**STATE OF MAINE**

**Department of**

**Health and Human Services**

**Office for Family Independence**

**10-144 Chapter 332**

**MAINECARE**

**ELIGIBILITY**

**MANUAL**

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**PART 1**

**GENERAL INFORMATION**

**SECTION 1: INTRODUCTION**

The Maine Department of Health and Human Services is responsible for administering the MaineCare Program in compliance with Federal and State statutes and administrative policies. It is also responsible for state funded assistance programs found within this manual. Within the Department, the Office for Family Independence (OFI) establishes and applies written policies and procedures for taking applications and determining eligibility for assistance, consistent with the objectives of the Program. It also respects the rights of individuals under the United States Constitution, the Social Security Act, Title VI of the *Civil Rights Act of 1964*, the *Americans with Disabilities Act* and all other relevant provisions of Federal and State laws which do not result in practices that violate the individual's privacy or personal dignity. The Department further holds any policies or procedures developed at the regional level to be consistent.

Title VI of the *Civil Rights Act of 1964* and the *Americans with Disabilities Act* states that no person shall be excluded from participation, be denied benefits, or be subjected to discrimination on the grounds of race, color, national origin, sex, gender orientation, religion or disability under any program or activity receiving federal financial assistance. Therefore, the programs of the Department, like every program or activity receiving financial assistance from the Federal Department of Health and Human Services, must be operated in compliance with the law.

In accordance with the Americans with Disabilities Act, no qualified individual with a disability will, by reason of such disability, be subjected to discrimination; or be excluded from participation or be denied the benefits of the services, programs or activities of the Maine Department of Health and Human Services.

**Section 1.1: Definitions**

“**Assistance unit**” means the individuals whose need the department considers when determining whether an applicant or recipient is eligible for program benefits.

An “**Administrative Hearing**” (Hearing) is a hearing between a participant and the Department that is less formal than a proceeding in traditional courtroom, but there still is an authority presiding and testimony and evidence are presented by both sides. A Hearings Officer or the Commissioner of the Department will oversee the Administrative Hearing by hearing both sides and review the action taken by the Department. The purpose of the Administrative Hearing is to ensure that Federal and State rules have been applied correctly. A hearing decision will be made in writing and provided to the participant and the Department within the timelines allotted in the Appendix.

**Federally Facilitated Marketplace:** The federally facilitated marketplace (FFM) is a website established and operated by the US federal government to facilitate the purchase of health insurance in accordance with the [Patient Protection and Affordable Care Act](http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act).

“**Intentional Program Violation**” means that a recipient, applicant, or any other individual in the “Assistance Unit” has intentionally misrepresented facts (including, but not limited to such facts as living arrangement, income, or assets) in order to receive MaineCare, and the recipient, applicant, or any other individual in the Assistance Unit would not have been eligible for MaineCare if the Department had been notified of the correct facts, or of a material change in facts. This includes, but is not limited to:

A. False or misleading statements or representations, or withholding of facts, or

B. An action intended to mislead, misrepresent, conceal or withhold facts.

“**Overpayment**” means program benefits that exceed the amount of program benefits, if any, for which an individual or assistance unit is actually eligible when the department or a court has determined that the benefits were provided as a result of an Intentional Program Violation by the individual.

“**Program benefits**” means payments for medical services or durable medical equipment and supplies, and/or the durable medical equipment and supplies, reimbursed by the department under the MaineCare program established pursuant to 22 MSRA ch. 855.

**SECTION 2: CONFIDENTIALITY**

The Department of Health and Human Services, in accordance with Federal Regulation (42 CFR 431.306) and State statutes, must maintain the individual's information in a manner which will ensure that this information is restricted to persons or agency representatives who are subject to standards of confidentiality comparable to those of the Department.

**Section 2.1: Release of Information**

Information from the case record will be released under the following circumstances:

I. The individual has the right to review information in their case record at any time. When the medical source requests that the medical information be kept confidential, that information may not be reviewed by the individual.

II. All information pertaining to a decision of eligibility for assistance, including medical and social data for preparation of an Administrative Hearing will be made available to the individual or the individual's representative. If the individual is being represented by an attorney, permission to release information to the attorney must be obtained in writing from the individual.

III. Financial information relating to eligibility will be given to general assistance administrators if necessary for making a determination of granting general assistance.

IV. Information relating to whether an individual is a recipient in a particular month will be given to hospitals, physicians, pharmacists, and other medical providers inquiring in order to determine whether to provide their service under MaineCare. The address of the individual is not to be released.

V. Information necessary for other Offices within the Department to administer their programs may be given. These Offices include Office of Child and Family Services (OCFS) – Child Protective Services, Office of Aging and Disability Services (OADS) – Adult Protective Services, Division of Support Enforcement and Recovery (DSER), Fraud Investigation and Recovery Unit (FIRU), the Preventive Health Program (PHP), and the Division of Administrative Hearings. Information may also be provided to other Offices within DHHS if there is a written Memorandum of Understanding between OFI and that Office.

VI. For those agencies having a contract with the Department information may be released that is needed for the agency to fulfill the terms of the contract. Agencies include Home and Community Based Waiver agencies and Community Action Programs.

VII. In the event of the issuance of a subpoena or order from the court for the case record or for any agency representative to testify concerning an applicant or recipient, the Department's attorneys will call the Court's attention to the statutory provisions and the regulations against disclosure of information. The decision in regard to release of information will be with the presiding judge.

 VIII. Pursuant to 42 CFR §435.1200, for Members or individuals who have been determined not eligible for Medicaid, the Department will transfer via secure electronic interface, the individual’s electronic account to other insurance affordability programs, such as the federally facilitated marketplace.

**Section 2.2: Written Release of Information**

With all other requests, a written release from the individual is required prior to sharing the information. Unless otherwise specified any written release of information is valid for one year from the date of signature by the individual. The release of information must specify the information to be released and to whom.

I. Release of medical reports to general assistance administrators will be made only if the individual has signed a written release.

II. Information will be made available upon receipt of written authorization from the individual (or adult family head in the case of children) giving the Department authorization to release information to the following:

A. Federal and State legislators;

B. attorneys;

C. social or financial service agencies requesting information beyond eligibility dates, or, if under contract with the Department, information beyond that necessary to administer their program.

III. Information about whether the individual is receiving MaineCare, the number of children in the assistance unit and the address of the children will be made available to absent parents inquiring about the status of the family only with written permission of the caretaker relative.

**Section 2.3: Information from an external source**

 For DHHS to obtain information:

I. the Eligibility Specialists must inform the individual of the Department’s need for collateral information; and

II. receive a signed release form from the individual identifying the information being requested and from whom.

Information in case records and computer files will be used only for Department business, never for obtaining information about friends, relatives or neighbors. Employees of the Department are not permitted to determine their own eligibility or that of their immediate family.

The names of individuals supplying information who wish to remain anonymous will not be kept in the case record.

**SECTION 3: REFERRALS**

Under certain circumstances referral to other Offices and Divisions within the Department of Health and Human Services are to be made. These include the Office of Child and Family Services (OCFS), the Office of Aging and Disability Services (OADS) and the Division of Fraud Investigation and Recovery Unit (FIRU) within OFI.

**Section 3.1: Referrals to Child and Adult Protective Services**

In compliance with Federal and State statutes, when information is brought to the attention of a staff member or there is reasonable cause to suspect abuse, neglect or exploitation, an immediate referral will be made to the Child or Adult Protective Unit which will investigate the suspected abuse.

**Section 3.2: Referral to the Fraud Investigation and Recovery Unit (FIR) from the Eligibility Unit**

If it appears that a recipient has purposely misrepresented actual circumstances (such as living arrangement, income, or assets) in order to receive MaineCare, and the individual would not have been eligible had the proper information been available at the time of application, re-determination of eligibility, or within ten days of the change in circumstances, a referral to the Fraud Investigation Unit will be made.

The report will include:

I. a detailed explanation of the misrepresentation and the effect it had on eligibility.

II. a claims history indicating the services that should not have been paid.

**Section 3.3: Referrals to the Fraud Investigation and Recovery Unit (FIR) from an outside source**

Complaints received directly by the Fraud Investigation and Recovery Unit may be referred to the Attorney General’s Office if it is determined that:

I. the individual was enrolled in MaineCare at the time alleged fraud occurred;

II. it appears that the individual has purposely misrepresented actual circumstances to receive MaineCare;

III. the individual would not have remained eligible if the complaint is valid; and

IV. MaineCare paid for services during the time period in question.

The name of individuals supplying information who wish to remain anonymous will not be kept in the case record.

**SECTION 4: REPLACEMENT OF MEDICAL IDENTIFICATION CARDS**

In those instances when an individual reports the loss or non-receipt of a medical identification card, the Department will issue a replacement card.

Requests may be made by telephone, in writing, or in person.

OFI will issue replacement cards for those individuals for whom they maintain case records or for SSI recipients. Child welfare recipients will be referred to Office of Child and Family Services (OCFS).

**SECTION 5: OUT OF STATE COVERAGE**

Medical Services provided outside of the State of Maine are coverable under the following circumstances:

I. Individuals are eligible for payment of services to qualified providers as long as the provider is located within fifteen miles of the Maine-New Hampshire border or within five miles of the Maine-Canada border.

II. Individuals absent from the State are eligible for coverage of emergency services. Routine medical services usually require prior authorization from the Office of MaineCare Services (OMS). In both circumstances the provider will need to enroll as a MaineCare provider.

**SECTION 6: OUTREACH**

State law (22 MRSA §3173) requires the Department of Health and Human Services to inform low-income households of the availability and benefits of MaineCare and provide reasonable and convenient access to the program. The Department publishes information explaining covered services and eligibility.

**SECTION 7: ADMINISTRATIVE HEARINGS**

An Administrative Hearing (Hearing) is an informal conference held by the Commissioner of the Department, or a Hearing Officer, to review the action taken by the Department in order to ensure that Federal and State policy have been applied correctly. This right is basic throughout all of the public assistance programs. (Administrative Hearings regulations for all of DHHS is found at 10-144 in the Code of Maine Regulations Chapter 1). If the Commissioner authorizes another agent to handle the hearing, the Hearing Officer must be:

I. impartial and not have participated in the action causing dissatisfaction;

II. sufficiently skilled in interviewing to obtain evidence and the facts necessary for a fair determination; and

III. qualified to evaluate all evidence fairly and realistically, to explain to the individual the policies under which the Department operated and to interpret and inform the Department of any evidence of unsound, unclear or inequitable policies or practices.

Written notification of the right to a hearing is given to all interested parties through the use of pamphlets and informational materials.

Every written notification of Department action on eligibility will include:

I. the right to a hearing;

II. the method by which a hearing can be obtained; and

III. the right to be represented by legal counsel, relative, friends, or other persons. The Department cannot pay for legal services.

**Section 7.1: Requesting an Administrative Hearing**

Federal and State laws assure that any individual or the individual's representative who believes that proper consideration has not been given to circumstances surrounding a request for assistance may request a hearing. Any oral or written request made by the individual or their representative to the Department that they want an opportunity to present the case to a higher authority is a request for a hearing.

All complaints which are not clear requests for a hearing will be answered by a personal contact or in writing by the Eligibility Specialist, Supervisor, or member of Central Office staff and will explain the individual's right to a hearing. If the individual is satisfied with the adjustment or explanation, activity on the complaint will end. If not, the individual will be offered the opportunity for a hearing.

The Department must assure that the individual understands the process. When a request is made, the Department will not limit or interfere with the individual's rights in any way. In fact, the emphasis of the Department will be on helping the individual submit the request and prepare the case. The Department's regional office will provide information regarding legal services available in the community to assist the individual in representation at hearings.

The Department may request that the Division of Administrative Hearings deny or dismiss a request for a hearing when:

I. the request is withdrawn in writing by the individual or individual's representative;

II. the sole issue is one of State or Federal law requiring automatic adjustment for groups of individuals unless the reason for an individual's appeal is disagreement of facts affecting eligibility (such as incorrect computation); or

III. the hearing is abandoned. Abandonment occurs when the individual or the individual's representative fails to appear at the hearing without a reason acceptable to the Hearing Officer.

The Department may respond to a series of individual requests for hearings by requesting the Division of Administrative Hearings conduct a single group hearing. The Department will consolidate only cases in which the sole issue involved is one of a single policy issue. If individuals request a group hearing on such an issue, the Department will grant it. In all group hearings, the policies governing hearings will be followed. Thus, individuals will be permitted to present their own cases and to be represented. If, at any time, an individual scheduled for a group hearing wants to withdraw and have an individual hearing, the request must be made to the Division of Administrative Hearings.

Any request for a hearing must be received by the local office within thirty days (plus two days for mail) starting with the date on the written notice of eligibility unless the Department decides to grant an extension of time.

The hearing process will take no longer than sixty days from the date of the initial request for the hearing except when the individual requests a delay. If the request for a delay is granted, additional time may be added to the sixty days.

A request for a hearing will be acknowledged in writing within five days of its receipt by the local office. The notice will be sent at least ten days prior to the hearing to allow for preparation of the case.

When additional medical information is requested by the individual, it will be obtained at Department expense from a medical source satisfactory to the individual. The Hearing Officer can also consider the physician's report or can request additional evidence. The medical report will be made in writing or by personal testimony for the hearing record. When the hearing involves medical issues, a medical assessment other than that of the persons involved in making the original decision will be obtained and made a part of the record if the Hearing Officer or the individual considers it necessary.

**Section 7.2: Continuation of Benefits**

If the individual requests a hearing at any time during the Adverse Action Notice Period, assistance will be continued until the written hearing decision is rendered. The Adverse Action Notice Period is the fifteen day period (ten days for notice plus five days for mail), starting with the date of the written notice of eligibility.

If a hearing is requested after the fifteen day period, assistance will not be continued or reinstated at its previous level pending a decision, unless the beneficiary shows that he or she did not receive the notice within the 5-day mailing..

Closure of temporary coverage is a denial and continuation of benefits cannot be made.

**Section 7.3: Conducting an Administrative Hearing**

The Eligibility Specialist and other Department representatives involved in the decision will participate in the hearing. All participants will testify under oath.

Either party may subpoena witnesses and evidence by request through the Division of Administrative Hearings Office. The party requesting the subpoena will bear any expenses of issuance and costs of reimbursement to witnesses. For the most up to date information about the procedure of administrative hearings, please see the *Administrative Hearing Unit Manual*.

All hearings will:

I. be conducted privately and be open only to the individual, anyone present at the individual's request, and members of the Department's staff, or others selected by the Hearing Officer for their participation in the hearing;

II. be conducted informally without technical rules of evidence. Hearings will be subject to the requirement of due process, the regulations of the Division of Administrative Hearings and the Administrative Procedure Act. All witnesses will testify under oath;

III. be opened by the Hearing Officer who will make a statement of points in issue, give all participants an opportunity to present relevant oral or written testimony or documentary evidence, offer rebuttal, question witnesses, examine all evidence presented at the hearing, and establish competency of witnesses offering subjective or technical opinions;

IV. be recorded to be available to members of the Department and to the individual or individual's representative. All documentary evidence submitted as exhibits at the hearing will be available;

V. be concluded when the Hearing Officer and the individual or individual's representative are satisfied that all available relevant evidence has been introduced and properly examined; and

VI. result in a decision based exclusively on evidence or testimony presented at the hearing.

**Section 7.3.1**: The Hearing Officer’s review of the Department’s decision shall include consideration of:

I. the Agency's failure to act with reasonable promptness. This includes undue delay in reaching a decision about eligibility or refusal to consider a request for assistance and termination or reduction of assistance.

II. an Agency decision regarding:

A. eligibility for assistance in both initial and subsequent determinations;

B. the level of coverage granted.

**Section 7.3.2**: The individual or the individual's representative will have the opportunity to:

I. examine all documents and records pertinent to the hearing;

II. present the case with or without the aid of others;

III. bring witnesses;

IV. establish all pertinent facts and circumstances;

V. present any relevant arguments without interference;

VI. question or refute any testimony or evidence; and

VII. confront and cross examine adverse witnesses.

Any information shared with the Hearing Officer must also be shared with the individual or the individual’s representative.

**Section 7.3.3**: Following the Hearing, a written decision will be prepared by the Hearing Officer.

The decision will contain:

I. a statement of the issue;

II. a list of participants;

III. relevant facts brought out at the hearing and items introduced into evidence;

IV. pertinent provisions in Department's policy governing the decision; and

V. the decision and the basis for the decision.

A copy of the hearing decision will be sent to the individual, the individual's representative, and the regional office.

The Department is bound by the hearing decision. The decision is applied to the case in question only.

**Section 7.4: Implementing Results**

The hearing decision will be implemented upon receipt of the written decision.

If the individual files an appeal to Superior Court benefits will continue if directed by the Attorney General or the court.

**Section 7.5: Judicial Review**

Within five days of the written decision by the Hearing Officer, the copy of the decision and notice of the individual's rights to judicial review under Maine *Administrative Procedure Act* 5 M.R.S.A., Sec. 11001 *et seq*. will be mailed to the individual and the individual's representative. The notice will also advise the individual that to take advantage of this right, a petition for review with the Superior Court must be filed within thirty days of the receipt of the decision.

For additional information on the preparation of a hearing, see Appendix I -Preparation for the Hearing Process.

**SECTION 8: RECORD RETENTION**

Material is kept for auditing purposes for three years. Material over three years old may be destroyed except for the first application which should be kept even if it is over three years old.

Individual case records are not to be filed in Archives for historical preservation and future review by historians or anyone else. Such retention has no bearing on the administration of MaineCare.

The only exception to this procedure is a case which has been referred to the Fraud Investigation and Recovery Unit (FIR) or Attorney General for collection or prosecution purposes. These case records shall be clearly marked "Do Not Destroy".

**SECTION 9: PROGRAM INTEGRITY**

Section 9.1 Intentional Program Violation

means that a recipient, applicant, or any other individual in the “Assistance Unit” has intentionally misrepresented facts (including, but not limited to such facts as living arrangement, income, or assets) in order to receive MaineCare, and the recipient, applicant, or any other individual in the Assistance Unit would not have been eligible for MaineCare if the Department had been notified of the correct facts, or of a material change in facts. This includes, but is not limited to:

A. False or misleading statements or misrepresentations, concealment, or withholding of facts, or

B. An act intended to mislead, misrepresent, conceal, or withhold facts or propound a falsity.

Section 9.2 Determining the Overpayment.

“Overpayment” means program benefits that exceed the amount of program benefits, if any, for which an individual or assistance unit is actually eligible when the department or a court has determined that the benefits were provided as a result of an Intentional Program Violation by the individual. Overpayments are calculated as follows:

A. For excess assets, the amount subject to recovery is the lesser of:

a. The amount of the payment made on behalf of the individual; or

b. The difference between the actual amount of countable resources and the applicable resource limit.

B. For excess income, the amount subject to recovery is the total amount of program benefits made on behalf of the individual during the months of the overpayment period.

C. For combinations of excess assets and excess income, the amount subject to recovery is the greater of either A. or B. in this Section.

D. For misrepresentation of circumstances other than income and assets, the amount subject to recovery is the total amount of payments made on behalf of the individual during the months of the overpayment period.

E. For Medically-Needy cases, as described in Part 10 of 10-144 CMR Chapter 332, the amount subject to recovery is the lesser of:

a. The amount of program benefits made on behalf of the individual; or

b. The difference between the amount of the deductible in effect during the overpayment period and the correct amount of the deductible.

F. Situations involving individuals receiving long-term care and waiver services:

a. Excess Income –

i. If the individual should not have been made eligible for MaineCare, the amount subject to recovery is the amount of program benefits made on behalf of the individual.

ii. If the individual was correctly made eligible for MaineCare but the cost of care was incorrectly calculated, the amount subject to recovery is the difference between the amount of the correct cost of care and the cost of care that was in effect during the overpayment period.

b. Excess Resources –

i. The amount subject to recovery is the difference between the actual amount of countable resources and the applicable resource limit.

ii. The individual may choose to make a payment of a lump sum to the long term care facility if the increase will reduce the resources to the appropriate limit. The reduction in resources shall be completed in one calendar month.

**Section 9.3 Notice of Overpayment/IPV.**

The eligibility office in cooperation with the Office of MaineCare Services shall provide the following information to the individual and/or assistance unit:

A. a detailed explanation of the misrepresentation and the effect it had on eligibility.

B. a claims history indicating the services that should not have been paid.

C. a request that the applicant contact the Office for Family Independence (OFI) within 10-days to discuss repayment of the benefits issued.

D. deadlines and methods for requesting an administrative hearing.

E. closings, denials, and eligibility notices will be handled according to Part 2 Sections 14 and 15.

**Section 9.4 Administrative Hearing –**

The Department will provide instructions on how to request an Administrative Hearing consistent with Part 1 Section 7 above.

