Utah Medical Program Summary

2024

medicaid.utah.gov

DHHS DWS 5-996 (01/2024)

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This summary provides information to community agencies as a public service. The summary gives a broad overview of medical assistance programs. It should not be used to determine eligibility.

Department of Health and Human Services
Department of Workforce Services

Equal Opportunity Employer/Program

Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240
Individual with speech and/or hearing impairments may call Relay Utah by dialing 711
Spanish Relay Utah: 1-888-346-3162

DHHS DWS 05-996-01/2024

Office of Eligibility Policy (OEP)
Department of Workforce Services (DWS)
Medical Programs Summary

Medical assistance is available to U.S. citizens and certain qualified non-citizens who live in Utah. Coverage for medical emergencies only is available to people who do not meet citizenship or qualified non-citizen criteria, but who do meet the other eligibility criteria for a Medicaid program.

To receive medical assistance, applicants must meet specific non-financial and financial criteria. This summary highlights different medical assistance programs. It does not explain all the eligibility criteria. Please call the Department of Workforce Services (DWS) if you have questions. A Medicaid Eligibility Worker can answer questions about qualifying for Medicaid or other medical assistance programs.

Definitions

- **Assets:** Assets include any type of “property,” such as cash on hand, bank accounts, items easily turned into cash like stocks or bonds, and other non-cash property like vehicles or vacation homes. Each program has its own rules about counting assets. We do not count some assets to decide your eligibility if you need them for normal living activities—for example, we do not count the home a family lives in, furniture, or most personal items as assets.
- **Children's Health Insurance Program (CHIP):** CHIP is for children under the age of 19 who do not qualify for Medicaid and do not have access to other health insurance. It is like private or employer-sponsored health insurance in which a family pays a modest monthly premium and copayments for certain services.
- **Deductions:** Deductions are the amounts subtracted from gross income before comparing it to the applicable income limit.
- **Federal Poverty Level (FPL):** This is the income level set by the federal government. It is used to determine who can receive certain public assistance. The income limit for many medical assistance programs is a percentage of the FPL.
- **Income:** Income is any kind of money coming into the household such as wages, self-employment income, child support, interest from investments or bank accounts, retirement benefits, Social Security, etc.
- **Medical bills as deductions:** Some medical programs may require a payment from monthly income to be eligible. We call this a "spenddown." If you owe a spenddown, we may deduct from your income the amount of medically

necessary services received by a family member that the family must pay. Medicaid will not pay the bills used to become eligible.

- **MWI premium:** A working disabled person who is eligible for the Medicaid Work Incentive (MWI) program may owe a premium, based on a percentage of income, to become eligible.
- **Retroactive coverage:** Some Medicaid programs allow the person to request coverage for the three months prior to the date of application. This is called "retroactive coverage." The Qualified Medicare Beneficiary program and CHIP programs do not allow retroactive coverage.
- **Spenddown:** Some members may be eligible for Medicaid by buying Medicaid coverage. This payment is called a "spenddown". The spenddown is the difference between the person's countable income and the program's income limit.

MEDICAID PROGRAMS

Parent/Caretaker Relative Medicaid (PCR)

Parent Caretaker Relative Medicaid provides coverage to low-income parents and caretaker relatives with dependent children. To qualify, at least one minor child in the home must be deprived of parental support due to the death, absence, incapacity or underemployment of a parent or caretaker relative. Underemployment means at least one parent is unemployed or working less than 100 hours per month. Households receiving Parent/Caretaker Relative Medicaid may qualify for 12-Month Transitional Medicaid when the earned income of a parent or caretaker relative increases above the income limit.

Income Limit: $438 for 1; $544 for 2; $678 for 3; $797 for 4.
Income Deductions: Expenses from Schedule 1 of the IRS 1040 form
Spenddown: Not allowed
Asset limit: None
Retroactive coverage is allowed.

Family Medically Needy Medicaid

This program provides Medicaid coverage to low-income families who do not qualify for Parent/Caretaker Relative Medicaid because of income. This program has the same deprivation of support requirements as the Parent/Caretaker Relative Medicaid program. Family Medically Needy is different because there is an asset test, income is counted differently, and the household size is based on relationship, not on who you claim on your tax form.

With the Family Medically Needy Medicaid program, clients may become eligible by paying the difference between their countable income and the income limit. This is called a "spenddown." The family may also use medical bills they owe to meet the income spenddown. Adults and children may be eligible for Family Medically Needy coverage. In some cases, though, children will be eligible for Child Medicaid without meeting a spenddown. Families who receive Family Medically Needy coverage do not qualify for the 12-month transitional Medicaid program.

