickle Pass Along, Disabled Adult Child (DAC) and Widow/Widower coverage. Do not deduct Medicare premiums for individuals in the EDG who are approved as Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB) or Qualifying Individual (QI).

e. Third Party Payments

If a medical expense is subject to partial payment by a third party, include only the portion for which the individual is liable in the determination of total incurred medical expenses.

Always verify, if possible, the reimbursement or medical expense by third parties before allowing a deduction. If verification of the reimbursement cannot be obtained within time limit constraints (application or change report processing period), determine from the third party the:

- **i.** Type of expense it will cover;
- **ii.** Rate or percentage or anticipate amount of reimbursement; and
- **iii.** Anticipated date of reimbursement.

If all possible efforts have been made and verification cannot be obtained about third party payment, allow the portion of the expense the individual/EDG states they are responsible for.

f. Budgeting Medical Expenses and Carry Forward

Regular recurring medical expenses (i.e., insurance premiums or installment payments) are counted as incurred on the date of application.

Only the portion of the medical expense that is necessary to meet spenddown will be used.

Any remaining medical expenses to carryover for the next spenddown period will be used if still owed or paid during the spenddown reapplication month in question.

When carrying over unused medical expenses for use in another spenddown period, do not allow any amount that TennCare or a third party will pay.

g. Carry Forward Example

Ms. Smith, a pregnant woman, and her 1 year old child apply for coverage. Ms. Smith has no unearned income. Her Net Countable Earned Income is $5,000. Ms. Smith pays $400 per week for childcare. She has $50,000 of incurred allowable medical expenses.

Ms. Smith's Net Countable Income is over the MNIS for an EDG size of 3. A spenddown of her allowable medical expenses of $4,393 is applied. She will have a Future Carry Forward Amount of $45,607 that will be considered when her eligibility is reassessed.

Spenddown Budget Calculation		
Total Net Countable Income (after allowable budget deductions)		$ 4,710.00
Income Limit	-	$ 317.00
Spenddown	=	$ 4,393.00
Current Year's Medical Expenses	-	$ 50,000.00
Previous Year's Carry Forward Amount	+	$ 0.00
Total Medical Expenses	=	$ 50,000.00
Remaining Spenddown Needed	=	$ 0.00
Future Carry Forward Amount	=	$ 45,607.00

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Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
07.05.2017		Legal Authority	1	Non-Substantive Change	AJ
07.05.2017	5.b.	Allowable Medicaid Expenses	3	Policy Clarification	AJ
03.18.2019	1.; 4.; 5.b.; 5.d.; 6.a.iii.	Policy Statement; Continuous Medically Needy Eligibility; Whose Expenses May be Counted; General Rule	1-2	Policy Clarification	ME
03.18.2019	3.; 6.c.ii.; 6.g.	Incurred Medical Expense; Non-Allowable Expenses; Carry Forward Example	1; 4; 6	Non-Substantive Change	ME
07.03.2023	6.b.xvi.	Allowable Medical Expenses	3	Non-Substantive Change	LW

TREATMENT OF RESOURCES: OWNERSHIP, EQUITY VALUE AND ACCESSIBILITY FOR MEDICALLY NEEDY

Legal Authority: 42 CFR 435.840; 42 CFR 435.845; 45 CFR 233.20

1. Policy Statement

A resource is real or personal property which has economic value. Resources can include, but are not limited to cash, savings, investments, houses, land, vehicles, etc. The household's resources are evaluated for ownership, accessibility and equity value. All resources are countable unless specifically excluded by regulation.

2. Definitions

Resource: Cash or other liquid assets, or any real or personal property that an individual owns jointly or individually that can be converted to cash and used for medical support and maintenance.

Resources are those assets the individual has on hand at the beginning of the month as opposed to income, which is any cash, wages, pensions or other funds received during the month.

3. Liquid and Non-Liquid Resources

Liquid resources are cash and other resources that can be readily converted to cash. Examples of resources that are ordinarily liquid include (but are not limited to) stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (savings, checking, time deposits/CDs) and similar items.

The value of countable liquid resources is typically based on the specific value of the resource, e.g., the amount in the financial account, the cash surrender value, or the value of the note held by the client.

Non-liquid resources are resources that cannot reasonably be immediately converted into cash.
A resource which has been determined to be non-liquid for any reason is not considered inaccessible or excluded simply because the value of the asset cannot be accessed at the time of application.

The value of countable non-liquid resources is based on the resource equity value.

4. Fair Market Value (FMV)

The FMV of a resource is determined based on the type of resource. For example, bank accounts are based on the amount of money in the account. Certificates of deposit and other time deposits are based on the amount of money that can be withdrawn after penalties for early withdrawal. Car values are based on National Automobile Dealers Association (NADA) values or statements from knowledgeable sources, such as area car dealers. Real estate is based on Total Market Appraisal, and can be found at http://www.assessment.cot.tn.gov/RE_Assessment/, which is the State of Tennessee's Comptroller of the Treasury's Real Estate Assessment Data listing. Nine counties do not provide property information through the Comptroller's listing. However, links to the property information for those nine counties can be found on the Comptroller's website.

Other types of resources are valued based on statements from knowledgeable sources or other means that are reasonable and appropriate to the type of resource being valued.

Fair market value is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria you use in appraising the value of assets for the purpose of determining Medicaid eligibility.

5. Equity Value

The equity value of a resource is the FMV minus the debt or amount owed on the resource (equity = FMV – amount owed). Only the equity value of an accessible resource is counted toward the resource limit, for resources other than vehicles.

Only debts (amounts owed) that are secured by liens or other legal encumbrances against the resource can be subtracted from the FMV when determining equity.

6. Resource Accessibility & Availability

Resources are considered available either when actually available to the individual or when the individual has a legal or equitable interest in the property or asset, and has the legal or equitable ability to access funds or convert non-cash property into cash. If the individual has the legal or equitable ability to access his or her funds, the resource is considered available regardless of whether the individual has the practical ability to access the resource or convert non-cash property into cash.

The individual's incompetence, whether presumed or actual, does not bar the person's legal authority to withdraw his or her liquid resources in the situation where a conservator, guardian or someone acting on the person's behalf has not been legally appointed.

The resources belonging to an individual whose conservator, guardian, or legally appointed representative does not cooperate with TennCare during the facilitation of accessing resources, shall be considered inaccessible, assuming the methods to access the resources have been fully exhausted.

For applicants who do not have a conservator, guardian or legally appointed representative, or for applicants whose conservator, guardian or legally appointed representatives cannot or will not perform his or her duties on behalf of the individual, contact the Eligibility Policy Unit for assistance.

Consider jointly-owned resources accessible according to the information above, unless the individual rebuts ownership or accessibility, and can verify that the joint ownership does block accessibility of the resource.

7. Ownership

a. Determining Ownership

Ownership of a resource is determined by the:

- Name(s) on the account, title, deed, contract, etc.;
- Source of the funds in the account or used to purchase the resource;
- Purpose for which the account or investment was opened or made; and
- Activity and use of the account or investment.

If the title, deed, contract, account, etc., has only one name listed, the resource belongs to that individual. If more than one name is listed, it is considered a jointly owned resource. Once a resource has been determined to be jointly owned, the resource's accessibility must be evaluated.

b. Jointly Owned Resources

Resources owned jointly with someone outside the household must be evaluated to determine accessibility to the household.

i. General Policy

Count the pro rata share of any countable resource jointly owned by an individual in the household and another owner (non-household member), If the individual can demonstrate that he or she only has access to less than a pro rata share, only the portion to which he or she has access is a countable resource. See section 7c. Rebuttal of 100% Ownership or Accessibility of a Resource.

If an asset cannot be sold or converted due to the conditions of joint ownership, exclude the applicant's equity value in determining resource eligibility. The applicant's equity value in a jointly owned asset can be excluded under the following conditions:

- The joint owner of the resource, who is not a Financially Responsible Relative (FRR), refuses to consent to the sale of the asset or to purchase the applicant's interest; or
- The applicant is free to sell his or her own individual interest in the property, but is unable to find a buyer.

ii. Joint Financial Accounts (Checking, Savings, CD)

1. Unrestricted Access to Funds

An individual with unrestricted access to the entire amount in a joint account has his or her pro-rata share of the value of the account as his or her available asset. Access to an "and" account requires the signatures of all owners of the account. Determine the accessibility of the value of an "and" account when the other owner(s) is a person other than the individuals FRR. If the joint owner is an FRR, the individual's pro-rata share of the entire value of the "and" account is available to him or her as a countable asset.

If an individual has unrestricted access to the funds in a joint account, but does not consider himself or herself to be the owner of the funds either fully or partially, he or she may rebut the ownership presumption.

2. Restricted Access to Funds

An individual's access to the funds in an account may be restricted by the legal structure of the account. Review the terms of the account to determine if the individual has restricted access. If funds are held in trust for the individual, determine who generated the funds. If the funds in the account are the product of the individual's resources or effort, the amount in the account is a countable resource. If it is verified that the funds in the account were deposited by someone else, the value of the account is not a countable resource for the individual.

Example: The following language restricts access to an account to one of the owners: "In trust for John Jones and Mary Smith, subject to the sole order of John Jones, balance at death of either to belong to the survivor." Only John Jones has unrestricted access to the account.

c. Rebuttal of Ownership

i. Rebuttal of 100% Ownership or Accessibility of a Resource

Applicants who wish to rebut a determination that he or she has unrestricted access to a resource will have 30 days from the date of application to present rebuttal evidence. If the individual presents all required rebuttal evidence corroborating his or her allegation of partial or non-ownership and the initial determination is rebutted, count only that portion of the resource the individual owns as an available asset.

ii. Rebuttal Evidence

Rebuttal of resource ownership and accessibility must be submitted in writing, and must be signed by all co-owners. The rebuttal must explain and include verification of the following:

- The reason co-ownership was established;
- The names of individuals whose funds were used to establish the account or purchase the asset, and the amounts each invested;
- The names of individuals who made deposits or withdrawals from an account or who have used the resource; and
- How the funds were spent or what the resources have been used to purchase.

iii. Successful Rebuttal

If the individual successfully rebuts the presumption of 100% ownership or accessibility, action must be immediately taken by the applicant to separate commingled funds, remove his or her name from the account or resource, or restrict his or her access to the account, as applicable to the situation.

d. Verification of Jointly-Owned Resources

If a resource is jointly-owned, or an individual successfully rebuts a presumption of 100% ownership or accessibility, verification of ownership and accessibility are required. Verification must include bank statements, agreements, deeds, titles or other collateral statements. The individual's statement is not sufficient verification.

8. Resource Time and Value Limits

A resource may be excluded for a limited period of time or excluded up to a certain amount. To determine applicable limits, see the specific resource type in the *Countable and Excluded Resources for Medically Needy Categories* policy. Time limits and value limits should be considered when assessing a commingled resource.

9. Commingled Resources

Excluded liquid resources must be kept separate from countable liquid resources in order retain their excluded status.

An excluded liquid resource that is commingled in an account with countable liquid resources will retain its excluded status for 6 months from the date the resources were commingled, unless the resource is specifically excluded for a longer period of time. See *Countable and Excluded Resources for Medically Needy* policy. After six months, for resources not specifically excluded for a longer period of time, the total amount of the commingled account is counted as a resource.

A resource that has been excluded because it is prorated income and has been commingled in an account with countable resources will not be counted as a resource for the period of time over which it has been prorated.

COUNTABLE AND EXCLUDED RESOURCES FOR MEDICALLY NEEDY CATEGORIES

Legal Authority: 26 USC 6409; 42 CFR 435.840; 42 CFR 435.845; 45 CFR 233.20; Public Law 113–295; Tenn. Code Title 71, Chapter 4, Part 8; Tenn. Comp. R. & Regs. 1200-13-20

1. Countable Resources

Countable resources are all those available assets whose value is considered in determining resource eligibility. The equity value of all resources (real and personal property) owned by the Eligibility Determination Group (EDG) are countable unless specifically excluded by regulation.

Count the resources of the following individuals:

a. Children under age 21 and pregnant women who apply for assistance; and
b. Their Financially Responsible Relatives (FRR), if the relative and child(ren)/pregnant woman are living together at the time.

NOTE: Do not count the resources of a pregnant woman's parents, even if they are living in the same home.

Do not include the resources of a FRR who is a Families First, Supplemental Security Income (SSI) or needs-based Veterans Affairs (VA) Benefits recipient. See the *Medically Needy Eligibility Determination Group* policy for additional information.

2. Definitions

Resource Characteristic: A description of a resource's intended use, source or a more specific description of a particular kind of resource. The resource characteristic often determines how to treat the resource, i.e. count or exclude. Not all resource types have a particular resource characteristic. Examples of a resource characteristic include: burial, business or self-employment, personal and specific types of retirement plans.

Resource Type: A liquid or non-liquid asset that an individual owns jointly or individually. The resource type describes the asset itself, and not its intended use, source or other specific features. Examples of a resource type include: checking account, insurance, trusts and property.

3. Resource Characteristics and Types

To determine whether a resource is countable or excluded, factors that must be considered are: the nature of the resource, the date it was created, its intended use, and the source of funds used to create the resource.

Achieving a Better Life Experience (ABLE) Accounts	Resource Type	ABLE accounts or 529A accounts are tax-advantaged savings accounts for individuals with disabilities that are established under a qualified ABLE program. The funds within an ABLE account are intended to cover the individual's qualified disability expenses (QDEs) related to his blindness or disability. QDEs include, but are not limited to: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, and funeral and burial expenses. The balance within a single ABLE account for an individual, including contributions and earnings, is excluded as a resource. This includes contributions made by an ABLE account owner from his own resources and contributions made by a third party, including a trust. Distributions from the ABLE account are excluded if used or intended to be used for QDEs as long as the distributions are identifiable. Distributions from an ABLE account used for non-qualified expenses are excluded if spent in the month of receipt. Distributions from an ABLE account are countable when: • Distributions are retained past the month of receipt and are used for or intended to be used for non-qualified expenses; • Distributions are retained past the month of receipt and were previously excluded because intended for a QDE, but used for a non-qualified expense. Count the amount of funds used as a resource the first of the month in which funds were spent; or • Distributions are retained past the month of receipt, have not been spent, and the intent to use the funds for a QDE has changed. Count the retained funds as a resource the first of the following month. Normal counting rules and exclusions apply to assets or other items purchased with funds from an ABLE account.

		Documentary evidence of an ABLE account should show the following information: • The name of the designated beneficiary or owner of the account; • The state ABLE program administering the account; • The name of the person who has signature authority (if different from the owner); • The unique account number assigned by the state to the ABLE account; • The date the account was opened; and • The first-of-the-month account balance.
Annuity	Resource Type	**1. General Rule** Annuities are contracts or agreements that, in exchange for a lump sum payment or series of payments, provide for the payment of income at regular intervals (i.e., monthly, quarterly, annually). Annuities establish a source of income for a future period, and are often used in retirement planning. Annuities may be counted as a resource or as unearned income, depending on the circumstances of the annuity. If an annuity is determined to be a countable resource, any payments from the annuity will be excluded as income. If the annuity is an excluded resource, the annuity payments received will be counted as unearned income. **2. Treatment of Annuities as a Resource** The countable resource value of an annuity is its FMV. If the applicant is able to provide the FMV of the annuity, verified by two credible sources in the legitimate business of selling and purchasing annuities, accept the verified value. If the applicant does not provide two credible statements of FMV, multiply the total annual payment by the period remaining to determine the countable value. Use the calculated value as the resource value. The calculated value of an annuity

		may be rebutted by providing statements of FMV amounts from two credible sources. A letter from the annuity company stating that the annuity has no value is simply a statement of the company's contractual obligations regarding cash value. This is irrelevant to the true market value of the annuity. There is a thriving secondary market for annuities; even non-assignable annuities can be sold.
Business or Self-Employment	Resource Characteristic	Excluded as essential for the production of earned income, either in trade, business or self-employment. Resources may include: • Tools/equipment; • Stock or raw materials; • Real property; • Personal property essential for income production; • Office equipment; • Business loans for the purchase of capital assets; • Inventory; • Machinery and equipment; • Business/commercial checking accounts; and • Life insurance. No exclusions listed in this section will be applied to property an EDG does not own, including use of such property, except by owners who are members of the EDG.
Burial	Resource Characteristic	Resources that are maintained for the explicit purpose of paying for costs related to the funeral and burial of a deceased EDG member are excluded as resources.
Burial Contract	Resource Type	Exclude burial contracts as a resource, whether revocable or irrevocable, for TennCare Medicaid Medically Needy categories. This applies to the applicant, as well as each EDG member. This does not include prepaid or pre-need burial agreements.
Burial Insurance	Resource Type	Excluded. Burial insurance is a contract whose terms specifically provide that the proceeds can only be used to pay the burial expenses of the insured.

Burial Plot	Resource Type	One burial plot for each member of the EDG is excluded. Burial plots and spaces include burial plots, crypts, mausoleums, urns and other repositories for bodily remains. It also includes vaults, headstones, markers, headstone, containers and arrangements for opening and closing the gravesite.
Cash	Resource Type	Cash is countable. Cash is money on hand or available in the form of currency or coins. Foreign currency or coins are cash to the extent that they can be exchanged for United States issue.
Certificate of Deposit	Resource Type	Certificates of Deposit (CDs) are countable if held in a personal account. The value of a CD is the net amount that could be received after penalties for early withdrawal, if applicable. Taxes are not deducted in determining net value. Determine the net value of a CD via a detailed breakdown from the institution holding the deposit. The breakdown must include the gross deposit, and identify any and all deductions and penalties that would be deducted from the gross deposit if the funds were withdrawn. See the *Treatment of Resources: Ownership, Equity Value & Accessibility for Medically Needy* policy for treatment of jointly owned CDs.
Checking Account	Resource Type	**1. Personal Checking Account** A personal checking account is countable. Determine the countable portion of the account based on ownership. **a. Single Owner Account** The countable resource is the portion of the account that is unencumbered as collateral for a loan, exclusive of funds representing current income. **b. Joint Account** See the *Treatment of Resources: Ownership, Equity Value & Accessibility for Medically Needy* policy for the treatment of jointly-owned checking accounts.

		2. Other Checking Accounts A checking account that is used for purposes other than personal use may be excluded on the terms of intended use. Other resource characteristics of a checking account include: • Burial; • Educational Income; • Individual Development Account; • Plan for Achieving Self-Support (PASS); • Prorated as Income; • Employment Business or Self-Employment; • Proceeds from the Sale of a House; • Disaster/Settlement; and • SSI/Social Security Administration (SSA) Retroactive Payment. Note: Income tax refunds (including any advance payments), such as the Child Tax Credit, are excluded as a resource for a period of 12 months following receipt.
Contract for Deed or Mortgage	Resource Type	The value of a contract for deed or mortgage may be a countable asset depending on the circumstances of the loan, including the individual's role as lender or borrower and the accessibility of the asset. **1. Definition** A mortgage is a security held by the lender on a particular property for the repayment of debt by the borrower within a particular time period. A contract for deed, land contract, and deed of trust are all mortgages on real property. **2. Individual is the Lender** **a. Countable Value** When the individual is the lender for a contract for deed, he may sell or transfer the instrument to have immediate access to the unpaid loan principal. The value of the contract is the unpaid loan principal. Any portion of a payment received that represents the loan principal is a

conversion of a resource. Any portion of a payment received that represents interest is considered unearned income in the month of receipt and a resource thereafter.

b. Excluded as a Resource

The value of the contract may be excluded from countable resources if the individual can demonstrate that the contract cannot be sold without the realization of a net loss.

Evaluate the current status of the contract at redetermination. Do not extend benefits pending a demonstration of unsaleability.

c. Establishing Value

The amount of the unpaid balance of the property agreement (mortgage, contract for deed, etc.) is the value of the countable asset and must be verified at each application and redetermination.

3. Individual is the Borrower

If the individual is the borrower, the property agreement is not a resource. However, the property purchased may be a countable resource following the month of transaction.

4. Reverse Mortgage

a. Description

A reverse mortgage is a loan against the equity in an individual's home that provides cash advances but requires no mandatory monthly repayment during the life of the loan. If the interest is unpaid, it is allowed to accrue against the value of the individual's home.

A reverse mortgage is similar to a conventional mortgage because the bank does not own the home but holds a lien on the property. The borrower continues to hold the title to the property. The bank cannot demand payment from any family member if there is not enough

		equity to cover paying off the loan and there is no penalty for paying off the mortgage early. **b. Policy Application** The proceeds received from a reverse mortgage are tax-free and available as a lump sum or fixed monthly payment for as long as the individual lives on the property. The loan is not due and payable until the borrower no longer occupies the home as a principal place of residence. When the owner no longer resides on the property, the balance of the borrowed funds is due and payable. After the amount received is repaid, any additional equity in the property belongs to the owners or their beneficiaries. When an individual has money in a reverse mortgage line of credit, this money does not count as a loan, or as income or a resource for determining TennCare Medicaid eligibility. If the individual transfers the money to an investment or to a bank account, the amount transferred will become a countable resource. In order to qualify for a reverse mortgage, an individual must be at least age 62 and the property must be the borrower's primary residence. When money is received from a reverse mortgage: • The money withdrawn is tax-free and can be used for any purpose; • The money can be received as a lump sum, line of credit, a monthly payment or any combination of the 3; • There are no mandatory monthly repayment requirements; • The loan can be repaid anytime without penalty; • The title of the home does not change; and • The lender sets the maximum loan amount.
Educational Income	Resource Characteristic	All educational income received under Title IV of the Higher Education Act of 1965, Bureau of Indian Affairs, Department of Veterans Affairs, and work-study programs for post-secondary

		education should be excluded as a resource; there is no time limit. The individual must be enrolled in school and attending classes to be considered a student. Grants, scholarships, fellowships and gifts intended to pay for tuition, fees or educational expenses are excluded as a resource.
Farm, Business or other Equipment	Resource Type	The equity value of non-business income producing real property, other than the homestead, is countable. If the property is used for business or self-employment, it is excluded as Business or Self-Employment. Rental property is a common form of income producing property. Rental property is countable if the individual who owns the property is not 'in the business of' renting property. An individual who is in the business of renting property is someone who materially participates in the operation and decision making of the rental business for at least 20 hours per week.
Household Goods and Personal Effects	Resource Type	**1. Definition** Household goods are items of personal property, found in or near the home, which the individual uses on a regular basis. The individual needs household goods for maintenance, use and occupancy of the premises as a home. Examples of household goods include: furniture, appliances, and electronic equipment. Personal Effects are items of personal property ordinarily worn or carried by the individual, or items that have an intimate relation to the individual. Examples of personal goods include: personal jewelry, personal care items and clothing, pets, educational or recreational items, and items of cultural or religious significance to the individual. Items required because of an individual's physical or mental impairment, such as prosthetic devices or wheelchairs, are also personal effects. **2. Treatment** Excluded.

Individual Development Account (IDA)	Resource Characteristic	IDAs may be established by or on behalf of an individual eligible for Families First assistance. An IDA is different from a regular savings account because funds deposited by a participant are matched by a separate entity and there are restrictions on the use of these funds. An IDA will provide an opportunity for a participant to build assets to further support the transition to self-sufficiency. Up to $5000 in the account is disregarded as a resource as long as the individual complies with the IDA eligibility rules and continues to maintain or make contributions into the account.
Income-Producing	Resource Characteristic	This is a resource characteristic that applies to real property used in a trade or business or non-business income-producing activity. Income producing property is not property that is necessary for self-employment. Income producing property in the Medically Needy categories is countable, if accessible to the individual.
Items of Unusual Value	Resource Type	**1. Definition** Items of unusual value are items that an individual acquires or holds because of their value or as an investment. These items may meet the definition of personal effects. Examples of an item of unusual value include: gems, art collections and animals owned for investment purposes. In general, an item may be considered an item of unusual value if the item is not excluded as a household good or personal effect, and the equity value of the item is over $500. **2. Treatment** An item of unusual value that generates income for the individual is a countable resource. Up to $2,000 of all total personal items of unusual value may be excluded. Amounts exceeding the $2,000 limit are countable resources.

Life Estates	Resource Type	**1. General Rule** A life estate is a property right with a duration limited to the life of the party holding it or to the life of some other party. The holder of a life estate does not have title to the property and cannot sell the property. However, the holder of a life estate can sell her interest in the property unless restricted by the terms of the contract, and is entitled to any income from the property. The income is deemed available to the holder, regardless of whether she actually receives the income. Upon the death of the owner of a life estate, full title and ownership usually passes to the individual named in the will or deed as entitled to the property. Property in which an individual holds a life estate is subject to the same exclusion rules as property the individual owns by title. **2. Life Estate Exclusions** • A life estate will be excluded as the home when the property is the individual's principal place of residence. • A life estate will be excluded when it is necessary for the production of earned income. See the *Business or Self-Employment* resource characteristic. • The terms of life estate contract prevents the holder from selling his interest in the property. **Countable Value** If the life estate is not excluded based on the criteria above, the entire value of the life estate is a countable resource. The life estate value is determined by multiplying the fair market value of the property by the percentage listed in the "*Life Estate Interest Table*" (https://secure.ssa.gov/poms.nsf/lnx/0501140120) for the age of the individual on whose lifetime the life estate is based. If more than one person owns the life estate, the value is based on the owner with the longest life expectancy.

Life Insurance	Resource Type	Excluded. Exclude the value of all life insurance policies owned by individuals for each EDG member. This includes any cash value that the policy may have accumulated.
Livestock	Resource Type	The value of livestock necessary for Business or Self-Employment, as a tool of the trade, or raised for home/personal consumption is an excluded resource. Income received is countable as self-employment income. Livestock that is used as non-business income-producing property is countable, and subject to the policy provided under the *Income-Producing* resource characteristic.
Lump Sum Payments	Resource Characteristic	Lump Sum payments are a countable resource in the month of receipt and thereafter as long as the funds are retained by the individual.
Oil and Mineral Rights	Resource Type	Oil and mineral rights may be included with land ownership or owned separately. If surface rights of the same property are excluded, for example, as a home, so are oil and mineral rights. Obtain verification of oil and/or mineral rights. Acceptable verifications are deeds, lease agreements, titles and homestead documents. If oil and/or mineral rights are producing income under a lease agreement, the owner may be constrained from selling or otherwise disposing of those rights. If the land is already excluded, the oil and/or mineral rights are excluded.
Personal	Resource Characteristic	A personal resource is typically for the use of the individual and his family. A personal resource is typically countable, unless excluded based on the terms of the asset.
Personal Consumption	Resource Characteristic	Exclude the equity value of non-business property used to produce goods or services essential to daily activities. Non-business property used for personal consumption can be real or personal property. It produces goods or services essential to daily activities if it is used, for example, to: • Grow produce or livestock solely for personal consumption in the individual's household; or • Perform activities essential to the production of food solely for home consumption.

		NOTE: This does not include any vehicle that is used for transportation.
PASS	Resource Characteristic	PASS is an SSI provision to help individuals with disabilities return to work. Any income an SSI recipient places in an approved PASS account is excluded as a resource. The PASS account itself is also excluded. This exclusion expires when the PASS contract expires or ends, or when the individual is no longer an SSI recipient.
Prepaid Burial Agreements	Resource Type	Exclude one burial agreement or burial trust with equity value of $1,500 or less per family member.
Proceeds from the Sale of a Home	Resource Characteristic	The proceeds from the sale of a home are excluded to the extent that the funds are intended to be used to purchase another home subject to the homestead exclusion, and the funds are used for such a purpose within 3 months of the date of receipt of the proceeds.
Promissory Note	Resource Type	**1. Promissory Note: Personal Use** A promissory note or other loan given by the EDG is considered personal property and is countable, unless the note or loan balance is inaccessible. The lender holds legal interest and has the legal ability to make available her share in the note or loan. The equity value of the note or loan is countable. **2. Promissory Note: Other Uses** Promissory notes that are made for purposes other than personal use are treated according to their intended use. Promissory notes may be used for the following purposes: • Burial; • Business or Self-Employment; and • Proceeds from the Sale of a Home.
Prorated as Income	Resource Characteristic	A resource that has been prorated as income is an excluded resource. Example: Farmer Jones sells his crop in September for $12,000. The money from the sale is intended to support his family for a

		year. The $12,000 is prorated as income, $1,000 a month. The $12,000 is excluded as a resource.
Real Property	Resource Type	Real property is any building and/or land, improved or unimproved, including recreational, residential and/or commercial property. **1. Countable Value** The equity value in all real property the individual owns individually or jointly is a countable resource with the following exceptions: • Property excluded as home; • The inaccessible equity value of real property; • Real property necessary for the production of earned income (see Business or Self-Employment). **2. Ownership by Title** **i. Ownership Types** **Sole Ownership:** Individual is the only person who owns the property and its sale or transfer is not subject to the approval of others. **Tenancy-in-Common:** Each owner has an undivided interest in the whole property and can sell his own interest without the consent of the other owner(s). Upon the individual owner's death, his share passes directly to his heir(s). **Joint Tenancy:** Each owner holds an individual interest in the whole property and can sell her interest at any time without the consent of the other owner(s). If specifically stated in the deed, the interest of one owner upon her death will automatically pass to the other owner. This is the "right of survivorship" and rarely occurs in Tennessee. **Tenancy by the Entirety:** This form of ownership can exist only between individuals validly married to each other. Any real property held jointly between two

spouses is held as "tenants by the entirety" unless the deed explicitly states otherwise. The owners are treated as if they were one entity, requiring the consent of both owners before any interest can be sold. Upon the death of one owner, his interest passes directly to the other owner.

Home: The home and surrounding property which is not separated from the home by intervening property owned by others. Public rights of way, such as roads which run through the surrounding property and separate it from the home, will not affect the exemption of the property. The home and surrounding property shall remain exempt when temporarily unoccupied for reasons of employment, training for future employment, illness, or uninhabitability caused by casualty or natural disaster, if the household intends to return. Households that currently do not own a home, but own or are purchasing a lot on which they intend to build or are building a permanent home, shall receive an exclusion for the value of the lot and, if it is partially completed, for the home.

ii. Verification

Verify ownership by accepting the individual's sworn statement as to property ownership, a copy of the deed or other public record. If copies of the deed or other public records are unavailable, contact the county Register of Deeds who can verify ownership information.

iii. Establishing Value

The countable value of real property is equal to the individual's equity value in it. The equity value is equal to the Total Market Appraisal, also known as the real value or Fair Market Value, of the property less any encumbrances, liens or other legal claims.

iv. Total Market Appraisal

Total Market Appraisal is determined using the property's assessed value, which can be easily verified. Assessed value is expressed as a percentage of Total Market Appraisal and in Tennessee the ratios are in the chart below.

Type of Property	**Assessed Value: Real Value**
Farm/Residential	25%
Commercial/Industrial	40%

Use the following formula to determine a property's real value:

Farm/Residential: Assessed Value x 4.0 = Real Value
Commercial/Industrial: Assessed Value x 2.5 = Real Value

v. Assessed Value

Determine and verify the assessed value by reviewing a recent tax assessment notice, contact with the county assessor's office, or written documentation of assessed/real value from the agency responsible for property assessment in another state, if appropriate.

The individual has the right to rebut the assessed value. He must provide two written appraisals from two knowledgeable real estate sources, such as a licensed real estate agent, or an appraiser for the Veterans Affairs (VA) or Federal Housing Administration (FHA) that substantiates the claim. In redetermining the value of the property, use the higher of the two appraisals. Retain copies of both appraisals for the case record. If the property value is redetermined in this way, the individual must have the opportunity to present a current alternated valuation at every reapplication or redetermination.

vi. Equity Value

To determine the individual's equity value in real property, subtract the following from the Total Market Appraisal:

- The unpaid mortgage principal, excluding interest;
- The value of any legal lien or claim filed against the property; and
- The amount of any unpaid taxes, excluding current taxes.

The remainder is the equity value and is a countable resource.

vii. Descent of Homestead/Right to Elective Share (Tenn. Code Ann. § 31-4-101)

Right to Elective Share

The surviving spouse of an intestate (without a will) decedent who elects against taking an intestate share, or a surviving spouse who elects against a decedent's will, has the right of election (unless limited by subsection (c) of this same title, to take an elective share amount equal to the value of the decedent's net estate as defined in subsection (b) of this title. The elective share is determined by the length of time the surviving spouse and the decedent were married to each other.

Share of Surviving Spouse and Heirs (Tenn. Code Ann. § 31-2-104)

The intestate share of the surviving spouse is:

- If there are no surviving descendants of the decedent, the entire intestate estate; or

- If there are surviving heirs of the descendants, either one-third or a child share's of the entire intestate estate, whichever is greater.

Countable Value

After the elective share amount has been determined, and all the funeral and administration expenses and debts by creditors have been secured, any remaining amount is countable to the surviving spouse.

The applicant's sworn statement of ownership is sufficient verification when property is inherited through right to elective share.

viii. Ownership Interest in Unprobated Estate

An individual may inherit an interest in property which she may sell or transfer even though the estate is still in probate, i.e. the inheritance has not been legally distributed.

Ownership interest in an unprobated estate is substantiated by the will which granted the individual her interest:

- Deceased died testate (with a will): Review a copy of the will or request that the individual provide a written statement from her attorney itemizing the property in which the individual has an interest. Value each item as is appropriate for its classification, i.e. real estate, personal property, vehicle, etc. The value is a countable resource unless the individual alleges it to be inaccessible and it is determined the availability of the asset provisions apply.

- Deceased died intestate (without a will): Collect the following information and submit it to the TennCare Eligibility Policy Unit with a request for assistance in determining the value and availability of the individual's interest in unprobated property:
  - Copies of deeds or titles to all properties owned by the deceased;
  - Description of other items owned by the deceased, e.g. motor vehicles;

		○ The individual's relationship to the deceased; ○ The date of the deceased's death; and The number of surviving relatives and their relationship to the deceased.
Retirement Account	Resource Type	IRAs, 401(k)s, Keogh or retirement accounts valued 20,000 or less are excluded as resources. If the amount of money in an IRA, 401(k) or Keogh is more than $20,000, only the amount in excess of the $20,000, minus penalty for early withdrawal, is a countable resource. Pension funds that are not accessible are excluded as a resource. If the pension becomes accessible due to retirement or termination, it becomes a countable resource.
Savings Account	Resource Type	The value of a savings account is a countable resource. If the current month's income has been deposited into the account it must be excluded when determining the current value of the account. See the *Treatment of Resources: Ownership, Equity Value & Accessibility for Medically Needy* policy for treatment of jointly owned accounts. A savings account may be excluded if it is used for one of the following purposes: • Burial funds; • Business or Self-Employment; • Educational Income; • Individual Development Account; • PASS; • Proceeds from the Sale of a Home (subject to time limits); • Prorated as income; • Settlement or Disaster Payment, if excluded by policy; and • SSI/SSA Retroactive Payment (subject to time limits). Note: Income tax refunds (including advanced payments), such as the Child Tax Credit, are excluded as a resource for a period of 12 months following receipt.

Settlement or Disaster Payment	Resource Characteristic	Payments or benefits provided under certain Federal statutes are excluded. Excluded settlement and/or disaster payments include:
		
		• Agent Orange Settlement Payments;
		• Disaster Relief Assistance received under the Disaster Relief Act of 1974;
		• Distribution of perpetual judgment funds to Indian tribes under the following:
		    o Indian Judgment Funds Distribution (P.L 93-134)
		    o Black Feet and Gros Ventre Tribes (PL 92-254)
		    o Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K;
		    o Tribes of groups under PL 93-134;
		    o Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL 94-433); and
		    o Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under PL 94-114.
		• Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products;
		• Filipino Veterans Compensation Fund Payments: Lump sum payments made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII;
		• Japanese-American and Aleutian Restitution Payments;
		• Payments made to individuals because of their status as victims of Nazi persecutions;
		• Payments to children born of Vietnam veterans diagnosed with spina bifida;
		• Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (state and local payments are only excluded for nine months);

		• Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act; and • State funds paid to crime victims (excluded for 9 months).
Sick and Disability Insurance	Resource Type	Excluded. Sick and disability insurance primarily provides income to the insured if he becomes disabled.
SSI/SSA Retroactive Payment	Resource Characteristic	SSI retroactive payments are benefits issued in any month after the calendar month for which they are paid. SSA retroactive payments are benefits issued in any month that is more than a month after the calendar month for which they are paid. SSI/SSA Retroactive payments are excluded for 9 months after the payment is received and counted after that 9 month exclusion period.
Stocks, Bonds and Mutual Funds	Resource Type	**1. Stocks** Stocks owned for personal use are countable resources. Shares of stock represent ownership in a corporation or business. For incorporation purposes, stock is assigned a "par value", but a stock's value as an asset is based on the market value. The market value of a stock is a countable resource. Accept the individual's attestation or a copy of the stock certificate, if available. The stock may be counted at a lower value than the market value of a stock if the individual can substantiate the lower value by providing written confirmation of the lower value from a local securities broker. **2. Bonds** Bonds owned for personal use are countable resources. A U.S. Savings Bond is a document issued by the government acknowledging that the money has been loaned to it and will be repaid to the owner with interest. The current value of a bond, which is its countable value, depends on the length of time elapsed since the date of issue and is subject to fluctuations in the interest rate. The name of the bond owner is printed on its face. Some bonds have conversion of "cash-in" restrictions.

Consult a bank to determine the current value of a U.S. Savings Bond and document the date the contact was made, the name of the institution contacted and the quoted value in case notes.

3. Mutual Funds

a. Personal

Personal mutual fund shares are countable. A mutual fund is a company that buys and sells securities and other property. The Current Market Value (CMV) of the shares in the mutual fund owned by an individual is a countable resource unless the individual can establish a lesser value. Determine the CMV by consulting a stockbroker or newspaper to verify the closing price of the stock market as of the day of application or redetermination.

Document the case record with the following information:

- Date that contact was made, or date of newspaper;
- Name of individual or newspaper consulted; and
- Price quoted.

The individual can substantiate a lower value by presenting written confirmation of a lower price from a local securities broker. Accept written verification of ownership from the mutual fund company or by viewing the shares themselves.

b. Mutual fund shares owned for other purposes

Mutual fund shares held for purposes other than personal use are subject to different treatment. Mutual funds shares may be owned for the following purposes:

- Burial;
- Business or Self-Employment;
- Educational Income;

		• Proceeds from the Sale of a Home; • Prorated as Income; or Settlement or Disaster Payment, if excluded by policy.
Tools of the Trade	Resource Characteristic	Tools of the Trade are excluded as essential for the production of earned income. Personal property required by the individual's employer for work is not counted regardless of the value while the individual is employed. An employer-employee relationship must exist between the owner of the resource and the employer that requires the individual to furnish a resource as a condition of employment. Examples of this type of personal property include tools, safety equipment, uniforms and similar items.
Trusts	Resource Type	A trust is any arrangement in which a grantor transfers real or personal property with the intention that it be held, managed, or administered by a trustee(s) for the benefit of the grantor or other beneficiary(ies). A trust and the income generated by a trust will be counted or excluded based on the nature of the trust, the date the trust was created, the source of funds used to create the trust and other factors. See the *Trusts and Medically Needy Categories* policy.
Vehicle	Resource Type	**1. Vehicle Types** Vehicles include cars, trucks, motorcycles, campers, motor homes, aircraft, snowmobiles, watercraft, boats and all-terrain vehicles (ATVs). **2. Determining Ownership** Accept the individual's sworn statement regarding motor vehicle ownership. If ownership is questionable, the following are acceptable verifications: • Vehicle registration; • Bill of sale; or • Title (individual named on title is the undisputed owner).

3. Current Market Value (CMV)

The CMV of a vehicle is the average price that particular year, make, model and condition will sell for on the open market in the particular geographical area involved.

a. Cars and Trucks

Use the average loan value in a current National Automobile Dealers Association (NADA) Used Car Guide Book (or website) to establish the CMV of a car or truck. If the vehicle is not listed in the Guide Book, request estimates of the vehicle's market value from two reputable dealers. Use the higher estimate to value the vehicle and make note of both estimates in Case Notes.

b. Other Vehicles

Contact a reputable dealer to obtain an estimate of the value of other types of vehicles, such as campers, motorcycles, etc. Document contact and estimate in Case Notes.

The individual can substantiate a lower value by submitting written statements of the vehicle's value by from 2 reputable dealers.

c. Motor Homes

Determine whether the motor home is attached or unattached to real property to develop its value.

i. Attached Motor Home

Motor homes attached to a foundation, underpinned or connected to a utility, such as electricity, natural gas or water, are real property. Attached motor homes are considered improvements to the land on which they are located for tax assessments; and are listed on the tax notice as part of the landowner's real property regardless of whether the landowner owns the motor home.

If the individual owns the land and the motor home to which it is attached, use the assessed value to determine the CMV. See Real Property, Section 2.

If the individual is the landowner and claims that the motor home is owned by someone else, he must provide evidence to support the claim. If it is established that the individual does not own the motor home, it is not a countable resource. If he cannot present evidence to support the claim, assume that the motor home belongs to the individual.

If the individual claims to only own the motor home, and not the land to which it is attached, verify the claim using the tax assessment information. Use the most recent tax assessment note to determine the assessed value of the motor home. Use the assessed value to determine the CMV. See Real Property, Section 2.

ii. Unattached Motor Home

An unattached motor home is not affixed to a foundation, underpinned or connected to a utility. Use the average loan value in a current NADA RV or Motor Home Guide Book (or web site) to establish the CMV of an unattached motor home. If the vehicle is not listed in the Guide book, request estimates of the vehicle's market value from a reputable dealer.

4. Equity Value

The equity value of a vehicle is its current market value minus any encumbrances.

5. Treatment as a Resource

Exclude from countable resources up to $4,600 of the equity value of one vehicle. If the vehicle's equity value is greater

		than $4,600, count the equity in excess of the limit. The exclusion should be applied in the manner most advantageous to the individual. In general, the exclusion will be applied to the vehicle with the greatest equity value. The equity value of any other vehicles is countable, unless the vehicle can be excluded under another provision; including: • Home (only applicable to cars, trucks, campers and motorhomes); • Business or Self-Employment; • PASS; or • Tools of the Trade. **6. Recreational Vehicles** Boats, snowmobiles, jet skis, ATVs and aircraft are generally considered recreational vehicles. The entire amount of the individual’s equity in this type of vehicle is a countable resource, unless the vehicle can be excluded under one of the vehicle exclusions listed in the Vehicle section above. Accept the individual’s attestation regarding ownership unless there is a reason to question his statement. Request the appropriate type of legal documentation of ownership is ownership is questionable. Contact a reputable dealer familiar with the type of asset in question to determine the item’s market value. The individual may substantiate a lower market value than that determined by submitting written statements of the vehicle’s value by two reputable dealers.

Document Title	Countable and Excluded Resources for Medically Needy				
First Published	08.11.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.17.2017	3.	ABLE Accounts	1-2	Policy Change	AJ
03.18.2019	1.	Countable Resources	1	Policy Clarification	ME
03.18.2019	2-3.	Definitions; ABLE Accounts; Annuity; Life Estates; Livestock; Personal Consumption; Saving Account; Vehicle	1-4; 11-13; 19; 23-26	Non-Substantive Change	ME
03.18.2019	3.	ABLE Accounts; Annuity; Business or Self-Employment; Burial; Burial Contract; Burial Plot; Contract for Deed or Mortgage; Educational Income; Retirement Account	2-7; 9; 19	Policy Clarification	ME
11.01.2021	3.	Legal Authority; Checking Account, Lump Sum Payments, Savings Account	6; 12; 20	Policy Clarification	MH

MEDICALLY NEEDY CONDITIONAL ASSISTANCE

Legal Authority: 45 CFR 233.20

1. Policy Statement

Conditional assistance may be available to an otherwise eligible TennCare Medicaid Medically Needy applicant based on the fact that she agrees to make reasonable efforts to sell excess real property for its Current Market Value (CMV). The applicant must also agree to repay TennCare for Medicaid costs during the conditional assistance period with proceeds of the sale of that real property. An individual is allowed to receive one period of conditional assistance during a period of eligibility.

2. Eligibility Conditions

To be eligible for conditional assistance, an individual must:

a. Meet all non-financial eligibility criteria;

b. Have countable resources (other than the property that can be excluded under the conditional assistance agreement) below the resource limit for the applicable Eligibility Determination Group (EDG) size;

c. Have countable income less than the Medically Needy Income Standard (MNIS) based on EDG size or have provided sufficient medical expenses in order to meet spenddown;

d. Have total countable resources which exceed the Medically Needy resource standard; and

e. Agree in writing to sell excess real property within the conditional assistance period.

All joint owners of a property must sign the *Medically Needy Agreement to Sell Property Form* in order for any joint owner to be considered for conditional assistance.

3. Real Property

Real property consists of land, buildings or immovable objects that are attached permanently to the land and do not meet the definition of a home.

An individual's home is her principal place of residence and can include land and buildings.

4. Eligibility Period

Conditional assistance may be allowed for eligible individuals up to 9 months while attempting to dispose of excess real property. There is no good cause extension for failure to dispose of real property within 9 months.

Conditional benefits end the earliest of the following:

a. The property is sold;
b. Reasonable efforts to sell the property end without good cause;
c. The individual requests in writing that conditional benefits end;
d. The individual becomes resource eligible without the property exclusion; or
e. The applicable conditional benefits eligibility period has ended.

The individual is required to sell all parcels of real property within one conditional assistance period. When eligibility is terminated, a new conditional benefits period is required if the person becomes eligible again.

5. Reasonable Efforts to Sell

Reasonable efforts to sell resources consist of taking all necessary steps to sell in the geographic area where the resource is located. Within thirty (30) days of signing a conditional assistance agreement, the individual must:

a. List the property with an agent;
b. List the property for sale at auction with an auction company; and
c. All of the following: begin continuously advertising in at least one of the appropriate local media; place a "For Sale" sign on the property in clear public view; begin conducting "open houses" or otherwise show the property to interested parties on a continuous basis; and attempt any other methods of sale.

An individual who enters into a conditional assistance agreement must provide verification that she is making reasonable efforts to sell the property. Verification may include, but is not limited to: copy of contract with real estate agent; collateral contact; or copy of property advertisement in local media. Efforts to sell should not have gaps of more than one week. The individual may not reject any reasonable offers on the property. An offer for real property is assumed to be reasonable if it's at least two-thirds of CMV. The individual has the burden of proving that rejected offers over two-thirds of CMV are not reasonable.

6. Property Not Sold During Conditional Assistance Period

If property under a conditional assistance agreement is not sold during the conditional assistance period, the property will become an inaccessible resource after the end of the conditional assistance period. An individual may receive one period of conditional assistance during the eligibility period.
If the property is sold after the period of conditional assistance is over, then the sale of the property will be reviewed as a conversion of resources, and the recoupment process for Medicaid costs incurred during the conditional assistance period will begin.

7. Procedure

Conditional assistance is not provided automatically if an individual is over the resource limit. An Eligibility Specialist must manually review the case to determine if an offer of conditional assistance can be made.

a. Completed application for TennCare Medicaid is submitted. Required verification is provided.

b. The individual is not determined eligible for any TennCare Medicaid category.

c. The EDG income qualifies the individual for Medically Needy coverage, or the individual is able to meet their calculated spenddown. However, the individual remains ineligible due to excess resources. The Eligibility Specialist will review the resources to determine if the EDG owns non-home, real property.

d. If the EDG owns non-home, real property, the Eligibility Specialist will offer conditional assistance to the individual if that property is the only thing placing the individual over resources. If the EDG does not own non-home, real property, the application will be denied.

e. The individual will complete the *Medically Needy Agreement to Sell Property Form*, ensuring signatures of all owners of the property, and return the form to TennCare.

f. Upon receipt of the *Medically Needy Agreement to Sell Property Form*, the application will be approved. The Eligibility Specialist must set a case alert at 9 months for real property, to determine whether property remains for sale or has sold.

8. Real Property

If real property is listed at the Total Market Appraisal (Fair Market Value), consider the value to be CMV. If real property is listed significantly below or above the Total Market Appraisal (Fair Market Value), obtain a statement from a knowledgeable and disinterested third party stating the value of the real property and why it should be considered current market value. If the individual is working with a real estate agent to sell the home, obtain the statement from the individual’s real estate agent. If the individual is selling the home himself, then request that the individual obtain a written statement from a third party real estate agent.

9. Recoupment

Individuals receiving conditional assistance are subject to the recoupment of Medicaid costs up to the total net proceeds received from the sale of excess real property. Only the Medicaid costs assumed during the period of conditional assistance are subject to recoupment.

The individual must continue making reasonable attempts to sell the property after the property becomes inaccessible due to the expiration of the conditional assistance period. If sold after the conditional assistance period ends, the recoupment amount is limited to the amount of Medicaid payments made during the conditional assistance period.

Document Title	Medically Needy Conditional Assistance				
First Published	11.01.2016				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	1.; 3.-5.; 7.	Policy Statement; Real Property; Eligibility Period; Reasonable Efforts to Sell; Procedure	1-3	Non-Substantive Change	ME
03.18.2019	2.	Eligibility Conditions	1	Policy Clarification	ME

INACCESSIBLE RESOURCES FOR MEDICALLY NEEDY

Legal Authority: 42 CFR 435.840; 42 CFR 435.845; 45 CFR 233.20

1. Policy Statement

A resource may be considered inaccessible if:

- An individual cannot legally access the value of the resource beyond her control, unless undue hardship exists, and all legal avenues have been exhausted in order to access the value of the resource; or
- An individual is unable to sell an asset due to limited use rights, mental impairment or due to conditions of joint ownership; or
- The resource is jointly owned real property AND sale of the property would result in the joint owner being homeless; or
- An individual is unable to locate a buyer for the asset, the conditional assistance period has expired, and the individual continues reasonable to sell the property; or
- The value is unavailable due to a lien against the asset; or
- The asset's value is not accessible to the individual due to litigation.

2. Limited Use Rights

If the individual has only limited use rights to a piece of real property such as lifetime occupancy or dower rights, he is not able to sell the property; however, he can sell his use rights.

Exclude the equity value due to inaccessibility in determining countable resources if the individual can demonstrate unsaleability by providing written statements from two licensed real estate agents substantiating that, in their professional opinion, the life estate (or other use rights arrangement) is unsaleable.

Note: Record in case notes the verbal statements of those in a position to know if they refuse to give a written statement or to sign a written statement.

3. Mental Impairment (applicable to non-liquid resources only)

a. General Rule

If the individual has a guardian, conservator, power of attorney or durable power of attorney at the time of application or renewal, the assets of the individual are considered available to the individual. That person is legally appointed to act on behalf of the individual and is expected to make the individual's assets available use by or for the care of the individual.

If the applicant/enrollee's mental impairment precludes her negotiating the sale of an asset, and she has no guardian or conservator to act on her behalf, exclude the asset as unavailable under certain conditions. It is not necessary that the applicant/enrollee be adjudicated incompetent by a court of law. If, in the Eligibility Specialist's opinion or that of the responsible party or person in a position to know the facts of the applicant/enrollee's situation, the applicant/enrollee is mentally impaired, apply the provision of this policy.

b. Mental Impairment at Application

i. Temporary Exemption

Exclude the asset as unavailable for up to 3 months from approval date if the applicant or the person applying on her behalf agrees to:

- Take steps to be appointed guardian or to contact the applicant's friends and/or relatives regarding their willingness to serve as the applicant's guardian/conservator;
- See that the individual who agrees to serve takes immediate steps toward appointment; AND
- Provide HCFA with substantial documentation of her action and that of the guardian designee.

If the applicant or responsible party is unable to perform the above-cited tasks, he must provide the names and addresses of individuals who might be willing to serve as the applicant's guardian. The HCFA Eligibility Specialist accepts the responsibility for contacting the named individuals in an effort to locate someone willing to act as guardian.

Contact each of the individuals by telephone or by mail explaining the situation and requesting their assistance in securing a guardianship for the applicant for the purposes of making available assets needed to meet his medical needs. Document the case thoroughly.

ii. Long-Term Exemption

An asset may continue to be considered unavailable beyond the initial 3 month period until the next renewal under the following conditions:

A. No guardian is found

If after 3 months, the efforts of the Eligibility Specialist and the person acting in the applicant/enrollee's behalf have failed to locate a potential guardian, document the case record establishing the asset's inaccessibility.

If the applicant/enrollee is otherwise eligible, continue assistance. Extend benefits if all of the following conditions are met:

- The applicant/enrollee requested benefits for that period;
- The same conditions regarding the disputed asset existed at that time; and
- The individual is otherwise eligible.

B. Potential Guardian is Found

Exclude the asset for an additional 30 days from the date the potential guardian agrees to serve to allow him to file a petition for guardianship with the court. If after 30 days the potential guardian has not initiated guardianship procedures for any reason, exclude the resource per instruction above under “no guardian is found”.

If after 30 days, the potential guardian has begun appointment procedures, continue to exclude the asset as unavailable until the next renewal.

Set an expected change at regular intervals (every 60 to 90 days) to follow up on the situation and to determine the court’s instructions regarding the asset.

Note: If it becomes necessary to delay action on an application in order to determine an asset’s availability as described in this item, secure the applicant’s written permission to hold the application pending beyond the processing time limits.

c. Enrollee’s Mental Impairment at Renewal

If the individual has a guardian, conservator, power of attorney or durable power of attorney at the time of application or renewal, the assets of the individual are considered available to the individual. That person is legally appointed to act on behalf of the individual and is expected to make the individual’s assets available for use by or for the care of the individual.

If the applicant/enrollee’s mental impairment precludes his negotiating the sale of an asset, and he has no guardian or conservator to act on his behalf, contact the Eligibility Policy Unit for further guidance.

4. Joint Ownership

a. General Rule

If an asset cannot be sold or converted due to the conditions of joint ownership, exclude the applicant’s equity value in determining resource eligibility. The applicant’s equity value in a jointly owned asset can be excluded under the following conditions:

- The resource is jointly owned with a person or persons who are not the applicant’s financially responsible relative (i.e., spouse or parent); and
- The joint owner refuses to consent to the sale of the asset or to purchase the applicant’s interest.
- Even though the applicant is free to sell his own individual interest in the property, she is unable to find a buyer.

Note: Any portion of real property owned through “tenancy-in-common” or “joint tenancy” arrangements is available to each owner for sale or transfer without the consent of the other (joint) owner(s).

b. Joint Ownership Policy Implementation at Application

Do not extend TennCare Medicaid benefits until the asset’s inaccessibility to the applicant has been substantiated by the following:

- The co-owner(s) written refusal to consent to the sale of the asset and to purchase the applicant's share, if applicable; or
- Substantiation (by deed or the written statement of a licensed real estate agent or an attorney) that the applicant is unable to sell his interest in the asset without the consent of the co-owner(s) OR that his individual share is unsaleable.

Note: If it is necessary to hold the application pending beyond the processing time limits, secure the applicant's written permission to do so.

c. Joint Ownership Policy Application at Redetermination

If the asset has not previously been excluded as described in this item, do not continue to extend benefits at review until the asset has been demonstrated to be unavailable as described above.

Take steps to close the case observing standard adequate and advance notice requirements.

Once the asset's inaccessibility has been verified and the individual has reapplied, benefits may be extended retroactively to the date of closure provided the individual was otherwise eligible.

At least 30 days before the review is due, secure the joint owner's written statement regarding his position on the sale of the asset and the purchase of the individual's share, if applicable. Request that the individual present written substantiation of his inability to sell the asset as described above. Continue to exclude the value of the asset if the individual's claim of inaccessibility is supported by the joint owner's statement.

5. Ownership Interest in an Unprobated Estate

If the applicant/enrollee has inherited an interest in real property that is part of an estate still in probate, his interest is a countable asset because he can legally sell it. It may, however, be difficult to do so.

Exclude the value of the asset if the applicant/enrollee can demonstrate that he is unable to sell his interest by providing statements from two knowledgeable sources, e.g., an attorney or real estate agent, that his interest cannot be sold. The exclusion can be applied to the asset only while it remains in probate.

Extend benefits only after the inaccessibility of the asset is substantiated as described above. Secure the applicant/enrollee's written permission to hold the application pending beyond the processing time limits, if necessary. Do not continue to extend benefits until receipt of current verification that the asset is unavailable.

6. Inability to Locate a Buyer

a. Policy Statement

If an individual owns an asset for which she has full use rights and the unrestricted right to sell, and is making a reasonable effort to sell the resource, but is unable to locate a buyer, the individual's equity value may be excluded as a countable resource. Before the property may be excluded, the individual must agree to a conditional assistance period (see *Medically Needy Conditional Assistance* policy). If the conditional assistance period expires without a sale, the property can be considered inaccessible. However, attempts to sell the property must continue.

b. Defined Terms

Offered for sale - means listing the property with a licensed real estate agent, advertising the property for sale using at least two alternate methods such as a sign on the property and a newspaper ad in a newspaper that serves the area where the property is located, or placing the property on auction.

Reasonable asking price - means a price that is not inflated, i.e., not in excess of 100% of the real value.

Legitimate offer - means one that is at least equal to the reasonable asking price, does not require the client to extend credit, and does not result in a net loss to the client. No reasonable offer to buy may be refused by the client or her authorized representative.

Mortgage or Promissory Note - A reasonable effort to sell a mortgage or promissory note exists when all the following conditions are met:

- The client has made an effort to offer the instrument to a bank or other financial institution; AND
- The best offer he received is more than 10% below the actual value of the remaining principal; AND
- The client presents written verification from the representative of at least two financial institutions that the mortgage or note could only be sold if discounted by more than 10%.

c. Policy Implementation - At Application

i. Initial Exclusion-Conditional Assistance

Once real property is exempt under the provisions of this policy, it must remain on the market at a reasonable asking price until it is sold OR the client is no longer eligible for and a recipient of TennCare Medicaid benefits.

d. At Redetermination - Reasonable Efforts to Sell

i. Initial Exclusion

If the asset has not previously been excluded based on the offer and acceptance of a conditional assistance period, do not continue to extend benefits until such an offer and acceptance occurs (see *Medically Needy Conditional Assistance* policy chapter). If the individual does not agree to the conditional assistance period, take steps to close the case observing standard adequate and advance notification procedures.

NOTE: Property cannot be exempt as homestead while it is being offered for sale. A property's exemption as homestead is voided by an attempt to sell the property.

ii. Real Estate

Once the asset has been proven unavailable, exclude the client's equity value in real estate effective the date it was placed for sale. This will allow any subsequent approval and include benefits retroactively to the date of closure. In order for the real property to continue in its exclusion status, it must remain on the market until it is sold or until the client's case is closed.

iii. Mortgage or Promissory Note

Exclude the value of a mortgage or note effective the date of the written verification or prior to that date if similar (documented) conditions existed, whichever is earlier.

iv. Asset Previously Excluded

At least 30 days before the redetermination is due, begin the review of asset availability. In order for real property to retain its exclusion under the terms of this item, it must remain on the market until sold or the client is no longer eligible. The client must provide current verification of the following regarding the property:

- The property is advertised for sale using at least two methods of advertisement OR is listed with a broker; AND
- Is listed with a reasonable asking price; AND
- The client has not declined any reasonable offers.

In order to continue exclusion of the unpaid principal on a mortgage or promissory note, the client must provide current (no older than 30 days) verification of his reasonable effort to sell as defined above.

7. Lien

Consider unavailable to the applicant/enrollee any portion of real or personal property against which a legal lien has been filed. The equity value in the remaining portion is an available asset. Do not exempt any portion of an asset under the provisions of this item until it is established that the lien is legal, i.e., filed, UNLESS the lien is one pending filing by the Department of Intellectual and Developmental Disabilities (DIDD). Deduct the amount of the legal (filed) lien from the individual's equity value in the asset to determine the portion that remains a countable asset.

Record the following information regarding the lien in the eligibility system:

- Name of the party filing the lien;
- Total amount of the lien;
- Filing date; and
- Place filed.

a. DIDD Liens

Exclude as unavailable an amount equal to the amount of the pending lien if written assurance from the DIDD that a claim will be filed within 90 days is received. Do not extend or continue benefits until confirmation of the DIDD's intent to file a lien is confirmed.

If a temporary 90 day exemption is extended, set up an expected change effective the 90th day. On the 91st day, secure a copy of the lien for the case record. If one has not been filed, discontinue the exemption and consider the entire amount of the individual's resources available to him.

8. Litigation

The equity value of any resource involved in litigation is considered to be unavailable to the individual. Litigation means involved in a lawsuit or some type of court action. Verify with the individual's attorney the fact of litigation or secure written documentation that substantiates the individual's allegation that the asset is involved in litigation. The asset is considered unavailable to the individual effective the date it became involved in the litigation action.

Document Title	Inaccessible Resources for Medically Needy				
First Published	6.1.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
11.1.2016	1	Policy Statement	1	Policy Change	NF
11.1.2016	2	Limited Use Rights	1	Non-Substantive Change	NF
11.1.2016	3	Individual's Mental Impairment (applicable to non-liquid resources only)	1-2	Non-Substantive Change	NF
11.1.2016	4	Joint Ownership	3-4	Non-Substantive Change	NF
11.1.2016	5	Ownership Interest in an Unprobated Estate	4	Non-Substantive Change	NF
11.1.2016	6-a	Inability to Locate a Buyer-Policy Statement	4-5	Policy Change	NF
11.1.2016	6-b	Inability to Locate a Buyer-Defined Terms	5	Policy Change	NF
11.1.2016	6-c	Inability to Locate a Buyer-Policy Implementation-At Application	5	Policy Change	NF
11.1.2016	6-d	Inability to Locate a Buyer-At	5-6	Policy Change	NF

		Redetermination-Reasonable Efforts to Sell			

TRUSTS AND MEDICALLY NEEDY CATEGORIES

Legal Authority: 42 USC 1396p; State Medicaid Manual § 3257

1. Overview

A trust is a right of funds or property held by an individual (the trustee) for the benefit of another (the beneficiary) or for self-benefit. A trust is composed of the initial amount used to create the trust (the principal) and any income (usually interest) it may produce. The trustee holds legal title to the trust and manages it for the benefit or use of the beneficiary.

Determine whether a trust is a countable or excluded resource when the applicant or household member is either the trust's trustee or beneficiary.

2. Definitions

Trust: A right of funds or property held by an individual, the trustee, for the benefit of another individual, the beneficiary, or by an individual for self-benefit.

Legal Instrument or Device Similar to a Trust: Any financial instrument that resembles a trust which includes, but is not limited to: escrow accounts, pension funds, annuities and other similar financial tools managed by an individual or entity with fiduciary responsibilities.

Grantor/Trustor: The person who creates a trust, including a court or administrative body with legal authority to act in place of or on behalf of or at the request or direction of the individual or his or her spouse.

Trustee: An individual who holds the legal title to funds for the benefit or use of another individual.

Beneficiary: An individual for whose benefit a trust is created.

Self-Settled Trust or Grantor Trust: The grantor of the trust is the sole beneficiary of the trust (i.e., the grantor established a trust for himself or herself).

Mandatory Trust: Requires the trustee to pay to or for the beneficiary's benefit, the trust's earnings and principal at certain times in specified amounts or for a specified type of care. The trustee has no discretion on distribution from the trust.

Discretionary Trust: The trustee has discretion to use the trust for the beneficiary's needs as he or she deems appropriate. The beneficiary has no control over the trust.

Totten Trust: A trust in which the grantor makes himself or herself trustee of his or her own funds for the benefit of another. The trustee or grantor can revoke the trust at any time. If the trustee dies before revoking the trust, the beneficiary becomes owner of the trust. The terms of the trust will indicate how the trust is to be used or what limits are placed on the use of the funds by the trustee.

3. Accessibility

Trusts must be evaluated for accessibility. If a trust is accessible, and verification is received that only a portion of the trust is available to the individual, only the available portion will be considered in the resource determination. If such verification is not received, the full value of the trust will be considered available to each beneficiary.

a. Revocable Trust

A revocable trust is a trust that can be modified or terminated by the grantor, or someone else, according to the terms of the trust. A trust which is called irrevocable but which terminates if the grantor or someone else takes some action is also considered a revocable trust.

i. Revocable Trust Established prior to 8/11/1993

The full amount of the trust is a countable resource. Interest which accrues to the account is counted as unearned income. Withdrawals from the trust are not considered income, as they are a conversion of a resource.

ii. Revocable Trust Established on or after 8/11/1993

Any revocable trust or similar device established on or after 8/11/1993 is considered an accessible resource. If an individual’s assets form part or all of the revocable trust, and it was established by the individual, his or her spouse, or an entity with legal authority to act in behalf or at the direction or request of the individual, the trust is subject to the following policy:

- The principal of the trust is a countable resource; and
- Any payments from the trust to or for the benefit of the individual are considered income for the individual;

b. Irrevocable Trust

An irrevocable trust is a trust that cannot be modified or terminated by the grantor or (in most cases) anyone else. A trust which is called irrevocable but which terminates if the grantor or someone else takes some action is considered a revocable trust. An irrevocable trust may be accessible and countable for eligibility purposes.

i. Irrevocable Trust Established prior to 8/11/1993

If the trust is legally irrevocable and the beneficiary is not a financially responsible relative (FRR) or one for whom the individual is not financially responsible, the individual does not have access to the funds unless he or she is also a beneficiary.

This policy does not apply to Medicaid Qualifying or Testamentary trusts.

ii. Irrevocable Trust Established on or after 8/11/1993

An irrevocable trust or similar device which contains an individual’s own assets, forms all or part of the principal of a trust and is established (other than by will) by the individual or spouse, or by a person/entity with legal authority to act on behalf of or at the direction of the individual or spouse is subject to the policy outlined below. This policy applies to the portion of the trust which includes the assets of the individual regardless of the purpose of the trust, whether the trustees have or exercise any discretion under the trust, or any restrictions on distributions or use of distributions:

- Any payments from the trust paid to or for the benefit of the individual for any purpose are considered income to the individual unless payment is made for medical care or other purposes not considered income.

- Income on the corpus (principal) of the trust or any portion of the principal which could be paid to or for the benefit of the individual is considered an available resource to the individual.

4. Medically Needy Trust Exclusion

This policy applies to inaccessible trusts that have been set up for a minor (under age 18). If the value of the inaccessible trust is $5,000 or less, the trust is an excluded resource.

If the value of the trust is greater than $5,000, the caretaker of the child beneficiary has 60 days from the date of application or redetermination to attempt to make the trust accessible or available. Exclude the value of the trust as an inaccessible asset during the 60-day period. At the expiration of the 60-day period, secure verification from the applicant’s caretaker that action has been taken to make the trust accessible. If the trust has been made accessible, evaluate the resource based on the trust type. If the trust has not yet been made accessible, follow-up on the status of the trust at least every 60 days. Continue to exclude the trust while steps are being taken to make it accessible.

If the value of the trust is greater than $5,000 and the caretaker of the child beneficiary does not take action to make the trust accessible, remove the caretaker from the household size but continue to count his or her income in household income. The trust will not be a countable resource if it remains inaccessible.

5. Trusts Types

a. Burial Trust

A burial trust is a trust established by an individual for purposes of setting aside funds for payment of burial expenses for the individual or someone else. Burial trusts are not the same as funds held in trust by a funeral home in conjunction with a prepaid funeral arrangement or burial contract.

A burial trust is excluded for the TennCare Medicaid Medically Needy categories.

b. Living Trust

A “living trust” is usually a revocable, self-settled trust often created for tax and estate planning purposes. A living trust is a countable resource for the TennCare Medicaid Medically Needy categories.

c. Self-Settled Trust

A self-settled trust is a trust created by a person with his or her own funds for his or her own primary benefit. A self-settled trust is a countable resource.

d. Testamentary Trust (Trust Created by a Will)

Determining the countable value of a testamentary trust as a resource to the beneficiary depends on the terms of the will. The terms of the will may specify that only the income or both the income and the principal are available to the beneficiary. In addition, the terms may specify that the beneficiary has limited access to the funds or that only the trustee or the court has access to the trust amount. If the trustee has the discretion to use the trust principal for the applicant's support and maintenance and/or medical needs, the value of the trust is an unavailable asset, but the trust itself is a third party medical resource and must be reported as a third party liability.

e. Medicaid Qualifying Trust

A Medicaid Qualifying Trust is not a countable resource for the TennCare Medicaid Medically Needy categories. See the *ABD Trusts* policy.

f. Pooled Trust

A Pooled Trust is not a countable resource for the TennCare Medicaid Medically Needy categories. See the *Trusts* policy in the ABD Manual.

g. Special Needs Trust

A Special Needs Trust is not a countable resource for the TennCare Medicaid Medically Needy categories. See the *Trusts* policy in the ABD Manual.

h. Medicaid Qualifying Income Trust (QIT) or Miller Trust

Only individuals who are applying for Institutional Medicaid and long term services and supports may establish a QIT.

6. Trust Income

a. If the trust is a testamentary trust and/or it is producing regular income for the beneficiary, the value of the trust is not a countable asset as long as the terms of the trust specify the following,:

- The beneficiary does not have access to the trust principal and/or income; and
- Such access is limited to the trustee or to the court; and
- The trust does not contain the beneficiary's own assets.

Any payments an individual receives from the trust are considered unearned income. Income is counted in the month it becomes available to the individual.

b. Dividends, interest, rents and other income generated by a trust fund, unless otherwise excluded, that can be paid to or for the benefit of the beneficiary are considered countable income to the beneficiary in the month they become available, regardless of whether the income is actually paid out to the beneficiary.

c. Income earned by a trust that can be, but is not distributed to the beneficiary, and is instead retained in the trust becomes a countable resource in the months following the month the income was available for distribution. This provision applies even if the remainder of the principal of the trust is not a countable resource to the beneficiary.

d. Funds withdrawn from the principal of an inaccessible or excluded trust, unless otherwise excluded, are countable as income in the month received.

e. Funds withdrawn from the principal of an accessible or countable trust are excluded as income because an accessible trust fund is a countable resource. Money cannot be considered both income and resource in the same month.

f. If the trustee has the discretion to use the trust principal for the individual's support and maintenance of medical needs, the value of the trust is an unavailable asset, but the trust itself is a third party medical resource and must be reported to HCFA Third Party Liability Unit.

FORMER FOSTER CARE CHILDREN UP TO AGE 26

Legal Authority: 42 USC 1396(a)(10)(A)(i)(IX); 42 CFR 435.150; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

The Affordable Care Act (ACA) of 2010 requires states to provide Medicaid benefits to individuals under the age of 26 who were previously in foster care in the state. Individuals under age 26 are eligible to receive TennCare Medicaid if they were under the responsibility of the Tennessee Department of Children's Services (DCS) and enrolled in TennCare Medicaid upon turning age 18.

Starting January 1, 2023, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, requires states to provide Medicaid benefits to individuals who were previously in foster care in any state. Individuals under age 26 are eligible to receive TennCare Medicaid if they were in foster care under the responsibility of any state, were enrolled in Medicaid when they aged out of foster care, and they meet all other non-financial eligibility requirements. Individuals who aged out of foster care in another state must have turned 18 on or after January 1, 2023. If an individual turned 18 prior to January 1, 2023, he must have aged out of DCS custody and received TennCare Medicaid at the time he aged out to be considered for eligibility in the Former Foster Care category.

2. Non-Financial Eligibility Requirements

a. **Age:** An individual eligible in this category may maintain eligibility up to age 26.
b. **Citizenship:** An individual must be a U.S. Citizen, U.S. National or eligible non-citizen. An individual is not required to provide documentary evidence of citizenship or national status if she was assisted under Title IV-B or received foster care maintenance or adoption assistance payments under Title IV-E.
c. **Enumeration:** An individual must possess and provide a valid Social Security Number, unless he meets an exception.
d. **Residency:** An individual must be a resident of the state of Tennessee.
e. **Former Foster Care Recipient:** An individual must have been in foster care under the responsibility of a state and received Medicaid until aging out at age 18 or older. If an individual aged out of foster care in another state, the individual must have turned 18 on or after January 1, 2023, to be considered a former foster care recipient for TennCare Medicaid eligibility purposes.

3. Financial Eligibility Requirements

There are no financial eligibility requirements for this category.

4. Verification

Former foster care information is received from DCS and stored in TennCare's Medicaid Management Information System (MMIS) for individuals who aged out of DCS custody. TennCare verifies former foster care status through MMIS for individuals who aged out of DCS custody and turned 18 prior to January 1, 2023.

For individuals who turn (or turned) 18 on or after January 1, 2023, TennCare accepts self-attestation of former foster care status, unless TennCare has information that is not compatible with the attested information. If TennCare has a reason to doubt an individual's former foster care status, and the individual's former foster care status cannot be verified electronically, additional verification may be requested.

Document Title	Former Foster Care Children Up To Age 26				
First Published	12.3.2014				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
12.02.2015	2	Enrollment Procedure	1	Policy Change	AF
01.03.2023		Legal Authority	1	Policy Clarification	AJ
01.03.2023	1.-2., 4.	Policy Statement; Non-Financial Eligibility Requirements; Verification	1-2	Policy Change	AJ

DEEMED NEWBORNS

Legal Authority: 42 CFR 435.4; 42 CFR 435.117; Section 1902(e)(4) of the Social Security Act

1. Policy Statement

Infants born to a mother eligible for and receiving TennCare Medicaid or Emergency Medical Services (EMS) at the time of birth are deemed automatically eligible (no income test) for TennCare Medicaid. Deemed Newborns remain eligible for one year from the date of birth. An application is not required to enroll a child as a Deemed Newborn.

Infants born to mothers eligible for TennCare Standard or CoverKids are not eligible as Deemed Newborns. A newborn or child under age 1 whose mother was not eligible for or receiving TennCare Medicaid at the time of birth is not automatically eligible and must apply for benefits.

2. Application

a. Mother Receiving TennCare Medicaid

No application is required to enroll an infant in the Deemed Newborn TennCare Medicaid category. Eligible infants are enrolled once TennCare is notified of the infant's birth.

b. Mother Receiving Emergency Medical Services

A pregnant woman may be approved for EMS for labor and delivery. If a pregnant woman applies, is determined eligible for and subsequently receives EMS on the date of her child's birth, the child should be enrolled as a Deemed Newborn from the date of birth. If the mother is found to be ineligible for EMS, then the newborn will be tested for TennCare Medicaid eligibility in the open Medicaid categories.

3. Period of Eligibility

A Deemed Newborn's eligibility begins on the date of birth, and extends to the child's first birthday.

4. Non-Financial Eligibility Requirements

To be eligible for the Deemed Newborn category an infant must:

a. Be under the age of 1;
b. Have been born to a mother eligible for and receiving TennCare Medicaid or EMS at the time of birth;
c. Continue to be a Tennessee resident.

5. Financial Eligibility Requirements

There are no financial (income) requirements for the Deemed Newborn category. If the infant's mother was eligible for TennCare Medicaid or EMS, the mother met financial requirements at the time her own eligibility was determined.

Document Title	Deemed Newborns
First Published	10.28.2014

Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
09.01.2016	1.	Policy Statement	1	Policy Clarification	AJ
09.01.2016	2b.	Application – Mother Receiving Emergency Medical Services	1	Policy Clarification	AJ
09.01.2016	3.	Period of Eligibility	1	Policy Clarification	AJ
02.01.2018	1.	Policy Statement	1	Policy Change	TN
02.01.2018	4.	Non-Financial Eligibility Requirements	1	Policy Change	TN

CHILD 0-1 MAGI

Legal Authority: 42 CFR 435.4; 42 CFR 435.112; 42 CFR 435.115; 42 CFR 435.118; 42 CFR 435.603

1. Policy Statement

TennCare Medicaid benefits are available to infants age 0 to 1 year old whose household income is equal to or less than 195% of the Federal Poverty Level (FPL) based on the Eligibility Determination Group (EDG) size, and who meet all non-financial eligibility requirements.

2. Non-Financial Eligibility Requirements

Children eligible for the Child 0-1 MAGI category must meet all non-financial eligibility requirements. Additional information about each condition of eligibility is available in the Non-Financial Eligibility Requirements section of the *Families and Children Manual*.

a. Age: A child must be from birth up to age 1.

b. Citizenship: A child must be a U.S. Citizen, U.S. national or eligible non-citizen.

c. Enumeration: A newborn child is not required to be enumerated until the age of 1.

d. State Residence: A child must be a resident of Tennessee.

e. Cooperation with Child Support Services: A child is not required to agree to cooperate with Child Support Services. If the parent or caretaker of a child who is applying for benefits refuses to cooperate, the child will not be penalized. The child will be reviewed for or maintain eligibility in this category.

3. Financial Eligibility Requirements

a. Eligibility Determination Group

The EDG for this category uses the Modified Adjusted Gross Income (MAGI) methodology. It is possible for household members to have different EDG sizes when determining eligibility. For additional information regarding EDG size see the *Eligibility Determination Group for MAGI* policy.

b. Income Standard

The income standard for the Child 0-1 MAGI category is 195% FPL.

c. Budget

Mr. and Mrs. Jones applied for Medicaid for their 5 month old dependent child. Mr. Jones is self-employed and with a Net Countable Self-Employment Income of $1,700. Mrs. Jones is employed with a Net Countable Earned Income of $2,600. Her Before/Pre-tax Contributions total $600. The couple claimed $300 of student loan interest on their tax return. The example budget is based on an EDG size of 3 and determines eligibility for the child with an Income Test Limit of $3,319.

Mr. and Mrs. Jones' Remaining Countable Earned/Self-Employment Amount, $3700, is over the Income Test Limit, $3,319. After application of the 1040 deduction and the MAGI 5% deduction, the child meets the Income Test Limit for the Child 0-1 MAGI category.

Income Budget Calculation		
Net Countable Self-Employment Income		$ 1,700.00
Net Countable Earned Income		$ 2,600.00
Before/Pre-tax Contribution Deductions	-	$ 600.00
Remaining Countable Earned/Self-Employment Amount	=	$ 3,700.00
Net Countable Unearned Income	+	$ 0.00
Countable Earned and Unearned Income	=	$ 3,700.00
1040 Deduction	-	$ 300.00
MAGI 5% Deduction	-	$ 86.00
Net Countable Income	=	$ 3,314.00
Income Test Limit		$ 3,319.00
Gap Filling Amount	-	$ 0.00
Total Net Countable Income	=	$ 3,314.00
Income Test Result		PASS

The above budget is current as of March 2017.

d. Resource Test

There is no resource test for the Child 0-1 MAGI category.

Document Title	Child 0-1 MAGI				
First Published	08.21.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	1.; 3.a.	Policy Statement; Eligibility Determination Group	1	Policy Clarification	SN
03.18.2019	2.; 3.c.	Non-Financial Eligibility Requirements; Budget	1-2	Non-Substantive Change	SN

CHILD 1-5 MAGI

Legal Authority: 42 CFR 435.4; 42 CFR 435.112; 42 CFR 435.115; 42 CFR 435.118; 42 CFR 435.603

1. Policy Statement

TennCare Medicaid benefits are available to children aged 1 through 5 whose household income is equal to or less than 142% of the Federal Poverty Level (FPL) based on the Eligibility Determination Group (EDG) size, and who meet all non-financial eligibility requirements.

2. Non-Financial Eligibility Requirements

Children eligible for the Child 1-5 MAGI category must meet all non-financial eligibility requirements. Additional information about each condition of eligibility is available in the Non- Financial Eligibility Requirements section of the *Families and Children Manual*.

a. Age: A child must be age 1 through 5.

b. Citizenship: A child must be a U.S. Citizen, U.S. national or eligible non-citizen.

c. Enumeration: A child must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN, unless they meet an exception.

d. State Residence: A child must be a resident of Tennessee.

e. Cooperation with Child Support Services: A child is not required to agree to cooperate with Child Support Services. If the parent or caretaker of a child who is applying for benefits refuses to cooperate, the child will not be penalized. The child will be reviewed for or maintain eligibility in this category.

3. Financial Eligibility Requirements

a. Eligibility Determination Group

The EDG for this category uses the Modified Adjusted Gross Income (MAGI) methodology. It is possible for household members to have different EDG sizes when determining eligibility. For additional information regarding EDG size see the *Eligibility Determination Group for MAGI* policy.

b. Income Standard

The income standard for the Child 1-5 MAGI category is 142% FPL.

c. Budget

Ms. Delaney applied for Medicaid for her 3 year old dependent child. Ms. Delaney is employed with a Net Countable Earned Income of $2,400. She has no Before/Pre-tax Contributions or 1040 Deductions. The following budget is based on an EDG size of 2 and determines eligibility for the child with an Income Test Limit of $1,922.

Ms. Delaney's Remaining Countable Earned/Self-Employment Amount, $2,400, is over the Income Test Limit, $1,922. Application of the MAGI 5% deduction does not result in the child meeting the Income Test Limit for the Child 1-5 MAGI category.

Income Budget Calculation		
Net Countable Self-Employment Income		$ 0.00
Net Countable Earned Income		$ 2,400.00
Before/Pre-tax Contribution Deductions	-	$ 0.00
Remaining Countable Earned/Self-Employment Amount	=	$ 2,400.00
Net Countable Unearned Income	+	$ 0.00
Countable Earned and Unearned Income	=	$ 2,400.00
1040 Deduction	-	$ 0.00
MAGI 5% Deduction	-	$ 68.00
Net Countable Income	=	$ 2,332.00
Income Test Limit		$ 1,922.00
Gap Filling Amount	-	$ .00
Total Net Countable Income	=	$ 2,332.00
Income Test Result		FAIL

The above budget is current as of March 2017.

d. Resource Test

There is no resource test for the Child 1-5 MAGI category.

Document Title	Child 1-5 MAGI
First Published	08.21.2015

Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	1.; 3.a.	Policy Statement; Eligibility Determination Group	1	Policy Clarification	SN
03.18.2019	3.c.	Budget	2	Non-Substantive Change	SN

CHILD 6-18 MAGI

Legal Authority: 42 CFR 435.4; 42 CFR 435.112; 42 CFR 435.115; 42 CFR 435.118; 42 CFR 435.603

1. Policy Statement

TennCare Medicaid benefits are available to children aged 6 through 18 whose household income is equal to or less than 133% of the Federal Poverty Level (FPL) based on the Eligibility Determination Group (EDG) size, and who meet all non-financial eligibility requirements.

2. Non-Financial Eligibility Requirements

Children eligible for the Child 6-18 MAGI category must meet all non-financial eligibility requirements. Additional information about each condition of eligibility is available in the Non- Financial Eligibility Requirements section of the *Families and Children Manual*.

a. **Age:** A child must be ages 6 through 18 years.

b. **Citizenship:** A child must be a U.S. citizen, U.S. national or eligible non-citizen.

c. **Enumeration:** A child must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN, unless they meet an exception.

d. **State Residence:** A child must be a resident of Tennessee.

e. **Cooperation with Child Support Services:** A child is not required to agree to cooperate with Child Support Services. If the parent or caretaker of a child who is applying for benefits refuses to cooperate, the child will not be penalized. The child will be reviewed for or maintain eligibility in this category.

3. Financial Eligibility Requirements

a. Eligibility Determination Group

The EDG for this category uses the Modified Adjusted Gross Income (MAGI) methodology. It is possible for household members to have different EDG sizes when determining eligibility. For additional information regarding EDG size see the *Eligibility Determination Group for MAGI* policy.

b. Income Standard

The income standard for the Child 6-18 MAGI category is 133% FPL. FPL Thresholds are rounded to the nearest dollar amount.

c. Budget

Mr. Thompson applied for Medicaid for his 14 year old dependent child. Mr. Thompson receives $1,550 a month in temporary disability insurance and has no other income. The example budget is based on an EDG size of 2 and determines eligibility for the child with an Income Test Limit of $1,800.

Mr. Thompson's Net Countable Unearned Income, $1,550, is under the Income Test Limit, $1,800. The MAGI 5% Deduction is not applied because the Total Net Countable Income is under the Income Test Limit for the Child 6-18 MAGI category.

Income Budget Calculation		
Net Countable Self-Employment Income		$ 0.00
Net Countable Earned Income		$ 0.00
Before/Pre-tax Contribution Deductions	-	$ 0.00
Remaining Countable Earned/Self-Employment Amount	=	$ 0.00
Net Countable Unearned Income	+	$ 1,550.00
Countable Earned and Unearned Income	=	$ 1,550.00
1040 Deduction	-	$ 0.00
MAGI 5% Deduction	-	$ 0.00
Net Countable Income	=	$ 1,550.00
Income Test Limit		$ 1,800.00
Gap Filling Amount	-	$ 0.00
Total Net Countable Income	=	$ 1,550.00
Income Test Result		PASS

The above budget is current as of March 2017.

d. Resource Test

There is no resource test for the Child 6-18 MAGI category.

Document Title	Child 6-18 MAGI				
First Published	08.21.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	1.; 3.a.	Policy Statement; Eligibility Determination Group	1	Policy Clarification	SN
03.18.2019	3.c.	Budget	2	Non-Substantive Change	SN

PRESUMPTIVELY ELIGIBLE PREGNANT WOMEN

Legal Authority: 42 CFR 435.4; 42 CFR 435.603; 42 CFR 435.956; 42 CFR 435.1101-1103

1. Policy Statement

The Presumptively Eligible Pregnant Women category provides temporary TennCare Medicaid coverage for pregnant women applying for TennCare Medicaid. The Tennessee Department of Health (DOH) facilitates the application process for pregnant women applying for TennCare Medicaid (presumptive and regular benefits) at local health departments throughout the state, and at the Memphis Health Center, a Federally Qualified Health Center (FQHC). The Presumptively Eligible Pregnant Women category is intended to provide a pregnant woman with coverage while she completes her TennCare Medicaid application.