**Section 9.5 Referral to Fraud Investigation & Recovery Unit (FIRU) for recovery of overpayments described in Section 9.2**

The OFI will send a copy of the above-referenced notice of over-payment to the Fraud Investigation and Recovery Unit:

A. if the individual or assistance unit does not appeal the department’s findings; or

B. the final written decision by the Administrative Hearing Officer finds in favor of the department and the individual does not request a judicial review; or

C. judicial review finds in favor of the department.

# PART 2

# BASIC ELIGIBILITY CRITERIA

## SECTION 1: PROGRAM SCOPE

MaineCare is the name used by the State of Maine for programs that help individuals pay for health care costs. The Department’s goal is to assist Maine residents in obtaining the benefits to which they are entitled. The programs are:

**Medicaid** (Title XIX of the Social Security Act). To be enrolled in Medicaid an individual must be both categorically and financially eligible. Each category has its own eligibility rules. Medicaid includes coverage for people living in the community or living in a long-term care facility.

**Categorically Needy** – This Medicaid category is made up of different mandatory and optional coverage groups covered within the state plan. An individual qualifies for Medicaid in this category if they meet the requirements of one of the Categorically Needy coverage groups.

**Medically Needy** – This Medicaid category provides coverage for individuals who meet the non-financial requirements of a Categorically Needy group but are financially ineligible. Coverage is gained by meeting a deductible.

**Medicaid Waiver Groups** – These are optional coverage groups approved by the Center for Medicare and Medicaid Services (CMS) under which an individual can become enrolled in Medicaid who might not otherwise be eligible. Examples are the Home and Community Based Waivers and the HIV Waiver.

**Cub Care** (Children’s Health Insurance Program (CHIP), Title XXI of the Social Security Act) – This program provides coverage for children under the age of 19 with higher income guidelines and different eligibility rules than Medicaid. CHIP also provides coverage to pregnant individuals who are eligible for Medicaid but for their noncitizen status.

**Medicare Savings Program** (Buy-In) – This Medicaid category is a benefit for those who are entitled to Medicare Part A and who meet certain income criteria. Depending on income, the benefit is payment of Medicare Part B premium or payment of Medicare Part A and B premiums as well as coinsurance and deductibles.

The Office for Family Independence (OFI) also administers the following additional benefits under MaineCare:

**Health Insurance Purchase Option** (HIPO) – This program provides 18 months of extended health coverage to children under the age of 19 who are no longer eligible for MaineCare due to changes in income. (See 10-144 C.M.R. Ch. 335.)

**Coverage for Noncitizens Under Age 21** – This state funded program provides coverage to individuals under the age of 21 who would be eligible for Medicaid but for their noncitizen status.

**Low Cost Drugs for the Elderly and Disabled** (DEL) – This state funded program assists elderly or disabled individuals with the cost of their medications. (See 10-144 C.M.R. Ch. 333.)

**Maine Rx Plus** – This state funded program assists Maine residents with the cost of their medications. Income guidelines are higher than under DEL and the benefit is less. (See 10-144 C.M.R. Ch. 334.)

**State Supplement** – This is a cash payment to SSI recipients, and individuals who would otherwise be eligible for SSI except for income or citizenship criteria. (See Part 11.)

**Spousal Living Allowance** – This is a cash payment to a spouse of a resident of a Residential Care Facility or Cost Reimbursed Boarding Home. The spouse must meet income and asset criteria. (See Part 12 Section 5.)

## SECTION 2: COVERAGE GROUPS AND ASSISTANCE UNITS

To be eligible for MaineCare an individual must fall within a category. With the exception of individuals who qualify for Medicaid under a waiver or for the Medicare Savings Program, individuals must fall into one of the Categorically Needy/Medically Needy coverage groups. Each coverage group has specific eligibility criteria and individuals can meet the eligibility criteria of more than one coverage group at the same time.

Once the Department has determined that an individual meets the criteria of one or more coverage groups possible assistance units for each coverage group are identified.

Choosing a coverage group:

An assistance unit is an individual or group enrolled in or applying for MaineCare. The assistance unit also includes individuals who are not covered, or not applying for coverage, but whose income, assets, and/or needs are considered in determining eligibility.

Individuals are placed in the coverage group and assistance unit that is most beneficial to them. An individual can be included in more than one assistance unit at the same time to ensure that everyone who wants coverage gets coverage. When not everyone who wants coverage can be covered and a decision needs to be made as to which family members will be covered, the Department shall inform the individual of the coverage options and give them the opportunity to choose which coverage is preferred.

## SECTION 3: CITIZENSHIP AND IDENTITY

MaineCare and Cub Care applicants must declare their United States citizenship or qualifying noncitizen status and have their status verified to receive MaineCare benefits. An individual who is not a citizen of the United States may be eligible for full MaineCare benefits, or they may be eligible for emergency services only.

### Section 3.1 Verification of Citizenship and Identity

I. Unless exempted below in Paragraph II(A) through (F), all members of a household applying for Medicaid and Cub Care (CHIP) must verify citizenship and identity. The Department will attempt to verify citizenship or qualifying noncitizen status through electronic services before requiring verification from the applicant or member.

II. The requirement to verify U.S. citizenship and identity does not apply to:

A. Current recipients of Supplemental Security Income (SSI).

B. Current recipients of Social Security benefits, based on the individual’s disability.

C. Individuals entitled to or enrolled in Medicare.

D. Children who receive child welfare assistance under IV-B of the Social Security Act or foster care assistance under IV-E of the Social Security Act. This exemption is for the child only, not the family providing the care.

E. A newborn whose mother receives Medicaid at the time of birth.

F. Individuals while covered under Presumptive Eligibility.

G. Individuals whose citizenship or eligible noncitizen status has been verified by the Department and for whom no change in status has been reported to the Department.

III. Applicants and household members who declare United States citizenship or a qualifying noncitizen status, who are otherwise eligible and only pending for verification of citizenship or noncitizen status, will be granted a reasonable opportunity period of 90 days from the date of request for verification to provide documentation necessary to prove citizenship or qualifying noncitizen status. MaineCare or Cub Care coverage will be provided during the reasonable opportunity period, starting with the first day of the month of application.

A reasonable opportunity period is not provided if an individual does not declare U.S. citizenship or a qualifying noncitizen status.

The reasonable opportunity period is defined as follows:

A. It begins the date after the member receives notice informing them they need to provide documentation of citizenship or qualifying noncitizen status. The date the notice is received is 5 days after the date on the notice.

B. It ends on the earlier of the date the Department verified the individual’s citizenship or immigration status or at the end of the 90-day period if verification of citizenship or satisfactory noncitizen status was not obtained.

The Department may extend the reasonable opportunity period if the individual is making a good faith effort to obtain any necessary documentation, or if the Department needs more time to complete the verification process.

If the applicant does not provide documentation necessary to verify citizenship or qualifying noncitizen status of the applicant and household members within 90 days, benefits for unverified household members will end. A reasonable opportunity period will not be provided on subsequent applications submitted by or on behalf of the applicant or household members.

IV. Failure to declare or prove citizenship or qualifying noncitizen status may result in ineligibility for Medicaid or Cub Care. Emergency Services may be provided to an applicant who does not declare or is unable to prove declared qualifying noncitizen status within the reasonable opportunity period.

If an individual within a household is not eligible due to inability to prove citizenship, identity or noncitizen status, the individual will still be counted as part of the household and that person’s income and assets will be included in determining eligibility for the rest of the household.

### Section 3.2 Citizenship and Identity Requirements

I. A United States citizen is:

A. An individual born in the United States or its territories, including Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands, except those born to a foreign diplomat, and who otherwise qualifies for U.S. citizenship under §301 *et seq*. of the Immigration and Nationality Act; [8 U.S.C. §§ 1401-1409].

B. An individual born of a parent who is a U.S. citizen or who otherwise qualifies for U.S. citizenship under §301 *et seq*. of the Immigration and Nationality Act; [8 U.S.C. §§ 1401-1409].

C. A naturalized citizen.

D. A national (both citizen and noncitizen national):

1. Citizen National. A citizen national is an individual who otherwise qualifies as a U.S. citizen under §301 *et seq*. of the Immigration and Nationality Act. [8 U.S.C. §§ 1401-1409].

2. Noncitizen National. A noncitizen national is an individual who was born in one of the outlying possessions of the United States, including America Samoa and Swain’s Island, to a parent who is a noncitizen national.

II. Primary Verification of Citizenship and Identity

The following documents may be accepted as proof of both citizenship and identity because each contains a photograph of the individual named in the document, and the citizenship and identity of the individual have been established by either the U.S. or a state government. Primary verifications satisfy both citizenship and identity requirements:

A. U.S. passport, including U.S. passport card: a U.S. passport need not be currently valid to be accepted as evidence of U.S. citizenship, if it was originally issued without limitation. However, a passport that was issued with limitation and is not currently valid may be used as proof of identity only. U.S. passports issued after 1980 show only one person. However, spouses and children were sometimes included on one passport through 1980. The citizenship and identity of the included person can be established when one of these passports is presented.

B. Certificate of Naturalization (Department of Homeland Security form N-550 or N‑570);

C. Certificate of U.S. Citizenship (Department of Homeland Security form N-560 or N‑561); or

D. Tribal enrollment documents, evidencing membership or affiliation with a Federally recognized tribe.

III. Secondary Verifications of Citizenship

If primary verification from the list in Paragraph II of this section is unavailable, the person should provide satisfactory documentary verification from Paragraph VI of this section to establish identity, and satisfactory verification of citizenship from the list below:

A. 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, Swain’s Island, or the Northern Mariana Islands (after November 4, 1986 (NMI local time)). The birth record document may be issued by the state, commonwealth, territory, or local jurisdiction. It must have been recorded before the person was 5 years of age. (A delayed birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship. See section V, paragraph B.

B. If the document shows the individual was born in Puerto Rico, Guam, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on the dates listed for each of the Territories. The following will establish U.S. citizenship for collectively naturalized individuals:

1. Puerto Rico

a. evidence of birth in Puerto Rico and the person’s statement that they were residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941; or

b. evidence that the person was a Puerto Rican citizen and the person’s statement that they were residing in Puerto Rico on March 1, 2017 and that they did not take an oath of allegiance to Spain.

2. U.S. Virgin Islands

a. evidence of birth in the U.S. Virgin Islands, and the person’s statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or

b. the person’s statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 2017 and residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927, and that the person did not make a declaration to maintain Danish citizenship; or

c. evidence of birth in the U.S. Virgin Islands and the person’s statement indicating residence in the U.S., a U.S. possession, or Territory or the Canal Zone on June 28, 1932.

3. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands {TTPI}):

a. 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 person’s statement that they did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

b. evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the person’s statement that they did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

c. evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

d. 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 person is not a U.S. citizen.

C. A Certification of Report of Birth (DS-1350)

The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS‑240. The DS-1350 is not issued outside the U.S.

D. A Report of Birth Abroad of a U.S. Citizen (Form FS-240)

The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

E. A Certification of Birth Issued by the Department of State (Form FS-545 or DS‑1350)

Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.

F. A U.S. Citizen I.D. Card

This form was issued as Form I-197 until the 1980s by INS. INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

G. A Northern Mariana Identification Card (I-873)

The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

H. An American Indian Card (I-872) issued by the Department of Homeland Security (DHS) with the classification code “KIC”

DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code of “KIC” and a statement on the back denote U.S. citizenship.

I. A final adoption decree showing the child's name and U.S. place of birth

In situations where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

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

The document must show employment by the U.S. government before June 1, 1976. Individuals employed by the U.S. Civil Service prior to June 1, 1976 had to be U.S. citizens.

K. U.S. Military Record showing a U.S. place of birth

The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth.)

L. A verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database. Inclusion in this database could prove citizenship through naturalization.

M. Evidence of meeting the automatic criteria for U.S. Citizenship outlined in the *Child Citizenship Act of 2000*.

N. Evidence of meeting the automatic criteria for U.S. citizenship under the provisions of the INA in effect on the person’s birthdate or adoption date, if the person’s birthdate or adoption date was prior to the February 27, 2001 enactment date of the *Child Citizenship Act of 2000* (citizenship laws are not retroactive, so the law applicable at the time the person was born or adopted applies, even if that law was subsequently repealed and replaced by a new section).

IV. Third-Level Verification of Citizenship

If verification from the lists in Paragraphs II and III of this section is unavailable and the person claims a U.S. place of birth, the person should provide satisfactory verification from Paragraph VI of this section to establish identity, and satisfactory verification of citizenship from the list below:

A. Extract of a hospital record on hospital letterhead, indicating a U.S. place of birth. The hospital record must have been established at the time of the person’s birth and created five years before the initial application date for Medicaid or Cub Care (For children under age 16, the document must have been created near the time of birth or five years before the date of application). A souvenir “birth certificate” issued by a hospital does not satisfy this requirement.

B. Life, health, or other insurance record showing a U.S. place of birth. The record must have been created at least five years before the initial application date for Medicaid or Cub Care.

C. Religious record recorded in the U.S. within three months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. (Entries in a family bible are not considered religious records.)

D. Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of the admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of the birth of the applicant's parents.

V. Fourth-Level Verification of Citizenship

If verification from the lists in Paragraphs II, III, and IV of this section is unavailable and the person claims a U.S. place of birth, the person should provide verification from Paragraph VI of this section to establish identity, and satisfactory documentary evidence of citizenship from the list below:

A. Federal or State census record showing U.S. citizenship or a U.S. place of birth. The census record must also show the applicant’s age.

Census records from 1900 through 1950 contain certain citizenship information. To secure this information, complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion “U.S. citizenship data requested”. Also add that the purpose is for Medicaid and Cub Care eligibility.

B. One of the following documents that show a U.S. place of birth and was created at least five years before the application for Medicaid and Cub Care:

1. Seneca Indian tribal census record;

2. Bureau of Indian Affairs tribal census records of the Navajo Indians;

3. U.S. State Vital Statistics official notification of birth registration;

4. A delayed U.S. public birth record that is recorded more than five years after the person's birth;

5. Statement signed by the physician or midwife who was in attendance at the time of birth; or

6. Bureau of Indian Affairs Roll of Alaska Natives.

C. Institutional admission papers from a nursing facility, skilled care facility or other institution, showing a U.S. place of birth, created at least five years before the initial application.

D. Medical (clinic, doctor, or hospital) record showing a U.S. place of birth. The record must have been created at least five years before the initial application date for Medicaid or Cub Care. (For children under age 16, the document must have been created near the time of birth or five years before the date of application.)

An immunization record alone is not considered a medical record for purposes of establishing U.S. citizenship.

E. Written Affidavits of Citizenship

F. Declarations should only be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:

1. There must be at least two affidavits by two people who have personal knowledge of the event(s) establishing the individual’s claim of citizenship (the two affidavits could be combined in a joint declaration).

2. At least one of the people making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.

3. In order for the affidavits to be acceptable, the people making them must be able to provide proof of their own citizenship and identity.

4. If the people making the affidavits have information that explains why documentary evidence establishing the individual’s claim of citizenship does not exist or cannot be readily obtained, the declaration should contain this information as well.

5. The applicant or recipient or other knowledgeable person (guardian or representative) must also provide an affidavit explaining why the evidence does not exist or cannot be obtained.

6. The affidavits must be signed under penalty of perjury.

VI. Evidence of Identity

The following documents, even if expired, may be accepted as proof of identity and must be submitted when the person uses, as proof of citizenship, the documents listed in Paragraphs II through V of this section. (A separate document proving identity need not be submitted when the person submits primary evidence of citizenship and identity as outlined in Paragraph II of this section):

A. A driver’s license issued by a U.S. state or territory. The license must either have a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color.

B. School identification card. The card must have a photograph of the individual.

C. U.S. military card or draft record.

D. Identification card issued by the federal, state, or local government. The card must have the same information that is required for driver’s licenses.

E. Military dependent’s identification card.

F. Native American tribal document.

G. U.S. Coast Guard Merchant Mariner card.

H. Certificate of Degree of Indian Blood, or another U.S. American Indian/Alaska Native Tribal document. The document must have a photograph or other personal identifying information relating to the individual.

A voter’s registration card does not meet this requirement, as the Centers for Medicare and Medicaid Services (CMS) does not view this as a reliable form of identification.

I. In the absence of the documents described in Section 3.2(VI)(A) through (H) of this part, three or more corroborating documents such as marriage licenses, divorce decrees, high school and college diplomas from accredited institutions, including general education and high school equivalency diplomas, property deeds or titles, and employer ID cards can be used to verify the identity of an individual.

If the individual submitted fourth level verification of citizenship, Section 3.2(VI)(I) does not apply.

VII. Special Identity Rules for Children and Certain Individuals with Disabilities

An individual with a disability in a residential care or institutional facility may have their identity attested to by the facility director or administrator when the individual does not have or cannot get any document on the preceding lists. The affidavit is signed under the penalty of perjury but need not be notarized.

Children under age 16 may have their identity documented using one of the following if none of the documents in Paragraph VI are available:

A. School record including report card, daycare or nursery school record, verified by the Department with the issuing school.

B. Clinic, doctor or hospital record.

C. An affidavit of identity. An affidavit of identity is only acceptable if it is signed under penalty of perjury by a parent, guardian, or caretaker relative stating the date and place of the birth of the child and cannot be used if affidavits were used to establish citizenship.

Identity affidavits may be used for children under age 18 in limited circumstances, when the child is from an area where a school ID with picture is not provided or a driver’s license with a picture is not available.

VIII. Documentary Evidence

Electronic data matching is the primary method of verifying citizenship and identity. If citizenship cannot be verified electronically, the applicant must provide documentary evidence of their citizenship as listed in Paragraph II through VII of this section.

A. All documents must be either originals or copies certified by the issuing agency.

B. Copies of citizenship and identification documents shall be maintained in the case record or electronic data base.

C. Individuals may submit documentary evidence without appearing in person at an OFI office. Documents may be tendered in person, by mail, or by a guardian or authorized

representative. Originals or certified copies presented by the applicant or recipient will be returned.

D. Presentation of documentary evidence of citizenship is a one-time activity; once a person's citizenship is documented and recorded in a state database, subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person’s citizenship.

E. The requirement to provide documentary evidence is the responsibility of the applicant. If documentation is not presented at application, the individual will be given a reasonable opportunity to provide the documentation.

### Section 3.3 Documentation and Verification for Noncitizens

An individual who is not a citizen or national of the United States must present alien registration documentation, other proof of immigration registration from the U.S. Citizenship and Immigration Services (USCIS), or other documents indicating the individual's qualifying noncitizen status. If the individual declares a satisfactory noncitizen status and documentation is not presented at application, the individual will be given a reasonable opportunity to provide the documentation. See Part 2, Section 3.1(III). Following the reasonable opportunity period, Temporary MaineCare coverage, as described in Section 12.3 of this part, will not be provided if the applicant cannot provide satisfactory documentation of noncitizen status.

The Systematic Alien Verification for Entitlements Program (SAVE) is the USCIS operative system for verification of noncitizen status for individuals applying for MaineCare. The noncitizen status of applicants who declare a qualifying noncitizen status must be verified through SAVE. If electronic verification indicates that additional documentation is required to verify attested noncitizen status, the Department will request further information from the individual. If an applicant disputes the USCIS response, they may submit additional documentation. The Department will submit additional documentation received by the Department to SAVE to reattempt electronic verification of attested status.

### Section 3.4 MaineCare Coverage for Noncitizens

The *Personal Responsibility and Work Opportunity and Reconciliation Act of 1996* (PRWORA), P.L. 104-193, describes noncitizens as either qualified or non-qualified aliens. PRWORA further defines aliens who are eligible to receive either full benefit Medicaid or emergency services only, and qualified aliens who are subject to the five-year bar from Medicaid eligibility.

An individual must provide documentation from the United States Citizen and Immigration Services (USCIS) to prove their noncitizen status.

If an individual admits to being an undocumented noncitizen, this information will not be shared with USCIS. All information is held confidential in accordance with Part 1, Section 2.

I. Noncitizens Eligible for Full Benefits

Below is a listing of noncitizen groups who may be eligible for full benefits. See Section 3.4(II) of this part for a listing of noncitizen statuses that are only eligible for Emergency Services.

A. Veteran or Active Duty Personnel

1. Lawfully residing in U.S.; and

2. A veteran of the U.S. Armed Forces with an honorable discharge or on active duty (not training) in the U.S. Armed Forces; or

3. Lawfully residing in the U.S. and a spouse or unmarried child of the veteran described in Paragraph I(A)(1) and (2) of this section. “Unmarried child” means a child is or could be claimed as dependent on veteran’s tax return and meets MaineCare requirements for a dependent child.