Income Limit: Set amounts based on family size. 3 person income limit is $583; 4 person income limit is $682; 5 person income limit is $777. It increases for each additional person.
Income Deductions: $90 work allowance, a $30 and 1/3 deduction,* childcare ($200 maximum per child under age two, $175 maximum over age two) from earned income; health insurance premiums; some medical bills.
**Each individual with earned income must meet certain requirements to qualify for the $30*

and 1/3 deduction
Spenddown: Allowed
Asset limit: 1 person is $2,000; 2 people is $3,000 (Add $25 for each additional person)
Retroactive coverage is allowed.

4-Month and 12-Month Transitional Medicaid

People who received Parent/Caretaker Relative Medicaid may receive an additional 4 to 12 months of Medicaid coverage for themselves and their children depending on the reason they became ineligible. Adults, and their children, who are no longer eligible for Parent/Caretaker Relative Medicaid because of increased earnings can receive up to 12 months of continued Medicaid coverage (12 Month Transitional Medicaid). A household must meet certain income and reporting requirements to qualify for 12 Month Transitional Medicaid.

Adult Expansion

Adults, age 19 through 64, may qualify for Medicaid under the Adult Expansion program. The Adult Expansion program is for people who do not qualify for another Medicaid program, and who do not have Medicare. It is for parents with income above the Parent/Caretaker Relative income limit, as well as for adults without dependent children.

Income Limit: 133% FPL
Income Deductions: 5% FPL and expenses from Schedule 1 of the IRS 1040 form
Spenddown: Not allowed
Asset limit: None
Retroactive coverage is allowed.

Pregnant Woman

The Pregnant Woman program provides full Medicaid coverage to pregnant women. The program covers the mother from application through her pregnancy and 12 months postpartum coverage. Once eligible, the woman remains eligible for the entire period. Children born to women on Medicaid in Utah can receive Medicaid through the month of their first birthday under the Child Under Age 1 program.

Income Limit: 139% FPL
Income Deductions: 5% FPL and expenses from Schedule 1 of the IRS 1040 form
Spenddown: Not allowed
Asset limit: None
Retroactive coverage is allowed.

Medically Needy Pregnant Woman

This program covers pregnant women who do not meet the income limits for the Pregnant Woman program. The advantage of the Medically Needy Pregnant Woman program is that a woman may pay a spenddown and receive coverage. The woman must pass an asset test. A woman who meets her spenddown in any month during her pregnancy is eligible for the duration of her pregnancy and 12 months of postpartum coverage. If the mother is covered in the month of the child's birth, the child will receive Medicaid for the first year under the Child Under Age 1 program with no spenddown.

Income Limit: Set amounts based on family size. 2 person income limit is $468; 3 person income limit is $583. It increases for each additional person.
Income Deductions: $90 work allowance, a $30 and 1/3 deduction (allowed in only certain situations), childcare ($200 maximum per child under age two, $175 maximum over age two) from earned income; health insurance premiums; some medical bills.
Spenddown: Allowed
Asset limit: 2 people is $3,000 (Add $25 for each additional person)
Retroactive coverage is allowed.

Child, Under Age 1

This program covers children from birth until age one when born to a mother on Medicaid. Mothers who were not on Medicaid when the baby was born may apply within the three months after the birth. If the mother is determined eligible for Medicaid back to the date of the baby's birth, the baby will receive one year of coverage. The household must report the child's birth and provide information about any possible insurance coverage for the child. These infants may continue to receive coverage even if they do not remain with the birth mother. If the infant is adopted, the adoptive family needs to reapply.

Child, Age 0-5

This program provides Medicaid coverage for children from birth through the month the child turns age six. A child does not have to reside with a relative to receive coverage.

Income Limit: 139% FPL
Income Deductions: 5% FPL and expenses from Schedule 1 of the IRS 1040 form
Spenddown: Not allowed
Asset limit: None
Retroactive coverage is allowed.

Child, Age 6-18

This program provides Medicaid coverage for children from age six through the month they turn 19. A child does not have to reside with a relative to receive coverage.

Income Limit: 133% of the FPL
Income Deductions: 5% of the FPL and expenses from Schedule 1 of the IRS 1040 form
Spenddown: Not allowed
Asset limit: None
Retroactive coverage is allowed.