2. Eligibility Period

Eligibility in this category begins on the date on which a qualified entity determines that an individual is presumptively eligible and ends on the earlier of:

- In a case where a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made; or
- In a case where a Medicaid application has been filed, the day on which a decision is made on a filed Medicaid application.

Only one period of presumptive eligibility is provided per pregnancy.

3. Non-Financial Eligibility Requirements

a. Age: There is no minimum or maximum age for the Presumptively Eligible Pregnant Women category.

b. Citizenship: A pregnant woman must be a U.S. Citizen, U.S. National or eligible non-citizen. Self-attestation of citizenship is accepted.

c. Enumeration: A pregnant woman that is eligible to have a Social Security Number (SSN) should provide an SSN, unless she meets an exception. Eligibility in the Presumptively Eligible Pregnant Women category should not be denied when an individual is unable to provide an SSN.

d. State Residence: A pregnancy woman must be a Tennessee resident. Self-attestation of residency status is accepted.

e. Child Support Cooperation: A pregnant woman is not required to cooperate with child support.

f. Pregnancy: A woman must be pregnant. Self-attestation of pregnancy is accepted.

4. Financial Eligibility Requirements

a. Income Standard

The income standard for this category is 195% Federal Poverty Level (FPL). Self-attestation of income is accepted when applying for presumptive eligibility.

b. Resource Test

There is no resource test.

5. Presumptive Eligibility Application Process

Staff at the DOH offices process eligibility for the Presumptively Eligible Pregnant Women category. DOH staff input the required eligibility information into the appropriate DOH system, which is then sent to interChange. Staff at the Memphis FQHC will complete a paper application and submit to the DOH state office for processing.

The DOH staff will also facilitate completion of a full TennCare Medicaid application when the woman is processed for presumptive eligibility.

PREGNANCY MAGI

Legal Authority: Sec. 1902 of the Social Security Act [42 USC 1396a]; 42 CFR 435.4; 42 CFR 435.112; 42 CFR 435.115; 42 CFR435.116; 42 CFR 435.603; 42 CFR 435.952; 42 CFR 435.956; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

TennCare Medicaid benefits are available to pregnant women whose household income is equal to or less than 250% of the Federal Poverty Level (FPL) based on Eligibility Determination Group (EDG) size, and who meet all non-financial eligibility requirements.

2. Coverage Period

Women who are determined eligible for and receive TennCare Medicaid while pregnant remain eligible for benefits through a 12-month postpartum period, beginning the last day of the pregnancy and ending on the last day of the month in which the 12-month period ends. The 12-month postpartum period is automatic and applicable to all pregnant women who have been determined eligible for and received TennCare Medicaid benefits prior to the end of the pregnancy, including women who received benefits in a retroactive period. Pregnant women who apply and whose eligibility begin date is after the end of their pregnancy are not eligible for a 12-month postpartum period but will maintain benefits through a 60-day postpartum period. The postpartum coverage period is applied regardless of any changes in circumstances and regardless of how the pregnancy ends.

The 12-month postpartum period will end prior to the end of the 12 months in the following instances:

a. Coverage is voluntarily terminated;
b. The woman is no longer a resident of Tennessee;
c. The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the woman or her representative; or
d. Death.

3. Non-financial Eligibility Requirements

Women eligible for the Pregnancy MAGI category must meet all non-financial eligibility requirements. Additional information about each condition of eligibility is available in the Non- Financial Eligibility chapters.

a. Age: There is no minimum or maximum age for the Pregnancy MAGI category.

b. Pregnancy: A woman is considered a pregnant woman through the 60-day postpartum period. TennCare accepts self-attestation of pregnancy at application or as a reported change, unless TennCare has information that is not reasonably compatible with such attestation. If TennCare has information that is not reasonably compatible with an attested pregnancy, TennCare will contact the individual and may request written medical verification of the pregnancy.

c. **Citizenship:** A pregnant woman must be a U.S. Citizen, U.S. National or eligible non-citizen.

d. **Enumeration:** A pregnant woman must possess and provide a valid Social Security Number (SSN) or proof of an SSN application, unless she meets an exception.

e. **State Residence:** A pregnant woman must be a resident of Tennessee.

f. **Cooperation with Child Support Services:** A pregnant woman is not required to agree to cooperate with Child Support Services for the unborn baby.

4. Financial Eligibility Requirements

a. Eligibility Determination Group

The Pregnancy MAGI category uses the Modified Adjusted Gross Income (MAGI) methodology to determine EDG size. When determining household size for a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. When determining EDG size for other applicants in the household, the pregnant woman is counted as one person. For additional information regarding EDG size see the *Eligibility Determination Group for MAGI* policy.

b. Income Standard

The income standard for this category is 250% FPL.

c. Budget

Ms. Richardson applied for Medicaid for herself. She is pregnant and has one dependent child. Ms. Richardson is employed with a Net Countable Earned Income of $2,670. Her Before/Pre-tax Contributions total $150 and 1040 deductions totaling $700. The example budget is based on an EDG size of 3 and determines eligibility with an Income Test Limit of $3,319.

Ms. Richardson's Net Countable Earned Income, $2,670, is under the Income Test Limit, $3,319. The MAGI 5% Deduction is not applied because the Total Net Countable Income is under the Income Test Limit for the Pregnancy MAGI category.

Income Budget Calculation		
Net Countable Self-Employment Income		$ 0.00
Net Countable Earned Income		$ 2,670.00
Before/Pre-tax Contribution Deductions	-	$ 150.00
Remaining Countable Earned/Self-Employment Amount	=	$ 2,520.00
Net Countable Unearned Income	+	$ 0.00
Countable Earned and Unearned Income	=	$ 2,520.00
1040 Deduction	-	$ 700.00

MAGI 5% Deduction	-	$ 0.00
Net Countable Income	=	$ 1,820.00
Income Test Limit		$ 3,319.00
Gap Filling Amount	-	$ .00
Total Net Countable Income	=	$ 1,820.00
Income Test Result		PASS

The above budget is current as of March 2017.

d. Resource Test

There is no resource test for the Pregnancy MAGI category.

Document Title	Pregnancy MAGI				
First Published	10.30.2014				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
08.01.2016	2.	Coverage Period	1	Policy Clarification	AJ
03.18.2019	1.; 3.b.; 4.a.	Legal Authority; Policy Statement; Pregnancy; Eligibility Determination Group	1-2	Policy Clarification	SN
03.18.2019	4.c.	Budget	2	Non-Substantive Change	SN
04.01.2022	2.	Coverage Period	1	Policy Change	TN
01.02.2024	1; 4.b.	Policy Statement; Income Standard	1-2	Policy Change	KF

CARETAKER RELATIVE MAGI

Legal Authority: 42 CFR 435.4; 42 CFR 435.110; 42 CFR 435.112; 42 CFR 435.115; 42 CFR 435.603; Tenn. Comp. R. & Regs. 1200-13-20

1. Overview

The Caretaker Relative MAGI category is only available to parents and caretaker relatives of dependent children under age 18, or 18 and a full-time student. Although there are some similarities between the Caretaker Relative MAGI category and the former AFDC-MO Medicaid category, there are a number of important differences:

- **a.** Eligible parents and caretaker relatives must have a dependent child under age 18, or 18 and a full-time student, living in the home, but the child does not have to be deprived of parental support;
- **b.** Children are not eligible under the Caretaker Relative MAGI category, unless the child is considered the caretaker relative of another child;
- **c.** The MAGI financial methodology is used for the Caretaker Relative MAGI category;
- **d.** The dependent child of the parent or caretaker relative is not required to be eligible for or receive TennCare Medicaid; and
- **e.** The Caretaker Relative MAGI category has a more limited set of relatives who may gain eligibility as a caretaker relative.

2. Policy Statement

TennCare Medicaid benefits are available to parents and caretaker relatives of a dependent child under age 18, or 18 and a full-time student, whose Eligibility Determination Group (EDG) income is at or below the income eligibility standard, by EDG size, and who meet all non-financial eligibility requirements.

3. Non-Financial Eligibility Requirements

- **a. Age:** There is no minimum or maximum age for the Caretaker Relative MAGI category.

- **b. Caretaker Relative Status:** A caretaker relative of a child is a relative by blood, adoption, or marriage with whom a dependent child under age 18, or 18 and full-time student, is living, who assumes primary responsibility for the child's care, and is one of the following:

  - **i.** The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or
  - **ii.** The spouse of such parent or relative, even after the marriage is terminated by death or divorce.

An assumption of primary responsibility may be apparent if the individual claims the child as a tax dependent, but it is not required.

c. Citizenship: A parent or caretaker relative must be a U.S. Citizen, U.S. National or eligible non-citizen.

d. Enumeration: A parent or caretaker relative must possess and provide a valid Social Security Number (SSN) or proof of an SSN application, unless she meets an exception.

e. State Residence: A parent or caretaker relative must be a resident of Tennessee.

f. Cooperation with Child Support Services: An eligible parent or caretaker relative must agree to cooperate with Child Support Services in establishing paternity of a child born out of wedlock and in obtaining medical support and payments for herself and anyone for whom the individual can legally assign rights. Proof of non-compliance from the Department of Human Services Child Support Enforcement Office may lead to ineligibility.

4. Financial Eligibility Requirements

a. Eligibility Determination Group

The EDG for this category uses the Modified Adjusted Gross Income (MAGI) methodology. It is possible for household members to have different EDG sizes when determining eligibility. For additional information regarding EDG size see the *Eligibility Determination Group for MAGI* policy.

b. Income Standard

Eligibility Determination Group Size	**Income Standard**	**Eligibility Determination Group Size**	**Income Standard**
1	**$1,018**	**11**	**$3,259**
2	**$1,329**	**12**	**$3,431**
3	**$1,611**	**13**	**$3,601**
4	**$1,867**	**14**	**$3,770**
5	**$2,102**	**15**	**$3,935**
6	**$2,320**	**16**	**$4,098**
7	**$2,524**	**17**	**$4,257**
8	**$2,718**	**18**	**$4,411**
9	**$2,903**	**19**	**$4,557**
10	**$3,084**	**20**	**$4,693**
		Add on	**N/A**

c. Budget

Ms. Thomas applied for Medicaid for herself. She is the caretaker of her 8-year-old grandson. Ms. Thomas is employed with a Net Countable Earned Income of $2,050. She claimed $450 in student loan interest on her tax return, which gives her a $37.50 per month deduction ($450/12 = $37.50). She plans to file taxes and claim her grandson. The example budget is based on an EDG size of 2 and determines eligibility with an Income Test Limit of $1,329.

Ms. Thomas' Remaining Countable Earned/Self-Employment Amount, $2,050, is over the Income Test Limit, $1,329. Application of the MAGI 5% deduction (100% FPL for household of 2 = $1,410) (5% of $1,410 = $71) does not result in Ms. Thomas meeting the Income Test Limit for the Caretaker Relative category.

Income Budget Calculation		
Net Countable Self-Employment Income		$ 0.00
Net Countable Earned Income		$ 2,050.00
Before/Pre-tax Contribution Deductions	-	$ 0.00
Remaining Countable Earned/Self-Employment Amount	=	$ 2,050.00
Net Countable Unearned Income	+	$ 0.00
Countable Earned and Unearned Income	=	$ 2,050.00
1040 Deduction	-	$ 37.50
MAGI 5% Deduction	-	$ 71.00
Net Countable Income	=	$ 1,941.50
Income Test Limit		$ 1,329.00
Gap Filling Amount	-	$ 0.00
Total Net Countable Income	=	$ 1,941.00
Income Test Result		FAIL

The above budget is current as of April 2019.

d. Resource Test

There is no resource test for the Caretaker Relative MAGI category.

Document Title	Caretaker Relative MAGI				
First Published	12.03.2014				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
04.01.2016	4.b.; 4.d.	Income Standard; Example Budget	2; 3-5	Non-Substantive Change	AF
03.31.2017	4.b.; 4.d.	Income Standard; Example Budget	2; 3-5	Non-Substantive Change	RH
03.05.2018	4.b.; 4.d.	Income Standard; Example Budget	2-5	Non-Substantive Change	TN
03.18.2019	1.; 3.b.; 3.d.; 4.b.; 4.c.	Overview; Caretaker Relative Status; Enumeration; Income Standard; Budget	1-3	Non-Substantive Change	SN
03.18.2019	2.; 4.a.	Legal Authority; Policy Statement; Eligibility Determination Group	1-3	Policy Clarification	SN
04.01.2019	4.c.	Budget	3	Policy Clarification	TN

CHILD MEDICALLY NEEDY

Legal Authority: 42 CFR 435.4; 42 CFR 435.301; 42 CFR 435.308; 42 CFR 435.602; 42 CFR 435.603; 42 CFR 435.831; 45 CFR 233.20; TCA 49-4-902(18) and (29); Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

TennCare Medicaid benefits are available to children under age 21 who are not eligible for a MAGI category, who have resources under the Medically Needy resource limit based on Eligibility Determination Group (EDG) size, and who have countable income equal to or less than the Medically Needy Income Standard based on EDG size, or have met the spenddown requirement. Eligible children must meet all of the Child Medically Needy non-financial eligibility requirements.

2. Non-Financial Eligibility Requirements

Children eligible for the Child Medically Needy category must meet all non-financial eligibility requirements. Additional information about each condition of eligibility is available in the Non-Financial Eligibility chapters.

a. **Age:** A child must be under age 21.

b. **Citizenship:** A child must be a U.S. citizen, U.S. national or eligible non-citizen.

c. **Enumeration:** A child must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN, unless they meet an exception.

d. **State Residence:** A child must be a resident of Tennessee.

e. **Cooperation with Child Support Services:** A child is not required to agree to cooperate with Child Support Services. If the parent or caretaker of the child who is applying for benefits refuses to cooperate, the child will not be penalized and will be reviewed for eligibility in this category.

3. Financial Eligibility Requirements

a. Eligibility Determination Group

The EDG for Medically Needy categories is based on the methods of the former AFDC program. The EDG includes individuals, living in the home, who impact the household size, and household income and resources considered for an applicant’s financial eligibility. For EDG composition details, see the *Medically Needy Eligibility Determination Group* policy.

b. Income Standard

EDG Size	Income Standard	EDG Size	Income Standard
1	$241	11	$683
2	$258	12	$733
3	$317	13	$792
4	$325	14	$842
5	$392	15	$900
6	$408	16	$950
7	$467	17	$1,000
8	$517	18	$1,058
9	$567	19	$1,108
10	$625	20	$1,167

Income eligibility for the Medically Needy Child category is determined using a two-step process. The first step determines the applicant's total net income, and the second step determines whether the applicant must meet spenddown. See the *Medically Needy Spenddown* policy for complete spenddown policy and procedures.

If the applicant's total net income does not exceed the Income Standard, and the applicant is otherwise eligible, the applicant will be approved for eligibility as Exceptionally Eligible.

If the applicant has total net income that exceeds the Income Standard, the applicant will have to spend down income using incurred or paid medical expenses.

c. Resources

The resource limit for the Child Medically Needy category is $2,000 for one individual and $3,000 for two individuals. An additional $100 is added for each additional individual.

d. Disregards

i. Earned Income

The following situations specify disregards that are applied to an individual's earned income.

1. Standard Work Expense Deduction

A $90 disregard for work expenses is permitted per month for each individual with earned income.

2. Dependent Care Deduction

A verified daycare expense of up to $175 per month per dependent age 2 or older is applied. A verified daycare expense up to $200 per month per dependent under age 2 is applied.

3. Irregular Earned Income Disregard

Exclude up to $30 per calendar quarter of earned income that is received either irregularly or infrequently. In order to be excluded, the income need only be irregular or infrequent. See the *Medically Needy Countable and Excluded Income* policy.

4. Student Income

Exclude the earnings of a full-time student who works part time.

Exclude the earnings of a full-time student who works full time.

Exclude the earnings of a part-time student who works part time.

Count the earnings of a part-time student who works full time.

A student is defined as a child under age 21 attending primary or secondary school, college, university or a course of vocational or technical training.

a. A child retains her student status during official school vacations and breaks if the requirement prior to the vacation or break were met, and the student plans to return.
b. A child who is receiving elementary/secondary or equivalent vocational/technical instruction from a homebound teacher meets student requirements.
c. An elementary school is defined as a state-approved educational institution comprised of grade kindergarten through eighth grade.
d. Participation in apprenticeships, correspondence courses, other courses of home study and rehabilitation programs other than academic, institutional, vocational or technical training do <u>not</u> qualify a child as a student.

A full-time student for college or university is an individual who is enrolled in at least 12 credit or semester hours per semester. A part-time student is an individual who in enrolled in at least 6 but less than 12 credit or semester hours per semester. (TCA 49-4-902(18) and (29)).

ii. Unearned Income

1. Child Support Disregard

Exclude up to $50 per month of current child support payments received per EDG.

2. Irregular Unearned Income Disregard

Exclude up to $30 per calendar quarter per household of unearned income that is received either irregularly or infrequently. See the *Medically Needy Countable and Excluded Income* policy.

iii. Child Support/Mandatory Expenses

1. Legally Obligated Child Support

When an applicant or Financially Responsible Relative (FRR) is making court-ordered child support payments for dependents outside the household, a deduction is permitted. Calculate the amount of the child support deduction by adding all monthly child support/mandatory expenses incurred.

2. Legally Obligated Child Support Arrearage

Deduct the amount of legally obligated child support arrearage payments being made by an applicant or FRR.

3. Legally Obligated Alimony

Deduct the amount of legally obligated alimony payments being made by an applicant or FRR.

e. Budget

Mr. Smith, a 20 year old full-time student, applied for medical assistance. He lives with his mother and two younger siblings, ages 2 and 3. Mr. Smith's mother has Net Countable Earned Income of $800. She pays $200 per month for childcare for her two younger children. The family incurred $350 of allowable medical expenses during the three months prior to the application. The following budget is based on an EDG size of 4.

The remaining Net Countable Income is over the MNIS of $325 for the applicant's EDG size of 4. A spenddown of $185 is needed to qualify. Mr. Smith meets the income standard once the spenddown of his family's allowable medical expenses of $350 is applied.

Income Budget Calculation		
Net Countable Self-Employment Income	+	$ 0.00
Net Countable Earned Income	+	$ 800.00
Combined Earned/Self-Employment Income	=	$ 800.00
Irregular Earned Income Disregard ($30)	-	$ 0.00
Standard Work Expense Deduction ($90)	-	$ 90.00
Dependent Care Deduction (Up to $200 depending on age)	-	$ 200.00
Remaining Countable Earned/Self-Employment Amount	=	$ 510.00
Net Countable Unearned Income	=	$ 0.00
Irregular Unearned Income Disregard ($30)	-	$ 0.00
Child Support Disregard	-	$ 0.00
Total Deemed Income	=	$ 0.00
Remaining Countable Unearned Income	=	$ 0.00
Child Support/Mandatory Expense	=	$ 0.00
Total Net Countable Income (Remaining Countable Earned/Self-Employment Amount + Total Deemed Income + Remaining Countable Unearned Income – Child Support/Mandatory Expense)		$ 510.00
Net Income Limit		$ 325.00
Spenddown Met		Yes
Income Test Result		PASS

The above budget is current as of March 2017.

Document Title	Child Medically Needy				
First Published	06.05.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
12.01.2016	4.e.3.	Student Income	6	Policy Clarification	RS
03.18.2019	1.; 3.a-3.e.	Legal Authority; Policy Statement; Financial Eligibility Requirements	1-6	Policy Clarification	ME
03.18.2019	1.	Non-Financial Eligibility Requirements	1	Non-Substantive Change	ME
10.01.2020	3.b.; 3.d.iii.1.	Financial Eligibility Requirements	2; 4	Non-Substantive Change	TN
10.01.2020	3.d.ii.2.; 3.e.	Financial Eligibility Requirements	4-5	Policy Clarification	TN

QUALIFIED PREGNANT WOMAN MEDICALLY NEEDY

Legal Authority: Sec. 1902 of the Social Security Act [42 USC 1396a]; 42 CFR 435.4; 42 CFR 435.301; 42 CFR 435.601; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

TennCare Medicaid benefits are available to pregnant women who are not eligible for the MAGI Pregnant Woman category, who have resources within the Medically Needy resource limit based on household size, and who have countable income equal to or less than the Medically Needy Income Standard (MNIS) based on Eligibility Determination Group (EDG) size, or meet the spenddown requirement. Eligible women must meet all of the Qualified Pregnant Woman Medically Needy non-financial eligibility requirements.

2. Coverage Period

Women who are determined eligible for and receive TennCare Medicaid while pregnant remain eligible for TennCare Medicaid benefits through a 12-month postpartum period, beginning the last day of the pregnancy and ending on the last day of the month in which the 12-month period ends. The 12-month postpartum period is automatic and applicable to all pregnant women who have been determined eligible for and received TennCare Medicaid benefits prior to the end of the pregnancy. Pregnant women who apply and whose eligibility begin date is after the end of their pregnancy are not eligible for a 12-month postpartum period but will maintain benefits through a 60-day postpartum period. The postpartum coverage period is applied regardless of any changes in household circumstances and regardless of how the pregnancy ends.

The 12-month postpartum period will end prior to the end of the 12 months in the following instances:

a. Coverage is voluntarily terminated;
b. The woman is no longer a resident of Tennessee;
c. The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the woman or the her representative; or
d. Death.

3. Non-Financial Eligibility Requirements

Pregnant women eligible for the Qualified Pregnant Woman Medically Needy category must meet all non-financial eligibility requirements. Additional information about each condition of eligibility is available in the Non-Financial Eligibility chapters.

a. **Age:** There is no minimum or maximum age for this category.

b. **Citizenship:** A pregnant woman must be a U.S. Citizen, U.S. National or eligible non-citizen.

c. **Enumeration:** A pregnant woman must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN, unless she meets an exception.

d. **State Residence:** A pregnant woman must be a resident of Tennessee.

e. **Cooperation with Child Support Services:** A pregnant woman is not required to agree to cooperate with Child Support Services for the unborn baby.

f. **Pregnancy:** A woman must be pregnant. Self-attestation of pregnancy is accepted and considered verified when determining eligibility.

4. Financial Eligibility Requirements

a. Eligibility Determination Group

The EDG determined for Medically Needy categories is based on the methods of the former AFDC program. The EDG includes individuals, living in the home, who impact the household size, and household income and resources considered for an applicant's financial eligibility. For EDG household composition details, see the *Medically Needy Eligibility Determination Group* policy.

b. Income Standard

EDG Size	Income Standard	EDG Size	Income Standard
1	$241	11	$683
2	$258	12	$733
3	$317	13	$792
4	$325	14	$842
5	$392	15	$900
6	$408	16	$950
7	$467	17	$1000
8	$517	18	$1,058
9	$567	19	$1,108
10	$625	20	$1,167

If the EDG income exceeds the Income Standard, the applicant is not considered income eligible and will need to spend down income to the applicable income standard. See the *Medically Needy Spenddown* policy.

c. Resources

The resource limit for the Qualified Pregnant Women Medically Needy category is $2,000 for one individualand $3,000 for two individuals. An additional $100 is added per additional individual.

d. Disregards

i. Earned Income

The following situations specify disregards that are applied to an individual's earned income:

1. Standard Work Expense Deduction

A $90 disregard per month for work expenses is permitted for each individual with earned income.

2. Dependent Care Deduction

A daycare expense of up to $175 per month per dependent age 2 or older is applied. A daycare expense up to $200 per month per dependent under age 2 is applied.

3. Irregular Earned Income Disregard

Exclude up to $30 per calendar quarter of earned income that is received either irregularly or infrequently. In order to be excluded, the income need only be irregular or infrequent. See the *Medically Needy Countable and Excluded Income* policy.

4. Student Income

Exclude the earnings of a full-time student who works part time.

Count the earnings of a full-time student who works full time.

Exclude the earnings of a part-time student who works part time.

Count the earnings of a part-time student who works full time.

A student is defined as a child under age 21 attending primary or secondary school, college, university, or a course of vocational or technical training.

a. A child retains her student status during official school vacations and breaks if the requirement prior to the vacation or break were met, and the student plans to return.

b. A child who is receiving elementary/secondary or equivalent vocational/technical instruction from a homebound teacher meets student requirements.
c. An elementary school is defined as a state-approved educational institution comprised of grade kindergarten through eighth grade.
d. Participation in apprenticeships, correspondence courses, other courses of home study and rehabilitation programs other than academic, institutional, vocational or technical training do not qualify a child as a student.

A full-time student for college or university is an individual who is enrolled in at least 12 credit or semester hours per semester. A part-time student is an individual who in enrolled in at least 6 but less than 12 credit or semester hours per semester. (TCA 49-4-902(18) and (29)).

ii. Unearned Income

1. Child Support Disregard

Exclude up to $50 per month of current child support payments received per EDG.

2. Irregular Unearned Income Disregard

Exclude up to $30 per calendar quarter per household of unearned income that is received either irregularly or infrequently. See *Medically Needy Countable and Excluded Income* policy.

iii. Child Support/Mandatory Expenses

1. Legally Obligated Child Support

When an applicant or Financially Responsible Relative (FRR) is making court-ordered child support payments for dependents outside the household, a deduction is permitted. Calculate the amount of the child support deduction by adding all monthly child support/mandatory expenses incurred.

2. Legally Obligated Child Support Arrearage

Deduct the amount of legally obligated child support arrearage payments being made by an applicant or FRR.

3. Legally Obligated Alimony

Deduct the amount of legally obligated alimony payments being made by an applicant or FRR.

e. Budget

Ms. Smith, a pregnant woman, and her 1 year old child are applying for medical assistance. Ms. Smith has no unearned income. Her Net Countable Earned Income is $5,000. Ms. Smith pays $400 per week for childcare. She has $50,000 of incurred allowable medical expenses.

Ms. Smith's Net Countable Income is over the Income Standard for an EDG size of 3. A spend down of her allowable medical expenses of $4,393 is applied. See the *Medically Needy Spenddown* policy. She is eligible for the Qualified Pregnant Woman Medically Needy category.

Income Budget Calculation		
Net Countable Self-Employment Income		$ 0.00
Net Countable Earned Income	+	$ 5,000.00
Combined Earned/Self-Employment Income	=	$ 5,000.00
Irregular Earned Income Disregard ($30)	-	$ 0.00
Standard Work Expense Deduction ($90)	-	$ 90.00
Dependent Care Deduction (Up to $200 depending on age)	-	$ 200.00
Remaining Countable Earned/Self-Employment Amount	=	$ 4710.00
Net Countable Unearned Income		$ 0.00
Irregular Unearned Income Disregard ($30)	-	$ 0.00
Child Support Disregard	-	$ 0.00
Total Deemed Income	+	$ 0.00
Remaining Countable Unearned Income	=	$ 0.00
Child Support/Mandatory Expense	-	$ 0.00
Total Net Countable Income (Remaining Countable Earned/Self-Employment Amount + Total Deemed Income + Remaining Countable Unearned Income – Child Support/Mandatory Expense)	=	$ 4,710.00
Net Income Limit	-	$ 317.00
Spenddown Met		Yes
Income Test Result		**PASS**

The above budget is current as of March 2017.

Document Title	Qualified Pregnant Woman Medically Needy				
First Published	06.04.2015				
Revision History					
08.01.2016	2.	Coverage Period	1	Policy Clarification	AJ
03.18.2019	1.; 4.a.; 4.b.; 4.d.	Legal Authority; Policy Statement; Eligibility Determination Group; Income Standard; Disregards;	1-5	Policy Clarification	ME
03.18.2019	3.; 4.a.; 4.b; 4.d.; 4.d.i.2-4.d.i.4; 4.d.ii.2; 4.e.	Non-Financial Eligibility Requirements; Eligibility Determination Group; Income Standard; Dependent Care Deduction; Irregular Earned Income; Student Income; Irregular Unearned Income Disregard; Budget	1-5	Non-Substantive Change	ME
10.01.2020	4.b.; 4.d.iii.1.	Financial Eligibility Requirements	2; 4	Non-Substantive Change	TN
10.01.2020	4.d.ii.2, 4.e.	Financial Eligibility Requirements	4-5	Policy Clarification	TN
04.01.2022	2.	Coverage Period	1	Policy Change	TN
04.01.2022	4.d.i.4.	Financial Eligiblity Requirements	3	Policy Clarification	TN

TRANSITIONAL AND EXTENDED MEDICAID

Legal Authority: 42 CFR 435.112; 42 CFR 435.115; 408(a)(11)(A), 1902(e)(1)(A), 1925 and 1931(c)(2) of the Social Security Act; Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10); TennCare II Medicaid Section 1115 Demonstration; Tenn. Comp. R. & Regs. 1200-13-20

1. Transitional Medicaid (TM)

a. TM Overview

Prior to implementation of the Patient Protection and Affordable Care Act (ACA), TM was an extension of Medicaid eligibility for individuals who were eligible in the Aid to Families with Dependent Children-Medicaid Only (AFDC-MO) TennCare Medicaid category, but who had lost eligibility due to increased earnings or work hours. Upon implementation of the ACA, the AFDC-MO category no longer exists, but states continue to be required to provide TM to eligible individuals.

Enrollees who are potentially eligible for TM benefits include individuals who were eligible for TennCare Medicaid who would have been eligible for the AFDC-MO category prior to the ACA changes. This includes individuals in the Caretaker Relative COE as well as their spouses and children. The state will use the current Caretaker Relative income standard to identify individuals in the Caretaker Relative COE who may be eligible for TM. Given that the state eliminated the deprivation requirement and no longer reviews whether a parent or caretaker relative is underemployed, an increase in work hours will no longer cause an individual to lose eligibility. The increase in income related to increased work hours may, however, affect eligibility.

b. TM Policy Statement

TM is authorized for enrollees who lose eligibility in the Caretaker Relative due to increased earnings, or children who have a parent or caretaker eligible for TM, and whose household income prior to losing eligibility was at or below the current Caretaker Relative income standard. Eligible parents or caretaker relatives must have been eligible for and receiving benefits in the Caretaker Relative COE for at least 3 out of the 6 months immediately preceding the month of ineligibility. Eligible individuals receive 12 months of Medicaid, known as the TM certification period.

c. Individuals Potentially Eligible for TM

TM is available for the following individuals:

i. Parent/Caretaker Relatives

TM benefits are provided to parents and caretaker relatives who lose Caretaker Relative eligibility when all of the following conditions are met:

1. The individual was eligible and enrolled in the Caretaker Relative COE for at least 3 of the last 6 months immediately preceding the month eligibility was lost;
2. Loss of eligibility is due to an increase in earnings; and
3. The parent or caretaker relative continues to have a dependent child in the home.

Note: If an individual is receiving TM, and their spouse is included in the household, then the spouse is eligible for TM for the remainder of the eligible spouse's certification period.

ii. Children

TM benefits are provided to children when all of the following conditions are met:

1. The child's lives with a parent or caretaker relative was previously eligible and enrolled in the Caretaker Relative COE with income under the Caretaker Relative income standard for at least 3 of the previous 6 months, but lost eligibility due to an increase in earnings and is eligible for TM; and
2. The child is not eligible in a Mandatory Child COE

Note: Mandatory Child COEs do not include children eligible in a Medically Needy COE.

d. TM Non-Financial Eligibility Requirements

All other non-financial eligibility requirements of the relevant Caretaker Relative or mandatory Child COE must continue to be met.

e. Addition of Members to the TM Certification Period

The following individuals may be eligible for and enrolled in TM for the remainder of the caretaker relative's TM certification period when ineligible in a Caretaker Relative or mandatory Child COE:

i. A child who loses eligibility in a mandatory Child COE;
ii. A child who is born or adopted into the household;
iii. A child returning home after a period of absence; or
iv. A spouse of the parent or caretaker relative who returns to the home and previously had Caretaker Relative eligibility.

Example: A mother who is currently eligible for and receiving TM benefits adopts a child. The child is not eligible in any mandatory Child COE. The newly-adopted child is eligible for TM for the remainder of the mother's TM certification period.

2. Extended Medicaid (EM)

a. EM Overview

Prior to implementation of the ACA, EM was an extension of Medicaid eligibility for individuals who were eligible in the AFDC-MO TennCare Medicaid category, but who had lost eligibility due to an increase in child or spousal support. Upon implementation of the ACA, the AFDC-MO category no longer exists, but states continue to be required to provide EM to eligible individuals.

Enrollees who are potentially eligible for EM benefits include individuals who were eligible for TennCare Medicaid who would have been eligible for the AFDC-MO category prior to the ACA changes. This includes subsets of individuals in the mandatory Child and the Caretaker Relative COEs. The state will use the current Caretaker Relative income standard to identify individuals in the Caretaker Relative and mandatory Child COEs who may be eligible for EM. Given that child support is not countable income under the MAGI methodology, EM will be provided only for individuals who lose eligibility due to increased spousal support.

b. EM Policy Statement

EM is authorized for enrollees who lose eligibility in the Caretaker Relative or mandatory Child COEs due to an increase in spousal support, and whose household income prior to losing eligibility was at or below the current Caretaker Relative income standard. Eligible individuals must have been eligible for and have receiving benefits in the appropriate COE for at least 3 out of the 6 months immediately preceding the month of ineligibility. Eligible individuals will receive 12 months of Medicaid, known as the EM certification period.

c. Individuals Potentially Eligible for EM

EM is available for the following individuals:

i. Parent/Caretaker Relatives

EM benefits are provided to parents and caretaker relatives who lose Caretaker Relative eligibility when all of the following conditions are met:

1. The individual was eligible and enrolled in the Caretaker Relative COE for at least 3 of the last 6 months immediately preceding the month eligibility was lost;
2. Loss of eligibility is due to an increase in spousal support; and
3. The parent or caretaker relative continues to have a dependent child in the home.

Note: If an individual is receiving EM, and their spouse is included in the household, then the spouse is eligible for EM for the remainder of the eligible spouse's certification period.

ii. Children

EM benefits are provided to children when all of the following conditions are met:

1. The child lives with a parent or caretaker relative who was previously eligible and enrolled in the Caretaker Relative COE with income under the Caretaker Relative income standard for at least 3 of the previous 6 months, but lost eligibility due to an increase in spousal support; and
2. The child is not eligible in a Mandatory Child COE.

Note: Mandatory Child COEs do not include children eligible in a Medically Needy COE.

d. EM Non-Financial Eligibility Requirements

All other non-financial eligibility requirements of the relevant Caretaker Relative or mandatory Child COE must continue to be met.

e. Addition of Members to EM Certification Period

The following individuals may be eligible for and enrolled in EM for the remainder of the caretaker relative's EM certification period when ineligible in a Caretaker Relative or mandatory Child COE:

i. A child who loses eligibility in a mandatory Child COE;
ii. A child who is born or adopted into the household;
iii. A child returning home after a period of absence; or
iv. A spouse of the parent or caretaker who returns to the home and previously had Caretaker Relative eligibility.

Example: At renewal, a child is found to be no longer eligible for Deemed Newborn and ineligible for any other Mandatory Child COE. His mother has been eligible for EM for 3 months. The child is eligible for the remaining 9 months of his mother's EM certification period.

Document Title	Transitional and Extended Medicaid				
First Published	05.12.2014				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
06.01.2017	1.a-c.; 2.a-c.	Overview; Policy Statement; Categories	1-3	Policy Clarification	RS
03.02.2020	1.a; 1.b; 2a.; 2.b.	Legal Authority; TM Overview; TM Policy Statement; EM Overview; EM Policy Statement	1; 3	Policy Clarification	TN
03.02.2020	1.c; 1.e.; 2.c; 2.e.	Individuals Potentially Eligible for TM; Addition of Members to the TM Certification Period; Individuals Potentially Eligible for EM; Addition of Members to the EM Certification Period;	1-4	Policy Change	TN
05.02.2022	1.c 2.c	Individuals Potentially Eligible for TM; Individuals Potentially Eligible for EM	2-4	Policy Clarification	SA

TENNCARE STANDARD

Legal Authority: Tenn. Comp. R. & Reg's. Chapter 1200-13-14; March 2014 Amendment to the TennCare II section 1115 Demonstration Project; Tenn. Comp. R. & Reg's. Chapter 1200-13-20

1. Policy Statement

Children under age 19 who are losing TennCare Medicaid eligibility will be reviewed for TennCare Standard eligibility. TennCare Standard is available to children losing TennCare Medicaid eligibility, whose family income is at or below 211% of the Federal Poverty Level (FPL) or are determined to be medically eligible, and who meet all other non-financial eligibility requirements. Children may only gain TennCare Standard eligibility when they are terminated from a TennCare Medicaid category in a process known as Medicaid Rollover.

Children under age 19 are not eligible to roll over into TennCare Standard if their TennCare Medicaid benefits were either:

a. Based on presumptive eligibility; or
b. For Emergency Medical Services (EMS) for undocumented and/or ineligible aliens.

2. Definitions

Medically Eligible: TennCare Standard Medically Eligible individuals are children under age 19 who meet all of the following criteria:

a. Are losing TennCare Medicaid;
b. Have no insurance or access to insurance;
c. Have Eligibility Determination Group (EDG) income above 211% of the FPL; and
d. Have a qualifying medical condition that would have prevented them from getting health insurance prior to the Affordable Care Act (ACA).

Medically Eligible (ME) Packet: A multi-page document that must be completed regarding the child applicant's physical or mental health, if there is no existing encounter data. Corroborating verification from the physician or mental health provider must be provided.

Qualifying Medical Condition: A medical condition which is included among a list of conditions established by TennCare and will render a qualified uninsured applicant medically eligible.

Tax Filing Threshold: An annual income amount set by the Internal Revenue Service that determines whether an individual is required to file income taxes. The threshold varies by age, marital status and the number of tax dependents claimed.

Uninsured: For the purpose of TennCare Standard eligibility, an uninsured person is a child under age 19 losing Medicaid with no insurance or access to insurance, and whose EDG income is at or below 211% of the FPL.

3. Application Procedures

a. TennCare Medicaid Closures based on Reported Changes

New applicants are not eligible for TennCare Standard. Individuals are only eligible for this category if they are losing TennCare Medicaid eligibility and rollover into TennCare Standard. When a reported change results in closing of the current TennCare Medicaid category, and ineligibility in any other category, processing for TennCare Standard as a Medicaid Rollover is required even if the child is not technically eligible. Although an actual application is not required, the individual must provide all required verifications to gain eligibility for TennCare Standard.

TennCare Standard rollover does not occur if:

- **i.** The individual requested his TennCare Medicaid closure;
- **ii.** TennCare Medicaid is closed because the individual left the state;
- **iii.** TennCare Medicaid closure is due to death; or
- **iv.** TennCare Medicaid closure is due to the child becoming eligible for SSI Medicaid.

4. Co-Pay Responsibility

a. General Rule

TennCare Standard enrollees with income at or above 100% of the FPL pay co-pays for most TennCare covered services. Co-pays for pharmacy benefits for covered name brand and generic drugs are required for individuals with co-pay responsibility.

b. Aggregate Cost-Sharing Cap

There are limitations on the amount of co-pays TennCare Standard children and their TennCare family members are obligated to pay. The aggregate cost-sharing cap is calculated by combining the TennCare cost sharing for all TennCare family members who have TennCare cost-sharing obligations, and may not exceed 5% of the family's annual income, prorated to a quarterly equivalent.

Family income will be calculated using the Modified Adjusted Gross Income (MAGI) methodology, and the family will be assigned to the corresponding income band to determine the standardized aggregate cap. The following income bands and corresponding aggregate annual caps will be used:

Income Band	Poverty Levels	Standardized Annual Aggregate Cap
1	0 – 99%	NA
2	100 – 149%	5% of the amount that corresponds to 100% FPL
3	150 – 199%	5% of the amount that corresponds to 150% FPL

4	200 – 249%	5% of the amount that corresponds to 200% FPL
5	250 – 299%	5% of the amount that corresponds to 250% FPL
6	300 – 349%	5% of the amount that corresponds to 300% FPL
7	350 – 399%	5% of the amount that corresponds to 350% FPL
8	400 – 449%	5% of the amount that corresponds to 400% FPL
9	500 – 599%	5% of the amount that corresponds to 500% FPL
10	600% and over	5% of the amount that corresponds to 600% FPL

c. Enrollee Responsibility

Families of TennCare Standard children are responsible for tracking their own incurred cost-sharing obligation including keeping copies of receipts or similar documentation, and notifying TennCare when they believe they have reached their cap for a particular calendar quarter. The quarterly cap amount is provided to the family when a child becomes eligible for TennCare Standard.

5. Non-Financial Eligibility Requirements

Children eligible for TennCare Standard must meet all non-financial eligibility requirements. Additional information about each condition of eligibility is available in the Non-Financial Eligibility chapters.

a. Age: TennCare Standard is only available for children under age 19 who are losing TennCare Medicaid eligibility.

b. Citizenship: A child must be a U.S. Citizen, U.S. National or eligible non-citizen.

c. Enumeration: A child must provide a valid Social Security number, unless they meet an exception.

d. State Residence: A child must be a resident of the State of Tennessee.

e. Child Support Cooperation: A child is not required to agree to cooperate with Child Support Services. If the parent of a child who is applying for benefits refuses to cooperate, the child will not be penalized and will be reviewed for eligibility in this category.

f. TennCare Medicaid Eligibility: The child must be losing eligibility and no longer eligible for any TennCare Medicaid category. At renewal, children are still considered to be "losing eligibility" during the redetermination reconsideration period. See the *Redetermination* policy regarding the reconsideration period.

6. Access to Insurance

a. Changes under the Affordable Care Act

To be eligible for TennCare Standard, a child must not have health insurance or access to health insurance in the group health insurance market. Health insurance market reforms under the ACA will affect an individual's ability to access insurance in the group market. However, the state is required by law to maintain all existing TennCare categories that cover children until September 30, 2019.

Note: Insurance policies offered on the Federally Facilitated Marketplace (FFM) are for the individual and small group insurance market. If an individual has purchased health insurance through the Exchange, then he is insured. However, for the purpose of TennCare Standard eligibility, the State does not consider the ability to purchase health insurance through the Exchange as access to insurance.

b. Current Access to Insurance Policy

i. In order to be eligible for TennCare Standard, an individual must:

1. Not have insurance or access to insurance in the group health insurance market; or
2. Have a qualifying medical condition that would have made the individual uninsurable prior to the ACA. If the individual has a qualifying medical condition, she must also not have insurance or access to insurance.

ii. Common Issues Related to Access to Insurance Policy

1. Children with Non-Custodial Parents:
a. A child for whom a non-custodial parent is court-ordered to provide health insurance but does not, does not have access to insurance; or
b. A child whose non-custodial parent has access to health insurance but does not add the child to his policy does not have access to insurance.
2. If a stepparent in the home has health insurance and could cover his stepchild but does not, it is not considered access to insurance.
3. If health insurance offered by a college to its students is comprehensive coverage, a student is considered to have access to health insurance.
4. If a parent begins a new job and his employer-offered health insurance will not start for a specified time period, the children would be considered to not have access to health insurance for the specified time period.

7. Financial Eligibility Requirements

a. Eligibility Determination Group

The TennCare Standard category uses MAGI methodology to determine EDG size. Tax filer rules are for applicants who file taxes or are claimed as tax dependents. Non-filer rules are for those applicants that do not file taxes, are not claimed as tax dependents, or meet a tax dependent exception. Refer to the *Eligibility Determination Group for MAGI* policy regarding application of MAGI EDG size for this category.
Note: If sibling income is over the tax filing threshold it is included in the applicant's budget, but if under the threshold it is removed as income to the applicant budget which is a change for this category.

b. Income Standard

For children that do not have access to insurance, the income standard for TennCare Standard is at or below 211% of the FPL.

For children with qualifying medical conditions and who are uninsured, the income standard is above 211% of the FPL.

c. Income Methodology

TennCare Standard uses MAGI methodology to determine countable and excluded income.

d. Resources

There is no resource test for TennCare Standard.

e. Budget

Ms. Franklin's 8 year old child is losing TennCare Medicaid. The child is being evaluated to determine eligibility for TennCare Standard. Ms. Franklin is employed with a Net Countable Earned Income of $2,640. She did not claim any deductions on her tax return. The following example budget is based on an EDG size of 2 and determines eligibility with an Income Test Limit of $2,856.

Ms. Franklin's Net Countable Income is under the Income Test Limit, $2,856. The MAGI 5% Deduction is not applied because the Total Net Countable Income is under the Income Test Limit for the TennCare Standard category.

Income Budget Calculation		
Net Countable Self-Employment Income		$ 0.00
Net Countable Earned Income		$ 2,600.00
Before/Pre-tax Contribution Deductions	-	$ 10.00
Remaining Countable Earned/Self-Employment Amount	=	$ 2,590.00

Net Countable Unearned Income	+	$ 50.00
Countable Earned and Unearned Income	=	$ 2,640.00
1040 Deduction	-	$ 0.00
MAGI 5% Deduction	-	$ 0.00
Net Countable Income	=	$ 2,640.00
Income Test Limit		$ 2,856.00
Gap Filling Amount	-	$ .00
Total Net Countable Income	=	$ 2,640.00
Income Test Result		PASS

The above budget is current as of March 2017.

f. Medically Eligible

When a reported income change causes an enrollee's EDG income to exceed 211% FPL, the child will be reviewed for TennCare Standard eligibility as Medically Eligible. See the *TennCare Standard Medical Eligibility* policy.

g. Grandfathered Eligibility

There are individuals in TennCare Standard that have "grandfathered" eligibility. This refers to children enrolled in TennCare Standard since December 31, 2001, who have family incomes at or below 211% FPL and who have not purchased insurance even if they have access to it. Once an individual loses eligibility in this category, they are no longer considered to have this grandfathered eligibility status.

Document Title	TennCare Standard				
First Published	07.24.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
04.05.2016	7.h.	Grandfathered Eligibility	7	Policy Clarification	JH
09.06.2016		Legal Authority	1	Policy Clarification	JH
03.18.2019	2.; 4.a.; 5.f.; 7.a.; 7.f.	Legal Authority; Definitions; General Rule; Non-Financial Eligibility Requirements; Eligibility Determination Group; Medically Eligible	1-3; 5-6	Policy Clarification	JH
03.18.2019	2.; 3.a.i-ii.; 4.c.; 6.; 7.e.-f	Definitions; TennCare Medicaid Closures based on Reported Changes; Enrollee Responsibility; Current Access to Insurance Policy; Budget; Medically Eligible	1-6	Non-Substantive	JH
03.18.2019	7.g.	Grandfathered Eligibility	6	Policy Change	JH

TENNCARE STANDARD MEDICAL ELIGIBILITY

Legal Authority: Tenn. Comp. R. & Reg's. Chapter 1200-13-14; March 2014 Amendment to the TennCare II section 1115 Demonstration Project

1. Overview

TennCare Standard Medically Eligible (ME) individuals are children under age 19:

- Losing TennCare Medicaid;
- Without insurance or access to insurance;
- With household income above 211% of the FPL; and
- With a qualifying medical condition.

To determine whether a child has a qualifying medical condition, HCFA uses existing and current medical encounter data in the TennCare system or requests information from the individual using the ME packet.

2. Definitions

Access to Insurance: Access to health insurance in the group health insurance market. See the *TennCare Standard* policy.

ME Encounter Data: Information in the TennCare system (interChange) identifying an individual as ME. The information is based on claims data submitted by the TennCare MCOs.

ME Packet: A multi-page document that collects information about the child's physical and mental health. The packet is used for individuals without ME encounter data to determine if they have a qualifying medical condition.

Qualifying Medical Condition: A medical condition which is included among a list of conditions established by HCFA and which will render a qualified uninsured applicant medically eligible.

3. Determining Medical Eligibility

Children meeting the following requirements must be processed for Medical Eligibility:

- **Children Losing TennCare Medicaid Eligibility:** These children must be under age 19; must not have access to or have health insurance; and must have household income above 211% FPL (if at or below 211% FPL, review for TennCare Standard Uninsured).

- **Currently Eligible TennCare Standard Uninsured Children Whose Household Income Increases Above 211% FPL:** These children must be under age 19; must not have access to or have health insurance; and must be no longer be eligible for TennCare Standard Uninsured based on a reported increase in household income.

  When a TennCare Standard child reports an increase in income above 211% FPL, determine whether the child is already open as ME. If so, process the reported change as an income change only.

NOTE: If a child was previously open as a grandfathered child and continues to have access to insurance, he is not eligible for ME.

a. ME Packet

Individuals not eligible for TennCare Standard will be reviewed for a TennCare Standard ME eligibility determination. An ME packet is required when an individual does not have ME encounter data in interChange. The ME packet must be completed and returned within 60 days, must include corroborating verification from a physician or mental health provider, and include medical records if required.

b. ME Packets Returned to HCFA

Returned ME packets will be reviewed to determine ME eligibility. Individuals are ME eligible when:

1. The ME packet includes a physician's attestation of a diagnosed qualifying medical condition listed on the ME packets; or
2. The HCFA Medical Review of health issues listed in the ME packet and medical records prove a qualifying medical condition.

If an individual fails to return the ME packet by the 60th day, she will be denied TennCare Standard Medical Eligibility.

Document Title	TennCare Standard Medical Eligibility				
First Published	7.1.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
4.3.17	1.	Overview	1	Policy Clarification	RS
4.3.17	2.	Definitions	1	Policy Clarification	RH
4.3.17	3.a	ME Packet	1	Policy Clarification	RH
4.3.17	3.b	ME Packets Returned to HCFA	2	Policy Clarification	RH, RS

HOSPITAL PRESUMPTIVE ELIGIBILITY

Legal Authority: 42 CFR 435.1101-1103; 42 CFR 435.1110; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

The Hospital Presumptive Eligibility (HPE) program provides a period of presumptive TennCare Medicaid eligibility to individuals determined eligible by Qualified Entities. All Qualified Entities make presumptive eligibility determinations for the Child 0-1 MAGI, Child 1-5 MAGI, Child 6-18 MAGI, Pregnancy MAGI, Caretaker Relative and Former Foster Care categories. Qualified Entities operated by DOH make presumptive eligibility determinations for the Breast or Cervical Cancer (BCC) category.

2. Qualified Entities

Participating hospitals who serve as Qualified Entities base presumptive determinations on self-attested financial and non-financial criteria for the category in which an individual groups. Employees of Qualified Entities are required to assist the applicant in completion of a full Medicaid application for any individual who applies for HPE, regardless of whether the individual is determined presumptively eligible. Employees of third-party contractors/vendors cannot make HPE determinations.

3. Eligibility Period

Eligibility for HPE begins the date a Qualified Entity determines an individual is presumptively eligible and will end the earlier of:

a. In a case where a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made; or
b. In a case where a Medicaid application has been filed, the date a determination is made on the Medicaid application.

Applicants are only allowed one period of HPE every two calendar years for non-pregnancy-related categories. For pregnant women, one period of presumptive eligibility is allowed per pregnancy.

4. Non-Financial Eligibility Requirements

a. Age: Individuals are required to meet age requirements for the category in which he groups. Self-attestation of age is accepted.

b. Caretaker Relative Status: Self-attestation of Caretaker Relative status is accepted. Refer to the *Caretaker Relative MAGI* policy regarding Caretaker Relative status.

c. Citizenship: Individuals must be a U.S. Citizen, U.S. National or eligible non-citizen. Self-attestation of citizenship or immigration status is accepted.

d. Enumeration: Individuals eligible for a Social Security Number (SSN) are required to provide a valid SSN. Self-attestation of enumeration is accepted. Individuals attesting to be a U.S. Citizen, U.S. National or eligible non-citizen should not be denied if unable to provide an SSN.

e. Former Foster Care Recipient: Self-attestation of Former Foster Care Recipient status is accepted. Refer to the *Former Foster Care Children up to Age 26* policy regarding Former Foster Care Recipient status.

f. Pregnancy: A woman must be pregnant to group in the Pregnancy MAGI category. Self-attestation of pregnancy is accepted.

g. State Residence: An applicant must be a Tennessee resident. Self-attestation of residency status is accepted.

5. Financial Eligibility Requirements

a. Household Composition

HPE applicants are subject to non-filer household composition rules. Self-attestation of household composition is accepted. The household includes the applicant and, if living with the applicant:

i. The applicant's spouse;
ii. The applicant's natural, adopted and stepchildren under age 19, or 21 if a full-time student;
iii. For applicants under age 19, or 21 if a full-time student, the applicant's natural, adopted or stepparent; and
iv. For applicants under age 19, or 21 if a full-time student, the applicant's natural, adopted and stepsiblings who are under age 19, or 21 if a full-time student.

When determining household size for a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. When determining household size for other applicants in the household, the pregnant woman is counted as one person.

b. Income Standard

Self-attested household income is evaluated against the income standard for the TennCare Medicaid category in which the applicant groups.

c. Resource Test

There is no resource test for HPE applicants.

6. Presumptive Eligibility Application Process

Staff at participating hospitals will process eligibility for HPE. After eligibility has been determined, hospital staff will input the required eligibility information into TennCare Online Services, which will update interChange and provide presumptive coverage for eligible applicants. Hospital staff will be notified of errors in data input that occur at the time of keying the eligibility and will be expected to submit error reports to correct the incorrect data. Hospitals are also encouraged to review the submitted information to ensure accuracy and can submit error reports without having been previously notified by TennCare.

Document Title	Hospital Presumptive Eligibility				
First Published	05.17.2016				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
08.01.2016	2.	Qualified Entities	1	Policy Clarification	AF
01.05.2017	3.	Eligibility Period	1	Policy Clarification	RH
03.18.2019	3.a.	Legal Authority; Eligibility Period	1	Policy Clarification	SN
03.18.2019	4.a-b.; 5.a.	Age; Caretaker Relative Status; Household Composition	1-2	Non-Substantive Change	SN
01.03.2023	4.e.	Former Foster Care Recipient	2	Policy Change	AJ

Emergency Medical Services

Legal Authority: Social Security Act § 1903(v); 42 CFR 435.350, 42 CFR 440.255; 42 CFR 435.915; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Individuals eligible for Emergency Medical Services (EMS) must meet all financial requirements and non-financial requirements for a TennCare Medicaid category, except for citizenship.

Federal law requires that state Medicaid programs cover EMS for undocumented and ineligible aliens when these individuals otherwise meet criteria for Medicaid eligibility.

An undocumented alien is a person who is not a citizen of the U.S. and who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Undocumented aliens were either never legally admitted to the U.S. for any period of time or were admitted for a limited period of time and did not leave the U.S. when that period of time expired.

An ineligible alien is a person other than an undocumented alien who is not a citizen of the U.S. and whose alien status prevents qualification for Medicaid. Examples include the following:

a. Certain qualified aliens arriving on or after August 22, 1996, that may have been lawfully admitted to the U.S. but may be prohibited from acquiring Medicaid during the first five years of their residence in the country. This period of time is referred to as the "five-year bar."

2. Non-Financial Eligibility Requirements

a. Qualifying Conditions

In order for an alien to be the recipient of EMS, the alien must incur a sudden onset of a medical condition, not related to an organ transplant procedure, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

i. Placing the patient's health in serious jeopardy;
ii. Serious impairment to bodily functions; or
iii. Serious dysfunction of any bodily organ or part.

3. Financial Eligibility Requirements

Household composition for this category is based MAGI methodology or the Financially Responsible Relative (FRR) principle depending on the TennCare Medicaid category in which the applicant groups.

If an individual meets all financial and non-financial criteria for a TennCare Medicaid category except for citizenship, then TennCare will determine if there is an emergency that qualifies them for EMS.

Note: An applicant for EMS is only potentially eligible for the following categories: Caretaker Relative MAGI; Child MAGI 0-1; Child MAGI 1-5; Child MAGI 6-18; Pregnancy MAGI, Child Medically Needy; and Qualified Pregnancy Woman Medically Needy. Undocumented and ineligible aliens are unable to meet all non-financial eligibility criteria for the other TennCare Medicaid categories.

4. Application Process

TennCare accepts applications from aliens requiring emergency medical services. Hospitals and birthing or women's centers, or others acting on behalf of these individuals have been advised to submit applications to TennCare on the first date of the emergency because no coverage will be granted prior to the date of application for applicants who do not meet the criteria for retroactive eligibility according to the criteria specified below in Section 5. Medical records must also be submitted to support the emergency.

TennCare Medical Review Nurses determine whether the service requested by an alien qualifies as an emergency service. If an individual qualifies for coverage of an emergency service, then that coverage would apply regardless of whether he receives the service in the Emergency Department or whether he is subsequently admitted to the hospital.

5. Eligibility Begin and End Dates

Applicants who are not pregnant women (as defined in the *Pregnancy MAGI* policy), or children under age 19 as described in Section 1902(l)(4) of the Social Security Act, will not have their coverage begin prior to the date of application, and coverage will not begin prior to the date of the emergent episode. Pregnant women (or women during the postpartum period beginning on the last day of the pregnancy), and children under age 19, described in Section 1902(l)(4) of the Social Security Act, who are eligible for EMS on the basis of Child MAGI, Pregnancy MAGI, or Caretaker Relative may receive coverage for the emergent episode if the emergent episode occurred during the retroactive period, and they meet all eligibility criteria. To qualify for EMS during the retroactive period on the basis of the Caretaker Relative category, the individual must be pregnant. See the *Eligibility Determination* policy for additional information on retroactive eligibility. Coverage will be limited to the length of time required to stabilize the emergent episode. Only the services involved in the emergency itself will be reimbursed and coverage is only provided for the single episode of care.

Document Title	Emergency Medical Services
First Published	04.01.2015

Revision History

Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
07.01.2021	3-4.	Legal Authority; Financial Eligibility Requirements; Application Process	1-2	Non-Substantive Change	MH
07.01.2021	4-5.	Application Process; Eligibility Begin and End Dates	2	Policy Change	MH
01.04.2022	5.	Eligibility Begin and End Dates	2	Policy Clarification	MH

COVERKIDS

Legal Authority: Sec. 2107 of the Social Security Act [42 U.S.C. 1397gg]; 42 CFR 457.310; 42 CFR 457.315; 42 CFR 457.320; 42 CFR 457.330; 42 CFR 457.348; 42 CFR 457.535; Tenn. Comp. R. & Regs. 1200-13-20

1. Overview

CoverKids is Tennessee's Children's Health Insurance Program (CHIP). CHIP is authorized by Title XXI of the Social Security Act. Similar to Medicaid, CHIP is jointly financed and administered by the federal and state governments.

2. Policy Statement

CoverKids consists of two separate Categories of Eligibility (COEs)

a. **CoverKids Child COE** is available to children who are under age 19, not eligible for TennCare Medicaid, whose household income is at or below 250% of the Federal Poverty Level (FPL) based on Eligibility Determination Group (EDG) size, and who meet all non-financial eligibility requirements.

b. **CoverKids Pregnant Woman COE** is available to unborn babies of pregnant women not eligible for TennCare Medicaid, whose household income is at or below 250% of FPL based on EDG size, and who meet all non-financial eligibility requirements.

3. Coverage Period

a. Children under Age 19

Children under age 19 determined eligible for CoverKids Child COE receive coverage for 12 continuous months except in the following instances:

- **i.** The child turns 19;
- **ii.** Coverage is voluntarily terminated;
- **iii.** The child is no longer a resident of Tennessee;
- **iv.** The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the child or the child's representative;
- **v.** Death; or
- **vi.** The child is determined eligible in a TennCare Medicaid category.

b. Women who are Pregnant

Women who are eligible for the CoverKids Pregnant Woman COE will remain eligible for benefits through a 60-day postpartum period, beginning the last day of the pregnancy and ending on the last day of the month in which the 60-day period ends. Children eligible for the CoverKids Child COE who are pregnant while under the age of 19 will remain eligible for CoverKids Child benefits through a 12-month postpartum period. The respective 60-day or 12-month postpartum period is automatic and applicable to all pregnant women who have applied, been determined eligible for and received CoverKids benefits. The postpartum coverage period is applied regardless of any change in household income for CoverKids pregnant women, regardless of any changes in household circumstances for pregnant CoverKids children under the age of 19, and regardless of how the pregnancy ends.

The 12-month postpartum period will end prior to the end of the 12 months for CoverKids Children who are pregnant in the following instances:

- **i.** Coverage is voluntarily terminated;
- **ii.** The child is no longer a resident of Tennessee;
- **iii.** The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the child or the child's representative; or
- **iv.** Death.

Note: If a child who is determined eligible for CoverKids Child while pregnant later becomes eligible for TennCare Medicaid during the 12-month postpartum period, she will remain enrolled in CoverKids Child until the postpartum period has ended. If she requests to move from CoverKids Child to TennCare Medicaid, the 12-month postpartum coverage, and subsequent postpartum benefits, will end.

4. Newborns

CoverKids benefits are deemed available to infants not eligible for TennCare Medicaid when the infant's mother has CoverKids eligibility at the time of birth.

TennCare Medicaid benefits are available for infants born to a CoverKids enrollee with household income at or below 195%. Eligibility begins the date of birth.

5. Co-Pay Responsibility

CoverKids enrollees may be required to pay co-pays for covered services and pharmacy benefits. Individuals with verified American Indian/Alaskan Native status receive additional cost-sharing benefits.

6. Non-Financial Eligibility Requirements

Individuals eligible for CoverKids must meet all non-financial eligibility requirements. Additional information about each condition of eligibility is available in the Non-Financial Eligibility chapters.

a. Age: A child must be under age 19.

b. **Citizenship:** A child must be a U.S. Citizen, U.S. National or eligible non-citizen. The unborn child of a pregnant woman is presumed to be a U.S. citizen, regardless of the citizenship or immigration status of the mother.

c. **Enumeration:** An individual eligible to receive a Social Security Number (SSN) must possess and provide a valid SSN or proof of application for an SSN, unless she meets an exception. See the *Enumeration* policy.

d. **State Residence:** The individual must be a resident of Tennessee.

e. **Pregnancy:** TennCare accepts self-attestation of pregnancy at application or as a reported change, unless TennCare has information that is not reasonably compatible with such attestation. If TennCare has information that is not reasonably compatible with an attested pregnancy, TennCare will contact the individual and may request written medical verification of the pregnancy.

f. **Primary Health Insurance:** CoverKids must be the individual's only health insurance plan. Health insurance plans include:

   i. Employer sponsored insurance;
   ii. COBRA;
   iii. Medicare;
   iv. TRICARE;
   v. Peace Corps; and
   vi. Other comprehensive medical coverage.

   Individuals enrolled in a limited benefit policy will not be considered to be enrolled in other insurance. A limited benefit policy is health coverage for a specific disease (e.g., cancer), or an accident occurring while engaged in a specified activity (e.g., school-based sports), or which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (e.g., hospital indemnity). Additionally, individuals enrolled in a Qualified Health Plan (QHP) through the Federally Facilitated Marketplace (FFM), are not considered to be enrolled in other insurance.

   If the applicant is a pregnant woman with health insurance, she may be eligible for pregnancy benefits if her health insurance does not cover pregnancy-related care.

7. Financial Eligibility Requirements

a. **Eligibility Determination Group**

   The EDG for CoverKids uses Modified Adjusted Gross Income (MAGI) methodology. It is possible for household members to have different household sizes when determining eligibility. When determining EDG size for a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. When determining EDG size for other applicants in the household, the pregnant woman is counted as one person. For additional information regarding EDG size, see the *Eligibility Determination Group for MAGI* policy.

b. Income Standard

Individuals must have income at or below 250% FPL.

c. Budget

Ms. Wilson applied for medical assistance for her 10 year old son. Ms. Wilson is employed with a Net Countable Earned Income of $3,000. Her Before/Pre-tax Contributions total $150. The example budget is based on an EDG size of two and determines eligibility for the child with an Income Test Limit of $3,430 (250% FPL).

Ms. Wilson's Remaining Countable Earned/Self-Employment amount, $2,850, is over the Income Test Limit for Child 6 to 18 MAGI, $1825. However, the income is under the Income Test Limit for CoverKids, $3430. The MAGI 5% Deduction is not applied because the Total Net Countable Income is under the Income Test Limit for the CoverKids category.

Income Budget Calculation		
Net Countable Self-Employment Income		$ 00.00
Net Countable Earned Income		$ 3,000.00
Before/Pre-tax Contribution Deductions	-	$ 150.00
Remaining Countable Earned/Self-Employment Amount	=	$ 2,850.00
Net Countable Unearned Income	+	$ 0.00
Countable Earned and Unearned Income	=	$ 2,850.00
1040 Deduction	-	$ 0.00
MAGI 5% Deduction	-	$ 0.00
Net Countable Income	=	$ 2,850.00
Income Test Limit		$ 3,430.00
Gap Filling Amount	-	$ 0.00
Total Net Countable Income	=	$ 2,850.00
Income Test Result		PASS

The above budget is current as of December 2018.

8. Resource Test

There is no resource test for CoverKids applicants.

Document Title	CoverKids				
First Published	12.03.2014				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
02.01.2016	1-6.	Overview of the CoverKids Program; Policy Statement; Coverage Period; Newborns; Co-Pay Responsibility; Non-Financial	1-2	Policy Change	NF
09.06.2016		Legal Authority	1	Non-Substantive Change	JH
04.06.2018	3-4.; 6.f.	Coverage Period; Newborns; Primary Health Insurance	1 -3	Policy Clarification	JH
03.18.2019	1.; 6.c.	Overview; Enumeration	1-2	Non-Substantive Change	SN
03.18.2019	2.; 3.; 7.a.; 7.c.	Legal Authority; Policy Statement; Coverage Period; Eligibility Determination Group; Budget	1; 3-4	Policy Clarification	TB
08.01.2019	3.	Coverage Period	1	Policy Clarification	TB
04.01.2022	3.	Coverage Period	1	Policy Change	TN
04.01.2022	2.; 6.f.	Policy Statement; Non-Financial Eligibility Requirements	1; 3	Policy Clarification	TN

ABD STATE RESIDENCE

Legal Authority: 42 CFR 435.403; TCA 71-5-120; TCA 40-38-601 *et seq.*; Tenn. Comp. R. & Regs. 1200-13-20; 1360-11-01

1. Policy Statement

An individual must be a Tennessee resident to be eligible for TennCare Medicaid. An individual is considered a Tennessee resident if the individual attests to living in Tennessee, intends to reside in Tennessee and there is no information to indicate otherwise. Individuals will not be required to reside in Tennessee for a specific amount of time to claim residency. Individuals considered temporarily absent from Tennessee may retain their Tennessee residency under certain circumstances.

2. Residency

a. Non-institutionalized Individuals under Age 21 who are not Emancipated or Married

For non-institutionalized individuals under age 21 who are not emancipated or married, and not receiving Title IV-E payments, the state of residence is:

i. The state in which the individual is living, with or without a fixed address; or
ii. The state in which the parent or caretaker resides.

b. Institutionalized Individuals under Age 21 who are not Emancipated or Married

For institutionalized individuals under age 21, who are not emancipated or married, and not receiving Title IV-E payments, the state of residence is:

i. The state in which the parent or legal guardian lives at the time of placement in an institution;
ii. The state in which the parent or legal guardian who files the application is currently living if the individual is institutionalized in that state; or
iii. The state in which the party who files the application lives, if the institutionalized individual has been abandoned by her parents and does not have a legal guardian.

c. Non-Institutionalized Individuals Age 21 and over, or under Age 21 and Emancipated or Married

For non-institutionalized individuals age 21 and over, or under age 21 who are emancipated or married and capable of indicating intent, the state of residence is:

i. The state in which they are living and intend to reside with or without a fixed address; or
ii. Where the individual lives and entered with a job commitment or seeking employment, whether or not they are currently employed.

d. Institutionalized Individuals Age 21 and Over

For institutionalized individuals age 21 and over who are capable of indicating intent and not receiving State Supplementary Payments (SSP), the state of residence is the state where the individual is living and intends to reside.

e. Institutionalized Individuals Age 21 and over who became Incapable of Indicating Intent before the Age of 21

For institutionalized individuals age 21 and over who became incapable of indicating intent before the age of 21 and not receiving Title IV-E or SSP, the state of residence is:

- **i.** That of the applying parent when the parents live in different states, or that of the applying legal guardian;
- **ii.** The state in which the parent or legal guardian lives at the time of placement in an institution;
- **iii.** The state in which the parent or legal guardian who files the application is currently living if the individual is institutionalized in that state; or
- **iv.** The state in which the party who files the application lives, if the institutionalized individual has been abandoned by his parents and does not have a legal guardian.

f. Institutionalized Individuals Age 21 and over who became Incapable of Indicating Intent after the Age of 21

For institutionalized individuals age 21 and over who became incapable of indicating intent after the age of 21 and not receiving SSP, the state of residence is the state where the individual is physically present, except where another state makes a placement.

g. Non-Institutionalized Individuals over Age 21 who are not Capable of Stating Intent

For non-institutionalized individuals over 21 and not capable of stating intent, the state of residence is the state in which they live.

h. Individuals in an Out-of-State Institution

- **i.** An individual placed out of state is considered a resident of the state that:

  1. Placed an individual in an out of state institution; or
  2. Arranged for placement of an individual in an out of state institution.

  This is true even when the reason for initiating placement is due to a lack of resources.

- **ii.** Action beyond providing basic information to individuals about Medicaid in another state is considered making or arranging placement, but the following is not:

1. Providing basic information about other states Medicaid programs, healthcare services and facilities; or
2. Helping individuals locate a facility when he or she is capable of indicating intent and independently decides to move.

If a competent individual leaves a state placement, the individual's state of residence is where the individual is physically located.

i. Individuals Receiving Federal Payments for Foster Care, Federal Payments for Adoption Assistance or SSP

An individual of any age receiving federal payments for foster care or adoption assistance under Title IV-E of the Social Security Act is a resident of the state in which the child lives. An individual of any age receiving a SSP is a resident of the state paying the SSP.

j. Individuals Participating in the State's Safe at Home Address Confidentiality Program

Tennessee's Safe at Home Address Confidentiality Program protects the home, school or work address of a relocated victim of domestic abuse or other listed offenses by providing a substitute address for the participant to provide in lieu of a current home or mailing address.

Participation in the Safe at Home Address Confidentiality Program is determined solely by the Secretary of State. For an individual participating in the state's Safe at Home Address Confidentiality Program, the state of residence is determined and verified by the Secretary of State.

3. Incapable of Indicating Intent

An individual is considered incapable of indicating intent when tests, determined acceptable by the Department of Intellectual and Developmental Disabilities (DIDD), indicate an individual has an I.Q of 49 or less or a mental age of 7 or less. An individual is also considered incapable of indicating intent if found legally incompetent. Medical documentation from a physician, psychologist or other person licensed by the state in the field of intellectual disability may also be used if the documentation indicates that the individual is incapable of indicating intent.

4. Student

Individuals attending school out of state, but considered to be dependents of a Tennessee resident are temporarily absent while attending school. Individuals aged 18 to 22 attending school in Tennessee, but considered to be dependents of a non-Tennessee resident will not be considered a resident of Tennessee.

5. Temporary Absence

A temporary absence from Tennessee does not preclude continued eligibility if the individual indicates her intent to return to Tennessee once the purpose for the visit is accomplished when:

a. The absence is for a specific purpose such as a temporary work assignment, visit, hospitalization, participation in an educational or rehabilitation program not available in Tennessee; or

b. The absence is for children in treatment centers.

If an individual indicates that she is temporarily out of state, she must provide an anticipated date of return. The individual's temporary absence status will be assessed within 10 days of the individual's anticipated date of return.

If at any time during the absence, the individual is determined no longer eligible for TennCare Medicaid benefits for any reason, the case must be closed. Application or receipt of Medicaid or Advanced Premium Tax Credits (APTCs) in another state indicates intent to reside elsewhere and results in the loss of Tennessee residency. If a redetermination is required during the period of absence, follow renewal procedures and secure assistance from the other state as necessary.

6. Disputed Residency

An individual's physical location determines the state of residence if two or more states are unable to resolve what state is the state of residence.

7. Verification

An individual is considered a Tennessee resident if the individual attests to living in Tennessee and intends to reside in the state. TennCare will conduct post-eligibility verification of state residency to ensure program integrity using national and state electronic verification sources. If an individual's state of residence is questionable, he will have 20 days to provide documentary evidence supporting his claim. Evidence of residency includes:

a. A statement of intent to reside in Tennessee; and

b. A current Tennessee rent or mortgage receipt or utility bill in the adult applicant's name;

c. A current Tennessee motor vehicle driver's license or identification card issued by the Tennessee Department of Safety in the adult applicant's name;

d. A current Tennessee motor vehicle registration in the adult applicant's name;

e. A document showing that the adult applicant is employed in Tennessee;

f. A document showing that the adult applicant has registered with a public or private employment service in Tennessee;

g. Evidence that the adult applicant has enrolled the applicant's children in a school in Tennessee;

h. Evidence that the adult applicant is receiving public assistance in Tennessee;

i. Evidence of registration to vote in Tennessee;

j. Evidence of participation in the Safe at Home Address Confidentiality Program; or

k. Other evidence deemed sufficient by TennCare as proof of residency in Tennessee.

Document Title	ABD State Residence				
First Published	03.20.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	2.j.; 7.j	Legal Authority; Individuals Participating in the State's Address Confidentiality Program; Verification	1; 3-4	Policy Clarification	TN
05.01.2019	2.j; 7.j.	Legal Authority; Individuals Participating in the State's Safe at Home Address Confidentiality Program; Verification	1; 3-4	Policy Clarification	TN

ABD CITIZENSHIP AND IMMIGRATION

Legal Authority: 42 CFR 435.406; 42 CFR 435.407; 42 CFR 435.956; 8 USCA § 1431; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

In order to be eligible for TennCare Medicaid or CoverKids, an individual must be a:

a. United States (U.S.) citizen;
b. U.S. national; or
c. Qualified non-citizen who meets the eligibility conditions associated with specific immigration statuses. See the *Qualified Non-Citizens* policy.

Individuals declaring U.S. citizenship or immigration status must have such declarations verified by TennCare in order to receive TennCare Medicaid or CoverKids. Individuals who are not U.S. citizens, but have been granted the right to reside in the U.S. will have an immigration status. If TennCare is unable to verify a declaration of U.S. citizenship or immigration status using an electronic data source, the individual must provide satisfactory documentary evidence of citizenship or immigration.

Declarations of citizenship or immigration status must be made by either the individual, an adult member of the individual's household, an authorized representative, or if the individual is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status.

2. Definitions

a. U.S. Citizen: An individual who was born in:

i. The U.S.;
ii. Puerto Rico;
iii. Guam;
iv. The U.S. Virgin Islands; or
v. The Commonwealth of the Northern Mariana Islands.

b. U.S. National: An individual who was born in the:

i. American Samoa; or
ii. Swains Island.

c. Naturalized Citizen: An individual who becomes a U.S. citizen after birth. Non-citizens do not automatically become citizens by marrying a U.S. citizen. Spouses, however, may apply for naturalization and, if eligible, become citizens through the court.

d. Derived Citizen: An individual who was adopted by or born abroad to at least one U.S. citizen parent. Citizenship may be conveyed to children through the naturalization of parents, to foreign-born children adopted by U.S. parents, or through birth abroad to at least one U.S. citizen parent.

e. Child Citizenship Act of 2000: According to the Child Citizenship Act of 2000, a child born outside of the U.S. to a citizen parent or adopted from abroad by a U.S. citizen parent automatically becomes a citizen of the U.S. when all of the following have been met on or after February 27, 2001:

- **i.** At least one parent of the child is a U.S. citizen, whether by birth or naturalization;
- **ii.** The child is under 18 years of age;
- **iii.** The child is lawfully admitted for permanent residence to the U.S. and is residing in the legal and physical custody of the citizen parent. The child will have either a permanent resident card (i.e., green card) or an I-551 stamp on her passport. The child may or may not have a certificate of citizenship; and
- **iv.** If adopted, the adoption is final.

f. Qualified Non-Citizen: An individual whose immigration status is included in one of the following groups (see *Qualified Non-Citizens* policy):

- **i.** Qualified non-citizens, as defined by the Personal Responsibility and Work Opportunity Act of 1996 (8 USC 1641);
- **ii.** Certain American Indians born outside of the U.S.; or
- **iii.** Non-citizens granted a certain humanitarian immigration status.

3. Exempt Groups

TennCare accepts declarations of U.S. citizenship from the following individuals without verification:

- **a.** Individuals receiving Supplemental Security Income (SSI) benefits;
- **b.** Individuals entitled to or enrolled in any part of Medicare;
- **c.** Individuals receiving Social Security benefits based on their disability;
- **d.** Individuals to whom child welfare services are made available based on the child being in foster care, or receiving adoption assistance or foster care assistance; and
- **e.** Newborns who are eligible for Medicaid on the basis of being born to a mother who was eligible for and receiving TennCare Medicaid at the time of birth. A newborn who is deemed eligible and enrolled in Medicaid is exempt from citizenship verification requirements for the rest of her life. This exemption applies to individuals enrolled as deemed newborns in other states.

Note: Pregnant women eligible for the CoverKids maternity benefits and pregnancy related services are not required to attest to citizenship or immigration status.

4. Verification of U.S. Citizenship and Immigration Status

a. Overview

Declarations of U.S. citizenship and immigration status must be accepted and then verified using an electronic data match with the Social Security Administration (SSA) or U.S. Department of Homeland Security. Federal law requires that the state first attempt to electronically verify citizenship and immigration status using the Federal Data Services Hub (the Hub). When unable to electronically verify citizenship or immigration status of an individual, the individual must provide satisfactory documentary evidence to TennCare.

Verification of U.S. citizenship is a one-time requirement. Once U.S. citizenship has been verified, it will be recorded in the individual's case and the state cannot request verification again, even if there is a break in coverage. Verification of immigration status is also a one-time requirement, unless the individual attests to, or TennCare receives information indicating, a change in status.

b. Electronic Verification of U.S. Citizenship and Immigration Status

i. Federal Data Services Hub

1. Applicant Attesting to U.S. Citizenship (Citizenship by Birth)

Confirmation of citizenship status by the SSA via the Hub is considered stand-alone evidence of citizenship. Applicants whose citizenship is confirmed via the Hub are not required to submit additional documentation of citizenship status.

2. Applicant Attesting to U.S. Citizenship (Naturalized and Derived Citizens)

Naturalized or derived citizens will have their citizenship status verified by the U.S. Department of Homeland Security via the Hub, if available. Applicants must provide their Alien Registration Number and information from their Naturalization Certificate or Certificate of Citizenship. Verification of citizenship status by the U.S. Department of Homeland Security via the Hub is considered stand-alone evidence of citizenship. Applicants whose citizenship is confirmed via the Hub are not required to submit additional documentation of citizenship status.

3. Applicant Attesting to Eligible Immigration Status

Applicants who are able to provide a U.S. Department of Homeland Security Alien Registration Number and/or other immigrant documentation numbers may have their immigration status verified by the U.S. Department of Homeland Security via the Hub. Electronic verification of immigration status by the U.S. Department of

Homeland Security is considered stand-alone evidence. Applicants whose immigration status is verified via the Hub are not required to submit additional information.

c. Documentary Evidence of Citizenship

When unable to verify citizenship or immigration status using electronic data sources, the individual must promptly provide satisfactory documentary evidence of citizenship status. Section 1903(x) of the Social Security Act requires that specific documentation be used to verify citizenship status, according to the reliability of the document (42 USC 1396b(x)).

Stand-alone evidence of citizenship is documentary evidence that must be accepted without any additional evidence of identity. If stand-alone evidence of citizenship cannot be provided, the second level of citizenship evidence must be accepted if the applicant also provides sufficient evidence of identity.

A photocopy, facsimile, scanned, or other copy of a document must be accepted to the same extent as an original document under this section, unless information on the submitted document is inconsistent with other information available or there is reason to question the validity of the document or information on the document.

i. Stand-alone Evidence of Citizenship

The following must be accepted as sufficient evidence of citizenship:

1. A U.S. passport, including a U.S. passport card issued by the U.S. Department of State, without regard to any expiration date as long as such passport or card was issued without limitation;
2. A Certificate of Naturalization;
3. A Certificate of U.S. Citizenship;
4. An enhanced driver's license issued by Michigan, Minnesota, New York, Vermont, or Washington;
5. A data match with the SSA; and
6. Documentary evidence issued by a federally recognized Indian Tribe, as published by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including Tribes located in a state that has an international border, which:

a. Identifies the federally recognized Indian Tribe that issued the document;
b. Identifies the individual by name; and
c. Confirms the individual's membership, enrollment, or affiliation with the Tribe.

Documents described in this subsection include, but are not limited to: a tribal enrollment card, Certificate of Degree of Indian Blood, Tribal Census Document, and documents on tribal letterhead, issued under the signature of the appropriate tribal official that provide the required information.

ii. Evidence of Citizenship

If an applicant does not provide stand-alone documentary evidence, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by acceptable evidence of identity:

1. 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 January 13, 1941), Guam, the Virgin Islands of the U.S., American Samoa, Swains Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (after November 4, 1986). The birth record document may be issued by a state, commonwealth, territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the CNMI before these areas became part of the U.S., the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

a. Puerto Rico:

i. Evidence of birth in Puerto Rico and the applicant's statement that he was residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941.

b. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

i. Evidence of birth in the NMI, TTPI citizenship, and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986, (NMI local time) and the applicant's statement that he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);

ii. Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975, and the applicant's statement that he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time);

iii. Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

2. A cross match with a state Vital Statistics agency documenting a record of birth;

3. A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.;

4. A Report of Birth Abroad of a U.S. Citizen;

5. A Certification of Birth in the U.S.;

6. A U.S. Citizen I.D. card;

7. A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency);

8. A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth;

9. Evidence of U.S. Civil Service employment before June 1, 1976;

10. U.S. Military Record showing a U.S. place of birth;

11. A data match with the SAVE program or any other process established by the U.S. Department of Homeland Security to verify that an individual is a citizen;

12. The following documentation demonstrating that a child meets the requirements of Section 101 of the Child Citizenship Act of 2000 as amended (8 USC 1431):

- **a.** The child's birth certificate or record;
- **b.** Marriage certificate of child's parents (if applicable);
- **c.** If the child's parents were married before their marriage to each other, proof of termination of any previous marriage of each parent (e.g., death certificate or divorce decree);
- **d.** Evidence of U.S. citizenship of parent, (i.e., birth certificate; naturalization certificate; FS-240, Report of Birth Abroad; a valid unexpired U.S. passport; or certificate of citizenship);
- **e.** If the child was born out of wedlock, documents verifying legitimation according to the laws of the child's residence or domicile or father's residence or domicile (if applicable);
- **f.** In case of divorce, legal separation, or adoption, documentation of legal custody;
- **g.** Copy of Permanent Resident Card/Alien Registration Receipt Card or other evidence of lawful permanent resident status (e.g. I-551 stamp in a valid foreign passport or Service-issued travel document);
- **h.** If adopted, a copy of the full, final adoption decree and, if the adoption was outside of the U.S. and the child immigrated as an IR-3 (orphan adopted abroad by U.S. citizen parent(s)), evidence that the foreign adoption is recognized by the state where the child is permanently residing; and
- **i.** Evidence of all legal name changes, if applicable, for the child and U.S. citizen parent;

13. Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth;

14. Life, health, or other insurance record that indicates a U.S. place of birth;

15. Official religious record recorded in the U.S. showing that birth occurred in the U.S.;

16. School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth;

17. Federal or state census record showing U.S. citizenship or a U.S. place of birth; and

18. If the applicant does not have one of the documents listed in 1-17 of this section, she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

iii. Evidence of Identity

1. TennCare must accept the following as proof of identity, provided such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

a. A driver's license issued by a state or territory;
b. A school identification card;
c. A voter's registration card;
d. A U.S. military card or draft record;
e. An identification card issued by the federal, state or local government;
f. A military dependent's identification card;
g. A U.S. Coast Guard Merchant Mariner card;
h. For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records; and
i. Two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees, and property deed or titles.

2. Finding of identity from a federal or state governmental agency. TennCare may accept as proof of identity a finding of identity from a federal agency or another state agency, including, but not limited to, a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

3. If the applicant does not have any documents listed in this section and identity is not verified by another agency, the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information. The affidavit does not have to be notarized.

iv. Verification of citizenship by a federal agency or another state

TennCare may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a federal agency or another state agency, if such verification was done on or after July 1, 2006.

v. Assistance with obtaining documentation

The state must provide assistance to applicants who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

d. Documentary Evidence of Immigration Status

When unable to verify immigration status using electronic data sources, the applicant must promptly provide satisfactory documentary evidence of immigration status. The United States

Citizenship and Immigration Services (USCIS) has several types of documents that a non-citizen might have to verify her status. These documents include, but are not limited to, the following:

- **i.** A Permanent Resident Card (I-551) or "Green Card" - Issued to eligible immigrants who enter the U.S. to permanently live;
- **ii.** A Permanent Resident Re-entry Permit (I-327) - Allows permanent residents to leave and re-enter the U.S.;
- **iii.** A Refugee Travel Document (I-571) - Issued to refugees and asylees for travel purposes;
- **iv.** A Temporary I-551 Stamp (on passport or I-94, I-94A) - A temporary I-551 stamp will have a handwritten or stamped issue date and a "valid until" date. Temporary I-551 stamps can be used to attest to permanent resident status;
- **v.** A foreign passport stamped by the U.S. Government indicating that the holder has been "Processed for I-551";
- **vi.** A machine readable immigrant visa (with temporary I-551 language) - Indicates permanent resident status;
- **vii.** An Arrival/Departure Record (I-94, I-94A) Form I-94 stamped with one of the following statuses: Asylee, Parolee or Parole, Refugee, Asylum, humanitarian parolee, or public interest parolee;
- **viii.** A court order stating that deportation has been withheld pursuant to Section 243(h) of the Immigration and Nationality Act (8 USC 1253);
- **ix.** A Notice of Action (I-797) - A form of communication from USCIS about immigration benefits;
- **x.** Document indicating membership in a federally recognized Indian tribe or American Indian born in Canada;
- **xi.** Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR); and
- **xii.** Office of Refugee Resettlement (ORR) eligibility letter (if under 18).