B. Legal Permanent Resident

1. Legal permanent resident status (LPR) granted under Immigration and Nationality Act (INA).

i. EXCEPTION**:** Legal permanent residents are not eligible for full benefits if they have been in the U.S. less than five years. There is no five-year waiting period if any of the following conditions applies:

a. The individual’s date of entry to the U.S. is prior to August 22, 1996;

b. The individual is a child under the age of 21;

c. The individual is pregnant;

d. Prior to adjustment to legal resident status regardless of the LPR status-granted date, the noncitizen’s status was Refugee (C, below), Asylee (D, below), Person whose deportation was withheld (E, below), Amerasian immigrant (J, below) , or Cuban or Haitian entrant (K, below). This noncitizen is eligible as a Refugee, Asylee, Deportee, Amerasian immigrant, or Cuban / Haitian entrant (per Medicaid State Plan).

C. Refugee

1. Refugee status granted under §207 of the INA

D. Asylee

1. Asylee status granted under §208 of the INA

E. Deportation Withheld

1. Deportee status granted under §243(h) of the INA as in effect prior to April 1, 1997; or §241(b)(3) of the INA, as amended

F. Parolee

1. Parolee status granted for at least a year under §212(d)(5) of the INA.

i. EXCEPTION:Parolees are not eligible for full benefits if they have been in the U.S. less than five years. There is no five-year waiting period if any of the following conditions applies:

a. The individual’s date of entry to the U.S. is prior to August 22, 1996;

b. The individual is a child under the age of 21;

c. The individual is pregnant.

G. Conditional Entrant

1. Conditional entrant status granted under §203(a)(7) of the INA in effect before April 1, 1980

i. EXCEPTION:Conditional entrants are not eligible for full benefits if they have been in the U.S. less than five years. There is no five-year waiting period if any of the following conditions applies:

a. The individual’s date of entry to the U.S. is prior to August 22, 1996;

b. The individual is a child under the age of 21;

c The individual is pregnant.

H. Battered Noncitizen or Battered Noncitizen’s Minor Child

1. While lawfully residing in the U.S. the noncitizen or the minor child was battered or subjected to extreme cruelty by a spouse, a parent, or a member of the spouse’s or parent’s family residing in the same household as the noncitizen; and

2. batterer(s) no longer lives in same household, and

3. The noncitizen or the minor child meets the conditions set forth in §431(c) of PRWORA as amended (Section 431(c) of PRWORA, as amended, is codified at 8 USC 1641(c)).

i. EXCEPTION**:** Battered Noncitizens are not eligible for full benefits if they have been in the U.S. less than five years. There is no five-year waiting period if one of the following conditions applies:

a. The individual’s date of entry to the U.S. is prior to August 22, 1996;

b. The individual is a child under the age of 21;

c The individual is pregnant.

I. Trafficking Victim

1. Noncitizens certified as a trafficking victim (TV) under 107(b)(1) of the *TV Protection Act of 2000*, P.L. 106-386.

J. Amerasian

1. Admitted to the U.S. pursuant to §584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988

K. Cuban or Haitian Entrant

1. As defined in §501(e) of the *Refugee Education Assistance Act of 1980*

L. American Indian Born in Canada

1. The individual is at least one-half American Indian blood and provisions of §289 of the INA apply

M. Native American who is a Member of a Federally-Recognized Indian Tribe

1. Member of an Indian tribe under Section 4(e) of the *Indian Self-Determination and Education Assistance Act*

N. Iraqi Special Immigrant Eligibility Under Public Law 110-161 and 110-181, Section 1244

1. Has same status as refugee under 2009 Department of Defense Bill.

O. Afghani Special Immigrant Eligible Under Public Law 110-161

1. Has same status as refugee under 2009 Department of Defense Bill.

P. Compact of Free Association (COFA) Migrants

1. Effective December 27, 2020 individual citizens from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Q. Lawfully Residing Pregnant Women, and Children Under the Age of 21

1. Under the *Children’s Health Insurance Program Reauthorization Act of 2009*, Section 214, lawfully residing pregnant women and children under the age of 21 include:

i. A “Qualified alien” otherwise subject to the five-year waiting period per Section 403 of the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*;

ii. A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

iii. An individual described in 8 C.F.R. § 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:

a. An individual currently in temporary resident status as an Amnesty beneficiary pursuant to Section 210 or 245A of the *Immigration and Nationality Act* (INA);

b. An individual currently under protected Status pursuant to Section 244 of the INA;

c. A family Unity beneficiary pursuant to Section 301 of Public Law 101-649 as amended by, as well as pursuant to, Section 1504 of Public Law 106-554;

d. An individual currently under Deferred Enforced Departure pursuant to a decision made by the President; and

e. An individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

iv. An individual in non-immigrant classifications under the INA who is remaining in the U.S. for an indefinite period, including the following as specified in Section 101(a)(15) of the INA:

a. A parent or child of an individual with special immigrant status under Section 101(a)(27) of the INA, as permitted under Section 101(a)(15)(N) of the INA;

b. A Fiancé of a citizen, as permitted under Section 101(a)(15)(K) of the INA;

c. A religious worker under Section 101(a)(15)(R);

d. An individual assisting the Department of Justice in a criminal investigation, as permitted under Section 101(a)(15)(S) of the INA;

e. A battered alien under Section 101(a)(15)(U) (see also Section 431 as amended by PRWORA); and

f. An individual with a petition pending for 3 years or more, as permitted under Section 101(a)(15)(V) of the INA.

II. Noncitizens Eligible for Emergency Services

A noncitizen who does not declare a qualified noncitizen status from Paragraph I of this section, or has no USCIS documents regarding their noncitizen status, or who is an ineligible noncitizen as defined in Subparagraph B below, or who is a qualified alien subject to the five-year waiting period for full Medicaid can get Medicaid or Cub Care (CHIP) Emergency Services only. Individuals must still meet financial requirements and be in a coverable group. These individuals must meet all basic eligibility requirements (including Maine residency) except for citizenship or noncitizen status and providing a Social Security number. If these individuals intend to remain in Maine at the time of application, they will be considered Maine residents.

MaineCare Emergency Services coverage is only available for the noncitizen groups listed below:

A. Undocumented Noncitizen

1. Non-qualified noncitizens who do not have USCIS documentation of their citizenship status.

1. EXCEPTION: Individuals under the age of 21 described in Part 3, Section 2.1(V) and pregnant individuals described in Part 3, Section 2.3 (III) may be eligible for full MaineCare benefits.

B. Ineligible Noncitizen

1. Non-qualified noncitizens legally admitted on a temporary basis or for a specific time period. The following are examples of individuals who are ineligible noncitizens:

Except for (x) below, these noncitizens should have one of the following types of INS documents: Form I-94, Arrival-Departure Record; Form I-185, Canadian Border Crossing Card; Form I-186, Mexican Border Crossing Card; Form SW-434, Mexican Border Visitor's Permit; Form I-95A, Crewman's Landing Permit; or Form I-184, Crewman's Landing Permit and Identification Card.

i. Foreign government representatives on official business and their families and employees;

ii. Visitors for business or pleasure, including exchange visitors;

iii. Aliens in travel status while traveling directly through the United States;

iv. Crewmen on shore leave;

v. Treaty traders and investors and their families;

vi. Foreign students;

vii. International organization personnel and their families and servants;

viii. Temporary workers, including agricultural contract workers;

ix. Members of foreign press, radio, film or other information media and their families

x. Parolee in the U.S. under Section 212(d)(5) for less than one year

2. EXCEPTION: Some ineligible noncitizens may be included for full coverage under CHIPRA 2009, Section 214. Lawfully residing pregnant individuals and children under age 21 may be eligible for full benefits—refer to Paragraph I(Q) of this section, “Noncitizens Eligible for Full Benefits.” The term “lawfully residing” includes nonqualified noncitizens who are in the U.S. lawfully.

C. Qualified Alien Subject to the Five-Year Waiting Period

1. Qualified aliens who enter the United States on or after August 22, 1996 are subject to a five-year waiting period for full Medicaid unless they are specifically exempt from this waiting period or otherwise included in the State Medicaid Plan.

2. As indicated in Section 3.4 (I), the following qualified aliens are not subject to the five-year waiting period:

i. Qualified Aliens who came to the United States before August 22, 1996

ii. Legal Permanent Residents whose prior qualified alien status was Refugee, Asylee, Person whose deportation was withheld, Amerasian immigrant, Haitian entrant, or Cuban entrant.

iii. Pregnant individuals

iv. Children under the age of 21

v. The following Qualified Aliens:

a. Veteran or Active Duty Personnel

b. Refugee

c. Asylee

d. Deportation Withheld

e. Trafficking Victims

f. Amerasians

g. Cuban and Haitian Entrants

h. American Indian born in Canada

i. Native Americans who are members of Federally-recognized Indian Tribes

j. Iraqi Special Immigrants

k. Afghani Special Immigrants

3. Immigrants who entered the United States prior to August 22, 1996 and did not remain “continuously present” in the U.S. until becoming a qualified alien on or after that date are also subject to the five-year waiting period. Any single absence of more than 30 consecutive days or a combined total absence of 90 days before obtaining qualified alien status interrupts “continuous presence.”

4. The five-year waiting period begins on the date the immigrant obtains qualified alien status. Once the five-year waiting period expires, the qualified alien is eligible for full Medicaid benefits.

## SECTION 4: RESIDENCY

Each individual must be a resident of Maine. A resident is an individual living in the State of Maine with the intent to remain indefinitely.

An individual who is in Maine temporarily (e.g., visitor, tourist, or student) is not a resident. The individual should apply to their actual state of residence for Medicaid.

If the individual is living in Maine and has entered the State with a job commitment or seeking a job (even if only a temporary job, e.g., migrant workers), the individual is a Maine resident.

When two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence for Medicaid purposes.

Eligibility cannot be denied or terminated because:

I. An individual has not resided in the State for a specified period;

II. The individual did not establish residence before entering a medical institution; or

III. An individual is temporarily or involuntarily absent from the State, provided the individual intends to return once the purpose of the absence has been accomplished, unless another state has determined the individual is a resident there.

IV. An individual does not have a fixed address (e.g., individual is homeless).

Eligible individuals who move out of Maine, intend to remain out of state, and are applying for Medicaid in that state, remain eligible until the other state determines eligibility.

### Section 4.1: Children

For purposes of residency a child is any individual under the age of 21. A dependent child is a resident of the state where the parent/caretaker relative resides. An independent child is a resident of the state where they reside with an intent to remain indefinitely.

An individual under age 21 who is a full-time student in the State of Maine will not be considered a resident of Maine if each of the following conditions exist:

I. Neither of the individual's parents reside in the State of Maine;

II. The individual is claimed as a tax dependent by someone who resides in a state other than Maine; and

III. The individual is applying for coverage on their own behalf.

### Section 4.2: Title IV-E of the Social Security Act

In any situation where a child is eligible for a Title IV-E payment (including the Federal Adoption Assistance Program) from another state, Medicaid determines the state in which the child is physically living as the state of residency (See Part 3, Section 3.). Children who are receiving services under the Interstate Compact for the Placement of Children (ICPC) and who are not receiving Title IV-E payments from another state are not considered residents of the State of Maine.

### Section 4.3: Residents of Medical Institutions

I. If a state arranges for an individual to be placed in an institution located in another state, the state making the placement is the individual's state of residence, regardless of the individual's indicated intent or ability to indicate intent.

II. For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is that of the individual's parents, or legal guardian. If the parents reside in separate states and there is no appointed legal guardian, the state of residence is that of the parent applying for Medicaid on the individual's behalf.

III. For an institutionalized individual who became incapable of indicating intent on or after age 21, the state of residence is the state in which the individual was living when the individual became incapable of indicating intent.

IV. The state where the institution is located is the individual's state of residence unless that state determines that the individual is a resident of another state by applying the rules under Paragraph I or II of this section.

V. For any other institutionalized individual, age 21 or over, the state of residence is the state where the individual is living with the intention to remain for an indefinite period of time.

### Section 4.4: SSI and State Supplement Recipients

An individual who is receiving SSI or State Supplemental payments is considered a resident of the state making the payment.

**Section 4.5: Ability to Indicate Intent**

An individual is considered incapable of indicating intent if:

I. The individual has an I.Q. of 49 or less, or has a mental age of seven or less based on tests acceptable to the Office of Aging and Disability Services (OADS);

II. The individual has been judged legally incompetent; or

III. Medical or other acceptable documentation supports a finding that the individual is incapable of indicating intent.

## SECTION 5: SOCIAL SECURITY NUMBERS

All individuals applying for Medicaid coverage are required to have a Social Security number or proof of having applied for one, except:

I. Undocumented noncitizens;

II. Individuals with a religious exemption; or

III. A child who is born to a mother covered by Medicaid at the time of their birth. By the time the child turns one a Social Security number or proof of having applied for one, must be provided.

All individuals applying for Medicaid coverage are asked to provide their Social Security number at the time of application.

Except as noted in Paragraphs I-III of this section, an applicant seeking benefits is required to furnish the Department with a Social Security number. If the applicant has a Social Security number but is unable to provide it, the Department must contact the Social Security Administration to obtain the number.

The applicant is required to apply to the Social Security Administration for a Social Security number if they do not have one. The Department must assist the individual in obtaining verification necessary to apply for a Social Security number. This includes obtaining documents to prove date of birth, citizenship, or identity if these materials cannot be provided by the individual. The Department cannot pay any costs incurred in obtaining this information. The applicant or recipient must provide the Department with verification that the application for a Social Security number has been made. The Social Security number will be provided by the Social Security Administration.

For a child born to a mother not covered by Medicaid at the time of the child’s birth, the Social Security number requirement must be met by the first day of the second month following the month in which the child's mother is discharged from the hospital.

**Examples**

1. A child is born on July 3. Mother leaves the hospital on July 6. Application for a Social Security number for the child must be completed by September 1.

2. A child is born on July 31. Mother leaves the hospital on August 2. Application for a Social Security number for the child must be completed by October 1.

MaineCare will not be withheld or terminated for lack of a Social Security number if an individual provides verification of application for a Social Security number for those requesting assistance. MaineCare will not be withheld or terminated while verification of the individual's Social Security number is being obtained from the Social Security Administration.

### Section 5.1: Social Security Non-Compliance and Sanctions

For any individual who fails to provide, or apply, for a Social Security number as required, Medicaid and/or Cub Care must be denied or terminated.

When the Social Security number requirements for a dependent child are not met, the parent/caretaker relative as well as the child must be denied or terminated for Medicaid and/or Cub Care.

I. When an individual is not eligible for MaineCare due to non-compliance, the individual is counted in the assistance unit and the individual’s income and assets (when applicable) are used to determine eligibility for other members within the assistance unit.

II. SSI-Related only - When a stepparent must be sanctioned for non-compliance, the stepparent’s income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Levels.

III. SSI-Related only - When a caretaker relative other than a parent or stepparent must be sanctioned for non-compliance, the caretaker relative’s income and assets are considered in the same manner as a sanctioned parent’s income and assets would be considered. However, such a sanctioned caretaker relative may choose to be excluded from the assistance unit.

An individual may request good cause for not providing a Social Security number. See Section 8 of this Part for specific information regarding good cause.

### Section 5.2: Retroactive Coverage

If otherwise eligible, retroactive coverage will be granted if the Social Security number requirements are met during the application process. If the Social Security number requirements are not met, but at a later date the individual cooperates with these requirements, the retroactive coverage cannot be granted.

**Examples**

1. A parent refuses to apply for a Social Security number for a child. The parent and the child are denied coverage. One month later, the parent agrees to comply. The parent and child are eligible, effective the first day of the month in which the application for a Social Security number is made. Retroactive coverage cannot be granted.

2. A parent refuses to apply for a Social Security number. Coverage for the parent only must be denied. A year later, the person reapplies and gives a Social Security number proving application for the number was made six months previously. Eligibility may be authorized with up to three months' retroactive coverage because the applicant complied with the Social Security number requirements prior to the retroactive period.

Individuals must be informed that the Social Security number will be used to administer the MaineCare benefit, including eligibility decisions, and will be used for verification of information such as wages, unemployment benefits and bank accounts.

## SECTION 6: ASSIGNMENT OF RIGHTS TO MEDICAL PAYMENTS

Certain individuals must assign their rights to payment for medical care from any third party to the Department of Health and Human Services and cooperate in obtaining these medical payments. This is done by a referral to the Third-Party Liability (TPL) Unit.

### Section 6.1: Who Must Comply

I. Parents or caretaker relatives applying on behalf of themselves and their children;

II. Individuals age 18 or over who are applying on their own behalf; and

III. Individuals under age 18 who are applying on their own behalf who are married or in the military.

This provision does not apply to individuals who are pregnant, or those receiving only the Medicare Savings Program or one of the State funded benefits listed in Section 1of this part.

### Section 6.2: Third-Party Liability Requirements

I. Assign rights to payment for medical care;

II. Cooperate with the TPL Unit in obtaining medical payments; or

III. Relinquish medical payments received directly from a third-party resource that were intended to cover services paid by Medicaid.

IV. Items for prospective, current, and retroactive periods that must be reported include:

A. Any court ordered responsibility to pay medical bills by a parent, unless it can be demonstrated that contact with the parent by the TPL Unit or Division of Support Enforcement and Recovery (DSER) could cause harm;

B. Medical insurance (except Medicare) covering the applicant or recipient. This includes private medical group insurance, TRICARE (formerly CHAMPUS), and supplemental policies such as companion plans from Blue Cross/Blue Shield, major medical, and indemnity insurance. Reporting is required whether the cost of premiums is paid by the individual, employer, or another party;

C. The portion of Worker's Compensation benefits for medical services for which the recipient is applying, receiving, or which terminated during the retroactive eligibility period; and

D. Information regarding settled or pending lawsuits involving personal injury.

### Section 6.3: Noncompliance

I. Individuals who fail to comply with assignment of rights to medical payments are not eligible for Medicaid. In cases where Medicaid is open at the time of the failure to comply, Medicaid will be closed. When parents or caretaker relatives are applying on behalf of themselves and their children, the parent or other caretaker relative applying on behalf of the child under age 18 is not eligible. The child remains eligible.

II. When an individual is not eligible for Medicaid due to non-compliance, the individual is counted in the assistance unit size and the individual’s income and assets (when applicable) are used to determine eligibility for the assistance unit.

III. SSI-Related Only – When a stepparent must be sanctioned, the stepparent’s income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Level.

IV. SSI-Related Only – When a caretaker relative other than a parent or stepparent must be sanctioned, the specified relative’s income and assets are considered in the same manner as a sanctioned parent’s income and assets are considered. However, such sanctioned caretaker relative may choose to be excluded from the unit.

An individual may request good cause for non-compliance with TPL. See Section 8 of this part for specific information regarding good cause.

## SECTION 7: COOPERATION IN OBTAINING MEDICAL SUPPORT FROM THE NON‑CUSTODIAL PARENT AND ESTABLISHING PATERNITY

### Section 7.1: Who Must Comply

Certain individuals must cooperate in obtaining medical benefits from the non-custodial parent of a dependent child (See Part 3) and in establishing paternity. If the individual can show that good cause for not cooperating exists, no referral will be made.

These individuals are parents or caretaker relatives applying on behalf of themselves and their children unless the assistance unit is being covered under Transitional Medicaid.

This provision does not apply to individuals who are pregnant, individuals covered under Transitional Medicaid, individuals enrolled only in the Medicare Savings Program, Maine Rx, DEL, or HIPO. An individual who does not comply with this requirement is not eligible for Medicaid. It is the parent or other specified relative applying on behalf of the child under age 18 who is not eligible, not the child.

### Section 7.2: Child Support Requirements

I. Identify and help locate those parents of a dependent child for whom Medicaid is requested.

II. Cooperation includes responding to requests for information from DSER and appearing as a witness at a judicial or other hearing or proceeding.

### Section 7.3: Noncompliance

I. If an individual who is required to do so fails to comply with these provisions, Medicaid is denied or terminated.

II. When an individual is not eligible for Medicaid because they do not cooperate with DSER the individual is counted in the assistance unit and the individual’s income and assets (when applicable) are used to determine eligibility for the assistance unit.

III. SSI-Related Only - When a stepparent must be sanctioned, the stepparent’s income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Level.

IV. SSI-Related Only - When a specified relative other than a parent or stepparent must be sanctioned, the specified relative’s income and assets (when applicable) are considered in the same manner as a sanctioned parent’s income and assets are considered. However, such a sanctioned caretaker relative may choose to be excluded from the assistance unit.

An individual may request good cause (See Section 8 of this part) for noncompliance with obtaining medical support and establishing paternity.

## SECTION 8: GOOD CAUSE

I. Applicant/Participant Rights

A. Every Medicaid or Cub Care applicant or recipient may claim good cause for refusing to cooperate with TPL, medical support, or cooperating with the Department’s establishment of medical support from the non-custodial parent. When the individual claims good cause, sanctions are not implemented unless it is finally determined that good cause does not exist.

B. Applicants receive an explanation of cooperation requirements, sanctions, and the right to claim good cause. The Department may attempt to establish paternity and collect medical support in cases where there is no risk to the individual or children.

C. If good cause is not granted, the individual is given the opportunity to withdraw from the benefit or provide additional information to substantiate the claim. If good cause is granted, no referral is made.