Child, Medically Needy

Children in households that do not meet the income limits for the Child Age 0-5 or Child Age 6-18 may be eligible for the Child Medically Needy program. Children must be under age 18 or between age 18 and 19, in school and expected to graduate before turning 19. Children do not have to be deprived of parental support or be living with a relative. The income and assets of adult household members who are not the parents of the child do not count. All other eligibility factors follow the guidelines under the Medically Needy Family program.

Income Limit: Set amounts based on family size. 1 person income limit is $382; 2 person income limit is $468; 3 person income limit is $583. It increases for each additional person.
Income Deductions: $90 work allowance, a $30 and 1/3 deduction (in certain situations), childcare ($200 maximum per child under age two, $175 maximum over age two) from earned income; health insurance premiums; some medical bills
Spenddown: Allowed
Asset limit: 1 person is $2,000; 2 people is $3,000 (Add $25 for each additional person)
Retroactive coverage is allowed.

Refugee Medical Assistance (RMA)

Refugees entering the United States who are not eligible for another medical program are eligible to apply for and receive medical assistance for 8-12 months after their date of entry depending on their immigration status and the date they were determined eligible. The same income and resource standards apply for Family Medically Needy Medicaid, except that refugee cash assistance is not counted as income. Refugee Financial Assistance automatically provides eligibility for Refugee Medical. RMA is available for refugees who meet immigration status and children born to mothers on RMA coverage. RMA is not available to full time students unless approved as part of an employment plan.

Medicaid Cancer Program

The Medicaid Cancer program provides full Medicaid benefits to uninsured individuals under age 65 who have been screened for breast or cervical cancer under the CDC (Center for Disease Control) Breast and Cervical Cancer Early Detection Program. The screening must indicate they need treatment for either breast or cervical cancer, including pre-cancerous conditions and early-stage cancer. The Utah Cancer Control Program (UCCP) is the CDC provider that completes the screening. If an individual has another type of cancer but the primary cancer is breast or cervical cancer, they may still meet the requirement. An individual diagnosed with a precancerous condition can only receive Medicaid for three months under the Cancer program.
An individual must meet the general Medicaid requirements along with the following requirements:

- Screened and referred by the UCCP
- Need treatment for breast or cervical cancer or a precancerous condition
- Cannot be eligible for any other Medicaid program (without cost)
- Have no creditable health insurance coverage which covers treatment of breast or cervical cancer
- Must be under the age of 65

Income test: The individual must meet the UCCP income requirements
Asset limit: None
Retroactive coverage is allowed, but not prior to the individual being screened by UCCP. The UCCP toll free referral number is 1-800-717-1811.

Foster Care Medicaid (Title IV-E)

The Foster Care Medicaid program (Title IV-E) provides full Medicaid coverage to individuals:

- who have been removed from their home, and
- who are in the custody of the state or tribe, and
- are in an out of home placement, and
- for whom a foster care maintenance payment is being made by DHHS, and
- who meet eligibility and reimbursement requirements for Title IV-E, determined by DHHS.

A child may qualify for this program until age 18, or until graduating from school if attending school full time and expecting to graduate before turning 19.
IV-E Medicaid is authorized along with IV-E payments when a child is:

- in state custody,
- determined to be IV-E eligible,
- lives with a licensed provider, or
- lives with a parent who is receiving in-patient substance abuse treatment.

IV-E Medicaid Coverage is also allowable for children in a preliminary placement within six months of a responsible party becoming a state licensed foster care provider. Kinship Guardianship IV-E Medicaid is also available for 14-18 year old foster children under certain circumstances. Utah is responsible to provide Medicaid for IV-E foster children placed in Utah from another state.

Retroactive coverage is allowed to the date of the child's removal from the home when entering state custody.

Foster Care Medicaid (Non IV-E)

The Foster Care Medicaid program (Non IV-E) provides full Medicaid coverage to children:

- who are in the custody of DHHS,
- for whom a foster care maintenance payment is being made by DHHS,
- who do not meet eligibility or reimbursement requirements for Title IV-E, as determined by DHHS, and
- who meet the requirement for another Medicaid program applicable for children.

Children under a tribal foster care program or with Catholic Community Services foster care for unaccompanied minors may also receive Medicaid. Income, assets, and other eligibility factors are as defined for other Medicaid programs such as Child Age 0-5, Child Age 6-18, Disabled Medicaid, or Child Medically Needy.

Retroactive coverage is allowed to the date of the child's removal from home when entering state custody.