A non-citizen may contact USCIS or otherwise obtain the necessary verification.

5. Reasonable Opportunity for Verification of Citizenship and Immigration

a. Overview

When an applicant makes a declaration of U.S. citizenship or satisfactory immigration status and the applicant's citizenship or immigration status cannot be promptly verified using an electronic data source or acceptable documentary evidence, TennCare will grant the applicant a period of reasonable opportunity to secure valid verification. The Reasonable Opportunity Period (ROP) begins on the date of application and extends 90 days from the date the applicant receives notice of the reasonable opportunity. The date on which the applicant receives notice is considered to be 5 days after the date on the notice, unless the individual shows that he did not receive the notice within the 5-day period.

Current enrollees may be granted an ROP to secure documentary evidence of citizenship or satisfactory immigration status. An enrollee is not required to re-verify citizenship or immigration status unless he reports a change or TennCare becomes aware of a change in the individual's status, and the enrollee's citizenship or immigration status cannot be verified using an electronic data source or by acceptable documentary evidence. For current enrollees, the 90-day ROP will begin on the date that the enrollee receives notice of the ROP. The date on which the enrollee receives notice is considered to be 5 days after the date on the notice, unless the individual shows that he did not receive the notice within the 5-day period.

During the ROP, TennCare must accept a declaration of citizenship or immigration. TennCare must not delay, reduce, or terminate benefits for an applicant who is otherwise TennCare Medicaid- or CoverKids-eligible during this period.

If an applicant must provide information in addition to verification of citizenship, for example, verification of residence, she has 10 days from the day on which the notice is received to return the additional information. If verification of residence is provided within the 10 days, but verification of citizenship remains outstanding, a period of reasonable opportunity for verification of citizenship will be invoked.

b. Reasonable Opportunity Period

During the ROP, the state must assist the applicant with securing acceptable verification. This may include, but is not limited to:

- **i.** Assisting the individual in obtaining a Social Security Number;
- **ii.** Attempting to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and data from an electronic data source, and resubmit corrected information to the electronic data source;
- **iii.** Providing the individual with information on how to contact the source of the electronic data so that he can attempt to resolve such inconsistencies; and
- **iv.** Permitting the individual to provide other documentation of citizenship or immigration status, as listed in this section.

If satisfactory citizenship or immigration verification is received by the 90th day, the individual's eligibility will continue based on the initial application date and no additional action will be taken.

If citizenship or immigration verification is received during the 90-day ROP that shows that the individual is not a U.S. citizen or an eligible immigrant, eligibility may be terminated. If satisfactory citizenship or immigration verification is not received by the 90th day, eligibility will be terminated.

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Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
08.01.2016	2	Definitions – Qualified Non-	2	Policy Clarification	AJ
05.01.2017	4.c-d.	Documentary Evidence of Citizenship	3-7	Policy Change	RS
08.01.2019	5	Legal Authority; Reasonable Opportunity for Verification of Citizenship and Immigration	1; 8-9	Policy Clarification	TB

ABD QUALIFIED NON-CITIZENS

Legal Authority: 42 CFR 435.139; 42 CFR 435.406; 42 CFR 440.255; 42 CFR 457.320; SSA SI 00502; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Non-citizen eligibility for TennCare Medicaid and CoverKids is limited to certain immigration statuses. In order to be eligible, an individual must be either:

a. A qualified non-citizen, as defined by Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 at 8 USC 1641;
b. An American Indian born outside of the U.S.; or
c. A non-citizen who has been granted a certain humanitarian status.

Ineligible non-citizens are potentially eligible for Emergency Medical Services (EMS) only. Ineligible non-citizens are not required to provide information regarding citizenship, immigration status or enumeration when applying for EMS.

2. Qualified Non-Citizen

The PRWORA created two categories of non-citizens for the purpose of public assistance eligibility: qualified and non-qualified (ineligible) non-citizens. A non-citizen's status is based on an individual's date of entry into the U.S. and their immigration status with the United States Citizenship and Immigration Services (USCIS).

A qualified non-citizen is an individual who belongs to one of several non-citizen categories, each of which is tied to a specific section of the Immigration and Nationality Act (INA) at 8 USC. 1101, *et seq*. Qualified non-citizens are potentially eligible for full TennCare Medicaid and CoverKids benefits just like U.S. citizens. However, certain categories of qualified non-citizens have periods of program ineligibility or time limits placed on eligibility.

Qualified non-citizens are:

a. Non-citizens lawfully admitted for permanent residence, a Lawful Permanent Resident (LPR), as an immigrant as defined in the INA (8 USC 1101);
b. Refugees admitted under Section 207 of the INA (8 USC 1157);
c. Asylees granted asylum under Section 208 of the INA (8 USC 1158);
d. Non-citizens paroled in the U.S. under Section 212(d)(5) of the INA (8 USC 1182(d)(5)) for a period of at least one year;
e. Non-citizens whose deportation is withheld under the INA (8 USC 1253 or 8 USC 1231(b)(3), as amended);
f. Battered immigrants and children who meet the conditions set forth in Section 431(c) of the PRWORA (8 USC 1641(c));

- **g.** Cuban or Haitian entrants as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;
- **h.** Non-citizens granted conditional entry under the INA (8 USC 1153(a)(7)) in effect before April 1, 1980; and
- **i.** Non-citizens who are victims of a severe form of trafficking or who have been granted nonimmigrant status under Section 101(a)(15)(T) of the INA or who have a pending application that sets forth a prima facie case for such nonimmigrant status.
- **j.** Non-citizens who lawfully reside in the U.S. in accordance with the Compacts of Free Association (COFA) between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

3. Other Eligible Immigration Statuses

The following immigration statuses are not statutorily defined as qualified non-citizens however, these groups are generally treated like qualified non-citizens for eligibility purposes:

- **a.** Non-citizens admitted as Amerasian immigrants under Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;
- **b.** Non-citizens who are members of a Federally-recognized Indian tribe as defined in the Indian Self-Determination and Education Assistance Act (25 USC 450(b)(e));
- **c.** Non-citizens who are American Indians born in Canada to whom the INA (8 USC 1359) applies;
- **d.** Afghan non-citizens granted Special Immigrant Status under Section 602(b) of the Afghan Allies Protection Act of 2009 as described in the INA (8 USC 1101(a)(27)); and
- **e.** Iraqi non-citizens granted Special Immigration Status under the National Defense Authorization Act for Fiscal Year 2008 as described in the INA (8 USC 1101(a)(27)).

4. Ineligible Non-Citizens

Ineligible non-citizens are not eligible to receive full TennCare Medicaid or CoverKids benefits, but may be eligible to receive EMS.

Ineligible non-citizens include:

- **a. Undocumented Non-Citizens:** Undocumented non-citizens are individuals who enter and reside in the U.S. without notification of or proper permission from the U.S. government.

- **b. Lawfully Present Non-Citizens:** Lawfully present non-citizens are a specific group of non-citizens who are eligible to receive health insurance coverage through the Federally Facilitated Marketplace (FFM), but who are unable to receive TennCare Medicaid or CoverKids benefits. Lawfully present non-citizens include:

  - **i.** Non-citizens paroled into the U.S. in accordance with 8 USC 1182(d)(5) for less than one year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

- **ii.** Non-citizens granted temporary resident status in accordance with 8 USC 1160 or 1255a;
- **iii.** Non-citizens granted Temporary Protected Status (TPS) in accordance with 8 USC 1254a and individuals with pending applications for TPS who have been granted employment authorization;
- **iv.** Non-citizens granted employment authorization under 8 CFR 274a.12(c);
- **v.** Family Unity beneficiaries in accordance with 8 USC 1182;
- **vi.** Non-citizens under Deferred Enforced Departure (DED) in accordance with a decision made by the President of the United States;
- **vii.** Non-citizens granted Deferred Action status;
- **viii.** Non-citizens granted an administrative stay of removal under 8 CFR 241;
- **ix.** Beneficiaries of approved visa petitions who have a pending application for adjustment of status;
- **x.** Individuals with a pending application for asylum under 8 USC 1158, or for withholding of removal under 8 USC 1231 or under the Convention Against Torture, who:
  1. Have been granted employment authorization; or
  2. Are under the age of 14 and have had an application pending for at least 180 days;
- **xi.** Non-citizens who have been granted withholding of removal under the Convention Against Torture (8 CFR 208.16);
- **xii.** Children who have a pending application for Special Immigrant Juvenile status as described in 8 USC 1101(a)(27)(J); and
- **xiii.** Non-citizens lawfully present in American Samoa under the immigration laws of American Samoa.

c. Non-Citizens Admitted for a Temporary Purpose

Some non-citizens are lawfully admitted to the U.S. for a temporary or specified period of time. They include foreign students, visitors, foreign government representatives on official business, crewmen on shore leave, treaty traders and investors and families, temporary workers, including agricultural contract workers, and members of the foreign press, radio, film and other media.

Examples of the types of documentation that a non-qualified or ineligible non-citizen may possess include:

- **i.** Form I-185, Canadian Border Crossing Card;
- **ii.** Form I-186, Mexican Border Crossing Card;
- **iii.** Form SW-434, Mexican Border Visitor’s Permit; and
- **iv.** Form I-95A, Crewman’s Landing Permit.

5. Five-Year Period of Ineligibility

The PRWORA established a five-year period of ineligibility for all federally funded benefits, including Medicaid and CoverKids, for certain qualified non-citizens entering the U.S. on or after August 22, 1996. The five-year period of ineligibility is not applied to qualified non-citizens admitted to the U.S. prior to August 22, 1996 who have been continuously present in the U.S. from the date of entry through the date the individual became a qualified non-citizen. An individual has been continuously present in the U.S. if the individual can demonstrate there has not been a single absence greater than 30 days or multiple absences totaling more than 90 days. Once the individual becomes a qualified non-citizen, absences from the U.S. do not impact the five-year period of ineligibility.

a. Non-Citizens Subject to the Five-Year Period of Ineligibility

The following qualified non-citizens are ineligible for TennCare Medicaid or CoverKids for a period of five years from the date they are granted qualified non-citizen status unless they meet an exception as described in 5.b.:

- **i.** LPRs admitted under the INA, 8 USC 1101, *et seq*., after August 22, 1996;
- **ii.** Non-citizens granted parole for at least one year under the INA (8 USC 1182(d)(5)); and
- **iii.** Battered immigrants and children who meet the conditions set forth in Section 431(c) of the PRWORA.

A qualified non-citizen may apply for coverage once the five-year period of ineligibility expires. The five-year period of ineligibility expires on the five-year anniversary of the date the individual was granted a qualified status. Once the five-year bar expires, a qualified non-citizen may apply for benefits as if he was a U.S. citizen. No previous application is required. If the qualified non-citizen meets the technical and financial eligibility criteria for a TennCare Medicaid or CoverKids category and the five-year period of ineligibility has expired, he is eligible to receive coverage in the appropriate category as of the date of application.

A non-citizen granted parole for at least one year is considered a qualified non-citizen from the date he is granted parole. For non-citizens paroled in the U.S. for at least one year, the five-year period of ineligibility begins on the first day of the parole period.

Qualified non-citizens who are subject to the five-year bar are eligible to receive EMS and CoverKids Pregnant Woman during their period of ineligibility, if otherwise eligible.

b. Non-Citizens Exempt from the Five-Year Period of Ineligibility

The five year period of ineligibility does not apply to the following qualified non-citizens:

- **i.** Non-citizens who are victims of a severe form of trafficking or who have been granted nonimmigrant status under Section 101(a)(15)(T) of the INA or who have a pending application that sets forth a prima facie case for such nonimmigrant status;
- **ii.** LPRs who first entered the country under another exempt category (i.e., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or non-citizen whose deportation is being withheld and who later converted to LPR status);
- **iii.** Non-citizens who are:
  - **1.** Honorably discharged veterans;
  - **2.** On active duty in the U.S. military; or

3. The spouses, the unmarried dependent children, or the unremarried surviving spouses of honorably discharged veterans or individuals on active duty in the U.S. military;

iv. Members of a federally-recognized Indian tribe;

v. American Indians born in Canada to whom the INA (8 USC 1359) applies; and

vi. Non-citizens granted a specific humanitarian entrance status by the USCIS (8 U.S.C. 1612), including:

1. Refugees and asylees;
2. Cuban and Haitian entrants;
3. Non-citizens whose deportation is being withheld;
4. Amerasian immigrants; and
5. Afghan and Iraqi non-citizens.

vii. Non-Citizens who lawfully reside in the U.S. in accordance with the COFA between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau and whose immigration status is currently COFA Migrant. Once a COFA Migrant adjusts to an LPR status, the five-year period of ineligibility applies.

viii. Afghan individuals paroled into the United States between July 31, 2021 to September 30, 2022 are considered Qualified Non-Citizens to the same extent as refugees under section 207 of the Immigration and Nationality Act (8 U.S.C. 1157). They are exempt from the five-year period of ineligibility. Afghan Parolees are considered Qualified Non-Citizens until March 31, 2023 or until the end of their parole term, whichever is later. Individuals who are paroled after September 30, 2022 must either be the parent, legal guardian, spouse or child of an Afghan parolee to be considered Qualified Non-Citizens to the same extent as refugees under section 207 of the Immigration and Nationality Act (8 U.S.C. 1157).

Note: Non-citizens granted a specific humanitarian entrance status by the USCIS are exempt from the five-year bar for TennCare Medicaid and CoverKids eligibility, but they are subject to a seven-year eligibility time limit.

6. Seven-Year Eligibility Time Limit for Certain Non-Citizens

a. General Rule

Non-citizens admitted into the U.S. by the USCIS under a specific section of the INA identified below are qualified non-citizens, and are potentially eligible for TennCare Medicaid and CoverKids for the first seven years after refugee, asylee, or other humanitarian status is granted.

b. Non-Citizens Subject to Seven-Year Eligibility Time Limit

Non-citizens granted a specific humanitarian status and subject to the seven-year eligibility time limit include:

i. Refugees admitted under Section 207 of the INA (8 USC 1157);

ii. Non-citizens granted asylum under Section 208 of the INA (8 USC 1158);

iii. Cuban-Haitian Entrant, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980;

iv. Non-citizens whose deportation is withheld under the INA (8 USC 1253) as in effect prior to April 1, 1997 or 8 USC 1231(b)(3), as amended;

v. Non-citizens admitted to the U.S. as an Amerasian Immigrant pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

vi. Afghan non-citizens granted Special Immigrant Status under Section 602(b) of the Afghan Allies Protection Act of 2009 as described in the INA (8 USC 1101(a)(27));

vii. Iraqi non-citizens granted Special Immigrant Status under the National Defense Authorization Act for Fiscal Year 2008 as described in the INA (8 USC 1101(a)(27)); and

viii. Spouses and unmarried children under age 21 of Afghan and Iraqi Special Immigrants who accompany or later join the Special Immigrant.

c. Expiration of Seven-Year Eligibility Time Limit

A non-citizen who is subject to the seven-year eligibility limit and does not have a change in immigration status or does not meet one of the exemptions listed in the following section will lose eligibility the first month after the seven-year anniversary date of entrance into the U.S. (or date that deportation was withheld under the INA (8 USC 1231 and 1253)).

d. Continuing Eligibility After the Seven-Year Eligibility Time Limit

A non-citizen who is subject to the seven-year eligibility time limit can remain eligible beyond the seven-year period if at the time of application or at any time during or after the seven-year period the USCIS determines that the non-citizen continues to be a qualified non-citizen and that she is one of the following:

i. An LPR; or

ii. An honorably discharged veteran, an active-duty member of the U.S. Armed Forces, or a spouse, an unmarried dependent child, or an unremarried surviving spouse of an honorably discharged veteran or active-duty member of the U.S. Armed Forces.

e. Adjustment to LPR Status within Seven-Year Eligibility Period

A qualified non-citizen subject to the seven-year eligibility time limit can adjust his status to LPR within the seven-year period. Non-citizens who adjust to LPR status within the seven-year period are not subject to the five-year bar and remain potentially eligible for benefits as an LPR beyond the seven-year period of eligibility.

7. Victims of Trafficking

The Trafficking Victims Protection Act (TVPA) of 2000 allows victims of human trafficking and non-citizens classified as nonimmigrants under Section 101(a)(15)(T) of the INA who are physically present in the U.S. to receive federally funded benefits and services to the same extent as refugees. Victims of human trafficking are non-citizens who are eligible to receive a special visa and benefits once they are identified.

a. Assistance Available to Victims of Human Trafficking

Adult victims of human trafficking who are certified by the U.S. Department of Health and Human Services (HHS) and are otherwise eligible may receive Medicaid in any Medicaid category available. Children under age 18 do not have to be certified by HHS to receive benefits. For an adult victim of trafficking to receive certification, she must:

i. Be a victim of human trafficking as defined by the TVPA or a non-citizen classified as a nonimmigrant under Section 101(a)(15)(T) of the INA;
ii. Be willing to assist with the investigation and prosecution of traffickers; and
iii. Have completed a bona fide application for a T Visa that has not been denied, or have received continued presence status from the U.S. Department of Homeland Security.

b. The T Visa - Under the TVPA of 2000

The T Visa was established to allow victims of severe forms of trafficking to become temporary residents of the U.S. The Trafficking Victims Protection Act recognizes that returning victims to their country of origin is often not in the best interest of victims and those victims need the opportunity to rebuild their lives without the threat of deportation. After three years since the first date of admission as a T-1 nonimmigrant, a recipient of a T Visa may be eligible for permanent residence status if he:

i. Is a person of good moral character;
ii. Has complied with any reasonable request for assistance in the investigation during the three-year period; and
iii. Will suffer extreme hardship if removed from this country.

c. The Certification Process

The certification process typically takes a few days after HHS is notified that a person has made a bona fide T Visa application or has been granted continued presence status (both of these actions are completed by the U.S. Department of Homeland Security). If the status of a person who has received HHS certification changes so that they are no longer eligible, HHS may be required to decertify that individual.

d. Verification of Victim Certification

A toll-free number can be used to verify victims of trafficking: 1-866-401-5510. Before victims can receive benefits, the Eligibility Specialist must call the toll-free trafficking victim verification line to verify the validity of the certification letter and to inform HHS that the individual has applied for program benefits.

8. Battered Immigrants and Children

a. Battered Immigrant Defined

Certain immigrants who have been subjected to battery or extreme cruelty in the U.S. by a family member with whom they reside are qualified non-citizens and are potentially eligible for TennCare Medicaid and CoverKids. The non-citizen must be either:

i. The individual battered; or
ii. The parent of a child who is battered; or
iii. A child whose parent has been battered.

A family member includes a spouse, parent, or member of the spouse or parent's family residing in the same household.

If admitted to the U.S. on or after August 22, 1996, a battered immigrant and/or child is subject to the five-year period of ineligibility for TennCare Medicaid and CoverKids benefits. The five-year period of ineligibility begins on the date she obtains qualified non-citizen status.

b. Eligibility Conditions

In order to be considered as a qualified non-citizen and become potentially eligible for TennCare Medicaid (subject to five-year bar) or CoverKids (subject to five-year bar), a battered immigrant must meet all of the requirements provided below.

i. The immigrant has been approved or has a pending petition which sets forth a prima facie case for:
  1. Immigrant status as a battered spouse or child of a U.S. citizen or LPR (Form I-360);
  2. Immediate Relative status (Form I-130);
  3. Cancellation of removal pursuant to 8 U.S.C. 1229b(b)(2); or
  4. Suspension of deportation and adjustment to LPR status;
ii. The immigrant must show that there is a substantial connection between such battery or cruelty and the need for benefits; and
iii. The immigrant must no longer be residing in the same household as the abuser.

Battered immigrants may be granted good cause for non-cooperation with child support when cooperation requires the involvement of the abuser.

9. American Indians

An Indian born in Canada who is at least one-half American Indian blood may enter and reside lawfully in the U.S., but this does not extend to the spouse or child of the Indian unless the child or spouse is also at least one-half American Indian. An Indian meeting the above criteria may be eligible for full TennCare Medicaid coverage if all other eligibility requirements are met.

The following documents may be used to verify an Indian is at least one-half American Indian blood:

- **i.** Birth or baptismal certificate issued on reservation;
- **ii.** Tribal record;
- **iii.** Letter from the Canadian Department of Indian Affairs; or
- **iv.** School records.

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08.01.2016	1-3.; 5.; 6.b.; 6.d.; 7.	Policy Statement; Qualified Non-Citizen; Other Eligible Immigration Statuses; Five-Year Period of Ineligibility; Non-Citizens Subject to 7-Year Eligibility Time Limit; Continuing Eligibility After the 7-Year Limit; Victims of Trafficking	1-2; 4-7	Policy Clarification	AJ
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ABD ENUMERATION

Legal Authority: 42 CFR 435.910

1. Policy Statement

Enumeration is the procedure by which the Social Security Administration (SSA) assigns and verifies Social Security Numbers (SSNs). As a condition of eligibility for TennCare Medicaid, applicants who are eligible to receive an SSN must provide HCFA with:

- A valid SSN; or
- The SSN application date, if the individual's SSN is unknown or a number has never been issued.

Benefits will not be delayed or denied to otherwise eligible individuals pending issuance or verification of an SSN by the SSA.

By law, non-applicants are not required to provide their SSN. HCFA can request a non-applicant's SSN under the following conditions:

- When provision of the SSN is voluntary; and
- HCFA provides clear notice to the individual that provision of the non-applicant's SSN is voluntary and information about how the SSN will be used.

2. Notification of the Enumeration Requirement

Individuals will receive notification of the regulation requiring that they furnish an SSN when applying for TennCare Medicaid and how the SSN will be used. Individuals will be informed that:

- They are only required to furnish an SSN for the individuals in their household applying for benefits. Provision of a non-applicant's SSN is voluntary;
- Each applicant's SSN will be used to verify program eligibility, income and the amount of medical assistance payments received;
- This is a requirement of the state and federal government;
- Failure to furnish an SSN or proof that the individual has applied can result in that individual's ineligibility.

If an applicant does not have an SSN or the SSN is questionable, the agency will provide the individual with information about how to obtain an SSN through the SSA.

3. Children Less than 1 Year of Age

A newborn can be added to their mother's case without waiting for the enumeration process to conclude. In most situations, the enumeration process (completion of SS-5 application, which is the application for a Social Security card) now occurs for newborns at the hospital. Newborns must be enumerated by age one or before they can be approved in another TennCare Medicaid category, whichever occurs first.

4. Refusal to Obtain an SSN

If an applicant fails or refuses to provide an SSN, then that individual is not eligible to receive benefits, unless he or she meets an exception or is a legal alien who is not eligible for an SSN.

a. Exceptions

An applicant may refuse to obtain an SSN because of a well-established religious objection. A well-established religious objection means that the applicant:

- Is a member of a recognized religious sect or division of that sect; and
- Adheres to the teachings of the sect or division of that sect and for that reason is opposed to applying for or using an SSN.

HCFA will provide a Medicaid identification number to an applicant who refuses to obtain an SSN due to a well-established religious objection. The Medicaid identification number will not be able to be used for eligibility verification purposes.

5. Enumeration of Legal Immigrants

The Affordable Care Act amended the enumeration requirement for individuals who are not eligible for a regular SSN. Legal immigrants who are ineligible for a work-related or regular SSN are not required to obtain a non-work SSN for the purpose of TennCare Medicaid eligibility. The SSA will continue to issue SSNs for people who do have work authorization when an SSN is required to obtain other program benefits. However, a non-work SSN cannot be used to obtain data from other programs or agencies to verify eligibility for TennCare Medicaid.

Legal immigrants who are not eligible for a regular SSN must still meet the citizenship and immigration requirements, as well as all other conditions of eligibility, in order to receive TennCare Medicaid benefits.

6. Verification

a. Individuals With an SSN

SSNs will be verified by the SSA via the Federal Data Services Hub (the Hub). If the Hub is unavailable, the state will verify the SSN using the State Verification Exchange System (SVES) daily interface. If the Hub or another electronic data source, such as the State On-Line Query (SOLQ), is unable to verify an individual's SSN or validates the SSN as someone else's SSN, the state must first address any possible discrepancies with the SSN that was entered. If the individual's SSN cannot be verified, the state will notify the applicant and request a copy of the individual's Social Security card in order to verify the individual's SSN.

b. Individuals Without an SSN

Individuals who report not having an SSN, but who are eligible to obtain a work-related SSN must apply for an SSN prior to approval for TennCare Medicaid. Acceptable verification of an application for an SSN is a copy of Form SS-5.

c. Individuals Ineligible for a Work-Related SSN

If an individual attests that he or she is ineligible for a work-related SSN and the U.S. Department of Homeland Security has verified his or her immigration status, the Eligibility Specialist will make note of the exception in the individual's case record. Non-work SSNs should not be used when applying for TennCare Medicaid since these cannot be used for verification.

ABD AGE

Legal Authority: 42 CFR 435.945; 42 CFR 435.952; 42 CFR 435.956

1. Policy Statement

In order to be eligible for TennCare Medicaid, an individual must meet the age requirement of the specific TennCare Medicaid category.

2. Verification

HCFA accepts self-attestation of the applicant's age, unless the HCFA has information that is not compatible with the attested information. If there is reason to believe that the attested age is incorrect, the state will attempt to verify the age of the individual using specific electronic data sources. If the individual's age is unable to be electronically verified, then acceptable documentary evidence of age must be provided.

a. Electronic Data Source

The following is a list of electronic data sources that may be used to verify the age of an applicant:

- Federal Data Services Hub (Hub);
- Social Security Administration interface; and
- Tennessee Vital Statistics.

b. Documentary Evidence

The following is a list of acceptable documentary evidence of age:

- A birth certificate;
- Birth verification;
- Census Bureau records;
- Immigration record;
- An insurance policy;
- A passport; and
- Proof of entitlement to Social Security benefits based on age.

If none of the examples of documentary evidence listed above can be provided, HCFA will accept a statement from the applicant which reasonably explains the discrepancy.

ABD DEATH

Legal Authority: 42 CFR 435.919; 42 CFR 431.213

1. Policy Statement

Eligibility for TennCare Medicaid will be terminated once an enrollee's death has been verified. Advance notice of action is not required if TennCare has factual information confirming the death of a beneficiary.

2. Verification

a. Notification of Death from the Enrollee's Family or Representative

If an enrollee's family member or representative reports an unverified date of death, then verification of the death must be obtained. Verification can either be obtained electronically by staff through Vital Statistics Inquiry or State On-Line Query Inquiry (SOLQi). When TennCare is unable to verify a date of death electronically, a hard copy of the obituary or death certificate, or a statement from a funeral home or medical provider is considered acceptable verification.

b. Notification of Death Through an Electronic Interface

TennCare accepts a date of death received electronically from Vital Statistics and such date will be applied systematically without requiring any additional verification. If the State receives a date of death through the State Verification and Exchange System (SVES), additional verification of death must be obtained. Additional verification can either be obtained electronically through Vital Statistics Inquiry or SOLQi. When additional verification is not available through Vital Statistics Inquiry or SOLQi, a hard copy of the obituary or death certificate or a statement from a funeral home or medical provider may be used as verification of death.

Document Title	Death				
First Published	10.28.2014				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.19.2015	1.	Legal Authority; Policy Statement	1	Policy Clarification	AF
03.18.2019	2.	Verification	1	Policy Clarification	AJ

ABD INCOME OVERVIEW

Legal Authority: 26 USC 6409; 42 CFR 435.601; 20 CFR 416.1102; 20 CFR 416.1103; 20 CFR 416.1111; 20 CFR 416.1123; State Plan, Supplement 11b to Attachment 2.6-A; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Income is any item an individual receives in cash or in-kind that can be used to meet his need for food or shelter. Income includes the receipt of any item which can be applied, either directly or by sale or conversion, to meet basic needs of food or shelter.

2. Types of Income

Income is either earned or unearned, and different rules apply to each. Either type may be cash or in-kind. Earned income is compensation an individual receives for the performance of services or as a result of his own efforts either as an employee or through self-employment. Unearned income is money an individual receives that is not the result of current work efforts, but accrues to an individual as the result of investment, inheritance, previous work efforts, etc. Income eligibility for the ABD TennCare Medicaid categories is determined according to the Social Security Administration (SSA) Supplemental Security Income (SSI) treatment of income rules.

a. Earned Income Includes:

i. Bonus;
ii. Combat Pay;
iii. Commission;
iv. Contractual;
v. Differential;
vi. Domestic Volunteer Act;
vii. Earned Income Tax Credit;
viii. Farming/Fishing;
ix. In-Kind Not Food/Shelter;
x. In-Kind Wages;
xi. Irregular or Infrequent Income;
xii. Military Allowances;
xiii. Older Americans Act;
xiv. Royalties/Honoraria;
xv. Self-Employment;
xvi. Severance Pay;
xvii. Sheltered Workshop;
xviii. Sick Pay/Disability Pay;
xix. Tips;
xx. Volunteers in Service to America/AmeriCorps;
xxi. Wages; and

xxii. Work Study.

b. Unearned Income Includes:

i. Achieving a Better Life Experience (ABLE);
ii. Adoption Subsidies;
iii. Alimony;
iv. Annuities;
v. Canceled Debts;
vi. Capital Gains;
vii. Care and Contribution in Exchange for a Transferred Asset;
viii. Cash Inheritance;
ix. Cash Support;
x. Child Support Arrearage;
xi. Child Support;
xii. Community Spouse Income Maintenance Allowance (CSIMA)/Dependent Income Maintenance Allowance (DIMA);
xiii. Death Benefits;
xiv. Education Income Not Work Study;
xv. Excluded Unearned Income;
xvi. Federal Emergency Management Agency (FEMA) Payment Disaster or Emergency;
xvii. Federal Emergency Management Agency (FEMA) Payment Non Disaster or Emergency;
xviii. Gambling, Prizes, and Awards;
xix. General Assistance;
xx. Gifts;
xxi. In-Kind Support and Maintenance (ISM);
xxii. Income Not Pursued;
xxiii. Income-Producing Resource;
xxiv. Interest Income;
xxv. Irregular or Infrequent Income;
xxvi. Jury Duty;
xxvii. Lump Sum;
xxviii. Long-Term Care (LTC) Insurance Payout;
xxix. Pension;
xxx. Protective Payee;
xxxi. Railroad Retirement;
xxxii. Reimbursements;
xxxiii. Rental or Lease;
xxxiv. Royalties/Honoraria;
xxxv. Settlements and Restitutions;
xxxvi. Sick/Disability Pay;
xxxvii. Social Security Disability Benefit (SSDI);
xxxviii. Social Security Survivor or Retirement Benefit;
xxxix. Supplemental Security Income (SSI);

- **xl.** Temporary Assistance for Needy Families (TANF) Allotment;
- **xli.** Temporary Disability Insurance;
- **xlii.** Trusts;
- **xliii.** Unemployment Insurance;
- **xliv.** VA Apportioned;
- **xlv.** VA Augmented Benefit;
- **xlvi.** VA Disability;
- **xlvii.** VA Education Grant;
- **xlviii.** VA Pension;
- **xlix.** VA Survivor (DIC); and
- **l.** Workers Compensation.

3. What is Not Income

Any item an individual receives that is not food or shelter or that cannot be used to obtain food or shelter is not income. When an individual receives items from the sale or exchange of property, the items received are not income, but are resources that have changed from one form to another. Items which are not income include:

- **a.** Bills Paid by a Third Party;
- **b.** Cash or In-Kind Items Received from the Sale, Exchange or Replacement of a Resource;
- **c.** Child Tax Credit payments (received either as monthly advance payments or a one-time refund)
- **d.** Income Tax Refunds;
- **e.** Loan Proceeds (excluding interest);
- **f.** Medical and Social Services (cash or in-kind);
- **g.** Payments Made by Credit Life or Credit Disability Insurance;
- **h.** Receipt of Certain Noncash Items (partially or totally excluded as a resource if retained the month after receipt);
- **i.** Replacement of Income Already Received;
- **j.** VA Aid and Attendance;
- **k.** VA Payments for Unreimbursed Medical Expenses;
- **l.** Vocational Rehabilitation; and
- **m.** Weatherization Assistance.

4. When Income is Counted

Count income at the earliest of the following points:

- **a.** When it is received;
- **b.** When it is credited to an individual's account; or
- **c.** When it is set aside for her use.

An exception to this is when a regular periodic payment (such as wages, Social Security, or Veterans Affairs benefits) is received in a month other than the month of normal receipt. If there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

When a payer advance dates a check because the regular payment date falls on a weekend or holiday, there is no intent to change the normal delivery date or to disrupt the existing relationship between the check receipt and SSI benefits.

When an individual's money goes to a bank by direct deposit, the funds may be posted to the account before or after the month they are payable. When this occurs, the funds count as income in the month of normal receipt.

When a third party payment results in an individual's receipt of In-Kind Support and Maintenance (ISM), determine the month in which the individual receives the ISM.

5. Amount Counted as Income

a. Garnishment or Other Withholding

Income includes amounts withheld because of a garnishment or other payments (such as payment of Medicare premiums). Income includes amounts withheld from income whether the withholding is purely voluntary, to repay a debt, or to meet a legal obligation.

Some items for which amounts may be withheld but considered received are:

- **i.** Federal, state or local income taxes;
- **ii.** Health or life insurance premiums;
- **iii.** Supplemental Medical Insurance (SMI) premiums;
- **iv.** Union dues;
- **v.** Penalty deductions for failure to report changes;
- **vi.** Loan payments;
- **vii.** Garnishments;
- **viii.** Legally obligated child support;
- **ix.** Legally obligated child support arrearage;
- **x.** Legally obligated alimony;
- **xi.** Court ordered bankruptcy;
- **xii.** Mandatory taxes;
- **xiii.** Service fees charged on interest-bearing checking accounts;
- **xiv.** Inheritance taxes; or
- **xv.** Guardianship fees if presence of a guardian is not a requirement for receiving the income.

Note: Mandatory deductions such as FICA and withholding tax on pensions and other unearned income are not included in gross income for Institutional Medicaid and the Medicare Savings Programs (MSPs).

b. Expenses of Obtaining Income

Unearned income does not include any portion of a payment used for expenses incurred in receiving the income. The expense must have been an essential factor in obtaining the income. For example, if an individual is paid for damages he received in an accident, the individual's medical, legal, or other expenses connected with the accident may be deducted from the payment, as long as the expenses are verified.

The payment of personal income taxes is not an expense and should not be deducted from unearned income.

6. Counting Income

Eligibility is determined based on monthly income. All income must be converted to a monthly figure. The following formulas are used to convert income to a monthly amount.

a. **Hourly Work:** Multiply the hourly wage by the number of hours the individual worked or is expected to work in a week to determine the weekly earnings figure.

b. **Weekly Income:** Multiply weekly income by 4.3333 to determine monthly income.

c. **Bi-Weekly Income:** Multiply the amount received every two weeks by 2.1666 to determine the monthly amount.

d. **Semi-Monthly Income:** Add the two semi-monthly amounts together to determine the monthly amount.

e. **Annual Income:** Divide the full amount of annual income by 12 to determine the average monthly amount.

7. Loss of Income

Self-attested loss of income is accepted, unless there is reason to suspect the income is still being received by the individual. See the *Verification* policy.

Document Title	ABD Income Overview				
First Published	03.20.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	2.a-b.; 3.; 4.; 5.a-b.	Legal Authority; Earned Income Includes; Unearned Income Includes; What is Not Income; Garnishment or Other Withholding; Amount Counted as Income	1-5	Policy Clarification	RZ
03.18.2019	4.	Garnishment or Other Withholding	4-5	Non-Substantive Change	RZ
03.18.2019	7.	Loss of Income	5	Policy Change	RZ
05.01.2019	6.b.; 6.c.	Counting Income	5	Policy Clarification	TN
11.01.2021	3.c.	Legal Authority; Types of Income	3	Policy Clarification	MH

ABD ELIGIBILITY DETERMINATION GROUP

Legal Authority: 20 CFR 416.1160–20 CFR 416.1165; 20 CFR 416.1202–20 CFR 416.1204; 42 CFR 435.601; State Plan Attachment 2.6-A; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

For the SSI-Related Categories of Eligibility (COE), the following individuals will be included in the applicant's Eligibility Determination Group (EDG), if living in the same home:

a. The applicant; and
b. The applicant's eligible spouse.

For Medicare Savings Programs (MSPs), the applicant's spouse and dependent children under age 21 will be included in the EDG when living in the applicant's home. Stepchildren are included in the EDG when they live in the home and their natural or adoptive parent is the spouse of the applicant and living in the home.

Income and resources of parents, siblings, children, and ineligible spouses not included in the EDG are still considered in the financial determination through deeming. See the *ABD Deeming of Income and Resources* policy.

2. Definitions

a. Child: Child includes individuals:
  i. Not married;
  ii. Not the head of a household; and
  iii. Under 18 years of age or under 22 years of age if a student regularly attending school.

b. Deeming: The term deeming identifies the process of considering another person's income and resources to be available for meeting an applicant/enrollee's basic needs of food and shelter.

c. Eligibility Determination Group (EDG): The EDG includes individuals who impact the household size for an applicant requesting assistance.

d. Holding Out Spouse: A holding out relationship exists when an unrelated man and woman present themselves to the community as husband and wife in the absence of a legal marriage. The concept of a holding out relationship does not apply to the MSPs or Institutional Medicaid COEs.

e. Ineligible Parent/Spouse: A parent or spouse who is not eligible or potentially eligible for the COE for which the applicant is being considered.

f. Parent: Parent as related to this policy includes natural and adopted parents. A parent is a natural, adoptive or, in certain situations, a stepparent. A stepparent is not included in the deeming budget if any of the following circumstances apply:

- **i.** The natural or adoptive parent to whom the individual was married has died;
- **ii.** The natural or adoptive parent and the individual are divorced; or
- **iii.** The natural or adoptive parent and the stepparent's marriage has been annulled.

g. Public Income-Maintenance Payments: Income provided based on a determination of need by the federal, a state, or local government. Public income-maintenance payments include:

- **i.** Temporary Assistance for Needy Families (TANF);
- **ii.** Supplemental Security Income (SSI);
- **iii.** Refugee Act of 1980 payments based on need;
- **iv.** Disaster Relief and Emergency Assistance Act benefits;
- **v.** General assistance programs of the Bureau of Indian Affairs;
- **vi.** U.S. Department of Veterans Affairs payments based on need; and
- **vii.** State or local government assistance programs based on need.

h. SSI-Related: SSI-Related includes the following TennCare Medicaid COEs:

- **i.** Pickle Passalong;
- **ii.** Disabled Adult Child (DAC); and
- **iii.** Widow/Widower.

i. Spouse: A spouse is:

- **i.** An individual's legally married spouse;
- **ii.** An individual determined by the Social Security Administration (SSA) as eligible to receive Social Security benefits as the spouse of another; or
- **iii.** An individual's holding out spouse for SSI-Related COE only.

3. SSI-Related Eligibility Determination Group

Financial eligibility in the SSI-Related COEs is determined based on an EDG size of one or two. Included EDG members are the applicant/enrollee and, if applicable, his eligible spouse if they have the same living arrangement. Otherwise, if there are additional household members, they will be considered in deeming budgets, if appropriate. For example, an ineligible spouse's income and resources may be deemed into the budget. If an ineligible spouse's income and resources are deemed into an applicant's budget, the EDG size will be two. See the *ABD Deeming of Income and Resources* policy for additional information. If the applicant is a child, her parent's assets and needs, e.g. financial responsibility to other children in the home, are considered in the deeming budget.

4. Institutional Medicaid Eligibility Determination Group

Financial eligibility for Institutional Medicaid COEs is determined based on an EDG size of one. The only included EDG member is the applicant/enrollee. However, the community spouse and dependents do impact budgeting of the post-eligibility treatment of income (i.e. patient liability), and the community spouse's resources are considered in the resource assessment. See the *Post-Eligibility Treatment of Income* and *Resource Assessment* policies.

5. Medicare Savings Program Eligibility Determination Group

MSP household composition is governed by the principle of Financially Responsible Relatives (FRR) and the applicant/enrollee's living arrangements. Financial responsibility is limited to spouse to spouse and parent to child. The living arrangement of each MSP applicant and, if applicable, his spouse and children, must be considered in determining EDG size. The following potential living arrangements should be taken into consideration for MSP applicants:

a. A married individual living alone in the community, separated from her spouse is treated as an individual for MSP.
b. A single or widowed individual living alone in the community is treated as an individual for MSP.
c. A married couple living together in the community will be included in the EDG of one another, except when one or both spouses are eligible for HCBS. When an individual is eligible for HCBS and has a spouse living in the home, his spouse will not be included in the EDG. The institutionalized spouse will be treated as an individual and will have an EDG size of 1 for MSP. The community spouse's EDG will include the institutionalized spouse and will be an EDG size of 2.
d. A couple who lives separately because one is in the community and one is in a nursing facility will have an EDG size of 1 because they do not live together.
e. A couple in which both spouses reside in a nursing facility will have an EDG size of 1 for MSPs, even if they share the same room.
f. Dependent children under 21 living in the household of the applicant will increase the EDG size, including the corresponding federal poverty level threshold, for the applicant.

6. Verification

The state accepts self-attestation of EDG members and relationships between the EDG members.

The state will use the Public Assistance Reporting Information System (PARIS) data post-enrollment to determine if any enrollees are receiving benefits in another state, and to identify children for whom non-custodial parents are applying for benefits through TennCare.

Document Title	ABD Eligibility Determination Group				
First Published	03.15.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
12.13.2016	4.	Medicare Savings Program (MSP) Household Composition	2	Non-Substantive Change	RH
03.18.2019	1.; 2.a.; 2.c.; 2.e.; 2.g.; 2.h.; 3-5.	Legal Authority; Policy Statement; Child; Eligibility Determination Group (EDG); Ineligible Parent/Spouse; Public Income-Maintenance Payments; SSI-Related; SSI-Related Eligibility Determination Group; Institutional Medicaid Eligibility Determination Group; Medicare Savings Program (MSP) Eligibility Determination Group	1-3	Policy Clarification	LW
03.18.2019	2.a.; 2.g.; 2.h.; 3-4.; 6.	Child; Public Income-Maintenance Payments; SSI-Related; SSI-Related Eligibility Determination Group; Institutional Medicaid Eligibility Determination Group; Verification	1-3	Non-Substantive Change	LW
10.01.2020	1.-3.; 5.	Policy Statement; Definitions; SSI-Related Eligibility Determination Group; Medicare Savings Program Eligibility Determination Group	1-3	Policy Clarification	AJ
10.01.2020	2.-4.	Definitions; SSI-Related Eligibility Determination Group; Institutional Medicaid Eligibility Determination Group	1-3	Non-Substantive Change	TN

ABD FINANCIALLY RESPONSIBLE RELATIVES

Legal Authority: 20 CFR 416.1160 – 20 CFR 416.1165; 20 CFR 416.1202 – 20 CFR 416.1204; 42 CFR 435.601; TennCare 1115 Demonstration Waiver, Amendment 27; TCA Title 36

1. Policy Statement

A family member's financial responsibility for an applicant/enrollee's basic needs of food and shelter is recognized when determining eligibility for TennCare Medicaid. The following are considered Financially Responsible Relatives (FRRs) for the purpose of TennCare Medicaid:

- A spouse is financially responsible for his or her spouse; and
- A parent is financially responsible for his or her child(ren).

The income and resources of the applicant/enrollee's FRR are considered part of the applicant/enrollee's available countable assets. Income and resources belonging to a FRR who receives Families First or SSI benefits are not deemed available to the applicant/enrollee.

2. Defined Terms

Deeming: The term deeming identifies the process of considering another person's income and resources to be available for meeting a TennCare Medicaid applicant/enrollee's basic needs of food and shelter.

Child: Child as related to this policy includes individuals:

- Not married; and
- Not the head of a household; and
- Under 18 years of age or under 22 years of age if a student regularly attending school.

Holding Out Spouse: A "holding out" relationship exists when an unrelated man and woman present themselves to the community as husband and wife in the absence of a legal marriage. The concept of a holding out relationship does not apply to the MSPs or Institutional Medicaid categories.

Ineligible Spouse: A spouse who is not eligible for an Aged, Blind and Disabled TennCare Medicaid category.

Parent: Parent as related to this policy includes natural and adopted parents. A parent is a natural, adoptive or, in certain situations, a step-parent. A step-parent is not included in the deeming budget if any of the following circumstances apply:

- The natural or adoptive parent to whom the individual was married has died;
- The natural or adoptive parent and the individual are divorced; or
- The natural or adoptive parent and the step-parent's marriage has been annulled.

Spouse: A spouse is:

- An individual's legally married spouse; or
- An individual determined by the Social Security Administration (SSA) as eligible to receive Social Security benefits as the spouse of another; or
- An individual's "holding out" spouse.

3. Spousal Financial Responsibility

a. When Financial Responsibility Applies

The income and resources of the individual's legally married spouse are considered available to him or her whether or not they are actually contributed:

- While the couple live together, including temporary absences; AND
- During the first month of separation by one member's admission to a medical institution, unless the couple had been living apart for at least six months prior to their separation.

A couple residing in a separate or the same room in a long-term nursing care facility is not considered to be sharing the same living arrangement and are each treated as individuals with no deeming of income or resources.

Financial responsibility by the ineligible or eligible spouse ends the month of separation for any reason such as:

- Admission to a medical institution when 30 days of continuous confinement is met; or
- Applying for Home and Community Based Services (HCBS); or
- The individual is determined to need and to be likely to receive services for a continuous period of at least 30 days going forward.

If an individual applies in the month of separation, his or her eligibility is determined as an individual only. At that point, only resources and income actually contributed to the individual are considered available to him.

b. Determining Marital Relationship

Accept the individual's attestation regarding marital status if he or she is married, unmarried or separated from his or her spouse.

c. Holding Out Spouse

A “holding out” relationship exists when an unrelated man and woman present themselves to the community as husband and wife in the absence of a legal marriage. The concept of a holding out relationship does not apply to the MSPs or Institutional Medicaid categories.

4. Parental Financial Responsibility

a. When Parental Financial Responsibility Applies

The income and resources of the parents of the child are considered available to the child in determining his or her financial eligibility:

- When the child and parent(s) live together; and
- During the child’s temporary absence from the home.

A child’s admission to a psychiatric facility is considered a temporary absence. Psychiatric care is not considered institutionalization for purposes of determining the under age 21 individual’s separation from his or her FRR.

b. When Parental Financial Responsibility Does Not Apply

The income and resources of the parents of the child are not considered available to the child in determining his or her financial eligibility when the child applies for Long-Term Supports and Services, unless a child under 18 is determined eligible at an “At Risk” for nursing facility Level of Care and is requesting HCBS services in the Employment and Communities First (ECF) program.

c. Step-parents

The income and resources of a step-parent living in the home are considered available to the child when the step-parent is the spouse of the child’s natural or adopted parent and the natural or adopted parent is living in the home with the child.

d.

i. Joint Custody/Parenting Time

For the purpose of determining Medicaid eligibility, the custodial parent, often referred to as the primary residential parent in Tennessee, is established based on physical custody specified in a court order, binding separation, divorce, or parenting plan. If there is no court order or parenting plan, custody of a child born out of wedlock is with the mother. If there is a parenting plan, the primary residential parent is the parent with whom the child spends most nights.

ii. Equally-Shared Joint Custody/Parenting Time

When an individual claims that equally-shared (50/50) joint physical and legal custody exists or provides a parenting plan that evenly divides the child(ren)'s living arrangement and parenting responsibilities, the parenting time situation must be carefully examined. Though a court order or parenting plan may evenly divide the care and control of the child(ren), the parents may not, in fact, be following the parenting plan.

In cases of alleged equal parenting time (50/50), the Eligibility Specialist must verify that:

- Both parents exercise parental guidance.

  Parental guidance may include issues such as which parent takes the child(ren) to and from school and/or day care, which parent does the school and/or daycare consider the responsible relative, who exercises responsibility for consenting to major medical treatment for the child, etc.

- Parents equally share physical custody.

  If one parent has the child(ren) a majority of the time, this is not considered equally shared parenting time. Child(ren) must spend an equal amount of time living with each parent. The living arrangement may be based on days, weeks, or months, but it must be equal (182.5 days per year with each parent) and parental functions of guidance and physical care cannot be substantially interrupted. (If equal time means six months at a time are spent with each parent, this will be considered extended visits. Eligibility for the parent ceases when the child is with the other parent.)

5. Other Relatives

There are no additional financial responsibilities for any other relatives other than the spouse to spouse and parent to child provisions set forth in this section.

The income and resources of the spouse or parent not living in the same household with the applicant are considered available only to the extent they are actually contributed.

Document Title	ABD Financially Responsible Relatives				
First Published	3.23.15				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
4.5.16	1	Policy Statement	1	Non-Substantive Change	AK
4.5.16	2	Defined Terms	1	Non-Substantive Change	AK
4.5.16	4-d-ii	Parental Financial Responsibility -Equally-Shared Joint Custody/Parenting Time	4	Non-Substantive Change	AK
7.1.16	4-b	Parental Financial Responsibility -When Parental Financial Responsibility Does Not Apply	3	Policy Clarification	LW

ABD EARNED INCOME

Legal Authority: 26 USC 6409; Social Security Act, Sections 1611 and 1612; 20 CFR 416.1100, et seq.; State Plan, Supplement 8A to Attachment 2.6-A; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Earned income is compensation an individual receives for the performance of services or as a result of his own efforts either as an employee or through self-employment. Income eligibility for the Aged, Blind and Disabled (ABD) TennCare Medicaid Categories of Eligibility (COEs) is determined using the Supplemental Security Income (SSI) treatment of income rules.

2. Earned Income

Bonus	Countable. A bonus is a one-time payment that an individual receives in addition to normal job wages or salary.
Census Wages	Excluded. Wages paid to an individual by the Census Bureau for temporary employment activities in connection with the full Census that occurs every 10 years are excluded.
Child Tax Credit	Excluded. Child Tax Credit payments received either as monthly advance payments or a one-time refund are excluded.
Combat Pay	Excluded. Payments made to an individual serving active duty in a combat zone. These payments are excluded in the month of receipt. Any amount of the payment retained into the following month is a countable resource unless otherwise excluded.
Commission	Countable. Commission is income received by an individual for services performed. Commission income often paid based on a percentage of a sale or a fixed amount per sale.
Contractual	Countable. Income paid to an individual based on a contractual agreement. To calculate contractual income, average the full amount of income paid on a contractual basis over the number of months the contract covers.
Differential	Countable. Payment made to an individual by an employer for a period during which he or she is performing service in the uniformed services while on active duty for a period of more than 30 days. Payment represents all or a portion of the wages the individual would have received if he was performing services for the employer.

Domestic Volunteer Act	Excluded. Payments to volunteers from the following programs are excluded: • Title II Retired Senior Volunteer Program; • Foster Grandparent Program; and • Title III Service Corps of Retired Executives, Senior Companion Program and Active Corps of Executives.
Earned Income Tax Credit (EITC)	Excluded. Earned income tax credit payments received as advance payments or as refunds are excluded.
Farming/Fishing	Farming or fishing income may be considered self-employment income. **1. Farming Income** Countable. An individual is in the business of farming if she cultivates, operates or manages a farm for profit, either as owner or tenant. A farm can include livestock, dairy, poultry, fish or fruit. It can also include plantations, ranches, ranges and orchards. **2. Fishing Income** Countable. Fishing income includes amounts an individual receives from catching, taking, harvesting, cultivating or farming fish, shellfish, crustacean, sponges, seaweeds or other aquatic forms of animal or vegetable life, as well as money from patronage dividends and fuel tax credits and refunds. **3. Counting Farming or Fishing Income** **a. Income Received on a Regular Business** If an individual has a federal tax return available to verify the earnings from last year and the business model remains the same, prorate the reported annual profit over 12 months. Count the result as earned income, taking into account any changes for the prorated period. If the individual does not have a federal tax return available from the previous year, determine the monthly income received and any expenses the applicant has paid or expects to pay in that month. **b. Income Received Annually or Infrequently** If farming or fishing income is received on an annual or infrequent basis, prorate the annual amount with anticipated

	changes over 12 months and count the monthly income as earned income. **4. Verification** If verification is required for farming or fishing income, request at least one of the following documents: • A copy of the agreement executed by the owner and the individual working the farm (the applicant could be either the owner or tenant); • A copy of the most recent profit or loss statement; or • A copy of the previous year's Federal income tax return.
In-Kind Not Food/Shelter	Excluded. This includes clothing that is not considered part of an employee's wages.
In-Kind Wages	Countable. Noncash compensation such as food, shelter or other items received by an individual for work performed in place of, or in addition to, wages, profit or payment in cash. The value of in-kind wages is determined by the current market value of the item(s) minus the amount of the outstanding balance due on the item, if any. Exceptions: In-kind payments of food or shelter to the following people, or under the following conditions, are treated as unearned income: • Certain agricultural employees (a farmer provides commodity payments—lodging, food, livestock, grain or milk products—to an employee and the commodity cannot be converted to cash or is equivalent to a cash payment); • Domestic employees; • Service not in the course of the employer's trade or business; • Service by certain home workers; • Members of the Uniformed Services; and • Provided on the employer's business premises, for the employer's convenience, and in the case of shelter received, its acceptance by the employee is a condition of employment.
Irregular or Infrequent Income	Countable. Exclude up to $30 per calendar quarter of earned income that is received either irregularly or infrequently. In order to be excluded, the income need only be irregular or infrequent. Income is considered to be irregularly received if an individual cannot reasonably expect to receive it. Income is received infrequently if an individual receives it only once during a calendar quarter from a single

	source and the individual did not receive that type of income in the previous month or in the month following the month in which the money was received. A single source of earned income is an employer, trade or a business.
Military Allowances	Countable. Military allowances are cash benefits that compensate the service member, at least in part, for the expenses of housing, food, clothing, and special situations during periods of active duty service. Military allowances paid to service members and their families, other than for on-base or privatized military housing, are counted as earned income. Such allowances include, but are not limited to: • The basic allowance for subsistence (BAS) (i.e. food allowance); • The basic allowance for housing (BAH); and • Clothing allowance. The basic allowance for housing (BAH) is counted as earned income when the payment is made to military personnel living in private housing. The BAH should be treated as unearned income in the form of in-kind support and maintenance (ISM) subject to the Presumed Maximum Value (PMV) rule for service members and their families who live on base or in privatized military housing. See *ABD Unearned Income.*
Older Americans Act	Countable. Title V of the Older Americans Act of 1965 provides part-time jobs for unemployed low-income people age 55 and older who have poor employment prospects. Count only wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income.
Royalties/Honoraria	Countable. Royalties are earned income when they are either received as part of a trade or business or received by an individual in connection with any publication of his work. Royalties are counted as unearned income in all other situations. For example, an individual may receive payment for the use of a patent or natural resource that he or she owns. Honoraria are payment for services when fees are not legally or traditionally required. Honoraria are counted as earned income. For example, a professional who speaks at a meeting may receive an honorarium for her service and time.

Self-Employment	Countable. Net earnings from self-employment count. Self-employment is the act of engaging in a trade or business; which is an activity carried on for a livelihood or in good faith to make a profit. Individuals may be contractors, franchise holders, owners, operators, partners, etc. An individual must meet all of the following criteria to be considered self-employed: • Earns income directly from the business or trade, not from wages or salary from an employer; • Is responsible for the payment of their entire Social Security and federal withholding taxes; • Does not have an employee/employer relationship with another individual and the services performed cannot be controlled by an employer; and • Should file self-employment tax forms (Schedule F, C, C-EZ, SE, etc.). Net income is the gross income from any trade or business less allowable deductions for that trade or business. Allowable deductions include expenses paid to operate the business or participate in the trade, including: • Car and truck expenses; • Depreciation; • Employee wages and fringe benefits; • Property, liability or business interruption insurance; • Interest on loans for your business; • Legal and professional services; • Rent or lease of business property and utilities; • Commissions, taxes, licenses and fees; • Advertising; • Contract labor; and • Repairs and maintenance. There are different types of business structures referred to as self-employment. Some of the common structures include: • Sole Proprietorship: A self-employment business that is not incorporated and has one or two owners. A Limited Liability Company (LLC) is not a sole proprietorship. • Independent Contractor: An individual who pays his own employment taxes and does not have an employee/employer relationship is considered self-employed, unless incorporated or an LLC. Sharecropper: If a sharecropper pays the costs of doing business and receives a portion of the net income in exchange for her labor, she is considered self-employed, unless incorporated or an LLC.

If an applicant is self-employed and has a partner or is a joint owner of a business, the applicant's self-employment net earnings will be based on his distributive share from the business.

Federal Income Tax Return Forms

1. Net Earnings from Self-Employment (NESE)

Self-employed individuals report their Net Earnings from Self-Employment (NESE) on the Schedule SE tax form. Other forms may be used to report income (Schedule C, Schedule F, etc.) but the amount listed on the Schedule SE should be used to verify self-employment earnings, whenever possible. The NESE is the gross income from any trade or business less allowable deduction for that trade or business. NESE also includes any profit or loss in partnership. For the purpose of determining eligibility, count the NESE on a taxable year basis and divide the total of these earnings equally among the months in the taxable year.

Verify net earnings from self-employment on Schedule SE. The amount of net earnings from self-employment that should be reported based on a Schedule SE may be found under:

- Section A, line 4; or
- Section B, line 4.c.

If line 4 or 4.c. show a positive amount of less than $400, then line 3 is used even if the amount on line 3 is greater than $400.

2. Schedule SE may not be available or usable when:

- An individual has started a new business and was not self-employed in the prior tax year; or
- An individual has applied for or is receiving Title II (Social Security) benefits.

3. Other Tax Forms and Business Records

If an individual does not have a Schedule SE, then other tax forms may be used to determine and verify net self-employment earnings. Other forms include:

- Schedule F: Used to report income and expenses from a farm operation. Net profit or loss is listed on the Schedule F.
- Schedule C: Used to report profit or loss from a Sole Proprietor business (general). Net profit or loss is listed on the Schedule C.
- Business Records: When a federal income tax return is not available, or the individual has changed, stopped or added to the business, business records may be used to determine net earnings. When business records are used, use the individual's

	gross income and allow the same deductions that are allowed by the IRS.
Severance Pay	Countable. Severance pay is countable earned income in the month received.
Sheltered Workshop	Countable. Sheltered workshops provide employment opportunities for individuals with developmental, physical or mental impairment. Sheltered workshops prepare the individuals for gainful work and provide rehabilitation, work training, and life skills. Sheltered workshops are operated by certain nonprofit organizations, or by state or local government institutions. Under some circumstances, income earned by enrollees in a nursing facility may be considered therapeutic. These individuals are recognized as having a greater need for personal income, because of the nature of their activities. Retention of additional income derived from work is considered essential for achieving a degree of independence. See the *Post-Eligibility Treatment of Income* policy for impact to patient liability for individuals receiving Long-Term Services and Supports (LTSS).
Sick Pay/Disability Pay	Countable. Sick or disability pay is a payment made to or on behalf of an employee by an employer or private third party for sickness or accident disability. Sick or disability pay is counted as earned income when it is received within 6 calendar months after the individual has stopped work. Sick or disability pay received more than 6 months after stopping work is counted as unearned income.
Tips	Countable. Tips that total more than $20 in a calendar month from any one employer are countable. See *ABD Unearned Income* policy for tips received totaling less than $20 in a calendar month.
Volunteers In Service To America (VISTA) Payments	Excluded. Volunteers in Service to America under Title I of the Domestic Volunteer Services Act of 1973 (VISTA) payments are excluded.

Wages	Countable. Wages include all payment from employment, and the term is generally defined to mean gross wages. Gross wages are the total amount paid to the individual before deductions. Wages are counted (considered available to the individual) at the earliest of the following: • When wages are received or paid; • When wages are credited to the individual's account; or • When wages are set aside for the individual's use. Deferred wage payment occurs when wages are paid at a time later than the wages normally would have been paid. If wage payments are deferred due to circumstances beyond the employee's control, consider the payment earned income when it is actually available to her. If the wage payment(s) is deferred at the employee's request, determine when the wages would normally have been paid and consider them earned income for that period.
Work Study	Excluded. Exclude educational income that is directly contingent upon the individual attending an institution of higher education, including work study and stipends.
Workforce Innovation and Opportunity Act (WIOA)	The WIOA funds a variety of programs designed to connect individuals with employment opportunities. Examples of WIOA-funded programs include: • Adult Services Program • Dislocated Workers Program • Job Corps Act • YouthBuild The wages, bonuses, or incentives received from these programs are considered as countable earned income, unless the payments are for supportive services such as child care, transportation, or job placement services. Any compensation received from a WIOA program that is not food or shelter, and cannot be used to obtain food or shelter, is excluded from income. This would include any type of voucher that can only be redeemed for items such as clothing or transportation.

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Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
07.05.2017	2.	Combat Pay; Military Allowances	1; 3-4	Policy Change	RH
03.18.2019	1.; 2.	Policy Statement; Bonus; Combat Pay; Differential; Domestic Volunteer Act; Farming/Fishing; In-Kind Not Food/Shelter; Military Allowances; Royalties/Honoraria; Self-Employment; Severance Pay; Sheltered Workshop; Volunteers In Service To America (VISTA) Payments; Wages; Work Study	1-7	Non-Substantive Change	RZ
03.18.2019	2.	Sheltered Workshop; Tips	3-7	Policy Change	RZ
03.18.2019	2.	In-Kind Wages; Irregular or Infrequent Income; Sheltered Workshop	3-4; 7	Policy Clarification	RZ
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ABD UNEARNED INCOME

Legal Authority: 20 CFR 416.1110; 20 CFR 416.1120; 20 CFR 416.1121; 20 CFR 416.1123; 20 CFR 416.1124; Public Law 113–295; Tenn. Code Title 71, Chapter 4, Part 8

1. Policy Statement

Unearned income is money an individual receives that is not the result of current work efforts, but accrues to an individual as the result of investment, inheritance, previous work efforts, etc. Unearned income for the ABD TennCare Medicaid categories is counted according to the Social Security Administration (SSA) Supplemental Security Income (SSI) financial methodology.

2. Unearned Income

Achieving a Better Life Experience (ABLE)	Excluded. ABLE accounts or 529A accounts are tax-advantaged savings accounts for individuals with disabilities that are established under a qualified ABLE program. The funds within an ABLE account are intended to cover the individual's Qualified Disability Expenses (QDEs) related to her blindness or disability. All contributions and ABLE account earnings in an ABLE account are excluded as income, except that contributions are not deducted from countable income of the individual making the contribution. Contributions to an ABLE account from a third party should not be considered countable as income or a resource. This includes funds from a trust. Distributions from an ABLE account are not income of the designated beneficiary in any month, regardless of whether the distribution is for non-housing QDEs, housing QDEs or non-qualified expenses. Distribution from an ABLE account is the conversion of a resource from one form to another. QDEs include, but are not limited to: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, and funeral and burial expenses, and basic living expenses.
Adoption Subsidies	Title IV adoption subsidies are intended to pay for general

	living expenses and are countable unearned income to the child. When the adoption subsidy is a reimbursement for child care while the adult responsible for the child is at work or seeking employment, or is for medical expenses, it is excluded.
Alimony	Countable. Payments an individual receives from a spouse he no longer lives with, or a former spouse, if paid as part of a divorce agreement, separation agreement or court order.
Annuities	Annuities are contracts or agreements that, in exchange for a lump sum payment or series of payments, provide income at regular intervals (i.e., monthly, quarterly, annually). Annuities establish a source of income for a future period, and are often used in retirement planning. Annuity payments count as unearned income the month received when the annuity is an excluded resource, except when the payments are from a State annuity. Payments to an individual or spouse from a State annuity are excluded if the annuity is paid by a state based on a determination that the individual is a veteran who is aged, blind or disabled. If an annuity is an excluded resource, the periodic payments are countable unearned income, unless specifically excluded under this policy. See the *ABD Countable and Excluded Resources* policy for resource treatment of an annuity.
Canceled Debts	Excluded. The amount of a debt an individual is no longer required to pay or that is forgiven.
Capital Gains	Countable. Income an individual receives when a capital asset is sold and an individual makes a profit from the sale. Capital assets include a home, household furnishings and stocks and bonds held in a personal account. When a capital asset is sold, the difference between the amount paid for the asset and the amount it is sold for is the capital gain or loss.

Care and Contribution in Exchange for a Transferred Asset	Countable. If the individual has transferred an asset and part or all of the compensation he received included a provision for lifetime total care and support, the value of the care and support contribution is unearned income.
Cash Inheritance	Countable. The value of inherited cash is counted as income in the month of receipt and if the individual retains it, as a resource in the months thereafter. The month of receipt for an inheritance composed of cash is the month the individual receives that money.
Cash Support	Countable. Count regular contributions made directly to the individual as unearned income unless it can be excluded as irregular or infrequent income.
Child Support Arrearage	Countable. Child support arrearages received, whether received on a regular monthly schedule or as a one-time payment. One-third (1/3) of the child support arrearage payment, received from an absent parent by a child under age 18 or under age 22 and regularly attending school, is excluded. The remaining 2/3 value is counted as unearned income in the month of receipt. The child support arrearage is counted in its entirety when the child is an ineligible child in a deeming budget or is applying for Institutional Medicaid.
Child Support	Child support payments are countable to the child(ren) the payments are intended to support. If the support order does not indicate the amount per child, assume the amount received is equally distributed among all of the non-custodial parent’s children for whom the payment is made. When determining eligibility for a disabled child under age 18 or under age 22 and regularly attending school, and the child

	support payment is countable to the child, 1/3 of the child support amount received from an absent parent is excluded. The remaining 2/3 value is counted as unearned income in the month of receipt. The one-third exclusion does not apply when the child is an ineligible child in a deeming budget or is applying for Institutional Medicaid. The value of support payments is counted in its entirety for individuals age 22 and older as unearned income in the month of receipt. Use one of the following to verify the value and frequency of support payments: • Copy of the child support award agreement; or • Written statement from the individual paying the support and a copy of the most recent support check or receipt.
Community Spouse Income Maintenance Amount (CSIMA) / Dependent Income Maintenance Amount (DIMA)	The CSIMA and the DIMA are income allocations made to certain spouses and dependents of individuals eligible in an Institutional Medicaid category. When an institutionalized individual has a community spouse or dependent living in the home, a portion of the individual’s income is allocated to the community spouse or dependent in order to cover the necessary costs of living in the home. The CSIMA and/or DIMA are countable unearned income for applicants ONLY when the institutionalized individual is NOT in the community spouse’s or dependent’s household. If the institutionalized individual is living in the applicant’s household, the CSIMA and DIMA are excluded.
Death Benefits	Countable. A death benefit is received as the result of another’s death. Examples of death benefits include: • Proceeds of life insurance policies received due to the death of the insured;

	• SSA, Veterans Affairs (VA) or Railroad retirement lump sum death benefits; • Inheritances in cash or in-kind; and • Cash or in-kind gifts given by relatives, friends or a community group to "help out" with expenses related to the death, etc. Recurring survivor benefits such as those received under Social Security Title II, private pension programs, etc. are not death benefits. Death benefits are income to an individual if the total amount exceeds the expense of the deceased person's last illness and burial paid by the individual to whom the death benefit is issued.
Education Income Not Work Study	Excluded. Income received through Federal Student Aid, such as grants and loans, except for income received through Work Study programs.
Federal Emergency Management Agency (FEMA) Payment Disaster or Emergency	Excluded. FEMA payments issued as a result of a presidentially declared emergency or major disaster are excluded. Payments made by comparable disaster assistance programs by states, local governments and disaster assistance organizations are also excluded.
Federal Emergency Management Agency (FEMA) Payment Non Disaster or Emergency	Countable. FEMA payments made to a household to pay for rent, food and utility assistance when there is NO major disaster or emergency declaration are countable.
Gambling, Prizes and Awards	Countable. The value of a prize or award is unearned income in the month the individual receives it. A prize is something won in a contest, lottery or game of chance. If the individual is offered a choice between an in-

	kind prize or cash, the cash offered is counted as unearned income even if the individual chooses the in-kind item and regardless of the value of the in-kind item. An award is received as the result of a decision by a court, board of arbitration, etc. Secure from the applicant any of the following types of verification: • Award letter; • Copy of the check received; • Contest advertisement; or • Income tax return for the year the prize or award was claimed.
Gifts	Countable. A gift is received by a household member without the giver's legal obligation or as repayment for goods or services. The value of a gift, either cash or in-kind, is counted as unearned income in the month of receipt. The cash gifts value is counted in whole the month of receipt, unless it can be excluded as infrequent or irregular income. The value of in-kind gifts is equal to the item's current market value. A gift of a house which is used as shelter is not counted as income and is exempted as a homestead. A gift of a house which is not used as shelter is not counted as income and is valued as a resource at its current market value. Gifts of commercial travel tickets for domestic travel are excluded from income if they are not converted to cash. Use any of the following methods to verify the type, amount and date of receipt of a gift: • Photocopy of the check; • A written or verbal statement from the donor regarding the gift's value and date given; or • In the absence of the first two verification types listed, the individual's sworn statement.
In-Kind Support and Maintenance (ISM)	Unearned in-kind income, in the form of food and/or shelter, is referred to as ISM and is countable income in the month

	received. See the *In-Kind Support and Maintenance* policy to determine the value of ISM.
Income Not Pursued	Countable. Income not pursued includes payments for which an individual could apply on an ongoing or one-time basis and may include annuities, pensions, retirement benefits or disability benefits. Note: This may decrease household size for other individuals in the household and the applicant may be found not eligible due to failure to apply for other benefits.
Income Producing Resource	Income earned off of an income-generating resource is counted or excluded based on the treatment of the resource. Income generating resources include: • Annuities; • Contract for Deeds; and • Promissory Notes. Income generated by a resource that is excluded is countable unearned income. Income generated by a resource that is countable is excluded as income. See the *ABD Countable and Excluded Resources* policy for determining when a resource is countable or excluded.
Interest Income	Interest income and dividends are a return on a capital investment such as stocks, bonds, mutual funds or savings accounts. A cash gift or incentive payment to open an account is considered interest income. Interest income and dividends can be countable or excluded, depending on the treatment of the source of the interest or dividend. If the interest-bearing resource is counted, the interest income is excluded. If the interest-bearing resource is excluded, the interest income is counted. Interest bearing resources include the following: • Certificate of Deposit; • Checking Account; • Life insurance;

	• Mutual Funds; • Retirement account; • Savings account; and • Stocks and Bonds. If interest income is countable, count it at the earliest of the following: • Income is credited to an individual's account and is available for use; • Income is set aside for the individual's use; or • When the income is actually received by the individual. See the *ABD Countable and Excluded Resources* policy for determining when a resource is countable or excluded.
Irregular or Infrequent Income	Exclude up to $60 per calendar quarter per household of unearned income that is received either irregularly or infrequently. In order to be excluded, the income need only be irregular or infrequent. Income is considered to be irregularly received if an individual cannot reasonably expect to receive it. Income is received infrequently if an individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the previous month or in the month following the month in which the money was received. A single source of unearned income is from one individual, household, organization or investment (single financial account, life insurance policy, rental property or other resource providing a return to its owner). Irregular or infrequent income is not excluded when determining Institutional Medicaid eligibility. See the *ABD Income Disregards and Expenses* policy.
Jury Duty	Jury duty is countable unearned income in the month it is received. Any jury duty pay that is turned over to an individual's employer is excluded. Countable jury duty pay does not include expense money provided during jury duty participation.
Lump Sum	Lump sum payments are countable income in the month

	received, if they are not from an excluded source.
Long Term Care (LTC) Insurance Payout	Long-Term Care (LTC) insurance policies are treated as Third Party Liability. The LTC policy must be assigned to the nursing home, the HCBS provider, or the Managed Care Organization (MCO). If the LTC policy is not assignable, the individual must provide any payments received to the nursing home, the HCBS provider, or the MCO. Payments made to the nursing home, HCBS provider, or the MCO are not treated as income. If an individual receives an LTC Insurance payout, and does not use the benefit to pay the nursing facility, the HCBS provider, or the MCO, the payout will be counted as unearned income in the month received.
Military Allowances	Countable. Military allowances are cash benefits that compensate the service member, at least in part, for the expenses of housing, food, clothing, and special situations during periods of active duty service. Military allowances paid to service members and their families are generally counted as earned income. See the *ABD Earned Income* policy. The basic allowance for housing (BAH) is a cash allowance that service members receive during periods of active duty military service to pay for housing. The BAH is treated as earned income when the payment is made to military personnel living in private housing. The BAH counts as unearned income in the form of in-kind support and maintenance (ISM) subject to the Presumed Maximum Value (PMV) rule when paid to service members and their families living in on-base housing or privatized military housing. See the *In-Kind Support and Maintenance* policy to determine the value of ISM.
Pension	Countable.

	Recurring pension payments are countable unearned income.
Protective Payee	Funds received by a protective payee (conservator, authorized representative or representative payee) and used for the care and maintenance of a third party beneficiary (adult or child) who may or may not be a member of the protective payee's household are excluded as income to the protective payee. Any part of the payment that is retained by the protective payee for his own use is countable income to the protective payee. Even if the protective payee retains a fee for his services, the entire payment issued to the beneficiary is countable income to the beneficiary. As a condition of eligibility, applicants and enrollees must take necessary steps to obtain all countable income to which they may be entitled. Therefore, the total amount intended for the beneficiary is counted to the beneficiary even if he is not actually receiving the income from the protective payee.
Railroad Retirement	Countable. Railroad Retirement Board benefits are countable unearned income in the month received.
Reimbursements	Reimbursements are any payments to reimburse past or future expenses that do not exceed the actual expenses and are excluded income to the extent that they do not exceed actual expenses. Examples of excluded reimbursements include: • Reimbursements for job or training-related expenses (travel, per diem, transportation); • Reimbursements for out-of-pocket expenses of volunteers incurred during the course of volunteer work; and • Medical and dependent care reimbursements.
Rental or Lease	Countable. Rent is payment for the use of real or personal property, such as land, housing or machinery. Rental income is considered unearned when the individual is not a real estate or property owner in the business of buying, selling and/or renting

	property for a profit. Count the net rental income in determining income eligibility. Gross income from rent is subject to deductions for paid expenses necessary for the production or collection of income. See Self-Employment.
Royalties/Honoraria	Countable. Royalties are countable unearned income when the individual receives payment based on the use of a natural resource for which he owns the usage rights.

Settlements and Restitutions	Excluded.
	
	The following settlements and restitution payments are excluded as unearned income:
	
	• Agent Orange Settlement Payments (and interest from payments);
	• Disaster Relief Assistance received under the Disaster Relief Act of 1974;
	• Distribution of perpetual judgment funds to Indian tribes under the following:
	    o Indian Judgment Funds Distribution (P.L 93-134);
	    o Black Feet and Gros Ventre Tribes (PL 92-254);
	    o Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K;
	    o Tribes of groups under PL 93-134;
	    o Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (PL 94-433); and
	    o Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under PL 94-114;
	• Factor VIII or IX Concentrate Blood Products Litigation. The settlement payments (and interest from payments) made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products;
	• Filipino Veterans Compensation Fund Payments: Lump sum payments (and interest from payments)

	made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII; • Japanese-American and Aleutian Restitution Payments (and interest from payments); • Payments made to individuals because of their status as victims of Nazi persecution (e.g., Austrian, German, and Netherlands Reparation Payments and interest from payments); • Payments to children born of Vietnam veterans diagnosed with spina bifida (and interest from payments); • Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (interest is not excluded); • Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act; • Radiation Exposure Compensation Trust Fund Payment; and • State funds paid to crime victims.
Sick/Disability Pay	Countable. Sick or disability payments made by an employer 6 months or more after the last month the individual worked are considered unearned income in the month of receipt. Verify the amount and date of receipt of these payments using one of the following documents: • Recent check stubs; or • Written statement from the employer or insurer indicating the amount of the payment, date paid and related information concerning continued payments.
Social Security Disability Benefit (SSDI)	Countable. Social Security Disability Insurance (SSDI) is received when an individual is under the full retirement age of 65, but has enough Social Security Credits and a severe medical impairment that prevents her from working for a year or more, or could result in death.

Social Security Survivor or Retirement Benefit	Countable. Social Security Retirement Benefits are received once an individual reaches the full retirement age of 65 and has enough Social Security Credits. Social Security Survivor's Benefits are received by a surviving spouse, dependent child or parent who received more than half of his support from the deceased wage earner.
Social Services	Excluded. A social service is any service (other than medical) which is intended to assist a handicapped or socially disadvantaged individual to function in society on a level comparable to that of an individual who does not have such a handicap or disadvantage. Cash received in conjunction with a social service is not income if it is for medical or social services already received or is restricted to the future purchase of a medical or social service. Social service programs include programs authorized under: • Title XX of the Social Security Act; • Title IV-B of the Act (Child Welfare); • Title V of the Act (Maternal and Child Health and Crippled Children's Services); and • The Rehabilitation Act of 1973 including vocational rehabilitation services to handicapped individuals. Food or shelter provided by a nongovernmental social services program is unearned income unless otherwise excluded (e.g., the food is provided during a medical confinement).
Supplemental Security Income (SSI)	Excluded. SSI is excluded unearned income.
Temporary Assistance for Needy Families (TANF) Allotment	Excluded. In Tennessee, the TANF program is known as Families First.

	TANF Allotment is cash assistance provided to families with dependent children when at least one parent is incapacitated, unemployed, deceased or absent from the home, and the family is unable to pay for essential living expenses.
Temporary Disability Insurance	Countable. Temporary Disability Insurance is countable as unearned income to the extent it is not a reimbursement for specific costs and is paid directly to the household.
Tips	Countable. Tips totaling less than $20 in a calendar month from any one employer are countable as unearned income. See the *ABD Earned Income* policy for tips totaling more than $20 in a calendar month.
Trusts	Dividends, interests, rents and other income generated by a trust fund, unless otherwise excluded, that can be paid to the beneficiary or to a third party on the beneficiary's behalf are countable income to the beneficiary for the period the fund is intended to cover, beginning the month the funds become available, regardless of whether the income is actually paid out to the beneficiary. When funds are withdrawn irregularly, the payments are countable in the month received. Monies withdrawn from the principal of an accessible (countable) trust fund are excluded as income to the beneficiary, because an accessible trust fund is a countable resource. Money cannot be considered income and a resource in the same month. Monies disbursed from the principal of an inaccessible trust fund are counted as income because an inaccessible trust fund is an excluded resource. Monies received by the trustee of a trust and used for the care and maintenance of a third party beneficiary (adult or child) are excluded as income for the trustee. See the *ABD Trusts* policy.

Unemployment Insurance	Countable. Count the full value of unemployment compensation benefits as available unearned income in the month of receipt. Unemployment compensation includes any amount you receive under an unemployment compensation law of the United States or a state. Verification If verification is required, verify the amount of unemployment benefits received with one of the following: • Documentary evidence from the TN Department of Labor; • Access through data matches available; or • Documentary evidence from the state of issue of unemployment if benefits are from another state.
VA Aid and Attendance and Housebound Allowances	Excluded. VA Aid and Attendance and Housebound allowances are payments made to a veteran, a veteran’s spouse, a surviving spouse, or a surviving parent based on the individual’s need of the aid of another person to perform functions required for everyday living, or if substantially confined to his immediate premises, due to permanent disability. Aid and Attendance and Housebound allowances cannot be received without some other form of VA payment.
VA Apportioned	Countable. An Apportioned benefit is a VA payment made to a dependent spouse, child or parent not residing with the veteran. The VA Apportioned amount is unearned income for the individual receiving the payment.
VA Augmented Benefit	Countable. A VA Augmented Benefit is an increase in payment to the veteran or his surviving spouse in order to provide for a dependent as defined by VA. An Augmented Benefit is unearned income to the dependent.

VA Disability	Countable. VA Disability is a benefit paid to veterans with disabilities as a result of a disease or injury incurred or aggravated during active military service or that arises after service but is thought to be related to her service. The benefit is graduated according to the degree of the veteran's disability on a scale from 10% to 100%.
VA Education Grant	Excluded. A VA Education Grant is for a veteran who is in an approved program and provides up to 36 months of education benefits. These benefits are intended to provide assistance as follows: • Tuition and fees; and • Annual books and supplies stipend. If the veteran receives a stipend to assist with housing, the stipend is countable unearned income.
VA Pension	Countable. A VA Pension is the standard benefit received by a veteran for wartime service which is based on financial need, not on a service-connected disability. A VA Survivors Pension is paid to the low-income, un-remarried surviving spouse and the unmarried child(ren) of a deceased veteran with wartime service. VA Pensions limited to $90 per month are excluded. For additional information, please see the *Post-Eligibility Treatment of Income* policy.
VA Survivor (DIC)	Countable. VA Dependency and Indemnity Compensation (DIC) is a benefit paid to eligible surviving dependents, including the spouse, of service members who died while on duty or survivors of veterans who died from their service-connected illness or injury.

	Parents' DIC is an income-based benefit for parents who were financially dependent on a service member or veteran who died from a service-related cause.
Workers' Compensation	Countable. Payments an individual receives for occupational sickness or injury, and paid under a workers' compensation act or statute in the nature of the workers' compensation act, are countable to the extent that they are not an expense attributable to obtaining the compensation.

Document Title	ABD Unearned Income				
First Published	04.17.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
12.02.2015	2.	In-Kind Unearned Income or In-Kind Support and Maintenance	9	Policy Clarification	LW
11.01.2016	2.	ABLE Accounts	1	Policy Change	AJ
11.01.2016	2.	Annuity Payments	1	Policy Clarification	AJ
07.05.2017	2.	Military Allowances	12	Policy Clarification	RH
03.18.2019	2.	Achieving a Better Life Experience (ABLE), Child Support Arrearage, Child Support, Excluded Unearned Income, Irregular or Infrequent Income, Long Term Care Insurance (LTC) Payout, , Social Security Disability Benefit (SSDI), Social Security Survivor or Retirement Benefit, Social Services, Temporary Assistance for Needy Families (TANF) Allotment, VA Aid and Attendance and Housebound Allowances, VA Apportioned, VA Augmented Benefit, VA Disability, VA Education Grant, VA Pension, VA Survivor (DIC), Workers' Compensation	1–16	Policy Clarification	RZ
03.18.2019	2.	Tips	14	Policy Change	TN

ABD IN-KIND SUPPORT AND MAINTENANCE

Legal Authority: 20 CFR 416.1120; 20 CFR 416.1121; 20 CFR 416.1130 – 1147; Tenn. Comp. R. & Regs. 1200-13-20-.06(3)(b)

1. Policy Statement

In-kind Support and Maintenance (ISM) is food or shelter that a person is given or receives because someone else pays for it. ISM can be received from a source outside of the household or from other household members. ISM is countable unearned income for the SSI-related categories: Pickle Passalong, Disabled Adult Child (DAC), and Widow/Widower.

2. Definitions

a. Current Market Value (CMV): The amount for which an item would sell on the local open market.

b. Household: A personal place of residence in which individuals share common living quarters and function as a single economic unit.

c. Household Operating Expenses: The average monthly amount in cash a household spends for food and shelter.

d. Pro Rata Share: An individual's share of the household operating expenses determined by dividing the household operating expenses by the number of persons residing in the household, regardless of age.

e. Shelter: Living quarters for an individual. Shelter items are mortgage payments, property insurance (if required by a mortgage holder), rent, gas, electricity, heating fuel, water, sewer, garbage collection service, and real property taxes.

f. Third-party Vendor Payment: A payment made directly to a vendor by a third party for goods or services provided to an individual or couple.

3. Determining the Value of ISM

There are two rules used to determine the value of ISM: The Value of the One-Third Reduction (VTR) rule and the Presumed Maximum Value (PMV) rule.

a. VTR Rule

The VTR rule is used to determine the value of ISM when an individual or an eligible couple:

i. Lives for a full calendar month in another person's household; and

ii. Receives food and shelter from the person whose household the individual or couple is living in.

The VTR is equal to one-third of the SSI Federal Benefit Rate (SSI-FBR) for an individual or a couple. Effective 01/01/2024, the VTR for an individual is $314.33 and for a couple $417.67, The VTR is counted in full or does not count at all. When the VTR applies in a given month, no other ISM is countable.

An individual is not subject to the VTR if his average monthly contribution toward household operating expenses equals or exceeds the pro rata share or is within $5 of the pro rata share. The pro rata share is determined by dividing the average monthly amount in cash the household pays for food and shelter by the number of individuals living in the household.

Example: Steven lives with his brother, Bill, Bill's wife, and son in Bill's apartment. There are 4 people in the household. The rent is $900 a month. The household pays $200 a month for electricity, water, and sewer and $500 a month for food. The total monthly household expenses are $1600. Steven's share of the household expenses is $400. Steven pays $400 a month toward household expenses. Because Steven pays a pro rata share, the VTR does not apply.

b. PMV Rule

The PMV is the maximum amount of ISM that can be counted in a given month. The PMV rule is used to determine the value of ISM when the VTR rule does not apply.