II. Acceptable Reasons for Good Cause

Good cause for not cooperating with TPL, medical support, or establishment of medical support from the non-custodial parent may be claimed by the individual if the individual can demonstrate that—

A. cooperation may reasonably be anticipated to result in physical or emotional harm to the child or physical or emotional harm to the caretaker relative which would hinder the ability to care for the child,

B. legal proceedings for adoption of the child are pending before a court or the individual has been working with a social agency to decide whether to relinquish the child for adoption, or

C. the child was conceived as the result of rape or incest.

III. Verification of Good Cause

Documents from court records, law enforcement agencies, medical sources, social service agencies and any other legal document may be used to substantiate rape, adoption and physical or emotional harm to the child or caretaker relative. If such documents are unavailable, information may be secured from other sources familiar with the claims of the individual. The Department should assist the individual in obtaining the required evidence, but no contact with collateral sources will be made without the individual’s knowledge and consent.

If the individual thinks that attempts to establish paternity or collect support would pose a risk to the individual or children, the individual must provide evidence to substantiate the claim of good cause not to cooperate.

The Department may make contact with the absent parent or putative father only if it is essential to the claim for good cause. The Department shall not make contact until the applicant or recipient has the opportunity to—

A. present additional evidence or information which makes contact with the absent parent or putative father unnecessary;

B. withdraw the application for assistance, or have the case closed; and

C. have the good cause claim denied.

IV. Good Cause Determinations

A. The Department determines whether an applicant’s request for good cause is approved or denied. This decision, and the reason for the decision, are documented by the Department and provided to the individual in writing.

B. If good cause is not granted and the individual continues to refuse to cooperate, sanctions are applied to the individual, and the TPL unit and DSER proceed to establish medical support from the non-custodial parent without the individual’s cooperation.

## SECTION 9: INDIVIDUALS RESIDING IN PUBLIC INSTITUTIONS

I. Medicaid coverage is authorized for inmates of state prisons, Mountain View Correctional Facility, Long Creek Youth Development Center, and local or county jails, if the individual meets financial and non-financial criteria applicable to non-inmates. Medicaid will only pay for any coverable in-patient service provided to the inmate while they are an in-patient in a hospital, nursing home, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or juvenile psychiatric facility.

II. Individuals admitted to a medical institution classified as an IMD (Institution for Mental Disease) for over 30 days. Examples of Institutions for Mental Disease are Spring Harbor, Acadia, Riverview Psychiatric Center, and the Dorothea Dix Psychiatric Center. The following applies:

A. If over age 20 and under age 65, these individuals are not Medicaid eligible until they are released, conditionally or unconditionally, or are on convalescent leave from the facility. Individuals may apply prior to discharge.

B. If under age 21 (through age 20) or age 65 or over, coverage is available for all Medicaid coverable services.

## SECTION 10: APPLICATION FOR OTHER BENEFITS

Individuals must apply for other benefits to which they may be entitled. This includes applying for the benefit and providing the Department with necessary information to determine eligibility.

I. Other benefits include, but are not limited to, Social Security, Railroad Retirement, Veteran's Pension/ Compensation, Worker's Compensation, and Unemployment Insurance. This provision does not apply to SSI, State Supplement, TANF cash benefits and other Federal, State, local or private programs which make payments based on need.

II. Individuals who apply for Medicaid and DEL and who are eligible for Medicare Parts A, B and/or D must be enrolled in or apply for these programs and a Medicare Part D Prescription Drug Plan at the next available opportunity to do so.

III. Individuals who are enrolled in Medicaid and DEL and subsequently become eligible for Medicare Parts A, B and/or D must be enrolled in or apply for these programs and a Medicare Part D Prescription Drug Plan at the next available opportunity to do so.

IV. There is good cause for not enrolling in Medicare and/or Medicare Part D Prescription Drug Plan if:

A. The individual is not eligible for Medicaid and DEL to pay any premiums and cost sharing for Medicare Parts A and/or B as described in Part 8.

B. The individual is denied enrollment by Medicare or by a Medicare Prescription Drug Plan due to circumstances beyond their control,

C. The individual has prescription drug coverage which is determined by the insurer to be creditable coverage. Creditable coverage means that the coverage on the average is at least as good as the standard Medicare Prescription drug plan. or

D. Enrollment is not cost effective as determined by the Pharmacy Benefits Manager.

V. The Department will not require an individual:

A. To file for other benefits when applying for them would result in no additional benefit which affects the individual's eligibility.

B. To pursue a claim for other program benefits through the appeals process.

C. Who is not applying for or covered by Medicaid to pursue a claim for other program benefits, for example, an ineligible spouse, parent or child.

## SECTION 11: APPLICATION PROCESS

I. An application is a signed request for MaineCare coverage made through one of the following methods:

A. a document approved by OFI as an application form;

B. the My Maine Connection website;

C. the Federally Facilitated Marketplace (FFM) (https://www.healthcare.gov/);

D. The State Based Marketplace (SBM) ([https://CoverME.gov](https://coverme.gov/)); or

E. the telephone or fax machine

II. The individual or someone acting on the individual’s behalf may sign the application form. The applicant may choose anyone to help in completing the form.

III. The date of application is the date the signed application form is received in any OFI office, the FFM, or the SBM. For presumptive eligibility, the date the form is signed and dated by both the applicant and the designated person at specified provider sites is considered the date of application (See Part 9 Section 4(2)(C) and Part 18, Section 4).

IV. All signed applications are acknowledged in writing. A written decision of eligibility is sent to the applicant.

V. A denied application is valid for the month of application and the following month. If new or required information is received to re-evaluate eligibility before the last day of the month following the application month, a new application is not required.

VI. All applicants or re-applicants for MaineCare are given information in writing, or verbally if appropriate, about the following:

A. services covered under MaineCare,

B. conditions of eligibility,

C. the individual's rights, including the right to an Administrative Hearing,

D. responsibilities of recipients, including reporting changes within ten days (See Section 12.2 of this Part), and

E. the 45-day application processing standard (See Section 12.3.1 of this Part).

### Section 11.1: Subsequent requests for eligibility

An individual does not need to complete a new application form if:

I. open MaineCare and requesting eligibility for new members orally or in writing. The application date for the new member is the date the request is made. Additional information may still be needed to determine eligibility.

II. open under one MaineCare program (for example Medicaid) and requesting coverage under another MaineCare program (for example Buy-in). In this situation the application date is the date that the request is made, either orally or in writing. Additional information may still be needed to determine eligibility.

III. open MaineCare and now requesting coverage in a facility or Home and Community Based Waiver services. Additional information may still be needed to determine eligibility.

IV. SSI recipients moving to a residential care facility where SSI benefits continue. Additional information may still be needed to determine eligibility.

SSI Individuals who move to a nursing facility need to complete an application. Community coverage is to be kept open while determining eligibility in the facility.

A reapplication is any signed application form received after the notice period (See Section 15 of this Part). This includes review forms returned after that period.

**Section 11.2: Recipients of SSI or State Supplement**

Individuals and couples who are aged, blind, or have disabilities, who are recipients of SSI or State Supplement are automatically covered as Categorically Needy unless they refuse to assign their rights to payments for medical care. A separate application for Medicaid (including coverage for any Home and Community Based Waiver program) is not needed for these groups.

## SECTION 12: CLIENT AND DEPARTMENT RESPONSIBILITIES

### Section 12.1: Verification of Eligibility Factors

The individual or the individual's authorized representative is responsible for verifying information for all persons in the household whose circumstances affect the eligibility determination. If this information is not provided and cannot be verified electronically by the Department, or electronic verification is inconsistent with the individual’s attestation, the Department will notify the individual or the authorized representative what items require resolution. If, following this notice, verifications are not received, the Department is not able to determine eligibility and a denial or closure notice will be issued. It is the responsibility of the Department to assist the individual in establishing eligibility for MaineCare.

Verification of information needed to determine eligibility must be requested initially from the individual. If information is requested from other sources (with the exception of public records) the individual must be informed. If collateral contacts are necessary to determine eligibility and the individual does not give consent, denial or closure must occur because the Department is unable to determine eligibility.

### Section 12.2: Reporting Responsibilities

It is the responsibility of the individual to report changes of income, assets, household composition and any other change in circumstances which affect eligibility for MaineCare. Such change is to be reported within ten days from occurrence. For income purposes, "occurrence" will be considered the date the increased income was received. For all other purposes, "occurrence" will be considered the date the change took place. Applicants and recipients are informed of reporting responsibilities in the notice of eligibility.

Eligibility will be recalculated within 30 days of the receipt of new information which may affect the level of MaineCare coverage or cause ineligibility.

### Section 12.3: Temporary Coverage

Temporary Coverage is medical coverage that is authorized because an application has not been processed, by no fault of the applicant or their representative, and an eligibility decision has not been issued, within forty-five days of the application date. As described in Section 3.3 of this part, Temporary Coverage will not be granted following the 90-day reasonable opportunity period.

**Section 12.3.1: 45-Day Processing Standard**

The applicant must be sent a notice of eligibility no later than 45 days after the date of application. The 45-day processing standard is the result of the settlement of a court case, *Polk, et al. v. Longley*. The consent decree stated that all applications must be acted upon and a decision made as quickly as possible.

I. Temporary Coverage is authorized when:

A. a decision is not made within 45 days. The Department must authorize temporary coverage. This provides medical coverage from day 46 until a final decision is made on the application.

B. it is necessary to obtain medical reports from physicians, hospitals, or other medical sources and such medical information is not requested from all necessary sources within five days after the date of application. If the reports are not received within 15 days of the first request, a second request must be sent. The applicant is to be notified whenever a second request is made to inform the individual that the necessary medical reports have not been received.

II. Temporary Coverage is not authorized if there is documentation that the applicant or the applicant's source of medical information has not cooperated in obtaining information necessary to make a decision.

Documented non-cooperation by the applicant or the source of the applicant's medical information means that the case record must contain sufficient information to show that the applicant or the source of the applicant's medical information was requested to provide specific information or verification, or carry out particular activities necessary to establish eligibility and that the applicant or medical source failed or delayed in doing so within a reasonable period of time.

**Section 12.3.2: Ten Day Processing Standard for Deductibles**

The consent decree filed as a result of *Polk, et al. v. Longley* also mandates that the Department issue a medical card no later than ten days after the applicant furnishes adequate information about incurred medical expenses in order to meet the deductible. See Part 10, Section 6 for information about verification of medical costs.

If the person is not issued a medical card within ten days of submitting the information, temporary coverage is issued, effective on the 11th day unless there is documentation that the individual is not cooperating.

**Section 12.3.3: Ending Temporary Coverage**

If the individual is found to be eligible, Medicaid coverage will go back to the first month of eligibility. This could be a retroactive month, the month of application or the first day of eligibility.

If the applicant is found ineligible after temporary coverage has been issued, the applicant is sent a notice of denial. There is no advance notice of adverse action (See Section 15 of this Part). The applicant becomes ineligible upon the receipt of the denial notice (five days from the day the notice is mailed).

In no instance may the dates of temporary coverage be eliminated. The individual may request a hearing regarding the denial, but temporary coverage will not continue pending the hearing decision. If the decision of the Hearing Officer is to remand the case back to the regional office for a new decision, temporary coverage is reinstated back to the date that the coverage stopped.

No payment for medical services provided to the individual during the period when the applicant was eligible for temporary coverage is recoverable from the applicant.

## SECTION 13: ELIGIBILITY PERIODS/REVIEWS

An individual's eligibility period is based on the month the application is received. Eligibility for the prospective period is determined for 12 months for all MaineCare programs except for Medically Needy and Maine Rx Plus. Eligibility for Medically Needy is determined for a six-month period. Eligibility for Maine Rx Plus is determined for a 24-month period.

The eligibility period begins on the first day of the application month unless temporary coverage is being given. (See "45-Day Processing Standard", Section 12.3.1 of this Part). In some instances, the individual is not eligible for coverage during the month of application but is eligible for the following month. In this situation, the length of the eligibility period remains the same (6, 12 or 24 months), depending on the type of coverage.

A review is a re-determination of eligibility. Reviews may be completed online through the My Maine Connection website or by using the review form provided by OFI. If the recipient is determined no longer eligible a timely and adequate notice of the adverse action must be sent (See Section 15 of this Part). Recipients are provided at least 30 days from the date of the renewal form to respond and provide any necessary information to determine ongoing eligibility. If the completed review form is not received by the Department by the end of the month in which it is due coverage will end.

If the completed review form and/or required verifications are submitted within 90 days after the date of termination, a new application for MaineCare coverage will not be required. If found eligible, the individual’s coverage will be reinstated back to the date of termination.

### Section 13.1: Changes within the Eligibility Period

Changes reported by recipients during the eligibility period must be reviewed to determine the effect of the change on the individual’s eligibility.

If the new information results in a change in the level of coverage, timely and adequate notice of the change of level or termination of benefits must be provided (See Section 15 of this Part.).

Certain categorically eligible individuals have a continuous period of eligibility even if changes occur. These groups are:

I. **Newborns**

If the newborn’s mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible regardless of the income of the assistance unit. The mother must be fully covered by Medicaid on the day of the baby’s birth. If mother meets the deductible amount on the day of the baby's birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

Coverage continues for one year without regard to changes in income or other household changes. Coverage under this category ends effective the last day of the month in which the child reaches age one.

II. **Children Under Age 19**

Any categorically eligible child is continuously eligible for full benefits for 12 months after eligibility is determined by application or review without regard to changes in income or composition of the assistance unit. This provision includes a child on newborn coverage as well as children found eligible for an SSI-Related coverage group even if the SSI or State Supplemental benefits or disability determination end prior to the next MaineCare review. It does not apply to those enrolled in Katie Beckett or those receiving coverage under Transitional MaineCare. The 12-month period begins with the month of application or review. Eligibility within the 12-month period will end:

A. at the end of the month the child turns 19;

B. if the child ceases to be a state resident; or

C. if mail addressed to the child or child’s household is returned as undeliverable.

III. **Pregnant Individual**

Effective August 1, 2022, pregnant individuals who are found eligible for MaineCare under Part 3, Section 2.3(I) are continuously eligible for 12 months beyond the date the pregnancy ends.

### Section 13.2: Medically Needy Eligibility Periods

Medically Needy recipients have a six-month eligibility period. Most must meet a deductible to gain eligibility. The only time the six-month deductible period is shortened is in situations when:

I. The individual, age 20, will turn 21 in less than six months;

II. The individual dies;

III. The individual becomes eligible for categorical coverage including coverage in nursing care status; or

IV. The individual voluntarily withdraws from the program. If the individual voluntarily withdraws and reapplies, new deductible periods (both retroactive and prospective) are established based on the new application. Some months of the retroactive coverage period from the first application may not be included in the new retroactive period which is established with the reapplication.

Medically Needy coverage begins on the day of the month that the deductible is met. The individual may have some responsibility for bills for medical services incurred on that day. If there is no deductible or the deductible is met with uncovered medical expenses, coverage begins on the first day of the month of eligibility.

Once the date of eligibility is established, unless there is a change in income which changes the deductible amount, or the individual becomes ineligible for Medicaid, coverage continues to the end of the deductible period. These individuals are entitled to review and timely and adequate notice as described in Section 13 of this part.

Although individuals who are eligible for Medically Needy coverage are in a deductible for six months, if their income is stable and is between the Categorically Needy income levels and the Protected Income Level (PIL) – (See Chart 5), a complete review is necessary once every 12 months rather than once every six months.

### Section 13.3: Changes within the Medically Needy Eligibility Period

Changes that impact eligibility are required to be reported and can result in a change in coverage or deductible amount. The Department shall review reported changes to determine the effect on the amount of the deductible or coverage. If the deductible amount or coverage changes, the recipient is provided timely and adequate notice of the change. (See Section 15 of this Part.)

### Section 13.4: Retroactive Period

An applicant for Medicaid may receive retroactive coverage of up to three months prior to the application month. The exception to this rule is when the individual is only eligible for the Qualified Medicare Beneficiary (QMB) Buy-In group for the retroactive period.

I. Eligibility for retroactive coverage must be determined separately from prospective coverage. It is possible for an individual to be covered as Medically Needy during the retroactive period and Categorically Needy prospectively or vice versa.

II. The individual must meet basic eligibility requirements for any month during which coverage is received. For example, a person who turned age 65 in the month of application cannot be covered retroactively under an SSI – Related category unless SSI-Related disability criteria are met during the retroactive period. The individual does not have to be eligible in the month of application to be eligible for retroactive coverage.

The entire three-month period may be covered if the individual is eligible for all three months. Medicaid will not cover the third month prior to the application month without including the first and second months unless the individual is ineligible due to basic eligibility requirements or excess assets during the intervening months.

**Examples**

1. The individual applies in August and has medical expenses incurred in May. There are no medical expenses for June or July. The individual has a deductible of $300 per month. To

cover the expenses incurred in May, the deductible is $900 for three months, not $300 for one month. June and July could be covered with a deductible of $600, or only July could be covered with a deductible of $300. Coverage must be continuously retroactive from the application month.

2. The individual applies in March and incurred medical expenses in December, January and February. They met basic eligibility and asset requirements for December and February, but not January. Expenses incurred in the month of January cannot be covered by Medicaid as the individual was not eligible. The person's deductible for December and February are added together. Expenses incurred in January for which the individual is still responsible can be used as non-covered items toward meeting the deductible. (See Part 10.)

The individual who has a deductible period may withdraw from the program and reapply for retroactive coverage. If an individual voluntarily withdraws, a new prospective period begins with the month of the new application and retroactive eligibility can be determined for up to three months prior to the month of the new application. In determining eligibility for the retroactive period, income received during that period is used.

Individuals who are determined to be eligible for SSI benefits and who indicate on their SSI application that they have medical expenses for the three months prior to their application for SSI do not need to make a separate application for retroactive Medicaid coverage.

If the individual meets the non-financial criteria and the Department has enough information in the case record about the individual's financial situation to determine eligibility for the retroactive period, the individual will be sent a notice of eligibility for MaineCare. If there is not enough information in the case record, or no case record exists, the Department will contact the individual in writing to request verification of specific information.

Individuals who are determined to be eligible for SSI and who indicate on the application for SSI that they do not have medical expenses for the three months prior to their application for SSI will be sent a notice of denial for the three-month period.

## SECTION 14: CLOSINGS AND DENIALS

Before MaineCare coverage is ended or denied, it must be determined that the individual is not eligible under any coverage group. This includes:

I. Doing a disability determination when there is information that the individual can potentially meet the disability criteria;

II. Determining medical and financial eligibility for a Waiver, Nursing Home Care, or Katie Beckett coverage groups when there is information that the individual can potentially meet these criteria;

III. Determining continuing coverage when SSI/State Supplement cash benefits end;

IV. Determining eligibility under Cub Care and Maine Rx.

When individuals lose eligibility for SSI and/or State Supplement payments and a review for continued MaineCare is needed, existing information in the case record is used to determine continuing eligibility for MaineCare. If there is insufficient information in the case record to determine eligibility or a disability determination is necessary, coverage must be continued until ineligibility is determined. If a review form is

necessary, it must be sent to the individual within ten days of the date SSI and/or State Supplement coverage has ended.

## SECTION 15: NOTICES

Individuals are notified in writing as soon as eligibility is determined. If some of the individuals applying for MaineCare are eligible and some are not, the notice must specify who is and who is not eligible and the reasons for each individual's ineligibility.

I. Individuals whose eligibility begins after the month of application must be sent a denial notice for the month(s) of ineligibility.

II. All individuals who apply for Medicaid must be notified of their eligibility for retroactive coverage. Such notification must indicate the months of eligibility or ineligibility.

III. When an individual is determined to be ineligible, the notification contains—

A. a statement that the application has been denied,

B. the specific reason(s) for the denial,

C. the manual citations which support the decisions, and

D. an explanation of the individual's right to request a hearing.

IV. In situations when the intended action is to discontinue eligibility or to reduce services, timely and adequate notice must be given to the recipient.

A. “Timely” means that the notice must be mailed 15 days before the intended change would be effective (ten days for notice plus five days for mail).

Timely actions resulting from computer matching mass changes, such as annual cost of living adjustments to Social Security and other Federal benefit updates require an advance notice of 30 days prior to the effective date of the action.

The only situations in which the timely notice guarantee is not required are as follows:

1. Factual information is received confirming the death of the recipient;

2. A written statement that assistance is no longer wanted is received by the Department. Such statement must be signed by the recipient or the recipient's representative;

3. The recipient has been committed to a public institution (See Section 9 of this Part.);

4. The recipient's cost of care changes (See Part 12, Sections 4.3.4; Part 13, Section 6; and Part 14, Section 6.2.);

5. The recipient's whereabouts are unknown and Departmental mail directed to the recipient has been returned;

6. An applicant for MaineCare has been covered temporarily due to the Department's failure to determine eligibility within the 45-day time limit and is later found to be ineligible; or

7. Documentation is obtained that the individual is currently receiving Medicaid in another state.

B. “Adequate” means a written notice which includes a statement of—

1. the action the Department intends to take;

2. the reasons for the intended action;

3. the regulations supporting such action;

4. an explanation of the rights to request a hearing; and

5. a statement explaining that if a hearing is requested within the notice period, the intended action will not become effective until after a hearing Decision is rendered.