Former Foster Care Youth and Foster Care Independent Living

The Former Foster Care Youth Medicaid program provides full Medicaid coverage to an individual who ages out of foster care. The following criteria apply:

- age 18 to 26, and living in Utah, and
- were enrolled in Medicaid and Foster Care sometime during the period of foster care in which they reached age 18, and
- were in a state foster care program, Catholic Community Services Unaccompanied Minor program, or a Tribal foster care program when foster care ended.

There is no income or asset limit.
Retroactive coverage is allowed.
Youth who do not meet the criteria above, but who age out of foster care, may qualify for the Foster Care Independent Living program until they reach age 21. No income or

asset test applies.

Custody Medical Care

The Custody Medical Care program enables children entering foster care to immediately access health care services. The program is for foster children who have not yet been approved for Medicaid, who do not qualify for any Medicaid eligibility while in custody, or who need health care services not covered by Medicaid. The program is state funded.

This program has no income, asset, or deprivation tests. DHHS Fostering Healthy Children Program nurse does the approval for each foster child. A child may qualify until becoming eligible for a Medicaid program or until state custody ends.

Subsidized Adoption Medicaid

Subsidized adoption Medicaid covers children who have an adoption assistance agreement in place between the adoptive parents and a state or local government agency. The adopted child may qualify for either Title IV-E or State Adoption Assistance. It does not matter if the child is receiving a monthly cash subsidy. There is no income or asset test for this type of Medicaid.

The adoption assistance agreement usually ends the month the child turns 18. However, the adoption assistance may extend through the month in which the child turns 21 if the child is determined by the agency originating the adoption assistance agreement to be physically, mentally or emotionally disabled. Subsidized Adoption Medicaid ends on the last day of the final month of the adoption assistance agreement.

Retroactive coverage is allowed, but no earlier than the date of the subsidized agreement.

Hospital Presumptive Eligibility

Hospital Presumptive Eligibility (HPE) is temporary Medicaid coverage for low-income individuals who are determined presumptively eligible by a qualified hospital provider. Self-attested information about income and household size for the client is used to determine eligibility. HPE coverage begins the same day a client is found eligible for the program and ends on the last day of the following month unless the client applies for Medicaid. If the client applies for Medicaid during the time they are covered under HPE, their HPE coverage continues until the Medicaid application is approved or denied. HPE covers the same services that regular Medicaid covers when provided by any Utah Medicaid provider. However, if pregnant, it does not cover the delivery of the baby. Clients can only receive HPE one time per calendar year or one time per pregnancy.

Income limit: Differs depending on HPE program type.
Asset limit: None
Retroactive coverage is not allowed. If approved for on-going Medicaid, retroactive coverage is allowed.

Baby Your Baby

Baby Your Baby (BYB) is temporary Medicaid coverage for low-income pregnant women determined presumptively eligible by a qualified health care provider. Self-attested information about the client's income and household size is used to determine eligibility. BYB coverage begins the same day a client is found eligible for the program and ends on the last day of the following month unless the client applies for Medicaid.

If the client applies for Medicaid during the time they are covered under BYB, their BYB coverage will continue until the Medicaid application is approved or denied. BYB covers outpatient pregnancy related services only. It does not cover the delivery of the baby. If the applicant is determined eligible for on-going Medicaid, coverage will continue through the rest of the pregnancy and the 12-month postpartum period. The baby will be covered for one year. Clients can only receive BYB one time per pregnancy.

Income limit: 139% FPL
Asset limit: None
Retroactive coverage is not allowed. If approved for on-going Medicaid, retroactive coverage is allowed.

Children's Health Insurance Program (CHIP)

CHIP is a state health insurance plan for children who do not have other health insurance and do not qualify for Medicaid. Depending on income and family size, children in uninsured Utah families may qualify. Once approved, CHIP covers well-child exams, immunizations, dental care, hearing and eye exams, and more. Depending on income, families may pay up to $75 every three months, as well as small co-pays for services like a visit to the doctor.

Age requirement: Under age 19
Income limit: 200% FPL
Deductions: 5% FPL and expenses from Schedule 1 of the IRS 1040 form
Asset limit: None
Retroactive coverage is not allowed.

Targeted Adult Medicaid (TAM)

The Targeted Adult Medicaid program provides full Medicaid benefits to adults who are

experiencing chronic homelessness, are involved in the justice system, or need mental health or substance abuse treatment, and have little to no income. Adults cannot be eligible for any other Medicaid program. Enrollment is open during specific open enrollment periods and may stop depending on available funding. Coverage extends for 12 months, once approved.

Age limit: 19 – 64
Income limit: 5% FPL
Deductions: Expenses from Schedule 1 of the IRS 1040 form
Asset limit: None
Additional: Does not qualify for other Medicaid programs; must be referred by specific approved agencies
Retroactive coverage is allowed.