The PMV is equal to one-third of the SSI-FBR, for an individual or couple, plus $20. Effective 01/01/2024, the PMV for an individual is $334.33 and for a couple $491.67. Under the PMV rule, an individual can rebut the amount of ISM counted as income. An individual can rebut the PMV by showing:

i. That the current market value of ISM received, minus any payment that an individual makes for the ISM, is lower than the PMV; or

ii. The actual amount of ISM received is lower than the PMV.

If the actual value of the ISM received is lower than the PMV, the Actual Value (AV) is used.

Example 1: Mr. and Mrs. Johnson live with their daughter, Barbara and her family in Barbara's home. There are 7 household members. Mr. and Mrs. Johnson have a special diet that requires them to purchase their own food. The household pays $1400 a month for shelter expenses. Mr. and Mrs. Johnson's pro rata share is $400 a month ($1400/7 = $200 x 2 = $400). The Johnsons pay their daughter $300 a month toward shelter expenses. Because the couple's contribution is less than the couple's pro rata share, they are receiving ISM. The actual value of the ISM that the couple receives is $100. Since the actual value is less than the PMV, the AV is used.

Example 2: Harriet lives alone rent-free in a house owned by her uncle, Stanley. The house would rent for $1200 a month if it was rented on the open market. The rent-free house is ISM. The actual value of the rent-free shelter that she receives is $1200 a month. Since the actual value is more than the PMV, the PMV is used.

4. Living Arrangement

The living arrangement of an individual determines whether ISM is valued under the PMV or the VTR rule. The living arrangement of an individual is where the individual lives. It also includes the type of household the individual lives in and who pays for the individual's food and shelter.

a. Living in the Household of Another

An individual lives in another person's household if:

i. The individual does not live in his own household; and
ii. The person who supplies the individual's food and shelter lives in the same household and is not the individual's spouse, a minor child, or someone whose income may be deemed to him.

b. Living in Own Household

An individual lives in her own household if:

i. She (or someone whose income may be deemed to her) has an ownership interest or a life estate interest in the home;
ii. She (or someone whose income may be deemed to her) is liable to the landlord for payment of any part of the rental charges;
iii. She lives in a noninstitutional care situation (e.g., foster or family care);
iv. She pays at least a pro rata share of the household operating expenses; or
v. She lives in a household in which all household members, including the individual, receive public-income maintenance payments. See public-income maintenance payments defined in the *ABD Deeming of Income and Resources* policy.

Note: An individual who lives in a household in which all members receive public-income maintenance payments does not receive ISM from other members inside the household.

Individuals who are homeless, transient (i.e., without a fixed place of residence) or living in an institution do not live in a household.

5. When ISM is Counted

ISM counts as income in the month that the individual has use of the food or shelter item, except when the ISM is from a third-party vendor payment. When a food or shelter item is obtained through a vendor extending credit to an individual and a third party later makes a payment directly to the vendor for the item as a gift, the third-party vendor payment is income in the month the payment is made.

6. Exceptions to Charging ISM

Food or shelter does not count as ISM if the food or shelter is not considered to be income or is excluded from income under federal statute. This includes food or shelter that:

- **a.** Has no CMV;
- **b.** Is provided under the terms of a bona fide loan agreement;
- **c.** Can be excluded as infrequent or irregular income;
- **d.** Is provided by someone in the household whose income may be deemed to the individual;
- **e.** Is specifically excluded by Federal law;
- **f.** Is provided under a governmental medical or social service program;
- **g.** Is assistance based on need from a state or political subdivision;
- **h.** Is received during a temporary absence;
- **i.** Is received during medical confinement in an institution;
- **j.** Replaces lost, damaged or stolen resources; or
- **k.** Is received because of payments made under the terms of credit life or credit disability insurance.

7. ISM from an Employer

Food or shelter provided by an employer to the following people, or under the following conditions, is considered ISM, including payments:

- **a.** To certain agricultural employees;
- **b.** To domestic employees;
- **c.** For service not in the course of the employer's trade or business;
- **d.** For service by certain home workers;
- **e.** For members of the Uniformed Services; and
- **f.** Provided on the employer's business premises, for the employer's convenience, and in the case of shelter received, its acceptance by the employee is a condition of employment.

8. Verification

TennCare accepts self-attestation of ISM, and applies the VTR rule or the PMV rule, depending on a person's living arrangement. If an individual alleges that his contribution towards household expenses is within $20 of the pro rata share or alleges that the actual value of ISM is less than the PMV, and he wishes to rebut the PMV, written documentation is required. Written documentation may include any of the following: a written statement from another adult household member other than the person's spouse, a written statement from the person paying for or providing the food or shelter, a copy of a bill, receipt or canceled check showing the actual value of the food or shelter item. If written documentation is not provided, ISM is counted based on the VTR or PMV rule.

Document Title	ABD In-Kind Support and Maintenance				
First Published	04.01.2024				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser

ABD INCOME DISREGARDS AND EXPENSES

Legal Authority: 20 CFR 416.1112; 20 CFR 416.1124; 42 CFR 435.1005; Tenn. Comp. R. & Regs. 1200-13-20

1. Overview

Certain types of income and verified expenses of an individual may be deducted or disregarded when determining financial eligibility for the ABD TennCare Medicaid categories. The types of income and expenses listed in this policy chapter are not deducted or disregarded when determining financial eligibility for Institutional Medicaid.

2. Unearned Income Disregards and Expenses

a. Irregular or Infrequent Income

The first $60.00 of unearned income received in a calendar quarter, if infrequent or irregular, is disregarded.

b. Child Support Disregard

A child support payment (including child support arrearage) is a payment from an absent parent to or for a child to meet the child’s needs for food and shelter. When determining eligibility for a disabled child under age 18 or under age 22 and a student regularly attending school, and the child support payment is countable to the child, 1/3 of the child support amount received from an absent parent is excluded. The remaining 2/3 value is counted as unearned income in the month of receipt.

c. General Deduction

A $20 monthly General Deduction is allowed per Eligibility Determination Group (EDG). The $20 monthly General Deduction is first applied to any of the applicant’s unearned income. If any of the $20 deduction is not offset by unearned income, apply the remainder of the deduction to a spouse’s unearned income and then to the applicant’s earned income before applying the Earned Income Deduction. The $20 monthly General Income Disregard does not apply to in-kind support and maintenance valued at one-third of the Federal Benefit Rate (FBR) (i.e., the Value of One-Third Reduction (VTR)) or to income based on need.

3. Earned Income Disregards and Expenses

a. Irregular Earned Income Disregard

The first $30.00 of earned income received in a calendar quarter, if infrequent or irregular, is disregarded.

b. Student Earned Income Exclusion

The Student Earned Income Exclusion (SEIE) applies to the earnings of the student who is under age 22 and regularly attending school. The exclusion may apply to an eligible or ineligible child, spouse, or parent(s). The SEIE monthly amount is determined by the Social Security Administration. The monthly exclusion for 2024 is $2,290. The maximum annual exclusion for 2024 is $9,230.

The SEIE does not apply to children attending elementary school.

i. A student is regularly attending school if he is:

1. In a college or university for at least 8 hours per week under a semester or quarter system;
2. In grades 7-12 for at least 12 hours per week;
3. In a training course preparing him for a paying job for at least 12 hours per week (if the course involves shop practice the hour minimum is 15); or
4. For less than the amount of time indicated above for reasons beyond the student's control, such as illness, if circumstances justify a reduced credit load or attendance.

ii. A home-schooled student if she is:

1. In grades 7-12 for at least 12 hours per week; and
2. In accordance with state or jurisdictional home school laws.

iii. A homebound individual is a student regularly attending school when he:

1. Must stay at home because of a disability;
2. Studies a course or courses given by a school (grades 7-12), college, university or government agency; and
3. Has a home visitor or tutor from school who directs the studying or training.

A child retains his student status during official school vacations and breaks if the individual met the conditions required to be considered a student prior to the vacation or break, and he plans to return to school after the break.

c. Earned Income Deduction

The first $65 of the earned income of each aged, blind or disabled individual is disregarded when determining financial eligibility. This is also known as the work expense disregard.

d. Impairment-Related and Blind Work Expenses

i. Overview

The gross countable earned income of each blind or disabled individual not living in a medical institution may be reduced by the amount of expenses attributable to earning the income. The allowable Blind or Blind and Disabled Work Expenses (BWE) and allowable Impairment-Related Work Expenses (IRWE) are not the same.

BWE and IRWE apply only to earned income. In order to deduct either BWE or IRWE, the individual must be:

1. Blind or disabled; and
2. Under age 65; or
3. Age 65 or older and received SSI payments due to blindness or disability the month before attaining age 65.

Work expenses must be verified and documented with receipts, etc. Work expenses must not be payable or reimbursable by a third party, such as Medicaid, Medicare or other insurance.

ii. Impairment-Related Work Expenses (IRWE)

IRWE are expenses for items or services which are directly related to enabling a person with a disability to work and which are necessarily incurred by that individual because of a physical or mental impairment.

A payment for a service or item is excludable as an IRWE when:

1. The individual is disabled and under age 65, or received SSI as a disabled person for the month before attaining age 65;
2. The severity of the impairment requires the individual to purchase or rent items and services in order to work;
3. The expense is reasonable;
4. The cost is paid in cash (cash, check, money orders or credit cards) by the individual; and
5. The payment is made in a month the individual receives earned income for a month in which she both worked and received the services or used the item; or
6. The individual is working but makes a payment before the earned income is received.

IRWE apply only to earned income and are deducted after any remaining portion of the General Income Disregard and the Earned Income Disregard, but before deducting the One-Half Disregard (see section 3.e. below).

iii. Blind Work Expenses (BWE)

BWE are expenses incurred by a blind person which are reasonably attributable to earning income. Allowable BWE are listed below under Allowable BWE and IRWE Types.

Items which are not BWE include:

1. In-kind payments;
2. Expenses deducted under other provisions (e.g., Plan for Achieving Self
3. Support (PASS));
4. Life maintenance expenses (meals outside of work, self-care items, savings plans, health insurance premiums);
5. Items furnished by others that are needed in order to work; and
6. Expenses claimed on a self-employment tax return.

iv. Allowable IRWE and BWE Types

Expense	**Blind Only**	**Blind and Disabled**	**Disabled Only**
Attendant Care	X	X	X
Drugs/Medical Services	X	X	X
Expendable Medical Supplies	X	X	X
Guide Dog	X	X	X
Medical Devices	X	X	X
Non-Medical Equipment Services	X	X	X
Federal, State and Local Income Taxes	X	X	
Social Security Taxes	X	X	
Fees	X	X	
Mandatory Contributions	X	X	
Meals Consumed During Work Hours	X	X	
Other Work-Related Equipment Services	X	X	X
Physical Therapy	X	X	X
Prosthetic Devices	X	X	X
Structural Modifications to the Home	X	X	X
Training to Use an Impairment-Related Device	X	X	X
Transportation To and From Work	X	X	X
Vehicle Modifications	X	X	X

e. One-Half Deduction

One-half of the remaining earned income in the month is disregarded. This disregard is deducted after IRWE but before deducting BWE. If the remainder before the one-half disregard is $0 or less, the BWE disregard will not be applied.

Document Title	ABD Income Disregards and Expenses
First Published	03.20.2015

Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
05.02.2016	2.a.; 3.a.	Legal Authority; Irregular or Infrequent Income; Irregular Earned Income Disregard	1	Policy Clarification	LW
05.02.2016	3.d.	Impairment-Related and Blind Work Expenses	3-4	Non-Substantive Change	LW
03.18.2019	1.; 2.b.; 2.c.; 3.b.; 3.e.	Legal Authority; Overview; Child Support Disregard; General Deduction; Student Earned Income Exclusion; One-Half Deduction	1-5	Policy Clarification	AJ
03.18.2019	3.d.i.	Overview	3	Non-Substantive Change	JH
01.02.2020	3.b.	Student Earned Income Exclusion	2	Non-Substantive Change	TN
01.04.2021	3.b.	Student Earned Income Exclusion	2	Non-Substantive Change	RS
01.04.2022	3.b.	Student Earned Income Exclusion	2	Non-Substantive Change	TN
01.03.2023	3.b.	Student Earned Income Exclusion	2	Non-Substantive Change	KF
01.02.2024	3.b.	Student Earned Income Exclusion	2	Non-Substantive Change	CE

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A $20 monthly General Deduction is allowed per Eligibility Determination Group (EDG). The $20 monthly General Deduction is first applied to any of the applicant's unearned income. If any of the $20 deduction is not offset by unearned income, apply the remainder of the deduction to a spouse's unearned income and then to the applicant's earned income before applying the Earned Income Deduction. The $20 monthly General Income Disregard does not apply to in-kind support and maintenance valued at one-third of the Federal Benefit Rate (FBR) (i.e., the Value of One-Third Reduction (VTR)) or to income based on need.

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ii. A home-schooled student if she is:

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2. In accordance with state or jurisdictional home school laws.

iii. A homebound individual is a student regularly attending school when he:

1. Must stay at home because of a disability;
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3. Has a home visitor or tutor from school who directs the studying or training.

A child retains his student status during official school vacations and breaks if the individual met the conditions required to be considered a student prior to the vacation or break, and he plans to return to school after the break.

c. Earned Income Deduction

The first $65 of the earned income of each aged, blind or disabled individual is disregarded when determining financial eligibility. This is also known as the work expense disregard.

d. Impairment-Related and Blind Work Expenses

i. Overview

The gross countable earned income of each blind or disabled individual not living in a medical institution may be reduced by the amount of expenses attributable to earning the income. The allowable Blind or Blind and Disabled Work Expenses (BWE) and allowable Impairment-Related Work Expenses (IRWE) are not the same.

BWE and IRWE apply only to earned income. In order to deduct either BWE or IRWE, the individual must be:

1. Blind or disabled; and
2. Under age 65; or
3. Age 65 or older and received SSI payments due to blindness or disability the month before attaining age 65.

Work expenses must be verified and documented with receipts, etc. Work expenses must not be payable or reimbursable by a third party, such as Medicaid, Medicare or other insurance.

ii. Impairment-Related Work Expenses (IRWE)

IRWE are expenses for items or services which are directly related to enabling a person with a disability to work and which are necessarily incurred by that individual because of a physical or mental impairment.

A payment for a service or item is excludable as an IRWE when:

1. The individual is disabled and under age 65, or received SSI as a disabled person for the month before attaining age 65;
2. The severity of the impairment requires the individual to purchase or rent items and services in order to work;
3. The expense is reasonable;
4. The cost is paid in cash (cash, check, money orders or credit cards) by the individual; and
5. The payment is made in a month the individual receives earned income for a month in which she both worked and received the services or used the item; or
6. The individual is working but makes a payment before the earned income is received.

IRWE apply only to earned income and are deducted after any remaining portion of the General Income Disregard and the Earned Income Disregard, but before deducting the One-Half Disregard (see section 3.e. below).

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5. Items furnished by others that are needed in order to work; and
6. Expenses claimed on a self-employment tax return.

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Drugs/Medical Services	X	X	X
Expendable Medical Supplies	X	X	X
Guide Dog	X	X	X
Medical Devices	X	X	X
Non-Medical Equipment Services	X	X	X
Federal, State and Local Income Taxes	X	X	
Social Security Taxes	X	X	
Fees	X	X	
Mandatory Contributions	X	X	
Meals Consumed During Work Hours	X	X	
Other Work-Related Equipment Services	X	X	X
Physical Therapy	X	X	X
Prosthetic Devices	X	X	X
Structural Modifications to the Home	X	X	X
Training to Use an Impairment-Related Device	X	X	X
Transportation To and From Work	X	X	X
Vehicle Modifications	X	X	X

e. One-Half Deduction

One-half of the remaining earned income in the month is disregarded. This disregard is deducted after IRWE but before deducting BWE. If the remainder before the one-half disregard is $0 or less, the BWE disregard will not be applied.

Document Title	ABD Income Disregards and Expenses				
First Published	03.20.2015				
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05.02.2016	2.a.; 3.a.	Legal Authority; Irregular or Infrequent Income; Irregular Earned Income Disregard	1	Policy Clarification	LW
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01.04.2021	3.b.	Student Earned Income Exclusion	2	Non-Substantive Change	RS
01.04.2022	3.b.	Student Earned Income Exclusion	2	Non-Substantive Change	TN
01.03.2023	3.b.	Student Earned Income Exclusion	2	Non-Substantive Change	KF
01.02.2024	3.b.	Student Earned Income Exclusion	2	Non-Substantive Change	CE

ABD TREATMENT OF RESOURCES: OWNERSHIP, EQUITY VALUE & ACCESSIBILITY

Legal Authority: 20 CFR 416.1201; 20 CFR 416.1208

1. Policy Statement

A resource is real or personal property which has economic value. Resources can include, but are not limited to, cash, savings, investments, houses, land and vehicles. The household's resources are evaluated for ownership, accessibility and equity value. All resources are countable unless specifically excluded by regulation.

2. Definitions

Resource: Cash or other liquid asset or any real or personal property that an individual owns jointly or individually that could be converted to cash and used for medical support and maintenance.

Resources are those assets the individual has on hand at the beginning of the month as opposed to income, which is any cash, wages, pensions or other funds received during the month.

3. Liquid and Non-Liquid Resources

Liquid resources are cash and other resources that can be readily converted to cash. Examples of resources that are ordinarily liquid include (but are not limited to) stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (savings, checking, time deposits/CDs) and similar items.

The value of countable liquid resources is typically based on the specific value of the resource, e.g., the amount in the financial account, the cash surrender value, or the value of the note held by the individual.

Non-liquid resources are resources that cannot reasonably be immediately converted into cash. A resource which has been determined to be non-liquid for any reason is not considered inaccessible or excluded simply because the value of the asset cannot be accessed at the time of application.

The value of a countable non-liquid resource is based on the resource equity value.

4. Fair Market Value (FMV)

The FMV of a resource is determined based on the type of resource. For example, bank accounts are based on the amount of money in the account. Certificates of deposit and other time deposits are based on the amount of money that can be withdrawn after penalties for early withdrawal. Car values are based on National Automobile Dealers Association (NADA) values or statements from knowledgeable sources, such as area car dealers. Real estate is based on Total Market Appraisal, which can be found at http://www.assessment.cot.tn.gov/RE_Assessment/, which is the State of Tennessee's Comptroller of the Treasury's Real Estate Assessment Data listing. Nine counties do not provide property information through the Comptroller's listing. However, links to the property information for those nine counties can be found on the Comptroller's web-site.

Other types of resources are valued based on statements from knowledgeable sources or other means that are reasonable and appropriate to the type of resource being valued.

Fair market value is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria you use in appraising the value of assets for the purpose of determining Medicaid eligibility.

5. Equity Value

The equity value of a resource is the FMV minus the debt or amount owed on the resource. (Equity = FMV – amount owed). Only the equity value of an accessible resource is counted toward the resource limit, other than for vehicles.

Only debts (amounts owed) that are secured by liens or other legal encumbrances against the resource can be subtracted from the FMV when determining equity.

6. Resource Accessibility & Availability

Resources are considered available either when actually available to the individual or when the individual has a legal or equitable interest in the property or asset, and has the legal or equitable ability to access funds or convert non-cash property into cash. If the individual has the legal or equitable ability to access his or her funds, the resource is considered available regardless of whether the individual has the practical ability to access the resource or convert non-cash property into cash.

The individual's incompetence, whether presumed or actual, does not bar the person's legal authority to withdraw his or her liquid resources in the situation where a conservator, guardian or someone acting on the person's behalf has not been legally appointed.

The resources belonging to an individual whose conservator, guardian, or legally appointed representative does not cooperate with TennCare during the facilitation of accessing resources, shall be considered inaccessible, assuming the methods to access the resources have been fully exhausted.

For applicants who do not have a conservator, guardian or legally appointed representative, or for applicants whose conservator, guardian or legally appointed representatives cannot or will not perform his or her duties on behalf of the individual, contact the Eligibility Policy Unit for assistance.

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Consider jointly-owned resources accessible according to the information above unless the individual rebuts ownership or accessibility, and can verify that the joint ownership does block accessibility of the resource.

7. Ownership

a. Determining Ownership

Ownership of a resource is determined by the:

- Name(s) on the account, title, deed, contract, etc.;
- Source of the funds in the account or used to purchase the resource;
- Purpose for which the account or investment was opened or made; and
- Activity and use of the account or investment.

If the title, deed, contract, account, etc., has only one name listed, the resource belongs to that individual. If more than one name is listed, it is considered a jointly-owned resource. Once a resource has been determined to be jointly owned, the resource's accessibility must be evaluated.

b. Jointly-Owned Resources

Resources owned jointly with someone outside the household must be evaluated to determine accessibility to the household.

Consider 100% of the resource as available to the household **<u>unless</u>** the:

- Household can demonstrate it only has access to a portion of the resource (count the value of the proportional interest owned by the household member), or;
  - The accessible portion of jointly-owned real estate or other titled or deeded property is the percent owned by the applicant;
  - The accessible portion of a bank account or other liquid resource is considered to be 100% unless otherwise restricted.
- The resource cannot be practically subdivided and the household's access to the resource is dependent on the agreement of a joint owner who refuses to comply. This provision does not apply to real property or
- The resource is a joint bank account. When two or more eligible individuals have unrestricted access as joint owners of a bank account (savings, checking and time deposits) with or without other ineligible owners, each eligible individual is presumed to own an equal share of the total funds in the account regardless of the source of the funds. The eligible individual(s) and/or his responsible party have the right to rebut the ownership presumption.

If an asset cannot be sold or converted due to the conditions of joint ownership, exclude the applicant's equity value in determining resource eligibility. The applicant's equity value in a jointly-owned asset can be excluded under the following conditions:

- The joint owner of the resource (who is not a Financially Responsible Relative) refuses to consent to the sale of the asset or to purchase the applicant's interest; or
- The applicant is free to sell his or her own individual interest in the property, but is unable to find a buyer.

c. Rebuttal of Ownership

i. Rebuttal of 100% Ownership or Accessibility of a Resource

Applicants who wish to rebut a determination that the he or she has unrestricted access to a resource will have 30 days from the date of application to present rebuttal evidence. If the individual presents all required rebuttal evidence corroborating his or her allegation of partial or non-ownership and the initial determination is rebutted, count only that portion of the resource the individual owns as an available asset.

ii. Rebuttal Evidence

Rebuttal of resource ownership and accessibility must be submitted in writing, and must be signed by all co-owners. The rebuttal must explain and include verification of the following:

- The reason co-ownership was established;
- The names of individuals whose funds were used to establish the account or purchase the asset, and the amounts each invested;
- The names of individuals who made deposits or withdrawals from an account or who have used the resource; and
- How the funds were spent or what the resources have been used for.

If the individual successfully rebuts the presumption of 100% ownership or accessibility, action must be immediately taken by the applicant to separate commingled funds, remove his or her name from the account or resource, or restrict his or her access to the account, as applicable to the situation.

d. Verification of Jointly-Owned Resources

If a resource is jointly-owned, or an individual successfully rebuts a presumption of 100% ownership or accessibility, verification of ownership and accessibility are required. Verification must include bank statements, agreements, deeds, titles or other collateral statements. The individual's statement is not sufficient verification.

8. Inaccessible Resources

A resource is not considered inaccessible simply because it is non-liquid. The practical inability to access the resource also does not make it inaccessible. See the *ABD Inaccessible Resources* policy.

9. Resource Time and Value Limits

A resource may be excluded for a limited period of time or excluded up to a certain amount. To determine applicable limits, see the specific resource type in the *ABD Countable and Excluded Resources* policy. Time limits and value limits should be considered when assessing a commingled resource.

10. Identifying Excluded Funds in Commingled Resources

Otherwise excludable resource funds must be identifiable to remain excluded when commingled with non-excludable funds. Funds are generally not required to be maintained separately to be considered identifiable, see the specific resource type in the *ABD Countable and Excluded Resources* policy to see if commingling is specifically prohibited. When assessing withdrawals from commingled funds, the withdrawal should be deducted from non-excluded funds first. Interest from excluded funds may also be excluded, see the specific unearned income type in the *ABD Unearned Income*.

ABD COUNTABLE AND EXCLUDED RESOURCES

Legal Authority: 42 USC 1396p(f); 26 USC 6409; 20 CFR 416 Subpart L; 42 CFR 483.10; Public Law 109-171 (Deficit Reduction Act of 2005); Public Law 113–295; Tenn. Code Title 71, Chapter 4, Part 8; Tenn. Comp. R. & Regs. 1200-13-20-.06(2)(c)

1. Countable Resources

Countable resources are all those available assets whose value is considered in determining resource eligibility. The equity value of all resources (real and personal property) owned by the Eligibility Determination Group (EDG) are countable unless specifically excluded by regulation.

Count the resources of the following individuals:

a. All individuals included in the EDG; and
b. The resources belonging to the Financially Responsible Relative (FRR) of the EDG members, if the relative and EDG members are living together at the time.

For Supplemental Security Income (SSI) recipients, TennCare relies on the resource and income determination made by the Social Security Administration (SSA) and the income information from available data sources. Additional requests for resources and income may occur when there is reason to believe that the individual has additional income or resources beyond what is known to SSA.

2. Definitions

Resource Characteristic: A description of a resource's intended use, source or a more specific description of a particular kind of resource. The resource characteristic often determines how to treat the resource, i.e. count or exclude. Not all resource types have a particular resource characteristic. Examples of a resource characteristic include: burial, business or self-employment, personal, and specific types of retirement plans.

Resource Type: A liquid or non-liquid asset that an individual owns jointly or individually. The resource type describes the asset itself, and not its intended use, source or other specific features. Examples of a resource type include: checking account, insurance, trusts and real property.

3. Resource Characteristics and Types

To determine whether a resource is countable or excluded, factors that must be considered are: the nature of the resource, the date it was created, its intended use, and the source of funds used to create the resource.

Achieving a Better Life Experience (ABLE) Accounts	Resource Type	ABLE accounts or 529A accounts are tax-advantaged savings accounts for individuals with disabilities that are established under a qualified ABLE program. The funds in an ABLE account are intended to cover an individual's Qualified Disability Expenses (QDEs) related to her blindness or disability. QDEs include, but are not limited to: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, funeral and burial expenses and basic living expenses. The balance within a single ABLE account for an individual, including contributions and earnings, is excluded as a resource. This includes contributions made by an ABLE account owner from his own resources and contributions made by a third party, including a trust. Distributions from an ABLE account are excluded if used or intended to be used for QDEs as long as the distributions are identifiable. Distributions from an ABLE account used for non-qualified expenses are excluded if spent in the month of receipt. Distributions from an ABLE account are countable when: • Distributions are retained past the month of receipt and are used for, or intended to be used for, non-qualified disability expenses; • Distributions are retained past the month of receipt and were previously excluded because intended for a QDE, but used for a non-qualified expense. Count the amount of funds used as a resource the month in which funds were spent; or • Distributions are retained past the month of receipt, have not been spent, and the intent to use the funds for a QDE has changed. Count the retained funds as a resource the following month. Normal counting rules and exclusions apply to assets or other items purchased with funds from an ABLE account.

		Documentary evidence of an ABLE account should show the following information: • The name of the designated beneficiary or owner of the account; • The state ABLE program administering the account; • The name of the person who has signature authority (if different from the owner); • The unique account number assigned by the state to the ABLE account; • The date the account was opened; and • The account balance.
Annuity	Resource Type	Annuities are contracts or agreements that, in exchange for a lump sum payment or series of payments, provide income at regular intervals (i.e., monthly, quarterly, annually). Annuities establish a source of income for a future period, and are often used in retirement planning. **1. Definitions** **Annuitant:** The person on whose life the income payments are based. Often, the annuitant is the contract owner and receives the benefits of the contract. Annuity payments may also be based on more than one life or based on a fixed period of time. **Annuitization:** The process of converting an annuity contract's value into a guaranteed income stream represented by periodic payments over a specified period of time. **Payee:** The individual or entity designated by the annuity owner to receive periodic payments. An annuity payee is sometimes referred to as an annuitant; however, a payee may not also be an annuitant. **Deferred Annuity:** An annuity contract under which payments begin sometime in the future. **Immediate Annuity:** An annuity contract purchased with a lump sum under which payments begin within a short period, always within 12 months. **Accumulation Phase:** The first phase of a deferred annuity during which the contract accumulates funds from the payments made into the annuity and accrues interest and earnings.

Free Look Period: Period of time after an annuity contract is delivered (usually between 10 and 30 days) when the owner may cancel the contract and receive either their initial payment or the current value of the annuity contract.

Maturity Date: The date specified in the annuity contract at which time the owner may choose to extend the contract, surrender the contract for a one-time lump sum payment, or annuitize the contract and receive periodic payments.

Systematic Withdrawal Plan: A distribution plan that allows a variable annuity contract owner to receive a specified amount or a percentage of funds from an annuity's contract value at regular intervals prior to the annuity start date.

Required Minimum Distribution (RMD): The minimum amount that an owner of a qualified annuity (established with pre-tax dollars) must withdraw annually starting with the year that he reaches 70½ years of age or, if later, the year in which he retires.

2. General Rule

An annuity is a countable resource when it is revocable, assignable or can be sold. Generally, annuities are revocable while in the accumulation phase though an annuity owner will not receive a full refund, unless the annuity is cancelled during the free look period. Once an annuity has been annuitized, the funds are typically unavailable as a lump sum.

3. Types of Annuities

Annuities can be classified in a number of ways based on the following:

- The time at which annuity payments begin (e.g., deferred, immediate);
- The nature of the periodic payments (e.g., fixed, variable);
- The period over which annuity payments will be made (e.g., term or period certain, life); and/or
- The type of annuity issuer (e.g., commercial, private).

4. Countable Value

Annuities may be counted as a resource or as unearned income, depending on the circumstances of the annuity. An annuity is a resource during the free look period and the accumulation phase.

Free Look Period

- During the free look period, the countable value of an annuity is the purchase value.
(Exception: The value of a variable annuity may be more or less than the purchase value.)

Accumulation Phase

- During the accumulation phase, the countable value of an annuity is the cash value, minus any withdrawals and surrender charges or penalty fees for early withdrawal.

Distributions from an annuity, such as systematic withdrawals and RMDs, should be considered conversions of a resource rather than income.

Some annuity contracts contain a provision allowing an individual to cash in the contract after annuitization. If an annuity contract contains such a provision, the annuity is a resource, and the countable value is the commuted cash value, i.e. the present value of all future payments. An annuity is unearned income when it has been irrevocably converted to an income stream and is no longer available as a lump sum.

Any portion of an annuity payment held following the month of receipt is a countable resource, except when the annuity is a State annuity for certain veterans. A State annuity for certain veterans is an annuity paid for by a state to an individual the state determined is a veteran, who is aged, blind or disabled, or to that individual's spouse.

5. Annuities Funded by a Pension or Retirement Fund

Annuities that are funded by a pension or retirement fund held by an employer or union should not be counted as a resource while the individual is employed, if termination of employment

		would be necessary to access the funds. If the annuity contains a special provision that allows the individual to access a portion of the funds or the funds in entirety under certain circumstances such as a medical emergency, the dollar amount available to the individual is a countable resource. Federal law requires individuals to take all necessary steps to obtain any annuity to which they are entitled, unless they can show good cause for not doing so. **6. Annuities Owned or Purchased by LTSS Applicants** Annuities owned or purchased by individuals applying for Long-Term Services and Supports (LTSS) are subject to additional requirements and should be reviewed according to transfer of assets policy. See the *Transfer of Assets and Penalty Periods* policy. **a. Disclosure Requirements of Interest in an Annuity at Application** Individuals applying for LTSS must disclose information regarding any interest that the individual or his spouse may have in an annuity. This disclosure requirement applies regardless of whether the annuity is counted or excluded as a resource. If the individual or his spouse refuses to disclose information related to an annuity, the individual will be denied Medicaid eligibility based on the individual's failure to cooperate.
Burial	Resource Characteristic	Certain otherwise countable resources may be excluded for burial. These resources must be separately identifiable and set aside for burial expenses, and may not be commingled. See the *Burial Contracts, Burial Plot and Space, Burial Reserves, and Burial Trusts* resource types for a complete description of the various types of resources.

Burial Contracts	Resource Type	**Burial Contracts** Legal Authority: Tennessee Code Annotated 62-5-401 through 409 **1. Prepaid or Preneed Burial Contracts** A prepaid or preneed burial contract is an agreement under which an individual pays in advance for a burial that the seller agrees to furnish upon the death of the individual or another designated individual. Sellers of prepaid burial contracts are individuals and entities in the funeral industry, e.g. funeral homes. Prepaid burial contracts can be funded numerous ways, including cash payment to the funeral home or the purchase of an annuity or life insurance with assignment to the funeral home (See Section b. for additional information about life insurance funded burial contracts). The funeral home is then required by state law to place those funds into a preneed burial trust, or a preneed burial insurance product. Note: Installment payments on a prepaid burial contract are treated as countable funds subject to the burial reserve exclusion, until the contract is paid off in full. Once the contract has been paid in full, apply burial space and funds exclusions as provided below. This applies to contracts under which the buyer is not entitled to the spaces or services listed in the contract until paid in full; and the seller is not obligated to provide spaces or services until the contract is paid in full. **a. Revocable Burial Contract** The value of a revocable prepaid burial contract is a countable resource. **b. Irrevocable Burial Contract** The value of an irrevocable prepaid burial contract is an excluded resource, under the following conditions: **i. Agreements established prior to 7/1/1981** A prepaid contract that has been declared irrevocable by a court of law is an excluded asset. It

is a countable asset if it has not been declared irrevocable by a court of law.

ii. Agreements established between 7/1/1981 and 7/1/1995

The entire value of the prepaid contract is excluded as a resource if the contract contains the following statement: “This contract is irrevocable and the funds paid hereunder are not refundable.”

iii. Agreements established 7/1/1995 or later

A prepaid burial contract under which is a trust or an insurance arrangement is established by the funeral provider is excluded if it meets the following conditions:

- Both the individual and the funeral home representative have signed the document;
- An itemized list of the services provided under the contract is provided;
- The price of all major services is specified;
- The total dollar amount of the agreement is specified;
- The individual was neither a minor or legally declared incompetent when the agreement was signed; and
- The agreement specifies in writing that the money is not refundable under any circumstances.

Review an excluded irrevocable burial contract under the *Transfer of Asset*s *and Penalty Periods* policy for individuals applying for Institutionalized Medicaid. If the individual is receiving Fair Market Value (FMV) for all services specified under the contract, then the burial contract does not constitute a transfer of assets for less than FMV.

Note: If an individual enters into an irrevocable contract with a funeral home, but he establishes a revocable trust to fund the contract, evaluate the revocable trust under the Burial Trust policy. The burial contract is not a resource in this scenario.

c. Ownership and Value

The owner of the burial agreement or contract is the individual who deposited the funds into the agreement, usually the beneficiary. Verify ownership by securing a copy of the burial contract. The current value of the contract is the sum of the amount of the initial deposit, any subsequent deposit and accrued interest, less any processing fees charged to the individual for dismantling or encroaching upon the trust. Verify the amount by reviewing the agreement, written verification from the funeral home or from the bank holding the funds.

2. Life Insurance Funded Burial Contract

A life insurance funded burial contract involves an individual purchasing a life insurance policy on her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a funeral provider. The purpose of the assignment is to fund a burial contract.

Life insurance funded burial contracts are <u>not</u> burial insurance.

a. Revocable Assignment

The resource value of the burial contract is equal to the Cash Surrender Value (CSV) of the life insurance policy, and is subject to the $1,500 burial reserve exclusion. The Face Value (FV) of the resource is not a factor in determining whether the $1,500 exclusion applies to the CSV of a life insurance-funded burial contract. Burial spaces included in the contract cannot be excluded because there is no obligation to provide any spaces until the individual dies.

Example: Mrs. White has a burial contract funded by the revocable assignment of a life insurance policy. The FV of both the burial contract and the life insurance policy is $3,000 and the CSV of the life insurance policy is $1,700. The total resource value of Mrs. White's burial

		contract is equal to the CSV of $1,700. The burial space exclusion does not apply to Mrs. White's burial contract, but $1,500 of the CSV can be excluded under the burial reserve. Mrs. White has no other resources to apply to the burial reserve. The remaining $200 is a countable resource. **b. Irrevocable Assignment** The life insurance policy and the burial contract are excluded resources if the burial contract meets the criteria described in (1)(a) of this section. If the burial contract includes an FV for services (not burial spaces/plots) included in the contract, that portion of the contract may offset the burial reserve. *Example: Mr. Jones has irrevocably assigned ownership of a life insurance policy to funeral home to fund a burial contract. The FV of the life insurance policy is $3,000. The burial contract includes the purchase of $1,300 of burial space/plot and $1,700 of burial funds. The contract is an excluded resource, and the $1,700 in burial funds will be counted against any possible burial reserve exclusion (limit of $1500), so Mr. Jones may not have any other excluded burial funds.*
Burial Plot and Space	Resource Type	Exclude the value of one burial space for each family member, e.g. spouse, child, parent, sibling) whether living in the home or not. Burial plots and spaces include a burial plot, gravesite, crypt, mausoleum, niche or other repository for bodily remains. It also includes vaults, headstones, markers, plaques, containers, and arrangements for opening and closing the gravesite. Burial plots are real property (if a single individual has two burial spaces, but no family member to which he may designate the second burial space).
Burial Reserves	Resource Type	**1. Burial Reserve** Individuals and their spouses are each allowed a $1,500 resource exclusion for funds set aside for burial expenses. This exclusion is separate from, and in addition to, the burial plot exclusion.

Funds allowed to be excluded under this provision include certain otherwise countable resources. These resources must be separately identifiable and set aside for burial expense, and they may not be commingled. To determine the amount of the burial reserve, the maximum $1,500 that may be excluded is first reduced by:

a. Life insurance, if the total value of all life insurance owned by the individual is $1,500 or less; and

b. Funds in an irrevocable burial agreement or contract (see above for irrevocable burial contract definition).

Any remaining amount of the reserve once the above reductions have been applied can be used to exclude other burial funds/expenses. Burial funds set aside for any relatives other than the individual and her spouse are not eligible for exclusion.

Burial funds must not be commingled with other resources. At application and redetermination, burial funds that are commingled with other resources will be counted unless the individual takes action to separate the burial funds.

If an impediment exists that prevents the separation of burial funds, the existing burial funds may be excluded if the individual remains otherwise continuously eligible for the exclusion.

2. Determining the Amount of the Reserve

Example: John owns life insurance with a total Face Value (FV) of $1,000 and an $800 savings account for burial. The value of the life insurance is excluded, and there is $500 remaining as the burial reserve.

$1,500	Maximum Burial Reserve
– $1,000	FV of Life Insurance Policy
$500	Amount of Remaining Burial Reserve

The $500 burial reserve is applied to his burial savings account, and the remaining $300 in the designated burial savings account is a countable resource. The value of any burial funds in excess of the $1,500 maximum is a countable resource.

		$1,800 Total Value of all Burial Assets – $1,500 Maximum Burial Reserve $300 Countable Asset **3. Treatment of Excluded Value** Interest earned on excluded burial funds is excluded as long as the individual remains continuously eligible for TennCare Medicaid. If an individual's eligibility is terminated, and she later applies for benefits, the full value of the asset (including interest) must be considered when evaluating for a burial exclusion. The value of the burial reserve loses its exclusion if any portion of the principal and accrued interest is used for any other purpose than to meet the individual's burial expenses.
Burial Trusts	Resource Type	A burial trust is a trust established by an individual for the purposes of setting aside funds or payment of burial expenses for the individual or someone else. A burial trust is a trust established with the individual's assets. It may be a revocable or irrevocable trust. Note: It is important to determine whether the trust was established with the individual's assets or with funds that have been irrevocably paid to the funeral provider. If it is the latter, then that trust is subject to the policies in the *Burial Contracts*, section (1)(a). All funds in a burial trust, established by an individual, including interest payments, are excluded if the value of the trust does not exceed $6,000 per individual. Interest payments and cost of transport which cause the trust value to exceed $6,000 are also excluded. This applies to both irrevocable and revocable burial trusts. Burial trusts, established by an individual, whose value exceeds $6,000 are subject to treatment according to the nature of the trust, including transfer of assets policy for Institutionalized Medicaid applicants.
Business or Self Employment	Resource Characteristic	Excluded as essential for the production of earned income either in trade, business or self-employment. Resources may include: • Tools/equipment; • Stock or raw materials;

		• Real property; • Personal property essential for income production; • Office equipment; • Business loans for the purchase of capital assets; • Inventory; • Machinery and equipment; • Business/commercial checking accounts; and • Life insurance. No exclusions listed in this section will be applied to property a household does not own, nor to use of such property except by owners who are members of the household. Property that represents the authority granted by a governmental agency to engage in an income-producing activity is also excluded if it is used in a trade or business or non-business income-producing activity or not used due to circumstances beyond the individual's control and there is a reasonable expectation that the use will resume.
Cash	Resource Type	Cash is money on hand or available in the form of currency or coins and is countable. Foreign currency or coins are cash to the extent that they can be exchanged for U.S. issue.
Certificate of Deposit	Resource Type	Certificates of Deposit (CDs) are countable if held in a personal account. The value of a CD is the net amount that could be received after penalties for early withdrawal, if applicable. Taxes are not deducted in determining net value. Determine the net value of a CD via a detailed breakdown from the institution holding the deposit. The breakdown must include the gross deposit and identify any and all deductions and penalties that would be deducted from the gross deposit if the funds were withdrawn. See the *ABD Treatment of Resources: Ownership, Equity Value & Accessibility* policy for treatment of jointly owned CDs.

Checking Account	Resource Type	A personal checking account is countable. Determine the countable portion of the account based on ownership. See the *ABD Treatment of Resources: Ownership, Equity Value & Accessibility* policy for treatment of jointly owned accounts. **1.** A checking account that is used for purposes other than personal use may be excluded on the terms of intended use. Other resource characteristics of a checking account include: • Burial needs; • Educational Income; • Individual Development Account (IDA); • Plan to Achieve Self Support (PASS); • Prorated as Income; • Business or Self-Employment; • Proceeds from the Sale of a House; • Disaster/Settlement Funds, if excluded by policy; and • SSI/Social Security Administration (SSA) Retroactive Payment. Note: Income tax refunds (including any advance payments), such as the Child Tax Credit, are excluded as a resource for a period of 12 months following receipt.
Christmas Club	Resource Type	The accessible funds of a Christmas Club account are a countable resource minus any fees that may be incurred for withdraw. A Christmas Club is a type of savings account designed to help the account holder save money for Christmas. Funds are typically accessible throughout the year, although a fee may be incurred for early withdraw. Determine any applicable fees or penalties associated with the withdrawal of funds. Subtract this amount from the balance of the Christmas Club to determine the value of the resource.
Continuing Care Retirement Community Entrance Fee or Deposit	Resource Type	**1. Description of Continuing Care Retirement Communities** Continuing Care Retirement Communities (CCRC), or life communities, provide living arrangements for individuals as they get older and who may require different levels of assistance. Many of these communities include independent living arrangements, memory support living arrangements and skilled nursing care.

CCRCs provide various options to individuals who wish to live in their community. Most contracts require significant entrance and monthly fees, which are used to cover all aspects of their needs within the community. Potential residents must provide extensive information about their finances, prior to being accepted for admission, and sign detailed contracts regarding current and future needs and payments.

2. CCRC Entrance Fee and Spousal Impoverishment

The Deficit Reduction Act of 2005 (DRA) amended the Social Security Act to require that CCRC contracts are subject to the Medicaid spousal impoverishment rules. CCRC contract provisions requiring the expenditure of resident entrance deposits must take into account the required allocation of resources and of the entrance or income to the community spouse before determining the amount of resources that a resident must spend on her own care.

3. CCRC Entrance Fees as a Countable Resource

Entrance fees paid to a CCRC may be a countable resource. The following three conditions must all be met in order for the entrance fee to be an available, countable resource:

- The entrance fee can be used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient;
- The entrance fee (or remaining portion) is refundable when the individual dies or terminates the contract and leaves the CCRC; and
- The entrance fee does not confer an ownership interest in the community.

It is not necessary for the CCRC to provide a full, lump-sum refund of the entrance fee to the resident in order to satisfy the first condition. If portions of the fee can be refunded or applied to pay for care as required, the condition is met.

		In order to meet the second condition listed above, it is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This condition is met as long as the resident could receive a refund were the contract to be terminated, or if the resident dies.
Contract for Deed or Mortgage	Resource Type	The value of a contract for deed or mortgage may be a countable asset depending on the circumstances of the loan, including the individual's role as lender or borrower and the accessibility of the asset. **1. Definition** A security held by the lender on a particular property for the repayment of debt by the borrower within a particular time period. A contract for deed, land contract, and deed of trust are all mortgages on real property. **2. Individual is the Lender** **a. Countable Value** When the individual is the lender for a contract for deed, he may sell or transfer the instrument to have immediate access to the unpaid loan principal. The value of the resource equity value is a countable asset. Any subsequent payments to the principal made by the debtor after approval are considered a resource because the unpaid loan principal is a resource. **b. Excluded as a Resource** The value of the contract may be excluded from countable resources if the individual can demonstrate that the contract cannot be sold without his realizing a net loss. Evaluate the current status of the contract at redetermination. Do not extend benefits pending a demonstration of unsaleability.

c. Establishing Value

The amount of the unpaid balance of the property agreement (mortgage, contract for deed, etc.) is the value of the countable asset and must be verified at each application and redetermination.

3. Individual is the Borrower

If the individual is the borrower, the property agreement is not a resource. However, the property purchased may be a countable resource following the month of transaction.

4. Reverse Mortgage

a. Description

A reverse mortgage is a loan against the equity in an individual’s home that provides cash advances but requires no mandatory monthly repayment during the life of the loan. If the interest is unpaid, it is allowed to accrue against the value of the individual’s home.

A reverse mortgage is similar to a conventional mortgage because the bank does not own the home but holds a lien on the property. The borrower continues to hold the title to the property. The bank cannot demand payment from any family member if there is not enough equity to cover paying off the loan and there is no penalty for paying off the mortgage early.

b. Policy Application

The proceeds received from a reverse mortgage are tax-free and available as a lump sum or fixed monthly payment for as long as the individual lives on the property. The loan is not due and payable until the borrower no longer occupies the home as a principal place of residence. When the owner no longer resides on the property, the balance of the borrowed funds is due and payable. After the amount received is repaid, any additional equity in the property belongs to the owners or their beneficiaries.

When an individual has money in a reverse mortgage line of credit, this money does not count as a loan, or as income or a resource for determining TennCare Medicaid eligibility. If the individual transfers the money to an investment or to a bank account, the amount transferred will become a countable resource.

In order to qualify for a reverse mortgage, an individual must be at least age 62 and the property must be the borrower's primary residence.

When money is received from a reverse mortgage:

- The money withdrawn is tax-free and can be used for any purpose;
- The money can be received as a lump sum, line of credit, a monthly payment or any combination of the 3;
- There are no mandatory monthly repayments and the loan can be repaid anytime without penalty;
- The title of the home does not change; and
- The lender sets the maximum loan amount.

5. Transfer of Asset Provisions

The purchase of a contract for deed or mortgage is subject to transfer of asset policy for Institutional Medicaid individuals. Funds used to purchase a mortgage on or after February 8, 2006 must meet the following conditions:

- The repayment terms 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; and
- The promissory note, loan or mortgage must prohibit the cancellation of the balance upon the death of the lender.

If an individual applying for LTSS purchases a mortgage within the look back period that does not meet these conditions, the purchase will be treated as a transfer of assets. The value used to

		determine the penalty period is the outstanding balance due on the date of the individual's application for TennCare Medicaid.
Economic-Impact Payments	Resource Type	Stimulus checks or recovery rebates, such as those authorized under the Coronavirus Aid Relief and Economic Security (CARES) Act, are excluded as a countable resource.
Educational Income	Resource Characteristic	Educational income received under Title IV of the Higher Education Act of 1965, such as Pell Grants, Federal Educational Loans and Work Study Programs, or Bureau of Indian Affairs (BIA) grants should be excluded as a resource; there is no time limit. Grants (other than Title IV or BIA grants) scholarships, fellowships, and gifts intended to pay for tuition, fees or educational expenses are excluded for 9 months beginning the month after receipt.
Excess Patient Liability Accumulated due to the Public Health Emergency (PHE)	Resource Type	During the Public Health Emergency (PHE) created by the COVID-19 pandemic, some members enrolled in Institutional Medicaid may not have had their Patient Liability (PL) adjusted. For those who accrued excess resources due to their PL amount not being adjusted, that amount will be excluded as a resource for 12 months following the end of the PHE.
Farm, Business/Self-Employment or other Equipment	Resource Type	The equity value of non self-employment income-producing real property, other than the homestead, is subject to the Rate of Return Test. See the *Income-Producing* resource characteristic. If the property is used for self-employment, it is excluded as Business or Self-Employment. Rental property is a common form of income-producing property. Rental property is countable, subject to the Rate of Return Test, if the individual who owns the property is not 'in the business of' renting property. This means that the individual does not buy, sell and/or rent property for a profit and participate in the operation of the property less than 20 hours per week. Someone who is 'in the business of renting property' is someone who materially participates in the operation and decision making of the rental business for at least 20 hours per week.
Health Reimbursement Account (HRA)	Resource Type	A Health Reimbursement Account is an employer-funded group health plan from which an employee is reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. An unused amount may be rolled over for use in subsequent years. The account is funded and owned by the employer, and is not a countable

		resource for the beneficiary. Any amounts paid to the employee that exceed the cost of medical expenses incurred in the year are countable income.
Homestead Exclusion	This policy applies to resource type **Real Property**, with the resource characteristic of **Home**	**1. General Rule** The entire value of the home, whether on land or water, all adjoining land not separated by property owned by others, and any related outbuildings are excluded in determining resource eligibility, as long as: • The home is the principal place of residence for the applicant, spouse or dependent relatives; and • Intent to return to the home is established, if the individual resides in a Long-Term Care Facility (LTCF). An individual must have lived in the home for it to be considered her home or principal place of residence. For an institutional individual, the individual is ineligible for payments of LTSS (CHOICES) when home equity exceeds $713,000, unless one of the following lawfully resides in the individual's home: • the spouse of such individual; • such individual's child who is under age 21; or • such individual's child who is blind or disabled according to 42 USC 1382c. If the individual's child is not receiving benefits from SSA, contact the Policy Unit for assistance. The home equity limit can be waived if an undue hardship is requested, and a determination is made that undue hardship exists. Undue hardship is considered to exist if the application of the home equity limit would deprive the individual of medical care, such that the individual's health or life would be endangered, or would deprive the individual of food, clothing, shelter, or other necessities of life.

2. Exclusion Based on Intent to Return

The value of the home and surrounding land will not be counted as a resource during the individual's absence from an unoccupied home when she intends to return to the property.

- **Absence from the Home**

  An absence from the home can be necessary to accomplish a specific purpose such as hospitalization, confinement in a nursing home or receipt of services, such as nursing or personal care services not available to the individual in her home.

- **Development of Intent to Return**

  When the individual is absent from her homestead, and it is not occupied by a spouse or dependent relative, verify the individual's intent to return home at each redetermination of eligibility.

- **When the Exemption Period Ends**

  An intent to return home is nullified by any efforts to sell or dispose of the property during the exemption period. The exemption based on the intent to return ends the first day of the month after the month efforts are made to sell or dispose of the homestead property.

  Rental of a homestead which has been excluded because of intent to return does not nullify the exclusion. The homestead retains the exclusion as long as there is a clear, non-contradictory intent to return, and no efforts are made to sell or dispose of the property. The rent will be counted as unearned income in the month received.

  The exemption based on residence of the enrollee's dependent relative ends the first day of the month after the relative last lived in the homestead, if the relative does not intend to return.

		3. Homestead Located Outside of Tennessee Real property located outside of Tennessee can be excluded from countable resources as homestead property, if there is substantiation of the individual's intent to return to the home OR the property is the principal residence of the individual's spouse or dependent relatives. **4. Dependent Relative (for purposes of Homestead Exclusion)** A homestead retains its exclusion if it is the principal residence for the individual, her spouse or relative within the specified degree below who is dependent on the individual. Dependency may be of any kind: financial, medical, residential, etc. Relatives include: Aunt — Grandson — Son Brother — Half brother — Stepbrother Cousin — Half sister — Stepdaughter Daughter — In-laws — Stepfather Father — Mother — Stepmother Granddaughter — Nephew — Stepsister Grandfather — Niece — Stepson Grandmother — Sister — Uncle Accept the signed statement by the individual's spouse or dependent relative regarding her relationship to the individual and residence in the homestead without question, unless it is contradictory.
Individual Development Account (IDA)	Resource Characteristic	IDAs may be established by or on behalf of an individual eligible for Families First assistance. An IDA is different from a regular savings account because funds deposited by a participant are matched by a separate entity and there are restrictions on the use of these funds. An IDA will provide an opportunity for a participant to build assets to further support the transition to self-sufficiency. Funds, including accrued interest, in the account are disregarded as a resource as long as the individual complies with the IDA eligibility rules and continue to maintain or make contributions into the account.

Income-Producing	Resource Characteristic	For property used in a trade or business (i.e. farming), see “Business or Self-Employment”. Income-producing resources can be real or personal property. Income-producing property is non-liquid property used in the passive production of income (i.e., not a business or trade). It may include such property as rental property (when the person is not in the business of managing rental properties), a non-working ownership in a business venture, or leased land in which the owner is not actively participating in the operation and decision-making of the business for at least 20 hours per week. If the owner is participating at least 20 hours per week throughout the year, claims the endeavor as self-employment, and, if filing taxes, reports the income on Schedule C, F or SE, the property is treated as property/equipment necessary for self-employment. Otherwise, the property is treated as income-producing property. Other income-producing resources include buildings, farm, business and other equipment and supplies, motor vehicles, livestock, oil and mineral rights and items of unusual value. **Rate of Return Test** Exclude up to $6,000 of an individual’s equity in an income-producing resource if it produces a net annual income to the individual of at least 6 percent of the property’s equity value. If the individual’s equity value is greater than $6,000, the amount that exceeds $6,000 is countable towards the resource limit. If an income-producing resource does not produce a net annual income of at least 6 percent of the resource’s equity value, the entire equity value of the resource is countable. If the individual owns more than one piece of income-producing resource and each produces income, each is reviewed to determine whether the 6 percent test is met. Then the amounts of the individual’s equity in all of those properties producing 6 percent are totaled to determine if the total equity of all properties is $6,000 or less. If the total equity value in the properties that meet the 6 percent rule is over the $6,000 equity limit, the amount exceeding $6,000 is counted as a resource.

Insurance	Resource Type	There are two types of insurance considered under this resource type: **1. Sick and Disability Insurance** Excluded. Sick and disability insurance primarily provides income to the insured if he becomes disabled. **2. Burial Insurance** Excluded. Burial insurance is a contract whose terms specifically provide that the proceeds can only be used to pay the burial expenses of the insured.
Items of Unusual Value Household Goods and Personal Effects	Resource Type	**Items of Unusual Value** An item of unusual value that generates income for the individual is countable. The countable value is determined by applying the Rate of Return test, see the *Income-Producing* resource charateristic. A personal item of unusual value is excluded from resources. Items that an individual acquires or holds because of their value or as an investment. These items may meet the definition of personal effects. Examples of an item of unusual value include: gems, art collections and animals owned for investment purposes. In general, an item may be considered an item of unusual value if the item is not excluded as a household good or personal effect, and the equity value of the item is greater than $500. **Household Goods and Personal Effects** Household good and personal effects are excluded from countable resources. Household goods are items of personal property, found in or near the home, which the individual uses on a regular basis. The individual needs household goods for maintenance, use and occupancy of the premises as a home. Examples of household goods include: furniture, appliances and electronic equipment. Personal Effects are items of personal property ordinarily worn or carried by the individual, or items that have an intimate relation to

		the individual. Examples of personal goods include: personal jewelry, personal care items and clothing, pets, educational or recreational items and items of cultural or religious significance to the individual. Items required because of an individual's physical or mental impairment, such as prosthetic devices or wheelchairs, are also personal effects.
Life Estates	Resource Type	**1. General Rule** A life estate is property right with a duration limited to the life of the party holding it or to the life of some other party. The holder of a life estate does not have title to the property and cannot sell the property. However, the holder of a life estate can sell his interest in the property, unless restricted by the terms of the contract, and is entitled to any income from the property. The income is deemed available to the holder, regardless of whether she actually receives the income. Upon the death of the owner of a life estate, full title and ownership usually passes to the individual named in the will or deed as entitled to the property. Property in which an individual holds a life estate is subject to the same exclusion rules as property the individual owns by title. **2. Life Estate Exceptions** • A life estate will be excluded as the home when the property meets the homestead exemption. • If the property is used in the passive production of income, the life estate is subject to the Rate of Return test. See Income-Producing. • A life estate will be excluded when ownership is necessary for the production of earned income. See the *Business or Self-Employment* resource characteristic. • The terms of the life estate contract prevent the holder from selling his interest in the property.

3. Countable Value

If the life estate is not excluded based on the criteria above, the entire value of the life estate is a countable resource. The life estate value is determined by multiplying the Fair Market Value (FMV) of the property by the percentage listed in the "*Life Estate Interest Table*" for the age of the individual on whose lifetime the life estate is based.

If more than one person owns the life estate, the value is based on the owner with the longest life expectancy.

4. Purchase of a Life Estate under Transfer of Asset Rules

When an individual purchases or receives as compensation in a transaction a life estate in another individual's home, the purchase of the life estate is considered an asset transfer subject to penalty, unless the individual then lives in the home for a period of at least one year after receiving the life estate.

If the individual does live in the home for a period of one year after receiving or purchasing the life estate, the amount of the transfer is the entire amount used to purchase the life estate.

If an individual purchases a life estate in another individual's home and then does live there for one year after the purchase, the life estate is an excluded resource while being used as the individual's (or the individual's spouse's home). However, if payment for a life estate exceeds the FMV of the life estate as calculated below, the difference between the amount paid and the FMV should be treated as an asset transfer. In addition, if an individual makes a gift or transfer of a life estate interest, the value of the life estate should be treated as a transfer of assets.

a. **Calculation:** See the "*Life Estate Interest Table*" https://secure.ssa.gov/poms.nsf/lnx/0501140120.

- Multiply the FMV of the property by the life estate factor that corresponds to the age of the individual at the time

		the life estate was established. The result is the life estate value at the time of the asset transfer. • Determine the amount of the uncompensated asset transfer by subtracting the life estate value from the FMV. • Use the uncompensated asset transfer value to determine the asset transfer penalty period. **b. Example** *Mrs. Jones, age 70, owns a house with a small farm attached to it, worth $100,000 in total. She deeds the house and farm to her son but retains a life estate in the property. Under the terms of the life estate, Mrs. Jones is entitled to live in the house for the rest of her life and to any produce, income, etc. generated by the farm. To determine the value of Mrs. Jones' life estate, the Current Market Value (CMV) of the property ($100,000) is multiplied by the life estate factor corresponding to her age in the table (0.60522), resulting in a life estate value of $60,522. The penalty is assessed for the difference between the value of the asset transferred ($100,000) and the value of the life estate ($60,522), or a penalty based on $39,478 of assets transferred for less than FMV.*
Life Insurance	Resource Type	Life insurance is determined countable or excluded based on the type of life insurance owned by the individual and/or its intended use. **1. Definitions** **Insured**: The individual upon whose life insurance is effected. **Beneficiary**: The individual, entity or organization named in the contract to receive the policy's proceeds upon the death of the insured. **Owner:** The individual who has the right to change the policy and is typically the person who pays the premiums. **Face Value (FV):** The amount that is contracted for at the time the life insurance policy is purchased (the amount to be paid out

when the insured dies). The FV does not include any dividend additions or additional amounts paid in the event of an accidental death or other special provision.

Cash Surrender Value (CSV): The amount, which increases with the age of the policy, the insurer will pay upon cancellation or surrender of the policy before the death of the insured or maturity date of the policy.

Dividends: Any interest paid by the insurance company to its policy holders. If dividends are paid, they may be paid directly to the owner, added to the CSV of the policy, or to purchase additional coverage.

2. Types of Life Insurance

There are two groups of life insurance policies: those that accrue a CSV and those that do not. Count only the CSVs of the types of life insurance policies that accrue a CSV.

Life Insurance with a CSV

Whole life insurance is a contract for which the insured pays premiums during his lifetime or up to age 100 and the insurer pays the FV of the policy to the beneficiary upon the death of the insured. The net CSV of whole life insurance is countable.

A limited payment policy is a contract for which the insured makes payments for a specific number of years rather than for his whole life. The insurer pays the FV of the policy to the beneficiary upon the death of the insured. The net CSV of limited payment life insurance is countable.

An endowment policy is a contract that promises payment of the FV of the policy either upon the death of the insured or within a specific period of time. The net CSV of an endowment policy is countable.

Life Insurance without a CSV

Term life insurance is a type of contract for which the insured receives temporary protection (for a specific period of time) or limited protection through a steadily decreasing FV. Term life insurance is excluded.

3. Life Insurance Limit

Exclude the CSV of all countable life insurance policies the individual owns if the total FV of those policies is equal to or less than $1,500. Exclude the CSV of all countable life insurance policies owned by each of the individual's Financially Responsible Relatives FRR(s) if the total FV of the policies owned by the FRR is less than $1,500.

Note: This exclusion of $1,500 may only be applied if no other funds have been excluded under the burial reserve provision. If the individual has a burial contract or burial trust, then the $1,500 burial reserve allowance is first reduced by the value of the burial contract or trust.

4. Countable Value

The total net CSV of life insurance policies owned by the individual is a countable resource if the total FV of those policies is greater than $1,500. The net value is equal to the total CSV less the amount of any outstanding loans made against the policy.

Count only the CSV of policies available to the individual. The CSV may be unavailable to the individual for the following reasons:

- The consent of the co-owner is required to surrender a policy for its CSV, the co-owner's consent cannot be secured, and he is someone other than the individual's FRR.

- When a policy has been assigned to another individual, that person's consent for surrender is required. If that person declines to consent, exclude the policy as an unavailable resource. If the individual is applying for long term care benefits and the assignment occurred within the look back period, examine the assignment under the *Transfer of Assets and Penalty Periods* policy.

5. Ownership

The owner of the policy is the person who has the right to change the policy. This is typically the same individual who pays the premiums. The owner of a life insurance policy is usually the insured individual and ownership can be verified by seeing the policy or written correspondence with the insurance company or the individual's insurance agent.

If the person alleges ownership of policies for which he is not the insured, verify ownership by determining whether the individual is listed on the policy or through written correspondence with the insurer or the individual's insurance agent.

6. Establishing Value

Consult the table of CSVs on the policy itself. The tables usually indicate CSV at one to five year intervals from the date the policy was issued. Use the CSV from the chart in determining the countable value of the policy unless the individual can provide written verification from the insurer of a lesser value. Document Case Notes if a lesser value is determined.

If the CSV table is not available, or the life insurance policy is paid up, the only acceptable verification of value is written correspondence from the insurer.

Verification of the following information must be obtained from the insurer or insurance agency:

- Full name of policy owner;
- Policy number;
- Status of policy;
- Date the policy was issued;
- FV;
- Paid-up cash value (if applicable);
- Amount of any outstanding loans;
- Current CSV; and
- Authorization to release information obtained by applicant or responsible party.

If verification cannot be provided in a timely manner, the Estimated CSV Method is used to estimate the life insurance policy's CSV.

Estimated CSV Method:

Use the following method to estimate the net CSV, unless it appears that dividends have been added to the basic CSV of the policy or the individual alleges that the policy is encumbered. If either of these conditions exist, accept only written verification of the CSV.

Estimated CSV Calculation:

- Determine the number of years the policy has been in effect.

- Consult the table entitled Presumed Valuation Table below to obtain the percentage amount that corresponds to the number of years in effect.

- Multiply the percentage amount by the life insurance policy's FV.

- The result is the Estimated CSV for the policy.

  Note: If the estimated value is used and later verification is received that the actual amount is greater, there is no penalty for using the estimated value for the time it took to secure verification.

PRESUMED VALUATION TABLE

Years in Effect	Percentage of FV
20 or more	60%
15 – 19	50%
11 – 14	45%
6 –10	30%
4 – 5	20%
3	10 %
2	5%
1	0%

		7. Additional Life Insurance Topics **Encumbered or Lapsed Policies** Secure written verification from the insurance company or the individual's insurance agent for any life insurance policies that are either encumbered, i.e. the owner has borrowed against the CSV, or the policy lapsed when the owner stopped paying premiums. **Accelerated Life Insurance Payments** A life insurance company, or a privately owned business, may offer to pay the owner of a life insurance policy money that would normally go only to the named beneficiary after the insurer's death. Accelerated payments usually provide payments to cover costs related to long term care, a catastrophic illness or a terminal illness. Payments may be received in a lump sum or monthly amounts. Accelerated payment plans involve early payout of some or most of the proceeds of the policy to the insured. Accelerated payments are income in the month received, and a resource if retained into the following month. The receipt of an accelerated payment is not treated as a conversion of a resource. Accelerated payments are not considered benefits for the purpose of the eligibility requirement to apply for other benefits. Therefore, an individual is not required to file for accelerated payments as a condition of eligibility.
Livestock	Resource Type	The value of livestock necessary for self-employment, as a tool of the trade, or raised for home/personal consumption is an excluded resource. Income received is countable as self-employment income. Livestock that is used as non-business income-producing property is countable, and subject to the policy provided under the *Income-Producing* resource characteristic.
Oil and Mineral Rights	Resource Type	Oil and mineral rights may be included with land ownership or owned separately. If surface rights of the same property are excluded (for example, as a home) so are oil and mineral rights. Oil and mineral rights are countable when owned for personal use, or when

		the surface rights of the same property are countable (non-homestead, real property). Obtain verification of oil and/or mineral rights. Acceptable verifications are deeds, lease agreements, titles and homestead documents. If oil or mineral rights are producing income under a lease agreement, the owner may be constrained from selling or otherwise disposing of those rights. If the land is already excluded, the oil and mineral rights are excluded. If oil or mineral rights are producing income to the individual, and she is not actively engaged in the production of income, the equity value of the rights is subject to the Rate or Return test. See the *Income-Producing* resource characteristic.
Patient Trust Account	Resource Type	Countable. A patient trust account is a bank account set up by the nursing home for the convenience of the resident. An enrollee may deposit her Personal Needs Allowance (PNA) into the account, as well as other funds the enrollee receives, such as irregular or infrequent income or sheltered workshop earnings. This type of account is not a trust fund subject to trust fund policy. A patient trust account is typically an interest-bearing checking account. However, a Nursing Facility (NF) holding a patient trust account with a balance of $50 or less is not required to pay interest on the account. Any earned interest on the account belongs to the patient/enrollee. The balance of the account at the time of application and redetermination is the countable amount. Verify the balance with the facility at every application, reapplication and redetermination. Document the contact with the facility and include the patient trust account number, date of contact, name of contact and the value of the trust account in Case Notes. If the amount in the account reaches $200 less than the SSI resource limit, the NF is required to notify the enrollee that if the amount reaches the SSI resource limit, he may lose Medicaid eligibility.
Personal	Resource Characteristic	A personal resource is typically for the use of the individual and his family. A personal resource is typically countable, unless excluded based on the terms of the resource.

Personal Consumption	Resource Characteristic	Up to $6,000 of the equity value of non-business property used to produce goods or services essential to daily activities is excluded from resources. Any portion of the property's equity value in excess of $6,000 is not excluded under this provision. Non-business property used for personal consumption can be real or personal property. It produces goods or services essential to daily activities if it is used, for example, to: • Grow produce or livestock solely for personal consumption in the individual's household; or • Perform activities essential to the production of food solely for home consumption. Note: This does not include any vehicle that is used for transportation. The property must be in current use or, if it is not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will resume.
Plan to Achieve Self Support (PASS)	Resource Characteristic	PASS is an SSI provision to help individuals with disabilities return to work. Any income an SSI recipient places in an approved PASS account is excluded as a resource. The PASS account itself is also excluded. This exclusion expires when the PASS contract expires or ends, or when the individual is no longer an SSI recipient.
Prepayment of Rent	Resource Type	Prepayment of an individual's mortgage is not considered a resource. Prepayment of rent, however, will be a countable resource unless the individual cannot receive the money back under any circumstances (i.e., the lease agreement includes a no refund policy, or the landlord provides a statement that the funds will not be returned to the renter).
Prepayment of Nursing Home Care	Resource Type	This resource type is only available to individuals who have entered Title XIX Long-Term Care Facilities (LTCFs). **1. Defined** Prepayment for care deposited by the individual upon admission to a TennCare Medicaid-participatingLTCF. The value of the deposit is a countable resource for the individual who is

subsequently approved for TennCare Medicaid benefits if the deposit was paid from the individual's own funds.

2. Deposit Policy

An LTCF may require a deposit or prepayment for the first month's care upon admission. Federal Medicaid regulations provide for certain restrictions regarding these deposits based on the individual's TennCare Medicaid eligibility status:

- Deposits for the currently eligible individual are limited to the amount of her patient liability. The facility may not require the full amount of a month's cost of care and may not require any deposit as a condition of admission.

- The facility may require a deposit of any amount not to exceed whatever the facility "normally requires of all admitted patients" from any individual ineligible for TennCare Medicaid benefits at admission, including individuals applying for TennCare Medicaid. If the individual is subsequently approved for benefits, the facility must refund that portion of the deposit that was not used to pay for the individual's care, i.e. the amount paid by the TennCare Medicaid program. A refund is made after the facility is notified of the individual's TennCare Medicaid approval.

3. Refund as a Countable Resource

The individual who paid a deposit upon admission to an LTCF and who is subsequently approved for TennCare Medicaid is eligible for a refund of the deposit (in whole or in part) from the facility.

The amount of the anticipated refund is a countable resource during the first month for which the individual has applied for TennCare Medicaid coverage, if the deposit was paid from the individual's own funds. Refunds of deposits paid from the funds of someone else other than the individual and/or her FRRs are not a countable resource.

		Use the following procedure to determine the amount of the deposit that is a countable resource: • Determine the total amount of the deposit and from whose funds it was paid. • Subtract the amount of the individual's patient liability effective the first month of her eligibility for TennCare Medicaid/CHOICES from the total deposit paid. • The result is the amount of the anticipated refund and part of the individual's countable resources for the first month in which the individual has applied for TennCare Medicaid. Use the following procedure to determine the individual's resource eligibility when part of or her countable resources is an anticipated deposit for prepaid institutional care: • Add the amount of the anticipated refund from the deposit to the rest of the individual's countable resources beginning with the first month for which the individual requested coverage. • If the amount of the individual's resources, including the anticipated refund, exceeds the resource reserve limit throughout the month, she is ineligible due to excess resources effective the first month for which coverage is requested. Assume the entire amount of the anticipated refund will be retained by the facility to cover the cost of care for the first month for which the individual requested TennCare Medicaid benefits and was determined to be resource ineligible. Beginning the first day of the following month, the anticipated refund is no longer a countable resource. • If the total amount of the individual's countable resources is within the appropriate resource limit, he is resource eligible. Do not verify or budget the refund as income in the month the individual actually receives it, because it has already been counted as an available resource. Beginning the month following the month in

		which the individual actually receives the refund, the value of the refund is considered a countable resource if retained. The value of the refund of a prepayment of institutional care belongs to the individual who paid the deposit. The facility can verify who paid the deposit upon the individual's admission. Resolve any discrepancies by requesting the individual or responsible party provide some verification of payment. Verify the full value of the deposit with the admitting facility or other verification of payment provided by the individual. Calculate the value of the anticipated refund of the item. The resultant amount is the value of the prepaid institutional care. It is not necessary to verify the actual amount of the refund.
Proceeds from the Sale of a Home	Resource Characteristic	The proceeds from the sale of a home are excluded to the extent that the funds are intended to be used to purchase another home subject to the homestead exclusion, and the funds are used for such a purpose within 3 months of the date of receipt of the proceeds.
Promissory Note and other Loans	Resource Type	**1. Promissory Notes: Personal Use** A promissory note or other loan given by the household is considered personal property and is countable, unless the note or loan balance is inaccessible or the promissory note is held for reasons other than personal use. The lender holds legal interest and has the legal ability to make available his share in the note or loan. The equity value of the note or loan is countable. **2. Promissory Notes and Transfer of Asset Policy** If a household makes a loan that is considered inaccessible, or is shown to have a significantly lower market value than the unpaid balance of the loan, the loan will be considered to be an uncompensated transfer of assets. The uncompensated asset transfer will be considered to be the outstanding balance due on the loan as of the date of the lender's application for LTSS (nursing facility or HCBS services). In addition, the Deficit Reduction Act of 2005 (DRA) provides that funds used to purchase a promissory note, loan or mortgage

		must meet the following criteria or the purchase will be treated as a transfer of assets for less than Fair Market Value (FMV): • The repayment term must be actuarially sound; • Payments must be made in equal amounts during the term of the loan with no deferral payment and no balloon payments; and • The promissory note, loan or mortgage must prohibit the cancellation of the balance upon the death of the lender. The actuarial standards used are those determined by the SSA. See the *"SSA Period Life Expectancy Table"* http://www.ssa.gov/oact/STATS/table4c6.html . If the above criteria are not met, the purchase of the promissory note or loan must be treated as a transfer of assets. The amount used to calculate a penalty will be the outstanding balance of the loan due as the date of application for TennCare Medicaid. **Promissory Notes: Other Uses** Promissory notes that are made for purposes other than personal use are treated according to their use. Promissory notes may be made for the following purposes: • Burial; • Business or Self-Employment; and • Proceeds from the Sale of a Home.
Prorated as Income	Resource Characteristic	A resource that has been prorated as income is an excluded resource. **Example:** Farmer Jones sells his crop in September for $12,000. The money from the sale is intended to support his family for a year. The $12,000 is prorated as income, $1,000 a month. The $12,000 is excluded as a resource.
Real Property	Resource Type	Real property is any building and/or land, improved or unimproved, including recreational, residential and/or commercial property.

1. Countable Value

The equity value in all real property the individual owns individually or jointly is a countable asset with the following exceptions:

- Property excluded as homestead;
- The inaccessible equity value of real property;
- Equity value of income producing property (subject to the Rate of Return test); and
- Real property necessary for the production of earned income (see the *Business or Self-Employment* resource characteristic).

2. Ownership by Title

a. Ownership Types

Sole Ownership: Individual is the only person who owns the property and its sale or transfer is not subject to the approval of others.

Tenancy-in-Common: Each owner has an undivided interest in the whole property and can sell his own interest without the consent of the other owner(s). Upon the individual owner's death, his share passes directly to his heir(s).

Joint Tenancy: Each owner holds an individual interest in the whole property and can sell her interest at any time without the consent of the other owner(s). If specifically stated in the deed, the interest of one owner upon her death will automatically pass to the other owner. This is the "right of survivorship."

Tenancy by the Entirety: This form of ownership can exist only between individuals validly married to each other. Any real property held jointly between a husband and wife is held as "tenants by the entirety" unless the deed explicitly states otherwise. The owners are treated as if they were one entity, requiring the consent of both owners before any interest can be sold. Upon the death of one owner, his interest passes directly to the other owner.

b. Verification

Verify ownership by accepting the individual's sworn statement as to property ownership, a copy of the deed or other public record AND telephone or personal contact with the county Register of Deeds who can verify ownership information.

3. Establishing Value

The countable value of real property is equal to the individual's equity value in it. The equity value is equal to the Total Market Appraisal, as known as the real value or Fair Market Value (FMV), of the property less any encumbrances, liens or other legal claims.

a. Total Market Appraisal

Total Market Appraisal is determined using the property's assessed value, which can be easily verified. Assessed value is expressed as a percentage of Total Market Appraisal and in Tennessee the ratios are in the chart below.

Type of Property	**Assessed Value: Real Value**
Farm/Residential	25%
Commercial/Industrial	40%

Use the following formula to determine a property's real value:

Farm/Residential: Assessed Value x 4.0 = Real Value
Commercial/Industrial: Assessed Value x 2.5 = Real Value

b. Assessed Value

Determine and verify the assessed value by reviewing a recent tax assessment notice, contact with the county assessor's office, or written documentation of assessed/real value from the agency responsible for property assessment in another state, if appropriate.

The individual has the right to rebut the assessed value. She must provide a written appraisal from a knowledgeable and disinterested source, such as a licensed real estate agent, or an appraiser for the Veterans Affairs (VA) or Federal Housing Administration (FHA) that substantiates the claim. If the property value is redetermined in this way, the individual must have the opportunity to present a current alternated valuation at every reapplication or redetermination.

c. Equity Value

To determine the individual's equity value in real property, subtract the following from the Total Market Appraisal:

- The unpaid mortgage principal, excluding interest;
- The value of any legal lien or claim filed against the property; and
- The amount of any unpaid taxes, excluding current taxes.

The remainder is the equity value and is a countable resource.

4. Descent of Homestead/Right to Elective Share (TCA 31-4-101)

The surviving spouse of an intestate (without a will) decedent who elects against taking an intestate share, or a surviving spouse who elects against a decedent's will, has the right of election, unless limited by subsection (c) of this same title, to take an elective share amount equal to the value of the decedent's net estate as defined in subsection (b) of this title. The elective share is determined by the length of time the surviving spouse and the decedent were married to each other.

Share of Surviving Spouse and Heirs (TCA 31-2-104)

The intestate share of the surviving spouse is:

- If there are no surviving descendants of the decedent, the entire intestate estate; or

- If there are surviving heirs of the descendants, either one-third or a child share's of the entire intestate estate, whichever is greater.

5. Ownership Interest in Unprobated Estate

An individual may inherit an interest in property which he may sell or transfer even though the estate is still in probate, i.e. the inheritance has not been legally distributed.

Ownership interest in an unprobated estate is substantiated by the will which granted the individual her interest:

- Deceased died Testate (with a will): Review a copy of the will or request that the individual provide a written statement from her attorney itemizing the property in which the individual has an interest. Value each item as is appropriate for its classification, i.e. real estate, personal property, vehicle, etc. The value is a countable resource unless the individual alleges it to be inaccessible and it is determined the availability of the asset provisions apply.

- Deceased died intestate (without a will): Collect the following information and submit it to the TennCare Eligibility Policy Unit with a request for assistance in determining the value and availability of the individual's interest in unprobated property:

    - Copies of deeds or titles to all properties owned by the deceased;
    - Description of other items owned by the deceased, e.g. motor vehicles;
    - The individual's relationship to the deceased;
    - The date of the deceased's death; and
    - The number of surviving relatives and their relationship to the deceased.

Qualified Tuition Savings Plan (529 Plans)	Resource Type	A Qualified Tuition Savings Plan, also known as a 529 plan, is a special savings plan operated by a state or educational institute. A 529 plan is intended to make it easier for an individual to save money for higher education. A 529 plan acts like a savings account, from which the account owner can withdraw funds at any time. The funds in a 529 plan are a countable resource to the individual who owns the account, minus any early withdrawal penalties. Funds distributed to a beneficiary and used or set aside for educational expenses are excluded as income in the month of receipt, and if retained into the month following the month of receipt, excluded for 9 months as a resource.
Retirement Accounts and Pension Funds	Resource Type	Retirement accounts and pension funds are work-related plans established for providing income when an individual retires. **General Rule** Retirement accounts and pension funds owned by an individual are resources if the individual has the option of withdrawing funds in a lump sum. The value of a retirement account or pension fund is the amount of money the individual can currently withdraw less any early withdrawal penalty. Retirement accounts and pension funds are excluded: • if termination of employment is necessary to access the funds; and • excluded from deeming, if owned by an ineligible spouse or an ineligible parent (non-institutional categories). Note: Retirement accounts and pension funds owned by a community spouse are considered in the resource assessment and in determining the institutionalized spouse's eligibility for Institutional Medicaid. When a retirement account or pension fund is an individual's resource, distributions and systematic withdrawals are not income, but are resources that have changed from one form to another.

Types of Retirement Plans

Retirement plans may be established by an employer for the benefit of employees or set up through a financial institution for the benefit of an individual. Qualified plans are employer-sponsored plans that qualify for tax-favored treatment because they meet the requirements of the Internal Revenue Code. There are two basic types of qualified plans: defined benefit plans and defined contribution plans.

Defined Benefit Plans

Defined benefit plans promise a participant a specified monthly benefit at retirement, often based on salary, age and length of employment. A traditional pension is the most common type of defined benefit plan. Generally, pension funds cannot be accessed until a participant retires or attains the normal or early retirement age specified in the plan, at which time the participant has the option to receive the funds in either a single lump sum or in periodic payments. Even after an individual is eligible to receive funds in a lump sum, pension funds are not counted as resources if the individual is eligible for periodic payments that could begin immediately.

Some defined benefit plans may allow a participant to choose more than one form of benefit. For example, an individual may receive a portion of the accrued benefit in periodic payments, but may also have the option of withdrawing a portion in a lump sum. If a defined benefit plan provides this option, each portion of the accrued benefit is treated separately. Any amount that can be withdrawn in a lump sum is counted as a resource. If periodic payments are received, the payments also count as unearned income in the month received.

Individuals eligible for periodic benefits must take all necessary steps to obtain any benefits to which they are entitled, unless they can show good cause for not doing so.

Defined Contribution Plans

Defined contribution plans do not promise a specific amount of benefits at retirement. An employee and an employer make contributions to the employee’s individual account under the plan. Typically, funds within a defined contribution plan can be accessed at age 59 ½ without a tax penalty, or before age 59 ½, with a tax penalty. Other withdrawal restrictions may apply depending on the

		plan. Examples of defined contribution plans include 401(k) plans, 403(b) plans, and Keogh plans. **401(k) and 403(b) Plans** Funds held in a 401(k) or 403(b) retirement account are countable when an individual is no longer job-attached or, if part of a profit-sharing plan or stock bonus plan, when an individual has attained age 59 ½. Funds for a Savings Incentive Match Plan for Employees (SIMPLE) account may be held in a 401(k). Funds in a SIMPLE plan set up as a 401(k) should be treated as a 401(k). **Keogh Plan** A Keogh plan established for a self-employed individual is considered accessible and is counted as a resource to the individual even if the household is not actually accessing the funds. **Individual Retirement Account (IRA)** Funds held in an IRA, established for the benefit of an individual, are considered accessible. Count the equity value of an accessible IRA when determining eligibility. Funds in a SIMPLE plan or a Simplified Employee Pension (SEP) may be held in an IRA. Funds in an SEP or SIMPLE plan set up as an IRA should be treated as an IRA. An IRA held in the form of an annuity must be evaluated as an annuity. If the accessibility of a retirement account or pension fund cannot be determined, the summary plan description or a written statement from the plan administrator must be obtained. Retirement funds are considered nonliquid resources unless there is evidence to suggest otherwise (i.e., that they can be converted to cash in less than 20 days). As such, an individual with excess nonliquid resources, including retirement funds, who is otherwise Medicaid eligible, may qualify for conditional assistance while waiting for funds to become available if the individual agrees in writing to use the funds to repay the benefits he received during the conditional assistance period. Any excess funds remaining after the repayment

		are considered a resource. See the *ABD Conditional Assistance* policy for additional information regarding conditional assistance.
Savings Account	Resource Type	The value of a savings account is a countable resource. If the current month's income has been deposited into the account it must be excluded when determining the current value of the account. See the *ABD Treatment of Resources: Ownership, Equity Value & Accessibility* policy for treatment of jointly owned accounts. A savings account may be excluded if it is used for one of the following purposes: • Burial funds; • Business or Self-Employment; • Educational Income; • Individual Development Account; • PASS; • Proceeds from the Sale of a Home (subject to time limits); • Prorated as Income; • Settlement or Disaster Payment, if excluded by policy; and • SSI/SSA Retroactive Payment (subject to time limits). Note: Income tax refunds (including any advance payments), such as the Child Tax Credit, are excluded as a resource for a period of 12 months following receipt.
Settlement or Disaster Payment	Resource Characteristic	Payments or benefits provided under certain federal statutes are excluded. Excluded settlement and/or disaster payments include: • Agent Orange Settlement Payments; • Disaster Relief Assistance received under the Disaster Relief Act of 1974; • Distribution of perpetual judgment funds to Indian tribes under the following: o Indian Judgment Funds Distribution (P.L. 93-134); o Black Feet and Gros Ventre Tribes (P.L. 92-254); o Grand River Band of Ottawah Indiana in Indian Claims Commission Docket No. 40-K; o Tribes of groups under P.L. 93-134; o Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation (P.L. 94-433); and

		o Receipts from land held in trust by the Federal government and distributed to certain Indian tribes under P.L. 94-114. • Factor VIII or IX Concentrate Blood Products Litigation: Settlement payments made as a result of the class action lawsuit to hemophilia patients infected with HIV through blood plasma products; • Filipino Veterans Equity Compensation Fund Payments: Lump sum payments made to certain veterans and spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during WWII; • Japanese-American and Aleutian Restitution Payments; • Payments made to individuals because of their status as victims of Nazi persecutions; • Payments to children born of Vietnam veterans diagnosed with spina bifida; • Payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (state and local payments are only excluded for 9 months); • Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act; • Radiation Exposure Compensation Trust Fund; and State funds paid to crime victims (excluded for 9 months).
Social Security Account	Resource Type	Any amount retained in a Social Security Account after the month of receipt is a countable resource. A Social Security Account is a bank account that is set up to receive payments as a direct deposit from the SSA. Identify the portion of the account balance that represents income received in the current month. This amount will be subtracted from the account balance to determine the total countable value of the resource. Note: A Social Security Account is distinguished from a “my Social Security” account (an online account that an individual can create on the SSA website and use to access their Social Security information).
SSI/SSA Retroactive Payment	Resource Type	SSI retroactive payments are benefits issued in any month after the calendar month for which they are paid. SSA retroactive payments are benefits issued in any month that is more than a month after the calendar month for which they are paid.