## SECTION 16: UNFUNDED CHECKS

An unfunded or bounced check is considered non-payment of a premium. Upon notice from State Treasury that a check has bounced, the household will be sent a notice of non-payment including the amount now due. If no payment is received within 30 days of the first notice, a second notice is sent. If no payment is received, the penalty will take effect the month following the month in which the second notice is sent, if the client has received 15 days advance notice.

**Example**

The family is sent a second notice of non-payment on May 10. No payment is received within fifteen days. The penalty starts June 1. If the notice was not sent until May 30, the penalty would take effect July 1.

The penalty is a period of time that the client cannot get coverage under the option for which there is a non-payment. The duration of the penalty period depends on the coverage option involved.

For Working Disabled, coverage cannot continue after the end of the current or last enrollment period unless the unpaid premiums are paid.

For the Special Benefit Waiver, coverage cannot continue after the end of the current period unless all outstanding premiums are paid.

For Katie Beckett, coverage cannot continue after the end of the current three-month premium period unless all outstanding premiums are paid.

**Note:** A family’s three-month enrollment period cannot be ended to impose this penalty.

**PART 3**

**ELIGIBILITY GROUPS REQUIREMENTS**

**SECTION 1: DEFINITIONS**

**DEPENDENT CHILD:** A dependent child means a child who is under the age of 18 or is age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

**FEDERAL POVERTY LEVEL (FPL):** A measure of income issued annually by the Department of Health and Human Services (HHS) that is used to determine financial eligibility for programs and benefits. The poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. § 9902(2).

**SECTION 2: ELIGIBILITY GROUPS FOR WHICH MAGI-BASED METHODOLOGY APPLIES**

To be eligible for MaineCare in a coverage group for which MAGI-based methodology applies, an individual must:

I. Be a covered individual;

II. Have an eligibility group;

III. Meet basic eligibility criteria in this Part and in Parts 2 and 17; and

IV. Meet income criteria.

To get Medicaid coverage under an eligibility group for which MAGI-based methodology applies, an individual must meet the criteria of at least one of the groups listed in Sections 2.1-2.4 of this part. An individual may meet the criteria of more than one group at the same time in which case they should be enrolled with the group which is the easiest way for them to get the best coverage.

**Section 2.1: Children**

**I. Newborns**

A. If the newborn’s mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible regardless of the income of the household. The mother must be fully covered by Medicaid on the day of the baby’s birth. If the mother meets the deductible amount on the day of the baby's birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

B. Coverage continues for one year. This means that the baby is eligible without regard to changes in income or composition of the household.

**II. Other Children Under Age One**

A. Individuals under the age of one who are living with a parent/caretaker relative or with unrelated others are eligible if they meet other applicable eligibility rules in Parts 2 and 17.

B. Countable income must be equal to or less than the applicable standard in Part 4. Types of countable income are described in Part 17.

C. If the individual is receiving inpatient hospital services on the last day of the month in which the first birthday occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria.

**III. Age 1 through Age 18**

A. Individuals age one up to and including age 18 (under age 19) who are living with a parent/caretaker relative or who are living alone or with unrelated others are eligible for Medicaid if they meet other applicable eligibility rules in Part 2 and Part 17.

B. Countable income must be equal to or less than the applicable income standard in Part 4. Types of countable income are described in Part 17.

C. If the individual is receiving inpatient hospital services on the last day of the month in which the 19th birthday occurs, eligibility continues until the last day of the inpatient stay if the individual continues to meet all other eligibility criteria.

**IV. Age 19 or 20**

A. Individuals age 19 or 20 who are living with parent/caretaker relatives or who are living alone or with unrelated others are eligible for Medicaid if they meet other applicable eligibility rules in Part 2 and Part 17.

B. Countable income must be equal to or less than the applicable income standard in Part 4. Types of countable income are described in Part 17.

C. If the individual is receiving inpatient hospital services on the last day of the month in which the 21st birthday occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria.

**V. Coverage for Noncitizens Under Age 21**

A. Effective July 1, 2022, individuals under the age of 21 who would be eligible for assistance under federal Medicaid programs listed in Section 2.1(I)-(IV) of this part, but for their noncitizen status are eligible for state-funded medical assistance through MaineCare.

B. Countable income must be equal to or less than the applicable income standard in Part 4. Types of countable income are described in Part 17.

C. If the individual is receiving inpatient hospital services on the last day of the month in which the 21st birthday occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria.

**Section 2.2: Parent/Caretaker Relative**

I. A parent/caretaker relative means a relative of a dependent child by blood, adoption or marriage with whom the child is living, who assumes primary responsibility for the child’s care (as may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income tax purposes), and who is one of the following:

A. The child’s father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

B. The spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

C. Another relative of the child based on blood (including those of half-blood), adoption or marriage.

Countable income must be equal to or less than the applicable income standard in Part 4. Types of countable income are described in Part 17.

**II. Maintenance of a Home**

The parent/caretaker relative must be living with a dependent child for whom a home is maintained. The child must be under age 18 or is age 18 and expects to graduate from high school prior to their 19th birthday.

The specified relative does not need to have legal custody as a result of court action in order to be considered to be maintaining a home for the child.

If the child lives part of the time with each parent, the parent with whom the child resides over 50% of the time must apply for the child.

If the child lives 50% of the time with each parent, either parent can apply for the child but not both.

If a child is living with their biological parents but the parents are not married, all three have a coverable group and are potentially eligible. Each parent has a coverable group because each is residing with their child under age 18 (or 18 and expects to graduate from high school by age 19).

If the only child is between the ages of 19 and 21, (or is age 18 and does not expect to graduate from high school prior to the 19th birthday), the parent or caretaker relative cannot receive Medicaid coverage unless the parent or caretaker relative is eligible in another category (e.g., a pregnant woman or meets SSI disability criteria).

**Examples**

A. The household consists of a single mother and her 18 year old son. In June, the boy graduates from high school. The boy may remain eligible for Medicaid since he has a coverable group (under age 21).

The mother is no longer eligible. She has no coverable group since she is not living with a dependent child covered by Medicaid and she is not pregnant and does not meet SSI disability criteria.

B. The household consists of a mother, father, and their 19 year old daughter. The daughter may be eligible, depending on the income requirements of her coverage group; however, the parents cannot be covered as a parent/caretaker relative.

C. The household consists of a mother, father, and 17 year old girl who is a sophomore in high school. On the child's 18th birthday, the parents' coverage is due to end. Discussion with the family prior to terminating the parents' coverage reveals that the mother has a condition which might meet disability criteria under the SSI program. Coverage for the girl continues. Coverage for the father is terminated. Coverage for the mother continues pending a decision from the Medical Review Team on her disability. If she does not meet criteria for SSI - Related disability (see Part 6, Section 4.3), her coverage must also end.

D. An individual, age 20, is the caretaker relative of their 18-year-old sister. When the sister graduates from high school, both can continue to receive Medicaid as both are still eligible for coverage through the infants and children under age 21 group.

**III. Physical Separation**

A child may be separated physically from their parent/caretaker relative and still be considered to be living with the parent/caretaker relative, provided that the parent/caretaker relative retains full and exclusive responsibility for the supervision and guidance of the child, offers a home during vacations, and any other delegation of authority to another by the parent/caretaker relative is temporary, voluntary, and revocable.

When separation occurs, it is expected that the child or parent/caretaker relative will return home at the completion of the reason for the separation. The following criteria meet the conditions for when a child or parent/caretaker relative is away from the home.

A. To secure education when high school facilities are not maintained in the place of residence or if existing facilities do not meet the child's educational or social needs. In this later instance, the assessment of needs and the development of a responsible plan must be made through the parent/caretaker relative and a recognized social service agency.

B. To secure planned supervised therapy in a private, organized treatment center such as Sweetser Home, when such is necessitated by special needs of a physical or emotional nature.

C. To attend Governor Baxter State School for the Deaf, provided that adequate resource for therapy cannot be found or developed in the child's own community.

D. To attend a vocational or technical school or college or university.

E. For care for a terminal illness which probably will prohibit eventual return to the home, although if possible, the individual would do so.

F. For other purposes, such as visiting or moving to another community and similar situations where temporary separation occurs. In such situations, the separation may not exceed four months, unless the individual can demonstrate that there is a good reason and that the separation will end as soon as possible.

**IV. Reunification**

MaineCare coverage may continue for parents/caretaker relatives who would otherwise lose eligibility due to a change in household size when their child is removed from the home by Child Protective Services pursuant to state law. Eligibility will continue until the parent is either:

A. No longer participating in the rehabilitation and reunification plan as required by the plan; or

B. Until the parental rights have been terminated.

If the parent/caretaker is no longer eligible for reasons other than the change in household composition (e.g., an income increase, failure to renew, etc.) MaineCare eligibility may end.

**Section 2.3: Pregnant Individuals**

I. Pregnant individual means an individual during pregnancy and the post-partum period, which begins on the date the pregnancy ends, and extends for 12 months beyond the month in which the pregnancy ends.

Pregnant individuals whose countable income is equal to or below the applicable income standard in Part 4 are eligible. The household size is increased by one (or by two if the individual is expecting twins). Cooperation with Third Party Liability (TPL) and Division of Support Enforcement and Recovery (DSER) is not a factor in determining eligibility.

Retroactive coverage may be granted for up to three months if the individual was pregnant and financially eligible.

If an individual is eligible as a pregnant individual in the month of application, or the retroactive period, or due to a change in ongoing eligibility, they continue to be eligible for 12 months beyond the month in which the pregnancy ends.

Only the pregnant individual is eligible under this coverage group. Other family members must be in another coverable group.

If the individual is receiving inpatient hospital services on the last day of the month in which coverage as a pregnant individual occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria in Part 2 and Part 17.

**II. Presumptive Eligibility for Pregnant Individuals**

A pregnant individual is eligible to receive ambulatory prenatal care beginning on the day that a qualified Medicaid provider determines that the pregnant individual's household’s countable MAGI-based income is less than the applicable income standard in Part 4. This coverage is called "presumptive eligibility".

The qualified Medicaid provider will use a presumptive eligibility application to establish the MAGI household size and income for the presumptive determination. The Medicaid provider must contact the Department within five working days after the date the presumptive determination is made to report the name, date of birth, and Social Security number of each individual determined eligible under the presumptive eligibility standards.

Once the Medicaid provider has made a presumptive determination, the individual is eligible through the last day of the month following the month in which a presumptive determination is made. If the individual applies for Medicaid during this presumptive eligibility period, presumptive eligibility ends the day that the Medicaid application is granted or denied. Presumptive eligibility can only be determined once per pregnancy.

**Example**

A pregnant individual is determined presumptively eligible by the Medicaid provider on September 14. They receive coverage under presumptive eligibility through October 31. On October 31 they file an application for Medicaid. Because they applied for Medicaid within the presumptive eligibility period, the individual continues to be presumptively eligible through the day the application is granted or denied.

The Department is required to provide appropriate notices based on the standard Medicaid application, but is not required to send any notice regarding the discontinuance of the presumptive eligibility period. The individual has no appeal rights for the discontinuance of presumptive eligibility.

It is the responsibility of the Medicaid provider to:

A. provide the applicant with an approved standard MaineCare application form;

B. notify OFI of the presumptive eligibility determination within five working days from the date the determination was made;

C. notify the applicant (in writing and orally if appropriate) that if the applicant does not file a standard MaineCare application with OFI before the last day of the following month, presumptive eligibility coverage will end on that last day;

D. notify the applicant (in writing and orally if appropriate) that if the applicant files a standard MaineCare application with OFI before the last day of the following month, presumptive eligibility coverage will continue until an eligibility determination is made on the application that was filed.

**III. Coverage for Pregnant Individuals for the Health of Unborn Children**

Effective July 1, 2022, prenatal care and pregnancy related services are available through the Children’s Health Insurance Program (CHIP) to pregnant individuals who are eligible for Medicaid but for noncitizen status. Eligibility ends when the pregnancy ends. Postpartum coverage is limited to the end of the month in which the pregnancy ends or a period necessary to allow for adequate and timely notice. See Part 2, Section 15(IV).

To be covered in this category the parent of the unborn child must be:

1. Pregnant
2. A resident of the State of Maine
3. Otherwise eligible for federally funded coverage but for citizenship.
4. Uninsured. Applicants are considered to be uninsured if they do not have credible health insurance that provides coverage of prenatal care services.
5. Countable income is equal to or less than the applicable income standard for Cub Care in Part 5, Section 6. Types of countable income are described in Part 17.

**Section 2.4: Expansion Adults**

Eligibility for this group must meet the qualifications below.

**Expansion Adults** means an individual between the ages of 19 and 64 who meets the following qualifications:

I. Is not pregnant;

II. Is not entitled to or enrolled for Medicare benefits Part A or Part B; and

III. Is not otherwise eligible for and enrolled in mandatory MaineCare coverage.

For parents and other caretaker relatives living with a dependent child under age 21 who meet the requirements in (I) through (III) of this section and either have income above 100% FPL or don’t meet the requirements for a parent/caretaker under Section 2.2 of this part, the child must receive benefits under Medicaid, CHIP, or otherwise be enrolled in minimum essential coverage as defined in 42 C.F.R. § 435.4 to be eligible as an expansion adult.

**SECTION 3: OTHER NON-MAGI ELIGIBILITY GROUPS**

Other special coverage groups refers to various special groupings created by federal and/or state legislation. Specifically, IV-E Eligible and State Adoption Assistance:

**I. Move-In from Out of State**

An individual under the age of 21, who is receiving Title IV-E funds from another state or is covered by a State Adoption Agreement from another state and moves to Maine, is eligible for Medicaid. The income and assets of the child and parents are not considered to determine eligibility for this child.

There must be an assignment of rights to medical support and the Department must be provided with a Social Security number for the child.

There are three groups of children who fall into this category:

A. Children whose medical and financial circumstances qualify them for federal IV-E adoption assistance;

B. Children whose medical and financial circumstances qualify them for federal IV-E foster care assistance; and

C. Children whose medical and financial circumstances qualify them for state adoption assistance.

The foster or adoptive parents in Maine are provided with a written explanation of their status by the state of origin which usually serves as verification of their status.

**II. Maine Residents**

The following children are eligible for Medicaid:

A. Foster children;

B. Children named in a Federal (IV-E) or Maine State Adoption Assistance Agreement;

C. Children who are placed in Permanency Guardianship by the State of Maine, as defined in 22 M.R.S. § 4038-C.

**III. Former Foster Care Children**

An individual is eligible to enroll in Medicaid if they:

A. Are under age 26;

B. Are not enrolled in another mandatory Medicaid coverage under 42 C.F.R. §§ 435.110 through 435.118 or 42 C.F.R. §§ 435.120 through 435.145; and

C. Effective January 1, 2023 were in foster care in any state in the United States and were enrolled in Medicaid at age 18. Prior to January 1, 2023 only individuals in foster care in the State of Maine were eligible under this coverage group.

The income and assets of the individual (or anyone else in their household) are not considered to determine eligibility for the individual.

**SECTION 4: TRANSITIONAL MAINECARE**

Transitional MaineCare (TM) is MaineCare coverage that is available to families who become ineligible for MAGI-based coverage due to increased earnings or hours of employment of the parent or caretaker relative (as defined by Section 2.2 in this Part), or because of receipt of or increase in alimony.

**Section 4.1: General Requirements**

**Section 4.1.1: Covered Individuals**

TM is available to individuals who were eligible for MAGI-based MaineCare coverage in either the Children Under 18, or the Parent/Caretaker groups (except Expansion Adults with income above 100% FPL).

TM households are determined on an individual basis using MAGI household composition rules. Some individuals may be granted TM while others may continue in MAGI coverage groups.

Membership in a TM household includes those individuals whose needs and income were included in determining eligibility for the MAGI coverage group at the time of closing.

The following individuals may also be added to a TM household:

I. a parent/caretaker relative who returns home whose needs and income would be considered in determining coverage under MAGI, and whose earnings/alimony, either alone or added to other income of the household, result in the loss of MAGI coverage;

II. a child or parent/caretaker relative who moves into the home after TM has started;

III. a child who is born after TM has started; or

IV. a pregnant woman who was included in a MAGI household and loses coverage after the end of her pregnancy, if her spouse and/or dependent children are receiving TM.

**Section 4.1.2: Conditions of Eligibility**

At least one member must have been eligible for and receiving coverage under an eligibility group for which MAGI-based methodology applies in one of the three months immediately preceding ineligibility. Retroactive coverage under an eligibility group for which MAGI-based methodology applies will be counted for this purpose even if there is only one month of retroactive coverage and no current eligibility under an eligibility group for which MAGI-based methodology applies.

**Example**

A family applies in July and requests retroactive coverage for one month. The family is covered under an eligibility group for which MAGI-based methodology applies for June (the retroactive month) and is ineligible for coverage in July due to increased earnings. TM eligibility exists starting in July.

An individual is not eligible for TM if:

I. The State makes a finding that, at any time during the last 6 months the individual was ineligible for Medicaid because of fraud; or

II. Information is received which indicates the household was incorrectly determined eligible for MAGI-based coverage.

Individuals receiving TM must continue to assign their rights to payment for medical care from any third party (See Part 2, Section 6). The custodial parent is not required to cooperate in obtaining medical support or payments from the non-custodial parent.

**Section 4.2: Eligibility for Transitional Medicaid: Individuals Who Become Ineligible for Coverage under MAGI-Based Coverage Due to Increased Earnings**

**Section 4.2.1: Computation of Transition Period**

Individuals who lose eligibility in a coverage group for which MAGI-based methodology applies due to the earnings of a parent/caretaker relative may remain eligible for Medicaid for up to 12 months. The scope of services will be the same as those provided to those eligible under an eligibility group for which MAGI-based methodology applies.

The 12-month count begins the month the individual would have become ineligible for MAGI coverage, which may not necessarily be the effective month of the loss of coverage under an eligibility group for which MAGI-based methodology applies.

**Example:**

A family reports an increase in the parent’s earnings on April 5. The parent is now ineligible in April. The first month for TM is April, the first month of ineligibility, and not May, which would be the effective month for the closing under an eligibility group for which MAGI-based methodology applies.

**Section 4.2.2: Termination of TM**

TM will be closed with timely and adequate notice when:

I. A child no longer resides within the household. The TM household must include a child who resides in the household. This child must be under the age of 18 or between the ages of 18 and 19, and a student regularly attending a secondary school on a full-time basis (or in the equivalent level of vocational or technical training at the high school level) and reasonably expected to complete the program prior to their 19th birthday.

II. The parent/caretaker relative is no longer employed. Note: good cause reasons will be requested for lack of employment and established by the Department. Some reasons for good cause for lack of employment include but are not limited to:

A. dismissal/termination by the employer;

B. illness of employed individual;

C. care of other ill family members who are residing within the household;

D. loss of transportation;

E. harassment;

F. risk to health and safety;

G. loss of child care if there is not any other adequate replacement; or

H. other reasons which indicate the action was not deliberate or willful.

III. The household moves out of state or the recipient’s whereabouts are unknown and Departmental mail has been returned.

IV. The member becomes eligible in another comparable MaineCare category.

A determination of whether the individual is potentially eligible for any other MaineCare categories must be made prior to the termination of Transitional Medicaid.

In situations when the intended Department action is to terminate coverage, timely and adequate notice must be given to the recipient as described in Part 2, Section 15.

**Section 4.2.3: Client Reporting Responsibilities**

The family must report when a child no longer resides within its household or when there are any other changes in the family composition. All changes must be reported within the time frames outlined in Part 2, Section 12.2.

**Section 4.2.4: Department Notice Requirements**

At the time of the closing under MAGI-Based rules, a determination must be made for the individual’s eligibility for Transitional Medicaid and a notice must be sent informing the individual of the following:

I. The individual's eligibility for the extension and a medical card which lists all eligible members; and

II. The conditions under which the initial extension may be terminated.

A review is due in the 12th month. It is used to determine continuing eligibility for MaineCare coverage when TM ends.

**Section 4.3: Eligibility for Transitional Medicaid: Individuals Who Become Ineligible for MAGI-Based Coverage Due to Increased Alimony**

Transitional Medicaid coverage for persons with increased alimony is limited to 4 months; it continues irrespective of other changes in household income or composition.

Coverage under a MAGI-based eligibility group must have been closed solely because of an increase in the amount of alimony being received by an individual in the household.

The individual must have been eligible under a MAGI-based eligibility group for three of the six months prior to the month they are determined ineligible.

The four-month count for extended Medicaid begins with the first month of ineligibility even if the closing under MAGI-based methodology is later.