Utah's Premium Partnership for Health Insurance (UPP)

UPP (pronounced "up") helps uninsured, working individuals and families pay their monthly health insurance premiums. If an employee's company offers health insurance, qualified individuals and families will receive monthly reimbursements for their cost of employer-sponsored health insurance coverage. If qualified, UPP will pay up to $150 per adult and up to $140 per child each month. UPP is for people who do not qualify for Medicaid, have access to health insurance through their employer and have not yet enrolled in their employer-sponsored health plan.

Age requirement: Under age 65
Income limit: 200% FPL
Deductions: 5% FPL and expenses from Schedule 1 of the IRS 1040 form
Additional: Does not qualify for Medicaid and does not have access to Medicare or veterans benefits
Requirements: Benefits
Asset limit: None
Retroactive coverage is not allowed.

Aged, Blind, Disabled Medical

This program provides Medicaid for individuals who are aged (65+), blind or disabled. People under age 65 must meet the Social Security criteria for being blind or disabled. Receipt of SSI or SSA disability benefits meets the criteria for disability. If the individual is not on SSI or SSA disability benefits, the state Medicaid Medical Review Board may make a disability decision. If Social Security has not denied disability based on medical evidence, the state Medicaid Medical Review Board can determine disability without considering substantial gainful employment. An asset test applies, and we count assets

of a spouse or parent.

Asset limits: 1 person is $2,000; 2 people is $3,000

SSI recipients: If the person receives SSI, there is no income test. We do not count the income of a spouse or parent. Some individuals who lose their SSI payments may still qualify without a spenddown under one of the SSI protected groups. (These are not described here.)

Non-SSI recipients: Income of a spouse or parent is counted along with the aged, blind or disabled person's income. Some deductions may apply to the income of a spouse or parent depending on the household composition.

Income limit: 100% FPL
Deductions: $20 general income exclusion, impairment-related work-expenses, the first $65 and then ½ of earned income that remains, health insurance premiums, and some medical bills
Spenddown: Allowed
Retroactive coverage is allowed.

Medicaid Work Incentive (MWI) Program

MWI is a Medicaid program for persons who meet the Social Security criteria for disability and are employed or self-employed. The household income limit is 250% of the FPL. If household net income does not exceed 100% of the FPL, the individual will not pay an MWI premium. If household net income is above 100% of the FPL, but below the 250% of the FPL, the individual will pay a monthly MWI premium.

Income test: Income of the recipient and of a spouse living in the home, or of the parents of a minor recipient counts and is compared to the 250% of the FPL. A spouse and minor children are counted in the household size to do the 250% FPL test.
Deductions: $20 general income deduction; impairment-related work expenses, then the first $65 and ½ of the remaining earned income. Allocations for children or parents are not allowed.
MWI Premium: Only the countable income of the disabled wage earner is used to determine the premium amount.
The MWI premium is calculated as follows:

Countable income	Multiply by:
More than 100% but not over 110%	5%
More than 110% but not over 120%	10%
Over 120% of FPL	15%

The MWI premium must be paid by check, money order or credit/debit card. DWS

cannot accept payment of an MWI premium from any Medicaid provider.

Asset limit: $15,000 for all household sizes (certain retirement accounts are exempt)
Retroactive coverage is allowed.

Emergency Medicaid

Emergency Medicaid is not a different Medicaid program. It refers to coverage for individuals who meet all of the other eligibility criteria for one of the Medicaid programs, but are not U.S. citizens or qualified non-citizens.

It only covers emergency medical services. Coverage is provided for the month the emergency occurs and is not provided ongoing. Pregnant women can apply one month before the expected date of delivery and receive coverage for the labor and delivery charges. Emergency Medicaid does not cover nursing home or other long term care services, and is not available for Medicare Cost-Sharing Programs or CHIP. An infant born to a woman eligible for emergency Medicaid when the baby is born is eligible for Medicaid through the month of the baby's first birthday.

MEDICARE COST-SHARING PROGRAMS

There are three Medicare cost-sharing programs for people with Part A Medicare. These programs help cover some of the member's costs for Medicare services. They are not Medicaid programs, but a Medicaid member who is eligible for or has Part A Medicare may be eligible for both Medicaid and one of the Medicare Cost-Sharing programs. Eligibility is based on how much income and assets the individual or couple has.