		SSI/SSA retroactive payments are excluded for 9 months after the payment is received and counted after that 9 month exclusion period.
Stocks/Bonds	Resource Type	**Stocks** Countable. Shares of stock represent ownership in a corporation or business. For incorporation purposes, stock is assigned a "par value", but a stock's value as an asset is based on the market value. The market value of a stock is a countable asset. Accept the individual's attestation or a copy of the stock certificate, if available. The stock may be counted at a lower value than the market value of a stock if the individual can substantiate the lower value by providing written confirmation of the lower value from a local securities broker. **Bonds** Countable. A U.S. Savings Bond is a document issued by the government acknowledging that the money has been loaned to it and will be repaid to the owner with interest. The current value of a bond, which is its countable value, depends on the length of time elapsed since the date of issue and is subject to fluctuations in the interest rate. The name of the bond owner is printed on its face. Some bonds have conversion or "cash-in" restrictions. Consult a bank to determine the current value of a U.S. Savings Bond and document the date the contact was made, the name of the institution contacted and the quoted value in the Case Notes. **Mutual Funds** **1. Personal** Personal mutual fund shares are countable. A mutual fund is a company that buys and sells securities and other property. The Current Market Value (CMV) of the shares in the mutual fund owned by an individual is a countable asset unless the individual can establish a lesser value. Determine the CMV by consulting a stockbroker or newspaper to verify the closing price of the stock market for the date of application or redetermination. Document the case record with the following information: • Date contact was made or date of newspaper;

		• Name of individual or newspaper consulted; and • Price quoted. The individual can substantiate a lower value by presenting written confirmation of a lower price from a local securities broker. Accept written verification of ownership from the mutual fund company or by viewing the shares themselves. **2. Mutual fund shares owned for other purposes** Mutual fund shares held for purposes other than personal use are subject to different treatment. Mutual funds shares may be owned for the following purposes: • Burial; • Business or Self-Employment; • Educational Income; • Proceeds from the Sale of a Home; • Prorated as Income; or • Settlement or Disaster payment, if excluded by policy.
Tools of the Trade	Resource Characteristic	Excluded as essential for the production of earned income. Personal property required by the individual's employer for work is not counted regardless of the value while the individual is employed. An employer-employee relationship must exist between the owner of the resource and the employer that requires the individual to furnish a resource as a condition of employment. Examples of this type of personal property include tools, safety equipment, uniforms and similar items. Tools of the trade that are not in current use may retain their excluded status if the tools have been in use AND there are reasonable plans to resume use of the property within 12 months of the last use. The 12 month period may be extended for an additional 12 months, if it is in non-use due to a disability condition. Case Notes must include the date of last use, the reason(s) for non-use at the current time, and when the individual expects to resume the activity, if at all.

Trusts	Resource Type	A trust is any arrangement in which a grantor transfers real or personal property with the intention that it be held, managed or administered by a trustee(s) for the benefit of the grantor or other beneficiary(ies). A trust and the income generated by a trust will be counted or excluded based on the nature of the trust, the date the trust was created, the source of funds used to create the trust, and other factors. See the *ABD Trusts* policy.
Vehicle	Resource Type	**1. Vehicle Types** Vehicle includes cars, trucks, motorcycles, campers, motor homes, aircraft, snowmobiles, watercraft, boats and all-terrain vehicles (ATVs). **2. Determining Ownership** Accept the individual's sworn statement regarding motor vehicle ownership. If ownership is questionable, the following are acceptable verifications: • Vehicle registration; • Bill of sale; or • Title (individual named on title is the undisputed owner). **3. CMV** The CMV value of a vehicle is the average price that particular year, make, model and condition will sell for on the open market in the particular geographical area involved. Use the average loan value in a current National Automobile Dealers Association (NADA) Used Car Guide Book (or website) to establish the CMV of a car or truck. If the vehicle is not listed in the Guide Book, request estimates of the vehicle's market value from two reputable dealers. Use the higher estimate to value the vehicle and make note of both estimates in Case Notes. Contact a reputable dealer to obtain an estimate of the value of other types of vehicles, such as campers, motorcycles, etc. Document contact and estimate in Case Notes.

The individual can substantiate a lower value be submitting written statements of the vehicle’s value by from two reputable dealers.

4. **Equity Value**

The equity value of a vehicle is the price it can reasonably be expected to sell for on the open market in the particular geographic area involved less any encumbrances.

5. **Exclusion of One Vehicle Regardless of Value**

One vehicle of any of the types listed above is excluded regardless of its value if it’s used for transportation of the individual or a member of her household.

Assume that a vehicle is used for transportation, absent evidence to the contrary.

6. **Applying the Exclusion When Individual Owns More than One Vehicle**

When an individual owns more than one vehicle that is used for transportation of household members, apply the exclusion in the manner most advantageous to the individual. In general, the total exclusion will be applied to the vehicle with the greatest equity value.

7. **Countable Value**

The equity value of any vehicle, other than the one wholly excluded, is a resource when it:

a. Is owned by the individual or a deemed household member; and

b. It cannot be excluded under another provision, including:
- Home (only applicable to cars, trucks, campers and motor homes);
- Business or Self-Employment;
- Income-Producing;
- PASS; or

		• Tools of the Trade (only applicable to cars, trucks, campers and motorhomes and only one vehicle may be excluded).
Recreational Vehicles	Resource Type	Boats, motorcycles, snowmobiles, jet skis, ATVs and aircraft are generally considered recreational vehicles. The entire amount of the individual’s equity in this type of vehicle is a countable resource, unless the vehicle can be excluded under one of the vehicle exclusions listed above. Accept the individual’s attestation regarding ownership unless there is reason to question his statement. Request the appropriate type of legal documentation of ownership if ownership is questionable. Contact a reputable dealer familiar with the type of asset in question to determine the item’s market value. The individual may substantiate a lower market value than that determined by submitting written statements of the vehicle’s value by two reputable dealers.

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11.01.2016	3.	ABLE Accounts	2-3	Policy Change	AJ
11.01.2016	3.	Annuity	3-8	Policy Clarification	AJ
12.01.2016	3.	Homestead Exclusion	17-18	Policy Clarification	RS
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03.18.2019	3.	Legal Authority; Burial Plot and Space; Burial Trusts; Checking Account; Contract for Deed or	1-48	Non-Substantive Change	ME

		Mortgage; Life Insurance; Patient Trust Account; Savings Account; Settlement or Disaster Payment; Stocks/Bonds; Trusts			
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ABD CONDITIONAL ASSISTANCE

Legal Authority: 20 CFR 416.1240 – 20 CFR 416.1245; 42 CFR 435.601

1. Policy Statement

Conditional assistance may be available to an otherwise-eligible TennCare Medicaid applicant who has excess non-liquid resources. Conditional assistance is a contractual agreement allowing Medicaid eligibility based on the individual's agreement to make reasonable efforts to sell excess non-liquid resources at current market value (CMV). The applicant must also agree to repay TennCare for Medicaid costs during the conditional assistance period with proceeds of the sale of the excess non-liquid resources. An individual is allowed to receive one period of conditional assistance during a period of eligibility.

2. Eligibility Conditions

To be eligible for conditional assistance, an individual must:

a. Meet all non-financial eligibility criteria (be aged, blind or disabled);

b. Have liquid assets below the limit of $2,000.00;

Note: When applying conditional assistance to a nursing home or waiver case with a community spouse, deduct the spousal resource maintenance allowance first from the community spouse's own assets, then from the joint liquid assets, and finally from the joint non-liquid assets up to the total spousal resource maintenance allowance. Test the remaining liquid assets to limit of $2,000.00 for the institutionalized individual.

c. Have total countable resources which exceed the Medicaid resource standard; and

d. Agree in writing to sell excess non-liquid resources within the conditional assistance period.

All joint owners of a property must sign the *Agreement to Sell Property Form* in order for any joint owner to be considered for conditional assistance.

3. Non-Liquid Personal Resources

A non-liquid real or personal resource is a property which is not cash, and cannot be converted to cash within twenty (20) workdays.

The following resource types are eligible to be sold under a conditional assistance agreement:

- Real property;
- Life Estates;
- Items of Unusual Value;
- Livestock;
- Oil and Mineral Rights;
- Farm/Business/Other Equipment; and
- Vehicles.

4. Liquid Resources

A liquid resource is cash or any other form of resource which can be converted to cash within twenty (20) workdays.

The following resource types are considered to be liquid resources:

- Stocks, bonds, and mutual fund shares;
- Checking and savings accounts and time deposits;
- United States Savings Bonds and Treasury bills, notes and bonds:
- Mortgages and promissory notes; and
- Life insurance.

5. Eligibility Period

Conditional assistance may be allowed to eligible individuals for up to 3 months while attempting to dispose of excess personal property, and up to 9 months while attempting to dispose of excess real property. An extension of 3 months may be given for good cause of failure to dispose of personal property timely. There is no good cause extension for failure to dispose of real property within 9 months.

Good cause exists when circumstances beyond an individual's control prevent him from maintaining reasonable efforts to sell the property. Examples of good cause may include:

- Receiving no offer despite good faith effort to sell, or being prevented from good faith efforts for reasons beyond the individual's control;
- Reliance on a legitimate offer that doesn't result in a sale;
- Escrow begins, but closing doesn't happen within disposal period;
- Being homebound or hospitalized for a prolonged period due to illness or injury, and unable to arrange for someone else to sell the property; or
- Joint owner dies and probate delays efforts to sell.

Conditional benefits end the earliest of the following:

- The property is sold;
- Once it's determined continued reasonable efforts to sell the property ended without good cause;
- The individual requests in writing that conditional benefits end;
- The individual becomes resource eligible without the property exclusion; or
- The applicable conditional benefits eligibility period has ended.

The individual is required to sell all parcels of real property within one conditional assistance period. When eligibility is terminated, a new conditional benefits period is required.

6. Reasonable Efforts to Sell

Reasonable efforts to sell resources consist of taking all necessary steps to sell in the geographic area where the resource is located. Within thirty (30) days of signing a conditional assistance agreement, the individual must:

1. List the property with an agent; or
2. All of the following: begin continuously advertising in at least one of the appropriate local media; place a "For Sale" sign on the property in clear public view; begin conducting "open houses" or otherwise show the property to interested parties on a continuous basis; AND attempt any other methods of sale.

An individual who enters into a conditional assistance agreement must provide verification that she is making reasonable efforts to sell the property. Verification may include, but is not limited to: copy of contract with real estate agent; collateral contact; or copy of property advertisement in local media. Efforts to sell should not have gaps of more than one week. The individual may not reject any reasonable offers on the property. An offer for real property is assumed to be reasonable if it is at least two-thirds of CMV. The individual has the burden of proving that rejected offers over two-thirds of CMV are not reasonable.

7. Property Not Sold During Conditional Assistance Period

If property under a conditional assistance agreement is not sold during the conditional assistance period, the property will become an inaccessible resource at the end of the conditional assistance period. An individual may receive one period of conditional assistance during the eligibility period.

If the property is sold after the period of conditional assistance is over, Medicaid costs paid during the conditional assistance period will be recouped from the proceeds of the sale up to the total amount received from the sale. Any remainder will be subject to review of resource eligibility limits. Additionally, the sale will be reviewed under transfer of assets policy. See the *Transfer of Assets and Penalty Periods* policy.

8. Procedure

Conditional assistance is not provided automatically if an individual is over the resource limit. An Eligibility Specialist must manually review the case to determine if an offer of conditional assistance can be made. Follow the steps below to determine whether an offer of conditional assistance is permissible:

i. A completed application for TennCare Medicaid is submitted. Required verification is provided.

ii. The individual is not determined eligible for any TennCare Medicaid category.

iii. The Eligibility Specialist determines if the individual would be eligible for an ABD TennCare Medicaid category if the non-liquid real or personal property was not considered.

iv. If the individual would be eligible for an ABD TennCare Medicaid category if the non-liquid real or personal property was not considered, the Eligibility Specialist will offer conditional assistance to the individual. If the answer to iii. is no, the application will be denied.

v. The individual will complete the *Agreement to Sell Property Form*, ensuring signatures of all owners of the property, and return the form to HCFA.

vi. Upon receipt of the *Agreement to Sell Property Form*, the application will be approved.

9. Real Property

If real property is listed at the Total Market Appraisal (Fair Market Value), consider the value to be CMV. If real property is listed significantly below or above the Total Market Appraisal (Fair Market Value), obtain a statement from a knowledgeable and disinterested third party stating the value of the real property and why it should be considered current market value. If the individual is working with a real estate agent to sell the real property, obtain the statement from the individual's real estate agent. If the individual is selling the real property herself, request that the individual obtain a written statement from a third party real estate agent.

10. Recoupment

Individuals receiving conditional assistance are subject to the recoupment of Medicaid costs up to the net proceeds (total sale price – any costs/taxes/mortgage/lien) received from the sale of excess personal or real property. Only the Medicaid costs assumed during the period of conditional assistance are subject to recoupment.

The individual must continue making reasonable attempts to sell the property after the property becomes inaccessible due to the expiration of the conditional assistance period. If sold after the conditional assistance period ends, the recoupment amount is limited to the amount of Medicaid payments made during the conditional assistance period.

ABD TRUSTS

Legal Authority: Social Security Act § 1917(d); 42 USC 1396p(d); State Medicaid Manual § 3259; Tenn. Comp. R. & Regs. 1200-13-20-.06

1. Overview

A trust is a right of funds or property held by an individual (the trustee) for the benefit of another (the beneficiary) or for self-benefit. A trust is composed of the initial amount used to create the trust (the principal) and any income (usually interest) it may produce. The trustee holds legal title to the trust and manages it for the benefit or use of the beneficiary. Determine whether a trust is a countable or excluded resource when an Eligibility Determination Group (EDG) member is either the trust's trustee or beneficiary.

2. Definitions

Beneficiary: The person for whose benefit the trust is created.

Discretionary Trust: The trustee has discretion to use the trust for the beneficiary's needs as he deems appropriate. The beneficiary has no control over the trust.

Grantor/Trustor: The person who creates a trust, including a court or administrative body with legal authority to act in place of, on behalf of, or at the request or direction of the individual or spouse.

Grantor Trust: A trust in which the grantor of the trust is the sole beneficiary of the trust (i.e., the grantor establishes a trust for himself).

Legal Instrument or Device Similar to a Trust: Any financial instrument that resembles a trust which includes, but is not limited to: escrow accounts, pension funds, annuities, and other similar entities managed by an individual or entity with fiduciary responsibilities.

Mandatory Trust: Requires the trustee to pay to or for the beneficiary's benefit, the trust's earnings and/or principal at certain times in specified amounts or for a specified type of care. The trustee has no discretion on distribution from the trust.

Totten Trust: A tentative trust in which the grantor is trustee of her own funds for the benefit of another. The trustee or grantor can revoke the trust at any time. If the trustee dies before revoking the trust, the beneficiary becomes owner of the trust. The terms of the trust will indicate how the trust is to be used or what limits are in place for the use of the funds by the trustee.

Trustee: An individual who holds the legal title to funds for the benefit or use of another individual.

3. Accessibility

Trusts must be evaluated for accessibility. If a trust is accessible, and verification is received that only a portion of the trust is available to the individual, only the available portion will be considered in the resource determination. If such verification is not received, the full value of the trust will be considered available to each beneficiary.

a. Revocable Trust

A revocable trust is a trust or similar legal device, which can be modified or terminated by the grantor or someone else according to the terms of the trust. A trust may be considered revocable if proof is provided that it can only be modified or terminated by a court. An irrevocable trust which terminates if some action is taken by the grantor is considered a revocable trust.

For revocable trusts created prior to 8/11/1993, the full amount of the trust is a countable resource. Interest which accrues to the account is counted as unearned income. Withdrawals from the trust are not considered income, as they are a conversion of a resource.

Revocable trusts created on or after 8/11/1993 which was established by the individual, a spouse, or a person/entity with legal authority to act on behalf of, at the direction of or by request of the individual or spouse, and the trust contains an individual's assets (assets form part or all of the trust), the following policy applies:

i. The principal of the trust is considered an available resource for all TennCare Medicaid categories;
ii. Any payments from the trust to or for the benefit of the individual are considered income to the individual in all TennCare Medicaid categories; and
iii. Any other payments from the trust for any other purpose must be considered under the *Transfer of Assets and Penalty Periods* policy (institutionalized TennCare Medicaid categories only).

b. Irrevocable Trust

An irrevocable trust is a trust or similar device which the grantor cannot revoke or modify in any way or under any circumstances.

i. Irrevocable Trusts Created Prior to 8/11/1993 are Excluded as Resources if:

1. The trust is legally irrevocable;
2. The beneficiary is not a Financially Responsible Relative (FRR) or one for whom the individual is financially responsible; and
3. The individual does not have access to the funds, unless he is also a beneficiary.

Review the terms of an irrevocable account, the principal amount and the income generated by such trust at every redetermination.

ii. Irrevocable Trust and Similar Devices Established on or After 8/11/1993:

An irrevocable trust or similar device which contains an individual's own assets, forms all or part of the principal of a trust and is established (other than by will) by the individual or spouse, or by a person/entity with legal authority to act on behalf of or at the direction of the individual or spouse is subject to the policy outlined below. This policy applies to that portion of the trust which includes the assets of the individual regardless of the purpose of the trust, whether the trustees have or exercise any discretion under the trust, or any restrictions on distributions or the use of distributions:

1. Any payments from the trust paid to or for the benefit of the individual for any purpose are considered income to the individual, unless payment is made for medical care or other purposes in which it is not considered income under Supplemental Security Income (SSI) policy; and
2. Income on the corpus (principal) of the trust or any portion of corpus which could be paid to or for the benefit of the individual is considered an available resource to the individual.

iii. For Institutionalized Individuals, the Following Additional Policy Requirements Apply:

1. Any other payments from the trust for any other purpose will be considered a transfer of assets for individuals subject to the transfer of assets policy;
2. If any portion of the trust containing the individual's assets cannot be considered as income or a resource, it is considered a transfer of assets from the date the trust is established or payment to the individual is foreclosed:
3. The look-back period for trust transfers of assets is 60 months if no payment can be made to or for the benefit of the individual, or if payment is made for any other purpose than to or for the benefit of the individual; and
4. The corpus (principal) of the trust is the value of the transferred asset. Any additions to the irrevocable trust in which no payments can be made will be considered a transfer of assets at the point the addition is made.

c. Value of an Accessible Trust

If a trust is accessible, and verification is received that only a portion of the trust is available to the individual, only that portion will be considered in the resource determination. If such verification is not received, the full value of the trust will be considered available to each beneficiary.

4. Trust Types

a. Burial

A burial trust is a trust established by an individual for purposes of setting aside funds for payment of burial expenses for the individual or someone else (typically a spouse or family member). Burial trusts under this provision are not the same as funds held in trust by a funeral home in conjunction with a prepaid funeral agreement/burial contract.

All funds in a burial trust, established by an individual, including interest payments, are excluded if the value of the trust does not exceed $6,000 per individual. Interest payments and cost of transport which cause the trust value to exceed $6,000 are also excluded.

A burial trust, established by an individual, with funds in excess of $6,000 will be treated under the normal trust provisions.

The owner of the trust is the individual whose assets were used to create the trust. Verify ownership by securing a copy of the burial trust. The current value of the trust is the sum of the amount of the initial deposits, any subsequent deposits and accrued interest.

b. Testamentary Trust (Trust Created by a Will)

The countable value of a testamentary trust depends upon the terms of the will. The terms of the will may specify that only the income or both the income and principal are available to the beneficiary. In addition, the terms may specify that the beneficiary has limited access to the funds or that only the trustee and the court has access to the trust. The principal of the trust is a countable asset if it is accessible to the beneficiary.

If the trustee has the discretion to use the trust principal for the individual's support and maintenance or medical needs, the value of the trust is an unavailable asset, but the trust itself is a third party medical resource and must be reported to TennCare. Send a copy of the trust document and a brief written summary of the circumstances to the TennCare Third Party Liability Unit.

c. Living Trust

A living trust is usually a revocable, self-settled trust often created for tax and estate planning purposes. The principal of a living trust is a countable resource.

d. Self-Settled Trust

A self-settled trust is a trust created by a person with his own funds for his primary benefit. A self-settled trust is a countable resource.

e. Special Needs Trust

A Special Needs Trust is a trust:

i. Established for the sole benefit of a disabled individual (as defined by the Social Security Act) who is under age 65 by:

1. The disabled individual;
2. A parent;
3. A grandparent;
4. A legal guardian; or
5. The court.

ii. Established with assets of the disabled individual under age 65; and

iii. Provides that upon the death of the disabled individual, the State of Tennessee will receive all amounts remaining in the trust up to the total amount of medical assistance paid on behalf of the individual during her lifetime.

NOTE: This trust exclusion continues after the individual reaches age 65. However, the trust cannot be added to or otherwise augmented after the beneficiary reaches age 65.

Funds contained in a Special Needs Trust are excluded as resources. Income of a Special Needs Trust is not counted as income to the disabled individual (beneficiary of the trust) unless actually distributed in the form of cash or in-kind payments for food or shelter.

The Estate Recovery Unit must be notified of the existence of a Special Needs Trust, as well as when a TennCare Medicaid individual with a Special Needs Trust passes away. When the individual passes away, the closure notice will remind the family to contact the Estate Recovery Unit.

f. Pooled Trust

A pooled trust is a trust:

i. Established for the sole benefit of a disabled person (as defined by the Social Security Administration (SSA)) by:

1. The disabled individual;
2. A parent;
3. A grandparent;
4. A legal guardian; or
5. The court.

ii. Established with assets of the disabled individual;

iii. Established and managed by a non-profit association with a separate account maintained for each trust beneficiary, but multiple trust accounts are pooled for investment purposes and management of funds; and

iv. Provides that upon the death of the disabled individual, any amount remaining in the account that is not retained by the trust will be paid to TennCare, up to the total amount of medical assistance paid on behalf of the individual during his lifetime.

Pooled trust established or modified by individuals age 65 or older must be evaluated for a potential transfer of assets. See the *Transfer of Assets and Penalty Periods* policy.

g. Income-Producing Trusts (Applies to trusts created on or after 8/11/1993)

i. If a trust fund is producing regular income for the beneficiary and the terms of the trust specify that the beneficiary does not have access to the trust principal or income, that such access is limited to the trustee or court, and the trust does not contain any of the beneficiary's own assets, then the value of the trust is an excluded asset. Any payments the individual receives from the trust are considered unearned income.

ii. Dividends, interest, rents and other income generated by a trust fund, unless otherwise excluded, that can be paid to or for the benefit of the beneficiary are considered countable income to the beneficiary in the month they become available, regardless of whether the income is actually paid out to the beneficiary.

iii. Income earned by a trust that can be distributed, but is not distributed to the beneficiary and is instead retained in the trust becomes a countable resource to the beneficiary in the months following the month the income was available for distribution.

iv. Funds withdrawn from the principal of an inaccessible or excluded trust, unless otherwise excluded, are considered countable income in the month received.

v. Funds withdrawn from the principal of an accessible or countable trust fund are excluded as income because an accessible trust fund is a countable resource. Money cannot be considered as income and a resource in the same month.

vi. If an individual is receiving regular payments from an inaccessible trust fund, and the trustee has the discretion to use the trust principal for the beneficiary's support and maintenance or medical needs, the value of the trust is an unavailable asset, but the trust itself is a third party medical resource and must be reported to the TennCare Third Party Liability Unit.

h. Qualified Income Trust (QIT) or Miller Trust

A QIT is a trust that is created specifically for the purpose of becoming eligible for TennCare Long-Term Services and Supports (LTSS). For individuals seeking LTSS whose gross income is over the income limit, the state allows the individual to create a QIT into which he or she directs income. This may enable an individual to qualify financially for TennCare Medicaid.

i. QIT Defined

A QIT is a trust consisting of the individual's income. Any type of income may be directed into the QIT, although Social Security income and pension income are among the more common types. A QIT is created for the purpose of establishing income eligibility for TennCare Medicaid in order to receive Medicaid coverage when an individual is or soon will be confined to a nursing facility or Home and Community Based Services (HCBS) Waiver program.

ii. QIT Policy

Individuals applying for or receiving TennCare Medicaid LTSS, whose income is over the income limit, may still qualify for Medicaid coverage if some or all of his or her income is placed in a valid QIT. This applies to both individuals who are or who will be confined to a nursing facility or enrolled in an HCBS waiver. Individuals who are eligible to create a QIT must also meet all other TennCare Medicaid and CHOICES eligibility requirements.

Income placed in a valid QIT will be treated as unavailable in accordance with federal standards. For the QIT to be considered valid, the individual's gross monthly income must be above the income limit. Income that is not placed in the QIT must be at or below the income limit. If income not placed in the QIT is over the income limit, the individual is not financially eligible regardless of the income placed in the QIT. An individual whose income is placed in a QIT and who is subsequently found to be eligible for Medicaid will be considered eligible on the first day of the month in which eligibility is established, or the date of admission to the nursing home or HCBS program, whichever is later.

iii. Income Test

The amount of income placed in a QIT cannot be limited nor can it be counted when testing income against the income limit. However, it is used in determining patient liability during post-eligibility treatment of income. Income that is not placed in the QIT is tested against the income limit. If the individual's income that is not placed in a QIT is over the income limit, the individual is not income-eligible for TennCare Medicaid.

iv. Criteria for a Valid Trust

The Trust must be irrevocable and cannot be modified or amended in whole or in part by the grantor at any time. However, the trustee or a court of competent jurisdiction shall have the right and jurisdiction to modify any provision of the Trust to the extent necessary to maintain the eligibility of the grantor for medical assistance.

Each month the trustee shall distribute the entire amount of income transferred into the Trust except for an amount not to exceed $20, or another verified amount, for the expenses of the Trust.

The sole beneficiaries of the Trust are the individual for whose benefit the Trust is established and the State of Tennessee. The Trust terminates upon the death of the individual, or when the Trust is no longer required to establish TennCare Medicaid eligibility in the State of Tennessee, or if nursing facility care or HCBS is no longer medically necessary for the individual, or if the individual is no longer receiving such services.

The Trust must provide that upon the death of the individual or termination of the Trust, whichever occurs sooner, the State of Tennessee shall receive all amounts remaining in the Trust up to the total amount of medical assistance paid by the State on behalf of the individual.

Amounts remaining in the Trust that are owed to the state must be paid to TennCare within three months after the death of the individual or termination of the Trust, whichever is sooner, along with an accounting of the payments from the Trust. TennCare may grant an extension if a written request is submitted within two months of the termination of the Trust.

v. Allowable Monthly Payments for Long-Term Care Facilities

Allowable payments from the Trust include:

1. Personal Needs Allowance (PNA) the amount the individual is allowed to retain for his or her personal needs under Tennessee’s TennCare Medicaid policies. As of January 1, 2005, this amount is $50 for confinement in a nursing facility or ICF/MR and 300% of the SSI-FBR for HCBS enrollees and Self-Determination Waiver; and 200% for the Comprehensive Aggregate Cap (CAC) and Statewide Waivers;
2. A deduction not to exceed $20, or another verified amount, for expenses necessary for managing the trust (i.e. bank charges);
3. Community Spouse Income Maintenance Allowance/Dependent Income Maintenance Allowance (CSIMA/DIMA), if applicable;
4. Health Insurance Premiums – allowed when the individual has health insurance other than TennCare Medicaid (for example, Medicare premium or a Medicare supplement policy); and

5. **5.** Item D deductions - payment for types of medical or remedial care recognized under state law, but not covered as medical assistance under TennCare Medicaid.

vi. Payment for Nursing Facility Care, HCBS, and other TennCare Medicaid-Covered Services

Any available income not placed in the QIT and any Trust income remaining after allowable deductions are made shall be paid monthly to the facility by the individual or from the Trust in an amount not to exceed the Medicaid reimbursement rate. Any excess income not distributed from the Trust shall accumulate in the Trust monthly.

vii. Restrictions on Other Expenses

No other deductions or expenses may be paid from the Trust. Expenses which cannot be paid from the Trust, except as specifically provided herein include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past due medical bills, and other debts.

viii. Home and Community Based Services (HCBS)

For an individual with a valid Trust receiving HCBS, the following methodology will be used to determine the financial liability of the individual for the cost of care.

1. Determine the amount of the individual's gross monthly income. Based on federal regulations and guidance, all of the individual's income is counted, including the amount placed in the Trust.
2. Deduct the individual's Personal Needs Allowance (PNA). The PNA for HCBS is 300% of the SSI/FBR for HCBS enrollees and Self-Determination Waiver; and 200% for the Comprehensive Aggregate Cap (CAC) and Statewide Waivers.
3. A deduction not to exceed $20, or another verified amount, for trust expenses, i.e. bank charges is allowed.
4. A deduction may be made for spousal allocation, health insurance or any approved non-covered medical or remedial care expense (Item D). Approved non-covered services are listed in TennCare State Rules.
5. The remainder, after the above deductions, is the individual's financial liability amount.

5. Undue Hardship

An individual applying for or receiving TennCare Medicaid-reimbursed LTSS may request an undue hardship waiver if application of the trust provisions would work an undue hardship. We will consider the possibility of undue hardship if:

a. Counting an irrevocable trust as a resource would make the individual ineligible due to excess resources;

b. The trustee is prohibited from disbursing funds from the trust for the individual's support and maintenance due to the terms of the trust; and

c. Application of the trust provisions would deprive the individual of essential medical care such that his health or life would be endangered, or would deprive the individual of food, clothing, shelter, or other necessities of life.

Note: If the trust is revocable, the requirements for undue hardship are not met, because the individual can access the trust funds for his support and maintenance.

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12.02.2015	4.h.; 4.h.i.	Qualified Income Trust (QIT) or Miller Trust; QIT Defined	7	Policy Clarification	AF
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ABD INACCESSIBLE RESOURCES

Legal Authority: 20 CFR 416.120; 20 CFR 416.1245

1. Policy Statement

A resource may be considered inaccessible if:

- An individual cannot legally access the value of the resource beyond her control and, unless undue hardship exists, all legal avenues have been exhausted in order to access the value of the resource; or
- An individual is unable to sell an asset due to limited use rights, mental impairment or due to conditions of joint ownership; or
- The resource is jointly owned real property AND sale of the property would result in the joint owner being homeless; or
- An individual is unable to locate a buyer for the asset, the conditional assistance period has expired, and the individual continues reasonable to sell the property;
- The value is unavailable due to a lien against the asset; or
- The asset's value is not accessible to the individual due to litigation.

2. Limited Use Rights

If the individual has only limited use rights to a piece of real property such as lifetime occupancy or dower rights, he is not able to sell the property; however, he can sell his use rights.

Exclude the equity value due to inaccessibility in determining countable resources if the individual can demonstrate unsaleability by providing written statements from two licensed real estate agents substantiating that, in their professional opinion, the life estate (or other use rights arrangement) is unsaleable.

Note: Record in case notes the verbal statements of those in a position to know if they refuse to give a written statement or to sign a written statement.

3. Individual's Mental Impairment (applicable to non-liquid resources only)

a. General Rule

If the individual has a guardian, conservator, power of attorney or durable power of attorney at the time of application or renewal, the assets of the individual are considered available to the individual. That person is legally appointed to act on behalf of the individual and is expected to make the individual's assets available for use by or for the care of the individual.

If the individual's mental impairment precludes her negotiating the sale of an asset, and she has no guardian or conservator to act on her behalf, exclude the asset as unavailable under certain conditions. It is not necessary that the individual be adjudicated incompetent by a court of law. If, in the Eligibility Specialist's opinion or that of the responsible party or person in a position to know the facts of the individual's situation, the individual is mentally impaired, apply the provision of this policy.

b. Individual's Mental Impairment at Application

i. Temporary Exemption

Exclude the asset as unavailable for up to 3 months from approval date if the individual or the person applying on his behalf agrees to the following:

- Take steps to be appointed guardian or to contact the individual's friends and relatives regarding their willingness to serve as the individual's guardian/conservator;
- See that the individual who agrees to serve takes immediate steps toward appointment; AND
- To provide HCFA with substantial documentation of his action and that of the guardian designee.

If the individual or responsible party is unable to perform the above-cited tasks, he must provide the names and addresses of individuals who might be willing to serve as the individual's guardian. The HCFA Eligibility Specialist accepts the responsibility for contacting the named individuals in an effort to locate someone willing to act as guardian.

Contact each of the individuals by telephone or by mail explaining the situation and requesting their assistance in securing a guardianship for the individual for the purposes of making available assets which the applicant needs to meet his medical needs. Document the case thoroughly.

ii. Long-Term Exemption

An asset may continue to be considered unavailable beyond the initial 3 month period until the next renewal under the following conditions:

A. No guardian is found

If after 3 months, the efforts of the Eligibility Specialist and the person acting on the individual's behalf have failed to locate a potential guardian, document the case record establishing the asset's inaccessibility.

If the individual is otherwise eligible, continue assistance. Extend benefits if all of the following conditions are met:

- The individual requested benefits for that period;
- The same conditions regarding the disputed asset still exist; and
- The individual is otherwise eligible.

B. Potential Guardian is Found

Exclude the asset for an additional 30 days from the date the potential guardian agrees to serve to allow him to file a petition for guardianship with the court. If after 30 days the potential guardian has not initiated guardianship procedures for any reason, exclude the resource per instruction above under No Guardian is Found section.

If after 30 days, the potential guardian has begun appointment procedures, continue to exclude the asset as unavailable until the next renewal.

Set an expected change at regular intervals (every 60 to 90 days) to follow up on the situation and to determine the court's instructions regarding the asset.

Note: If it becomes necessary to delay action on an application in order to determine an asset's availability as described in this item, secure the applicant's written permission to hold the application pending beyond the processing time limits.

c. Individual's Mental Impairment at Renewal

i. Exclusion Previously Granted

If an asset has previously been excluded as unavailable as described in this item, at least 30 days before the renewal is due, secure current information to substantiate that the asset remains inaccessible because:

- A guardian has not been located; or
- Guardianship proceedings have begun but are not complete or the court has issued no instruction regarding the asset.

ii. Initial Exclusion

If the asset has not been previously excluded as inaccessible as described, but since the last renewal its equity value along with other countable assets results in the individual's ineligibility, and the individual cannot dispose of the asset due to his mental condition, do not continue to extend TennCare Medicaid benefits until the asset's inaccessibility has been substantiated as described above.

Take action to close the case observing the adequate and advance notice requirements. Once the asset's inaccessibility is verified and the individual has reapplied, benefits may be extended retroactively to the date of closure provided the individual is otherwise eligible.

4. Joint Ownership

a. General Rule

If an asset cannot be sold or converted due to the conditions of joint ownership, exclude the individual's equity value in determining resource eligibility. The individual's equity value in a jointly owned asset can be excluded under the following conditions:

- The resource is jointly owned with a person or persons who are not the individual's Financially Responsible Relative (i.e., spouse or parent); and
- The joint owner refuses to consent to the sale of the asset or to purchase the individual's interest.
- Even though the individual is free to sell his own individual interest in the property, he is unable to find a buyer.

Note: Any portion of real property owned through "tenancy-in-common" or "joint tenancy" arrangements is available to each owner for sale or transfer without the consent of the other (joint) owner(s).

b. Joint Ownership Policy at Initial Application

Do not extend TennCare Medicaid benefits until the asset's inaccessibility to the individual has been substantiated by the following:

- The co-owner(s) written refusal to consent to the sale of the asset and to purchase the individual's share, if applicable; or
- Substantiation (by deed or the written statement of a licensed real estate agent or an attorney) that the individual is unable to sell his interest in the asset without the consent of the co-owner(s) OR that his individual share is unsaleable.

Note: If it is necessary to hold the application pending beyond the processing time limits, secure the individual's written permission to do so.

c. Joint Ownership Policy at Redetermination

If the asset has not previously been excluded as described in this item, do not continue to extend benefits at review until the asset has been demonstrated to be unavailable as described above.

Take steps to close the case observing standard adequate and advance notice requirements. Once the asset's inaccessibility has been verified and the individual has reapplied, benefits may be extended retroactively to the date of closure provided the individual was otherwise eligible.

At least 30 days before the review is due, secure the joint owner's written statement regarding his position on the sale of the asset and the purchase of the individual's share, if applicable. Request that the individual present written substantiation of his inability to sell the asset as described above. Continue to exclude the value of the asset if the individual's claim of inaccessibility is supported by the joint owner's statement.

5. Ownership Interest in an Unprobated Estate

If the individual has inherited an interest in real property that is part of an estate still in probate, her interest is a countable asset because she can legally sell it. It may, however, be difficult to do so.

Exclude the value of the asset if the individual can demonstrate that he is unable to sell his interest by providing statements from two knowledgeable sources, e.g., an attorney or real estate agent, that his interest cannot be sold. The exclusion can be applied to the asset only while it remains in probate.

Extend benefits only after the inaccessibility of the asset is substantiated as described above. Secure the individual's written permission to hold the application pending beyond the processing time limits, if necessary. Do not continue to extend benefits until receipt of current verification that the asset is unavailable.

6. Inability to Locate a Buyer

a. Policy Statement

If the individual owns an asset for which he has full use rights and the unrestricted right to sell, and he is making reasonable efforts to sell the resource, but he is unable to locate a buyer, his equity value may be excluded as a countable resource. Before the property may be excluded, the individual must agree to a conditional assistance period (see *ABD Conditional Assistance* policy chapter). If the conditional assistance period expires without a sale, the property can be considered inaccessible. However, attempts to sell the property must continue.

b. Defined Terms

Offered for sale - means listing the property with a licensed real estate agent, advertising the property for sale using at least two alternate methods such as a sign on the property (real or personal) and a newspaper ad in a newspaper that serves the area where the property is located, or placing the property on auction.

Reasonable asking price - means a price that is not inflated, i.e., not in excess of 100% of the real value.

Legitimate offer - means one that is at least equal to the reasonable asking price, does not require the individual to extend credit, and does not result in a net loss to the individual. No reasonable offer to buy may be refused by the individual or his/her authorized representative.

Mortgage or Promissory Note - A reasonable effort to sell a mortgage or Promissory note exists when all the following conditions are met:

- The individual has made an effort to offer the instrument to a bank or other financial institution; AND
- The best offer he received is more than 10% below the actual value of the remaining principal; AND
- The individual presents written verification from the representative of at least two financial institutions that the mortgage or note could only be sold if discounted by more than 10%.

c. Policy Implementation-At Application

i. Initial Exclusion-Conditional Assistance

Once property is exempt under the provisions of this policy, it must remain on the market at a reasonable asking price until it is sold OR the individual is no longer eligible for and a recipient of TennCare Medicaid benefits.

ii. Mortgage or Promissory Note

Before excluding the value of a mortgage or promissory note, entered into on or after February 8, 2006, the repayment terms must be actuarially sound. The actuarial standards to be applied are those determined by the Office of the Chief Actuary of the Social Security Administration (SSA, the table called the Period Life Table can be found on Sosa's Actuarial Publications Standard Table and can be assessed at (http//:www.ssa.gov/OACT/STATS/table4c6.html). The agreement must provide for payments to be made in equal amounts during the term of the loan and with no deferral or balloon payments. It must prohibit the cancellation of the balance upon the death of the lender. If the required criteria are not met, the purchase of the promissory note, loan or mortgage's outstanding balance that is owed at the time of application must be treated as a transfer of assets.

EXAMPLE: Ms. Jones made an application for nursing home Medicaid on November 8, 2006. She sold her home to her daughter that same day, for $80,000. Her daughter agrees to pay $100 per month for 19 years and 11 months with a balloon payment in the last month of the term loan. Their agreement was notarized by a notary republic. Because this loan was not actuarially sound and had a balloon payment on the end, this loan must be treated as a transfer of asset.

Exclude the value of the mortgage or note effective the date of application unless the individual can establish that the same conditions existed in the retro period. On excluded notes, any payments made by the debtor towards the principle or interest are counted as unearned income to the individual in the month of receipt.

If a buyer cannot be found, before excluding the value of the loan or promissory note, the individual must provide written substantiation from two knowledgeable sources that the note could be sold only if discounted by more than 10%.

The importance of timely reporting any change of status regarding the sale of the property must be discussed and emphasized with the individual or his/her authorized representative. An Expected Change must be scheduled to review the progress of the sale no later than three months from the date the property is placed for sale or from the date of approval if the case continues to be active.

d. At Redetermination - Reasonable Efforts to Sell

i. Initial Exclusion

If the asset has not previously been excluded based on the offer and acceptance of a conditional assistance period, do not continue to extend benefits until such an offer and acceptance occurs (see *ABD Conditional Assistance* policy chapter). If the individual does not agree to the conditional assistance period, take steps to close the case observing standard adequate and advance notification procedures.

NOTE: Property cannot be exempt as homestead while it is being offered for sale. A property's exemption as homestead is voided by an attempt to sell it.

ii. Real Estate

Once the asset has been proven unavailable, exclude the individual's equity value in real estate effective the date it was placed for sale. This will allow any subsequent approval and include benefits retroactively to the date of closure. In order for the real property to continue in its exclusion status, it must remain on the market until it is sold or until the individual's case is closed.

iii. Mortgage

Exclude the value of a mortgage or note effective the date of the written verification or prior to that date if similar (documented) conditions existed, whichever is earlier.

iv. Asset Previously Excluded

At least 30 days before the redetermination is due, begin the review of asset availability. In order for property to retain its exclusion under the terms of this item, it must remain on the market until sold or the individual is no longer eligible. The individual must provide current verification of the following regarding the property:

- The property is advertised for sale using at least two methods of advertisement OR is listed with a broker; AND
- Is listed with a reasonable asking price; AND
- The individual has not declined any reasonable offers.

In order to continue exclusion of the unpaid principal on a mortgage or promissory note, the individual must provide current (no older than 30 days) verification of his reasonable effort to sell as defined above.

7. Lien

Consider unavailable to the individual any portion of real or personal property against which a legal lien has been filed. The equity value in the remaining portion is an available asset. Do not exempt any portion of an asset under the provisions of this item until it is established that the lien is legal, i.e., filed, UNLESS the lien is one pending filing by the Department of Intellectual and Developmental Disabilities (DIDD). Deduct the amount of the legal (filed) lien from the individual's equity value in the asset to determine the portion that remains a countable asset.

Record the following information regarding the lien in the eligibility system:

- Name of the party filing the lien;
- Total amount of the lien;
- Filing date; and
- Place filed.

a. DIDD Liens

Exclude as unavailable an amount equal to the amount of the pending lien if there is written assurance from the DIDD's Office of General Counsel that a claim will be filed within 90 days is received. Do not extend or continue benefits until confirmation of the DIDD's intent to file a lien is confirmed.

If a temporary 90 day exemption is extended, set up an expected change effective the 90th day. On the 91st day, secure a copy of the lien for the case record. If one has not been filed, discontinue the exemption and consider the entire amount of the applicant's resources available to him.

8. Litigation

The equity value of any resource involved in litigation is considered to be unavailable to the individual. Litigation means involved in a lawsuit or some type of court action. Verify with the individual's attorney that litigation is ongoing or secure written documentation that substantiates the individual's allegation that the asset is involved in litigation. The asset is considered unavailable to the individual effective the date it became involved in the litigation action.

Document Title	ABD Inaccessible Resources				
First Published	04/15/2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
11.1.2016	1	Policy Statement	1	Policy Change	LW
11.1.2016	2	Limited Use Rights	1	Non-Substantive Change	NF
11.1.2016	3	Individual's Mental Impairment (applicable to non-liquid resources only)	1-3	Non-Substantive Change	NF
11.1.2016	4	Joint Ownership	4-5	Non-Substantive Change	NF
11.1.2016	5	Ownership Interest in an Unprobated Estate	5	Non-Substantive Change	NF
11.1.2016	6-a	Inability to Locate a Buyer-Policy Statement	5	Policy Change	LW
11.1.2016	6-b	Inability to Locate a Buyer-Defined Terms	5-6	Policy Change	LW
11.1.2016	6-c	Inability to Locate a Buyer-Policy Implementation	6-7	Policy Change	LW
11.1.2016	6-d	Inability to Locate a Buyer-At Redetermination-Reasonable Efforts to Sell	7	Policy Change	LW

BREAST OR CERVICAL CANCER

Legal Authority: 1902(a)(10)(A)(ii)(XVIII) of the Social Security Act; Tenn. Comp. R. & Regs. 1200-13-20

1. Overview

The Center for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides funding to all 50 states, the District of Columbia, 5 U.S. territories, and 11 American Indian/Alaska Native tribes or tribal organizations to provide low-income individuals with screening, diagnostic and referral services for breast and cervical cancer. The Department of Health (DOH) Tennessee Breast and Cervical Cancer Screening Program (TBCCSP) provides these screening services to individuals at DOH local offices throughout the state.

The TBCCSP provides clinical breast exams, mammograms and Pap tests and other needed cervical services for eligible individuals, free of charge. In order to receive these services free of charge, an individual must be:

a. Under a certain income level based on family size; and
b. Uninsured, or insured by a health policy that does not cover these screening tests.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows states to offer individuals in the NBCCEDP access to treatment through the Medicaid program. In Tennessee, eligible individuals receive Medicaid benefits in the Breast or Cervical Cancer (BCC) Category of Eligibility (COE). The CDC and the Centers for Medicare and Medicaid Services (CMS) provide matching funds to the program, equal to the state's Medicaid Federal Medical Assistance Payment (FMAP).

2. Policy Statement

TennCare Medicaid benefits are available to individuals who receive breast or cervical cancer diagnoses, including for precancerous conditions, through the TBCCSP. Eligible individuals must require ongoing treatment for the cancer, meet all non-financial and financial eligibility requirements, and not be eligible in any other TennCare Medicaid or TennCare Standard COE. Individuals diagnosed with breast or cervical cancer by the DOH may receive presumptive eligibility for the TennCare Medicaid program, if they are otherwise eligible. Presumptive eligibility provides coverage through the end of the month after the eligibility determination is made.

3. Presumptive Eligibility

Presumptive eligibility for the BCC COE is determined by the DOH.

a. Primary Screening Providers and Locations

All DOH offices are expected to provide assistance to qualified individuals who are diagnosed with breast or cervical cancer, or who have suspicious symptoms related to these two forms of cancer. Participating statewide providers, including local DOH offices and certain primary care clinics provide screening services.

A list of participating Community Health Centers is available on the DOH Breast and Cervical Cancer Screening Program website:
https://www.tn.gov/health/health-program-areas/localdepartments.html

b. Presumptive Eligibility Requirements

To be eligible for presumptive eligibility, an individual must:

- **i.** Have a verified diagnosis of breast or cervical cancer, including precancerous conditions;
- **ii.** Be under age 65;
- **iii.** Be uninsured or lack creditable health insurance coverage;
- **iv.** Participate in the TBCCSP program; and
- **v.** Have income at or below 250% of the Federal Poverty Level (FPL), based on family size.

Note: Self-attestation of income is accepted by TBCCSP when determining presumptive eligibility.

c. Presumptive Eligibility Benefits

Presumptive eligibility benefits include TennCare Medicaid coverage not limited to the treatment of breast and/or cervical cancer but does not include experimental treatments.

Presumptive eligibility extends through the end of the month following the month in which presumptive eligibility is established. If an individual files a Valid Application during that period, the individual's presumptive eligibility will remain open until final disposition of the Valid Application.

d. DOH Responsibilities

i. Establishing Presumptive Eligibility

Once the TBCCSP determines presumptive eligibility, DOH staff complete the Presumptive Eligibility application using TennCare Access. DOH staff will either assist or instruct the individuals eligible for presumptive coverage to apply for Medicaid

ii. Services and Treatment-Related Expenses

The DOH TBCCSP provides all screening tests necessary to make a cancer diagnosis, as well as post-screening diagnostic services, such as surgical consultations and biopsy, to ensure that all individuals with abnormal results receive timely and adequate referrals.

4. Coverage under the BCC COE

a. Applicants with Presumptive Eligibility

i. Individuals who file a Valid Application during their presumptive eligibility period may receive continuous eligibility (i.e., no interruption between presumptive eligibility and TennCare Medicaid coverage) in the BCC COE if they meet all non-financial and financial eligibility requirements. See all non-financial and financial eligibility requirements listed below.

ii. Individuals who file a Valid Application up to 45 days prior to the approval of the presumptive eligibility period may receive continuous eligibility in the BCC COE if they meet all non-financial and financial eligibility requirements. Individuals will not be required to file a subsequent application during the presumptive period

b. Applicants who Require a Referral to DOH TBCCSP

If TennCare Medicaid applicants indicate that they have breast or cervical cancer, and they are not eligible in any open non-BCC TennCare Medicaid COE, they must be referred to the DOH TBCCSP program.

5. Non-Financial Eligibility Requirements

a. Age

Eligible individuals must be under the age of 65.

b. Citizenship

Eligible individuals must be U.S. citizens, U.S. nationals or eligible non-citizens.

c. Residency

Eligible individuals must be residents of Tennessee.

d. Enumeration

Eligible individuals must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN.

e. TBCCSP Participant

Eligible individuals must be participants of the TBCCSP program. They must have received a cancer diagnosis from the TBCCSP and be approved for presumptive eligibility.

f. Cancer Diagnosis and Ongoing Treatment

Eligible individuals must have a diagnosis of breast or cervical cancer, including cancerous or precancerous conditions, and require on-going treatment. In order to be continuously eligible in the BCC COE after presumptive eligibility is established, individuals must submit a treatment plan to TennCare. The treatment plan is also submitted at each redetermination.

Once a treatment plan is received by TennCare, it is reviewed by TennCare Member Services. Coverage in the BCC COE provides full TennCare Medicaid benefits; however, TennCare Medicaid does not cover experimental treatments.

g. Lacks Creditable Coverage

Eligible individuals must be uninsured. An individual who lacks “creditable coverage” is considered to be uninsured. “Creditable coverage” includes:

- **i.** Other health insurance, including individual plans;
- **ii.** Group health insurance plans;
- **iii.** Medicare;
- **iv.** Medicaid (Individuals applying for coverage will be screened for all open TennCare Medicaid COEs prior to being determined eligible in the BCC COE);
- **v.** Military health plans;
- **vi.** Medical care programs of the Indian Health Services or tribal organizations;
- **vii.** State risk pools;
- **viii.** Public health plans; and
- **ix.** Health plans under Section 5(e) of the Peace Corps Act.

Note: Once third party coverage of cancer has been exhausted, the applicant will be considered to no longer have health insurance. Insurance through the Exchange does not prevent eligibility for the BCC COE.

h. TennCare Medicaid Eligibility

An eligible individual cannot be eligible for any other open TennCare Medicaid COE.

6. Financial Eligibility Requirements

Income and resources are not taken into account by TennCare when providing continuing eligibility in the BCC COE after presumptive eligibility is approved. However, this information is required for processing the eligibility determination of other open TennCare Medicaid COEs.

7. Coverage in another TennCare Medicaid COE

If an individual receiving coverage in the BCC COE gains eligibility in another TennCare Medicaid COE, BCC coverage will close. This policy applies to all COEs, except Emergency Medical Services (EMS) and both Presumptive Pregnancy and BCC.

8. Case Closure

a. Presumptive Eligibility

If an individual is diagnosed with breast or cervical cancer and is approved for presumptive eligibility, and the diagnosis is determined to be benign or the individual fails to provide necessary information for ongoing coverage in the BCC COE (or other TennCare Medicaid COE), the presumptive eligibility coverage will end the last day of the month following the month in which presumptive eligibility was established.

b. BCC Eligibility

Once an oncologist determines that the enrollee is cancer-free or in remission, the BCC coverage will be terminated. Individuals losing eligibility in the BCC COE will be reviewed for coverage in an open TennCare Medicaid COE prior to termination.

Document Title	Breast or Cervical Cancer				
First Published	03.10.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
05.02.2016	1.	Overview of the Breast and Cervical Cancer Early Detection Program	1	Policy Clarification	AK
05.02.2016	3.a.	Primary Screening Provider and Locations	2	Non-Substantive Change	AK
05.01.2017	4.b.	Applicants who Require a Referral to DOH TBCCEDP	2	Non-Substantive Change	RS
03.18.2019	1.; 3.a; 3.d.i	Overview; Primary Screening Providers and Locations; Services and Treatment-Related Expenses	1-3	Non-Substantive Change	RZ
03.18.2019	5.g.	Lacks Creditable Coverage	4 - 5	Policy Clarification	RZ
07.01.2019	3.a; 3d.i; 5.g.	Legal Authority; Primary Screening Providers and Locations; Establishing Presumptive Eligibility; Lacks Creditable Coverage	1-3	Policy Clarification	TN
07.01.2019	4.a.ii	Applicants with Presumptive Eligibility	3	Policy Change	TN
07.01.2021	1.; 3.a.	Overview; Primary Screening Providers and Locations	1-2	Non-Substantive Change	TB

DISABLED ADULT CHILDREN

Legal Authority: 42 USC 1383c; Social Security Act 1634(c)

1. Policy Statement

Medicaid benefits are extended to individuals who would be eligible for Supplemental Security Income (SSI) payments but for entitlement to OR increase in the amount of the Disabled Adult Child's (DAC) Social Security benefits. When SSI recipients lose SSI eligibility because of entitlement to or increase in Social Security DAC benefits, they remain eligible for Medicaid as long as they would meet SSI income guidelines but for their initial entitlement to or increase in DAC payments and any other non-Cost of Living Adjustment (COLA) Social Security increase.

This coverage applies to an individual who is:

a. At least 18 years of age;
b. Receiving Social Security benefits as a DAC on the basis of blindness or disability which began before age 22;
c. SSI was terminated after July 1987; and
d. The individual was at least 18 or older when SSI terminated.

2. Non-Financial Eligibility Requirements

a. Age

This coverage applies to an individual who is at least 18 years of age AND is receiving Social Security benefits as a DAC on the basis of blindness or disability which began before age 22.

b. Citizenship

Individuals must be U.S. citizens, U.S. nationals or eligible non-citizens. Individuals are not required to provide documentary evidence of citizenship or national status if they are entitled to or enrolled in any part of Medicare.

c. Residency

Individuals must be residents of Tennessee.

d. Enumeration

Individuals must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN.

e. DAC Status

This coverage applies to an individual who is at least 18 years of age AND is receiving Social Security benefits as a DAC. A DAC must be unmarried, age 18 or older, and have a disability that started before age 22. The DAC benefit is considered a “child’s benefit” because the recipient is paid on a parent’s Social Security earnings record. DAC benefits typically begin when the parent begins receiving OASDI or dies.

f. Marital Status

In order to be eligible for Social Security benefits as a DAC, the individual must be unmarried. However, individuals may continue to be DAC eligible if they marry a Social Security beneficiary who is also eligible for DAC benefits, OASDI benefits, or Widow/Widower benefits. Individuals will not continue to be DAC eligible if they marry a Social Security beneficiary under the age of 19 or an individual who is not a Social Security beneficiary.

The SSA will determine whether a married individual remains eligible for the DAC Social Security benefit.

g. SSI Termination Date

Eligible individuals must have had their SSI terminated after July 1987. Individuals must have been age 18 or older when his SSI terminated.

3. Financial Eligibility Requirements

a. Eligibility Determination Group

To receive DAC Social Security benefits, an individual must be unmarried. However, if a DAC beneficiary marries another Social Security beneficiary, with certain limits, her DAC eligibility will continue. See Marital Status above. A DAC eligible couple must both meet all DAC eligibility criteria to qualify as a DAC eligible couple. If the individual’s spouse is ineligible for the Disabled Adult Child category, income may be deemed to the individual. See the *ABD Deeming of Income and Resources* policy.

b. Income Limit

The income limits for this category are the same as the current SSI Federal Benefit Rates (SSI-FBRs).

c. Resource Limit

Resource limits for individuals in this category are $2,000 for an individual and $3,000 for a couple.

4. Budget Overview

a. DAC Increase

i. Initial DAC Entitlement

If the initial entitlement to the DAC benefit caused SSI ineligibility, the entire initial entitlement is disregarded from the applicant's income.

ii. Increase in DAC Benefit

If an increase in the DAC benefit caused SSI ineligibility, the amount of the increase is disregarded from the applicant's income.

iii. Social Security COLA or non-COLA Increase

Any Social Security COLA or non-COLA increases received by the individual after SSI was terminated will be disregarded

b. Budget

Mr. Black is an SSI recipient. While his father works, he receives a monthly SSI payment of $498. When his father retired and began receiving $1,000 a month in Social Security, Mr. Black began receiving a DAC payment of $500 a month. This lowered his SSI monthly benefit to $218. Mr. Black's father passes away in January 2014, which increases his monthly DAC benefit to $750 and results in the loss of SSI eligibility. Mr. Black has earned income of $200 per month and has proof of $50 in disabled work expenses per month.

Mr. Black's total countable income, $42.50, is less than the current $735 SSI-FBR, so he is income eligible in the DAC category.

Income Budget Calculation		
Unearned Income		$ 750.00
Irregular Unearned Income Disregard	+	$ 0.00
In-Kind Support and Maintenance	+	$ 0.00
Ineligible Spouse's Deemed Unearned Income	+	$ 0.00
Ineligible Parent's Deemed Income	+	$ 0.00
General Deduction ($20)	-	$ 20.00
Child Support Disregard	-	$ 0.00
Widow/Widower Entitlement Disregard	-	N/A
DAC Entitlement Disregard	-	$ 750.00
COLA Disregard	-	0.00

Total Net Unearned Income	=	$ 0.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 200.00
Irregular Earned Income Disregard	-	$ 0.00
Student Earned Income Exclusion	-	$ 0.00
Ineligible Spouse's Deemed Earned Income	+	$ 0.00
Remaining General Deduction	-	$ 0.00
Earned Income Deduction	-	$ 65.00
Impairment Related Work Expense	-	$ 50.00
½ Deduction	-	$ 42.50
Blind Work Expense	-	$ 0.00
Total Net Earned Income	=	$ 42.50
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 42.50
Qualified Income Trust	-	$ 0.00
Net Countable Income		$ 0.00
Income Test Limit		$ 733.00
Income Test Result		PASS
Patient Liability		$ 0.00

The above budget is current as of Januray 2017.

Document Title	Disabled Adult Children				
First Published	03.11.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.13.2015	1.	Policy Statement	1	Policy Clarification	AK
03.13.2015	3.b.	Income Limit	2 - 3	Policy Clarification	AK
03.13.2015	4.a.i.	Initial DAC Entitlement	3	Policy Clarification	AK
03.13.2015	4.b.5.	Countable Income Computation	4	Policy Clarification	AK
08.27.2015	2.h.	DAC-OASDI Coverage	2	Non-Substantive Change	NF
01.29.2016	2.h.	DAC-OASDI Coverage	2	Non-Substantive Change	SN
01.05.2017	2.h.	DAC-OASDI Coverage	2	Non-Substantive Change	RH
01.05.2017	3.b.	Income Limit	2	Policy Clarification	RH
01.05.2017	4.b.5	Countable Income Computation	4	Policy Clarification	RH
01.05.2017	4.c.6.	Countable Income Computation	6	Policy Clarification	RH
04.02.2018	1.	Policy Statement	1	Policy Clarification	RZ
04.02.2018	2.g.	SSI Termination Date	2	Policy Clarification	RZ
04.02.2018	2.h.	DAC Coverage	2	Non-Substantive Change	RZ
04.02.2018	3.a.	Household	2	Policy Clarification	RZ
04.02.2018	3.b.	Income Limit	2 - 3	Non-Substantive Change	RZ
04.02.2018	4.a.	DAC Entitlement or Increase	3	Policy Clarification	RZ
04.02.2018	4.b.i	Child Support Calculation	4	Policy Clarification	RZ
04.02.2018	4.b.iv.	Total Net Unearned Income Computation	4	Policy Clarification	RZ
04.02.2018	4.c.vi.	Countable Income Computation	6	Non-Substantive Change	RZ
03.18.2019	1.; 2.g.; 3.a.; 4.a.iii.;	Policy Statement; SSI Termination Date; Eligibility Determination Group; Social Security COLA or non-COLA Increase	1-3	Policy Clarification	SN
03.18.2019	3.b.; 4.a.i-ii.; 4.b.	Income Limit; Initial DAC Entitlment; Increase in DAC Benefit; Budget	2-4	Non-Substantive Change	SN

INSTITUTIONAL MEDICAID

Legal Authority: 42 CFR 435.236; 42 CFR 435.1005; 42 CFR 435.1009; 42 CFR 435.1010; 42 CFR 435.520; 42 CFR 435.540; 42 CFR 435.541; TennCare 1115 Medicaid Demonstration; Section 1902(a)(10) of the Social Security Act; Tenn. Comp. R. & Regs. 1200-13-20; State Plan Amendment TN-21-0010

1. Policy Statement

Medicaid benefits and potentially Long-Term Services and Supports (LTSS) payments are available to eligible individuals receiving care in a medical institution (regardless of age) provided they are not:

a. An inmate of a public institution; or
b. A patient in an Institution for Mental Disease (IMD), unless she is:

  i. Under age 22 and receiving inpatient psychiatric services; or
  ii. At least 65 years of age.

LTSS payments are available for individuals receiving Nursing Facility (NF) care and approved for CHOICES. Individuals approved for Institutional Medicaid based on 30-day continuous confinement will not receive LTSS payments unless they are admitted to a NF or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) with an approved PAE. Medicaid benefits and LTSS payments are also available for aged adults and physically disabled adults (age 21 and older) when approved for and receiving CHOICES Home and Community Based Services (HCBS), and individuals of all ages with Intellectual and Developmental Disabilities (IDD) who are eligible for and receiving Employment and Community First (ECF) CHOICES services.

2. Definitions

a. Aged: Individuals age 65 or older.

b. Blind: Individuals who have been determined to be legally blind by the Social Security Administration (SSA).

c. Disabled: Individuals who have been determined to be disabled by the SSA or TennCare. Generally, an individual is considered disabled when he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to last for a continuous period of not less than 12 months.

3. Non-Financial Eligibility Requirements

a. Age

To be eligible as aged, an individual must be age 65 or older. There is no age requirement for individuals who are eligible on the basis of disability or blindness.

b. Citizenship

An individual must be a U.S. Citizen, a U.S. National or eligible immigrant. Individuals are not required to provide documentary evidence of citizenship or national status if they are entitled to or enrolled in any part of Medicare, entitled to or receiving Supplemental Security Income (SSI) or Social Security disability benefits.

c. Enumeration

An individual must possess and provide a valid Social Security Number (SSN) or proof of application, unless she meets an exception.

d. State Residence

An individual must be a resident of Tennessee. Individuals placed by an agency of the State of Tennessee in an institution out of state are still considered Tennessee residents. See the *ABD State Residence* policy.

e. Institutional Status

An individual must have an institutional status to be eligible for the Institutional Medicaid category. See the *Institutional Status* policy.

4. Financial Eligibility Requirements

a. Eligibility Determination Group (EDG)

The EDG for the Institutional Medicaid category is based on the principle of the Financially Responsible Relative (FRR). See the *ABD Financially Responsible Relatives* policy.

b. Resources

Eligible individuals must have countable resources below the Institutional Medicaid Aged, Blind and Disabled (ABD) resource standard. The resource standard is $2,000.

The resources of an individual's spouse or of an institutionalized child's parent(s) may be deemed available to the individual. See the *ABD Deeming of Income and Resources* policy.

All individuals with a spouse must have a Resource Assessment completed prior to receiving an eligibility determination in the Institutional Medicaid category. Resources owned individually or jointly by members of a married couple are considered in the Resource Assessment and will be used to determine the Community Spouse Resource Maintenance Allowance (CSRMA). See the *Resource Assessment* policy.

Countable and excluded resources are determined using the ABD resource methodology as defined in the legal authority that governs SSI eligibility. See the *ABD Countable and Excluded Resources* policy.

c. Income

i. General Rule

Individuals must have countable income below the Medicaid Income Cap (MIC). The MIC is 300% of the SSI Federal Benefit Rate (SSI-FBR), a number which is annually updated by the SSA.

Income eligibility is determined by comparing the individual’s gross income to the MIC. If gross income is equal to or less than the MIC, the individual is income eligible in the Institutional Medicaid category. If gross income is greater than the MIC, the individual will be provided with the opportunity to establish a Qualified Income Trust (QIT). A QIT is a specific type of trust used only to establish Medicaid eligibility, in which an individual places certain types of monthly income. Once a QIT is established, the individual’s income eligibility is tested again to determine income eligibility. See the *Qualified Income Trust (QIT) or Miller Trust* section in the *ABD Trusts* policy.

ii. MIC

The MIC is $2,829 effective 01/01/2024.

iii. Budgeting Process, Based on Eligibility Determination Group

1. Adult Individual with No Spouse or Spouse is Institutionalized

Income eligibility for an adult individual with no spouse, or who has a spouse who is already institutionalized, is determined based on the individual’s income only.

2. Adult Individual with a Community Spouse

Income eligibility for an adult individual with a community spouse is determined based on the applying individual’s income only. The community spouse’s income is considered post-eligibility when determining the appropriate Community Spouse Income Maintenance Allowance (CSIMA). This may include individuals where the community spouse is eligible for and receiving HCBS.

3. Individual is a Dependent Child and Lives with Parents (Prior to Institutionalization or Application for HCBS)

If the individual is a dependent child (under age 18), income from the individual's FRRs is deemed available to him when determining income eligibility until the child applies for LTSS. No income is deemed available to him when determining income eligibility after application for LTSS has been made, unless a child under 18 is requesting HCBS services in the ECF CHOICES program, and an exception does not apply. See the Parent-to-Child Deeming section in the *Employment and Community First CHOICES* policy for more information.

iv. 250% Federal Poverty Level (FPL) Disregard

Earned income up to 250% of the FPL is disregarded for the Comprehensive Aggregate Cap (CAC), Self-Determination, and Statewide Waivers. For more information on the Department of Intellectual and Developmental Disabilities (DIDD) waivers, see the *Institutional Status* policy and the *TennCare CHOICES in Long-Term Services and Supports* policy.

d. Income Budget

Income eligibility is first determined for the individual without consideration of a QIT. This is necessary in order to determine if the individual needs to establish a QIT to become income eligible. If the individual passes the initial budget, it is not necessary for her to establish a QIT.

If the individual fails the income eligibility determination, then the individual must be provided with the opportunity to establish a QIT. If the individual is able to establish a QIT, her income eligibility will be tested again.

e. Example Budget

Mr. Mason was admitted to a nursing home and is applying for medical assistance. He is 64 years old and receives $2,800 in Social Security per month. He also receives $800 per month from a pension. Since his monthly income total is determined to be above the MIC, he must establish a QIT to qualify.

Income Budget Calculation		
Unearned Income		$ 3600.00
Irregular Unearned Income Disregard	+	N/A
In-Kind Support and Maintenance	+	N/A
Ineligible Spouse's Deemed Unearned Income	+	N/A
Ineligible Parent's Deemed Income	+	N/A
General Deduction ($20)	-	N/A

Child Support Disregard	-	N/A
Widow/Widower Entitlement Disregard	-	N/A
DAC Entitlement Disregard	-	N/A
COLA Disregard	-	N/A
Total Net Unearned Income	=	$ 3600.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 0.00
Irregular Earned Income Disregard	-	N/A
Student Earned Income Exclusion	-	N/A
Ineligible Spouse's Deemed Earned Income	+	N/A
Remaining General Deduction	-	N/A
Earned Income Deduction	-	N/A
Impairment Related Work Expense	-	N/A
½ Deduction	-	N/A
Blind Work Expense	-	N/A
Total Net Earned Income	=	$ 0.00
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 3600.00
Qualified Income Trust	-	$ 2800.00
FPL 250% Disregard		N/A
Net Countable Income		$ 800.00
Income Test Limit		$ 2313.00
Income Test Result		PASS

The above budget is current as of February 2019.

Mr. Mason establishes a QIT, to which he allocates his SSA income. His Net Countable Income is under the MIC. He is income eligible for Institutional Medicaid.

Document Title	Institutional Medicaid				
First Published	04.17.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
07.01.2016	1.; 4.c.iii.	Policy Statement; Budgeting Process Based On Household Composition	1; 4	Policy Clarification	LW
12.01.2016	2.c.; 4.d.i.a.	Disabled; Total Gross Unearned Income Computation	1; 4	Policy Clarification	RS
01.05.2017	4.c.i.; 4.d.i.c.	General Rule; Countable Income Computation	3; 4	Non-Substantive Change	RH
06.01.2017	2.c.	Disabled	1	Policy Clarification	RS
06.01.2017	3.a.	Age	2	Non-Substantive Change	RS
03.18.2019	1.; 2.c.; 4.c.iii; 4.d.; 4.e.	Policy Statement; Disabled; Budgeting Process, Based on Eligibility Determination Group; Income Budget; Example Budget	1-5	Non-Substantive Change	ME
03.18.2019	4.a.	Eligibility Determination Group (EDG)	2	Policy Clarification	ME
05.01.2019	4.c.ii; 4.e.	Legal Authority; MIC; Example Budget	1-5	Policy Clarification	TN
05.01.2020	4.c.ii.	MIC	3	Policy Clarification	TN
05.01.2020	1; 2.c.	Legal Authority; Policy Statement; Disabled	1	Policy Change	TB
01.04.2021	4.c.ii.	MIC	3	Policy Clarification	TN
01.04.2022	4.c.ii.	MIC	3	Policy Clarification	SA
06.01.2022	2.c.	Disabled	1	Policy Clarification	AJ
09.01.2022	4.c.iii.3.	Individual is a Dependent Child and Lives with Parents (Prior to Institutionalization or Application for HCBS)	4	Policy Change	AJ
09.01.2022	4.c.iv.; 4.e.	250% FPL Disregard; Example Budget	4	Policy Change	AJ
01.03.2023	4.c.ii.	MIC	3	Non-Substantive Change	KF
01.02.2024	4.c.ii.	MIC	3	Non-Substantive Change	CE

PICKLE PASSALONG

Legal Authority: 42 CFR 435.135; Tenn. Comp. R. & Regs. 1200-13-20

1. Overview

The Pickle Passalong Medicaid category is named in honor of U.S. Congressman J.J. Pickle and was established in 1977. To be eligible in the Pickle Passalong category, an individual must have been receiving both Supplemental Security Income (SSI) and Social Security benefits. The individual must have then lost SSI eligibility but would remain SSI-eligible if the Social Security Cost of Living Adjustments (COLAs) received since the SSI termination were disregarded.

2. Policy Statement

TennCare Medicaid benefits are available to individuals who would be eligible for SSI payments if increases in Social Security benefits due to COLAs were disregarded. An individual who meets all other non-financial and financial eligibility requirements remains eligible for TennCare Medicaid if he:

- **a.** Is currently receiving Social Security benefits (Old Age, Survivors, or Disability Insurance (OASDI));
- **b.** Is not currently receiving SSI;
- **c.** Was entitled to both OASDI and SSI benefits in the same month after April 1977; and
- **d.** Has countable income (including in-kind income) equal to or less than the current SSI-Federal Benefit Rate (FBR) after deducting all OASDI COLAs received since the last month in which the individual was eligible for both OASDI and SSI.

3. Non-Financial Eligibility Requirements

a. Age

An individual must have attained at least age 65 or meet the Social Security Administration (SSA) requirements of blindness or disability. Individuals are not required to provide documentary evidence of age if they are entitled to or enrolled in any part of Medicare.

b. Citizenship

Individuals must be U.S. citizens, U.S. nationals or eligible non-citizens. Individuals are not required to provide documentary evidence of citizenship or national status if they are entitled to or enrolled in any part of Medicare and/or receiving Social Security disability benefits.

c. Residency

Individuals eligible for this category must be residents of Tennessee.

d. Enumeration

Individuals must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN.

e. Eligible For and Receiving Social Security Benefits

Individuals must be eligible for and receiving Social Security benefits as authorized under Title II of the Social Security Act.

4. Financial Eligibility Requirements

a. Eligibility Determination Group

The Eligibility Determination Group (EDG) is governed by the principle of Financially Responsible Relatives (FRR). Financial responsibility is limited to spouse to spouse and parent to child. See the *ABD Eligibility Determination Group* policy.

b. Couples

A Pickle Passalong eligible couple must both meet all Pickle Passalong eligibility criteria to qualify as a Pickle Passalong eligible couple. If the individual's spouse is ineligible for Pickle Passalong, income may be deemed to the individual. See the *ABD Deeming of Income and Resources* policy.

c. Income

i. Income Eligibility

An individual is income eligible if her net countable income less all appropriate Social Security COLAs is less than the appropriate SSI-FBR.

ii. COLA Disregards

Disregard the following, if applicable:

1. All Social Security COLAs that caused or have occurred since the applicant's SSI eligibility was terminated;
2. The spouse's Social Security COLAs that caused or have occurred since the SSI termination, if the spouse's income is deemed to the applicant; or
3. The parents' Social Security COLAs which occurred since the applicant's SSI termination, if the applicant is a child.

iii. Determining the Amount of the COLA Disregard

Determine the amount of the COLA disregard by multiplying the applicant's current Social Security benefit by the appropriate conversion factor. Follow the steps below:

1. Verify the current Social Security benefit amount;
2. Verify the SSI termination date;
3. Locate the appropriate conversion factor based on the month and year of SSI termination;
4. Multiply the current Social Security benefit by the conversion factor; and
5. Take the result (after multiplication by the conversation factor) and deduct it from the current Social Security benefit to determine the COLA disregard amount.

iv. Pickle Conversion Factor Table

Timeframe	Factor	Timeframe	Factor
May-June 1977	0.189	Jan-December 2000	0.544
July 1977-June 1978	0.201	Jan-December 2001	0.563
July 1978-June 1979	0.221	Jan-December 2002	0.578
July 1979-June 1980	0.252	Jan-December 2003	0.585
July 1980-June 1981	0.281	Jan-December 2004	0.598
July 1981-June 1982	0.301	Jan-December 2005	0.614
July 1982-Dec 1983	0.323	Jan-December 2006	0.639
Jan-December 1984	0.333	Jan-December 2007	0.661
Jan-December 1985	0.345	Jan-December 2008	0.676
Jan-December 1986	0.356	Jan 2009-December 2011	0.715
Jan-December 1987	0.361	Jan-December 2012	0.740
Jan-December 1988	0.375	Jan-December 2013	0.753
Jan-December 1989	0.390	Jan-December 2014	0.765
Jan-December 1990	0.409	Jan 2015-December 2016	0.777
Jan-December 1991	0.432	Jan-Dec 2017	0.779
Jan-December 1992	0.448	Jan-December 2018	0.795
Jan-December 1993	0.460	Jan-December 2019	0.818
Jan-December 1994	0.473	Jan-December 2020	0.830
Jan-December 1995	0.486	Jan-December 2021	0.842
Jan-December 1996	0.498	Jan-December 2022	0.892
Jan-December 1997	0.513	Jan-December 2023	0.969
Jan-December 1998	0.524	Jan-December 2024	1.000
Jan-December 1999	0.530		

d. Resource Limit

Resource limits for this category are $2,000 for an individual and $3,000 for a couple.

5. Budget

Mrs. Stonewall was an SSI and OASDI benefit recipient until October 2013, when her SSI eligibility ended due to an OASDI COLA. She and her husband live together with no children. Mr. Stonewall is ineligible for SSI or TennCare Medicaid, and $290 of his unearned income and $650 of his earned income is deemed available to Mrs. Stonewall. Mrs. Stonewall has $155 in monthly earned income and $600 in OASDI benefits. She applies for medical assistance on February 1, 2020.

Mrs. Stonewall's total countable income, $1,184.20, is greater than the current SSI-FBR for a couple, $1,175, so she is not income eligible for the Pickle Passalong category.

Income Budget Calculation		
Unearned Income		$ 600.00
Irregular Unearned Income Disregard	+	$ 0.00
In-Kind Support and Maintenance	+	$ 0.00
Ineligible Spouse's Deemed Unearned Income	+	$ 290.00
Ineligible Parent's Deemed Income	+	$ 0.00
General Deduction ($20)	-	$ 20.00
Child Support Disregard	-	$ 0.00
Widow/Widower Entitlement Disregard	-	N/A
DAC Entitlement Disregard	-	N/A
COLA Disregard	-	$ 55.80
Total Net Unearned Income	=	$ 814.20
Self-Employment Income		$ 0.00
Earned Income	+	$ 155.00
Irregular Earned Income Disregard	-	$ 0.00
Student Earned Income Exclusion	-	$ 0.00
Ineligible Spouse's Deemed Earned Income	+	$ 650.00
Remaining General Deduction	-	$ 0.00
Earned Income Deduction	-	$ 65.00
Impairment Related Work Expense	-	$ 0.00
½ Deduction	-	$ 370.00
Blind Work Expense	-	$ 0.00
Total Net Earned Income	=	$ 370.00
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 1,184.20
Qualified Income Trust	-	$ 0.00
Net Countable Income		$ 1,184.20
Income Test Limit		$ 1,175.00
Income Test Result		FAIL
Patient Liability		N/A

The above budget is current as of January 2020.

Document Title	Pickle Passalong				
First Published	03.13.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.16.2016	4.c.iii.	Determining the Amount of the COLA Disregard	3	Policy Clarification	LW
03.16.2016	5.b.vi.	COLA Disregard and Eligibility Determination	6	Policy Clarification; Non-Substantive Change	LW
05.02.2016	2.	Policy Statement	1	Policy Clarification	LW
01.05.2017	4.c.iii,	Determining the Amount of the COLA Disregard	3	Policy Clarification	RH
01.05.2017	5.b.vi.	COLA Disregard and Eligibility Determination	6	Policy Clarification	RH
03.09.2018	1.	Overview	1	Policy Change	TN
03.09.2018	2.	Policy Statement	1	Policy Clarification	TN
03.09.2018	4.b.	Couples	2	Policy Clarification	TN
03.09.2018	4.c.iii.	Determining the Amount of the COLA Disregard	3	Policy Clarification	TN
03.09.2018	5.a.6.	Countable Income Computation	5		TN
03.09.2018	5.b.	Example Budget	5 - 6	Non-Substantive Change	TN
03.18.2019	4.a.; 4.c.iii.	Eligibility Determination Group; Determining the Amount of the COLA Disregard	2-3	Policy Clarification	TB
03.18.2019	5.	Budget	3 - 4	Non-Substantive Change	SN
01.02.2020	4.b.iv.; 5.	Legal Authority; Pickle Conversion Factor Table; Budget	1; 3-5	Non-Substantive Change	TN
01.04.2021	4.b.iv.	Pickle Conversion Factor Table	3	Non-Substantive Change	TN
01.04.2022	4.b.iv.	Pickle Conversion Factor Table	3	Non-Substantive Change	SA
01.03.2023	4.b.iv.	Pickle Conversion Factor Table	3	Non-Substantive Change	KF

01.02.2024	4.b.iv.	Pickle Conversion Factor Table	3	Non-Substantive Change	CE

SSI CASH RECIPIENT

Legal Authority: 20 CFR 416.260; 20 CFR 416.903; 20 CFR 416.974; 42 CFR 435.120; Title XVI of the Social Security Act; Tenn. Comp. R. & Regs. 1200-13-20

1. The SSI Program and Medicaid Eligibility

The Social Security Act, as amended, established a national program, effective January 1, 1974, to provide Supplemental Security Income (SSI) to individuals who have attained age 65 or are blind or disabled and meet financial requirements. The program is intended to assure a minimum level of income for individuals who are aged, blind, or disabled that have insufficient income and resources to maintain a standard of living at the established federal minimum income level.

Individuals who are eligible for SSI are entitled to Medicaid. SSI eligibility is determined by the Social Security Administration (SSA) in Tennessee. Applications for SSI benefits may be filed at the Social Security office.

TennCare does not conduct an independent evaluation of income and resource eligibility before issuing regular TennCare Medicaid benefits to an SSI recipient.

2. Policy Statement

TennCare Medicaid is provided to aged, blind or disabled individuals eligible for SSI under Section 1602 of the Social Security Act. Tennessee residents determined eligible for SSI benefits are automatically enrolled in TennCare Medicaid.

SSI recipients who are enrolled in TennCare Medicaid also receive automatic buy-in for Medicare Parts A & B.

3. Date of TennCare Medicaid and SSI Eligibility

TennCare Medicaid coverage for SSI cash recipients begins according to data TennCare receives from the SSA regarding SSI eligibility.

4. SSI Benefit and TennCare Medicaid Termination

SSA alerts TennCare when an SSI recipient’s SSI payments end. At that time, TennCare will review the enrollee for eligibility in all other categories prior to termination.

Note: SSI payments may be suspended for an Achieving a Better Life Experience (ABLE) account owner if his ABLE account balance exceeds $100,000 or distributions from his ABLE account for housing-related qualified disability expenses (QDEs) are retained past the month of receipt and exceed the SSI resource limit. If the individual’s SSI was suspended for no other reason, the ABLE account owner remains eligible for SSI Medicaid.

5. Financial Eligibility Requirements

a. Income Standard

The SSA uses the Federal Benefit Rate. For 2024 the income standard is:

i. $943 for an individual; or
ii. $1,415 for a couple.

b. Resource Test

Resource limits used by the SSA are:

i. $2,000 for an individual; or
ii. $3,000 for a couple.

6. Additional Criteria for TennCare Medicaid Coverage

As a condition of receiving TennCare Medicaid coverage, SSI cash recipients are subject to the following additional requirements:

a. Cooperation with Third Party Liability

SSI cash recipients must provide TennCare with any and all information necessary to obtain medical support or payment including, but not limited to, names of parties responsible for payment, address, and policy, account or claim numbers. See *Assignment of Third Party Medical Support* policy.

b. Long Term Services and Supports (LTSS) Requirements

SSI recipients who are requesting LTSS, either in a nursing facility or through Home and Community Based Services (HCBS), must have an approved Preadmission Evaluation (PAE). In addition, SSI recipients requesting LTSS who have a community spouse must complete a resource assessment and have asset transfers made within the look back period evaluated. In order to comply with the resource assessment requirements, SSI cash recipients seeking LTSS may be required to submit additional information to TennCare.

***7.* Cluster Daniels and SSI Terminations SSI Medicaid Only**

SSI Medicaid Only recipients, also known as the Cluster Daniels individuals, are those individuals that remain eligible for TennCare Medicaid because they received a minimum of one SSI check in Tennessee since November 1987 and had their SSI terminated while a resident of Tennessee. The Daniels injunction was lifted on January 8, 2009 and reverification of this group of enrollees began in

June 2009. Any SSI Medicaid Only recipients who have not yet been processed are reviewed for eligibility in open categories of Medicaid.

8. SSI Cash Recipient Enrollment Procedure

TennCare receives a file directly from the SSA that contains all SSI eligibility determinations. TennCare automatically loads the State Data Exchange (SDX) file to TEDS to enroll SSI cash recipients in TennCare Medicaid.

SDX data may also be used as needed for verification of SSI benefit information.

Document Title	SSI Cash Recipient
First Published	3.18.2015

Revision History

Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.01.2016	1.; 2.	The SSI Program and Medicaid Eligibility; Policy Statement	1	Policy Clarification	LW
06.17.2016	4.	SSI Benefit and TennCare Medicaid Termination	1	Policy Clarification	AJ
01.05.2017	5.a.	Financial Eligibility Requirements	2	Policy Change	RH
01.02.2020	8.	Legal Authority; SSI Cash Recipient Enrollment Procedures	1-3	Policy Clarification	TN
01.02.2020	1;3-4; 5.a.; 6; 8	The SSI Program and Medicaid Eligibility; Date of TennCare Medicaid and SSI Eligibility; SSI Benefit and TennCare Medicaid Termination; Financial Eligibility; Additional Criteria for TennCare Medicaid Coverage; SSI Cash Recipient Enrollment Procedure	1-3	Non-Substantive Change	TN
01.04.2021	5.a.	Financial Eligibility Requirements	2	Non-Substantive Change	RS
01.04.2022	5.a.	Financial Eligibility Requirements	2	Non-Substantive Change	TN
01.03.2023	5.a.	Financial Eligibility Requirements	2	Non-Substantive Change	KF
01.03.2023	6.b.	Long Term Services and Supports (LTSS) Requirements	2	Policy Clarification	AJ
01.02.2024	5.a.	Financial Eligibility Requirements	2	Non-Substantive Change	CE

WIDOW/WIDOWER CATEGORIES

Legal Authority: Social Security Act §1634(d); 42 CFR 435.137; 42 CFR 435.138; 1990 OBRA § 5103; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

TennCare Medicaid benefits are available to certain widows/widowers who would be eligible for Supplemental Security Income (SSI) payments if initial entitlement to and/or increases in their Social Security widow/widower benefit were disregarded. Widows/widowers who are eligible for TennCare Medicaid on the basis of their widow/widower status must meet all other non-financial and financial eligibility conditions.