**Example**

A client reports in May that their alimony has increased and now the countable income exceeds program standards. The four-month extension begins in May, even though the MAGI-based coverage cannot be closed for May.

At the end of the four-month period, the individual's coverage is to be reviewed for potential future coverage. If eligibility does not exist, coverage is to be ended following timely and adequate notice procedures (Part 2 Section 15).

# PART 4

# BUDGETING FOR ELIGIBILITY GROUPS FOR WHICH

# MAGI-BASED METHODOLOGY APPLIES

## SECTION 1: DEFINITIONS

**FAMILY SIZE**: Family size means the number of persons counted as members of an individual’s household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as 1 person.

**FEDERAL POVERTY LEVEL (FPL):** A measure of income issued annually by the Department of Health and Human Services (HHS) that is used to determine financial eligibility for programs and benefits. The poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. § 9902(2).

**HOUSEHOLD INCOME**: Household Income means the sum of the MAGI-based income, of every individual included in the individual’s household (subject to the rule described in Section 2(C) below), EXCEPT that income in the following circumstances will not be included in household income: (1) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent, and is not expected to be required to file a tax return under section 6012(a)(1) of the Internal Revenue Code for the taxable year in which eligibility for Medicaid is being determined, whether or not the individual files a tax return; and/or (2) The MAGI based income of a tax dependent who is an individual other than a spouse or a biological, adopted, or step child who expect to be claimed as a tax dependent by another taxpayer, who is not expected to be required to file a tax return under section 6012(a)(1) of the Internal Revenue Code for the taxable year in which eligibility for Medicaid is being determined, whether or not such tax dependent files a tax return.

**MAGI-BASED INCOME**: MAGI-Based income is as defined in Part 17, Section 2.1.

**TAX DEPENDENT**: Tax dependent, pursuant to 42 C.F.R. § 435.4, has the same meaning as the term “dependent” under section 152 of the Internal Revenue Code, as an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.

## SECTION 2: BASIC BUDGETING PRINCIPLES

To determine an individual’s eligibility for Medicaid, the following calculation applies:

A. Determine the individual’s Household.

B. Determine the individual’s Household Income.

C. Compare the individual’s Household Income to the Income Standard. If the individual’s Household Income is over the income standards, subtract an amount equal to 5 percentage points of the Federal poverty level for the applicable family size and reassess by comparing the individual’s Household income to the Income Standard.

## D. If the individual’s household income is at or below the Income Standard, then the individual is eligible for Medicaid.

## SECTION 3: HOUSEHOLD

1. For purposes of “Household Income”, household will be defined as follows:

(1) **Basic rule for taxpayers not claimed as a tax dependent:** If an individual requesting coverage expects to file a tax return for the taxable year in which an eligibility determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer, the individual’s spouse if living with and/or filing jointly, and any person(s) the taxpayer expects to claim as a tax dependent.

(2) **Basic rule for individuals claimed as a tax dependent:** If an individual requesting coverage expects to be claimed as a tax dependent for the taxable year in which an eligibility determination or renewal of eligibility is being made (even if he/she also expects to file a tax return), his/her household will consist of the tax filer who expects to claim the individual as a tax dependent, the tax filer’s spouse if living with and/or filing jointly, and any person(s) the tax filer expects to claim as a tax dependent (including the individual) unless the individual meets one of the following exceptions.

(a) The individual expects to be claimed as a tax dependent of someone other than the individual’s spouse or biological, adopted or step parent;

(b) The individual is a child under age 19 living with both parents, but expects to be claimed as a tax dependent by only one parent because the parents don’t file jointly;

(c) The individual is a child under age 19 who expects to be claimed by a non-custodial parent.

(3) **Rules for individuals who neither file a tax return nor are claimed as a tax dependent OR who meets one of the exception from Section 3A(2) of this Part:** If an individual meets one of the three exceptions listed in Section 3A(2), or if an individual does not expect to be a tax filer for the taxable year in which an eligibility determination or renewal of eligibility is being made and does not expect to be claimed as a tax dependent, his/her household will consist of:

* 1. The individual;
	2. The individual’s spouse if living with the individual;
	3. The individual’s natural, adopted and step children under the age of 19 if living with the individual; and/or
	4. If the individual is under the age of 19, the individual’s natural, adopted and step parents and natural, adoptive and step siblings also under age 19 if living with the individual.

## SECTION 4: HOUSEHOLD INCOME STANDARD

The Income Standard for the following groups is as follows:

1. parents or caretaker relatives as defined in Part 3, Section 2.2: equal to or less than 100% of the Federal Poverty Level.
2. children age 19 and 20 as defined in Part 3, Section 2.1(IV): equal to or less than 156% of the Federal Poverty Level.
3. pregnant individuals as defined in Part 3, Section 2.3: equal to or less than 209% of the Federal Poverty Level.
4. effective March 1, 2023 children under age 1 as defined in Part 3, Section 2.1(II): equal to or less than 208% of the Federal Poverty Level. Uninsured children under age 1, with income between 191% and 208% of the Federal Poverty Level, may be covered under Cub Care (See Part 5)
5. effective March 1, 2023 children age 1 up to and including age 18 (under age 19) as defined in Part 3, Section 2.1(III): equal to or less than 208% of the Federal Poverty Level. Uninsured children age 1 and up to age 19, with income between 157% and 208% of the Federal Poverty Level, may be covered under Cub Care (See Part 5)
6. Expansion Adults as defined in Part 3, Section 2.4: equal to or less than 133% of the Federal Poverty Level, except for Expansion Parents and Caretaker Relatives eligible under Part 3, Section 2.4, whose income must be between 100% and 133% of the Federal Poverty Level.

## SECTION 5: BUDGET PERIOD

Financial eligibility for Medicaid must be based on current monthly household income and family size.

## SECTION 6: NO ASSET LIMIT

There is no asset limit for any individuals in any of the eligibility groups for which MAGI-based methodology applies.

## SECTION 7: GAP-FILLING

If an individual is found ineligible through the application of this Part, but his/her household income is below 100% FPL when determined in accordance with 26 C.F.R. § 1.36B-1(e), eligibility will be determined in accordance with the latter.

Under this circumstance, the individual will be asked by OFI to provide documentation to explain the difference between the two determinations. If the documentation provided adequately substantiates the reason for the difference, Medicaid financial eligibility for the individual will be determined in accordance with 26 C.F.R. § 1.36B-1(e).

# PART 5

# CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) –

# CUB CARE

## SECTION 1: DEFINITIONS

**STATE-BASED MARKETPLACE:** The state-based marketplace (SBM) is a website established and operated by Maine’s offical marketplace to facilitate the purchase of health insurance in accordance with the [*Patient Protection and Affordable Care Act*](http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act) (CoverME.gov).

**MYMAINECONNECTION:** MyMaineConnection ([www.mymaineconnection.gov](http://www.mymaineconnection.gov)) is a website administered by the Office for Family Independence in which residents of the State of Maine can apply online for medical coverage.

## SECTION 2: SCOPE

The Children’s Health Insurance Program (CHIP), known as CubCare in Maine, is authorized under Title XXI of the *Social Security Act*. It provides health coverage as an expansion of Medicaid to uninsured children who are under the age of 19 who meet certain other requirements as identified in this section.

Maine also implements a separate CHIP for pregnant individuals for the health of the fetus. See Part 2, Section 2.3 (III) for eligibility requirements.

The Department has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever the Medical ID was used.

## SECTION 3: BASIC ELIGIBILITY REQUIREMENTS

To be eligible for Cub Care, individuals must meet the basic eligibility requirements for Medicaid coverage as identified in Part 2. There is no requirement to refer the non-custodial parent without health insurance to the Division of Support Enforcement and Recovery (DSER).

1. **Children Excluded from Coverage**

1. A child who is eligible for coverage under a Medicaid program. This includes Transitional Medicaid (TM).

2. A child age 19 and over.4. A child who is covered under a group health insurance plan through an employer.

3. A child who is covered under health insurance as defined by the *Health Insurance Portability and Administrative Act* (HIPAA). This includes most insurance plans except for those covering one particular service or illness only, such as insurance for dental care or cancer. This exclusion applies regardless of whether the coverage is provided through an adult who resides with the child or through an adult living in another household.

## SECTION 4: APPLICATION PROCESS

1. An application is the request for medical coverage made by signing and dating an approved application form. The individual or anyone acting on the individual’s behalf may sign the application form. The applicant may choose to have another person help them complete the form.

The date of application is the date the signed application form is received in or by any OFI regional office, My Maine Connection, or the State Based Marketplace. My Maine Connection or the State Based Marketplace will forward the application to OFI. Applications must be processed within 45 days of their receipt by the Department. If the applicant is not sent a notice of the eligibility decision within 45 days, temporary coverage will be authorized. (See Part 2 § 12.3.)

All signed applications will be acknowledged in writing. A written eligibility decision will be sent to the applicant.

An application is valid for authorizing coverage starting the month the application is received.

1. When an individual applies for medical coverage, this is considered to be an application for Medicaid and Cub Care.
2. Verification of information needed to determine eligibility must be requested initially from the individual. If information is requested from other sources (with the exception of public records) the individual must be informed. If the individual does not give consent for other sources to provide the Department with the requested information, denial or termination must occur. (See Part 2 § 12.1.)

When a decision cannot be made due to inconclusive or conflicting information, the individual will be notified what questions remain and what needs to be resolved. If the Department cannot determine that eligibility exists after contacting the individual or collateral contacts, assistance will be denied or terminated.

## SECTION 5: ASSETS

There is no asset criteria for eligibility under Cub Care.

## SECTION 6: INCOME STANDARD

Household income for children

1. Age 0 up to age 1: Greater than 191% and equal to or less than 208% of the Federal Poverty Level for a the family size.
2. Age 1 up to age 6: greater than 140% and equal to or less than 208% of the Federal Poverty Level for the family size.

C. Age 6 up to age 19: greater than 132% and equal to or less than 208% of the Federal Poverty Level for the family size.

## SECTION 7: ELIGIBILITY BUDGETING PRINCIPLES

Medicaid rules will be followed as identified in Part 2 and Part 4 to determine the appropriate household and whose income will be budgeted.

## SECTION 8: ELIGIBILITY PERIODS

1. Coverage under Cub Care is determined for a twelve-month enrollment period for all members of a household, beginning with the month of application or, if ineligible for that month, coverage starts in the following month. There is only one enrollment period for a household.
2. Eligible children may receive retroactive coverage of up to three months prior the application month. The rules in Part 2, Section 13.4 apply.
3. The child remains eligible for the 12-month period without regard to changes in household income.

D. The individual must complete a renewal, and be found eligible, in order for coverage to continue beyond the initial twelve month enrollment period.

The individual will be sent a renewal notice at least 30 days before the 12-month enrollment period ends. .

E. A child who has been covered by Cub Care and whose household income exceeds 208% of the Federal Poverty Level at the end of the 12-month enrollment period will be provided notice that their application was transferred to the SBM and informed of the option to purchase extended coverage through the Health Insurance Purchase Option (HIPO). Refer to Chapter 335 Health Insurance Purchase Option (HIPO) in this manual. (10-144 C.M.R. Ch. 335)

## SECTION 9: NOTICES

1. **Eligibility Notices**

Individuals will be notified in writing as soon as eligibility is determined. If some of the individuals applying for medical coverage are eligible and some are not, the notice must specify who is or is not eligible and the reasons for each individual's ineligibility.

Individuals whose eligibility begins after the month of application must be sent a denial notice for the month(s) of ineligibility.

When an individual is determined to be ineligible, the notification will contain a statement that the application has been denied, the specific reason(s) for the denial, the manual citations which support the decisions, and an explanation of the individual's right to request a hearing.

1. **Adverse Action Notices**

In situations when the intended action is to discontinue eligibility or to reduce services, timely and adequate notice must be given to the recipient. However, coverage will not be continued beyond the enrollment period pending a hearing decision.

"Timely" means that the notice must be mailed 15 days before the intended change would be effective (ten days for notice plus five days for mail).

"Adequate" means a written notice which includes a statement of the action the Department intends to take, the reasons for the intended action, the regulations supporting such action, and an explanation of the rights to request a hearing.

1. **Denials**

If an application is denied for MAGI- Related Medicaid or Cub Care, notification will be given that other coverage may be available if the household has large medical bills or a child has a disabling condition. The application will be transferred to the SBM.

1. **Closings**

Before MaineCare or Cub Care coverage is ended or denied, it must be determined that the individual is not eligible under any coverage group.

If coverage under Cub Care is ended for a reason other than that the enrollment period has ended, the individual will be given adequate and timely notice.

## SECTION 10: ADMINISTRATIVE HEARINGS

Rules regarding hearings are identified in Part 1, Section 7.

**PART 6**

**SUPPLEMENTAL SECURITY INCOME (SSI) - RELATED MEDICAID COVERAGE**

**SECTION 1: SSI AND MEDICAID**

The Social Security Administration administers the SSI Program which was established to meet the needs of aged, blind or disabled individuals. The basic needs in the SSI Program are established for individuals and couples by the Federal government.

Individuals who receive SSI or State Supplement payments, or are eligible under Section 1619(b) of the *Social Security Act* do not need to file a separate application for Medicaid. They are automatically eligible for Medicaid unless they refuse to assign their rights to medical payments (see Part 2, Section 6) for medical care or are ineligible due to Medicaid Qualifying Trust rules (see Appendix H). Section 1619(b) individuals are those who are considered disabled but their earned income disqualifies them for an SSI payment. However, due to the use of a higher income guideline by SSI, they continue to be carried as an open SSI case and they are Medicaid eligible.

In general, the criteria in this section follows those used by the Social Security Administration when determining the eligibility for Supplemental Security Income (SSI) for individuals who are aged (at least age 65), blind or disabled. When the SSI office makes an eligibility decision based on disability or blindness the decisions may not be overturned by the Department unless new information is presented, or conditions change. In this case, an independent decision of the individual's or couple's eligibility Medicaid may be made.

**SECTION 2: SSI APPEALS OF DISABILITY DECISIONS**

If the Department of Health and Human Services has an open Medicaid case in any category, except for temporary coverage, this coverage will continue until a decision is reached on an SSI application or appeal regarding disability or until other Medicaid eligibility criteria are not met. The appeal must be filed in a timely manner according to SSI rules.

**SECTION 3: RETROACTIVE MEDICAID BENEFITS FOR SSI RECIPIENTS**

An individual who has been determined by the Disability Determination Services (DDS) to meet the disability criteria for receipt of SSI also meets the disability criteria for SSI - Related Medicaid benefits for the three months prior to application for SSI benefits. If there is an indication that the onset of the disability was between the first day of the third prior month and the application date eligibility begins with the first month of disability. Unless there is information to the contrary, the individual's statement of the onset may be accepted. If there is an indication that the individual was not disabled on the first day of the third month prior to the application for SSI, and if there is no information which would indicate the date of the onset of disability, then the procedures outlined in Section 4.3 of this Part must be followed. In determining retroactive Medicaid eligibility for all SSI recipients (aged, blind or disabled) all eligibility factors must be met. The best information available regarding income and assets should be used.

**SECTION 4: BASIC ELIGIBILITY REQUIREMENTS**

Individuals who are aged, blind or disabled and are not receiving SSI or a State Supplement payment may be eligible for Medicaid as SSI - Related if they meet the basic criteria of the SSI Program below.

**Section 4.1: Aged**

The individual must be 65 years of age in or before the month in which eligibility begins.

**Section 4.2: Blind**

The individual must have, in terms of ophthalmic measurement, central visual acuity of 20/200 (can see on the eye examination chart at 20 feet what a normal vision can see at 200 feet) or less in the better eye with best correcting glasses or must have a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends at an angular distance of no greater than 20 degrees or must have a visual field efficiency reduced to 20% or less; or if in the opinion of the consulting ophthalmologist the visual field limitation encroach on the central visual axis sufficient to interfere with useful vision. Such a person has what is known as economic blindness which prevents the performance of ordinary activities for which eyesight is essential. For determining the visual field efficiency, the amount of radial contraction in the eight principal meridians shall be determined, and the sum of these eight, divided by 420 (the sum of the eight principal radii of the industrial visual field) multiplied by 100 will give the visual field efficiency of one eye in percentage.

**Section 4.3: Disabled**

Current eligibility for Social Security, Railroad Retirement, Medicare or SSI benefits based on disability or blindness is proof of disability.

For individuals whose SSI Benefits are terminated, for reasons other than disability, a contact to the local Social Security Office should be made to determine the next disability review date. For Medicaid purposes this review date will be adopted.

If the individual is not currently receiving benefits from one of the sources above, then an independent disability decision must be made. To determine if a person meets the SSI standard of disability, a referral will be made to the Medical Review Team (MRT). This group consists of a physician and a caseworker who specialize in medical eligibility determinations. This group makes the decision as to whether or not the individual meets the SSI standard of disability and establishes any additional reviews of medical disability.

**Section 4.3.1: Making the Decision**

I. This decision is based on a medical report which must include a substantive diagnosis based either on existing medical evidence or upon current medical examination. To end coverage based on disability, the Medical Review Team must determine that medical improvement as set forth in 20 CFR 416.994 has occurred in relation to the most recent decision that was favorable to the individual.

The medical evidence must be from an acceptable source. Acceptable sources are:

A. licensed physicians;

B. licensed osteopaths;

C. licensed or certified psychologists;

D. licensed optometrists for the measurement of visual acuity and visual fields. (A report from a physician may be required to determine other aspects of eye diseases);

E. a hospital, clinic, sanitarium, medical institution or health care facility; or

F. P.E.T. and other school medical records.

Reports from chiropractors are not acceptable.

II. The social history must contain sufficient information to make it possible to relate the medical findings to the activities of substantial gainful employment and to determine if the individual is disabled.

III. An impairment or combination of impairments is not severe if it does not significantly limit physical or mental ability to do basic work activities.

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include:

A. physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

B. capacities for seeing, hearing and speaking;

C. understanding, carrying out, and remembering simple instruction;

D. use of judgment;

E. responding appropriately to supervision, co-workers and usual work situations; and

F. dealing with changes in a routine work setting.

IV. The following are criteria which the MRT uses to determine if an individual meets the definition of initial disability and any additional reviews for SSI - Related disability coverage:

An individual is determined to be disabled only if the physical or mental impairments have lasted or can be expected to last for a continuous period of not less than twelve months, expected to end in death, or are so severe that the individual is not only unable to do previous work, but cannot (considering age, education and work experience) engage in any kind of Substantial Gainful Activity (SGA) which exists in the community regardless of:

A. whether a specific job vacancy exists; or

B. whether the individual would be hired if application for work were made.

If the individual is not working, disability must be based on activities which still can be performed despite limitations (residual functional capacities). Activities, age, education and work experience will be used when the limitations would not permit the individual to return to prior work in order to determine if the individual can participate in any other type of work.

V. A child is considered disabled if there is any medically determinable physical or mental impairment of comparable severity.

VI. The physical or mental impairment must be one that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. The individual must follow any prescribed treatment plan.

VII. Coverage may be granted or continued if the individual has good reason for not following a prescribed treatment plan. These reasons include:

A. the specific medical treatment is contrary to the established teaching and tenets of the individual's religion.

B. the prescribed treatment is cataract surgery for one eye but there is an impairment of the other eye resulting in a severe loss of vision which is not subject to improvement through treatment.

C. surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

D. the treatment is very risky, unusual, or of a great magnitude such as open heart surgery or organ transplants.

E. the treatment involves amputation of an extremity or a major part of an extremity.

VIII. A person who otherwise qualifies for medical benefits, by reason of disability, cannot be an eligible individual for any month if determined to be a drug addict or an alcoholic unless undergoing treatment that may be appropriate and available for that condition. If the individual is in an institution it must be approved for this purpose and treatment must be available.

IX. An applicant may receive Medicaid coverage if the Medical Review Team (MRT) determines that s/he is presumptively disabled or blind and meets all other financial and non-financial requirements for Medicaid. A final determination must be made within six months of the presumptive decision.

A. Presumptive eligibility entitles the individual to full Medicaid benefits. If subsequently found not medically or otherwise eligible, adequate and timely notice must be given before coverage stops.

B. The start date for presumptive decisions is the first day of the month in which the decision is made. If the final decision is that the individual is not eligible, the closing will take place even if a hearing is requested. A reconsideration cannot be done.

C. If an individual’s prior application has been denied base on medical factors, a presumptive decision can be made only when there is sufficient evidence of an worsening of his/her physical or mental condition (or the existence of a new impairment) which could demonstrate a strong likelihood that the subsequent presumptive decision should be allowed.

D. A presumptive decision can be made when the alleged impairment falls within the following categories:

1. amputation of two limbs or a leg at the hip;

2. total deafness or blindness;

3. a stroke more than three months ago with continued marked difficulty in walking or using a hand or arm;

4. cerebral palsy, muscular dystrophy or muscle atrophy;

5. diabetes with amputation of a foot;

6. Down Syndrome;

7. mental retardation;

8. HIV infection;

9. a child age 6 months or younger showing low weight at gestational age (age at birth based on date of conception);

10. a physician or knowledgeable source confirms an individual is receiving hospice services due to terminal cancer; or

11. spinal cord injury producing the inability to ambulate without the use of a walker or bilateral hand-held assistive device.