About three months after becoming eligible for a Medicare cost-sharing program, the state begins paying the Medicare Part B premium. If this is being deducted from your Social Security check, you will see an increase in your Social Security check. Social Security will reimburse you for each month of eligibility during which a Medicare premium was deducted from your check back to the month you became eligible for the Cost-Sharing program.

Qualified Medicare Beneficiaries Program (QMB)

The QMB program pays Medicare Part A and Part B premiums, deductibles, and copayments for low-income Medicare recipients. People who receive, or are eligible to receive, Part A Medicare may apply for QMB. Coverage begins the first of the month following the month the client is determined eligible. Eligible individuals receive reduced Part D costs.

Income limits: 100% FPL

Deductions: $20.00; impairment-related work expenses, $65 and ½ of remaining earned income
Spenddown: Not allowed
Asset limits: These limits go up on January 1 each year. To view asset limits in Table II: https://oepmanuals.dhhs.utah.gov
Retroactive coverage is not allowed.

Specified Low-Income Medicare Beneficiaries (SLMB)

The SLMB program pays the Part B Medicare premium only. Part B Medicare covers a person's physician care, and a variety of outpatient services including outpatient hospital services. Applicants must pass all the QMB rules, except that they must be receiving Part A coverage, their income is over 100% of the FPL and not over 120% of the FPL. No card is issued for someone who only has the SLMB program. An individual may be eligible for both Medicaid and SLMB.

Income limits: 120% FPL
Deductions: $20.00; impairment-related work expenses, $65 and ½ of remaining earned income
Asset limits: These limits go up on January 1 each year. To view asset limits in Table II - https://oepmanuals.dhhs.utah.gov/
Retroactive coverage is allowed.

Qualifying Individuals (QI)

The QI program pays the Part B Medicare premium. Applicants must pass all the QMB rules except that they must be receiving Part A Medicare and their income is over 120% of the FPL but not over 135% of the FPL. The individual cannot be receiving Medicaid. This is not an entitlement program. States have been granted a set amount of federal money to cover the benefits paid by the QI program. When funds have been allocated for a calendar year, no new applicants will receive any benefits. Eligibility in future calendar years is not guaranteed. No card is issued for the QI program.

Income limits: 135% FPL
Deductions: $20.00; impairment-related work expenses, $65 and ½ of remaining earned income
Asset limits: These limits go up on January 1each year. To view asset limits in Table II: https://oepmanuals.dhhs.utah.gov/.
Retroactive coverage is allowed.

Medicare Cost-Sharing Program for Part B-ID Recipients

This Medicare Cost-Sharing program is for people with Medicare Part B-ID only. This is

not a Medicaid program and the recipient cannot have both this program and any Medicaid program or other health insurance. The state only pays the Part B-ID premium. Eligibility is based on how much income and assets the individual or couple has.

Income limits: 135% FPL
Deductions: $20.00, $65 and ½ remaining earned income
Asset limits: These limits go up January 1st of each year. To view asset limits in Table II: https://oepmanuals.dhhs.utah.gov/.
Retroactive coverage is allowed.

MEDICAID FOR LONG TERM CARE

To get Medicaid to pay for long term care, people must be financially and medically eligible. The individual may enter a medical facility such as a nursing home or may be able to receive care in his or her own home under one of the home and community based waivers.

Space is limited in home and community based waivers; it may not be available in all areas. Home and community based waivers allow Medicaid to pay for some specialized services that would not otherwise be covered by Medicaid in community settings.

Transfer of assets: Most people seeking Medicaid for long term care are subject to transfer of asset rules. Transfers of assets for less than the fair market value can result in the person being ineligible for nursing home, or home and community based waiver Medicaid services for a period of time. At application, the eligibility worker will ask for asset and income information from the prior 60 months to determine what the person has done with assets. This is called the look-back period. If assets or income are given away during the look-back period, the client may be ineligible for Medicaid.

Substantial home equity: These limits go up on January 1 each year. To view asset limits in Table II-A: https://oepmanuals.dhhs.utah.gov/.

Nursing Home (NH)

Nursing home Medicaid pays for nursing home services and other medical costs. An individual must meet medical criteria for nursing home level of care to be eligible for Medicaid in a nursing facility. Income and asset rules are different for married couples.