Widows/widowers may qualify for this category of TennCare Medicaid coverage under one of two categories:

a. Widow/Widower Spousal Retirement; or
b. Widow/Widower Actuarial Reduction.

The Social Security Widow/Widower benefit is based on the deceased spouse's Title II Old-Age, Survivors and Disability Insurance (OASDI) benefit.

2. Eligibility Categories

a. Widow/Widower Spousal Retirement

A disabled widow/widower is eligible for TennCare Medicaid for any month in which he is entitled to a Social Security Widow/Widower benefit, but is not eligible for SSI, if he:

i. Was eligible for SSI based on his own disability;
ii. Was entitled to the Social Security Widow/Widower benefit any time after the age of 50;
iii. Received an SSI benefit the month before the Social Security Widow/Widower benefit began;
iv. Would be eligible for SSI if the Widow/Widower entitlement and all subsequent COLAs were disregarded;
v. Is not entitled to Medicare Part A; and
vi. Is at least age 50 and up to age 65.

b. Widow/Widower Actuarial Reduction

NOTE: This category is closed to enrollment.

TennCare Medicaid benefits continued for certain disabled widows/widowers who lost SSI eligibility in 1984 due to an increase in the Social Security Widow/Widower benefit that occurred as a result of a change in the way the benefit was calculated. In order to receive TennCare Medicaid benefits in this category; the individual must:

i. Have been entitled to a monthly Title II disabled Social Security Widow/Widower benefit for December 1983;

ii. Have been entitled to a received a Title II Social Security Widow/ Widower benefit for January 1984;

iii. Have lost SSI eligibility in the first month that her increased Widow/Widower benefit was paid, due to the elimination of the reduction factor;

iv. Have been entitled to the Social Security Widow/Widower benefit prior to age 60;

v. Have continuously been entitled to the Widow/Widower benefit from the month the benefit was increased;

vi. Have continued to be eligible for SSI when the Widow/Widower increase and all subsequent COLAs were disregarded; and

vii. Have applied for Medicaid benefits on the basis of this change in the Widow/Widower benefit prior to July 1, 1988.

3. Non-Financial Eligibility Requirements

a. Age

Individuals must be at least age 50 and up to age 65 when they lost SSI due to receipt of the Social Security Widow/Widower benefit.

b. Citizenship

Individuals must be U.S. citizens, U.S. nationals or eligible non-citizens. Individuals are not required to provide documentary evidence of citizenship or national status if they are receiving Social Security benefits.

c. Residency

Individuals must be residents of Tennessee.

d. Enumeration

Individuals must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN.

e. Received an SSI Payment

Individuals would continue to be eligible for SSI if the Social Security Widow/Widower benefit and subsequent COLAs were not counted as income.

f. Medicare Eligibility

Eligible individuals cannot be entitled to Medicare Part A.

4. Financial Eligibility Requirements

a. Eligibility Determination Group

Applicants/enrollees in the Widow/Widower Spousal Retirement category are treated as an individual, or have an Eligibility Determination Group (EDG) size of one.

b. Income Limit

The income limits for this category are the same as the current SSI Federal Benefit Rates (SSI-FBRs).

c. Resource Limit

The individual's countable resources must be under $2,000.

5. Budget Overview

a. Widow/Widower Entitlement Disregard

i. Initial Entitlement

The initial Widow/Widower entitlement amount is disregarded from the applicant's income.

ii. Social Security COLA or non-COLA Increase

Any Social Security COLA or non-COLA increases received by the individual after SSI was terminated are also disregarded.

b. Budget

Mrs. Jones became SSI-eligible based on disability. At age 62, she became entitled to Social Security Widow/Widower benefits of $500. This additional income placed Mrs. Jones over the SSI-FBR and her SSI payments terminated. She is not entitled to Medicare Part A. She has $200 of unearned pension income per month, and $300 of earned income.

Mrs. Jones' net countable income is $297.50. Since this amount is less than the SSI-FBR, $735, she is eligible in the Widow/Widower Spousal Retirement category.

Income Budget Calculation		
Unearned Income		$ 700.00
Irregular Unearned Income Disregard	+	$ 0.00

In-Kind Support and Maintenance	+	$ 0.00
Ineligible Spouse's Deemed Unearned Income	+	N/A
Ineligible Parent's Deemed Income	+	N/A
General Deduction ($20)	-	$ 20.00
Child Support Disregard	-	N/A
Widow/Widower Entitlement Disregard	-	$ 500.00
DAC Entitlement Disregard	-	N/A
COLA Disregard	-	$ 0.00
Total Net Unearned Income	=	$ 180.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 300.00
Irregular Earned Income Disregard	-	$ 0.00
Student Earned Income Exclusion	-	N/A
Ineligible Spouse's Deemed Earned Income	+	N/A
Remaining General Deduction	-	$ 0.00
Earned Income Deduction	-	$ 65.00
Impairment Related Work Expense	-	$ 0.00
½ Deduction	-	$ 117.50
Blind Work Expense	-	$ 0.00
Total Net Earned Income	=	$ 117.50
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 297.50
Qualified Income Trust	-	N/A
Net Countable Income		$ 297.50
Income Test Limit		$ 735.00
Income Test Result		PASS
Patient Liability		N/A

The above budget is current as of January 2017.

Document Title	Widow/Widower Categories				
First Published	03.13.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
01.05.2017	1.	Policy Statement	1	Non-Substantive Change	RH
01.05.2017	4.b.	Income Limit	3	Policy Clarification	RH
01.05.2017	5.b.5.; 5.c.6.;	Net Earned Income Computation; Countable Income Computation	4-5	Non-Substantive Change	RH
03.05.2018	4.b.; 5.b.v.; 5.c.vi.	Income Limit; Total Net Earned Income Computation; Countable Income Computation	3-5	Non-Substantive Change	SN
03.18.2019	2.a-2.a.iii.; 5.a.; 5.a.i;	Legal Authority; Widow/Widower Spousal Retirement; Widow/Widower Entitlement Disregard; Initial Entitlement	1-3	Policy Clarification	TN
03.18.2019	5.b.	Budget	4-5	Non-Substantive Change	AJ

KATIE BECKETT

Legal Authority: Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982; Family Opportunity Act of 2005; 42 CFR 435.225; Tenn. Code Ann. § 71-5-164; TennCare II Medicaid Section 1115 Demonstration

1. Policy Statement

The Katie Beckett program provides medical assistance to children under age 18 with disabilities or complex medical needs who live at home and do not otherwise qualify for Medicaid due to their parents' income or resources. Parent to child deeming is waived so that parents' income and resources are not counted in determining the child's eligibility. Katie Beckett Part A and B enrollment is subject to the availability of state appropriations.

2. Katie Beckett Groups

a. Katie Beckett Part A (Institutional Level of Care Group)

Children are potentially eligible for Katie Beckett Part A if they qualify for care in a medical institution and would qualify for Supplemental Security Income (SSI) but for their parents' income or resources. Children enrolled in Katie Beckett Part A receive full TennCare Medicaid benefits and up to $15,000 of specified Home and Community Based Services (HCBS) wraparound services.

b. Katie Beckett Part B (Diversion Group)

Katie Beckett Part B is for children with disabilities or complex medical needs who qualify for care in a medical institution or are at risk of institutionalization. Children enrolled in Katie Beckett Part B receive up to $10,000 of services, including specified HCBS through the Department of Intellectual and Developmental Disabilities (DIDD), but do not receive full TennCare Medicaid benefits.

c. Katie Beckett Continued Eligibility Group

The Katie Beckett Continued Eligibility Group is for children who are enrolled in TennCare Medicaid, are losing eligibility, and would qualify to enroll in Katie Beckett Part A, but for whom there is no Katie Beckett Part A slot available. Children enrolled in the Katie Beckett Continued Eligibility Group receive full TennCare Medicaid benefits.

3. Non-Financial Eligibility Requirements

Children eligible in a Katie Beckett group must meet all non-financial eligibility requirements.

a. Age: A child must be under age 18. Children enrolled in Katie Beckett Part A or the Katie Beckett Continued Eligibility Group may remain enrolled for up to 12 months following their 18th birthday if they have a pending application for SSI or their SSI application is in appeal status.

b. Level of Care (LOC): A child must be determined by the Long-Term Services and Supports (LTSS) Unit to qualify for the following LOC:

i. Katie Beckett Part A: Care in a medical institution
ii. Katie Beckett Part B: Care in a medical institution or at risk of institutional placement.
iii. Continued Eligibility Group: Care in a medical institution.

c. Citizenship: A child must be a U.S. citizen, U.S. national, or eligible non-citizen.

d. Enumeration: A child must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN, unless they meet an exception.

e. State Residence: A child must be a resident of Tennessee.

f. TennCare Medicaid Eligibility: A child must be ineligible for any other TennCare Medicaid or TennCare Standard category.

g. Private or Employer-Sponsored Insurance: For Katie Beckett Part A, a child must be enrolled in or obtain private or employer-sponsored insurance that provides minimum essential coverage, in accordance with 45 CFR 156.110(a). Private or employer-sponsored insurance may also be referred to as Third Party Liability (TPL).

h. Slot Status: Children must be granted a slot in order to be enrolled in Katie Beckett Part A or Katie Beckett Part B.

4. Requirement to Purchase and Maintain Health Insurance

Parents must obtain private or employer-sponsored insurance for children who do not have insurance upon enrollment in Katie Beckett Part A. Children who do not have private or employer-sponsored insurance and are enrolled in Katie Beckett Part A before October 1st of the current year will have until February 15th of the next year to be enrolled in and submit proof of insurance. Children who do not have private or employer-sponsored insurance and are enrolled in Katie Beckett Part A after October 1st of the current year will have until February 15th of the year following the next year to be enrolled in and submit proof of insurance.

a. Hardship Exception for Premium Assistance

A hardship exception for premium assistance can only be requested if a child does not have private or employer-sponsored insurance when the child is first enrolled in Katie Beckett Part A. A hardship is considered to exist if:

i. The cost of the child's portion of available private or employer-sponsored insurance, including the cost of coverage for the parent when the parent is required to purchase health coverage in order to obtain coverage for the child, exceeds 5% of the family's Modified Adjusted Gross Income (MAGI); or

ii. The family's MAGI is less than 400% of the Federal Poverty Level (FPL) and the child does not have access to employer-sponsored insurance through either parent's employer.

A family who meets hardship criteria must still purchase health insurance for the child but may be granted premium assistance to help cover the child's portion of the cost of insurance. For more information on premium assistance see section 8.

b. Loss of Health Insurance

Children enrolled in Katie Beckett Part A who lose their private or employer-sponsored insurance will have 60 days to be enrolled in and submit proof of other insurance. A hardship exception for premium assistance is not available to children who have lost insurance but had private or employer-sponsored insurance at the time of enrollment in Katie Beckett.

5. Financial Eligibility Requirements

Financial eligibility for the Katie Beckett COE is determined using Institutional Medicaid rules. Parent to child deeming of income and resources does not apply.

a. Eligibility Determination Group (EDG)

Financial eligibility is determined based on an EDG size of one. The only EDG member included is the applicant.

b. Income Limit

The income of the child must be no more than 300% of the SSI Federal Benefit Rate (SSI-FBR).

c. Resource Limit

The child's resources must not exceed $2,000.

6. Example Budget

Susie Smith, an eight-year old, lives in the household with her mom, stepdad, and two siblings. Susie is disabled but does not qualify for SSI due to her family's income and resources. The household is over the income limit for all Medicaid categories and does not have enough medical bills to meet a spenddown. Susie receives $300 month in child support and has no resources. She is covered under her father's insurance at work.

Income Budget Calculation		
Unearned Income		$ 300.00
Irregular Unearned Income Disregard	+	N/A
In-Kind Support and Maintenance	+	N/A
Ineligible Spouse's Deemed Unearned Income	+	N/A
Ineligible Parent's Deemed Income	+	N/A
General Deduction ($20)	-	N/A
Child Support Disregard	-	N/A
Widow/Widower Entitlement Disregard	-	N/A
DAC Entitlement Disregard	-	N/A
COLA Disregard	-	N/A
Total Net Unearned Income	=	$ 300.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 0.00
Irregular Earned Income Disregard	-	N/A
Student Earned Income Exclusion	-	N/A
Ineligible Spouse's Deemed Earned Income	+	N/A
Remaining General Deduction	-	N/A
Earned Income Deduction	-	N/A
Impairment Related Work Expense	-	N/A
½ Deduction	-	N/A
Blind Work Expense	-	N/A
Total Net Earned Income	=	$ 0.00
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 300.00
Qualified Income Trust	-	N/A
Net Countable Income		$ 300.00
Income Test Limit		$ 2,349.00
Income Test Result		PASS

The above budget is current as of January 2020.

Susie meets nursing facility LOC and has been granted a Katie Beckett Part A slot. Susie is eligible for Katie Beckett Part A.

7. Katie Beckett Part A Premium Payment Requirement

a. General Rule

As a condition of enrollment and continued eligibility for Katie Beckett Part A, children whose families have income of more than 150% of the FPL may be required to pay a monthly premium. The child's premium is determined based on the family's income and household size, using the MAGI methodology. The premium is calculated on a sliding scale using the table below:

Household Income (MAGI)	**Premium % of income for a household of two**	**Monthly premium**
>150% - 250% FPL	1.5%	$25
>250% - 300% FPL	2.5%	$75
>300% - 400% FPL	3%	$125
>400% - 500% FPL	4%	$225
>500% FPL - No limit	5%	$350 + $70 for every 100% above 500%

The Katie Beckett Part A premium is reduced by the cost of the child's portion of employer-sponsored or private insurance. If the child's portion of employer-sponsored or private insurance (including the cost of coverage for the parent when the parent is required to purchase health coverage in order to obtain coverage for the child) equals or exceeds the child's monthly premium for Katie Beckett Part A, the child will not have a premium obligation for Katie Beckett Part A.

Example 1: Jacob Zimmerman lives in the home with his mother, father, and sister. The family's MAGI is $10,000 a month. The FPL for a household of 4 for 2020 is $2,184 a month. The family's household income is more than 400% of the FPL. Since the household income is between 400% and 500% of the FPL, the Katie Beckett Part A premium would be $225 per month. However, Jacob has private insurance. The total cost of the family's private insurance is $400 per month. Jacob's father is not required to obtain coverage for himself in order to obtain coverage for Jacob. Jacob's portion of insurance is calculated by dividing the total cost of the insurance by the number of household members covered under the insurance. Jacob's insurance is $100 per month ($400/4 = $100). Jacob's monthly premium for Katie Beckett Part A is reduced by his portion of his family's private insurance. Jacob's monthly Katie Beckett Part A premium is $125 per month ($225 - $100 = $125).

Example 2: Emily Cruz lives in the home with her mother, father, and 3 siblings. The family's MAGI is $8,800 a month. The FPL for a household of 6 for 2020 is $2,930 a month. The family's household income is more than 300% of the FPL. Since the household income is between 300% and 400% of the FPL, the Katie Beckett Part A premium would be $125 per month. However, Emily has insurance through her mother's employer. The total cost of the family's insurance is $375 per month. Emily's mother is required to purchase insurance for herself in order to obtain coverage for Emily. Emily's portion of insurance, including the cost of coverage for her mother, is calculated by dividing the total cost of the insurance by the number of household members covered under the insurance and multiplying by 2. Emily's insurance is $125 per month ($375/6 = $62.50 x 2 = $125). Emily's monthly premium for Katie Beckett Part A is reduced by her portion of her family's insurance. Emily's monthly Katie Beckett Part A premium is $0 per month ($125 -$125 = 0). Emily does not have a Katie Beckett Part A premium obligation.

b. Initial Premium Payment

The first month's Katie Beckett Part A premium, along with electronic automatic payment arrangements for subsequent premiums, must be received before children who have a premium obligation can be enrolled in Katie Beckett Part A. The first month's premium is due 60 days from the date the notice is mailed informing the household of the Katie Beckett Part A premium obligation amount. If the first month's premium is not received within 60 days of the notice, the child will be denied for Katie Beckett Part A. The Katie Beckett Part A program slot will not be held unless a timely appeal is filed. If a timely appeal is filed, the Katie Beckett Part A program slot will be held until the conclusion of the appeal process.

c. Non-Payment of Premiums

After the initial Katie Beckett Part A premium payment is made, ongoing premium payments must be made via automatic bank draft on the first of each month. If all or part of a premium is more than 30 days in arrears, an advance notice of suspension will be sent and program benefits for Katie Beckett Part A will be suspended if the premium is not paid. If all or part of premium payments are more than 60 days in arrears, an advance notice of program termination for non-payment of premiums will be sent. If the premium payments in arrears are paid in full before the effective date of termination, program benefits will return to active status back to the date they were suspended. If the premium payments in arrears are not paid in full before the effective date of termination, the child will be disenrolled from Katie Beckett Part A.

An appeal may be filed regarding the premium amount calculated or premium payments made. If an appeal is filed after the date of suspension, benefits will remain in suspended status pending the appeal but will be retroactively reinstated if resolved in the enrollee's favor. A child who no longer qualifies for Katie Beckett Part A due to non-payment of premiums will be disenrolled from TennCare only after also being determined ineligible for all open TennCare categories. If the child later reapplies for Katie Beckett Part A, all arrearages and the first month's premium must be paid in advance for the child to be re-enrolled in Katie Beckett Part A.

8. Premium Assistance

If a family meets the requirements of a hardship exception, the family may receive premium assistance to help with the cost of the child's private or employer-sponsored insurance, including the cost of coverage for the child's parent when the parent must purchase health coverage in order to obtain coverage for the child. See Hardship Exception for Premium Assistance in section 4.a. Premium assistance will begin from the date the premium assistance is authorized or the date the individual enrolls in and pays their initial private or employer-sponsored insurance premium, whichever is later.

Assistance with premium payments is limited to the lesser of:

a. The amount by which the child's portion of the family's monthly private or employer-sponsored insurance premium exceeds the child's Katie Beckett Group Part A premium; or
b. The amount by which the lowest cost silver-level child-only plan in the highest rating region in Tennessee offered through the Federally Facilitated Marketplace (FFM).

Effective 01/01/2024, the lowest cost silver-level child-only plan in the highest rating region in Tennessee offered through the FFM is $343 per month.

If the child's monthly Katie Beckett Part A premium equals or exceeds the child's portion of private or employer-sponsored insurance or the lowest cost silver-level child-only plan in the highest rating region in Tennessee offered through the FFM, whichever amount is less, the premium assistance amount is $0.

Example: Ryan White lives with his parents and 2 siblings. The family's MAGI is $7,500 a month. The FPL for a household of 5 for 2020 is $2,557. Since the family's MAGI is less than 400% of the FPL, and Ryan does not have access to insurance through either of his parent's employer and was not enrolled in private insurance when he was enrolled in Katie Beckett Part A, Ryan meets the conditions for hardship and may receive premium assistance to help cover the cost of insurance. The cost of private insurance for the family is $600 a month. Ryan's portion of the insurance is $120 ($600/5 = $120). Since the household income is between 250% and 300% of the FPL, his Katie Beckett Part A Premium is $75 per month. Ryan is eligible for $45 per month in premium assistance ($120 - $75 = $45).

9. Katie Beckett Effective Date

a. Katie Beckett Part A

i. For children who do not have a Katie Beckett Part A premium obligation, Katie Beckett Part A begins on the date the case is approved in the eligibility determination system.

ii. For children who have a Katie Beckett Part A premium obligation, Katie Beckett Part A begins on the date the initial premium payment is received in full, along with automatic electronic payment arrangements for ongoing premiums.

b. Katie Beckett Part B

Katie Beckett Part B begins on the date of application or the date all eligibility requirements are met, whichever is later.

c. Katie Beckett Continued Eligibility Group

Katie Beckett Continued Eligibility Group begins on the date of transition from TennCare Medicaid.

10. Redetermination

Financial eligibility and level of care are redetermined annually for children enrolled in any part of the Katie Beckett program. DIDD is responsible for completing the annual redetermination for children enrolled in Katie Beckett Part B. Families must report changes during the eligibility period that affect a child's eligibility for services. Families of children enrolled in Katie Beckett Part A are not required to report changes in family income that may impact a child's Katie Beckett Part A premium until the next redetermination.

Document Title	Katie Beckett
First Published	11.23.2020

Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
06.01.2021	3.f.-g.; 4.; 8.	Non-Financial Eligibility Requirements; Requirement to Purchase and Maintain Health Insurance; Premium Assistance	2-3; 6-7	Policy Clarification	TN
01.04.2022	4.; 8.	Requirement to Purchase and Maintain Health Insurance; Premium Assistance	2; 7	Policy Clarification	TN
02.01.2023	8.	Premium Assistance	7	Non-Substantive Change	SA
01.02.2024	8.	Premium Assistance	7	Non-Substantive Change	CE

MEDICARE SAVINGS PROGRAMS OVERVIEW

Legal Authority: Social Security Act § 1905(p)(1); 42 CFR 400.200; 42 CFR 435.406

1. Overview

Medicare is a national health insurance program administered by the federal government for individuals aged 65 and above, and disabled individuals. Medicare is a comprehensive health insurance program, but Medicare enrollees are required to pay premiums, certain out of pocket costs, and for services not covered by the program. The Medicare Catastrophic Coverage Act (MCCA) of 1988 created the Medicare Savings Programs (MSPs), which are a set of Medicaid programs available only to Medicare enrollees who meet specific resource and income standards. The MSPs provide for payments of Medicare premiums, coinsurance, and deductibles for Medicare-covered services.

The four MSPs are:

- Qualified Medicare Beneficiaries (QMB);
- Specified Low-Income Medicare Beneficiaries (SLMB);
- Qualifying Individuals (QI1); and
- Qualified Disabled Working Individuals (QDWI).

2. Medicare Eligibility

An individual is entitled to receive Medicare benefits when:

- He or she is 65 years or older, is a U.S. citizen or has been permanent legal residents for 5 continuous years, and the individual or his or her spouse has paid Medicare taxes for at least 10 years; or
- He or she is under age 65 and has been receiving either Social Security or Railroad Retirement Board disability benefits for at least 24 months; or
- He or she is receiving dialysis for End Stage Renal Disease (ESRD) or needs a kidney transplant; or
- He or she is eligible for Social Security Disability Insurance (SSDI) and has ALS or Lou Gehrig’s disease.

Most Medicare beneficiaries are automatically enrolled in Medicare Parts A and B when they become eligible. Those who are not entitled to premium-free Medicare Part A, such as those individuals who are over age 65 but did not pay enough Medicare taxes, must apply for coverage and pay a monthly premium. These individuals are considered entitled to enroll in Medicare and are eligible for the MSPs.

3. Medicare Enrollment Period

There are two enrollment periods for Medicare Parts A and B:

a. The initial enrollment period, which includes:

- The three months prior to an individual's 65th birthday or 25th month of disability benefits receipt;
- The month of the 65th birthday or 25th month of disability benefits receipt; and
- The three months after the month of the 65th birthday or 25th month of disability benefits receipt.

b. The general enrollment period, which includes the months of January, February, and March of each year.

c. Enrollment Period Exceptions

Enrollment period requirements are waived for certain MSP applicants and enrollees. The following list provides situations when an individual can be immediately enrolled into Medicare Part A or B.

- Applicants who are enrolled in Medicare Part A, but who refused Part B coverage during initial Medicare enrollment are enrolled into Part B by the state upon approval of an MSP (QMB, SLMB or QI1).
- Applicants who have established Medicare Part B, but who do not have Medicare Part A coverage, are enrolled into Part A by the state upon approval of QMB only.

Note: Tennessee is a Part A Buy-In state, which means the state has elected to cover QMB for individuals who are eligible to purchase Medicare Part A. The Part A Buy-In program allows a state to enroll a QMB-eligible individual into Part A if the individual has already established Part B.

See a description of TennCare's Medicare Buy-In Unit below.

4. Medicare Parts and Benefits Overview

Medicare is made up of four separate "Parts": A, B, C and D.

a. Medicare Part A

i. Eligibility

An individual who receives Social Security benefits and has sufficient work quarters is eligible for premium-free Medicare Part A, if one of the following applies:

1. Age 65 or older;
2. Disabled for 24 months or more;
3. Fits into a special Medicare-covered group;
4. Enrolled through ESRD program;

5. No longer considered disabled due to work activities (limited eligibility period).

Individuals who are not eligible for premium-free Medicare may become eligible by paying the Part A monthly premium. An individual under age 65 who does not receive SSDI benefits cannot buy into Part A coverage.

ii. Benefits

Medicare Part A coverage includes inpatient hospitalization, some follow-up and 100 days of skilled level nursing home care.

b. Medicare Part B

i. Eligibility

Medicare Part B coverage is available to any individual age 65 or older, or to individuals who have enough work quarters and have been disabled for a minimum of 24 months. Eligible individuals must pay monthly premiums.

ii. Benefits

Medicare Part B coverage includes physician services, laboratory and x-ray services, medical supplies, outpatient hospital care, and other services.

c. Medicare Part C

Medicare Part C is also known as the Medicare Advantage plans. Individuals who are eligible for Medicare Parts A and B may choose to receive their Medicare benefits through private health insurance plans. These plans are administered by health insurance companies, rather than the federal government.

d. Medicare Part D

Medicare Part D is the outpatient prescription drug coverage component of Medicare. Anyone who is eligible/enrolled in Part A or B is eligible for Part D. Part D is administered by private health insurance companies and pharmacy benefit managers but is regulated by CMS.

5. Application for MSPs

a. Application Forms

Acceptable application forms for the MSPs include the TennCare application or an application submitted to the FFM. The TennCare application and FFM account transfer are processed by TennCare. In addition, the Low-income Subsidy (LIS) applications for Medicare Part D also initiate an application for the MSPs.

The Social Security Administration (SSA) transmits LIS files to the State daily, which triggera review for MSP eligibility.

The MSP application date is the date the LIS application is filed with SSA. If an LIS application is approved for SLMB or QI1, the benefits will begin the date the LIS application was filed at the SSA office. If approved for QMB, the benefits will begin the month after the approval is authorized.

b. TennCare's Medicare Buy-In Unit

For applicants and enrollees who must have Medicare Part A or B established by the state, the Medicare Buy-In Unit is responsible for notifying CMS and/or SSA to begin coverage. The Buy-In Unit sends a manual notification to CMS to begin Medicare in the following situations:

- An applicant is approved for QMB, SLMB, or QI1 and needs to be enrolled in Medicare Part B;
- An SSI-recipient has reached aged 65 and must have Medicare Part A established. (The SSA establishes Medicare Part B.);
- An applicant is approved for QMB and is enrolled in Medicare Part B, but must have Medicare Part A established;
- An applicant already has active Part B enrollment, needs to have Part A enrollment started with a Part A buy-in, and is eligible for QMB and/or SSI;
- An applicant is already actively enrolled in both Parts A and B, is approved for QMB and/or SSI, Part A is not free, and the applicant needs to have a Part A buy-in set up so the state can take over payment of Part A premiums;
- An applicant is already actively enrolled in both Parts A and B, does not have free Part A, is approved for QMB and/or SSI, and has buy-in(s) for one or both parts from another state which are either still active or recently closed.

Document Title	Medicare Savings Programs Overview				
First Published	3.4.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
1.3.2018	2	Medicare Eligibility	1	Policy Clarification	AJ
1.3.2018	3(c)	Medicare Enrollment Period – Enrollment Period Exceptions	2	Policy Clarification	AJ
3.1.2024	3(c)	Medicare Enrollment Period – Enrollment Period Exceptions	2	Policy Clarification	LW
3.1.2024	5(b)	Application for MSPs-TennCare’s Medicare Buy-in Unit	4	Policy Clarification	LW

QUALIFIED MEDICARE BENEFICIARY

Legal Authority: Social Security Act §1905(p)(1); 42 CFR 400.200; 42 CFR 435.406; Tenn. Comp. R. & Regs. 1200-13-20-.08(7)(a)

1. Overview

The Medicare Catastrophic Coverage Act (MCCA) of 1988 established the Qualified Medicare Beneficiary (QMB) program. The QMB program provides Medicaid benefits to individuals who are entitled to Medicare Part A, have monthly income and resources under the specific limits and who meet the non-financial eligibility requirements of the Medicaid program. Individuals enrolled in QMB receive Medicaid payment of Medicare premiums, coinsurance, and deductibles for Medicare-covered services.

2. Policy Statement

To be eligible in the QMB category an individual must be entitled to Medicare Part A, have income that does not exceed 100% of the Federal Poverty Level (FPL) and not have resources over $9,430 for an individual or $14,130 for a couple.

3. QMB Benefits

QMB benefits include payment of:

a. Medicare Part A premiums (for individuals who do not receive premium free Part A coverage);
b. Medicare Part B premiums;
c. Medicare deductibles; and
d. Medicare coinsurance (the cost share amount the enrollee is responsible to pay).

Note: QMB recipients are not subject to Medicare copay provisions.

QMB eligibility will establish Medicare Part B effective the month after approval, even if the individual had previously refused Part B coverage. QMB eligibility will also establish Medicare Part A, if the applicant has already established Part B coverage. TennCare will establish Part A or B coverage with the Social Security Administration (SSA), therefore it is not necessary to refer these individuals to the SSA.

4. QMB Effective Date

The eligibility start date is the first day of the month after the application is approved.

Note: QMB is the only MSP in which the coverage effective date is first day of the month after the application is approved.

5. Non-Financial Eligibility Requirements

a. Medicare Part A (Hospital Insurance)

Individuals must be entitled to Medicare Part A benefits. Individuals may be either entitled to receive premium-free Medicare Part A, or eligible to purchase Medicare Part A. See the *Medicare Savings Program Overview* policy.

TennCare will use an individual's Social Security Number (SSN) to verify his entitlement to and receipt of Medicare Part A benefits with the SSA.

Applicants who are enrolled in Part B only, but are otherwise eligible for QMB, will be determined eligible for QMB and the state will enroll them into Medicare Part A once the Medicare Buy-in Unit is notified by the eligibility worker. See the *Medicare Savings Program Overview* policy for additional information on when to notify TennCare's Medicare Buy-in Unit.

b. Age

If an applicant is eligible on the basis of age, he must be age 65 or older. There is no age limit for individuals who are eligible on the basis of disability.

c. Citizenship

Individuals must be U.S. citizens, U.S. nationals, or eligible non-citizens. Individuals are not required to provide documentary evidence of citizenship or national status if they are entitled to or enrolled in any part of Medicare.

d. Enumeration

Individuals must possess and provide a valid SSN or proof of application for an SSN, unless they meet an exception.

e. State Residence

Individuals in this category must be residents of Tennessee.

6. Financial Eligibility Requirements

a. Eligibility Determination Group

The Eligibility Determination Group (EDG) is governed by the principle of Financially Responsible Relatives (FRR) and the applicant/enrollee's living arrangements. See the *ABD Eligibility Determination Group* policy.

b. Income Limit

The income limit for receiving benefits in this category is up to 100% FPL.

c. Resource Limit

The resource limit for receiving benefits in this category is:

i. $9,430 for an individual; or
ii. $14,130 for a couple.

d. Cost-of-Living Adjustment (COLA) Disregard

The SSA is responsible for applying COLA to its benefit programs, including Old-Age, Survivors, and Disability Insurance (OASDI), Railroad Retirement Benefits (RRB), and Supplemental Security Income (SSI). If the SSA applies a COLA for a given year, it is applied on January 1st of that year. However, the annual update for FPLs is not typically released until March or April. This can cause individuals who were previously QMB eligible to become income-ineligible due to their increased Social Security income in the period between the COLA adjustment and the FPL increase.

To address the discrepancy caused by the timing of the COLA and FPL adjustments, QMB enrollees who become income-ineligible in January are provided with a COLA disregard for the months of January, February, March, and if needed, April. The COLA disregard is equal to the amount of the monthly COLA increase.

e. Budget

Mr. Johnson is applying for medical assistance. He is entitled to and enrolled in Medicare Parts A and B and meets all non-financial eligibility requirements. Mr. Johnson has $750 in OASDI payments per month, $150 in unearned income per month, and $0 in earned income. Mr. Johnson is not married.

Mr. Johnson’s net countable monthly income of $880 is less than 100% FPL, $1,005 for an EDG size of 1, so he is income eligible in the QMB category.

Income Budget Calculation		
Unearned Income		$ 900.00
Irregular Unearned Income Disregard		$ 0.00
In-Kind Support and Maintenance	+	$ 0.00
Ineligible Spouse’s Deemed Unearned Income	+	$ 0.00
Ineligible Parent’s Deemed Income	+	$ 0.00
General Deduction ($20)	-	$ 20.00

Child Support Disregard	-	$ 0.00
Widow/Widower Entitlement Disregard	-	$ 0.00
DAC Entitlement Disregard	-	$ 0.00
COLA Disregard	-	$ 0.00
Total Net Unearned Income	=	$ 880.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 0.00
Irregular Earned Income Disregard	-	$ 0.00
Student Earned Income Exclusion	-	$ 0.00
Ineligible Spouse's Deemed Earned Income	+	$ 0.00
Remaining General Deduction	-	$ 0.00
Earned Income Deduction	-	$ 0.00
Impairment Related Work Expense	-	$ 0.00
½ Deduction	-	$ 0.00
Blind Work Expense	-	$ 0.00
Total Net Earned Income	=	$ 0.00
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 880.00
Qualified Income Trust	-	$ 0.00
Net Countable Income		$ 880.00
Income Test Limit		$ 1,005.00
Income Test Result		PASS
Patient Liability		N/A

The above budget is current as of April 2017.

7. QMB and TennCare Medicaid Eligibility

Individuals may be eligible for both TennCare Medicaid and QMB, with the exception of TennCare Standard. Only individuals with "grandfathered status" in TennCare Standard may be eligible for both TennCare Standard and QMB because TennCare Standard enrollees, other than those with grandfathered status, are not allowed to have access to third party insurance.

Applicants/enrollees may not receive benefits in more than one MSP.

Document Title	Qualified Medicare Beneficiary
First Published	03.18.2015

Revision History

Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
06.02.2017	2.	Policy Statement	1	Non-Substantive Change	RH
06.02.2017	6.c.	Resource Limit	2-3	Policy Clarification	RH
01.03.2018	1.; 6.c.	Overview; Resource Limit	2-3	Policy Clarification	AJ
01.03.2018	2.	Policy Statement	1	Policy Change	AJ
03.18.2019	2; 6.a.; 6.c.; 6.e.	Legal Authority; Policy Statement; Resource Limit; Eligibility Determination Group; Budget	1-4	Policy Clarification	SN
01.02.2020	2.; 6c.	Policy Statement; Resource Limit	1; 3	Non-Substantive Change	TN
01.04.2021	2.; 6c.	Policy Statement; Resource Limit	1; 3	Non-Substantive Change	TN
01.04.2022	2.; 6c.	Policy Statement; Resource Limit	1; 3	Non-Substantive Change	TN
01.03.2023	2.; 6c.	Policy Statement; Resource Limit	1; 3	Non-Substantive Change	KF
01.02.2024	2.; 6c.	Policy Statement; Resource Limit	1; 3	Non-Substantive Change	CE
03.01.2024	5.a.	Medicare Part A (Hospital Insurance)	2	Policy Clarification	LW
03.08.2024	3.	QMB Benefits	1	Policy Clarification	LW

QUALIFYING INDIVIDUALS 1

Legal Authority: Social Security Act § 1902(a)(10)(E), §1933; 42 USC 1396a(a)(10)(E)(iv); 42 CFR 435.406; Tenn. Comp. R. & Regs. 1200-13-20

1. Overview

The Balanced Budget Act (BBA) of 1997 created the Qualifying Individuals 1 (QI1) program for states to assist eligible individuals with payment of the Medicare Part B premium. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 permanently extended the QI1 program.

2. Policy Statement

To be eligible in the QI1 category an individual must be entitled to Medicare Part A, have income at least at 120%, but less than 135%, of the Federal Poverty Level (FPL) and not have resources over $9,430 for an individual or $14,130 for a couple. To be eligible in the QI1 category, individuals must not be enrolled in TennCare Medicaid or TennCare Standard.

3. QI1 Effective Date

Eligibility begins the date a TennCare application or Low-Income Subsidy (LIS) application is filed or the date all eligibility requirements are met, whichever is later.

4. QI1 Benefits

The QI1 program only pays the current Medicare Part B premium. If an applicant is approved for QI1 and previously refused Part B coverage, the QI1 approval will automatically establish Part B coverage.

5. Non-Financial Eligibility Requirements

a. Medicare Part A (Hospital Insurance)

Individuals must be enrolled in Medicare Part A. Individuals may either be entitled to receive premium-free Medicare Part A or eligible to purchase Medicare Part A. See the *Medicare Savings Program Overview* policy.

TennCare will use an individual's Social Security Number (SSN) to verify her entitlement to and receipt of Medicare Part A benefits with the Social Security Administration (SSA).

b. Age

If an applicant is eligible on the basis of age, he must be age 65 or older. There is no age limit for individuals who are eligible on the basis of disability.

c. Citizenship

Individuals must be U.S. citizens, U.S. nationals or eligible non-citizens. Individuals are not required to provide documentary evidence of citizenship or national status if they are entitled to or enrolled in any part of Medicare.

d. Enumeration

Individuals must possess and provide a valid SSN or proof of application for an SSN, unless they meet an exception.

e. State Residence

Individuals in this category must be residents of Tennessee.

6. Financial Eligibility Requirements

a. Eligibility Determination Group

The Eligibility Determination Group (EDG) is governed by the principle of Financially Responsible Relatives (FRR) and the applicant/enrollee's living arrangements. See the *ABD Eligibility Determination Group* policy.

b. Income Limit

The income limit for receiving benefits in this category is at least 120%, but less than 135% FPL for an individual or couple.

c. Resource Limit

The resource limit for receiving benefits in this category is:

i. $9,430 for an individual; or
ii. $14,130 for a couple.

d. Cost-of-Living Adjustment (COLA) Disregard

The SSA is responsible for applying COLA to its benefit programs, including Old-Age, Survivors, and Disability Insurance (OASDI), Railroad Retirement Benefits (RRB) and Supplemental Security Income (SSI). If the SSA applies a COLA for a given year, it is applied on January 1st of that year. However, the annual update for FPLs is not typically released until March or April. This can cause individuals who were previously QI1 eligible to become income-ineligible due to their increased Social Security income in the period between the COLA adjustment and the FPL increase.

To address the discrepancy caused by the timing of the COLA and FPL adjustments, QI1 enrollees who become income-ineligible in January are provided with a COLA disregard for the months of January, February, March, and if needed, April. The COLA disregard is equal to the amount of the monthly COLA increase.

e. Budget

Mrs. Harrison is applying for medical assistance. She is entitled to and enrolled in Medicare Parts A and B, and meets all non-financial eligibility requirements. Mrs. Harrison receives $850 in OASDI payments per month, $430 in additional unearned income per month, and $0 in earned income. Mrs. Harrison is not married.

Mrs. Harrison's total countable income, $1,260, is greater than 120% FPL but less than 135%, so she is eligible for the QI1 category.

Income Budget Calculation		
Unearned Income		$1,280.00
Irregular Unearned Income Disregard		$ 0.00
In-Kind Support and Maintenance	+	$ 0.00
Ineligible Spouse's Deemed Unearned Income	+	$ 0.00
Ineligible Parent's Deemed Income	+	$ 0.00
General Deduction ($20)	-	$ 20.00
Child Support Disregard	-	$ 0.00
Widow/Widower Entitlement Disregard	-	N/A
DAC Entitlement Disregard	-	N/A
COLA Disregard	-	N/A
Total Net Unearned Income	=	$1,260.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 0.00
Irregular Earned Income Disregard	-	$ 0.00
Student Earned Income Exclusion	-	$ 0.00
Ineligible Spouse's Deemed Earned Income	+	$ 0.00
Remaining General Deduction	-	$ 0.00
Earned Income Deduction	-	$ 0.00
Impairment Related Work Expense	-	$ 0.00
½ Deduction	-	$ 0.00
Blind Work Expense	-	$ 0.00
Total Net Earned Income	=	$ 0.00
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$1,260.00
Qualified Income Trust	-	N/A
Net Countable Income		$1,260.00
Income Test Limit		$1357.00

Income Test Result		PASS
Patient Liability		N/A

The above budget is current as of April 2017.

7. QI1 and TennCare Medicaid Eligibility

QI1 enrollees may not also enroll in TennCare Medicaid or TennCare Standard. If an applicant is eligible for a TennCare Medicaid category and QI1, she should be determined eligible in the TennCare Medicaid category.

Applicants/enrollees may not receive benefits in more than one Medicare Savings Program.

Document Title	Qualified Individuals 1				
First Published	03.18.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
06.02.2017	1.; 6.c.	Policy Statement; Resource Limit	1-2	Policy Clarification	RH
01.03.2018	2.; 5.a.; 6.c	Policy Statement; Medicare Part A (Hospital Insurance); Resource Limit	1-2	Policy Clarification	AJ
03.18.2019	2.; 6.a.; 6.c.; 6.e.	Legal Authority; Policy Statement; Eligibility Determination Group; Resource Limit; Budget	1-2	Policy Clarification	ME
07.01.2019	5.a.	Legal Authority; Medicare Part A (Hospital Insurance)	1	Policy Clarification	AJ
01.02.2020	2.; 6.c.	Policy Statement; Resource Limit	1; 3	Non-Substantive Change	TN
01.04.2021	2.; 6.c.	Policy Statement; Resource Limit	1; 2	Non-Substantive Change	TN
01.04.2022	2.; 6.c.	Policy Statement; Resource Limit	1; 2	Non-Substantive Change	TN
01.03.2023	2.; 6c.	Policy Statement; Resource Limit	1; 2	Non-Substantive Change	KF
01.02.2024	2.; 6c.	Policy Statement; Resource Limit	1; 2	Non-Substantive Change	CE

QUALIFIED DISABLED WORKING INDIVIDUALS

Legal Authority: Social Security Act § 1905(s)

1. Overview

Section 6012 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 provides an option to purchase Medicare Hospital Insurance Benefits (Part A) for an indefinite period for certain Disabled Working Individuals (DWI) under age 65 who are no longer entitled to premium-free Medicare Part A because they returned to work. Section 6048(s) of OBRA 1989 requires states to "buy in" the Medicare Part A only premium for those DWIs who meet all the requirements of being a Qualified Disabled Working Individual (QDWI).

2. Policy Statement

To be eligible in the QDWI category an individual must:

a. Be under age 65;
b. Have a disabling impairment (determined by the Social Security Administration (SSA));
c. Be eligible to enroll in Medicare Part A, but no longer entitled to free Medicare Part A due to Substantial Gainful Activity (SGA);
d. Have income that does not exceed 200% of the Federal Poverty Level (FPL);
e. Not have resources over $4,000 for an individual or $6,000 for a couple;
f. Not be eligible for TennCare Medicaid; and
g. Meet all non-financial eligibility requirements.

3. SSA's Responsibility

When an individual who was previously disabled returns to work, the SSA will:

a. Determine continuous disability;
b. Determine whether the income the individual receives exceeds the SGA limits;
c. Notify the individual of Medicare termination and the opportunity to purchase continued coverage and/or apply for Medicaid assistance; and
d. Update the Social Security system with the DWI eligibility determination and enrollment.

4. QDWI Benefits

QDWI individuals receive payment of Medicare Part A premiums only. QDWI eligibility does NOT pay for Part B Medicare premiums, co-insurance or deductibles.

If the individual is enrolled as a DWI more than 3 months prior to becoming eligible as a QDWI, the individual may be responsible for the premiums in the months prior to QDWI eligibility.

5. QDWI Effective Date

Eligibility begins the date a TennCare application or LIS application is filed or the date all eligibility requirements are met, whichever is later.

6. Non-Financial Eligibility Requirements

a. Age

Individuals must be under age 65 to be eligible in this category.

b. Citizenship

Individuals must be U.S. citizens, U.S. nationals or eligible non-citizens. Individuals are not required to provide documentary evidence of citizenship or national status if they are entitled to or enrolled in any part of Medicare.

c. Enumeration

Individuals must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN, unless they meet an exception.

d. State Residence

Individuals in this category must be residents of Tennessee.

7. Financial Eligibility Requirements

a. Eligibility Determination Group

The Eligibility Determination Group (EDG) is governed by the principle of Financially Responsible Relatives (FRR) and the applicant/enrollee's living arrangements. See the *ABD Eligibility Determination Group* policy.

b. Income Limit

The income limit for receiving benefits in this category is up to 200% FPL for an individual or couple.

c. Resource Limit

The resource limit for receiving benefits in this category is:

i. $4,000 for an individual; or
ii. $6,000 for a couple.

d. Cost of Living Adjustment (COLA) Disregard

The SSA is responsible for applying COLA to its benefit programs, including Old-Age, Survivors, and Disability Insurance (OASDI), Railroad Retirement Benefits (RRB) and Supplemental Security Income (SSI). If the SSA applies a COLA for a given year, it is applied on January 1st of that year. However, the annual update for FPLs is not typically released until March or April. This can cause individuals who were previously QDWI eligible to become income-ineligible due to their increased Social Security income in the period between the COLA adjustment and the FPL increase.

To address the discrepancy caused by the timing of the COLA and FPL adjustments, QDWI enrollees who become income-ineligible in January are provided with a COLA disregard for the months of January, February, March, and if needed, April. The COLA disregard is equal to the amount of the monthly COLA increase.

e. Budget

Mr. Davis is 60 years old, has been determined a DWI by SSA, but is no longer entitled to premium free Medicare Part A. Mr. Davis receives $1,300 in earned income per month, and $200 in unearned income per month. Mr. Davis is not married.

Mr. Davis's total countable income, $797.50, is less than 200% FPL, $2,010, so he is income eligible for the QDWI category.

Income Budget Calculation		
Unearned Income		$ 200.00
Irregular Unearned Income Disregard	+	$ 0.00
In-Kind Support and Maintenance	+	$ 0.00
Ineligible Spouse's Deemed Unearned Income	+	$ 0.00
Ineligible Parent's Deemed Income	+	$ 0.00
General Deduction ($20)	-	$ 20.00
Child Support Disregard	-	$ 0.00
Widow/Widower Entitlement Disregard	-	N/A
DAC Entitlement Disregard	-	N/A
COLA Disregard	-	N/A
Total Net Unearned Income	=	$ 180.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 1,300.00
Irregular Earned Income Disregard	-	$ 0.00
Student Earned Income Exclusion	-	$ 0.00
Ineligible Spouse's Deemed Earned Income	+	$ 0.00
Remaining General Deduction	-	$ 0.00
Earned Income Deduction	-	$ 65.00
Impairment Related Work Expense	-	$ 0.00
½ Deduction	-	$ 617.50
Blind Work Expense	-	$ 0.00
Total Net Earned Income	=	$ 617.50
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 797.50

Qualified Income Trust	-	$ 0.00
Net Countable Income		$ 797.50
Income Test Limit		$ 2,010.00
Income Test Result		PASS
Patient Liability		N/A

The above budget is current as of March 2017.

8. Termination of QDWI Benefits

An individual will lose QDWI eligibility when:

a. He becomes eligible for any category of TennCare Medicaid;
b. Personal resources exceed the resource limit;
c. Income exceeds 200% of the current FPL;
d. She becomes age 65 and is entitled to premium-free Medicare Part A; or
e. SSA notifies TennCare that the individual is no longer considered disabled.

Document Title	Qualified Disabled Working Individuals				
First Published	03.18.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	7.a.	Eligibility Determination Group	2	Policy Clarification	RZ
03.18.2019	7.e.	Budget	3 - 4	Non-Substantive Change	RZ

INSTITUTIONAL STATUS

Legal Authority: 42 CFR 435.1009; 42 CFR 435.1010; 42 CFR 435.236; 42 CFR 435.622; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

An individual must be institutionalized in order to receive benefits in the Institutional Medicaid category.

An individual is considered institutionalized when he has:

a. Been admitted to a medical institution (i.e. hospital, Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)), and has been continuously confined for at least 30 days;
b. Been admitted to a Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and has been or determined by TennCare to be likely to be continuously confined for at least 30 days going forward;
c. Applied to enroll in the Home and Community-Based Services (HCBS) waiver program, and has been determined to need and likely to receive services for a continuous period of at least 30 days going forward; or
d. Died while in long-term care nursing facility prior to meeting the 30 days continuous confinement requirement.

2. Continuous Confinement

a. Individuals with a Pre-Admission Evaluation (PAE)

An individual with a PAE is considered continuously confined when she has:

i. Been admitted to a NF or ICF/IID and has been determined by TennCare to be likely to be continuously confined for at least 30 days going forward, demonstrated by an approved PAE which is effective for at least 30 days;
ii. Been admitted to a NF or ICF/IID and the period of time spent in a medical institution combined with the period of time for which an approved PAE is effective exceeds 30 days; or
iii. Been determined to need and likely to receive HCBS for a continuous period of at least 30 days going forward, demonstrated by an approved PAE and a CHOICES Enrollment form or 2350 form, as applicable. If a 2350 form is used, the form must be received from the Department of Intellectual and Developmental Disability (DIDD) for enrollment into an DIDD waiver program.

b. Individuals without a PAE

An individual without a PAE is considered continuously confined when he:

i. Has been admitted to a medical institution and is continuously confined in a medical institution (i.e. hospital, NF or ICF/IID) for at least 30 days;
ii. Is dually-eligible for Medicare and Medicaid, and is receiving Level 2 Skilled Nursing Facility (SNF) care paid by Medicare. Medicare pays for the first 100 days of Level 2 SNF care; or
iii. Has been admitted to a NF to receive hospice services for any length of time.

Note: A dual-eligible individual receiving SNF care paid for by Medicare does not need to be in an Institutional Medicaid category for TennCare to pay the Medicare co-pay. She must receive QMB, but may be eligible as a Supplemental Security Income (SSI) recipient or in another TennCare Medicaid category.

Note: If the dual-eligible individual continues to need Long-Term Services and Supports (LTSS) after his Medicare-covered stay in the SNF, then he must apply for CHOICES. If the individual is applying for HCBS services, he will need a PAE. If the individual applies for nursing facility care, he will need a PAE or may be approved based on continuous confinement.

3. Institution Types

An institution is an establishment that provides food, shelter, treatment and services to four or more individuals. Types of institutions include:

a. Medical Institution

An institution authorized by state law and organized to provide medical care, including nursing and convalescent care. Examples of medical institutions include: hospitals, convalescent or progressive care centers, and Long-Term Care Facilities (LTCFs), providing both skilled and intermediate care.

b. Institution for the Intellectually and Developmentally Disabled

An institution organized primarily for the diagnosis, treatment or rehabilitation of the intellectually and developmentally disabled. It provides a protected residential setting for the evaluation, rehabilitation and 24-hour supervision of the patient.

c. Institution for Mental Disease (IMD)

An institution licensed to provide diagnosis, treatment or care for persons with mental diseases.

TennCare Medicaid reimbursement is limited to care provided for an eligible individual who is at least 65 years of age and confined to an approved ward.

Confinement in an IMD does satisfy and establish institutional status for individuals under age 65 and those confined to unapproved wards; therefore, when subsequently admitted to a medical institution these individuals may already meet confinement.

d. Public Institution

A public institution is an institution serving more than 16 residents that is the responsibility of or controlled by a governmental unit. A public institution does not include:

i. A medical institution; or
ii. An intermediate care facility (ICF), including those providing services to individuals age 65 and older in institutions for tuberculosis or mental disease.

e. Institution for Tuberculosis

A facility established and maintained primarily for the care and treatment of tuberculosis. Tennessee does not have any chest disease or tuberculosis hospitals. Reimbursement is available to an out-of-state hospital for a Tennessee resident who requires such care.

4. Special Low-Income Group

The following individuals are considered to be institutionalized when confined to a medical institution (i.e. hospital) for at least 30 days and are not eligible in another TennCare Medicaid Category of Eligibility (COE):

a. Children (under 18 years of age or under 22 years of age if a student regularly attending school);
b. Pregnant women;
c. Aged individuals as defined in the *Institutional Medicaid* policy;
d. Blind individuals as defined in the *Institutional Medicaid* policy; or
e. Disabled individuals as defined in the *Institutional Medicaid* policy.

Note: Institutionalized individuals cannot be considered caretaker relatives as individuals confined to a medical institution for 30 days or more no longer meet the Caretaker Relative Status criteria as defined in the *Caretaker Relative MAGI* policy.

5. Inmate of a Public Institution

a. Inmate Status

Inmate means any person living in a public institution who was committed under the penal system with no exception. Inmate status suspends receipt of Medicaid benefits, but is no longer considered a factor when looking at non-financial eligibility criteria.

The following would not be considered inmates:

i. Individuals in public educational or vocational institutions designed for the primary purposes of educational or vocational training designed to prepare her for gainful employment;

ii. Individuals temporarily confined pending other arrangements appropriate to his needs; or

iii. Individuals receiving medical treatment in a ward approved by TennCare, such as patients in certified wards of State Developmental Centers for Intellectual and Developmental Disabilities, including certified ICF/IID wards and certified SNF, as well as patients in certified wards of State Mental Health Hospitals and Private Certified Mental Health Hospitals.

b. Termination of Inmate Status

Inmate status is interrupted or terminated when an individual is admitted as an inpatient to a medical institution for more than 24 hours, except for those committed under the penal system. Inmate status for those committed under the penal system terminates upon release from custody. Release means:

i. Parole;

ii. Pardon;

iii. Bail; or

iv. Dismissal of charges.

6. Verification of Institutional Status

Establish the individual’s institutional status using any one of the following methods or evidence as appropriate.

a. Continuous Confinement to a Medical Institution for 30 Days (Hospital or Similar Institution)

Verify that the individual has been continuously confined in a medical institution for a period of at least 30 days. Check with the hospital admission office either by phone or written correspondence to verify admission and discharge dates. Review the individual’s bill for hospital charges as it may include an admission and a discharge date.

b. LTCF

Evidence of an individual’s institutional status includes:

i. An approved PAE in the appropriate TennCare Pre-Admission Evaluation System (TPAES) queue; or

ii. A completed Form 2350, Notice Recipient-Patient Admitted to or Discharged from Skilled Nursing Home Care or Intermediate Care.

c. Confinement to an IMD

Form 2350 from a Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) facility is sufficient evidence that the unit to which the individual was admitted is one qualified for TennCare Medicaid reimbursement. The voluntary admission form the individual signed prior to admission to substantiate that the individual is not an inmate.

d. Enrollment in HCBS

The individual must have an approved PAE to be eligible to receive HCBS. An approved PAE is verification of institutionalized status.

7. Patient in an IMD

Patient includes an individual receiving professional services in an IMD, but does not include an individual on conditional release or convalescent leave from such an institution.

8. Coverage for Former Patients and Inmates of IMDs

a. Overview

A qualifying individual who is no longer a patient in an IMD or has had his inmate status interrupted may be eligible for TennCare Medicaid benefits upon his admission to a medical institution that is a Title XIX facility. Interruption of IMD patient status occurs when the individual is released, transferred from or receives convalescent leave from an IMD. Inmate status is interrupted when an individual is admitted to a medical institution unless he was admitted under the penal system, which requires release from the institution, i.e., parole, pardon, bail or dismissal of charges.

b. Tennessee IMD

An individual may qualify for TennCare Medicaid benefits as an institutionalized individual when his patient or inmate status in one of the following public institutions is interrupted:

- **i.** Memphis Mental Health Institute, Memphis;
- **ii.** Middle Tennessee Mental Health Institute, Nashville;
- **iii.** Western Mental Health Institute, Bolivar; or
- **iv.** Moccasin Bend Mental Health Institute, Chattanooga

These individuals must follow all procedures for filing an application for assistance and must meet all non-financial and financial requirements for TennCare Medicaid. As applications are processed for this group, refer to any individuals who might qualify for Supplemental Security Income (SSI) cash assistance to Social Security. Eligibility for SSI cash assistance includes TennCare Medicaid benefits.

The IMD representative will arrange for placement in a medical institution and will develop a plan with either the individual's family or the medical facility to apply for TennCare Medicaid. Because of the individual's former patient or inmate status, TennCare should be able to secure all necessary information from an IMD representative. If the IMD representative applies on behalf of the patient, she will act as the responsible person for the patient.

9. Children in Residential Treatment Centers

Children in residential treatment centers are not considered to be continuously confined for the purpose of determining institutional status.

When a child is ordered by Juvenile Court or by a treating physician to undergo a psychiatric evaluation or treatment for a sex offense, alcohol and drug abuse or some other type of residential treatment, the cost of care is the responsibility of the child's family if the child remains in the custody of his parents or other caretaker relative.

a. Children not Currently Receiving TennCare Medicaid

If a child is placed in a residential treatment center and the family cannot afford to pay the cost of care, the family may apply for medical assistance. The child will be considered a member of the household whose absence from the home is temporary. This policy is applied to children who are in approved treatment centers, whether in state or out of state facilities.

Note: Residential treatment when medically necessary is a TennCare covered service for children.

b. Children Currently Receiving TennCare Medicaid

TennCare Medicaid or TennCare Standard children who enter residential treatment facilities, such as those for sex offenses or alcohol and drug abuse and are in the custody of a parent or caretaker relative may be eligible in their existing COE. Children in this situation should still be considered a member of the household whose absence from the home is temporary.

As long as the child intends to return, the child will continue to be considered a member of her household and retain eligibility in the original COE received prior to placement in the treatment facility. If at any time during the absence it is determined that the child is no longer eligible for benefits, eligibility will be terminated.

10. HCBS

a. General Description

HCBS is provided in a home or community setting as an alternative to, or to delay the need for, LTSS in a NF or ICF/IID. HCBS is available to individuals who qualify for and are enrolled in CHOICES.

b. Waiver Types

i. HCBS

The HCBS program is authorized by a waiver of TennCare Medicaid statutory requirements. In this waiver program:

1. Services are provided to individuals in their own homes or in a facility participating in the HCBS program who would otherwise require the level of care (LOC) provided in an ICF;
2. Services are required to be furnished under an individual written plan of care; and
3. Individuals enrolled must meet the same eligibility criteria as if admitted to an ICF.

Note: Group homes are considered a community-based setting, so individuals living in those settings could be eligible for HCBS benefits.

ii. Employment and Community First (ECF) CHOICES

ECF CHOICES is an HCBS program designed to support individuals with intellectual and developmental disabilities (I/DD) of all ages in realizing their employment and independent living goals. Individuals enrolled must either meet NF LOC or be at risk for NF placement in the absence of HCBS. In addition, enrollees must:

1. Have been assessed and found to have an intellectual disability manifested before eighteen (18) years of age or a developmental disability manifested before twenty-two (22) years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); and

Note: For children five years old or younger a "developmental disability" refers to a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disability if services and supports are not provided.

2. Be enrolled in TennCare Medicaid as an SSI recipient or through one of the demonstration groups: ECF CHOICES 217-Like Group or Interim ECF CHOICES At-Risk Group.

Eligibility for the ECF CHOICES 217-Like Group and the Interim ECF CHOICES At-Risk Group is determined based on Institutional Medicaid non-financial and financial eligibility rules.

iii. DIDD Waivers

The DIDD waivers provide LTSS for individuals with intellectual disabilities through ICF/IIDs and HCBS.

Individuals eligible for a DIDD waiver must meet the non-financial and financial eligibility requirements of the Institutional Medicaid category or receive Medicaid through SSI. There are three DIDD HCBS waivers for individuals with intellectual disabilities:

1. Comprehensive Aggregate Cap Waiver

Individuals qualify for, and absent the provision of waiver services would be placed in, an ICF/IID.

To enroll in this waiver program, an individual must:

a. Meet TennCare ICF/IID LOC criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a PAE approved by TennCare;
b. Have been assessed and found to have an intellectual disability manifested before eighteen 18 years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); and
c. Have been identified by the state as a former member of the certified class in the United States vs. State of Tennessee, et al. (Arlington Developmental Center), a current member of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), or an individual transitioned from the Statewide Waiver (#0128) upon its renewal on January 1, 2015, because he was identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver.

2. State-Wide ID Waiver

The Statewide ID Waiver provides services to Tennessee children with developmental delays and adults and children with intellectual disabilities who meet the ICF/IID LOC criteria.

To enroll in this waiver program, an individual must:

a. Meet TennCare ICF/IID LOC criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a PAE approved by TennCare; and
b. Have been assessed and found to:

i. Have an intellectual disability manifested before eighteen (18) years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); or

ii. Have a developmental disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in an intellectual disability and be a child five (5) years of age or younger.

3. Self-Determination Waiver

The Self-Determination Waiver provides community-based services to individuals with developmental disabilities who would otherwise require the level of care provided in an ICF/IID

To enroll in this waiver program, an individual must:

a. Meet TennCare ICF/IID LOC criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a PAE approved by TennCare;

b. Have been assessed and found to:

i. Have an intellectual disability manifested before eighteen (18) years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); or,

ii. Have a developmental disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting an intellectual disability and be a child five (5) years of age or younger; and

iii. Not require residential waiver services (e.g., family model, residential habilitation, supported living) and have an established non-institutional place of residence where the individual lives with family, a non-related caregiver or the individual’s own home.

Document Title	Institutional Status				
First Published	4.17.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
07.01.2016	9.b.ii	Employment and Community First (ECF) CHOICES	6-7	Section Addition	AJ
04.01.2020	2.a.; 2.b.; 7.b.; 8.b.	Legal Authority; Individuals with a Pre-Admission Evaluation (PAE); Individuals without a PAE; Tennessee IMD; Children Currently Receiving TennCare Medicaid	1-2; 5-6	Policy Clarification	TN
05.01.2020	5.b-5.d	LTCF; Confinement to and IMD; Enrollment in HCBS	4	Non-Substantive Change	TN
05.01.2020	1; 2.a-b.; 4; 5.a	Policy Statement; Continuous Confinement, Special Income Level Group; Verification of Institutional Status	1	Policy Change	TB

TRANSFER OF ASSETS AND PENALTY PERIODS

Legal Authority: Social Security Act § 1917(c)**;** 42 USC 1396p; State Medicaid Manual § 3257; Tenn. Comp. R. & Regs. 1200-13-20-.08(5)(i-j)

1. Transfer of Assets for Less than Fair Market Value (FMV)

a. Policy Statement

The uncompensated value of a transferred asset is considered available and countable for the purpose of determining eligibility for TennCare Medicaid Long-Term Services & Supports (LTSS) payments. The uncompensated value of a transferred asset is the equity value minus the amount received by the individual. An otherwise eligible Medicaid applicant or recipient is ineligible for payment of LTSS payments (nursing facility or Home and Community Based Services (HCBS)) for a period directly related to the uncompensated value of an asset transferred for less than Fair Market Value (FMV).

Only the uncompensated value of an asset transferred on or after an individual's look-back date is considered available and countable for the purpose of determining eligibility for TennCare Medicaid LTSS payments.

b. Definitions

Asset	Asset refers to the value of the resource involved in the transfer, e.g., cash, bank accounts, bonds, real estate, etc. As of 8/11/1993, asset also refers to the value of the income, as well as the resource, of the total uncompensated value transferred.
Equity Value	The price that an item can reasonably be expected to sell for on the open market in a particular geographic area minus any encumbrances.
FMV	The price that an item can reasonably be expected to sell for on the open market in a particular geographic area at a given time.
Legal Representative	A guardian conservator or one who has the individual's power of attorney. Effective 10/1/1993 for transfers occurring on or after 8/11/1993, legal representative includes any court or administrative body or any person acting on behalf or at the request or direction of the institutionalized individual or his spouse.
Sole Benefit of a Transfer	A transfer of assets for the sole benefit of a spouse, blind or disabled child, or disabled individual is a transfer that is arranged in such a way that no other individual or entity may benefit from the assets transferred at the time of the transfer or at any time in the future.
Transfer	Transfer means the sale, exchange, donation or divestiture of a liquid or non-liquid asset including the exchange of an asset for one of less value, e.g., transfer of real property in exchange for a life estate in the property.

Uncompensated Value	The uncompensated value of an asset is the difference between the individual's equity in the asset at the time of transfer and the compensation he received in the transaction.
Institutionalized Individual	An institutionalized individual, for application of transfer of assets policy, includes the institutionalized individual, the institutionalized individual's spouse, legal representative (including a court or administrative body), or any person acting at the request of or direction of the institutionalized individual or the institutionalized individual's spouse.

c. Types of Transfers

In addition to giving away or selling property for less than FMV, the actions listed below may be considered uncompensated transfers of assets:

i. Altering or establishing joint accounts in which the individual gives up or limits his rights or access to or interest in the asset;
ii. Establishing an irrevocable trust;
iii. Purchasing an annuity that does not satisfy the Deficit Reduction Act (DRA) of 2005 requirements or making a change to an annuity that alters the course of payments or the treatment of the income or principal;
iv. Waiving entitled income or benefits;
v. Waiving or giving up an inheritance;
vi. Refusal to take legal action to obtain child support or alimony that is not being paid; or
vii. Purchasing an irrevocable burial trust that exceeds the value of merchandise and services.

d. Look-Back Period and Look-Back Date

The look-back period is sixty (60) months for all resource transfers made on or after 02/08/2006. An individual's look-back period is established on the first date the individual has applied for TennCare Medicaid and:

i. Is institutionalized; or
ii. Is determined to have met the requirements for home and community-based services.

When an individual is already enrolled in TennCare Medicaid and becomes institutionalized, the individual's look-back period is established on the first date of institutionalization.

The look-back date is the beginning of the look-back period and the earliest date on which a transfer of assets made for less than FMV can impact an individual's eligibility for LTSS. Once the look-back date is established for an individual, the look-back date does not change, regardless of multiple applications or multiple periods of eligibility. All transfers of assets made on or after the look-back date must be evaluated.

Example 1: Ms. Merriweather is institutionalized on January 3, 2017. She applies for Medicaid on February 8, 2017, but is denied. She reapplies for Medicaid on April 24, 2017. The look-back date is 60 months prior to the first date the individual met both requirements (i.e., institutionalization and application for Medicaid). Thus, the look-back date is February 8, 2012.

Example 2: Mr. Armstrong applies for Medicaid on August 8, 2016 and is approved. Mr. Armstrong becomes institutionalized on June 11, 2017. The look-back date is 60 months prior to the first date the individual met both requirements (i.e., institutionalization and application for Medicaid). Thus, the look-back date is June 11, 2012.

e. Effective Date Real Property is Evaluated as a Transfer of Assets

The effective date of the transfer of real property is the date the deed is registered with the Register of Deeds.

Example: Mrs. Jones quitclaims her homestead to her two sons on 10/15/2010. The deed is signed that day in the presence of a notary. The deed is not registered until 07/1/2012. TennCare must use the date the deed is registered as the effective date of the asset transfer.

In the Tennessee Attorney General Opinion 04-161, "failure to register a deed of conveyance for real property meant that such transfer has not occurred and that the property is still owned by the seller". Therefore, if the property has not been registered with the Register of Deeds office, it is still owned by its original owner.

The Eligibility Specialist may need to contact the Register of Deeds office for the county where the land is located to determine if a reported transfer of real property has been recorded. The Eligibility Specialist may also check how the deed is registered at the Tennessee Property Data home page at https://www.assessment.cot.tn.gov/RE_Assessment/. This proof will determine when or if ownership status of the real property changed.

f. Determining Whether a Transfer Occurred

i. Jointly Held Assets

Creation or alterations of jointly held assets which reduce or eliminate an asset for the institutionalized individual are transfers for less than FMV.

1. Transfers Involving Jointly Held Assets

Examples of transfers for less than FMV include:

a. An individual is added to an "and" account and the new owner refuses to sign for a withdrawal of funds; or

b. Removal of an institutionalized individual's name from an account that he previously co-owned; or
c. Addition of a joint owner who removes funds from the account for uses not allowed by policy (i.e., not for the sole benefit of a spouse or blind or disabled child).

2. Evaluation of Evidence

To determine whether a transfer took place under these conditions, evaluate the evidence and ask these questions:

a. How long has the asset been jointly owned?
b. Who contributed the largest share to purchase the asset?
c. Why did the joint owner transfer the asset or remove funds?

Document the case notes with information pertinent to the determination of whether the action constituted a transfer of assets.

ii. Transfer Executed by a Financially Responsible Relative (FRR) or Others

Effective 10/01/1993, transfers made 08/11/1993 or later by the institutionalized individual, the community spouse or legal representative including a court or administrative body at the request, direction or on behalf of the institutionalized individual or community spouse may result in a penalty for the institutionalized individual.

iii. Asset Exchange versus Asset Conversion

1. Exchange

The exchange of one asset for another is not a transfer provided the individual received FMV for the exchanged item. The exchange of a countable asset for one which is excluded is not a transfer of assets for less than FMV as long as the individual remains the owner.

Example: An individual exchanges $1000 cash surrender value of life insurance for an irrevocable burial arrangement of the same value. This is not a transfer of assets for less than FMV.

2. Conversion

The conversion of one asset for another is not a transfer of assets for less than FMV provided the individual receives FMV in the exchange, e.g. the individual uses $1500 cash to purchase an automobile valued at $1500.

g. Exempt Asset Transfers

Transfers of assets made under the following circumstances are not considered as transfers of assets for less than FMV:

i. The asset was transferred to the individual’s spouse or to another for the sole benefit of the individual’s spouse prior to establishment of Institutional Medicaid eligibility.

ii. The asset was transferred from the institutionalized or HCBS spouse to a community spouse during the 12-month transfer period after approval of TennCare Medicaid and was part of the Community Spouse Resource Maintenance Allowance (CSRMA). See the R*esource Assessment* policy.

iii. The asset was transferred to, or to a trust for the sole benefit of, the individual’s minor or adult child who is blind or disabled according to 42 USC 1382c.

iv. The asset was transferred to a trust established for the sole benefit of an individual under age 65 who is disabled according to 42 USC 1382c. See the *ABD Trust* policy. Contact the Policy Unit regarding assets transferred into a pooled trust for individuals age 65 and over.

v. The asset transferred is the individual’s home and title to the home was transferred to:

1. The spouse of the owner;
2. A child of the owner who is under age 21;
3. The owner’s adult child who is blind or disabled according to 42 USC 1382c;
4. A sibling of the owner who has equity interest in and has resided in the home for at least one year prior to the individual’s institutionalization; or
5. A child of the owner, regardless of age, who:
   - **a.** Resided with the individual for two years immediately prior to the individual’s nursing home admission; and
   - **b.** Provided care which permitted the individual to reside at home.

vi. The asset was transferred exclusively for a purpose other than qualifying for TennCare Medicaid, such as satisfaction of legally enforceable debts.

Note: The timing of payment of debts should be considered. For example, if a family member suddenly remembers or decides to collect on an alleged debt that has purportedly been outstanding for years, and no convincing evidence exists that either the individual affirmatively acknowledged the debt or worked toward satisfying the debt and the individual to whom the debt was owed made previous efforts to collect the debt, the validity of the debt and whether it is legally enforceable may be questionable.

h. Annuities

i. Overview

Although usually purchased in order to establish a source of income for retirement, annuities may be used to shelter assets so that the individual purchasing them may become eligible for Medicaid. The DRA of 2005 added new requirements with respect to the disclosure and treatment of annuities for Medicaid. Individuals applying for long-term services and supports must:

1. Disclose any interest the individual or spouse has in an annuity (see the *ABD Countable and Excluded Resources* policy);
2. Name the State of Tennessee as a remainder beneficiary under any annuity purchased on or after February 8, 2006; and
3. Demonstrate that the purchase of any annuity and any annuity-related transaction made by the individual or spouse on or after February 8, 2006 was not a transfer of assets for less than fair market value.

ii. Requirement to Name the State as a Remainder Beneficiary

LTSS applicants and spouses must designate the State of Tennessee as the primary beneficiary of any death benefit payable under any annuity purchased on or after February 8, 2006. If the individual has a community spouse, or a minor or disabled child, the State may be named in the second position following one of these individuals. If the State is named in the second position following a community spouse or child, the annuity must also provide that the State becomes the remainder beneficiary in the first position if the community spouse, the child, or their representative disposes of any of the remainder of the annuity for less than fair market value.

As a remainder beneficiary, the State may receive the total amount of medical assistance paid for long-term care on the individual's behalf. The State will notify the issuer of the annuity of the State's right as the preferred remainder beneficiary. The issuer must notify the State if there are any changes in the amount of income or principal being withdrawn.

Any annuity purchased by an individual or community spouse on or after the individual's look-back date that is not amended to meet these criteria should be treated as a transfer of assets for less than FMV. If an annuity does not have a death benefit or does not allow someone other than a surviving spouse to be named as a beneficiary, verification from the annuity issuer is required.

iii. Annuity Purchases

The purchase of an annuity on or after February 8, 2006 by or on behalf of an institutionalized individual who has applied for LTSS should be treated as a transfer of assets for less than fair market value, when it occurs on or after the individual's look-back date, unless the annuity:

1. Is considered either:

- **a.** An individual retirement annuity (Section 408(b) of the Internal Revenue Code of 1986 (IRC)); or
- **b.** A deemed Individual Retirement Account (IRA) under a qualified employer plan (Section 408(q) of the IRC).

OR

2. Is purchased with the proceeds from one of the following:

- **a.** A traditional IRA (Section 408(a) of the IRC);
- **b.** Certain accounts or trusts which are treated as traditional IRAs (Section 408(c) of the IRC);
- **c.** A simple retirement account (Section 408(p) of the IRC);
- **d.** A simplified employee pension (Section 408(k) of the IRC); or
- **e.** A Roth IRA (Section 408A of the IRC).

OR

3. Meets all of the following requirements:

- **a.** Is irrevocable;
- **b.** Is non-assignable;
- **c.** Is actuarially sound; and
- **d.** Provides for payments in equal amounts during the term of the annuity, with no deferral or balloon payments.

Note**:** The above criteria should not be applied to annuities that are purchased with the applicant's or couple's assets that are held by the community spouse, annuities that are purchased entirely with the assets of someone other than the applicant or spouse, and annuities that are determined to be available to the applicant as a resource (see the *ABD Countable and Excluded Resources* policy).

4. Determining Whether an Annuity is Actuarially Sound

An annuity is actuarially sound when the expected return on the annuity will be paid within the actual or expected lifetime of the annuitant.

To determine whether an annuity is actuarially sound, multiply the annual amount scheduled to be paid out by the period of the annuity. If the period of the annuity is based on the annuitant's lifetime, the annual payments are multiplied by the individual's life expectancy at the time of annuitization, see *SSA Period Life Table* http://www.ssa.gov/oact/STATS/table4c6.html. If the annuity is a period certain annuity, annual payments are multiplied by the annuitant's life expectancy or the period certain, whichever is less. The calculated amount is the amount the annuity is expected to pay out during the individual's lifetime. If this amount is equal to or greater than the cash value of the annuity on the date it was annuitized, the annuity is actuarially sound.

When the cash value of the annuity on the date it was annuitized is greater than the amount that is expected to be paid out during the individual's lifetime, the difference between the two is an uncompensated transfer of assets.

iv. Annuity Transactions

Since annuities owned by an applicant must be considered in determining the state's obligation towards the cost of long-term care and/or the applicant's eligibility for TennCare Medicaid, certain annuity transactions made on or after February 8, 2006 by an applicant, or by someone acting on his behalf, on or after the look-back date, can be considered asset transfers made for less than FMV. Transactions include any action taken that changes the course of payments to be made by an annuity or the treatment of the income or principal of an annuity.

Annuity transactions include, but are not limited to:

1. Adding unscheduled contributions to an annuity;
2. Making elective withdrawals from an annuity;
3. Assigning an annuity or payments in whole or in part to another person or entity;
4. Annuitizing the contract;
5. Changing the beneficiary of an annuity, in such a way that the annuity no longer names the state in the proper position; and
6. Changing the annuitant or distribution from an annuity, in such a way that the annuity no longer pays out the full value of the annuity to the applicant in equal amounts during the applicant's lifetime.

Example: Mr. Greenfield discloses at application that he has assigned annuity payments to an irrevocable trust, from which no payments can be made to or for his own benefit. Since the transaction occurred on or after the look-back date and the transfer is not exempt under transfer of assets rules, the annuity transaction is a transfer of assets for less than FMV.

Annuity transactions made by a community spouse prior to the establishment of Institutional Medicaid eligibility may also be evaluated as improper transfers. Routine changes (e.g., change of address, notification of the death or divorce of a remainder beneficiary) and changes beyond the individual's control are not considered transfers of assets for less than FMV.

v. Annuity is a Transfer of Assets for Less than FMV

If an annuity purchase or transaction is determined to be an uncompensated transfer of assets, a penalty period will be applied. The amount used to calculate the penalty period is the full purchase price of the annuity, with two exceptions. When an annuity is determined to not be actuarially sound, the penalty period is determined using the difference between the cash value of the annuity on the date it was annuitized and the amount the annuity is expected to pay out during the individual's lifetime. If an annuity transaction is determined to be a transfer of assets for less than FMV, the penalty period is determined using the difference between the transaction amount and any compensation received.

i. Excluded Resources Requiring Transfer Information

Transfers of the following excluded resources must be evaluated in order to determine that adequate compensation was received. The initial exclusion of these resources was based on their intended use, and a transfer may void the exclusion:

i. Burial space excluded based on its intended use; and
ii. Real property excluded as property essential to self-support or as a homestead.

j. Transfer Executed by an Individual's Legal Representative

A transfer of assets for less than FMV made by any of the following people or entities will result in a penalty period for the institutionalized individual:

i. A person, court, or administrative body with legal authority to act on behalf of or in place of the individual and/or her spouse; or
ii. A person, court or administrative body acting at the direction of or request of the individual and/or her spouse.

k. Compensation

i. Determining Compensation

To determine whether the individual received fair compensation for the transferred asset, subtract the amount the individual received in the transaction from the FMV of the asset, as follows:

FMV – Compensation Received = Uncompensated Value (Round the result to the nearest whole dollar)

If the individual alleges that part or all of his compensation is in-kind, attach a dollar value to the support and/or maintenance and subtract that value from the FMV as shown above. If the individual alleges he has an agreement for total support and care from the individual to whom he transferred the asset, determine the monthly amount of the support and care contribution. If the individual has transferred an asset in exchange for lifetime medical care, he may not be eligible for TennCare Medicaid benefits. See Section 1(n) Life Care Contracts.

ii. Fair Compensation

An individual receives fair compensation for a transferred asset if the compensated value is equal to or greater than 100% of the FMV of the asset on the date of transfer or contract for sale. Compensation may be in cash or in-kind.

iii. In-Kind Compensation

In-kind compensation is limited to agreements of support or maintenance. Compensation in the form of support or maintenance is acceptable if the individual can provide verification of the value of the in-kind compensation in written documentation form, including cancelled checks, receipts, etc.

A transfer of assets in exchange for total support and care requires a determination of the amount of the monthly support and care contribution provided by the individual to whom the asset was transferred.

iv. Unfair Compensation

An asset is transferred for less than FMV if the compensated value received by the individual is less than the FMV of the asset on the date of transfer or contract for sale. If the asset was transferred for less than FMV, presume that the asset was transferred to establish eligibility for TennCare Medicaid benefits unless one of the following applies:

1. The individual can rebut either of the transfer presumptions:
   a. transfer to attain TennCare Medicaid eligibility, or
   b. receipt of unfair compensation; or
2. The transfer was executed by the individual’s legal representative, other than a spouse, without her knowledge or permission prior to 08/11/1993; or
3. Hardship is determined to exist for transfers of assets belonging to institutionalized individuals occurring 07/01/1988 or later.

The uncompensated value of the transferred asset is counted in determining the period of ineligibility for LTSS payments.

l. Rebuttal of the Transfer Presumption

An individual may rebut one or both of the following presumptions regarding a transferred asset: the transfer was done to establish eligibility for TennCare Medicaid benefits; or the individual received inadequate compensation, i.e. less than FMV for the asset.

i. Rebuttal of the Transfer to Establish TennCare Medicaid Eligibility

The individual has the right to rebut the presumption that an asset was transferred to establish TennCare Medicaid eligibility. He must present convincing evidence that the transfer was executed solely for some other purpose and that TennCare Medicaid eligibility was not a factor in his decision.

Request substantiating evidence and a written statement from the individual that includes the following:

1. The individual’s reasons for transferring the asset;
2. The individual’s attempts to dispose of the asset for its FMV; and
3. The individual’s reasons for accepting less than the FMV in the exchange.

The Eligibility Specialist will document the individual’s cooperation in providing needed information regarding the transfer immediately.

ii. Rebuttal of the Inadequate Compensation Determination

The individual can rebut the determination that fair compensation was not received for the transferred asset.

Request a written statement from the individual that includes a description of attempts to dispose of the asset for its FMV and reasons for accepting less than the FMV.

1. **Written Statement**

   Request that the individual provide written documentation from at least two knowledgeable sources familiar with the type of transferred asset, e.g. real estate agent that contains:

   a. The specific reason(s) the transferred resource could not be sold for its FMV; and
   b. A statement that indicates that the price the individual realized in the transaction was justified under the circumstances.

iii. Successful Rebuttal

If the individual is successful in her rebuttal of either of the above assumptions, do not count any uncompensated asset value as an available asset in determining her eligibility. Document in the case notes a thorough explanation of the decision and the facts upon which it is based.

iv. Unsuccessful Rebuttal

If the individual's rebuttal is unsuccessful, consider the uncompensated value of the transferred asset as an available asset in the eligibility determination.

1. **Evaluation of Evidence**

   Evaluate the individual's evidence carefully and consult a supervisor, keeping in mind the following consideration:

   a. Did the individual make an effort to obtain a fair price?
   b. Regarding the compensation received:
      i. What percentage of the real value did the individual receive?
      ii. Why did the individual accept less than FMV?
      iii. Are the reasons the individual accepted less than FMV supported by factual evidence and was the individual's action justified?
      iv. What was the timing of the transfer with the Medicaid application? Was it before the individual knew about TennCare Medicaid or the program's resource limitation, or did the transfer take place just before the individual applied or just after being advised of ineligibility due to excess resources? Were the assets unreported and later transferred after eligibility was established, based on erroneous information provided by the individual or responsible/legal representative?

m. Hardship

Hardship is considered to exist if the institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limit and application of the penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of loss of food, clothing, shelter, or other necessities of life.

Note: If the community spouse has available assets, he is legally obligated for the support of his spouse; therefore, hardship does not exist.

Requests for hardship must be filed within ninety (90) days of the date of application, or if filed later, no later than forty (40) days after the date of the denial or termination notice. A request for hardship can also be filed if an individual experiences a change in circumstances while serving a penalty period. TennCare will determine whether hardship exists and notify the individual within thirty (30) days of receiving a request for hardship. A hardship denial may be appealed within forty (40) days.

n. Life Care Contracts

An individual who has transferred her available assets to a third party in exchange for full medical care for life is considered to have entered into a life care contract. Because the individual has a third party medical resource legally responsible for all her medical needs, these individuals are not eligible for TennCare Medicaid benefits. These provisions apply even if the full amount of the individual's assets have been spent by the third party for her care, unless the contract between the two parties is void or not enforceable for some reason.

If the individual entered into a contract of more limited scope, i.e., the terms of the contract specified certain medical care limitations, she may be eligible for benefits.

i. Third Party Defined

For purposes of this policy, third party includes any individual, institution, corporation, or public or private agency liable or potentially liable for all or part of an individual's medical costs.

ii. Enforceable Contract

An enforceable contract does not exist when its terms cannot be fulfilled and are void or rescinded. A contract is rescinded when the third party is financially unable to fulfill its contractual responsibilities. Under these circumstances, the third party is legally obligated to return to the individual any remaining assets from those originally assigned in the contract.

The individual may be eligible for TennCare Medicaid after requiring a financial accounting from the third party of the following:

1. The full amount of income and resources originally assigned to the third party by the terms of the contract;
2. Total expenses paid and fees charged by the third party; and
3. The full amount of the refund.

The full amount of the refund is a countable asset.

iii. Contractual Agreement Limited in Scope

The contractual agreement that is limited in scope, i.e. limited to basic room and board, or basic room and board and partial medical services, may not preclude TennCare Medicaid eligibility.

Determine the individual's eligibility and review his transfer of assets to the third party as described in the transfer of assets policy, Section 1 *Transfer of Assets for Less than Fair Market Value (FMV)* of this chapter.

If the individual is determined to be eligible, TennCare Medicaid reimbursement is available for those items encompassed within the State Plan that are not included in the life care contract. The individual must fax or mail a copy of the life care contract to the Third Party Liability Unit of the Bureau of TennCare, who will enter the resource in the database.

Bureau of TennCare
Third Party Liability Unit
310 Great Circle Road
Nashville, TN 37243
Fax Number: 615-253-5588

2. Penalty Periods For Assets Transferred for Less than FMV

a. Policy Statement

An otherwise eligible TennCare Medicaid individual is ineligible for payment of TennCare Medicaid LTSS payments if a transfer of assets for less than FMV has occurred. Individuals in long term care facilities (LTCF) may be approved for TennCare Medicaid benefits in an Institutional Medicaid category (not LTSS payments), if otherwise eligible. HCBS applicants are not eligible for Institutional Medicaid, including demonstration equivalent categories such as 217-Like and the At-Risk Demonstration categories, during a penalty period. Institutional Medicaid eligibility for HCBS applicants is conditioned upon the actual receipt of HCBS services, which cannot commence until the applicant is able to enroll in the CHOICES program.

b. Calculating the Penalty Period for Assets Transferred on or after 02/08/2006

The penalty period for NF and HCBS applicants is calculated in the same manner. To determine the penalty period, divide the uncompensated value of the asset(s) transferred by the average daily private pay rate for nursing facility care at the time of application for TennCare Medicaid or the date of transfer, whichever is later.