**Section 4.3.2: Referral to Vocational Rehabilitation**

Persons under age 65 who are blind or disabled, are to be referred to Vocational Rehabilitation for review of the individual's need to use their services.

**Section 4.3.3: Reconsiderations (Appeals)**

An individual may request a reconsideration (appeal) within thirty days of notification of the disability decision. A reconsideration is done when additional information regarding the original impairment is available. If requested within ten days of the date of the denial notice, the original application date is used and temporary coverage may be granted on the 46th day.

For individuals being closed because it has been determined that they are no longer disabled, coverage will continue if a reconsideration is requested within ten days of the closing notice.

Any request for reconsideration made more than thirty days from the date of the notice of the disability decision requires a new application.

**Section 4.3.4: Determination of Continued Eligibility when the Disabled Individual Begins to Work**

When earnings are reported the Medical Review Team (MRT) will be alerted when:

I. a medical review has not been done nor has one been scheduled in the past or coming six months. These are usually situations of longer term disability such as asthma. The MRT will reschedule a review within the next six to twelve months. This gives the individual an opportunity to try the job, on an ongoing basis, to see if work is possible on this basis.

II. the MRT has identified the situation as one in which recovery is expected even if a review has been done or is expected to be done in the past or coming six months. In this instance the MRT may do a complete review regardless of the scheduled review date and request current medical information if recovery is expected within six months. Usually these are situations with a short term disability such as recovery from an accident.

If the individual is not scheduled for further medical review, the MRT does not need to be alerted when earnings are reported, but any earnings must be budgeted. These are usually situations of terminal illness or severe disability with no chance of recovery.

**SECTION 5: COVERED INDIVIDUALS**

**Section 5.1: Definitions**

When determining SSI - Related eligibility, individuals are considered to be eligible individuals, ineligible spouses, eligible couples or an eligible child.

An "eligible individual" is the person who is applying for or receiving Medicaid.

An "ineligible spouse" is the person to whom the individual is married, who is living with the individual, and who is not applying for or is not receiving Medicaid. The spouse can choose to be an ineligible spouse.

An "eligible couple" are married individuals, living together, who both have made application for or are recipients of SSI, the State Supplement or SSI - Related Medicaid. Both individuals must meet all eligibility criteria. It is not possible to treat each spouse as an eligible individual if they are living together. Each spouse is considered an eligible individual effective the month after they cease to live together. For married couples who are residing in the same nursing home room (see Part 14, Section 4.2) or who are applying for waiver services in the community (see Part 13, Sections 4 and 6), special criteria may need to be considered.

An individual whose marriage has been terminated through death, divorce or annulment is considered not married.

An "eligible child" is an individual who has a disability or visual impairment and who is neither married nor the head of a household and

\* under age 18; or

\* under age 22 (through age 21) and a student regularly attending school or college or training designed to prepare him/her for a paying job. The child/student can have the student earned income exclusion (See Part 17, Section 4.54) and an ineligible child allocation (See Part 7, Section 2.2.1).

Child status ends effective with the month after the month of attainment of age 18 (age 22 if a student) or the month after the month s/he last meets the definition of a child.

**Section 5.2: Eligible Groups**

All SSI - Related Medicaid eligible individuals and couples must meet financial guidelines and be a member of one of the following groups:

**Section 5.2.1: Individuals or Couples Meeting SSI/State Supplement Criteria**

Individuals or couples who meet the criteria for SSI or the State Supplement and who have not applied or who do not want to apply for either or both cash payments.

**Section 5.2.2: Individuals or Couples Eligible Under the Pickle Amendment or Lynch VS. Rank**

Commencing 4/1/77, those individuals or couples formerly entitled to concurrent benefits from SSI and Social Security who would be eligible for SSI if annual cost of living adjustments are not counted (See Appendix C for specifics).

**Section 5.2.3: Individuals or Couples Residing in Adult Foster Homes (Private or State Assisted) or Flat Rate Boarding Homes**

Individuals or couples who are residing in these homes have special income guidelines for State Supplement eligibility. If income exceeds these special guidelines the individual or couple may still be eligible for MaineCare (See Part 12).

**Section 5.2.4: Individuals or Couples Residing in Cost Reimbursement Boarding Homes, and Residential Care Facilities**

Individuals or couples who are residing in these homes have special income limits for MaineCare coverage (See Part 12).

**Section 5.2.5: Individuals in Nursing Care Facilities**

Individuals must be in a facility licensed by the Department of Health and Human Services to provide nursing care services. There are four types of facilities:

I. General Hospitals (Awaiting Placement)

II. Skilled Nursing Care Facilities (SNF)

III. Intermediate Nursing Care Facilities (ICF)

IV. Nursing care sections of the following institutions for the care of the mentally disabled:

A. Riverview Psychiatric Center (RPC)

B. Dorothea Dix Psychiatric Center (DDPC)

Individuals in these types of facilities must meet special eligibility criteria (See Part 14).

**Section 5.2.6: Individuals Receiving Nursing Care in Community Settings**

There are programs available for individuals who require nursing home care and are living in the community. These programs are called "Home and Community Based Waiver Programs" because they provide special services and follow special eligibility criteria (See Part 13).

The waiver programs are:

 I. Home and Community Benefits for the Elderly and for Adults with Disabilities Waiver

 II. Support Services for Members with Intellectual Disability or Autistic Disorders

III. Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder Waiver

IV. Home and Community Based Waiver Benefit for Children with Intellectual Disabilities and/or Pervasive Developmental Disorders (ID and/or PDD)

V. Home and Community Based Waiver Benefit for Adults with Other Related Conditions Aged 21 and Over

VI. Home and Community Based Waiver Benefit for Adults with Brain Injury

**Section 5.2.7: Newborns Born to Mothers on Medicaid**

If the newborn’s mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible for coverage regardless of the newborn’s income or assets. The mother must be fully covered by Medicaid on the day of the baby’s birth. In other words, if mother meets the deductible amount on the day of the baby’s birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

Coverage continues for one year. This means that the baby is eligible without regard to: changes in family income or composition, cooperation with DSER, cooperation with TPL, obtaining a Social Security number or declaring citizenship status.

**Section 5.2.8: Children Eligible Under “Katie Beckett”**

Individuals under this eligibility option are children with disabilities, age 18 and younger, who are living in the community and would be eligible for Medicaid if they were in need of institutional level of care. There are no special services provided to this group (See Part 7, Section 5).

**Section 5.2.9: Certain Individuals Receiving Social Security Disabled Widow(er)’s Benefits who are not Receiving Medicare**

These are individuals who are not eligible for Medicare and who lost their SSI or State Supplement benefits due to receipt of disabled widow(er)'s benefits from Social Security. If the individual meets all other SSI criteria and would be eligible for SSI or State Supplement benefits if the amount of Social Security benefits received as a disabled widow(er) were excluded income, the individual is eligible for categorically needy, SSI - Related Medicaid coverage. The exclusion of income from the Social Security disabled widow(er) continues until the individual is eligible for Medicare or would be ineligible for SSI or State Supplement benefits for a reason other than the income from Social Security disabled widow(er)'s benefits.

**Section 5.2.10: Disabled Adult Children (DAC)**

A Disabled Adult Child is an individual who lost his/her eligibility for SSI or State Supplement on or after 7/1/87 due to an increase in or initial receipt of Social Security Benefits based on their DAC status. These individuals who maintain their DAC status with Social Security may continue to receive Medicaid coverage. In determining eligibility for Medicaid, the increase in Social Security Benefits that resulted in SSI ineligibility will be disregarded. Other changes in income will be taken into account and will affect eligibility. Countable income must be under the current SSI or State Supplement income limit.

A person receives Social Security Benefits under DAC status if the following conditions are met:

I. s/he is the child (or eligible grandchild) of a retired, deceased or disabled worker;

II. the individual is at least 18 years of age; and

III. disability (including blindness) began before age 22.

Individuals may lose coverage under this group and later regain it. Continued eligibility is not necessary.

**Section 5.2.11: Other Covered Groups**

Within this section there are other groups which are included in Federal Law. These are listed in Appendix D for informational purposes.

**Section 5.2.12: Individuals under Age 18 Who are Closed From SSI Due to August, 1996 Change in Disability Criteria**

Individuals under age 18 are Medicaid eligible if the individual:

I. was in current pay status with SSI in August, 1996;

II. is closed due to not meeting the child disability standards that became effective on 8/23/96;

III. continues to meet the SSI child disability criteria in effect prior to 8/23/96; and,

IV. continues to meet federal SSI income and resource standards.

If the individual is closed from SSI for a reason other than not meeting the changed disability criteria, such as being over income or assets, or failing to cooperate in establishing eligibility, this protected status does not apply and the individual must then meet current Medicaid eligibility criteria.

Once an individual has been receiving Medicaid under this protected status and they fail to meet any of the criteria in I – IV above, the protected status is lost and eligibility is determined using the current Medicaid criteria.

**Section 5.2.13: Working Disabled**

This coverage group includes individuals who meet the SSI standard for disability and who have earnings subject to federal tax withholding but are not eligible for Medicaid under any other coverage group. These individuals may buy into Medicaid by paying a monthly premium if the specific requirements of this coverage group are met. This is an SSI - Related coverage group using SSI - Related rules for treatment of income and assets, however, there are income and asset limits specific to this coverage group.

**Section 5.2.14: Section 1619(b)**

Section 1619(b) refers to the section in the *Social Security Act* which authorizes coverage for this group. These are individuals who are considered disabled by SSI but their earned income disqualifies them for an SSI payment. However, due to the use of a higher income guideline by SSI, they continue to be carried by SSI case as an open case and they are Medicaid eligible.

**PART 7**

**SSI - RELATED MEDICAID BUDGETING**

This Part describes the budgeting process for income and assets in SSI - Related Medicaid coverage.

**SECTION 1: TREATMENT OF SSI - RELATED ASSETS**

Assets, other than those excluded in Part 16, must be under the following limits on any day of the month to be eligible for that month.

**Section 1.1: Categorically Needy Asset Limit**

$2000 for a single individual, a married individual not living with a spouse or a child.

$3000 for an individual living with an ineligible spouse or an eligible couple.

**Section 1.2: Working Disabled Asset Limits**

$8000 for a single individual, a married individual not living with a spouse or a child.

$12,000 for an individual living with an ineligible spouse or an eligible couple.

**Section 1.3: Deeming of Assets**

When an eligible individual is living in the same household with an ineligible spouse, or if the eligible individual is a child under age 18 residing in the same household with a parent, the assets of the spouse or parent must be included in determining eligibility.

The assets of an ineligible spouse, or parent living with the individual, are deemed to the individual and are combined with the applicant's own assets.

**Section 1.3.1 Exclusions to Deeming Process**

The assets listed below are excluded in determining the amount of the ineligible spouse's or ineligible parent's assets:

I. Assets excluded in Part 16 are also excluded here.

II. Assets owned by a stepparent.

III. Pension Funds (and other retirement accounts) which belong to the ineligible spouse or ineligible parent.

IV. Parent's assets are not considered in determining eligibility for the "Katie Beckett" coverage group.

V. If the asset is only in the child's name, then it does not affect the parent's eligibility since there is no deeming from child to parent.

VI. In determining eligibility for a child some assets may be deducted for legal parents and the balance applied to the child’s asset limit. No assets are deducted for a stepparent.

The non-excluded assets of the parent in excess of $2000 (if the child is living with one legal parent) or $3000 (if the child is living with both parents) are deemed to the child and combined with the child's own non-excluded assets. The combined amount of deemed and own assets must be under the $2000 limit.

**Example**

The legal parents of Joe have non-excluded assets that total $4000. Joe has $200 of non-excluded assets of his own. We will deem $1000 of the parent’s assets to Joe. Joe now has $1200 of countable assets which will be applied against his $2000 asset limit.

**Section 1.3.2: Duration of Deeming**

I. Deeming ends the month after the ineligible spouse and eligible individual cease to live together for any reason.

II. Deeming from parent to child stops the month after the child reaches age 18 or the month after the child no longer resides with the parents.

**SECTION 2: SSI – RELATED INCOME BUDGETING PROCESS**

This section describes the method used to budget income of household members when eligibility is being determined for SSI - Related Medicaid (see also Part 17 – Income).

**Section 2.1: Disregards**

The following are deducted from the individual's or couple's gross non-excluded income in this order:

**Section 2.1.1: Federal Disregard**

Twenty dollars a month from earned or unearned income.

**Note**: The $20.00 disregard is not applied to income based on need. This means there is no $20.00 exclusion of a VA Pension or Veteran's Financial Assistance (which is based on need). The $20.00 disregard does apply to VA Compensation (which is not based on need).

**Section 2.1.2: Impairment - Related Work Expenses (IRWE)**

Impairment - Related Work Expenses (IRWE) are to be deducted from a SSI - Related disabled individual's gross earnings. IRWE allowable deductions and limits are outlined in Appendix B.

**Section 2.1.3: Earned Income Disregard**

$65.00 is deducted from earned income. One half of the remaining earnings is also disregarded. This does not pertain to Sheltered Workshop Income (See Section 2.1.5 of this Part).

**Section 2.1.4: State Disregard**

The State of Maine also allows an added deduction of $55.00 for an individual and $80.00 for a couple.

**Note**: There is no $55.00 state disregard of income when determining eligibility for State Supplement for individuals residing in residential care living arrangements defined in Part 12, Section 1.

**Section 2.1.5: Special Group Disregards**

I. **Pickle Disregard**

Individuals or couples covered under the Pickle Amendment (see Appendix C) have all Cost of Living Adjustments (COLA's) to Social Security benefits received since the closure of concurrent entitlement for SSI or State Supplement and Social Security disregarded. This disregard applies also to COLA increases of the spouse even if the spouse is not eligible as a Pickle.

II. **Disabled Adult Children Disregard**

Individuals or couples receiving Social Security benefits as Disabled Adult Children have a portion of their Social Security benefits disregarded. The amount of the disregard equals the amount of either the increase in, or the initial receipt of, DAC benefits that resulted in SSI ineligibility..

The individual or couple loses this disregard when they marry, unless they marry another DAC.

III. **Disabled Widow(er) (DWB) Benefit Disregard**

The amount of the disregard as a Disabled Widow(er) is the amount of the Social Security benefits that caused the loss of SSI or State Supplement benefits. Disabled Widow(er)s maintain this status when they marry as long as they are still disabled.

IV. **Shelter Workshop Disregard**

Subtract $20 Federal disregard, if not previously deducted

Subtract $50 from remaining sheltered workshop income

Subtract 1/2 of remaining sheltered workshop income

**Section 2.2: Deeming of Income**

When an eligible individual is living in the same household with an ineligible spouse, or if the eligible individual is a child under age 18 residing in the same household with a parent, the income of the spouse or parent must be included in determining eligibility.

The income of an ineligible spouse, or parent living with the individual is deemed to the individual, and is combined with the applicant's own income.

**Section 2.2.1: Allocation**

Before income is deemed an amount is deducted from income which is set aside for the support of certain individuals other than the eligible individual. Specifically:

I. **Ineligible child allocation**

A. when determining eligibility for an eligible child, allow an allocation from the parent’s income for each ineligible child living in the household. In a household where there is a stepparent to an eligible child, use the legal parent’s income to meet the allocation for mutual children.

B. when determining eligibility for an individual or a couple, allow an allocation from the parent’s income for each ineligible child living in the household.

1. for SSI, the State Supplement and when using the Pickle, DWB, or DAC disregards, an allocation is allowed only from the income of an ineligible spouse

2. in other Medicaid determinations, an allocation is allowed from the income of the eligible individual or couple as well as the ineligible spouse.

3. stepparents can allocate to legal children only (including mutual), not to step-children.

4. allow an allocation for a child who is under age 22 (through age 21) and a student regularly attending school or college or training designed to prepare him/her for a paying job. The allocation can be used for a child who is away at school as long as they are considered to be temporarily absent. A child away at school is considered temporarily absent if s/he returns home on some weekends, holidays, or vacations and parent(s) have authority to make decisions on the child’s behalf whether or not this authority is exercised.

5. allocations from a spouse's or parent’s income for an ineligible child in the household (or temporarily absent from the household) end the month the child attains age 18, or if a student, age 22.

6. the amount of the allocation is equal to the difference between the ineligible child allocation amount in Chart 3 and the ineligible child’s gross monthly income. Gross monthly income for this purpose is gross non-excluded income (Part 17) minus the specific exclusions in Section 2.2.2 of this Part.

II. **Parent Allocation** - when determining eligibility for an eligible child:

A. deduct an amount from an ineligible parent’s own income when deeming parental income to an eligible child. This is the parent allocation.

B. the amount is equal to the parent’(s) allocation in Chart 3.2.

C. step-parents are not included in the parent allocation.

**Section 2.2.2: Exclusions to Deeming Process**

I. The following is excluded income when determining the income to be deemed from the ineligible spouse to the eligible spouse:

A. All income that is excluded for an eligible individual.

B. Income from TANF, General Assistance or federal program benefits that are based on need (such as Veteran’s Pension). In addition, exclude any income that was counted or excluded by any of these benefits.

C. Income used to comply with the terms of court ordered support and Title IV-D support payments.

D. When deeming from an ineligible spouse to an eligible spouse, exclude an amount equal to the “ineligible spouse standard” in Chart 3.5. This exclusion is taken first from unearned income and any remainder is taken from earned income.

II. The following is excluded income when determining the income to be deemed from an ineligible parent to an eligible child:

**Note**: Income is not deemed from a stepparent. When looking at the parent allocation, look at the amount for a one-parent household. The eligible child is treated as "living with others”.

A. All income that is excluded for an eligible individual.

B. Income from TANF, General Assistance or federal program benefits that are based on need (such as Veteran’s Pension). In addition, exclude any income that was counted or excluded by any of these benefits. No parent allocation is made.

C. Income used to comply with the terms of court ordered support and Title IV-D support payments.

III. The following is excluded income when determining the income of an ineligible child to whom an income allocation is made:

All income that is excluded for an eligible individual with one exception. There is no one-third exclusion of child support received for the ineligible child.

**Note**: An ineligible child allocation is not made to a child who is receiving TANF, SSI or State Supplement.

IV. When determining eligibility for a child:

If siblings receive SSI or State Supplement, treat them as eligible children in the budgeting process. Exclude the SSI or State Supplement payments the siblings receive.

**Section 2.2.3: Duration of Deeming**

I. Deeming ends the month after the ineligible spouse and eligible individual cease to live together for any reason.

II. Deeming from parent to child stops the month after:

A. the child reaches 18; or

B. the month after the child no longer resides with the parents for any reason.

**SECTION 3: SSI - RELATED BUDGETS FOR AN INDIVIDUAL/CHILD**

The following describes budgeting for:

\* SSI or State Supplement for eligible individuals.

\* Pickle, DAC, DWB for eligible individuals.

\* Categorically Needy Medicaid for eligible individuals.

\* SSI, State Supplement and Categorically Needy Medicaid for eligible children.

**Note**: If an individual is over income or assets under Categorically Needy, eligibility needs to be determined under Medically Needy criteria (See Part 10).

**Section 3.1: Budget for SSI or State Supplement Payment**

I. Combine all gross unearned income.

II. Subtract the $20.00 Federal Disregard where applicable. The remainder is the net unearned income.

III. Combine all gross earned income.

IV. Subtract any remainder of the $20.00 Federal Disregard not deducted from unearned income.

V. Subtract any Impairment-Related Work Expenses (IRWE) outlined in Appendix B.

VI. Subtract the earned income disregard of $65.00.

VII. Divide the remaining earned income by two. The remainder is net earned income.

VIII. Combine net earned and unearned income. The remainder is total net income.

If total net income is below the appropriate SSI Income Standard for one, based on living arrangement, the individual meets the income criteria for an SSI payment.

If receiving SSI, the individual also gets a State Supplement. If over income for SSI, s/he may be eligible for a State Supplement only payment.

IX. Subtract the State Disregard for one ($55.00), except for those in living arrangements D, E, F, G, I (See Chart 3.6). The remainder is countable income.

If countable income is below the appropriate State Supplement Income Standard for one, based on living arrangement, the individual meets the income criteria for the State Supplement only payment (See Part 11 for more information on State Supplement eligibility).

**Section 3.2: Budget for Medicaid Coverage Under Pickle Amendment or Disabled Adult Child (DAC) or Disabled Widow(er) Disregards**

Follow the budgeting process in Section 3.1 for an individual, except that the Pickle, DAC, and/or DWB income disregard(s) are subtracted after step I. and before step II (Federal Disregard).

Follow the budgeting process for a disabled child in Section 3.4 of this Part. In determining the child’s countable income deduct the Pickle disregard between steps I and II (Federal disregard).