Income limits: Generally a person's monthly income must be less than the private cost for nursing home care. Most individuals on Medicaid in a nursing home keep $45 a month for personal needs and pay the rest of their income to the facility as their share of the cost. Single people who expect to be in a nursing home for less than six

months keep a higher amount of their monthly income. A married person whose spouse is not living in a medical institution may be allowed to give some income to the spouse each month.
Supplemental income: SSI recipients in nursing homes receive an SSI payment of $30 a month, plus a state supplemental payment of $15.
Deductions: Complex; under the Spousal Impoverishment law, a spouse at home may be allowed to keep a portion of the income of the nursing home resident for living expenses. Medical insurance premiums are an allowable deduction.
Spenddown: Allowed. It is considered a contribution to care and is paid to the nursing home.
Asset limits: Complex; under the Spousal Impoverishment law, the nursing home resident is allowed $2,000. Subject to certain limits, the spouse at home may keep ½ the total amount of countable assets that the couple owned when the patient entered the nursing home. These limits go up on January 1 each year. Clients must report all annuities in which the client or spouse have an interest. Annuities must name the state as the beneficiary upon the death of the client.
Retroactive coverage: Allowed for nursing home charges only from the date the patient is determined medically eligible. Ancillary (non-nursing home) charges are allowed retroactively.

Aging Home and Community Based Waiver

This waiver is for members who would be medically appropriate for institutional care. members are eligible for some medical services not generally available to Medicaid recipients in community settings such as day treatment programs, personal alert, and in-home respite care. To qualify, recipients must be at least 65 years old. The referral process begins with the Area Agency on Aging (AAA). A case manager from AAA must complete an evaluation of the individual's appropriateness for the waiver.

Income limits: Similar to nursing home Medicaid, but client keeps 100% of the FPL for personal needs.
Deductions: $125 earned income deduction; spousal and family allowance; health insurance premiums; medical expenses; some shelter costs.
Spenddown: Allowed
Asset limits: Complex. $2000; same Spousal Impoverishment rules as Nursing Home.
Retroactive coverage is allowed. However, waiver services received prior to the date the person met the medical criteria, as certified by the AAA worker, cannot be paid.

Utah Community Supports Waiver

This waiver helps severely disabled people of any age remain in community residences rather than be institutionalized. Applications are taken through the Division of Services

for People with Disabilities (DSPD). Parent's income and assets are not counted in determining a minor child's eligibility. Also, an intensive service plan is written for the client. To be eligible for this program, clients must have been disabled before age 22.

Income limits: Similar to Nursing Home Medicaid, but client keeps 100% of the FPL for personal needs.
Deductions: Earned income deduction equal to SSA's substantial gainful activity level; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.
Spenddown: Allowed
Asset limits: Complex. $2000; same Spousal Impoverishment rules as Nursing Home
Retroactive coverage is allowed. However, waiver services received prior to the date the client met the medical criteria, as certified by DSPD, cannot be paid.

Technology Dependent Children Waiver

This program helps medically fragile children remain in their home rather than be institutionalized. Children must be under age 21 when they enter the waiver and remain on after turning age 21. Applications are taken through the Division of Family Health Services. A parent's income or assets are not counted towards the child's eligibility. An intensive service plan is written for the client and parents receive specialized training in how to provide some of the care the child needs. Families usually receive private-duty nursing services due to the complex medical condition of these children. To be eligible for this program, clients must meet specific medical criteria.

Income limits: Similar to Nursing Home Medicaid, but client keeps 100% of the FPL for personal needs.
Deductions: Earned income deduction equal to Substantial Gainful Activity for a disabled or blind individual, health insurance premiums; medical bills; and a deduction for a dependent spouse or children.
Spenddown: Allowed
Asset limits: Complex. $2000; same Spousal Impoverishment rules as nursing home.
Retroactive coverage is allowed. However, waiver services received prior to the date the client met the medical criteria, as certified by the Division of Family Health Services cannot be paid.

Brain Injury Waiver

This waiver is for members who have a brain injury and would be medically appropriate for institutional care. These members are eligible for some medical services not generally available to Medicaid recipients in community settings, such as supported employment, day treatment programs, behavioral training and in-home respite care.

Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD).

Income limits: Similar to nursing home Medicaid, but client keeps 100% of the FPL for personal needs. Only the waiver client's income is counted.
Deductions: 100% FPL for one person, $125 earned income deduction; some shelter expenses; health insurance premiums; medical bills; a deduction for a dependent spouse or children.
Spenddown: Allowed
Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home.
Retroactive coverage is allowed, but not before the date the client met the medical criteria.

Physical Disabilities Waiver

This waiver is for people with a physical disability who would be medically appropriate for institutional care. Additional services provided by the waiver may include personal care assistance, consumer training, and personal emergency response services. Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD).