Note: In order to comply with the requirement that partial month penalties are assessed, TennCare Medicaid will use the average daily rate of nursing facility care to calculate the penalty period.

Average Cost of Nursing Facility Care		
Date	**Daily Rate**	**Monthly Rate**
06/01/2011 – 11/30/2012	$152.23	$4,567.00
12/01/2012 – 02/28/2015	$153.02	$4,591.00
03/01/2015 – 12/31/2020	$182.42	$5,472.00
01/01/2021 – 12/31/2021	$219.36	$6,580.80
01/01/2022 – 12/31/2022	$228.41	$6,852.30
01/01/2023 – 12/31/2023	$236.34	$7,090.20
01/01/2024 – Present	$274.00	$8,220.00

The penalty period will determine the number of days in which the individual is ineligible for nursing facility services. Eligibility cannot begin until the full number of days has passed.

See Section 1.k.i. Determining Compensation.

Example: Mr. Haywood transferred an asset in January 2015 with an uncompensated value of $10,000. He applied for TennCare Medicaid on February 1, 2015. He is eligible for TennCare Medicaid, but for the transfer of asset for less than FMV. The individual has been in the nursing facility since February 1, 2015. The uncompensated value is divided by the average daily cost of nursing facility care to determine the penalty period: $10,000/153.02 = 65.3 days. Round down to the nearest whole number to determine the penalty period of 65 days.

The penalty period will begin on February 1, 2015, and will run for 65 days.

c. Penalty Periods for Assets Transferred On or After 02/08/2006

i. The DRA of 2005

The DRA of 2005 made the following changes to asset transfers occurring on or after 02/08/2006:

1. The look-back period for all transferred assets is 60 months; and

2. For applicants, the penalty period begins on the date on which the individual is eligible for TennCare Medicaid and would otherwise be receiving institutional level of care services but for the application of the penalty period.

ii. Penalty Period Start Date

1. Nursing Facility Individuals

For Nursing Facility individuals the start date for the penalty period is the later of:

a. The date the individual is eligible for Institutional Medicaid and would have been eligible for CHOICES if not for an improper transfer, or
b. The first day of the month in which the assets were transferred.

2. HCBS Individuals

For HCBS individuals that would be eligible for CHOICES if not for an improper transfer, the start date for the penalty period is the later of:

a. The date the individual would have been eligible for Institutional Medicaid (based on receipt of waivered services, i.e., CHOICES) if not for an improper transfer, or
b. The first day of the month in which the assets were transferred.

3. Other Considerations

The penalty period cannot begin until the expiration of any existing period of ineligibility. There is no limit on the maximum months of ineligibility. Once a penalty period begins, it will continue to run uninterrupted even if the individual subsequently stops receiving institutional level of care services.

Penalty periods for more than one transferred asset will run consecutively, not concurrently. Any uncompensated value from multiple transfers is added to the initial uncompensated value if penalty periods overlap to determine the consecutive penalty period.

When an enrollee is already receiving CHOICES, the individual is provided an advance notice before CHOICES benefits end.

Example: Ms. Crabtree entered the nursing facility and was enrolled in CHOICES on June 30, 2016. On March 28, 2017, Ms. Crabtree reported that she transferred an asset on March 20, 2017 with an uncompensated value of $7,000. She is eligible for TennCare Medicaid, but for the transfer of asset for less than FMV. The uncompensated value is divided by the average daily cost of nursing facility care to determine the penalty period:

$7,000/182.42 = 38.3 days. The penalty period of 38 days cannot begin until after an advance notice of adverse action is provided. If action is taken timely on the case, the earliest possible effective date for denial of LTSS payments is May 1, 2017. The penalty period starts on May 1, 2017.

d. Spousal Transfer Causes Penalty for Institutionalized Individual

If a spousal transfer results in a penalty for the institutionalized individual and the spouse becomes institutionalized during the established penalty period, the remaining penalty months must be apportioned between both spouses.

Example: Mrs. Carver enters a nursing home in 10/2007. A 60 month penalty beginning 10/2007 was assessed due to a transfer by Mr. Carver, the community spouse. In 8/2008, Mr. Carver goes into the nursing home and requests TennCare Medicaid beginning 8/2008 (the 11th month of the penalty period). In 8/2008, the remaining penalty period of 49 months is apportioned between both spouses, giving each a penalty period of 24.5 months or 745 days. During this penalty period, no nursing home payment is paid for either spouse.

If one spouse dies or is discharged from nursing care, the total remainder penalty period remaining for both spouses must be served by the spouse receiving nursing services.

e. Return of Transferred Asset

If the entire transferred resource is returned, the period of ineligibility does not apply. To meet this exception, the individual must reacquire the same percentage of ownership interest in the resource that existed prior to the original transfer. If partial ownership of the transferred resource is returned, the period of ineligibility is adjusted based on the ownership interest not returned. Reacquiring physical possession of the resource is not sufficient to meet this exception; the individual must also reacquire legal ownership of the resource.

f. Less Than the Entire Resource is Returned

If the entire resource is not returned, the period of ineligibility does not end. Re-compute the uncompensated value based on the adjusted uncompensated value. If additional funds are subsequently returned, it will be necessary to re-compute the uncompensated value again.

Note: The return of the resource to the individual is not counted as income to the individual.

g. Waiving of Entitled Income Benefits

When a single lump sum of income is transferred for less than FMV, calculate the penalty based on the total lump sum divided by the average private pay nursing home charge. Apply a partial month penalty if the amount of the uncompensated value is less than the average monthly private pay nursing home charge.

If a stream of income (i.e., income paid on a regular basis such as a pension or other benefit) is transferred to another for less than FMV, determine the approximate value of the income to be received during the individual's life expectancy. Divide the anticipated total of transferred income by the average private pay nursing home charge to determine the penalty period beginning with the month of transfer.

Example: Mrs. Dale, age 67, is entitled to a royalty payment of $200 per month or $2400 per year, but she has transferred that right to her nephew. At age 67, Mrs. Dale has a life expectancy (see SSA Period Life Table http://www.ssa.gov/oact/STATS/table4c6.html) of 18.76 years x $2400 year = $45,024. This uncompensated value divided by the average private pay nursing home charge equals the number of days of penalty.

h. Supplemental Security Income (SSI) Recipients (Effective 07/01/1988)

If it is determined that an SSI recipient or her spouse's assets have been transferred for less than FMV, the SSI recipient must serve the penalty period associated with that transfer prior to receiving TennCare Medicaid payment of long-term services and supports.

i. Notification

Before taking any action on the application, i.e., approval, closure, continuation or rejection, contact the individual (by telephone contact or failing that, by mail) and give him the following information:

- **i.** The decision regarding the transfer;
- **ii.** Identification of the transferred asset;
- **iii.** The amount of the uncompensated value;
- **iv.** The impact on the individual's resource eligibility;
- **v.** The length of the penalty period;
- **vi.** The individual's rebuttal rights and those procedures.

Allow the individual 10 days to respond with an indication of his rebuttal intention. If he does not respond, take the appropriate action observing standard advance notification procedures. Document the contact in the case notes. If a penalty period is imposed on an individual, a notice of denial of LTSS payments is issued.

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Revision History

Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
11.01.2018	1.a.-e.	Transfer of Assets for Less than Fair Market Value (FMV)	1-3	Policy Clarification	AJ
11.01.2018	1.g.	Exempt Asset Transfers	5	Policy Clarification	AJ
11.01.2018	1.h.	Annuities	6-9	Policy Change	AJ
11.01.2018	1.k.iii	In-Kind Compensation	10	Non-Substantive Change	AJ
11.01.2018	2.b.	Calculating the Penalty Period for Assets Transferred on or after 2/8/2006	15	Policy Change	RS
11.01.2018	2.c.i.	The DRA of 2005	15	Policy Clarification	AJ
11.01.2018	2.c.ii.	Penalty Period Start Date	16	Policy Change	AJ
11.01.2018	2.g.	Waiving of Entitled Income Benefits	17-18	Policy Change	AJ
11.01.2018	2.h.	Supplemental Security Income (SSI) Recipients (Effective 7-1-88)	18	Non-Substantive Change	AJ
11.01.2018	2.i.	Notification	18	Non-Substantive Change	AJ
05.03.2021	1.k.i.; 2.b.	Legal Authority; Determining Compensation; Calculating the Penalty Period for Assets Transferred on or after 02/08/2006	10; 15	Non-Substantive Change	TN
01.04.2022	2.b.	Calculating the Penalty Period for Assets Transferred on or after 02/08/2006	15	Non-Substantive Change	SA
03.01.2023	2.b.	Calculating the Penalty Period for Assets Transferred on or after 02/08/2006	15	Non-Substantive Change	KF
01.02.2024	2.b.	Calculating the Penalty Period for Assets Transferred on or after 02/08/2006	15	Non-Substantive Change	CE
03.01.2024	1.m.	Legal Authority; Hardship	1; 19	Policy Clarification	TC

d. Longevity of the Assessment

For residents in a medical institution, an assessment remains in effect until a TennCare Medicaid application is filed, regardless of any interruptions in confinement. For HCBS, staff should use the effective date of the earliest approved PAE to conduct the resource assessment. Staff should contact the Eligibility Policy Unit for additional guidance if there is a significant gap between PAE approval periods or the resource assessment effective date is unclear.

If a resource assessment is completed and the individual applies for TennCare Medicaid, but is found ineligible, the original resource assessment is still valid if the individual applies again in the future.

e. Application Filed at Assessment Request

When an assessment is requested, the individual or representative must provide all necessary documentation and verification in a timely manner to ensure that an accurate assessment can be completed. Once all necessary documentation and verifications are received, the assessment will be completed within a reasonable amount of time (i.e., 30 days from the date all required documentation is received).

Transfer of assets is considered as part of the application process whether a resource assessment has been previously requested or is requested at application.

3. Responsibilities of LTCF

LTCFs are required by law to notify all admitted residents, spouses, and representatives of their right to request an assessment of the resident’s assets and the assets of the community spouse.

The provider must inform all residents, spouses and representatives orally and in writing that they may request an assessment of their resources by contacting TennCare.

4. Resource Assessment Procedure

When a resource assessment is requested, appropriate documentation must be provided to verify resources included in the resource assessment. Once the assessment is completed and the amount of CSRMA is determined, a notice of the CSRMA determination is sent to the head of the household and, if applicable, the authorized representative.

5. CSRMA

a. CSRMA Amount

The CSRMA is based on the spouses' combined countable resources documented in the resource assessment. The amount of the CSRMA, based on the year of the snapshot date of the resource assessment, is the greater of:

- **i.** One-half (1/2) of the total countable resources, but not less than $30,828 or greater than $154,140 (as of January 2024);
- **ii.** One-half (1/2) of the total countable resources, but not less than $29,724 or greater than $148,620 (as of January 2023);
- **iii.** One-half (1/2) of the total countable resources, but not less than $27,480 or greater than $137,400 (as of January 2022);
- **iv.** One-half (1/2) of the total countable resources, but not less than $26,076 or greater than $130,380 (as of January 2021);
- **v.** One-half (1/2) of the total countable resources, but not less than $25,728 or greater than $128,640 (as of January 2020);
- **vi.** One-half (1/2) of the total countable resources, but not less than $25,284 or greater than $126,420 (as of January 2019);
- **vii.** One-half (1/2) of the total countable resources, but not less than $24,720 or greater than $123,600 (as of January 2018);
- **viii.** One-half (1/2) of the total countable resources, but not less than $24,180 or greater than $120,900 (as of January 2017);
- **ix.** One-half (1/2) of the total countable resources, but not less than $23,844 or greater than $119,220 (as of January 2015);
- **x.** One-half (1/2) of the total countable resources, but not less than $23,448 or greater than $117, 240 (January – December 2014);
- **xi.** The court-ordered amount; or
- **xii.** The amount determined by an appeals officer due to a hardship situation (extreme financial duress).

When an application is filed by or on behalf of the spouse seeking LTSS, the CSRMA amount determined in the resource assessment is the amount allocated to the community spouse. This amount is deducted from the combined resources of both spouses as of the first day of the first month for which assistance is requested. None of the community spouse's share of the resources is considered available to the individual when determining his TennCare Medicaid eligibility.

b. Refusal of CSRMA

A community spouse who receives Families First (FF), Supplemental Nutrition Assistance Program (SNAP) benefits, Supplemental Security Income (SSI), TennCare Medicaid, Veterans Affairs (VA) pension, Qualified Medicare Beneficiary (QMB) benefits, or other needs-based assistance may accept or decline all, some or none of the CSRMA if the allocation would cause the loss of or decrease in those program benefits. If the community spouse accepts only a portion of the CSRMA, the remainder amount is counted as part of the institutionalized spouse's resources.

c. CSRMA Examples

Example 1: The combined resources of Mr. and Mrs. Smith total $27,000. The total divided by 2 equals $13,500. Mr. Smith's, the community spouse's, share of the total resources is the required minimum ($26,076 for 2021). This leaves $924 available to the institutionalized spouse. Mrs. Smith is resource-eligible for Institutional Medicaid.

If the resources determined available to the institutionalized spouse exceed the $2,000 resource limit, the institutionalized individual is not eligible until resources are within allowable limits. See the *ABD Countable and Excluded Resources* policy.

Example 2: The combined resources of Mr. and Mrs. Revco total $54,000. The total divided by 2 equals $27,000. Since one-half of the total is above the required minimum for 2021, Mrs. Revco's share equals $27,000. This leaves $27,000 available to the institutionalized spouse. Mr. Revco must decrease his share of the resources to $2,000 in order to be resource-eligible. When total resources do not exceed $29,000 ($27,000 + $2,000), Mr. Revco will be resource eligible.

6. Resource Transfer as a Result of Assessment

a. CSRMA "Grace Period"

Sometimes a legal transfer of resources must occur to effectuate the results of a resource assessment (e.g., separating commingled funds, removing a spouse's name from a resource, establishing separate bank accounts). Following a resource assessment and initial approval of eligibility, resources must be transferred within 12 months of the approval. Both spouses must agree to the transfer in order to use the institutionalized spouse's share in determining her eligibility. The transfer may require conveyance of resources from the institutionalized individual to the community spouse, or vice versa.

b. Transfer Refusal

When the community spouse refuses to transfer resources to the institutionalized individual, the institutionalized spouse may still be eligible if the Eligibility Appeals Unit finds that undue hardship circumstances exist.

c. Hardship

Hardship may be determined when the institutionalized spouse and/or his spouse have resources in excess of the resource limit, the institutionalized spouse is otherwise eligible, and for whom TennCare Medicaid ineligibility will result in loss of essential nursing care which is not available from any other source.

If the community spouse has available assets, she is legally obligated to provide support. Hardship cannot be determined to exist unless assets have been reallocated as the result of an appeal decision or a court order.

7. CSRMA Appeals

a. When the Individual and/or Spouse Has Appeal Rights

Appeal rights are considered only after a TennCare Medicaid application has been filed and either spouse alleges that the assessment or eligibility determination decision is incorrect. An assessment completed exclusive of a filed application cannot be appealed.

b. CSRMA Revisions

The amount of the community spouse's resource maintenance allowance may only be revised by TennCare if additional verification or documentation is provided.

The CSRMA may only be revised when:

- **i.** The initial assessment was alleged to be incorrect and an administrative judge confirms the allegations;
- **ii.** An administrative judge determines a larger CSRMA is necessary to raise the community spouse's available income to the Maintenance Needs Standard or to an amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income; or
- **iii.** A court order is received against an institutionalized spouse for the support of the community spouse and resources are transferred pursuant to the court order.

c. Allocation of Additional Resources to the Community Spouse

i. When Additional Resources May be Allocated to the Community Spouse

In the event that the institutionalized spouse does not have enough income to provide the community spouse with sufficient income to meet the Maintenance Needs Standard and the CSRMA is not enough to offset the income shortfall, additional resources may be allocated to the community spouse by an appeals hearing officer if the couple has additional resources above the community spouse's protected amount (CSRMA).

The Deficit Reduction Act (DRA) of 2005 requires all states to allocate the maximum amount of available income of the institutionalized spouse to the community spouse before granting an increase in the CSRMA. This is referred to as the "income-first" method.

ii. Procedure

TennCare uses the Single Fixed Annuity model to address appeals when there is insufficient income to provide the community spouse with the Maintenance Needs Standard and the couple has additional resources. A single fixed annuity can turn a portion of an individual's savings in to income payments made for the rest of the individual's life. The procedure for establishing a single fixed annuity is listed below.

1. Additional resources may be allocated to the community spouse through the administrative appeals process to make up any shortfall between the amount of income allocated from the institutionalized spouse to the community spouse and the Maintenance Needs Standard, if determined appropriate by an administrative judge.

2. The amount of additional resources that are necessary to cover the income shortfall shall be determined in reference to the purchase of a single premium annuity as follows:

   a. By calculating the shortfall between the amount of income allocated and the Maintenance Needs Standard, and then determining the amount of resources that must be invested in a single premium annuity in order to generate the income necessary to cover the shortfall.
   b. The amount of resources needed to cover the shortfall shall be determined in reference to an annuity calculator as adopted by TennCare.
   c. Additional resources may be allocated to the community spouse if the amount of resources needed to cover the shortfall is greater than the CSRMA.

3. The additional resource allocation to the community spouse does not require the actual purchase of a single premium annuity that is used for purposes of calculating the amount of the additional resource allocation.

4. If a single premium annuity is actually purchased pursuant to these rules, the annuity must comply with all other relevant requirements of state and federal law. See Annuities in the *Transfer of Assets and Penalty Periods* policy.

5. The amount of additional resources that are necessary to cover the shortfall shall not be determined in reference to any investment which contemplates the return of the entire principal at maturity.

Example: Mr. Smith enters a nursing facility in January 2018, requests a resource assessment, and submits an application for Institutional Medicaid. Mrs. Smith lives in the home and is not applying for or receiving Medicaid. Mr. Smith has an approved PAE in TPAES. Mr. Smith receives $800/month in Social Security benefits and $200/month in pension. Mrs. Smith has no income. Mrs. Smith's total shelter cost is $500 per month and she receives the Standard Utility Allowance ($311). Her calculated CSIMA is $2,232. Mrs. Smith is allocated all of Mr. Smith's income (less $50 Personal Needs Allowance (PNA) as the applicant is in a nursing facility), which is $950. Given that the income allocation is less than the CSIMA, there is an income shortfall of $1,282.

The Smiths have $260,000 in combined countable resources. Mrs. Smith receives the maximum resource allocation of $123,600. The remaining $136,400 is available to Mr. Smith. Given that Mr. Smith's resources exceed the $2,000 resource limit, Mr. Smith is resource-ineligible for TennCare Medicaid.

The Smiths appeal the TennCare Medicaid denial on the basis of Mrs. Smith's income shortfall as the community spouse. An appeals hearing officer determines that the CSRMA, in relation to the amount of income it generates, is insufficient to raise the community spouse's available income to the Maintenance Needs Standard, and that additional resources above the CSRMA are needed in order to make up the shortfall. The CSRMA can then be overridden by the appeals hearing officer.

Note: For HCBS cases, the process is the same as in the above example, except the PNA is 300% of the Federal Benefit Rate (FBR). The community spouse of an individual receiving HCBS services may be eligible to receive an additional resource allocation when monthly income does not meet the Maintenance Needs Standard.

8. Transfer of Assets for Less than Fair Market Value (FMV)

A transfer of assets for less than FMV is not considered to have occurred when resources are transferred from the institutionalized individual to the community spouse or vice versa in accordance with a completed resource assessment. This also holds true for any spouse-to-spouse transfers that take place after September 30, 1989. There will be no penalty applied for transfers between spouses after that date.

Should the spouse who received the allocation according to the resource assessment then transfer the resource to someone else for less than FMV, the transfer will not be treated as a transfer of assets since the resources of a couple are treated separately after the establishment of Institutional Medicaid eligibility.

Transfer of assets for less than FMV is considered part of the application process whether or not a resource assessment has been requested previously or is requested at application. Transfer of assets is not considered if only a resource assessment is requested (no TennCare Medicaid application filed concurrently). See *Transfer of Assets and Penalty Periods* policy.

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POST-ELIGIBILITY TREATMENT OF INCOME

Legal Authority: 42 CFR 435.725; Tenn. Code Ann. § 71-5-147; State Plan, Attachment 2.6-A, Supplement 3; State Plan, Attachment 2.6-A, Supplement 13; 42 USC 1396a(r)(1)(B); Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Individuals determined eligible for Institutional Medicaid and receiving Long-Term Services and Supports (LTSS) or hospice are required to contribute to the cost of care. Patient liability, the individual's required monthly contribution, is calculated based on the individual's total income after certain allowable deductions.

2. Determination of Total Income

While countable income is used to determine eligibility for Medicaid, total income is used in the post-eligibility process. Total income includes all income available to an individual whether counted or excluded in the eligibility determination. Total income does not include items which are not considered to be income. See the *ABD Income Overview* policy.

a. Income not Included in Total Income

The following income is not included in total income:

i. Supplemental Security Income (SSI) benefits paid under section 1611(e)(1)(E) and (G) of the Social Security Act to individuals who receive care in a hospital, nursing home, skilled nursing facility (SNF), or intermediate care facility (ICF);
ii. Austrian Reparation Payments made under sections 500-506 of the Austrian General Social Insurance Act;
iii. German Reparations Payments made by the Federal Republic of Germany;
iv. Japanese and Aleutian Restitution Payments;
v. Netherlands Reparation Payments based on Nazi persecution;
vi. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement;
vii. Radiation Exposure Compensation; and
viii. VA pensions limited to $90 per month.

b. VA Pensions Limited to $90 Per Month

VA pension payments are limited to $90 per month for the following individuals who receive Medicaid-covered nursing home care in a Medicaid-approved nursing facility:

i. Veterans who do not have a spouse or a dependent child;
ii. Surviving spouses of veterans who do not have a dependent child; and

iii. Surviving children of veterans.

When the VA pension payment is limited to $90 per month, the payment is aid and attendance and is not included in total income. The VA pension is not limited to $90 per month when the individual receives Home and Community-Based Services (HCBS) or is in a state veterans home. If a veteran or the surviving spouse of a veteran is in a state veterans home and receives more than $90 per month in VA pension, the VA pension, including any payment made for aid and attendance or for unreimbursed medical expenses, is counted in total income and applied to the state veterans home's cost of providing nursing home care to the veteran or surviving spouse.

3. PETI Deductions from Total Income

a. Allowable Deductions

The following are deducted from total income to determine patient liability:

i. A Personal Needs Allowance (PNA) for clothing and other personal needs while residing in the institution;
ii. Mandatory expenses, such as garnishments, conservatorship or guardianship fees, court-ordered bankruptcy, court-ordered child support, court-ordered alimony, and Qualified Income Trust (QIT) fees;
iii. A Community Spouse Income Maintenance Allowance (CSIMA), for institutionalized individuals with a spouse residing in the community;
iv. A Dependent Income Maintenance Allowance (DIMA), for institutionalized individuals with a dependent residing in the community;
v. Health insurance premiums, coinsurance and deductibles;
vi. Incurred medical expenses not covered by TennCare Medicaid and allowed under the State Plan; and
vii. An Incurred Medical Expenses Carry Forward Amount, for allowable medical expenses not previously deducted.

b. PNA

The PNA is provided to cover the institutionalized individual's personal needs and incidentals while residing in the nursing facility or receiving HCBS waiver services. Apply the appropriate PNA based on the type of LTSS the individual receives.

i. Nursing Facility

Subtract a $50 PNA from the total income of an individual in a nursing facility or in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). For an individual with greater need who participates in a sheltered workshop, subtract up to $100 of earnings plus $50 for the PNA.

ii. HCBS (including ECF CHOICES), PACE and Self-Determination ID Waivers

Subtract 300% of the Supplemental Security Income Federal Benefits Rate (SSI-FBR) from the total income of an individual receiving HCBS, PACE or Self-Determination ID Waiver services.

iii. Statewide ID and Comprehensive Aggregate Cap Waivers

Subtract 200% of the SSI-FBR from the total income of an individual receiving Statewide ID and Comprehensive Aggregate Cap (CAC) Waiver services.

c. Mandatory Expenses

Mandatory expenses are expenses an individual is legally obligated to pay. Verified mandatory expenses may be deducted from total income when determining patient liability. Mandatory expenses include but are not limited to: garnishments and other withholdings, conservatorship or guardianship fees, court-ordered bankruptcy, court-ordered child support, court-ordered alimony, and QIT fees.

i. Garnishments and Other Withholdings

A garnishment is a withholding from earned or unearned income to satisfy a debt or legal obligation. Most garnishments are court-ordered. A court order is not required for collection of unpaid taxes owed to the IRS or non-tax debts owed to other federal agencies. When an institutionalized individual's income is being garnished, a deduction for the garnishment is allowed in the patient liability calculation until the debt has been paid in full or the garnishment has been withdrawn.

Other withholdings that are required by law, such as federal income tax, FICA, state and/or local taxes are subtracted from total income when determining patient liability. A deduction is not allowed when the withholding is voluntary.

ii. Conservatorship or Guardianship Fees

A conservator or guardian is a third party appointed by a court to manage the property, financial affairs, and well-being of an individual. A conservatorship or guardianship fee paid by an individual may be deducted if the individual has a legally appointed guardian or conservator, the guardian or conservator charges a fee, and the fee is court-ordered.

iii. Court-Ordered Bankruptcy

Bankruptcy is a legal procedure by which a debtor seeks relief from all or part of his debt. When a debtor, who has regular income, files a petition through a bankruptcy court, he may propose a plan to repay his creditors over a period of time, usually three to five years. The debtor must begin making plan payments to the trustee within 30 days after filing the bankruptcy case, even if the plan has not yet been approved by the court. Payments are made directly to the trustee or through payroll deduction. Payments made by an institutionalized individual as a part of a repayment plan may be deducted when determining patient liability until the individual is released from all dischargeable debts provided for by the plan.

iv. Court-Ordered Child Support Payments

A child support payment is a payment from a parent to or for the child to meet the child's needs for food and shelter. In order to be allowed as an expense, child support must be court-ordered.

When an individual verifies that he is paying court-ordered child support for a child who is not living in his household, the amount actually paid, up to the full court-ordered obligation is deducted as a mandatory expense.

A child support arrearage payment is a payment that was past due, but not paid in a timely manner for the appropriate period. The arrearage is being paid to comply with an unfulfilled past obligation to support the child. If the individual is making a payment that includes both current support and an amount applied toward arrears, the entire amount may be allowed as a deduction, as long as the arrears were also part of the court-ordered support order when incurred.

A deduction for court-ordered child support is not allowed for the same child for whom a DIMA is allowed in the post-eligibility budget.

v. Court-Ordered Alimony Payments

Alimony is a payment for a spouse or former spouse under a divorce or separation instrument. Alimony expenses do not include voluntary payments. The payments must be in cash, including checks and money orders, to be considered alimony. Alimony is an expense to the payer of the alimony and is allowed when alimony is paid.

When an individual verifies that he is paying court-ordered alimony to a spouse or former spouse, the amount actually paid, up to the full court-ordered obligation is deducted as a mandatory expense.

A deduction for court-ordered alimony is not allowed for the same spouse for whom a CSIMA is allowed in the post-eligibility budget.

vi. QIT Fees

A QIT is a trust established for individuals seeking LTSS who are ineligible for TennCare Medicaid due to excess income. See the *Qualified Income Trust (QIT) or Miller Trust* section in the *ABD Trusts* policy.

Individuals who establish a QIT for the purpose of becoming TennCare Medicaid eligible in Institutional Medicaid are allowed a QIT allowance. The purpose of the QIT allowance is to cover any bank fees associated with maintaining the QIT.

Subtract a $20 QIT Allowance, or other verified amount, from total income for individuals who establish a QIT for TennCare Medicaid eligibility purposes, if applicable.

d. CSIMA

When determining an institutionalized individual's patient liability, an allowance is deducted from his or her income for the needs of the community spouse. The CSIMA is allowed unless specifically refused by the institutionalized spouse. Funds must actually be transferred to the community spouse to be deducted.

i. When to Allow a CSIMA

1. The CSIMA is allowed unless specifically refused by the institutionalized spouse.
2. Funds must actually be transferred to the community spouse in order to be deducted.
3. A CSIMA is not allowed if both spouses are institutionalized.
4. A CSIMA is allowed when one spouse is institutionalized in a nursing facility and the other is eligible for HCBS in the community.
5. If the community spouse applies for TennCare Medicaid, the CSIMA will be counted as unearned income.
6. A community spouse receiving SSI, Families First (FF), Veteran's Affairs (VA) Pension, TennCare Medicaid or means-tested benefits does not have to accept the total or any of the income allocation if it will result in the termination or decrease of those benefits.
7. If a couple is married but living separately, and consider themselves to be separated, the CSIMA may be allowed if both individuals agree to the allocation and the community spouse is not institutionalized.
8. If the community spouse lives out of state, the CSIMA is allowed if the community spouse can be located and the couple is still married.

ii. CSIMA Calculation

1. Terms and Standards

a. Standard Maintenance Amount (SMA): The poverty level standard used to determine the community spouse's monthly maintenance needs. The SMA is 150% of the Federal Poverty Level (FPL) for a household of 2.

The SMA is $2,465.00, effective July 1, 2023.

b. Maintenance Needs Standard: The minimum amount of monthly income necessary to meet the community spouse's maintenance needs and prevent impoverishment. The Maintenance Needs Standard is determined by adding the SMA and Excess Shelter Allowance (ESA).

c. Utility Allowance: The utility allowance under the Supplemental Nutrition Assistance Program (SNAP) used in lieu of the community spouse's actual utility expenses.

i. The **Standard Utility Allowance** (**SUA**) is used when the community spouse is responsible for heating or cooling costs. If the SUA is used, then it is considered to cover all utilities, including garbage, water, lighting, etc.

The SUA is $430, effective October 1, 2023.

ii. The **Basic Utility Allowance** (**BUA**) is used when the community spouse is responsible for at least two utility expenses, but is not responsible for heating or cooling costs.

The BUA is $164, effective October 1, 2023.

iii. The **Standard Telephone Allowance** is used when the community spouse is responsible for a telephone expense, but is not entitled to any other utility allowance.

The Standard Telephone Allowance is $35, effective October 1, 2023.

d. Standard Housing Allowance (SHA): The SHA is used to determine whether the community spouse requires an Excess Shelter Allowance.

The SHA is $739.50, effective July 1, 2023.

2. CSIMA Calculation

The CSIMA is calculated using three steps:

a. Determine Excess Shelter Allowance (ESA)

An ESA is allowed when the total shelter costs for rent, mortgage, taxes and insurance, maintenance charges and utility costs exceed the SHA. The SHA is 30% of the SMA.

The SUA is used when the community spouse is responsible for heating and/or cooling costs. If the SUA is used, it is considered to cover all utilities (no additional allowance for garbage, telephone, etc.) When there is no or reduced cost to the community spouse because the cost of a particular utility is paid by a third party (in cash or in kind), reduce the amount of the SUA by the third party payment.

Determine ESA:

  Rent, mortgages, taxes, insurance, etc.
+ SUA
– SHA
  ESA

b. Determine Community Spouse Net Income

Determine the Community Spouse's total net income, including SSI and FF payments. The Community Spouse net income is defined as income over which the Community Spouse has control over and which is actually available. Income which is not considered available to the Community Spouse includes child support payments and other types of court-ordered payments made by the community spouse.

c. Calculate CSIMA

The CSIMA is calculated by adding the SMA and the ESA, and then subtracting the Community Spouse's net income.

  SMA ($2,465.00)
+ ESA (Amount determined in Step 1 of CSIMA budget)
– Community Spouse Net Income (Amount determined in Step 2)
= Community Spouse Maintenance Allowance

3. CSIMA Example

Casey Jones is approved for Institutional Medicaid. Shannon Jones, the community spouse, remains in the community and resides at home. Casey receives $800 per month in Social Security benefits, and $200 in monthly pension. Shannon receives $600 per month in Social Security benefits.

Shannon Jones pays the mortgage of $400 per month, which includes taxes and insurance. She is responsible for all monthly heating and cooling costs.

a. Determine ESA

$400.00	Mortgage, taxes, insurance
+ $430.00	SUA
– $739.50	SHA
$ 90.50	ESA

b. Determine Community Spouse Net Income

Countable income is determined according to the *ABD Earned Income* policy *and ABD Unearned Income* policy. The community spouse's net income is defined as income over which the community spouse has control and which is actually available to him or her.

c. Calculate CSIMA

$2,465.00	SMA
+ $ 90.50	ESA
– $ 600.00	Community Spouse Net Income
= $1,955.50	CSIMA

Casey's monthly income is $1,000. Since the income is less than the calculated CSIMA, all of the income (less $50 PNA) will be allocated to Shannon.

Note: In the event that the institutionalized spouse does not have enough income to provide the community spouse with the allowed CSIMA and income that may be generated from the Community Spouse Resource Maintenance Allowance (CSRMA) is inadequate to raise the community spouse's available income to the Maintenance Needs Standard, there may be an allocation of additional resources to the community spouse to make up for the income shortfall if the couple has additional resources above the CSRMA. This must be done by appeal and a TennCare Appeals Officer will determine whether the additional resource allocation is needed. See the *Resource Assessment* policy.

e. DIMA

When determining patient liability, an allowance is deducted from the individual's income for the needs of her dependents.

i. General Rules

1. Dependent relatives include the individual's or spouse's adult dependent children, parents, siblings, and minor children who are residing with the community spouse.
2. A DIMA is not allowed for any dependent receiving HCBS or who is institutionalized.
3. A dependent does not have the option of declining all or a portion of the income allocation for any reason according to the TennCare interpretation of the Medicare Catastrophic Coverage Act (MCCA), even if needs-based benefits may be decreased or lost because of the allocation.
4. The DIMA for each additional dependent family member is equal to one-third of the difference between the SMA and the dependent's gross income.

ii. Calculate DIMA

The dependent allocation(s) equals the SMA for the community spouse minus the dependent's own gross countable income divided by 3 (SMA – gross countable income = deficit/3 = dependent allocation).

1. Determine Dependent's Gross Income

Earned Income
+ Self-Employment Income
+ Unearned Income (other than Child Support)
+ <u>Gross Child Support</u>
= Dependent Gross Income

2. Calculate DIMA

SMA	$2,465.00
– Dependent Gross Income	Determined in Step 1
÷ <u>3</u>	1/3 of the difference of the subtotal
= DIMA	

iii. Dependent Relatives Living in the Home Without a Community Spouse

When determining patient liability, an allowance is deducted from the individual's income for the needs of dependent relatives living in the home without a community spouse.

1. Calculate DIMA

An amount equal to the Medically Needy Income Standard (MNIS) may be allocated to dependent relatives living in the home without a community spouse if the total net countable income of the dependent(s) is less than the MNIS for the household size. To determine a dependent's net countable income, first subtract $65 from the dependent's gross earned income and divide the remainder in half. The result is the dependent's net earned income. Add the dependent's net earned income and gross unearned income together. The result is the dependent's net countable income.

a. Determine Dependent's Net Countable Income

Gross Earned Income
– Earned Income Disregard ($65)
– ½ Remainder
= Net Earned Income

Gross Unearned Income
\+ Net Earned Income
= Net Countable Income

b. Calculate DIMA

Add the net countable income of all dependents together.
Compare the combined total to the MNIS for the household size. See the MNIS chart in the *Child Medically Needy* policy.

If the combined total is more than the MNIS, no dependent allocation is given. If the combined total is less than the MNIS, the dependent allocation is the amount of the MNIS for the household size.

f. Health Insurance Premiums

Verified health insurance premiums may be deducted when determining an individual's patient liability. When health insurance premiums for several coverage months are due in a given month, the premiums paid in that given month cannot be prorated over the coverage period. Any premium amount which exceeds the individual's income can be applied against his or her patient liability in following months.

i. Criteria for Deduction of Health Insurance Premiums

Premiums are deducted for health insurance policies that meet the following criteria:

1. The policy is reported to TennCare as third party liability (TPL);

2. Benefits are assignable and the individual has agreed to assign them to the State of Tennessee (TennCare); and
3. Premiums are paid by the individual, and not by a third party.

Life insurance premiums are not allowed as a deduction.

ii. Medicare Premiums

Medicare Parts A, B, C or D premiums are deductible as health insurance premiums, unless:

1. The individual is SSI eligible;
2. The individual is enrolled as an SSI Pickle Pass Along or Disabled Adult Child (DAC); or
3. The individual is enrolled in any of the following Medicare Savings Programs: Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), Qualifying Individual (QI) or Qualified Disabled Working Individual (QDWI).

g. Incurred Medical Expenses for Institutionalized Individuals

The law allows for the deduction of expenses incurred by the eligible individual for medical or remedial care that are recognized by state law as medical or remedial care items but are not included in the State Plan. Tennessee calls these non-covered expenses Incurred Medical Expenses (IMEs).

IMEs also include expenses incurred during the three (3) months immediately prior to application for coverage of institutional care.

Institutional charges incurred during an institutional coverage ineligibility period due to an uncompensated transfer of assets may not be used as IME deductions.

Cost items are those medical or remedial services and goods that must be provided by the nursing care providers. Cost items cannot be charged to the patient or allowed as an IME deduction.

i. Criteria for Deduction of an Expense

1. The expense(s) must not be subject to payment by a third party not expecting reimbursement, e.g., medical or health insurance, medical trust fund, Medicare, etc.

2. The expense may be unpaid or paid by the client during the month(s) of eligibility determination or paid by a member of the client's family and reimbursement is expected by the family member.

3. The expense must not have been allowed previously as a necessary item.

4. The expense must be outstanding and considered collectible by the party who provided the medical service and one for which the client is legally liable. Debt sent to a collection agency is still considered collectible by the original party for purposes of this IME policy.

5. Medical expenses incurred up to three months prior to the month of application during TennCare Medicaid ineligibility do not impact whether the bill is an allowable medical expense, e.g. while an applicant is spending down resources to become eligible.

Example: Mrs. Carter applied for TennCare Medicaid for the month of January. She did not meet TennCare Medicaid eligibility for that month due to exceeding the resource limit. She reapplied on April 1, 2016. She incurred charges for the facility stay from January, February, and March. The facility charges may be used as an allowable expense as they occurred during the three months prior to eligibility.

ii. Incurred Medical Expenses in the Budget

Verified IME deductions are allowed from patient liability for qualifying paid medical expenses. IMEs are allowed until the full unpaid balance has been deducted, or until the expenses are paid in full, whichever comes first.

iii. Qualifying Expenses

Payments for the following types of medical or remedial care recognized under state law, but not encompassed within the State Plan, are subject to the following criteria:

1. **Eyeglasses and necessary related services**

   Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges or the Medicaid fee schedule:

   a. Examination and refraction;
   b. Frame;
   c. Lenses (bifocal); and
   d. Lenses (single).

   No deductions should be made for the first pair of eyeglass or contact lenses after cataract surgery, since those are allowed by TennCare.

2. **Hearing aids and necessary related services**

   Deductions can only be made for the following services and must be the least of the provider's usual and customary charges, billed charges or the Medicaid fee schedule:

- **a.** Audiogram;
- **b.** Ear mold;
- **c.** Hearing aid;
- **d.** Batteries; and
- **e.** Hearing aid orientation.

3. Dental services

Effective January 1, 2023, dental services are a covered benefit for all adults enrolled in TennCare Medicaid. Dental services covered by the adult dental benefit are not allowed as an IME for TennCare enrollees. A list of covered procedures is posted on the TennCare website. Deductions can be made for dental services that are not covered by the adult dental benefit, in accordance with TennCare’s dental fee listing, whether such services are provided at a dental office, on-site at the Long-Term Care Facility (LTCF), or through a mobile dental services provider. Denied dental services may be eligible as an IME and will be reviewed on a case-by-case basis but only after denial of coverage by TennCare dental insurance.

4. Other medical service recognized under state law but not covered by TennCare Medicaid

Deductions for any other medical service recognized under state law but not covered by TennCare Medicaid will be made at the least of the provider's usual and customary charges, billed charges or 80% of the Medicare fee schedule. Deductions will be allowed only for services that are determined by the State to be medically necessary for the particular individual on whose behalf the services are being requested.

5. Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days

Charges for nursing home days incurred as the result of bed-holds or therapeutic leave days that are in excess of the number of days covered under the State Plan for the type of facility in question are not allowable deductions.

6. Prescription Drugs

There are four criteria that a prescription drug must meet to be an allowable IME:

- **a.** It must not be subject to a payment by a third party (e.g., Medicare or private insurance);
- **b.** It must be recognized under State law;
- **c.** It must not be covered by Medicaid; and
- **d.** It must be determined by the state to be medically necessary.

Here are the IME coverage policies for four frequently requested drugs:

Drug	Covered by Medicare?	Covered by Medicaid/ TennCare?	Status as an allowable IME deduction?	Reasoning
Medically necessary benzodiazepines	Yes	Yes	Not allowed	Drug is covered by both Medicare and TennCare
Medically necessary cough and cold products	Yes, EXCEPT products used for symptomatic relief of cough and colds	Yes, EXCEPT products used for symptomatic relief of cough and colds	*Only if* the products are used for the symptomatic relief of cough and colds	IME deduction can only be applied to drugs not covered by TennCare and Medicare
Medically necessary prescription vitamin and mineral products	Yes, but ONLY IF the items are prenatal vitamins and fluoride preparations	Yes, but ONLY IF the items are prenatal vitamins and fluoride preparations	*Only if* the items are NOT prenatal vitamins and fluoride preparations	IME deduction can only be applied to drugs not covered by TennCare and Medicare
Medically necessary smoking cessation products	Prescription-only smoking cessation products are COVERED; non-prescription drugs are NOT COVERED	Yes	Not allowed	Prescription-only smoking cessation products are covered by Medicare and TennCare; non-prescription drugs are covered by TennCare

TennCare does not cover prescription drugs for individuals who are dually eligible for both Medicare and TennCare. These individuals are considered to have access to Medicare Part D for their prescription drug coverage, regardless of whether they choose to enroll in Medicare Part D or not.

iv. Dental Services Provided in a LTCF

There are certain requirements that must be met by the mobile dental service providers in order to have their services covered as an incurred medical expense.

1. These are the requirements of the mobile dental service:

a. To obtain a signed consent form from the responsible party prior to performing any dental services. If the responsible party fails or refuses to sign the consent form and has not made any arrangements for alternative dental care, the LTCF is authorized to sign the form on behalf of the resident. The consent will remain valid for the length of the resident’s stay (only one form per patient, not one per procedure), unless otherwise revoked by the responsible party.

b. To deliver the consent form, along with the verification of services form, via hand delivery, mail or facsimile to TennCare Connect.

c. To contract with a dentist licensed in the State of Tennessee who is a Medicare/Medicaid provider. A licensed dentist must perform all services. The dentist's name and provider number must be entered on the IME request form prior to submitting the bill to TennCare.

d. To create and supply all new forms that are submitted from the mobile dental service provider and the LTCF. The facility should ensure that a copy of these forms is kept on file in the patient records at the facility, along with proof that the services were provided by a licensed dentist.

2. These are the requirements for TennCare Member Services:

a. Prior to authorizing a deduction for any IME received from a mobile dental services provider, the Eligibility Specialist must view and document in the data base that the consent form, the IME request form, and the verifications of service form have been provided.

b. Any services related to the provision of dentures deemed medically necessary must be thoroughly documented in the electronic case record. Process the IME request within thirty (30) days after receipt.

c. Once the bills have been processed, Tenncare must notify the responsible party and the LTCF of any action taken to approve or deny the expense as an IME deduction. These expenses will be deducted from the patient's total income. This will reduce the patient liability.

Note: Payment can only be made from the patient liability amount, not from the patient's trust account or the PNA. If the patient liability is already zero, then payment cannot be allowed.

v. Information Needed with Incurred Medical Expense (IME) Submission

The Incurred Medical Expense (IME) submission must include the following information:

1. A verification of service/item received,
2. Consent for receipt of service/item,
3. Information relating to medical necessity, and
4. Other identifiers relating to the IME, including the provider number and a description of the service/item received.

h. Incurred Medical Expenses Carry Forward Amount

When the total of incurred medical expenses (and health insurance premiums) is greater than the individual’s total income less PNA, mandatory expenses, CSIMA and DIMA deductions for the month, deduct only the amount equal to the available income. Incurred medical expenses in excess of the individual’s total available income are carried over into the next month as an IME Carry Forward Amount from the previous month. Expenses will be carried over until the full amount of the expense is deducted or the expense is paid in full, whichever occurs first.

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LONG-TERM CARE PARTNERSHIP POLICY

Legal Authority: 42 USC 1396p

1. Long-Term Care Partnership (LTCP) Insurance Overview

The LTCP program is a joint effort between the Federal Medicaid program and Long-Term Care (LTC) insurers. The program was developed to encourage people to plan for their future LTC needs, such as residing in a nursing facility or receiving services in a home and community-based setting.

The LTCP program in Tennessee involves private LTC insurers, TennCare and the Tennessee Department of Commerce and Insurance (TDCI). The LTCP program is overseen by CMS and states are given flexibility in how the program is administered at the state level. In Tennessee, qualified LTCP insurance policies must provide a specific amount of inflation protection based on the person's age when the policy is purchased. An LTCP policy must also meet other requirements determined by TDCI.

To participate in TennCare's LTCP program, a person must have purchased and received the benefits of a qualified LTCP policy. A person who requests TennCare Medicaid payment of LTC services after exhausting some or all LTCP policy benefits may have an amount of assets "disregarded" equal to the amount paid by the LTCP policy at the time the person is determined eligible for TennCare Medicaid.

These assets are NOT counted when the individual's TennCare Medicaid eligibility is determined and will NOT be recovered during estate recovery when the individual dies.

2. LTCP Program and TennCare Eligibility

a. Long-Term Care Partnership Policy Participants

An LTCP participant in Tennessee is someone who either:

- **i.** Requests TennCare Medicaid payment of LTC services after exhausting all benefits of a qualified LTCP policy; Requests and receives TennCare Medicaid payment of LTC services before exhausting all benefits of a qualified LTCP policy; or
- **ii.** Receives TennCare Medicaid payment of LTC services and dies before the LTCP policy benefits are exhausted.

b. Asset Disregard

When determining eligibility for TennCare Medicaid, TennCare shall disregard an individual's assets in an amount equal to the amount of payments made by the individual's qualifying LTC policy for services covered under the policy.

TennCare Medicaid individuals will be required to submit written proof of benefits paid from their LTCP policies.

c. Partnership Program Benefits

An LTCP participant receives the following benefits during his lifetime:

- **i.** Assets may be disregarded in an amount equal to the benefits paid out by the qualified LTCP policy as of the effective date of the initial TennCare Medicaid approval;
- **ii.** Disregarded assets are not counted toward the TennCare Medicaid asset limit for eligibility purposes; and
- **iii.** Assets may be transferred to any other person without penalty.

NOTE: Additional benefits paid by the qualified LTCP policy after initial TennCare Medicaid approval shall not be disregarded in future renewal or determination of TennCare Medicaid eligibility.

d. LTCP and Estate Recovery

After the LTCP/TennCare Medicaid enrollee is deceased:

- **i.** Assets which were disregarded during the TennCare Medicaid eligibility determination process because the enrollee purchased an LTCP policy are protected from estate recovery.
- **ii.** When the amount of assets disregarded during the TennCare Medicaid eligibility determination process are less than the total benefits paid by the LTCP policy, additional assets up to the total amount of payments made by the LTCP policy may be protected during the estate recovery process.

3. Individual Responsibilities

It is the responsibility of the LTCP policyholder to inform TennCare that he has an LTCP policy.

TennCare Medicaid is typically the payor of last resort. Enrollees with other health care coverage or who have another party liable for their medical expenses will have medical costs paid by those sources before TennCare pays claims. Enrollees are required to cooperate with providing information regarding other payment sources. This includes LTC and LTCP insurance.

LTCP insurance benefits may not be used to offset the amount the enrollee is required to contribute, pursuant to federal post-eligibility provisions, to the cost of TennCare Medicaid reimbursed LTC services (known as “patient liability”), but rather, must be used to help offset the cost of LTC services that would otherwise be reimbursable by TennCare. Thus, both the LTC insurance benefits and patient liability reduce the TennCare payment for LTCP services.

4. When an LTCP Policy Holder Should Apply for TennCare Medicaid

- **a.** If the LTCP policy holder exhausts the benefits of his LTCP policy; or
- **b.** When the LTCP policyholder, a spouse, a family member or friend feels that the policyholder can no longer afford to pay for the cost of care.

5. Does an LTCP policy guarantee access to TennCare Medicaid?

No, owning an LTCP policy does not guarantee access to TennCare Medicaid even if the policy holder exhausts his benefits. Individuals must still meet all other eligibility requirements. The LTCP allows policy holders to have a portion of their assets disregarded (i.e., not counted) during the eligibility determination process and subsequently protected from estate recovery.

A copy of the LTCP *Statement of Benefits Paid* must be mailed or faxed to:

The Bureau of TennCare
Third Party Liability/Estate Recovery Unit
310 Great Circle Road, 4E
Nashville, TN 37243

Fax number: 615-253-5588

6. Examples

a. Example 1: LTCP Benefits have been Exhausted When an Institutionalized Individual Applies for TennCare Medicaid

Patricia McVey is a resident of Happy Homes nursing facility. Her qualified $90,000 LTCP policy has been paying for her care. When Ms. McVey applies for TennCare Medicaid, she verifies that the benefits of her LTCP policy have been exhausted and were used towards her cost of care.

Ms. McVey has the following countable resources: a $6,000 savings account; a $7,500 checking account; and $80,000 in a Certificate of Deposit.

TennCare verifies her countable resources equal $93,500 ($6,000 + $7,500 + $80,000). Her TennCare Medicaid resource limit is $2,000.

Because Ms. McVey has fully exhausted her LTCP policy benefit, $90,000 of her countable resources will be protected. The protected resources do not count toward her $2,000 TennCare Medicaid resource limit.

Ms. McVey has $80,000 in a Certificate of Deposit, $6,000 in her savings account and $4,000 in her checking account that are protected. This leaves her with $3,500 in resources that are to be considered when determining her eligibility for TennCare Medicaid. The resource limit is $2,000 and since she does not have a prepaid burial plan, she can designate $1,500 for burial. She is now TennCare Medicaid eligible.

b. Example 2: LTCP Benefits have been Exhausted While Institutionalized Individual is Receiving TennCare Medicaid

Some individuals may request Medicaid payment of LTC services before LTCP benefits are exhausted when:

The LTCP policy does not cover all LTC needs, and the person's income and resources are not sufficient to pay the LTC expenses that are not covered by the LTCP policy.

Joan and Beth are sisters. Both receive home care services that are partially covered by their separate qualified $20,000 LTCP policy. They have both used $10,000 of their policy benefits and each has $3,000 in separate savings accounts. Neither has enough income or resources to pay for their daily services that are not covered by their LTCP policies. Joan and Beth both apply for and are eligible for TennCare Medicaid through HCBS. Their LTCP policies are treated as third party liability and Medicaid pays for services not covered by the LTCP policies.

When applying for and while receiving TennCare Medicaid, they each own the following assets: a $3,000 savings account; a home with an equity value of $50,000; and a prepaid burial trust valued at $6,000

The savings account is the only countable resource and is a disregarded asset. The home and burial trust are excluded resources.

Joan dies after using another $5,000 of LTCP benefits, for a total expenditure of $15,000. Although she did not benefit from the full value of the policy ($20,000), the policy is considered exhausted and $15,000 of her assets may be protected from estate recovery. The $3,000 savings account and $12,000 from the value of the house will be protected from estate recovery.

Beth exhausts the remaining $10,000 of her LTCP policy benefits during her first six months of receiving TennCare Medicaid. Because the full $20,000 of her LTCP benefits has been exhausted, TennCare Medicaid now pays for services that were previously covered by her LTCP policy. Beth may protect $20,000 from estate recovery.

At Beth's death, the $3,000 in the savings account and $17,000 from the value of her house will be protected from estate recovery.

7. LTCP and Third Party Liability

When an individual has an LTCP insurance policy and applies for TennCare Medicaid prior to exhausting all LTCP benefits, the individual or his representative shall be informed that:

a. The insurance policy must be assigned to the nursing home or HCBS lead agency;
b. Any payments received from the LTCP policy must be assigned to the nursing home in which the individual is a resident or to the HCBS lead agency;
c. The nursing home or HCBS lead agency will collect any payments made on the benefit of the patient prior to billing TennCare; and
d. TennCare Medicaid is the payor of last resort.

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TENNCARE CHOICES IN LONG-TERM SERVICES AND SUPPORTS

Legal Authority: Social Security Act § 1915(c); 42 CFR 435.217; TennCare 1115 Medicaid Demonstration; Tenn. Comp. R. & Regs. 1200-13-01; Tenn. Comp. R. & Regs. 1200-13-20

1. Overview

The TennCare CHOICES in Long-Term Services and Supports (LTSS) program was established in 2008 with the dual purpose of expanding Home and Community-Based Services (HCBS) in the TennCare program and improving access to HCBS and other long-term care services to those who qualify. The CHOICES program allows the State of Tennessee to integrate all Nursing Facility (NF) care and HCBS into the existing managed care system. Individuals who are eligible for CHOICES are approved under different groups based on the setting in which they receive services, and their own Level of Care (LOC) needs.

CHOICES enrollees have their care in the Long-Term Care Facility (LTCF) or HCBS program paid for by TennCare Medicaid. These payments, called LTSS payments, are separate from the regular TennCare Medicaid benefit. An applicant/enrollee must have an approved Pre-Admission Evaluation (PAE) and be enrolled in CHOICES in order to be eligible for LTSS payments.

Within TennCare, the LTSS Unit is responsible for administering the CHOICES program. The LTSS Unit is responsible for determining whether a CHOICES applicant meets the LOC requirements (also known as medical eligibility) and manages enrollment into long-term care programs and the LTSS database. The Member Services Unit is responsible for determining Medicaid eligibility for a CHOICES applicant. In order to receive CHOICES HCBS, an individual must be eligible in an Institutional Medicaid category or be a Supplemental Security Income (SSI) cash recipient. An individual may not receive CHOICES HCBS without being eligible for Institutional Medicaid or SSI.

2. Definitions

a. Group 1	Individuals who are receiving Medicaid-reimbursed LTSS in a NF. Individuals must be eligible for Medicaid and meet NF Level of Care (LOC) criteria.
b. Group 2	Individuals age 65 and older, and adults age 21 and older with physical disabilities as defined in TennCare Rule 1200-13-01-.02, who meet the NF LOC criteria, who are eligible for Medicaid either as SSI cash recipients or in an Institutional category and who need and are receiving HCBS instead of NF care.
c. Group 3	Individuals age 65 and older, and adults age 21 and older with physical disabilities as defined in TennCare Rule 1200-13-01-.02, as SSI recipients or members of the CHOICES At-Risk Demonstration

Group, who do not meet the NF LOC criteria but who, in the absence of HCBS, are "At Risk" for institutionalization. Group 3 enrollees are eligible for payment of HCBS. For individuals who are not SSI cash recipients, there must be an available slot for the individual to be enrolled.

New enrollment in Group 3 was limited to SSI cash recipients from July 1, 2015, to September 30, 2022.

d. Inactive SSI Enrollee Individuals whose SSI cash benefits have been terminated by the Social Security Administration (SSA) and who remain eligible for TennCare until they have been reviewed for coverage in other eligibility categories. Inactive SSI enrollees are not eligible for CHOICES.

e. LTSS Payments For purposes of this policy, benefits paid to cover the cost of long-term care in a NF or payments for HCBS for CHOICES-eligible institutionalized individuals.

f. Personal Needs Allowance (PNA) Deduction from the institutionalized individual's total income (as calculated for patient liability) to cover personal needs and incidentals. Currently amounts are:

- **i.** $50 per month for individuals in a NF or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
- **ii.** 300% of the Supplemental Security Income – Federal Benefit Rate (SSI-FBR) for HCBS enrollees, PACE, and Self-Determination Waiver; and
- **iii.** 200% of the SSI-FBR for the Comprehensive Aggregate Cap (CAC) and Statewide Waivers.

g. Pre-Admission Evaluation (PAE) Evaluation of an individual's LOC, or medical need, for LTSS. The PAE is completed by the Area Agency on Aging and Disability (AAAD), discharging hospital, Managed Care Organization (MCO), or NF, and is reviewed by the TennCare LTSS Unit. For Medicaid eligible individuals, the PAE is submitted by the MCO, discharging hospital, or NF.

h. Pre-Admission Screening/Resident Review (PASRR) The process by which the State determines whether an individual who resides in or seeks admission to a Medicaid-certified Nursing Facility has, or is suspected of having, a mental illness or an intellectual disability. If so, the PASRR then allows the State to determine whether the individual requires specialized services and is appropriate for NF placement. See TennCare Rule 1200-13-01-.02.

3. General Eligibility Criteria

In order to be enrolled in CHOICES, an individual must be determined eligible to receive CHOICES by the LTSS Unit and be approved for Institutional Medicaid by the Member Services Unit or be eligible for Medicaid as an SSI cash recipient. It is only once both determinations are made that the individual is enrolled in the programs. An applicant must meet the following conditions to receive CHOICES:

a. The individual has been determined to need and likely to receive LTCF services for a continuous period of at least 30 days going forward as evidenced by an approved CHOICES Group 1 PAE and actual admission to a NF;
b. The individual has been admitted to a NF or an Intermediate Care Facility for Individuals with Intellectual Disabilities ICF/IID, and the period of continuous confinement in the institution, combined with the period of time for which a PAE is approved, exceeds 30 days;
c. The individual is receiving HCBS and has been determined to need HCBS for a continuous period of at least 30 days going forward, as evidenced by an approved CHOICES Group 2 PAE; or
d. The individual is age 65 or older, or an adult age 21 or older with physical disabilities, who has entered a NF and does not meet the NF LOC criteria, but in the absence of HCBS is determined to be at risk for NF care. These individuals will have an approved CHOICES Group 3 PAE and will begin receiving CHOICES benefits once they are in the home or community-based setting, and there is an open slot available; and
e. The individual meets the non-financial and financial eligibility requirements of one of the following TennCare Medicaid categories:
 i. SSI Cash Recipient; or
 ii. Institutional Medicaid.
f. The individual is not in a penalty period for an uncompensated transfer of assets, and the value of the individual's home does not exceed the home equity limit.

Note: Certain individuals who have met 30 days continuous confinement may be approved for Institutional Medicaid, but they are not enrolled in CHOICES until a PAE is submitted and approved. See Section 6 in this chapter, the *Institutional Medicaid* policy, and section 4 in the *Institutional Status* policy for groups of individuals covered.

4. CHOICES Application Process

a. Overview of Application Process

The application and enrollment process for CHOICES requires collaboration between TennCare, the local AAAD, LTCFs and the TennCare MCOs.

The AAADs serve as the Single Point of Entry (SPOE) into LTSS for the majority of elderly and physically disabled individuals. When the application process begins with the AAADs, the AAADs submit the Medicaid application to TennCare and complete the LOC assessment. When the application is received without a PAE from another entity (nursing facilities, hospitals, families, or individuals), TennCare refers the HCBS individuals to the AAAD in their area for the LOC assessment only. Enrollment through the AAAD is not mandatory.

TennCare Medicaid MCOs help facilitate enrollment into LTSS for their current members, i.e., individuals who already have TennCare Medicaid eligibility.

The TennCare Application can be used for all new applicants or enrollees who are required to submit a new application. Individuals only enrolled in a Medicare Savings Program (QMB, SLMB, QDWI or QI1) who are applying for Institutional Medicaid and CHOICES must submit a TennCare Application and work with their local AAAD or NF to apply for CHOICES. For more information on the application process, see *The Application Process* policy.

b. SSI Cash Recipients

i. Overview

SSI Cash recipients who apply for LTSS do not need to file a TennCare application and, in general, will not be moved into an Institutional Medicaid category (see exception for SSI Cash recipients with Other Income). An SSI Cash recipient who applies for LTSS must have the following documents:

1. An approved, unexpired PAE; and
2. An *MCO-LTSS Eligibility Checklist (if PAE is submitted by the MCO)*.

When approving an SSI Cash recipient for LTSS, and at subsequent renewals, TennCare will rely on resource eligibility as determined by SSA and income information from the State Data Exchange (SDX) as reported to and verified by SSA. <u>A new TennCare application or additional verification of resource and income eligibility is not permitted</u> unless there is reason to believe that the individual has additional income or resources beyond what is known to SSA.

ii. SSI Cash Recipients Applying for HCBS

The MCOs facilitate the application process for SSI Cash recipients applying for HCBS. The MCO will submit a PAE to the TennCare LTSS Unit for review.

At the time of PAE application, the MCO representative will act as a contact with the individual and her family or other authorized representative and will notify them of their obligation to report any changes in income to the SSA and to TennCare within 10 days.

iii. SSI Cash Recipients in Long-Term Care Facilities

When an SSI Cash recipient enters an institution, such as a NF, the SSA reduces the SSI cash benefit. The individual's benefit is typically lowered to $30 a month.

1. SSI Cash Recipients with no other income

When an SSI Cash recipient who has no other income (or less than $50 in other income) enters a LTCF, his SSI cash benefit will be reduced, but he will retain SSI eligibility. SSI Cash recipients in a LTCF do not have a patient liability.

An SSI Cash recipient is eligible for CHOICES when she has the following documents:

a. An approved, unexpired PAE; and
b. *MCO-LTSS Eligibility Checklist*.

2. SSI Cash Recipients with at least $50 of other income

SSI Cash recipients who enter an institution, and who have at least $50 in other income, will lose their SSI cash benefit eligibility at some point in the future. Once the individual's SSI cash benefit terminates, she will also lose her SSI Medicaid eligibility. Once the SSA terminates the SSI cash benefit, the individual will be reviewed for Institutional Medicaid.

Note**:** TennCare will rely on resource eligibility as determined by SSA and income information from the SDX as reported to and verified by SSA. A new TennCare application or additional verification of resource and income eligibility is not required, unless there is reason to believe that the individual has additional income or resources beyond what is known to SSA.

c. Inactive SSI Enrollees

Individuals who are eligible as Inactive SSI Enrollees must have eligibility established in an Institutional Medicaid category before CHOICES, an HCBS waiver, or Program of All-Inclusive Care (PACE) can be approved. Inactive SSI Enrollees must have:

i. An approved, unexpired PAE; and
ii. A completed TennCare Application.

5. Institutional Medicaid Eligibility and CHOICES Enrollment Dates

a. Institutional Medicaid

i. If approved for Institutional Medicaid and CHOICES Group 1 (NF), the Medicaid approval date is the latter of the date of application or the date of NF admission.

ii. If approved for Institutional Medicaid and CHOICES Group 2 (HCBS), the Medicaid approval date is the date the case is approved/authorized in the eligibility determination system.

iii. If approved for Institutional Medicaid and CHOICES Group 3 (At Risk HCBS), the Medicaid approval date is the date the case is approved/authorized in the eligibility determination system.

Note: If an applicant requires a QIT or is required to spend down resources to establish eligibility for Institutional Medicaid, then the approval date is the first day of the month in which the QIT is established or resources are at or below the resource limit, but not before the application date or date of NF admission.

b. CHOICES Enrollment

CHOICES enrollment cannot begin until both financial eligibility and medical eligibility have been determined.

6. Institutional Medicaid Approval based on 30 Days Continuous Confinement

An applicant in a medical institution who has met 30 days continuous confinement may be determined eligible for Institutional Medicaid. Categorically eligible individuals approved for Institutional Medicaid based on 30 days continuous confinement are not eligible for payment of NF services but are eligible for TennCare Medicaid benefits. Eligibility will be established in an Institutional Medicaid category based on the special income standard (300% of the SSI-FBR) if:

a. The applicant is categorically eligible (i.e., aged, blind, disabled, a child under age 21, or pregnant);

b. The applicant has been admitted to a medical institution and has been continuously in a medical institution (i.e., hospital, NF, ICF, SNF or ICF/IID) for at least 30 days; and

c. Has met all financial and non-financial eligibility criteria for Institutional Medicaid.

Individuals approved for Institutional Medicaid who have met 30 days continuous confinement may not have an approved, unexpired PAE. Categorically eligible individuals approved for Institutional Medicaid based on 30 days continuous confinement in a medical institution, who then later have an approved, unexpired PAE for CHOICES Group 1, will be eligible and enrolled in CHOICES.

Institutional Medicaid eligibility for individuals who have met 30 days continuous confinement in a medical institution only lasts as long as the individual is institutionalized. If the enrollee is discharged from the medical institution, his Institutional Medicaid eligibility will be terminated.

Applicants for HCBS cannot be approved for Institutional Medicaid based on 30 days continuous confinement. All HCBS applicants must have an approved, unexpired PAE.

7. Medicare Recipients Requiring Co-Pays or Cross-Over Payments for Skilled Nursing Facility Care (Medicare Cross-Over Payments)

Medicare Part A covers the first 100 days in a SNF, when the Medicare enrollee is in the SNF for the purpose of rehabilitation. Medicare typically pays 100% of the cost for the first 20 days, and 80% of the cost for days 21-100. If the Medicare enrollee is also TennCare Medicaid eligible in an Institutional Medicaid category and/or has QMB, TennCare will pay the Medicare co-pays, or cross-over payments, for days 21-100 of the SNF stay. An approved PAE is not required to establish Medicare cross-over payments. However, for Medicare recipients (who are not QMB eligible) who are approved for Institutional Medicaid based on 30 days continuous confinement, patient liability must be established to process the cross-over payment.

Note: Medicare may pay for more or less than 100 days of SNF, however, 100 days is the general rule. For the sake of this policy, the Institutional Medicaid eligibility will cover the SNF Medicare co-payment from the date of eligibility through day 100 or the last day of Medicare-approved skilled stay day.

8. Short Term Stay

A short-term stay is one of 90 or less days. HCBS-eligible enrollees who enter a NF may remain active in their HCBS case for 90 days. An enrollee cannot be moved out of HCBS if the NF stay is anticipated to be short-term and the enrollee plans to return home to receive HCBS.

During a 90-day short-term nursing facility stay for a person in HCBS, the HCBS Personal Needs Allowance (PNA) will continue to apply (300% of the SSI-FBR). This is to allow the enrollee to maintain his community residence in order to facilitate transition back home.

If the enrollee remains in the NF beyond 90 days (or such time that it is determined the enrollee needs to remain in the NF beyond 90 days), the MCO will facilitate the member's transition via the CHOICES Transition process.

9. Other Long-Term Services and Supports Programs

PACE and the DIDD HCBS waivers are not part of the CHOICES program but provide similar services to the eligible populations. More information about PACE and the DIDD HCBS waivers is available at https://www.tn.gov/tenncare/long-term-services-supports.html.

a. PACE

PACE is a community-based health and social services program whose purpose is to serve the frail elderly residents of Hamilton County. Participants must:

- **i.** Be age 55 or older;
- **ii.** Meet criteria for Level 1 nursing home care; and
- **iii.** Meet financial criteria.

The PACE program also provides an adult day care center and covers all medical needs of the individual including, but not limited to, hospitalization and nursing home coverage.

b. DIDD Waivers

Although the DIDD HCBS waivers are not a part of the CHOICES program, individuals eligible for a DIDD HCBS waiver must meet the non-financial and financial eligibility requirements of an Institutionalized Medicaid category or receive SSI Cash benefits. Medical eligibility (i.e., LOC) is determined by TennCare's LTSS Unit. There are three DIDD waivers for individuals with intellectual disabilities: the Statewide Waiver, Comprehensive Aggregate Cap Waiver, and Self-Determination Waiver.

The Department of Intellectual and Developmental Disabilities (DIDD) serves as the Operational Administrative Agency for the DIDD HCBS waivers which are administered under the supervision of TennCare.

i. Statewide Waiver

The Statewide waiver provides services to Tennessee children under age 6 with developmental delay and adults and children with intellectual disabilities who meet the ICF/IID LOC criteria.

ii. Comprehensive Aggregate Cap Waiver

The Comprehensive Aggregate Cap (CAC) Waiver, formerly known as the Arlington Waiver, provides services to individuals with intellectual disabilities who are former class members in the *United States vs. The State of Tennessee, et al.* (Arlington Developmental Center), former class members in the *United States vs. the State of Tennessee, et al.* (Clover Bottom Developmental Center), individuals discharged from the Harold Jordan Center following a stay of at least 90 days, and individuals transitioned from the Statewide Waiver upon its renewal on January 1, 2020. Individuals eligible under the CAC Waiver have been institutionalized in a public institution, are part of a certified class because they were determined to be at risk of placement in a public institution or require a LOC that would otherwise require placement in an ICF/IID, if they were not receiving services provided under the waiver.

iii. Self-Determination Waiver

The Self-Determination Waiver provides community-based services to children and adults with intellectual disabilities and children under age 6 with development delay who would otherwise require the LOC provided in an ICF/IID.

To enroll in this wavier program, an individual must:

1. Be a Tennessee resident;
2. Be financially eligible for TennCare Medicaid (Institutional Medicaid or SSI Cash);
3. Meet TennCare Medicaid criteria for payment of institutional ICF/IID care; and
4. Have an adequate support system to assure health and safety while receiving services in a home and community-based setting.

10. Facility Types

TennCare Medicaid LTSS payments are available to eligible individuals receiving LTSS in the following medical institutions:

a. State Developmental Centers for the Developmentally Disabled, which include:

i. Certified Intermediate Care Facility for People with Developmental Disability wards for patients of any age; and
ii. Certified Level II nursing wards for patients of any age. Patients in non-certified wards in Level II care are not eligible for TennCare Medicaid, except when transferred to a Title XIX (TennCare Medicaid approved) facility.

b. State Mental Health Hospitals and Private Certified Mental Health Hospitals

State Mental Health Hospitals and Private Certified Mental Health Hospitals include general hospital wards for patients age 65 and older and certified Level I and Level II wards for patients age 65 and older.

Patients in non-certified wards and all patients under age 65 are not eligible for TennCare Medicaid in psychiatric facilities with the following three exceptions:

i. A patient who was already an active TennCare Medicaid recipient when admitted to the psychiatric facility will be eligible the month of admission (no LTSS payment will be authorized). Coverage cannot extend beyond the month of admission, or the earliest month action can be taken to close the case.

ii. Ineligible patients who are transferred to a Title XIX facility located off the hospital grounds may attain eligibility during their absence from the facility.

iii. Patients under age 21 may be eligible for TennCare Medicaid if they are receiving active in-patient treatment in an accredited psychiatric hospital. These cases are not defined as long-term institutional cases, as no LTSS payment is made.

c. Licensed Public and Private Nursing Homes, which include:

i. Level II, ICF, for patients of any age;
ii. Level II, SNF, for patients of any age; and
iii. Tuberculosis Care Units for patients age 65 and older.

Tennessee does not have any chest disease/tuberculosis hospitals or care units. Care is limited to Tennessee residents at least age 65 whose out-of-state care has been approved by TennCare.

Residents of unlicensed nursing homes or custodial homes are not considered to be receiving medical care and therefore do not meet the medical institutionalization technical requirement. These individuals are not eligible for TennCare Medicaid in an institutional category and are not eligible for LTSS payments.

d. Certified Institutions

LTCFs are certified by TennCare and have a TennCare Medicaid per diem rate established by the State Comptroller's Office. A list of certified facilities and their rates are furnished by the Comptroller's office. A list is also available at the Department of Health's website at: https://www.tn.gov/health.

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		Enrollees; Short Term Stay			

Employment and Community First CHOICES

Legal Authority: TennCare III Medicaid Section 1115 Demonstration; Tenn. Comp. R. & Regs. 1200-13-20

1. Overview

The Employment and Community First (ECF) CHOICES program was established in 2016 to provide managed long-term services and supports (LTSS) for individuals with intellectual or developmental disabilities (I/DD) in a home and community-based setting. This includes individuals with I/DD who were previously on the waiting list for Department of Intellectual and Developmental Disabilities (DIDD) waivers, individuals with intellectual disabilities who were not receiving home and community-based services (HCBS), and individuals with developmental disabilities previously ineligible for DIDD waivers. The managed LTSS individuals receive are integrated with the physical and behavioral health benefits coordinated by their Managed Care Organization (MCO). The purpose of the program is to promote and support integrated, competitive employment and independent community living as the first and preferred option for individuals with I/DD.

2. Target Populations

ECF CHOICES provides HCBS to six target populations:

- **a.** Children under age 21 with I/DD living at home with family and who meet nursing facility (NF) level of care (LOC);
- **b.** Children under age 21 with I/DD living at home with family and who do not meet NF LOC, but who, in the absence of HCBS, are at risk of NF placement;
- **c.** Adults age 21 and older with I/DD who meet NF LOC and need specialized services for I/DD;
- **d.** Adults age 21 and older with I/DD who do not meet NF LOC, but who, in the absence of HCBS, are at risk of NF placement;
- **e.** Children under age 21 with I/DD and severe co-occurring behavioral health and/or psychiatric conditions who are living at home with family or other permanent guardian(s) in a long-term family living arrangement and who meet NF LOC; and
- **f.** Adults age 21 and older with I/DD and severe co-occurring behavioral health and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment, who meet NF LOC, and need specialized services for I/DD.

3. General Eligibility Requirements

In order to qualify for ECF CHOICES, an individual must:

- **a.** Have been assessed and found to have an intellectual disability manifested before eighteen (18) years of age or a developmental disability manifested before twenty-two (22) years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); and

b. Be enrolled in TennCare Medicaid as an SSI cash recipient or through one of the ECF CHOICES demonstration groups.

4. ECF CHOICES Demonstration Groups

The ECF CHOICES demonstration groups are:

a. ECF CHOICES 217-Like Group;
b. Interim ECF CHOICES At-Risk Group;
c. ECF CHOICES At-Risk Group; and
d. ECF CHOICES Working Disabled Group.

The Interim ECF CHOICES At-Risk Group was closed to new enrollment upon implementation of the ECF CHOICES At-Risk and ECF CHOICES Working Disabled Groups. Individuals already enrolled in the Interim Group may remain enrolled as long as they continue to meet the financial eligibility requirements, the nursing facility level of care (LOC) criteria in place on June 30, 2012, and remain continuously eligible and enrolled in the Interim ECF CHOICES At-Risk Group.

5. Non-Financial Eligibility Requirements for the Demonstration Groups

a. Age

There is no age requirement.

b. Level of Care (LOC)

An individual must be determined by the LTSS Unit to qualify for the following LOC:

i. ECF CHOICES 217-Like Group: NF LOC
ii. Interim ECF CHOICES At-Risk Group: At Risk LOC
iii. ECF CHOICES At-Risk Group: At Risk LOC
iv. ECF CHOICES Working Disabled Group: NF LOC or At Risk LOC

c. Target Population

An individual must be in one of the target populations.

d. Citizenship

An individual must be a U.S. citizen, U.S. national, or eligible non-citizen.

e. Enumeration

An individual must possess and provide a valid Social Security Number (SSN) or proof of application for an SSN, unless he meets an exception.

f. State Residence

An individual must be a resident of Tennessee.

g. Slot Status

An individual must meet the eligibility and enrollment criteria for an ECF CHOICES benefit group, qualify in a group for which enrollment is currently open, and there must be an available slot for the individual to be enrolled. In certain instances, an individual can be enrolled outside the enrollment target for an ECF CHOICES benefit group if there is no slot available.

h. Earned Income

To be eligible for the ECF CHOICES Working Disabled Group, an individual must have earned income.

6. ECF CHOICES Benefit Groups

Enrollment in a benefit group depends on an individual's age, I/DD status, and medical and/or functional needs. The ECF CHOICES benefits individuals receive are based on the benefit group into which they are enrolled. The ECF CHOICES benefit groups include:

a. Essential Family Supports (ECF CHOICES Group 4)

ECF CHOICES Group 4 is for children under age 21 and adults age 21 and older with I/DD who live with family caregivers, meet the NF LOC or who, in the absence of HCBS, are at risk for institutionalization.

b. Essential Supports for Employment and Community Living (ECF CHOICES Group 5)

ECF CHOICES Group 5 is for adults age 21 or older with I/DD who, in the absence of HCBS, are at risk for institutionalization. Adults age 21 and older with I/DD who meet NF LOC may be enrolled in ECF CHOICES Group 5 if their needs can be safely and appropriately met in Group 5.

c. Comprehensive Supports for Employment and Community Living (ECF CHOICES Group 6)

ECF CHOICES Group 6 is for adults age 21 or older with I/DD who meet NF LOC and need specialized services for I/DD.

d. Intensive Behavioral Family Supports (ECF CHOICES Group 7)

ECF CHOICES Group 7 is for children under age 21 with I/DD who meet NF LOC, live with family caregivers, have severe behavioral health and/or psychiatric conditions that:

- **i.** Place the child or others at imminent and significant risk of serious physical harm (that does not rise to the level of inpatient treatment or for which such treatment would not be appropriate);
- **ii.** Significantly strain the family's ability to adequately respond to the child's needs;
- **iii.** Threaten the sustainability of the family living arrangement; and
- **iv.** Place the child at imminent and significant risk of placement outside the home.

e. Comprehensive Behavioral Supports for Employment and Community Living (ECF CHOICES Group 8)

ECF CHOICES Group 8 is for adults age 21 and older with I/DD who have severe behavioral and/or psychiatric conditions, are transitioning out of a highly structured and supervised environment (e.g., criminal justice system, foster care system, long-term institutional placement, psychiatric hospital), meet NF LOC, and need specialized services for I/DD. A person's psychiatric symptoms or behaviors must:

- **i.** Place the person or others at imminent and significant risk of serious physical harm (that does not rise to the level of inpatient treatment or for which such treatment would not be appropriate); and
- **ii.** Necessitate continuous monitoring and supervision by 24-hour staff to ensure the person's safety and/or the safety of others.

Note: Young adults ages 18 to 20 with I/DD not living at home with family, who meet eligibility criteria, on a case-by-case basis, may be permitted to enroll in ECF CHOICES Group 5, 6 or 8. Individuals who do not meet the NF LOC, but who meet the ICF/IID criteria who are transitioning from the Statewide or Comprehensive Aggregate Cap (CAC) waivers or from an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) may be granted an exception to enroll in ECF CHOICES Group 6 or 8.

7. Financial Eligibility Requirements for the Demonstration Groups

a. Eligibility Determination Group (EDG)

Financial eligibility is determined based on an EDG size of one. The only EDG member included is the applicant.

b. Parent-to-Child Deeming

The income and resources of a child's parents are deemed available to a child under age 18, unless the child:

i. Is age 17 or older and meets NF LOC;
ii. Will be enrolled in ECF CHOICES Group 7;
iii. Is transitioning from ECF CHOICES Group 7 to ECF CHOICES Group 4; or
iv. Was enrolled in ECF CHOICES before November 23, 2020 (i.e., the date the Katie Beckett program was implemented.

Note: Children who were enrolled in ECF CHOICES without parental deeming are considered to have "grandfathered" eligibility status. Parent-to-child deeming will be waived for a child who is grandfathered as long as the child remains continuously enrolled in the ECF CHOICES program.

c. Resources

The individual's countable resources must not exceed $2,000. Parent-to-child deeming rules apply, with some exceptions, if the individual is a child under age 18. See the Parent-to-Child Deeming section in this policy and the Resource Deeming section in the *ABD Deeming of Income and Resources* policy. A resource assessment must be conducted if the individual has a community spouse. See the *Resource Assessment* policy.

d. Income

i. ECF CHOICES 217-Like Group and Interim ECF CHOICES At-Risk Group

The individual's gross countable income must not exceed 300% of the SSI Federal Benefit Rate (SSI-FBR). See example budget in the *Institutional Medicaid* policy. Parent-to-child deeming rules apply, with some exceptions, if the individual is a child under age 18. See the Parent-to-Child Deeming section in this policy and the Ineligible Parent Income Deeming section in the *ABD Deeming of Income and Resources* policy.

ii. ECF CHOICES At-Risk Group

The individual’s net countable income must be at or below 150% of the Federal Poverty Level (FPL). See the *ABD Income Disregards and Expenses* policy for specific disregards and expenses. Parent-to-child deeming rules apply, with some exceptions, if the individual is a child under age 18. See the Parent-to-Child Deeming section in this policy and the Ineligible Parent Income Deeming section in the *ABD Deeming of Income and Resources* policy.

iii. ECF CHOICES Working Disabled Group

There are two income tests for the ECF CHOICES Working Disabled Group.

1. For the first test, the individual’s net countable income must be at or below 250% of the FPL. See the *ABD Income Disregards and Expenses* policy for specific disregards and expenses. Parent-to-child deeming rules apply, with some exceptions, if the individual is a child under age 18. See the Parent-to-Child Deeming section in this policy and the Ineligible Parent Income Deeming section in the *ABD Deeming of Income and Resources* policy.

2. For the second test, the individual’s net countable income (including deemed income), after his earned incomed is disregarded, must be below the SSI-FBR. Parental and spousal deeming rules apply. The individual would be eligible for SSI but for his earned income.

Note: If an individual’s income is over the income limit for the ECF CHOICES 217-Like, the Interim ECF CHOICES At-Risk, the ECF CHOICES At-Risk Groups, or for the first income test for the ECF CHOICES Working Disabled Group, the individual will be provided an opportunity to establish a Qualified Income Trust (QIT). See the “Qualified Income Trust (QIT) or Miller Trusts” section in the *ABD Trusts* policy.

e. LTSS Payments

All other provisions related to payment of TennCare Medicaid LTSS payments apply (e.g., patient liability, transfer of assets, home equity limit, etc.). See the *Post-Eligibility Treatment of Income*, *Transfer of Assets and Penalty Periods*, and *ABD Countable and Excluded Resources* policies for more information.

8. Example Budget

a. ECF CHOICES At-Risk Group

Stephen Miller, a 17-year-old with I/DD, is applying for ECF CHOICES. He is determined eligible for an At-Risk LOC, and there is currently an available slot in an ECF CHOICES benefit group that Stephen can be enrolled in. He lives at home with his mother and younger sister. Stephen works part-time and receives $400 a month in earned income. His sister does not have any income. Stephen's mother receives $3,500 a month in earned income, of which $715 is deemed to Stephen.

Income Budget Calculation		
Unearned Income		$ 0.00
Irregular Unearned Income Disregard	+	$ 0.00
In-Kind Support and Maintenance	+	N/A
Ineligible Spouse's Deemed Unearned Income	+	0.00
Ineligible Parent's Deemed Income	+	715.00
General Deduction ($20)	-	20.00
Child Support Disregard	-	0.00
Widow/Widower Entitlement Disregard	-	N/A
DAC Entitlement Disregard	-	N/A
COLA Disregard	-	N/A
Total Net Unearned Income	=	$ 695.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 400.00
Irregular Earned Income Disregard	-	0.00
Student Earned Income Exclusion	-	0.00
Ineligible Spouse's Deemed Earned Income	+	0.00
Remaining General Deduction	-	0.00
Earned Income Deduction	-	65.00
Impairment Related Work Expense	-	N/A
½ Deduction	-	167.50
Blind Work Expense	-	0.00
Total Net Earned Income	=	$ 167.50
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 862.50
Qualified Income Trust	-	0.00
Net Countable Income		$ 862.50
Income Test Limit		$ 1610.00
Income Test Result		PASS

The above budget is current as of July 2021.

Stephen's net countable income, $862.50, is less than 150% of the FPL. Stephen is income-eligible for the ECF CHOICES At-Risk Group.

b. ECF CHOICES Working Disabled Group

Linda Davis, a 32-year-old with I/DD, is applying for ECF CHOICES. She is determined eligible for an At-Risk LOC, and there is currently an available slot in an ECF CHOICES benefit group that Linda can be enrolled in. Linda lives in the household with her husband Jerry. Linda is working and receives $3,400 a month in earned income. Jerry is working and receives $2,000 a month in earned income.

i. 250% FPL Test

Income Budget Calculation		
Unearned Income		$ 0.00
Irregular Unearned Income Disregard	+	0.00
In-Kind Support and Maintenance	+	N/A
Ineligible Spouse's Deemed Unearned Income	+	0.00
Ineligible Parent's Deemed Income	+	0.00
General Deduction ($20)	-	0.00
Child Support Disregard	-	0.00
Widow/Widower Entitlement Disregard	-	N/A
DAC Entitlement Disregard	-	N/A
COLA Disregard	-	N/A
Total Net Unearned Income	=	$ 0.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 3400.00
Irregular Earned Income Disregard	-	0.00
Student Earned Income Exclusion	-	0.00
Ineligible Spouse's Deemed Earned Income	+	0.00
Remaining General Deduction	-	20.00
Earned Income Deduction	-	65.00
Impairment Related Work Expense	-	0.00
½ Deduction	-	1657.50
Blind Work Expense	-	0.00
Total Net Earned Income	=	$ 1657.50
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 1657.50
Qualified Income Trust	-	N/A
Net Countable Income		$ 1657.50
Income Test Limit		$ 2684.00
Income Test Result		PASS

The above budget is current as of July 2021.