Income limits: 300% of the SSI rate. If income exceeds the 300% of SSI rate, the person must spenddown to the medically needy income limit for disabled people. Income deductions allowed for a disabled person apply. Only the waiver member's income is counted.
Deductions: If income is below 300% of the SSI rate, all income is deducted. If over 300%, deduct $20; impairment related work expenses, $65 and ½ of the remaining earned income; health insurance premiums and certain uncovered medical expenses.
Spenddown: Allowed when income is over 300% of SSI.
Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home.
Retroactive coverage is allowed. However, waiver services received prior to the date the client met the medical criteria, as certified by the DSPD worker, cannot be covered.

New Choices Waiver

The New Choices Waiver (NCW) provides home and community based services for eligible members who require the level of care provided in a nursing facility. The primary goal of the NCW is to move people out of institutional care to a less restrictive community care setting.

To be eligible for the NCW, an individual must be age 65 or older, or must be age 18

through 64 and meet SSA disability criteria. Individuals must then meet the criteria for one of the following eligibility coverage groups:

- SSI recipients
- SSI protected group individuals: 1619(a) and (b); Adult Disabled Child; Disabled Widows/Widowers; Pickle Amendment
- 100% FPL Aged and Disabled (not spenddown clients)
- Medicaid Work Incentive (MWI)
- Special Income Group (income not over 300% of the SSI rate. Income is not deemed from a spouse; resources follow institutional resource rules.)
- Spenddown Waiver Group for individuals who cannot qualify under any other group (income is not deemed from a spouse; resources follow institutional resource rules).

Medically Complex Children Waiver

This program serves children with disabilities and complex medical conditions. It provides traditional Medicaid services, specialty care, and respite care services. Parents' income and assets will not prevent the child from qualifying for this waiver. Children can qualify for this waiver through the month in which they turn age 19. Enrollment is limited, so applications are accepted only during open enrollment periods. Children must meet medical criteria, as well as financial criteria to qualify.

Income limits: Similar to nursing home Medicaid, but client keeps 100% of the FPL for personal needs.
Deductions: Earned income deduction equal to SSA's substantial gainful activity level; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.
Spenddown: Allowed
Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home
Retroactive coverage is allowed. However, waiver services received prior to the date the client met the medical criteria cannot be paid.

Community Transitions Waiver

Community Transitions Waiver is for people of all ages who have intellectual disabilities and need help with activities of daily living. People on this waiver must meet an aged, blind, or disabled Medicaid category.

Individuals must then meet the criteria for one of the following eligibility coverage groups:

- SSI recipients
- SSI protected group individuals: 1619(a) and (b); Adult Disabled Child; Disabled Widows/Widowers; Pickle Amendment

- 100% FPL Aged and Disabled (not Spenddown members)
- Medicaid Work Incentive (MWI)
- Special Income Group (income not over 300% of the SSI rate. Income is not deemed from a spouse; resources follow institutional resource rules.)
- Spenddown Waiver Group for individuals who cannot qualify under any other group (income is not deemed from a spouse; resources follow institutional resource rules).

Limited Supports Waiver

Limited Supports Waiver is for people of all ages who have intellectual disabilities and related conditions, or those with an acquired brain injury. People on this waiver must meet an aged, blind, or disabled Medicaid category.

Individuals must then meet the criteria for one of the following eligibility coverage groups:

- SSI recipients
- SSI protected group individuals: 1619(a) and (b); Adult Disabled Child; Disabled Widows/Widowers; Pickle Amendment
- 100% FPL Aged and Disabled (not Spenddown members)
- Medicaid Work Incentive (MWI)
- Special Income Group (income not over 300% of the SSI Rate. Income is not deemed from a spouse; resources follow institutional resource rules.)
- Spenddown Waiver Group for individuals who cannot qualify under any other group (income is not deemed from a spouse; resources follow institutional resource rules).

Other Information About Medical Assistance

To understand medical assistance programs, there are some other things you need to know.

- **Estate recovery:** is a process where the state recovers all Medicaid funds spent on behalf of a recipient from the recipient's estate. It applies to people who receive medical assistance after reaching age 55. The Office of Recovery Services (ORS) is the agency responsible for doing estate recovery.
    - For more information, see the Estate Recovery flyer and FAQ (https://medicaid.utah.gov/medicaid-education-materials/).
- **Payments to be eligible:** If you owe a spenddown or other fee to receive medical assistance, you must pay such amount to DWS to be eligible, unless you reside in a nursing home, in which case you pay the nursing home. DWS cannot accept payments from Medicaid providers for your spenddown or other fee that you owe. DWS will accept payments if the provider is your representative payee and the payment is made with your funds.