Linda's net countable income, $1657.50, is less than 250% of the FPL. Linda has passed the first income test.

ii. SSI-FBR Test

Income Budget Calculation		
Unearned Income		$ 0.00
Irregular Unearned Income Disregard	+	0.00
In-Kind Support and Maintenance	+	N/A
Ineligible Spouse's Deemed Unearned Income	+	0.00
Ineligible Parent's Deemed Income	+	0.00
General Deduction ($20)	-	0.00
Child Support Disregard	-	0.00
Widow/Widower Entitlement Disregard	-	N/A
DAC Entitlement Disregard	-	N/A
COLA Disregard	-	N/A
Total Net Unearned Income	=	$ 0.00
Self-Employment Income		$ 0.00
Earned Income	+	$ 0.00
Irregular Earned Income Disregard	-	0.00
Student Earned Income Exclusion	-	0.00
Ineligible Spouse's Deemed Earned Income	+	2000.00
Remaining General Deduction	-	20.00
Earned Income Deduction	-	65.00
Impairment Related Work Expense	-	0.00
½ Deduction	-	957.50
Blind Work Expense	-	0.00
Total Net Earned Income	=	$ 957.50
Total Countable Income (Total Net Unearned Income + Total Net Earned Income)	=	$ 957.50
Qualified Income Trust	-	N/A
Net Countable Income		$ 957.50
Income Test Limit		$ 1191.00
Income Test Result		PASS

The above budget is current as of July 2021.

Linda's net countable income (after disregarding her earned income), $957.50, is less than the SSI-FBR for a couple. Linda has passed the second income test. She is income-eligible for the ECF CHOICES Working Disabled Group.

9. ECF CHOICES Effective Date

Eligibility in an ECF CHOICES demonstration group begins on the date the case is approved in the eligibility determination system based on a determination that all applicable eligibility and enrollment criteria have been met. An individual is enrolled into ECF CHOICES on the date the individual is determined eligible for and will begin receiving LTSS.

Document Title	Employment and Community First CHOICES				
First Published	07.01.2021				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
09.01.2022		Legal Authority		Policy Clarification	AJ
09.01.2022	4.	ECF CHOICES Demonstration Groups	2	Non-Substantive Change	AJ
09.01.2022	7.b-c.; 7.d.i - iii.1.	Parent-to-Child Deeming; Resources; ECF CHOICES 217-Like Group and Interim ECF CHOICES At-Risk Group; ECF CHOICES At-Risk Group; ECF CHOICES Working Disabled Group	5-6	Policy Change	AJ

CONFIDENTIALITY & PRIVACY

Legal Authority: 42 CFR 431.300; 42 CFR 431.305; 45 CFR 160-164

1. Policy Statement

Federal and state law provides safeguards that restrict the use or disclosure of information concerning the individual to purposes directly connected with the administration of the Medicaid program. Such purposes include establishing eligibility, determining the amount of medical assistance, providing services to the individual and conducting or assisting in an investigation or prosecution of administrative, civil or criminal proceedings related to program administration.

2. The Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act

HIPAA and HITECH require TennCare to protect the privacy and security of any protected health information (PHI) received, used, stored and created in the course of business. PHI is any information about a past, present or future physical or medical condition, provision of health care or payment for health care that can be linked to a specific individual. This includes, but is not limited to, any part of a patient's medical record or payment history. HIPAA privacy rules give patients privacy rights regarding access to and use of their medical records in all forms, including electronic and paper records, and oral communications.

Privacy protections apply to all requests for information from outside sources, including governmental bodies and the courts, as well as law enforcement officials. Information subject to privacy protections includes but is not limited to:

i. The individual's name, date of birth, and address;
ii. Unique identifiers such as Social Security or medical records numbers;
iii. Agency evaluation of personal information;
iv. Social and economic conditions or circumstances;
v. Medical services provided;
vi. Medical information including past history of disease or disability, current diagnosis, and future planned or needed care;
vii. Any information received for the purpose of verifying income eligibility and amount of medical assistance payments. Income information received from the Social Security Administration (SSA) or Internal Revenue Services (IRS) must be safeguarded according to the requirements of the agency that furnished the data; and
viii. Any information received in connection with the identification of legally liable third party resources.

3. Requests for Information by Outside Parties Regarding Eligibility of Clients and Related Medical Information

Federal and state statutes restrict the provision of information about an individual to outside parties. This includes PHI as well as the individual's eligibility status, and medical, financial and other information used to determine eligibility for TennCare Medicaid. When TennCare employees or TennCare contractors are contacted by outside parties, including family members, family friends and attorneys or their staff, who represent an individual receiving TennCare Medicaid, TennCare employees and contractors must adhere to the following policies and procedures:

a. When contacted by an attorney, or someone from the attorney's office such as a paralegal or member of the clerical staff, about the status of a particular enrollee:

i. Inform the person that TennCare requires appropriate authorized representative documentation and that it is TennCare policy to refer attorney inquiries about an individual's TennCare Medicaid case to the TennCare Office of General Counsel (OGC), Privacy Office when needed.
ii. Take the person's name, number and relevant inquiry details, and tell the person that someone from the Privacy Office will contact him or her.
iii. Immediately send the individual's contact information to Privacy.TennCare@tn.gov
iv. Call the Privacy Office at 615-507-6855 or 615-507-6820 to confirm receipt of the information. Do not discuss the individual's case with the requesting party or provide the person with any information (written or otherwise) about the individual's case unless otherwise notified by OGC staff.

b. Contact by any other third party (including a person who claims to be a relative or friend of the individual):

i. Inform the requesting party that federal law prohibits discussion of the individual's case with a third party unless there is written consent from the individual, or unless the individual is present and provides verbal consent to the discussion.
ii. To authorize individuals or organizations to receive healthcare information and make decisions on behalf of an applicant/enrollee, the applicant/enrollee may verbally designate a representative or submit a Tennessee Health Care Finance and Administration Authorization form, or otherwise provide appropriate documentation (e.g. power of attorney, custody/guardianship order) when an authorized representative is not designated on the application.

The Authorized Representative forms are available at: Authorization of Representative - Individual and Authorization of Representative - Organization.
There are separate forms for entities and individuals being designated as representatives, and the correct one must be submitted in each case. Once an individual is verbally designated as a representative or appropriate document or

completed form is received, discuss the individual's TennCare Medicaid only with the person(s) being authorized to receive the information.

To authorize individuals or organizations to receive healthcare information, but not make decisions on behalf of an applicant/enrollee, a Permission to Release Protected Health Information form is required when it is not designated on the application. Offer to mail or fax the requesting party or individual a blank form that the individual can complete, execute and mail or fax to Tennessee Health Connection (TNHC). The form is available at: https://www.tn.gov/content/dam/tn/tenncare/documents/releaserecord.pdf

Once the completed form is received, discuss the individual's TennCare Medicaid only with the person(s) listed on the form as being authorized to receive the information.

If TennCare receives a signed authorization form that is different from the form provided, forward the form to the TennCare OGC, Privacy Office for approval at Privacy.TennCare@tn.gov or via fax to 615-734-5289. In order to be valid, the authorization form must be completely filled out. The authorization form must also contain an expiration date. Always check the expiration date on the form to ensure that the authorization has not expired.

If approval is not provided by the Privacy Office, the authorization form will not be considered acceptable to authorize the individual to represent the applicant/enrollee.

4. Application by Department Employees and their Relatives

A TennCare employee must notify his supervisor as soon as practicable if and when the employee, the employee's family member or person with whom the employee maintains a close personal relationship applies for benefits.

a. Definitions

Family Member: A family member is defined as one of the following

i. Relationships by blood: parent, child, grandparent, grandchild, brother, sister, uncle, aunt, nephew, niece, first cousin; and

ii. Relationships by marriage: husband, wife, step-parent, stepchild, brother-in-law, sister-in-law, father-in-law, mother-in-law, son-in-law, daughter-in-law, half-brother, half-sister, uncle, aunt, nephew, niece, spouse of any of the above.

Close Personal Relationship: A close personal relationship is one defined as but not limited to:

i. A dating or co-habiting relationship;

ii. A domestic partnership;

iii. A relationship in which business transactions are regularly conducted; and
iv. A personal friendship that transcends a casual acquaintance, such as:

a. A person whose home is frequently visited by the employee, or vice versa; and
b. A person with whom the employee socializes on a regular basis.

5. Social Media Relationship

A TennCare employee shall disclose to the employee's supervisor if and when the employee becomes aware of a person with whom the employee maintains a social media relationship has applied for benefits. The TennCare employee shall not be involved in or access records related to an individual with whom the employee maintains a social media relationship.

Document Title	Confidentiality and Privacy
First Published	08.10.2015

Revision History

Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
02.01.2018	3.b.ii	Requests for Information by Outside Parties Regarding Eligibility of Clients and Related Medical Information	3	Policy Change	TN

RIGHTS AND RESPONSIBILITIES

Legal Authority: Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000 et seq.*;* 45 C.F.R. pt. 80); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794 et seq.; 45 C.F.R. pt. 84); The Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.; 45 C.F.R. pts. 90 and 91); Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.; 45 C.F.R. pt. 86); The Americans with Disabilities Act (42 U.S.C. § 12101 et seq.; 28 C.F.R. pts. 35 and 36); Section 1557 of the Affordable Care Act (42 U.S.C. § 18116); Tenn. Code Ann. Title 4, Chap. 21, pt. 4.; The National Voter Registration Act of 1993 (52 U.S.C. § 20506); Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

Federal and State laws do not allow TennCare to treat you differently because of your race, color, national origin, age, sex, disability, language, religion, or other protected status. These laws allow individuals, such as applicants, members, representatives, or providers (also called “complainants”) to file a complaint with TennCare’s Office of Civil Rights Compliance (“OCRC”) if they think they have been treated in a discriminatory manner (such as denied a service or benefit) based on one of the above listed factors. Under the civil rights laws an organization cannot retaliate against a person for filing a complaint. You can find more information about filing a discrimination complaint online at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

TennCare, at all administrative levels, shall not discriminate against any individual for reasons of age, race, color, sex, disability, religion, creed, national origin or any other group protected by the applicable federal and state civil rights laws. Individuals with Limited English Proficiency (LEP) and individuals with disabilities have equal access to TennCare programs.

TennCare is required to seek and recover certain funds paid by the TennCare Medicaid program. TennCare Medicaid individuals who receive institutionalized care are subject to estate recovery. Individuals are notified of estate recovery in the TennCare application and can find more information here: https://www.tn.gov/tenncare/legal/estate-recovery.html.

TennCare is required to provide individuals the opportunity to register to vote at the time of application, renewal, and a reported address change.

2. Federal Non-Discrimination Laws

The federal non-discrimination laws listed below prohibit discrimination on the basis of race, color, national origin, age, sex and disability in programs or activities that receive or benefit from federal financial assistance. Discrimination on the basis of disability is prohibited in all programs, services or activities of public entities. The Americans with Disabilities Act (ADA) coverage does not depend on receipt of federal funds.

a. Title VI of the Civil Rights Act of 1964 ("Title VI"): Prohibits discrimination, denial of benefits or being excluded from participation on the basis of race, color or national origin in any program or activity that receives federal financial assistance from the U.S. Department of Health and Human Services.

b. The Americans with Disabilities Act of 1990 and Amendments ("ADA"): Prohibits discrimination on the basis of disability by both public and private entities, whether or not they receive federal financial assistance.

c. The Age Discrimination Act of 1975 ("ADEA"): Prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance.

d. Section 504 of the Rehabilitation Act of 1973 ("Section 504"): Protects a qualified individual with a disability from discrimination in the provision of any benefit or service provided under any program or activity receiving funds from the Department of Health and Human Services.

e. Title IX Education Amendments of 1972 ("Title IX"): No person shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving federal financial assistance

f. Section 1557 of the Patient Protection and Affordable Care Act ("Section 1557"): An individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or Section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance.

3. Title VI Prohibition on Discriminatory Conduct in Federally Funded Programs and Activities

Under Title VI, TennCare shall not discriminate against people on the basis of race, color or national origin in how its programs are administered.

TennCare shall not exclude or deny benefits to persons based on their race, color or national origin.

TennCare shall not impose different standards or procedures to determine who may receive benefits on the basis of race, color or national origin.

Examples:

a. Staff shall not reject an individual for benefits because he is, or appears to be, African American, Hispanic, Asian, American Indian, Alaskan Native or a member of another racial or ethnic group.

b. Staff shall not reject an application based on the assumption that a person with a foreign-sounding last name is not a U.S. citizen and therefore not eligible.

c. Staff shall not deny benefits to persons who are not fluent in English (known as being LEP) because they assume persons who are or appear to be from other countries are not eligible for such benefits. Instead, staff shall ensure that appropriate language assistance services are provided to the individual such as contacting a language interpreter or arranging translation of documents.

d. Where a qualified immigration status requires verification for eligibility, staff shall not accept a self-declaration of that status from individuals who appear to be of African origin, yet require that all immigrants from Spanish-speaking nations submit documentation because of an assumption that these individuals are undocumented.

4. Section 504, Section 1557, and the ADA Prohibit Discriminatory Conduct on the Basis of Disability

TennCare shall not discriminate against any qualified individual with a disability in providing services or administering any program or activity, whether or not the program receives federal financial assistance. In general, an individual with a disability is qualified if that person meets the essential eligibility requirements for receipt of services or the participation in programs or activities provided by TennCare. TennCare shall not refuse to allow a person with a disability to participate because the person has a disability. There cannot be unnecessary eligibility standards or rules that deny an individual with a disability an equal opportunity to participate. TennCare shall not harass an individual based on a disability.

TennCare is required to make reasonable modifications in its policies, practices and procedures so that qualified individuals with disabilities can take part in TennCare's programs, services or activities, unless a requested modification would result in a fundamental alteration or undue financial and administrative burden to TennCare.

5. Effective Communication (LEP and Individuals with Disabilities)

To ensure compliance with Title VI, Section 1557, the ADA and Section 504, individuals with LEP and/or disabilities must have meaningful access to TennCare's programs, services or activities. To do this, TennCare works to ensure that communications with members and potential members and these individuals' families or representatives are as effective as communications with others who are not LEP or have disabilities by using language and communication assistance services and/or auxiliary aids or services that are free to these individuals.

a. Individuals with Disabilities

Under Section 504, Section 1557, and the ADA, effective communication is required except where TennCare can show that providing effective communication would fundamentally alter the nature of the service or program in question or would result in an undue financial and administrative burden. In order to be effective communication, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability.

Remember, the type of auxiliary aid or services needed by an individual can change during a conversation or service encounter. During brief or simple face-to-face exchanges, very basic aids are usually appropriate. For example, exchanging written notes may be effective when an individual with a hearing disability asks for a copy of a form at a doctor's office. Conversations that are more complex or lengthy may require more advanced aids and services. Consideration should be given to how important the communication is, how many people are involved, the length of the communication anticipated, and the context.

When an auxiliary aid or service is requested by someone with a disability, they must be provided an opportunity to request the auxiliary aids and services of their choice, and TennCare must give primary consideration to the individual's choice. "Primary consideration" means that TennCare must honor the choice of the individual with a disability, with certain exceptions (see below for a list of the exceptions). The individual with a disability is in the best position to determine what type of aid or service will be effective.

The requirement for consultation and primary consideration of the individual's choice applies to orally communicated information (i.e., information intended to be heard) as well as information provided in visual formats.

The requesting person's choice does not have to be followed if:

- **i.** TennCare can demonstrate that another equally effective means of communication is available;
- **ii.** Use of the means chosen would result in a fundamental alteration in the service, program or activity; or
- **iii.** The means chosen would result in an undue financial and administrative burden.

b. LEP Individuals

Similar steps are taken to ensure effective communication with individuals with LEP. It is important that LEP individuals understand their rights and the services, programs and activities that are available.

In order to ensure that LEP individuals are not excluded from equal program participation, TennCare makes available free qualified interpreters and translators who can provide appropriate oral and/or written language assistance services to accommodate these individuals. TennCare may:

- **i.** Contract with an outside interpreter or translation service; or
- **ii.** Use a telephone interpreter service.

LEP individuals must be advised that a free interpreter is available. It is not advisable to use friends and family members as interpreters. Using friends and family as interpreters may compromise the effectiveness of the communication, create a conflict of interest and violate confidentiality and privacy safeguards. At the request of the LEP individual, they may use friends and family as their interpreter. However, if the friend or family member is not competent or appropriate, a trained interpreter should be used to ensure reliable and correct interpretation of information. Minor children cannot be used as interpreters.

The LEP individual's decision to accept or decline the offer of free interpreter services must be documented. TennCare has an Interpreter Waiver form in English and Spanish that documents the individual's decision to use either a free interpreter or a family member. This form is located on OCRC's webpage, which is listed above. If requested, this form can be translated into other languages by contacting OCRC.

Questions regarding when an interpreter should be used, or when written materials should be translated, should be directed to supervisory staff. If you need to use an interpreter in order to assist an individual, use TennCare's contracted Language Services vendors. You may need to ask your supervisor for assistance with contacting the vendors. If, after speaking with your supervisor, you still need help communicating with an applicant or member, contact OCRC at (615) 507-6841. Individuals who need help communicating with TennCare such as during a hearing, meeting, or training, can complete a free, online Communication Help Form located at:
https://stateoftennessee-cvlyz.formstack.com/forms/communication_help_form.

Some of TennCare's documents have been translated into the Spanish language and are available on the TennCare website at: https://www.tn.gov/tenncare.

6. Civil Rights Contacts:

TennCare Office of Civil Rights Compliance 310 Great Circle Road, Floor 3W Nashville, Tennessee 37243 Email: HCFA.Fairtreatment@tn.gov Phone: 1-855-857-1673 (TRS 711) **You can file a complaint online at:** https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html	**U.S. Department of Health & Human Services Office for Civil Rights** 200 Independence Ave SW, Rm 509F, HHH Bldg Washington, DC 20201 **Phone:** 1-800-368-1019 **(**TRS 711**)** **You can get a complaint form online at:** https://www.hhs.gov/sites/default/files/ocr-60-day-frn-cr-crf-complaint-forms-508r-11302022.pdf **Or you can file a complaint online at:** https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

You can also file a discrimination complaint with the: **U.S. Department of Justice** Civil Rights Division 950 Pennsylvania Ave., NW Washington, D.C. 20530 Fax: (202) 307-1197 Call: 855-856-1247 (TRS 711) **To file a complaint online:** https://civilrights.justice.gov/report/	**Tennessee Human Rights Commission** 312 Rosa L. Parks Ave, 23rd Floor Nashville, TN 37243 Free: 800-251-3589 **You can file a complaint online at:** https://stateoftennessee.formstack.com/forms/2023_complaint_form

7. Estate Recovery

Estate recovery occurs when the State files a claim with the deceased individual's estate for reimbursement of certain TennCare Medicaid expenditures incurred during the individual's period of eligibility. Estate recovery is required by Federal and State law.

a. Estate recovery applies to:

i. TennCare Medicaid-covered services received by individuals permanently confined to a long-term care facility, regardless of age;

ii. TennCare Medicaid-covered services received in a long-term care facility or in a home and community-based services setting and related hospital and prescription drug services, by individuals age 55 or older.

b. Adjustment or recovery from the recipient's estate may be pursued only:

i. After the death of the individual's surviving spouse, if any; and

ii. Only at a time when the individual has no surviving child who is under eighteen (18) years of age or no surviving child, as defined in § 1614 of the Social Security Act, who is blind or permanently and totally disabled, or a child who became blind or permanently and totally disabled after reaching majority, if TennCare and the personal representative agree, or, in the event of a disagreement, the court, after de novo review, finds that repayment would constitute an undue hardship to the blind or disabled child. See Tenn. Code Ann. § 71-5-116(c)(1).

TennCare Member Services is required to inform the responsible party of individuals in long-term care facilities about the estate recovery provisions. Information about estate recovery is available in the TennCare application. The State cannot impose a lien on real property which is occupied by an applicant for TennCare Medicaid.

c. Estate Recovery Unit

The Estate Recovery Unit is responsible for the estate recovery program. The TennCare Reform Act of 2002 requires a release to be obtained from TennCare indicating that no money is owed by a former Medicaid recipient before an estate can be settled. For further information, attorneys or relatives may contact:

Bureau of TennCare
Estate Recovery Unit
310 Great Circle Road
Nashville, TN 37243
Telephone: 1-866-389-8444
Fax: 615-413-1941

8. Voter Registration

a. Background

The National Voter Registration Act of 1993 (NVRA), also known as the "Motor Voter Act," requires states to provide uniform voter registration at offices that provide public assistance and state-funded programs primarily engaged in providing services to individuals with disabilities. The enactment of the NVRA enhances opportunities for individuals to register to vote and maintain voter registration.

TennCare provides voter registration forms when requested and offers to mail voter registration forms when an individual applies, at renewal, and when reporting an address change. When an individual does not want a voter registration form, such declination will be documented by TennCare. Voter registration or declination does not impact an individual's TennCare eligibility.

b. Receipt of Voter Registration Form

If an individual returns the voter registration form to TennCare, TennCare will forward the voter registration form to the individual's local County Election Commission within 10 days of receipt, or within 5 days if the form is received within 5 days before the last day to register to vote in an election.

If an individual believes that someone has interfered with his right to register or to decline to register to vote, he may file a complaint with the Election Commission at: https://sos.tn.gov/products/elections/how-do-i-file-complaint.

Document Title	Rights and Responsibilities				
First Published	03.23.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
11.03.2015	7.	Estate Recovery	6 - 7	Policy Clarification	AF
01.29.2016	6.	Filing Discrimination Complaints	5	Non-Substantive Change	SN
03.18.2019	1.; 8.	Legal Authority; Policy Statement; Voter Registration	1; 7-8	Policy Clarification	JH
02.01.2022	1.; 2.; 3.c-d; 4.;5.; 6.	Legal Authority; Policy Statement; Federal Non-Discrimination Laws; Section 504, Section 1557, and the ADA Prohibit Discriminatory Conduct on the Basis of Disability; Title VI Prohibition on Discriminatory Conduct in Federally Funded Programs and Activities; Civil Rights Contacts	1-3; 6-8	Policy Clarification	KF
02.01.2024	6	Civil Rights Contacts	6	Non-Substantive Change	TC

APPLICATION FOR OTHER PROGRAM BENEFITS

Legal Authority: 42 CFR 435.608

1. Policy Statement

As a condition of eligibility, individuals are required to take all necessary steps to obtain benefits to which they are entitled, except for public assistance programs to which the individual is entitled, unless the individual can show good cause for failure to apply. If the individual cannot demonstrate good cause for failure to apply for other benefits, he or she is not eligible for benefits.

2. Definitions

Benefits: Benefits include financial benefits in the form of annuities, pensions, retirement, and disability benefits, including but not limited to:

- Veterans' compensation, pension and Veterans Affairs (VA) contract payments (but not VA benefits or Aid and Attendance benefits);
- Old Age, Survivors and Disability (OASDI) benefits (Social Security);
- Railroad Retirement benefits;
- Unemployment compensation; and
- Workers' Compensation benefits.

Public Assistance: Public Assistance includes Supplemental Security Income (SSI) and Families First/Temporary Aid for Needy Families (TANF).

3. Possible Entitlement Hints

a. Black Lung Benefits

An individual is:

- A coal miner and who is totally disabled due to pneumoconiosis; or
- The dependent spouse, surviving or divorced spouse, or the child (under 18) of an eligible miner (or eligible at death).

b. Railroad Retirement Benefits

The individual or his Financially Responsible Relative (FRR) worked for the railroad or a company closely connected to the railroad, and he or she is at least age 60 or disabled.

c. Social Security Benefits

An individual or his or her FRR is:

- At least age 62; or
- Disabled based on Social Security criteria; or
- Is a child under 18 of a deceased, retired or disabled worker; or
- Is the child who became disabled before age 22 of a deceased, retired or disabled worker.

d. SSI

An individual who is:

- At least age 65; or
- Disabled or blind based on Social Security criteria; and
- Has monthly income limited to the amount of the current SSI Federal Benefit Rate (FBR) or less, if living in the household of another; and
- Has resources limited to $2,000 for an individual or $3,000 for a couple.

e. Veterans' Benefits

An individual who is:

- A veteran of services in the U.S. Armed Forces and discharged under conditions other than dishonorable; or
- A dependent or surviving spouse of a veteran.

f. Workers' Compensation

An individual:

- Injured or disabled on the job; or
- The surviving dependent of a worker who was killed on the job.

4. Good Cause

An individual is considered to have good cause for failure to apply for other benefits if he or she does not have someone available to act on his or her behalf AND he or she cannot apply. Examples of good cause include, but are not limited to, the following:

- The individual is not able to apply for benefits due to his or her own illness (explain that the Social Security Administration (SSA) can have a telephone interview); OR
- The individual applied for benefits at one time, was denied, and he or she remains ineligible for the same reason.

The individual is considered to have good cause for failure to apply if HCFA failed to advise them of the availability of other benefits.

5. Application of Good Cause Provision

Once good cause has been established, take one of the following actions depending on the circumstances of the case:

a. Hold the Application Pending

If the TennCare Medicaid application is held pending, give the individual a specific deadline for filing an application for other benefits.

If the deadline exceeds the processing time limits and the TennCare Medicaid application becomes overdue, document the case record with an explanation of the reasons the application continues in a pending status. An Eligibility Specialist is not considered at fault in this situation if the case record is well-documented.

If at expiration of the deadline the individual has failed to apply, and does not have good cause for his or her failure to apply, the application is denied.

6. Approve the Application

If the individual is otherwise eligible, approve his or her application for benefits. Inform the applicant that the requirement to apply for other benefits has been temporarily waived, and he or she has an obligation to apply in the future. The time limit for that application and acceptable evidence of application for other benefits must be provided.

Set up a case worker alert to follow up on the individual's application for other benefits, and upload evidence of his or her application for other benefits to the case.

7. Applying the Provision at Redetermination

If all other conditions and eligibility criteria are satisfied, consider the redetermination complete and document the Case Notes with an explanation of the waiver of this requirement. Set up a case worker alert to follow-up on the individual's application for other benefits if the requirement has been temporarily waived.

8. Verification

At application, self-attestation by an individual regarding application for other programs is accepted.

PROHIBITION AGAINST CONCURRENT RECEIPT OF BENEFITS

Legal Authority: 42 CFR 435.403; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

An individual is prohibited from receiving TennCare benefits from two or more categories of eligibility. This restriction does not apply to individuals who are eligible for a Medicare Savings Program (MSP) and TennCare. An individual is also prohibited from receiving Medicaid benefits from another state concurrent with TennCare Medicaid or CoverKids eligibility.

Tennessee does not reimburse medical expenses using an individual's Medicaid card from another state. TennCare Medicaid or CoverKids reimburses only on a TennCare Medicaid or CoverKids Identification number.

2. Out-of-State SSI Benefits

If a Tennessee resident is receiving SSI benefits from another state, refer the recipient and her responsible party to the Social Security Administration (SSA) to effect transfer of their SSI and Medicaid benefits to Tennessee. Inform the recipient and his responsible party that the SSA must change the client's address to the new Tennessee address. The eligibility effective date for TennCare Medicaid will be the date the individual receives SSI in Tennessee

3. Public Assistance Reporting Information System (PARIS)

Tennessee participates in PARIS, which is an information exchange system between states designed to identify individuals who may be receiving benefits or have unreported income in more than one state. Other states may request information to assist in resolving matches concerning individuals who appear to be receiving benefits in more than one state. If TennCare receives a PARIS match indicating that an individual is receiving concurrent benefits in another state, TennCare will attempt to confirm Tennessee residency prior to taking steps to terminate TennCare coverage

Document Title	Prohibition Against Concurrent Receipt of Benefits				
First Published	09.03.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
03.18.2019	4.	Legal Authority; Recipients of Out-Of-State Medicaid	1	Policy Clarification	TB
01.02.2020	1-3.	Policy Statement; Out-of-State SSI Benefits; Public Assistance Reporting Information System (PARIS)	1	Policy Clarification	TB

ASSIGNMENT OF THIRD PARTY MEDICAL SUPPORT

Legal Authority: 42 CFR 435.610

1. Policy Statement

As a condition of eligibility, an individual is required to assign his or her rights to medical support or other third party payments to the State, and to cooperate with the State in obtaining medical support and payments.

Third party medical support is also referred to as Third Party Liability (TPL).

2. Definitions

Assignment of Rights: When the individual or responsible party signs the application for benefits, he or she agrees that rights to any medical support or payment for medical expenses are assigned or given to the State.

The State reserves the right to receive reimbursement from any third party, including an insurance company, for any medical expenditure made on the individual's behalf.

The individual is required to return to the State any support or payments for medical expenses he or she may receive from a third party.

Medical Support: Medical Support is financial support available to an individual for his or her medical expenses.

Third Party Payments: Any payment made by an entity that is not the individual and not the State, including a responsible relative or an insurance company.

3. Cooperation with the State

The individual is required to provide the State any and all information necessary to obtain medical support or payment including but not limited to the following:

- The name(s) of the third party;
- The address;
- Any identifying information required to claim payment such as the subscriber's information, the subscriber's Social Security Number (SSN), the policy number, and the group or certification number;
- Household members covered by a health insurance policy; and
- The individual's signature on all forms required for reimbursement.

The individual is required to cooperate in any other way with the State in obtaining the medical support or payments to which he or she is entitled.

4. Refusal to Cooperate In Assignment

The refusal to cooperate with the State in reporting and obtaining medical support, or in the assignment of such support or third party payment to the State results in the individual's ineligibility for program benefits.

5. Medical Trust Fund

The individual is required to provide information regarding a medical trust fund established to defray or to entirely absorb his or her medical expenses including but not limited to the following:

- Location of the account;
- Account trustee;
- Account number; and
- Availability of the funds (e.g. limitations on disbursement).

6. Individual Responsibilities

The individual is required to provide sufficient information to obtain the third party medical support to which he or she is entitled such as:

- The name(s) of the third party;
- The address;
- Any identifying information required to claim payment such as the subscriber's information, the subscriber's Social Security Number (SSN), the policy number, and the group or certification number;
- Household members covered by a health insurance policy; and
- The individual's signature on all forms required for reimbursement.

The individual is required to cooperate with the State in any collection efforts including but not limited to his or her signature on all forms required to obtain reimbursement.

The individual is required to report within 10 days the receipt of any cash reimbursement for medical expenses including the following:

- Insurance settlement and refunds;
- Medical support paid by an absent parent; and

- Medical trust fund proceeds.

7. Reporting Third Party Medical Support

a. Overview

TPL information is collected at application and renewal. The individual is required to provide information about third party support and the information is collected in interChange.

8. Reporting Changes in Third Party Medical Support

Individuals must report any changes in third party support. Types of changes that must be reported include:

- Addition of third party support (e.g. purchase of health insurance or gaining Medicare eligibility);
- Deletion of third party support (e.g. termination of health insurance coverage for any reason);
- Third party change (e.g. coverage changed from one insurance company to another); and
- Receipt of cash reimbursement for medical expenses.

9. HCFA TPL Unit

The HCFA TPL Unit is responsible for pursuing TPL collection. All third party medical support is entered into interChange. If TPL information must be submitted via mail or fax, the individual should send the information to Tennessee Health Connection (TNHC) at:
Tennessee Health Connection
P.O. Box 305240
Nashville, TN 37230-5240

FAX: 1-855-315-0669

Document Title	Assignment of Third Party Medical Support				
First Published	3.11.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
1.29.2016	9	HCFA TPL Unit	3	TPL information is now sent to TNHC.	SN

APPLICATION PROCESS

Legal Authority: 42 CFR 435.906; 42 CFR 435.907; 42 CFR 435.909; 42 CFR 435.910; 42 CFR 457.330; 42 CFR 457.340; Tenn. Comp R & Regs 1200-13-20-.05

1. Overview

The Affordable Care Act (ACA) of 2010 reformed the Medicaid application process. The ACA provides that a single, streamlined application must be used to collect information sufficient to determine an individual's eligibility for Medicaid, Children's Health Insurance Program (CHIP, or CoverKids in Tennessee) and subsidies available for insurance policies sold on the Marketplaces. If the information collected in the single, streamlined application is not sufficient to determine an individual's eligibility for Medicaid and CHIP (e.g. an individual applying for Long-Term Services and Supports - LTSS) then supplemental application materials may be used.

The ACA reformed the application process for TennCare Medicaid and CoverKids, establishing a no wrong door approach between the state and federal government. Applications may be submitted electronically, by phone or by mail. Individuals may also apply in person at local Department of Human Services (DHS) offices using a TennCare kiosk. Applications may also be submitted through the Federally Facilitated Marketplace (FFM). Under the ACA, all of these methods of application are acceptable and will be processed accordingly.

2. Policy Statement

An individual who wants to file an application for TennCare Medicaid or CoverKids must have the opportunity to do so without delay. Applications must be voluntary and initiated by the person in need, or if the applicant is incompetent or incapacitated, someone responsible for acting on her behalf.

Individuals are not required to provide proof of eligibility prior to applying for assistance. However, proof of eligibility is required before assistance can be granted. Proof of eligibility may be secured by TennCare when information is readily available, or provided by the applicant, depending on the information type and circumstances.

3. TennCare Application

The TennCare application is used to determine eligibility for TennCare Medicaid categories, CoverKids, and Medicare Savings Programs (MSPs). Information collected on the TennCare application may also be used to determine eligibility for federal subsidies for other Insurance Affordability Programs (IAPs). Applications for individuals ineligible for TennCare Medicaid and CoverKids, but potentially eligible for other IAPs will be transferred to the FFM.

4. Application Forms

Acceptable application forms include the:

a. TennCare Paper Application;
b. TennCare Electronic Application; or
c. FFM Application for Assistance (Health Insurance Marketplace, Application for Health Coverage & Help Paying Costs).

5. Who May Submit an Application

An application and any documentation required to determine eligibility may be submitted by the following individuals:

a. The individual who is requesting assistance (the applicant)
b. A minor child must be a "mature minor" to submit his application. In determining who is a "mature minor," Tennessee common law follows the "Rule of Sevens."

i. Under the age of seven, there is no capacity. The application and any documentation required to determine eligibility must be submitted by an adult who lives in the home with the applicant, an authorized representative, or an individual acting responsibly for the applicant (unless a statutory exception applies).
ii. Between the ages of seven and fourteen, there is a rebuttable presumption that there is no capacity. The application and any documentation required to determine eligibility generally should be submitted by an adult who lives in the home with the applicant, an authorized representative, or an individual acting responsibly for the applicant (unless a statutory exception applies).
iii. Between the ages of fourteen and eighteen, there is a rebuttable presumption of capacity. The applicant may submit an application and any documentation required to determine eligibility, unless it is determined that the minor is not sufficiently mature to make her own health care decisions.

c. An adult who lives in the home with the applicant, if the applicant is a minor. This may be the applicant's biological, step or adopted parent, a family member who claims the applicant as a tax dependent, or another individual who is in a position to know the applicant's circumstances.
d. The primary residential parent or either parent when there is equally shared joint custody.
e. An authorized representative.
f. An individual acting responsibly for the applicant, if the applicant is a minor or incapacitated. A responsible party may be a relative, friend, guardian, conservator or other individual who is in a position to know of the applicant's circumstances.
g. A representative of the long term care facility where the individual resides.

NOTE: When an applicant cannot sign an application, TennCare may accept an application signed by the social worker, hospital, or nursing home facilitator. The signing individual must include a statement on the application indicating why the applicant is unable to sign the application. Valid reasons include: applicant is comatose, in emergency surgery or physically unable to sign and there are no family members present. Applications completed online have a section to include additional notes that an individual may use to indicate why the applicant is unable to sign the application.

6. How to Submit a TennCare Application and Application File Date

An application may be filed and will be accepted by TennCare through the following modes of submission:

a. Electronic Application: An applicant may submit an application via TennCare Connect, https://tenncareconnect.tn.gov/. This may be done independently, with informal assistance from a friend or family member, or with formal assistance (e.g. DHS staff, Area Agencies on Aging and Disability (AAAD) staff, hospital staff or others). Assistance may be in-person or provided over the phone. The application file date is the date a Valid Application is submitted through TennCare Connect..

b. Telephone Application: An individual may apply by phone through TennCare Connect. TennCare Connect will guide the applicant through the application process. The application file date will be the date a Valid Application is submitted by phone at TennCare Connect..

c. Faxed Application: Applications may be faxed to TennCare Connect. The application file date for applications faxed to TennCare Connect is the date a Valid Application is received by TennCare Connect .

d. Mailed Application: Paper applications may be mailed to TennCare Connect. The application file date for applications mailed to TennCare Connect is the date a Valid Application is received by TennCare Connect .

e. In-person Application: An individual may apply in person at the local DHS county office.

Individuals applying at a DHS office will complete an online application at a designated kiosk or by telephone. DHS staff are available to assist the applicant with the application process. The application date will be the date a Valid Application is submitted through TennCare Connect.

f. Applications Submitted to the FFM

Applications filed with the FFM, using the FFM website, call center or paper application are processed by the FFM. Once processed, the federal government transmits the applicant's information to TennCare through an electronic file if the individual is potentially eligible for TennCare Medicaid or CoverKids. The application file date will be the date provided to TennCare by the FFM.

7. When an Application May Be Submitted

Applications may be filed at any time throughout the year. In-person interviews are not required to complete or submit an application, or to renew eligibility.

8. Applicant Requirements

Applicants must provide complete and accurate information regarding their individual circumstances within specified time limits. Applicants and enrollees must report changes in their individual circumstances within 10 days. Enrollees of TennCare Standard must report changes within 30 days. Failure to report changes within the required timeframe may be interpreted as a willful attempt to commit fraud and any resultant overpayment of benefits is subject to recovery by TennCare.

9. Limits on Information

Individuals are only required to provide information needed to determine eligibility, or for administration of TennCare, CoverKids, and MSP. TennCare may request information needed to determine eligibility for other IAPs.

Social Security Numbers (SSNs) may be provided for non-applicants on a voluntary basis. The SSN is used to determine eligibility for TennCare, CoverKids, and MSP and may be shared with the FFM to determine eligibility for IAPs. When an SSN is provided, individuals are informed that provision of an SSN by non-applicants is voluntary. An individual must also be told how his SSN will be used.

10. Obtaining an Application

To file an online application, an individual must visit https://tenncareconnect.tn.gov/. To file a paper application, an individual may request an application in any of the following ways:

a. Download the TennCare paper application at: https://www.tn.gov/tenncare/members-applicants/how-do-i-apply-for-tenncare.html;
b. Request an application by calling TennCare Connect at 855-259-0701; or
c. Visit a local DHS county office to pick up a paper application.

11. Valid Application

The following information is the minimum required information needed for TennCare to accept an application:

a. Applicant's name;
b. Applicant's mailing address; and

c. Applicant's or responsible party's signature.

NOTE: To approve benefits, a Complete Application must be filed as described below.

12. Signatures Required

Individuals must sign initial applications and renewal forms under penalty of perjury. Individuals may submit paper signatures, electronic signatures such as telephonically recorded signatures, and signatures transmitted by any other electronic transmission.

13. Complete Application

While the receipt of an application according to the policy stated above determines the application date, coverage cannot be approved or authorized until:

a. All required questions on the application are answered;
b. All necessary verifications are received, unless otherwise excepted by policy (i.e., reasonable opportunity to verify citizenship).

14. Application Processing Time Limits

Federal regulations require that TennCare process an application and notify the applicant of the eligibility determination within 45 days, or 90 days for individuals who apply for Medicaid on the basis of disability.

15. Reinstatement of Withdrawn FFM Applications

If an individual is assessed and found ineligible for TennCare Medicaid or CoverKids by the FFM, the FFM reviews the individual for Advanced Premium Tax Credits (APTCs) and cost sharing reductions. The FFM gives these individuals the option of withdrawing the TennCare Medicaid or CoverKids application. If the individual elects to withdraw the TennCare Medicaid or CoverKids application and appeals an APTC or cost sharing reduction determination by the FFM, the original FFM application date is reinstated on appeal when the Office of Marketplace Eligibility and Appeals (OMEA) finds the individual potentially eligible for TennCare Medicaid or CoverKids.

16. Assistance with Application and Renewal

a. Accessibility

The TennCare application is accessible to individuals with Limited English Proficiency (LEP) and individuals that have disabilities. Language services and auxiliary aids and services are provided at no cost to LEP individuals and individuals with disabilities.

b. Application Assistance

Assistance is available to individuals that need help with applications or with renewing eligibility.

i. **In-person assistance:** In-person assistance is available at local DHS offices. Individuals applying for coverage at a local DHS office will be instructed on how to use a designated TennCare kiosk to file an application. If the applicant requires assistance, a DHS worker will be available to assist with application completion. Access to a telephone to file an application with TennCare Connect is also available in local DHS offices.

NOTE: DHS workers are not TennCare Eligibility Specialists, but each county office has personnel that have completed TennCare training and are available to assist with online application filing.

In person assistance is also available through local AAADs. Individuals that do not have TennCare and are interested in receiving in-home LTSS services may contact the local AAAD at 1-866-836-6678 for assistance with the application process.

Assistance from the AAADs is not limited to individuals applying for LTSS. Individuals with disabilities that need assistance completing an application may contact the AAAD at 1-866-836-6678.

Individuals with disabilities that need additional assistance in person may also contact TennCare Connect for a referral to the Tennessee Community Services Agency (TNCSA). TNCSA will reach out to the individual to assist with the application process. TNCSA makes referrals to AAADs for individuals identified as needing in-person assistance to complete an application.

In-person assistance is also available to the following specific groups of individuals:

1. Pregnant women may receive application assistance through the Tennessee Department of Health (TDH) staff; and

2. Women with breast or cervical cancer may receive application assistance with DOH staff.

ii. **Telephone assistance:** Telephone assistance is available through TennCare Connect. TennCare Connect is able to assist an individual with completing an application by phone or providing assistance to an applicant filing an online application.

iii. **Online assistance:** Individuals requiring assistance who intend to file an online application may call TennCare Connect for assistance while completing the application.

Assistance is available for all applicants and enrollees. All assistance provided will be in a manner that is accessible to individuals that are LEP and individuals with disabilities. An individual may choose to have someone help him with the application process or renewal.

17. Automatic Medicaid Eligibility Based on Eligibility in Other Programs

Individuals are not required to file a separate application when determined eligible for Supplemental Security Income (SSI). TennCare receives notice of SSI eligibility via an electronic file from the Social Security Administration (SSA) and automatically enrolls SSI recipients.

18. Medicare Part D: Low Income Subsidy

The Medicare Modernization Act (MMA) of 2003 established a new voluntary Part D Prescription Drug Program. The Centers for Medicare and Medicaid Services (CMS) has overall responsibility for the drug program, and the SSA is required to take applications and determine eligibility for the Low Income Subsidy (LIS) program, which provides Medicare drug payment assistance for low-income individuals.

Those who are deemed eligible are automatically eligible for LIS and do not need to apply. SSI recipients, and QMB, SLMB and QI1 recipients are considered “deemed” eligible. Here are ways an individual can apply for the LIS program:

a. Apply online at SSA website: http://www.ssa.gov/;
b. Call the SSA at 1-800-772-1213 or (TTY 1-800-325-0778);
c. Visit the local SSA field office; or

Eligibility for LIS will be determined by SSA. SSA will mail notification of eligibility (eligible or ineligible). If determined to be ineligible, the individual can file an appeal with SSA. SSA also sends TennCare electronic files on LIS applicants that are required to be processed by TennCare as an application for a Medicare Savings Program.

19. Katie Beckett

The Katie Beckett program provides medical assistance to children under age 18 with disabilities or complex medical needs who live at home and do not otherwise qualify for Medicaid due to their parents' income or resources.
To apply for Katie Beckett, members must submit an online application.

Document Title	The Application Process
First Published	03.19.2015

Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
09.19.2016	5.	Who May Submit an Application	2-3	Policy Clarification	NF
09.19.2016	6.	How to Submit an Application and Application File Date	3-4	Policy Change	NF
03.18.2019	1.; 3-4.; 6.a-e.; 10.; 16.a.; 16.b.i-iii.	Overview; TennCare Application; Application Forms; How to Submit an Application and Application File Date; Obtaining an Application; Accessibility; Application Assistance	1-7	Policy Change	JH
03.18.2019	5.f.; 15.	Who May Submit an Application; Reinstatement of Withdrawn Applications at the FFM	3; 6	Non-Substantive Change	JH
05.01.2024	5; 6.a-d; 10; 16.b; 19	Who May Submit an Application; How to Submit an Application and Application File Date; Obtaining an Application; Application Assistance; Katie Beckett	2; 3-4; 6	Non-Substantive Change; Policy Clarification	SA

VERIFICATION

Legal Authority: 42 CFR 435.945; 42 CFR 435.948; 42 CFR 435.949; 42 CFR 435.952; 42 CFR 435.956; 42 CFR 457.380; 42 CFR 435.1101; 42 CFR 435.1102; 42 CFR 435.1103

1. Overview

The Affordable Care Act (ACA) of 2010 reformed the verification processes used to determine eligibility for TennCare Medicaid and CoverKids. To support a streamlined application process, state Medicaid agencies must use electronic data sources, if available, to verify information provided by an individual. If an electronic data source is not available, or there are discrepancies between the information provided by the individual and the information obtained via an electronic data source, the state may request additional verification if the information is necessary to make the eligibility determination.

2. Policy Statement

Verification is the process of confirming or substantiating information provided by an individual. Non-financial and financial information must be verified and documented for all TennCare Medicaid and CoverKids individuals.

It is the responsibility of the applying individual to provide additional information that is requested. TennCare is required to verify information provided by the individual using electronic data sources, whenever possible. If information is available through an electronic data source, TennCare must use the information available prior to requesting additional information or documentation from the individual.

TennCare follows the verification procedures for TennCare Medicaid and CoverKids as established in TennCare's Verification Plan, or as otherwise agreed to by the Single State Agency and the Centers for Medicare and Medicaid (CMS).

NOTE: Self-attestation is accepted for certain non-financial eligibility criteria for TennCare Medicaid and CoverKids, unless other procedures are required by law (such as for citizenship and immigration status and enumeration). Self-attestation is accepted for all eligibility criteria for presumptive categories.

3. The Federal Data Services Hub

The Federal Data Services Hub (the Hub) is an electronic service established by the U.S. Department of Health and Human Services (HHS) to facilitate sharing of data and other information between federal agencies, state agencies and other entities involved in administering Insurance Affordability Programs (IAPs). The Hub allows TennCare to verify data from the following sources:

a. SSA Composite;

b. Remote Identity Proofing (RIDP);
c. Verify Current Income (VCI);
d. Verify Annual Household Income (VAHI);
e. Renewal and Redetermination Verification (RRV); and
f. Verify Lawful Presence (VLP).

Federally Facilitated Marketplace (FFM) applications are also received through the Hub.

TennCare will use eligibility-related information received through the Hub, when available.

4. Use of Electronic Data and Requesting Additional Information

Information provided by an individual at application, when reporting a change, and at renewal is verified with available date sources. Individuals are not required to provide additional documentation when the information is available for verification, as long as the information provided by the individual is reasonably compatible such data sources. See the *Reasonable Compatibility and Verification* policy for further explanation of reasonable compatibility.

When additional information or documentation is requested, individuals have until the due date specified on the notice to provide the requested documentation. Information returned from an electronic data source that is determined not to be reasonably compatible with information provided by the individual cannot be used to deny or terminate eligibility without first requesting additional information from the individual. If the requested information is not received by the due date specified on the notice, a denial or termination notice is sent to the individual for failure to respond to the request for documentation.

5. Documentary Evidence

a. Official Evidence

Official documentation is documentation that is prescribed or recognized as authorized, and is most commonly provided by businesses, agencies and organizations engaged in specific enterprises or service delivery. A Social Security card, utility bill and award letter are examples of official documents.

b. Unofficial Evidence

Unofficial documentary evidence may include such items as handwritten notes from an employer, an estimate from a real estate agent, etc.

c. Exception for Special Circumstances

When providing documentary evidence is an insurmountable procedural barrier to accessing coverage, TennCare may, on a case by case basis and in limited circumstances, accept self-attestation for all eligibility criteria when documentation does not exist, or is not reasonably available, such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster.

6. Non-Financial Eligibility Requirements

The list below provides an overview of how each eligibility requirement is verified. Additional information about verification requirements can be found in the relevant policy chapters.

a. Age

TennCare verifies date of birth systematically through the Hub. When date of birth is unable to be verified systematically, Staff conduct electronic data inquires through the State Verification and Exchange System (SVES) and the State Online Query Internet (SOLQi). If TennCare is unable to electronically verify age, additional verification may be requested.

b. Citizenship and Immigration Status

Federal law requires TennCare to use SSA and DHS data to verify citizenship and immigration status. An individuals' attested status is verified systematically through the Hub. If an individual's status is not verified systematically, Staff conduct electronic data inquires through the Systematic Alien Verification for Entitlements Program (SAVE), SOLQi and SVES.

If TennCare is unable to verify status electronically, additional verification may be requested.

c. Death

Death is verified systematically through Vital Statistics and TennCare's Medicaid Management Information System (MMIS). If an individual's death is not systematically verified, staff conduct electronic data inquires through SVES and SOLQi. If TennCare is unable to verify status electronically, additional verification may be requested. See the *Death* or *ABD Death* policy.

d. Health Insurance Information

TennCare accepts self-attestation of health insurance information. TennCare verifies state health insurance benefits post-eligibility through the State Benefits Administration (SBA) and TennCare's MMIS. TennCare requests verification, when applicable, for individuals that indicate a lack of coverage or lack of access to coverage. See the *TennCare Standard*, *CoverKids* and *Breast or Cervical Cancer* policies.

e. Identity

If TennCare is given a reason to doubt an individual's identity, additional verification may be requested. See examples of documentary evidence of identity in the *Citizenship and Immigration* or *ABD Citizenship and Immigration* policy.

f. Medicare Parts A and B

Medicare Parts A and B are systematically verified through BENDEX. TennCare may also conduct electronic data inquires through SOLQi and BENDEX inquiry.

If Medicare eligibility cannot be verified electronically, additional verification may be requested.

g. Parent/Caretaker Relative Status

TennCare accepts self-attestation of parent and caretaker relative status. If there is a discrepancy in information provided by multiple caretakers of a child, additional verification may be requested.

h. Pregnancy

TennCare accepts self-attestation of pregnancy as required by federal law. If TennCare has reason to doubt the individual's pregnancy status, additional verification may be requested.

i. Residence

TennCare accepts self-attestation of residency. TennCare conducts post-eligibility verification of state residency using the Public Assistance Reporting Information System (PARIS). When TennCare has reason to doubt self-attestation of residency, such as receipt of benefits in another state, staff conduct electronic data inquires through PARIS. When there is reason to doubt attestation of residency, additional verification may be requested.

j. Social Security Number (SSN)

SSNs can be verified systematically through the Hub. If the SSN is unable to be verified systematically, TennCare will attempt to verify the SSN electronically through SOLQi and SVES.

If unable to verify an individual's SSN electronically, a copy of the individual's SSN card or a copy of the Application for a Social Security Card (SS-5 form) can be used as verification of SSN.

7. Financial Information

a. Income

Earned income is verified systematically through the Hub, The Work Number (TALX) and Department of Labor - Quarterly Wage (DOL-QW).

Unearned Income can be verified systematically through the Hub, Low Income Subsidy (LIS), BENDEX and Department of Labor - Unemployment Insurance (DOL-UI).

If an individual's income is not systematically verified, staff will conduct electronic data inquiries through SOLQi, LIS and DOL. If TennCare is unable to verify status electronically, paper documentation may be requested.

b. Resources

Resources are not verified through the Hub. If unable to verify resources from available sources, paper documentation may be requested. Verification of resources may include bank statements, stock certificates, titles, contracts or information regarding real property provided by knowledgeable sources.

Document Title	Verification
First Published	03.23.2015

Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
12.02.2015	4.	Use of Electronic Data and Requesting Additional Information	2	Non-Substantive Change	SN
06.01.2018	2.	Policy Statement	1	Policy Clarification	NF
06.01.2018	5.c.	Exception for Special Circumstances	2	Policy Change	NF
06.01.2018	7.g.	Identity	4	Policy Clarification	NF
03.18.2019	1.; 3-4.; 5.c.; 6.a-d.; 6.f.; 7.	Overview; Federal Data Services Hub; Use of Electronic Data and Requesting Additional Information; Exception for Special Circumstances; Age; Citizenship and Immigration Status; Death; Health Insurance Information; Medicare Parts A and B; Financial Information	1-5	Policy Clarification	JH
03.18.2019	2.; 6.; 6.e.; 6.i-j.	Policy Statement; Non-Financial Eligibility Requirements; Identity; Residence; Social Security Number (SSN)	1; 3-4	Non-Substantive Change	JH

ELIGIBILITY DETERMINATION

Legal Authority: Sec. 1902 of the Social Security Act [42 USC 1396a]; 20 CFR 416.701; 20 CFR 416.708; 20 CFR 416.714; 42 CFR 435.906; 42 CFR 435.907; 42 CFR 435.908; 42 CFR 435.909; 42 CFR 435.910; 42 CFR 435.911; 42 CFR 435.912; 42 CFR 435.913; 42 CFR 435.915; 42 CFR 435.926; 42 CFR 435.172; 42 CFR 457.340; 42 CFR 457.330; 42 CFR 457.340; TennCare III Demonstration Waiver; Tenn. Comp. R. & Regs. 1200-13-20

1. Policy Statement

All Valid Applications are disposed of by a finding of eligibility or ineligibility, unless there is supporting documentation that the applicant is deceased prior to the application date, cannot be located, or has voluntarily withdrawn her application. An individual is eligible for TennCare Medicaid or CoverKids when he meets the financial and non-financial eligibility requirements. All facts used by TennCare to substantiate an eligibility determination are recorded in the individual's case. A decision will be rendered in each case, and the individual will be notified of the decision.

2. Timely Determinations and Processing Time Limits

a. Processing Time Frames

An eligibility determination and notice of such determination must be sent to an individual:

i. Within ninety (90) days from the date of application for individuals applying for Medicaid based on a disability; or
ii. Within forty-five (45) days from the date of application for all other individuals.

The above time standards are not used as a waiting period to determine eligibility, nor considered an acceptable reason to deny eligibility when the determination is not made within these standards.

b. Extension to Processing Time Frames

The 45 and 90-day processing time frame may be extended in the following situations:

i. The individual delays required action until the end of the allowed timeframe;
ii. The individual has requested assistance in obtaining verifications; or
iii. An administrative or other emergency beyond TennCare's control.

All processing delays must be fully explained and documented in the individual's case notes.

3. Withdrawn Applications

If an application is withdrawn, document the individual's request to withdraw an application in the case notes and issue a notice to the individual regarding the withdrawn application.

4. Unable to Locate an Individual

If notified that the individual has changed her location or contact information, attempt to locate the individual and document all efforts to locate the individual in case notes, including phone calls and written requests for contact. Include the following about all sources of information or verification:

a. Identity of the source;
b. Relationship or connection to the individual;
c. Type of contact: written correspondence, telephone contact, personal contact, etc.;
d. Date of contact, correspondence or pay stubs; and
e. The nature of the information provided by the source.

If the individual does not respond to verification requests, a termination notice will be issued. If TennCare is notified that the individual no longer lives in Tennessee, TennCare will attempt to verify Tennessee residency. A termination notice will be issued if verification is not received.

5. Individual is Deceased

Once an individual's death has been verified, the date of death must be entered in the individual's case.

6. Case Documentation

All facts used by TennCare to substantiate an eligibility determination are recorded in the individual's electronic case. TennCare will record all pertinent information and documentation reviewed, or online verifications obtained or used in the eligibility determination process (i.e., birth certificate, Medicare information, property deed, etc.). Pertinent information and facts include, but are not limited to:

a. Type and date of document used, information verified by the document, form or document number, name and title of signatory on document; and
b. Date the documentation is viewed and by whom.

Note: TennCare does not retain original documents and will return original documents after documents are reviewed.

7. Notice of Determination

Notice of eligibility determinations are sent to individuals promptly after an eligibility determination is finalized. Once an eligibility determination is finalized, a notice of the eligibility determination is sent to the individual or her responsible party. The notice includes the following:

a. The decision regarding the individual's eligibility;

b. If eligibility is denied, the specific reason for denial and citations of specific regulations that support the denial;

c. A statement to inform the individual of his right to appeal the eligibility determination. The notice will provide additional information about how to file an appeal; and

d. A reminder to report any household changes within 10 days of the date the notice is received.

8. Eligibility Effective Date

The TennCare III Medicaid Section 1115 Demonstration waiver enables TennCare to waive the eligibility begin date requirement under the Social Security Act § 1902(a)(34) and 42 CFR 435.915 for all applicants except for pregnant women (as defined in the *Pregnancy MAGI* policy), and children under age 19 described in Section 1902(l)(4) of the Social Security Act. For applicants who do not meet the criteria to be considered for retroactive eligibility, eligibility is not extended to a date prior to the date an application is received.

Pregnant women (as defined in the *Pregnancy MAGI* policy), and children under age 19 described in Section 1902(l)(4) of the Social Security Act, who attest to receiving a service covered under the Medicaid state plan during the three months prior to the month of application (referred to as the retroactive eligibility period), will be tested for eligibility during the retroactive eligibility period. Eligibility could begin as early as the first day of the third month prior to the month of application if the individual meets all eligibility requirements.

Note: Pregnant women and children are potentially eligible for retroactive eligibility in one of the following categories: Child MAGI 0-1, Child MAGI 1-5, Child MAGI 6-18, Pregnancy MAGI, and Caretaker Relative. To qualify for retroactive coverage in the Caretaker Relative category, the individual must be pregnant. A pregnant woman or child under the age of 19 and grouping for Emergency Medical Services on the basis of a mandatory Category of Eligibility (COE) (i.e., Child MAGI, Pregnancy MAGI or Caretaker Relative) is also eligible to be tested for coverage during the retroactive eligibility period.

Effective Date	**Child and Families Categories**	**Aged, Blind and Disabled Categories**
The effective date of eligibility is the date determined by the Social Security Administration.		• SSI Cash Recipient
The effective date of eligibility is the date determined by the qualified entity.	• Presumptively Eligible Pregnant Women • Hospital Presumptive Eligibility • Presumptive Breast or Cervical Cancer	

The effective date of eligibility is the child's date of birth, if the mother was eligible for and receiving TennCare Medicaid at the time of birth.	• Deemed Newborns	
The effective date of eligibility is the application file date or the date all eligibility requirements are met, whichever is later. Note: For pregnant women and children under age 19 who attest to receiving a service covered under the Medicaid state plan in the retroactive eligibility period, the effective date of eligibility is the first of the month up to three months prior to the month of application, or the application file date if the individual does not meet all eligibility requirements in the retroactive eligibility period. This is applicable for pregnant women and children eligible in the following categories: Child MAGI, Pregnancy MAGI, and Caretaker Relative. To be eligible for retroactive coverage in the Caretaker Relative category, the individual must be pregnant.	• Former Foster Care • Child MAGI • Pregnancy MAGI • Caretaker Relative • Child Medically Needy • Qualified Pregnant Women Medically Needy • TennCare Standard • Transitional and Extended Medicaid • CoverKids	• Disabled Adult Child • Institutional Medicaid • Pickle Passalong • Widow/Widower • Breast or Cervical Cancer • Specified Low-Income Medicare Beneficiaries • Qualifying Individuals 1 • Qualified Disabled Working Individuals
The effective date of eligibility is the first day of the month following the month in which the application is approved.		• Qualified Medicare Beneficiary

The effective date of eligibility must not begin prior to the date of the emergent service and must not begin prior to the date of application for all applicants who are not a pregnant woman or child under the age of 19. Applicants who are pregnant or a child under age 19 who are eligible for Emergency Medical Services (EMS) on the basis of Child MAGI, Pregnancy MAGI, or Caretaker Relative may be reviewed for EMS during the retroactive eligibility period. To qualify for EMS during the retroactive period on the basis of the Caretaker Relative category, the individual must be pregnant.	• Emergency Medical Services	

See *The Application Process* policy for more details about the date of application.

9. Reported Changes

a. Changes

Changes must be reported by an individual within 10 days of the changed circumstance. Changes may be reported using any of the acceptable modes of submission: telephone, mail, fax, or online. The change will be considered reported on the date the change is received. If sent to TennCare via U.S. mail, this will be the date the envelope is date-stamped.

b. Who May Report Changes

A change and any documentation required to determine eligibility may be reported by the following individuals:

i. The individual who is requesting assistance (the enrollee or applicant) - a minor child must be a “mature minor” to submit his application. In determining who is a “mature minor,” Tennessee common law follows the “Rule of Sevens.”

1. Under the age of seven, there is no capacity. The change and any documentation required to determine eligibility must be reported by an adult who lives in the home with the enrollee or applicant, an authorized representative, or an individual acting responsibly for the enrollee or applicant (unless a statutory exception applies).

2. Between the ages of seven and fourteen, there is a rebuttable presumption that there is no capacity. The change and any documentation required to determine eligibility generally should be reported by an adult who lives in the home with the enrollee or applicant, an authorized representative, or an individual acting responsibly for the enrollee or applicant (unless a statutory exception applies).
3. Between the ages of fourteen and eighteen, there is a rebuttable presumption of capacity. The enrollee or applicant may report a change and any documentation required to determine eligibility, unless it is determined that the minor is not sufficiently mature to make her own health care decisions.

ii. An adult who lives in the home with the enrollee or applicant, if the enrollee or applicant is a minor. This may be the enrollee's or applicant's biological, step or adopted parent, a family member who claims the applicant as a tax dependent, or another individual who is in a position to know the enrollee's or applicant's circumstances.

iii. The primary residential parent or either parent when there is equally shared joint custody.

iv. An authorized representative.

v. An individual acting responsibly for the enrollee or applicant, if the enrollee or applicant is a minor or incapacitated. A responsible party may be a relative, friend, guardian, conservator, or other individual who is in a position to know of the applicant's circumstances.

vi. A representative of the long-term care facility where the individual resides.

c. What Changes Should Be Reported

The following are examples of changes that should be reported to TennCare:

i. Address changes.

ii. Household member changes

iii. Applicant, enrollee or household income changes.

iv. Applicant, enrollee or household resource changes.

v. A change in marital status.

vi. Applicant or enrollee death, or death of a household member.

d. Continuous Eligibility

i. Pregnant Women

1. TennCare Medicaid

Women who have been determined eligible for and enrolled in TennCare Medicaid while pregnant and children under the age of 19 who have been determined eligible for TennCare Medicaid, TennCare Standard, or CoverKids Children while pregnant will remain eligible for that respective benefit through the last day of the month of a 12-month postpartum period, which begins on the day pregnancy ends, regardless of most changes in circumstance and regardless of how pregnancy ends. These women will generally remain in the same benefit category for the duration of the 12-month postpartum period, and they will not have their eligibility redetermined until the end of the 12-month postpartum period. This is true even if it has been greater than 12 months since their last eligibility determination. Women in a presumptive eligibility period are not eligible for continuous eligibility.

NOTE: Women who are approved for the Pregnancy MAGI COE with an effective date of eligibility after the end of their pregnancy will remain eligible for benefits through the last day of the month of a 60-day postpartum period.

The 12-month postpartum period will end prior to the end of the 12 months in the following circumstances:

a. Coverage is voluntarily terminated;
b. The individual is no longer a resident of Tennessee;
c. The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the woman or her representative; or
d. Death.

2. CoverKids

Women who are eligible for and enrolled in the CoverKids Pregnant Woman COE will remain eligible for benefits through the last day of the month of a 60-day postpartum period The postpartum period begins on the pregnancy end date, regardless of changes in circumstance and regardless of how pregnancy ends.

ii. Children under the age of 19 Enrolled in Medicaid

Children under the age of 19 who are determined eligible for and enrolled in certain TennCare Medicaid categories will remain eligible for that respective benefit through a 12-month continuous eligibility period, regardless of most changes in circumstance. Continuous eligibility for children is not applicable to the following TennCare Medicaid categories: IE Foster Care, Widow/Widower, Medically Needy Child, Medically Needy Pregnancy, Katie Beckett Part B, Transitional Medicaid, Extended Medicaid, or EMS. Children in a presumptive eligibility period are not eligible for continuous eligibility. At the end of the 12-month continuous eligibility period, eligibility will be redetermined.

A child may transition to another TennCare Medicaid COE that provides continuous eligibility during the 12-month period. At that time, they will be granted a new 12-month continuous eligibility period. Exceptions to the 12-month continuous eligibility period are as follows:

1. The child turns 19;
2. Coverage is voluntarily terminated;
3. The child is no longer a resident of Tennessee;
4. The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the child or the child's representative; or
5. Death.

If a child is enrolled in the Child MAGI COE and is confined in a hospital at the time they turn 19, their coverage will remain open until they have been discharged.

iii. CoverKids Children

Children under the age of 19 determined eligible for and enrolled in CoverKids Child are eligible for a 12-month continuous eligibility period, regardless of most changes in circumstance. At the end of the 12-month continuous eligibility period, eligibility will be redetermined. At that time, they will be granted a new 12-month continuous eligibility period. Exceptions to the 12-month continuous eligibility period are as follows:

1. The child turns 19;
2. Coverage is voluntarily terminated;
3. The child is no longer a resident of Tennessee;
4. The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the child or the child's representative;
5. Death; or.
6. The child is determined eligible in a TennCare Medicaid category.

First Published	03.19.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
09.19.2016	8.	Eligibility Effective Date	3-4	Policy Clarification	NF
11.01.2016	9.	Reported Changes	4-5	Section Addition	RH
01.02.2020	8.	Legal Authority; Eligibility Effective Date	1; 3	Policy Clarification	TB
01.02.2020	1-2.; 4-7.; 9.	Policy Statement; Timely Determinations and Processing Time Limits; Unable to Locate an Individual; Individual is Deceased; Case Documentation; Notice of Determination; Reported Changes;	1-5	Non-Substantive Change	TB
07.01.2021	8.	Eligibility Effective Date	3-4	Policy Change	MH
01.04.2021	8.	Eligibility Effective Date	3-5	Policy Clarification	MH
07.01.2023	9.	Legal Authority; Reported Changes	6-8	Policy Change	MH
01.02.2024	9.	Reported Changes	7	Policy Change	LW

07.01.2023	9.	Legal Authority; Reported Changes	6-8	Policy Change	MH

REDETERMINATION

Legal Authority: Sec. 1902 of the Social Security Act [42 USC 1396a]; 20 CFR 404, Subpart J; 42 CFR 435.911; 42 CFR 435.916; 42 CFR 435.926; 42 CFR 435.172; 42 CFR 457.343; 42 CFR 431.210; 42 CFR 431.211; 42 CFR 431.213; 42 CFR 407.47; Tenn. Comp. R. & Regs. 1200-13-20-.09(1); 1200-13-20-.08(7)(a)(7)

1. Overview

The redetermination process established for Modified Adjusted Gross Income (MAGI) Medicaid categories and Children's Health Insurance Program (CHIP) will also be applied to the Medically Needy categories, and Aged, Blind and Disabled (ABD) Medicaid categories, with certain exceptions. Supplemental Security Income (SSI) Cash Recipients, eligible for TennCare Medicaid, follow the redetermination requirements of the Social Security Administration (SSA).

2. Policy Statement

Eligibility for Medical Assistance must be redetermined once every 12 months, and no more frequently than once every 12 months, unless there is a reported change. TennCare redetermines eligibility during the 12-month period when a reported change may affect eligibility. Individuals are reviewed for all categories of eligibility during the redetermination process.

SSI Cash Recipients shall follow the SSA program redetermination requirements. Upon confirmation that an individual is no longer eligible for SSI payments, TennCare will review for eligibility in all other Medical Assistance categories.

3. Definitions

Medical Assistance: Includes TennCare Medicaid, TennCare Standard, CoverKids, Katie Beckett, and Medicare Savings Program (MSP) categories.

4. Redetermination Process

a. Eligibility Period

TennCare redeterminations occur for individuals currently eligible for Medical Assistance every 12 months. A redetermination of eligibility occurs during the 12-month eligibility period when a reported change, whether from a data source or individual, may affect eligibility. During the 12-month period individuals are required to report any change in circumstance.

b. Continuous Eligibility

i. Pregnant Women

1. TennCare Medicaid

Women who have been determined eligible for and enrolled in TennCare Medicaid while pregnant and children under the age of 19 who have been determined eligible for TennCare Medicaid, TennCare Standard, or CoverKids Children while pregnant will remain eligible for that respective benefit through the last day of the month of a 12-month postpartum period, which begins on the day pregnancy ends, regardless of most changes in circumstance and regardless of how pregnancy ends. These women will generally remain in the same benefit category for the duration of the 12-month postpartum period, and they will not have their eligibility redetermined until the end of the 12-month postpartum period. This is true even if it has been greater than 12 months since their last eligibility determination. Women in a presumptive eligibility period are not eligible for continuous eligibility.

NOTE: Women who are approved for the Pregnancy MAGI Category of Eligibility (COE) with an effective date of eligibility after the end of their pregnancy will remain eligible for benefits through the last day of the month of a 60-day postpartum period.

The 12-month postpartum period will end prior to the end of the 12 months in the following circumstances:

a. Coverage is voluntarily terminated;
b. The individual is no longer a resident of Tennessee;
c. The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the woman or her representative; or
d. Death.

2. CoverKids

Women who are eligible for and enrolled in the CoverKids Pregnant Woman COE will remain eligible for benefits through the last day of the month of a 60-day postpartum period. The postpartum period begins on the day pregnancy ends, regardless of changes in circumstance and regardless of how pregnancy ends.

ii. Children under the age of 19 Enrolled in Medicaid

Children under the age of 19 who are determined eligible for and enrolled in certain TennCare Medicaid categories will remain eligible for that respective benefit through a 12-month continuous eligibility period, regardless of most changes in circumstance. Continuous eligibility for children is not applicable to the following TennCare Medicaid categories IE Foster Care, Widow/Widower, Medically Needy Child, Medically Needy Pregnancy, Katie Beckett Part B, Transitional Medicaid, Extended Medicaid, or EMS. Children in a presumptive eligibility period are not eligible for continuous eligibility. At the end of the 12-month continuous eligibility period, eligibility will be redetermined.

A child may transition to another TennCare Medicaid COE that provides continuous eligibility during the 12-month period. At that time, they will be granted a new 12-month continuous eligibility period. Exceptions to the 12-month continuous eligibility period are as follows:

1. The child turns 19;
2. Coverage is voluntarily terminated;
3. The child is no longer a resident of Tennessee;
4. The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the child or the child's representative; or
5. Death.

If a child enrolled in the Child MAGI COE and is confined in a hospital at the time they turn 19, coverage will remain open until they have been discharged.

iii. CoverKids Children

Children under the age of 19 determined eligible for CoverKids Child will remain eligible for a 12-month continuous eligibility period, regardless of most changes in circumstance. At the end of the 12-month continuous eligibility period, eligibility will be redetermined. At that time, they will be granted a new 12-month continuous eligibility period. Exceptions to the 12-month continuous eligibility period are as follows:

1. The child turns 19;
2. Coverage is voluntarily terminated;
3. The child is no longer a resident of Tennessee;
4. The State determines that eligibility was erroneously granted at the most recent eligibility determination or renewal of eligibility because of state error, or fraud, abuse, or perjury attributed to the child or the child's representative; or
5. Death.
6. The child is determined eligible in a TennCare Medicaid category.

c. Ex Parte Review

An ex parte review will be done for individuals during the redetermination process. The ex parte process attempts to redetermine eligibility without requesting additional information from individuals. The review is automatically processed and completed using information available to

TennCare, including information from electronic data sources. The ex parte process considers eligibility for all categories of Medical Assistance.
Individuals in the following categories do not go through the ex parte process:

- **i.** Presumptive Breast and Cervical Cancer;
- **ii.** Presumptive Pregnancy;
- **iii.** Hospital Presumptive Eligibility;
- **iv.** Emergency Medical Services;
- **v.** Supplemental Security Income (SSI) individuals (while still receiving SSI payments); and
- **vi.** Immediate Eligibility (IE) Foster Care.

When an individual is redetermined eligible, TennCare will notify the individual of the eligibility determination. When TennCare is unable to auto-renew eligibility based on available information, a renewal form will be provided to the individual.

5. Renewal Form

When TennCare is unable to auto-renew eligibility based on available information, TennCare will provide the individual with a prepopulated renewal form. The renewal form will request information necessary to consider the individual for all categories of Medical Assistance. Individuals will have 40 days from the date on the renewal form to complete, sign, and submit the renewal form to TennCare. The renewal form may be submitted online, by phone, in-person, by mail, or by fax. TennCare will request additional information, when needed, to redetermine eligibility. See the *Verification* policy.

6. Determination

Individuals must receive notice of a renewal determination. If an individual fails to submit information needed for a determination or submits information and is no longer eligible for Medical Assistance, TennCare will provide advance notice of termination. An adverse action taken on an individual’s case requires advance notice. Adverse actions include termination of benefits or reduction of benefits.

7. Advance Notification

If an individual reports a change that will reduce or terminate Medical Assistance benefits, is determined ineligible, or fails to submit necessary information during the renewal process, a 20-day advance notice will be sent. Adverse action is not taken until the 20-day adverse action period has expired. The adverse action notice period allows the individual to provide any information that will alter the decision to reduce or terminate benefits. If the individual submits information requested during the advance notice period, eligibility will continue until a determination of eligibility is completed.

Advance notice of termination is not required in the following situations:

a. Verified report of the individual’s death;

b. Written statement from the individual waiving his right to advance notification;
c. The individual's whereabouts are unknown and the post office returns mail directed to him indicating no forwarding address;
d. Confirmed report that individual is receiving Medicaid or CHIP in another state;
e. Individual has been admitted to an institution where he is not eligible to receive benefits;
f. To an enrolled child that is removed from the home as a result of a judicial determination or is voluntarily placed in foster care by her parents or guardian, and the child's eligibility category is changed; or
g. Assistance is to be discontinued or reduced as the result of an appeal decision.

Note: A two-day advance termination is provided for voluntary termination requests.

8. Reconsideration Period

If the individual fails to submit the renewal form or requested information and eligibility is terminated, TennCare will reconsider eligibility without requiring a new application if the requested information is provided within 90 days of the termination date. Unless an exemption applies, TennCare will fill a gap in coverage when the information provided during the 90-day reconsideration period results in an approval. In accordance with federal law, an exception is the Qualified Medicare Beneficiary (QMB) group, which can only be effective the first day of the month after the individual is approved.

9. In-person Interview

Individuals are not required to complete in-person interviews for redetermination.

10. Redetermination for Individuals Losing SSI Eligibility

SSI recipients who lose their SSI coverage will undergo a redetermination of eligibility for Medical Assistance upon notification of SSI termination after all SSI appeal rights have been exhausted. If an individual has an open SSI appeal, TennCare Medicaid coverage will continue until the resolution of the SSI appeal and redetermination of eligibility takes place. There will be a 75-day wait period before redetermination can begin after loss of SSI and between each level of SSA appeals.

There are four levels of SSI appeals:

a. Reconsideration.
b. Hearing by an administrative law judge.
c. Review by the Appeals Council.
d. Federal Court review.

Document Title	Redetermination				
First Published	3.19.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
06.06.2019	4-5.	Legal Authority; Renewal Determination; Reconsideration Period	1-2	Policy Clarification	JH
04.01.2022	4.a.	Redetermination Process	1-2	Policy Change	TN
04.01.2022	3.	Definitions	1	Policy Clarification	TN
07.01.2023	4.b.	Legal Authority; Redetermination Process	2-3	Policy Change	MH
01.02.2024	4.b.ii	Children Under the Age of 19 Enrolled in Medicaid	2-3	Policy Change	LW
04.10.2024	8.	Reconsideration Period	5	Policy Clarification	LW

APPEALS

Legal Authority: 42 CFR 431.205; 42 CFR 431.206; 42 CFR 431.230; 42 CFR 431.221

1. Policy Statement

Applicants and enrollees in TennCare Medicaid and CoverKids may file an appeal with HCFA when dissatisfied with an action taken on the individual's eligibility case. Appeal requests will be given prompt and careful attention, and corrective action, when indicated, will be taken immediately. Tennessee Health Connection (TNHC) or HCFA staff will provide the appellant with a HCFA Appeal form, or complete the form on the individual's behalf. HCFA must provide whatever assistance the complainant requires in appealing for a fair hearing.

2. Appeal Rights

Every applicant and recipient of TennCare Medicaid and CoverKids has the right to appeal if he or she is aggrieved by an action or lack of action taken by HCFA. Individuals should be informed of their right to a hearing, how to obtain a hearing, and that the individual may represent himself or herself, use legal counsel, a relative, a friend or other spokesman. An individual must be informed of his or her hearing rights:

- At application;
- When an action taken by HCFA affects his or her claim;
- When a skilled nursing facility or nursing facility notifies a resident of a transfer or discharge (not including movement to a bed within the same certified facility); and
- When an individual receives an adverse action from a preadmission screening and annual resident review under §1919(e)(7) of the Social Security Act.

HCFA will inform the individual of free legal representation that is readily available in the individual's area. All HCFA hearing records and decisions are available for public inspection and copying, subject to the disclosure safeguards provided by federal regulations. The names and addresses of appellants will be kept confidential.

3. Appealable Actions

Appeals may arise from conflicts or dissatisfaction related to an action or lack of action by HCFA such as, but not limited to:

- A decision regarding eligibility for TennCare Medicaid or CoverKids, such as a denial for eligibility or eligibility begin date;
- Termination of TennCare Medicaid or CoverKids benefits;
- Failure to make a timely eligibility determination;
- Discriminatory treatment or practice (See *Rights and Responsibilities* policy); and

- Amount of a co-pay obligation for TennCare Medicaid or CoverKids.

4. Timely Appeal

An appeal filed within 40 days from the date of the termination or denial notice is considered timely. Benefits will be continued if the request is filed within 20 days of the notice or before the end date of coverage if that is later, pending the final decision of the Administrative Judge. However, the individual must be informed that if HCFA's decision is upheld, he or she may be responsible for repaying the benefits paid pending the decision. If benefits are to continue pending the outcome of the appeal, the Eligibility Appeals Unit will manually continue the benefits, as applicable.

If benefits are continued, HCFA will not terminate benefits before a decision is reached unless:

- It is determined at the hearing the issue at hand is one of federal or state law or policy; and
- HCFA informs the beneficiary in writing that services will be terminated or reduced pending the hearing decision.

5. Good Cause for an Untimely Appeal

Appeals may be accepted after the 40 day time limit if the appellant can show good cause as to why the appeal could not be filed within 40 days. In addition, benefits can be continued if the appellant can show good cause for failing to file the request within 20 days. The decision regarding good cause is made by designated attorneys within the Eligibility Appeals Unit.

6. Filing an Appeal

An individual may file an appeal by phone, mail, or fax. Individuals may file appeals with TNHC.

Mailing Address:
Tennessee Health Connection
P.O. Box 305240
Nashville, TN 37230-5240

Toll-free Phone:
1-855-259-0701

Toll-free Fax:
1-855-315-0669

Document Title	Appeals				
First Published	3.23.2015				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
11.3.2015	6	Filing an Appeal	2	Policy Change	AF
12.2.2015	4	Timely Appeal	2	Correction	SN

FOR ADDITIONAL INFORMATION PLEASE REFER TO: TennCare Policy Manual, Policy No: EED 06-001

Eligibility of Inmates of Public Institutions

Legal Authority: SSA § 1905(a)(29), see 42 USC § 1396d(a)(29)(A); 42 CFR 435.1010; 42 CFR 435.1009(a)(1); Tenn. Code Ann. § 71-5-106(r)

1. Policy Statement

An individual's status as an inmate of a public institution does not prevent eligibility for TennCare Medicaid or TennCare Standard. Federal Financial Participation (FFP) is not available for payment of benefits provided to inmates of public institutions eligible for TennCare with the exception of inmates who are patients in a medical institution for more than 24 hours. Applicants/enrollees involuntarily confined in a public institution are placed in a temporary suspended status to prevent inappropriate payments.

2. Definitions

Inmate: An individual involuntarily confined in a local, state, or federal prison, jail, youth development center (YDC), or other penal or correctional facility, including a furlough from such facility. An individual is not considered an inmate in a public institution if he is in a:

- Public educational or vocational training institution for the primary purpose of receiving education or vocational training; or
- Public institution for a temporary period pending other arrangements appropriate to his needs.

Patient: An individual receiving professional services directed by a licensed practitioner of the healing arts for maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

Public Institution: A public institution is one that provides shelter, food and treatment or services and is the responsibility of or controlled by a governmental unit. A public institution includes any private facility that is under direct contract with a governmental entity to provide correctional services, or that acts as an institution for incarceration on behalf of the state's criminal justice system. A public institution does not include:

- A medical institution;
- An intermediate care facility; or
- A child-care institution for children receiving foster care payments under IV-E or AFDC foster care under title IV-A.

Medical Institution: An institution that:

- Is authorized under State law to provide medical care;
- Is organized to provide nursing and convalescent care;
- Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients continuously and according to accepted standards; and
- Is staffed by professional personnel responsible to the institution for professional medical and nursing services. Services must include:
    - Adequate and ongoing medical care and supervision by a physician;
    - Registered nurse or licensed practical nurse supervision and services and nurses' aid services; and
    - A physician's guidance on the professional aspects of operating the institution.

Examples of medical institutions include: hospitals, convalescent or progressive care centers, Long-Term Care Facilities (LTCFs), providing both skilled and intermediate care, and juvenile psychiatric facilities. Medical institutions eligible for FFP are those that are generally available to the public, organized primarily for the provision of medical care, and do not operate primarily or exclusively to serve inmates.

3. Inmates of Public Institution Status Verification

HCFA receives incarceration information through electronic interfaces with the Tennessee Department of Corrections (TDOC) for prisons and from a contractor who works with county jails. Individuals reported as incarcerated are placed in suspended enrollment status and notice of such status is sent to the individual's mailing address and the correctional facility.

HCFA removes an individual's suspended status for individuals no longer considered inmates of public institutions based on TDOC reports and the contractor's reports once the inmate status on the report is verified. HCFA will also manually remove an enrollee's suspended status upon notification by the enrollee and once that notification has been verified. The move from suspended status will be prospective from the point of notification to the state.

4. Eligibility Requirements

An individual's inmate status does not prevent Medicaid eligibility or enrollment, but an individual's inmate status does impact payment of Medicaid services and MCO assignment. Inmates of public institutions must meet non-financial requirements to receive eligibility in a Medicaid category. For example, an individual must continue to meet the requirements as a caretaker relative to be considered for eligibility in the Caretaker Relative category.

Inmates of public institutions must also meet financial requirements for the individual to receive eligibility in a Medicaid category. Tax filer rules should be used for tax filers and tax dependents when making a Modified Adjusted Gross Income (MAGI) eligibility determination, unless there is evidence to the contrary.

5. Suspended Status

The need for suspended status can be determined by asking the following two questions:

- Is the individual considered an inmate? Refer to the inmate definition above.
- Is the individual involuntarily confined in a public institution? Refer to the public institution definition above.

When the answer to both questions is yes, the individual should be placed in suspended enrollment status. If the answer to either of these questions is no, the individual is not an inmate living in a public institution, is eligible for FFP and should not be placed in suspended status.

Eligibility of an applicant/enrollee in a jail is placed in suspended status when he has been in the jail for more than 90 days. There is no 90 day wait for an individual in state or federal prison. When an individual is placed in a suspended status, the individual's MCO will temporarily be changed to TennCare Select. An individual is removed from suspended status when he remains Medicaid eligible and is no longer considered an inmate living in a public institution. When an individual's suspended status is removed, the individual's MCO will revert back to an at-risk MCO.

Note: Department for Children's Services (DCS) and Programs for All-Inclusive Care for the Elderly (PACE) enrollees are currently not placed in suspended status and maintain Medicaid eligibility.

Examples of individuals not considered inmates in a public institution include:

- Infants living with the inmate in a public institution;
- Paroled individuals;
- Individuals on probation;
- Individuals on home release except when reporting to a public institution for overnight stay;
- Individuals living voluntarily in a detention center, jail or county penal facility after adjudication while determining other living arrangements;
- Individuals released to the community pending trial, including those under pre-trial supervision; and
- Individuals residing in state or local, publicly or privately owned, supervised community residential facilities (e.g., halfway houses). Individuals must be able to work outside of the facility, be able to use community resources, and be able to seek health care treatment in the broader community.

Examples of individuals considered inmates in a public institution include:

- Inmates involuntarily residing at a wilderness camp under governmental control;
- Inmates receiving outpatient care, while living in a public institution; and
- Inmates residing in Federal Residential Reentry Centers (RRCs).

6. Reinstatement

Once it has been verified with TDOC or the local jail that an individual no longer meets the requirements to be considered an inmate involuntarily confined in a public institution, the individual is removed from suspended status. The individual is no longer in a suspended status effective the day after such verification.

Document Title	Eligibility of Inmates of Public Institutions				
First Published	2.29.2016				
Revision History					
Revision Date	Section	Section Title	Page Number(s)	Reason for Revision	Reviser
5.2.2016	For Additional Information Please Refer To:		1	TennCare Policy Manual, Policy No: EED 06-001, published	AK
10.3.2016	2.	Definitions	1-2	Policy Clarification	AJ
10.3.2016	5.	Suspended Status	4	Policy Change	AJ