If countable income is below the State Supplement Income Standard, the individual is Medicaid eligible.

**Section 3.3: Budget for Categorically Needy Medicaid Coverage**

Individuals who are not eligible under Section 3.1 or Section 3.2 or who choose not to apply for SSI/State Supplement, may get Medicaid coverage (if otherwise eligible) by using the following budget process.

I. Combine all gross unearned income.

II. Subtract the $20.00 Federal Disregard, where applicable. The remainder is the net unearned income.

III. Subtract any allocation to an ineligible child. An ineligible child is one who is not receiving TANF, SSI or State Supplement.

To determine the allocation, deduct each child’s countable income from the maximum child allocation (see Chart 3.2). The remainder for each child is combined to determine the total allocation. The remainder is the individual’s net unearned income.

IV. Combine all gross earned income.

V. Subtract any remainder of the $20.00 Federal Disregard not deducted from the unearned income.

VI. Subtract any remainder of the ineligible child allocation not deducted from the unearned income.

VII. Subtract any Impairment-Related Work Expenses (IRWE) outlined in Appendix B.

VIII. Subtract the earned income disregard of $65.00.

IX. Divide the remaining earned income by two. The remainder is net earned income.

X. Combine the net earned and unearned income.

XI. Subtract the State Disregard for 1 ($55.00). The remainder is the countable income.

If countable income is equal to or below 100% of the Federal Poverty Level for one and eligibility is based on age or disability, the individual is Medicaid eligible.

**Note**: The State Supplement budgeting criteria must be used for an individual whose eligibility is based solely on blindness. However, if the individual also meets the SSI criteria for disability use the budgeting criteria in this section.

If countable income is greater than the Federal Poverty Level for one, go to the Medically Needy Part 10.

**Section 3.4: SSI, State Supplement and Categorically Needy budget for a child**

I. **Unearned Income to the Eligible Child(ren)**

A. Subtract the allocation for ineligible children and/or aliens from the parental unearned income.

B. If the allocations are greater than the unearned income, or there is no unearned income, subtract the excess allocations from the parental earned income.

C. Subtract the $20.00 Federal Disregard from any remaining parental unearned income.

D. If the remaining unearned income is less than $20.00, subtract the remainder of the $20.00 from the parents’ combined earned income.

E. Subtract $65.00 from the remaining earned income.

F. Subtract one-half the remaining earned income from the result of Step V.

G. Add the result of Step III (countable unearned income) to the result of Step VI (countable earned income).

 H. Subtract the parental living allowance (see Chart 3.2) from the result of Step VII (parental countable unearned and earned income).

I. Divide the result of Step VIII by the number of eligible children in the household. This is unearned income to the eligible child(ren).

If there is more than one eligible child in the household, divide the deemed income equally among them. However, do not deem in excess of the amount which, when combined with the child's own income, would make the child ineligible. That excess is deemed in equal amounts among the other eligible children in the household in addition to their equal shares of the deemed income (See Example 2 below).

II. Determine the child's countable income:

A. Combine the deemed income with the child's own unearned income.

B. Subtract the $20.00 Federal Disregard. The remainder is the net unearned income.

C. Combine all gross earned income.

D. Subtract any remainder of the $20.00 Federal Disregard not deducted from the unearned income.

E. Subtract any Impairment Work-Related Expenses (IRWE) outlined in Appendix B.

F. Subtract the earned income disregard of $65.00.

G. Divide the remainder by two. The remainder is the net earned income.

H. Combine the net earned and unearned income.

I. Subtract the State Disregard for one (see Chart 3.1). The remainder is the countable income.

If the countable income is below the SSI/State Supplement Income Standard for one, see Chart 3.4, (living in the household of another) the child may be eligible for a SSI / State Supplement payment (See Part 11).

If countable income is equal to or below 100% of the Federal Poverty Level for one the child is Medicaid eligible.

If countable income is greater than the Federal Poverty Level for one, go to the Medically Needy Part 10.

**Examples**

1. Mr. and Mrs. Fry have two children, Linda (age 10) and Mike (age 11). Mike has been found disabled through the Medical Review Team. Mr. Fry earns $600 weekly. There is no other income for the family.

 $ 600 weekly gross income (Mr.)

X 4.3

 $ 2580 monthly gross income

- $ 319 ineligible child allocation to Linda

 $ 2261

- $ 20 federal disregard

 $ 2241

- $ 65 earned income disregard

 $ 2176

- $ 1088 earned income disregard (1/2 the remainder)

 $ 1088

- $ 956 living allowance for two parents (Chart 3.2)

 $ 132 deemed to Mike

- $ 20 federal disregard

 $ 112

- $ 55 state disregard

 $ 57 countable income for Mike

Mike’s income is less than the SSI/State Supplement standard for one. He is eligible for Medicaid and may be eligible for SSI.

If the countable income was equal to or above the appropriate SSI/State Supplement Standard compare the countable income to 100% of the Federal Poverty Level for one.

2. Kevin and Beth Ham have two children, Barbara and Dick, both of which meet disability criteria. Dick receives an annuity of $600 monthly due to an accident.

$3765.00 Kevin’s monthly earnings

- $ 20.00 federal disregard

 $3745.00

- $ 65.00 earned income disregard

 $3680.00

- $1840.00 earned income disregard (1/2 the remainder)

 $1840.00

- $ 934.00 parent allocation

 $ 906.00 income to be deemed to eligible children

The $906.00 would be deemed equally between the two eligible children. Doing so would make Dick over income. As a result, we will deem an amount to Dick up to the Categorical Income limit and the balance is deemed to Barbara. This will result in both Barbara and Dick being eligible for Medicaid.

 $ 926.00 Categorical Income limit

 $ 600.00 Dick’s annuity

 $ 326.00 amount deemed to Dick

 $ 906.00 income to be deem to eligible children

- $ 326.00 amount deemed to Dick

 $ 580.00 amount deemed to Barbara

**SECTION 4: BUDGET FOR A COUPLE OR FOR AN ELIGIBLE INDIVIDUAL WITH AN INELIGIBLE SPOUSE**

The following describes budgeting for an eligible couple or eligible individual with an ineligible spouse:

\* SSI or State Supplement

\* Pickle, DAC, DWB

\* Categorically Needy Medicaid

\* SSI, State Supplement and Categorically Needy Medicaid

**Note**: If over income or assets under Categorically Needy, eligibility needs to be determined under Medically Needy criteria (See Part 10).

In SSI - Related coverage groups, when one spouse is receiving an SSI/State Supplement benefit, that spouse is included in the assistance unit. The SSI/State Supplement payment is excluded income. All other countable income of the SSI/State Supplement recipient is used to determine eligibility for the assistance unit.

**Example**

Barb VanMarpel receives SSDI of $600 and SSI of $57.00. Her husband Antonio, age 83, has retirement income of $300, monthly. Barb is eligible for Medicaid because she receives SSI. Eligibility needs to be determined for Antonio. The budget for his eligibility will use Barb’s SSDI of $600 and his retirement of $300. The budgeting process used is for an eligible couple.

**Section 4.1: Budget for SSI or State Supplement Payment**

I. **Budget for an Eligible Couple**

Follow the budgeting steps for an individual with the following exceptions:

A. the income of the couple is used

B. the State Disregard for two is used in Step IX ($80.00).

C. Net income is compared to the SSI Income Standard for two based on living arrangement.

D. If ineligible for SSI, countable income is compared to the State Supplement Income Standard for two based on living arrangement.

II. **Budget for an Eligible Individual with an Ineligible Spouse**

A. **Pretest**

The individual must have countable income less than the SSI or State Supplement Income Standard for one.

1 Determine the eligible individual's countable income, using steps I – IX in Section 3.1.

2 If this figure is equal to or greater than the SSI or State Supplement Income Standard for one the individual does not meet the pretest and is not eligible under this section.

3 If this figure is less than the SSI or State Supplement Income Standard for one, based on the living arrangements (see Chart 3.4), the individual is potentially eligible for SSI or State Supplement.

The SSI or State Supplement budgeting process continues with deeming income from the ineligible spouse.

B. **Deeming of income from the ineligible spouse**

**Note**: See Section 2.2.2 of this Part on Deeming of Income for special income exclusions allowed from the income of an ineligible spouse.

1. Combine all of the ineligible spouse’s unearned income.

2. Subtract any allocation to an ineligible child. An ineligible child is one who is not receiving TANF, SSI or State Supplement. To determine the allocation, deduct each child’s countable income from the maximum child allocation (see Chart 3.2).

The remainder for each child is combined to determine the total allocation.

**Note**: For SSI or State Supplement eligibility, only the ineligible spouse can allocate income to an ineligible child.

The remainder is the spouse’s net unearned income.

3. Combine all of the ineligible spouse’s earned income.

4. Subtract any remaining child allocation from the earned income.

The remainder is the spouse’s net earned income.

C. **Eligibility of the Eligible Spouse**

1. Combine the individual’s gross unearned income with the spouse’s net unearned income (after the child allocation has been deducted).

2. Subtract the $20.00 Federal Disregard, where applicable.

3. Combine the individual’s gross earned income with the spouse’s net earned income (after any remaining child allocation is deducted).

4. Subtract any remainder of the $20.00 Federal Disregard not deducted from the unearned income.

5. Subtract any Impairment-Related Work Expenses (IRWE) outlined in Appendix B.

6. Subtract the earned income disregard of $65.00.

7. Divide the remaining earned income by 2. The remainder is the net earned income.

8. Combine the net earned and unearned income. This is the total net income.

If total net income is below the SSI Income Standard for two, based on living arrangement, and the individual met the pretest, the eligible individual meets the income criteria for an SSI and State Supplement payment.

If over income for SSI, s/he may be eligible for just a State Supplement payment.

9. To determine if the eligible individual can receive just a State Supplement payment subtract the State Disregard for two ($80.00), except for those in living arrangement D, E, F, G (See Part 11). The remainder is the countable income.

If the countable income is below the State Supplement Income Standard for two, (See Chart 3.4) based on living arrangement, and the individual met the pretest, the eligible individual meets the income criteria for just a State Supplement payment

Part 11 has additional information on State Supplement.

If countable income is greater than the Federal Poverty Level for one, go to the Medically Needy Part 10.

**Section 4.2: Budget for Medicaid for Coverage Under Pickle Amendment or Disabled Adult Child (DAC) or Disabled Widow(er) (DWB) Disregards**

Follow the budgeting process in section 4.1, steps A, B and C, except that the Pickle DAC, and/or DWB income disregard(s) are subtracted before the Federal Disregard.

If countable income is below the State Supplement Income Standard for two, the individual is Medicaid eligible.

**Section 4.3: Budget for Categorically Needy Medicaid Coverage**

A couple or an eligible individual with an ineligible spouse who is not eligible under 4.1 or 4.2 or who chooses not to apply for SSI/State Supplement, may get Medicaid coverage (if otherwise eligible) by using the following budget process.

**Note**: See Section 2.2.2 of this Part on Deeming of Income for special income exclusions allowed from the income of an ineligible spouse.

Combine all gross unearned income of the couple.

I. Subtract the $20.00 Federal Disregard where applicable.

II. Subtract any allocation to an ineligible child. An ineligible child is one not receiving TANF, SSI or State Supplement. To determine the allocation, deduct each child’s countable income from the maximum child allocation (See Chart 3.2). The remainder for each child is combined to determine the total allocation. The remainder is the net unearned income.

III. Combine all gross earned income of the couple.

IV. Subtract any remainder of the $20.00 Federal Disregard not deducted from unearned income.

V. Subtract any remainder of the ineligible child allocation.

VI. Subtract any Impairment-Related Work Expenses (IRWE) outlined in Appendix B.

VII. Subtract the earned income disregard of $65.00.

VIII. Divide the remaining earned income by two. The remainder is net earned income.

IX. Combine the net earned and net unearned income.

X. Subtract the State Disregard for two ($80.00). The remainder is countable income.

If countable income is equal to or below 100% of the Federal Poverty Level for two and eligibility is based on age or disability, the individual or couple is Medicaid eligible.

**Note**: The State Supplement budgeting criteria must be used for an individual or couple whose eligibility is based solely on blindness. However, if the individual or couple also meets the SSI criteria for disability use the budgeting criteria in this section.

**SECTION 5: KATIE BECKETT COVERAGE**

Katie Beckett is a MaineCare coverage group for children who are ineligible under a Family - Related or any other SSI - Related coverage group and who:

I. are age 18 and under (up to age 19);

II. reside in the community (not in a medical institution);

III. meet the SSI/SSA criteria for disability; and

IV. need in-patient care provided by a hospital, nursing facility, psychiatric hospital, or an ICF‑MR. The cost of providing care outside the facility must not exceed the annual cost of institutional care needed by the child as determined by the Office of MaineCare Services.

V. If a child covered under Katie Beckett no longer resides with the parent(s), parental deeming under SSI - Related rules ends (See Section 2.2.3 of this Part). The child may then be eligible as SSI - Related and may not need the Katie Beckett coverage group.

**Section 5.1: Income and Assets**

If the criteria in I – IV above are met, the income and assets of the child only are considered in determining financial eligibility. Parental income and assets are disregarded. There is no cost of care and there is no penalty for transfer of resources.

I. The child’s gross income as defined in SSI - Related coverage must be less than or equal to the Categorical Nursing Care Limit (see Chart 4.1). If income exceeds this amount, the individual is not eligible.

II. The child’s countable assets as defined in Part 16 must be less than $2,000.

**Section 5.2: Premiums**

I. Except for Alaska Natives and Native Americans who are members of Federally-recognized Tribes, the Department must receive monthly premiums as described below, in order for the child to receive Katie Beckett coverage.

A. **Amount**

1. The amounts of the monthly premiums, based on family income as a percentage of the Federal Poverty Level, are identified in Chart 3.12.

2. The premium amounts in the chart apply to a family, regardless of the number of Katie Beckett children in the family.

3. For purposes of calculating family income as a percentage of Federal Poverty Level to determine monthly premiums, family size is the total of the child or children covered under the Katie Beckett group, his or her siblings and his or her parents who reside in the household. Family income is based on gross monthly non- excluded income of the family. Income excluded by SSI - Related coverage and stepparent income (unless the stepparent is to be counted in the family size) are both excluded.

a. There are no deductions or disregards from income.

b. Current income is projected over a twelve month period.

c. SSI - Related Medicaid rules are used in anticipating income and in the treatment of irregular, fluctuating, contract, seasonal and self-employment income.

d. Premium amounts due can be changed if there is a change in income or health insurance that is expected to last for more than a full calendar month. The change in premium amount is effective the month after the month the change in income or health insurance occurred, as long as the change

 in income or health insurance is reported within ten days of its occurrence; otherwise, the change in premium is effective the month after the month the change in income or health insurance is reported. Adverse action notice will be given when a premium is increased.

e. There are two premium schedules:

i. a standard premium for children without any other creditable private health insurance coverage. Creditable insurance coverage is defined in 42 U.S.C. §300gg(c)(1) and includes any health benefits plan, individuals or group, a medical care program of the Indian Health Service or another tribal organization, any government insurance plan for Armed Forces, Peace Corps volunteers or government employees, provided by a carrier for the purposes of providing, paying for or reimbursing expenses for health services. Creditable insurance coverage does not include coverage which is limited in scope such as dental insurance or vision care insurance; and

ii. a discounted premium for children covered by a private health insurance plan.

**Note**: For families using the Private Health Insurance Program (PHIP) benefit, the standard premium schedule applies.

B. **Payment**

1. Payment is due to be received by the Department on the first day of the month for which the child receives coverage.

2. Premiums can be paid monthly, for more than one month at a time, or in advance for the twelve month eligibility period. Payments will first be credited to the earliest months of coverage during the current twelve month eligibility period. If retroactive coverage is granted according to Part 2, Section 13.4, then payment will also be due for the retroactive months of coverage. These payments for retroactive coverage will be created first.

**For example**: A monthly premium of $92.00 is due during the twelve month review period from January to December and the first payment of $92.00 is received on March 1st. Month one (January) will be credited with a premium paid. The February and March payments are overdue.

3. Payment must be paid up to date every three months. If not, advance notice of closing will be sent to end coverage the last day of the 3rd month.

**For example**: The 1st month of coverage is January. As of March 1st, premiums for January, February, and March are paid. As of June 1st, payments are received by DHHS for April, but no payment is received for May or June. Action is taken to end Medicaid coverage effective June 30th.

4. There is a grace period for nonpayment of premiums. The grace period extends through the last day of every 3rd month.

5. If payment is received the month following the month coverage has ended, a new medical assessment is not needed to determine if the child is in the need of institutional level of care. Reapplications for any following months require a new medical assessment. A prior decision on meeting the SSA disability criteria can be used if the review date of this decision is in the future.

6. If MaineCare coverage under the Katie Beckett group is closed due to non-payment or non-timely payment of a premium, coverage under Katie Beckett cannot be reinstated for twelve months starting with the month the closing is effective unless all past due premiums are paid in full.

7. Coverage under this group can be reinstated in fewer than 12 months if there is good cause for late or non-payment of premiums because of one of the following reasons:

a. mail delay;

b. illness of the parent; or

c. unanticipated emergency beyond the control of the parent or the responsible individual.

C. **Refunds**

A refund is due if an agency error occurs. Any adjustment will be limited to twelve months prior to knowledge that an agency error has occurred.

II. If a child under age 18 is getting Medicaid coverage through the SSI cash program and he/she becomes ineligible for an SSI cash payment due to the parents' income or assets, the child may continue to get full Medicaid coverage and a $40.00 payment through the SSI and State Supplement program if the child:

A. is disabled;

B. received SSI benefits while in a medical facility (hospital or nursing home) for at least one month; and

C. meets the inpatient level of care standard for Katie Beckett.

The SSI office will ask the state Department of Health and Human Services to see if the child meets the medical need standard for the Katie Beckett option. The SSI office will let the parents know if the child meets the criteria and can get the $40.00

payment from SSI/State Supplement as well as continued Medicaid coverage. SSI may refer to this option as the "waiver of parental deeming".

**SECTION 6: BUDGETING FOR WORKING DISABLED**

There is a two step test of income that must be met.

I. Countable unearned income must be equal to or less than 100% of the Federal Poverty Level.

II. Countable unearned and earned income subject to federal tax withholding must be less than 250% of the FPL.

**Section 6.1: Earnings**

The individual must have earnings subject of federal tax withholding but there is no minimum work requirement and no SGA earnings test.

**Section 6.2: Disability**

The individual must meet the SSI criteria for disability. This criteria is met if there is currently in effect a decision by the Social Security Administration that this disability criteria is met.

**Section 6.3: Changes**

If the individual becomes eligible for Medicaid without a premium because of a change in income and that change is expected to last for a full calendar month, the individual will be moved to Medicaid coverage without a premium. This change is made effective the month the change occurred as long as this change is reported within ten days of its occurrence; otherwise, it is effective the month the change is reported. “Occurrence” is the date the change takes place.

The individual will be given a refund for any prepaid months in which s/he is subsequently moved to coverage without a premium.

**Section 6.4: Premiums**

I. **Due Date/Amount of Premium**

A premium payment is due for each month the individual is open for Medicaid under this coverage group unless s/he is exempt from a premium as identified below.

If a couple is eligible under this coverage group, there is one premium for the couple based on the couple’s countable income.

Premiums are due on the first day of each month of coverage.

The premium amount is based on countable monthly income projected for the twelve month eligibility period and does not change. A premium is effective the month an individual is added for coverage under this coverage group. Any decrease in premium is effective the month the individual’s coverage under this group ends.

If countable monthly income is over 150% and equal to or less than 200% of the FPL, the monthly premium is $10.00. If countable monthly income is over 200% and less than 250% of FPL the monthly premium is $20.00

II. **Exemptions from Premium Payment**

An individual is exempt from a premium:

A. if countable income is less than or equal to 150% of the Federal Poverty Level;

B. if s/he is responsible for paying for their Medicare Part B premium; or

C. if there is good cause for premiums not paid or not paid when due because of one of the following reasons:

1. mail delay;

2. illness of the individual or their responsible relative; or

3. an anticipated emergency beyond the control of the individual or their responsible relative.

D. For periods of retroactive coverage or temporary coverage.

III. **Payment of Premiums**

A. Premiums can be paid monthly, for more than one month at a time, or they can be paid in advance for the twelve month eligibility period. Payments will be credited to the earliest months of coverage first, during the current 12 month eligibility period.

**Example**

A monthly premium of $10.00 is due during a twelve month eligibility period from January to December and the first payment of $50 is received on June 1st. Months one through five will be credited with a premium paid. The June payment is overdue.

B. When a premium is not paid by the first of the month in which it is due the Department will give notice of nonpayment.

C. There is a grace period for nonpayment of premiums. The grace period extends through the last day of the twelve month eligibility period.

**Example**

If the eligibility period is January through December, the individual has until December 31st to pay his or her premiums for the period January to December. If the last day of the month falls on a weekend or holiday the premium is then due on the next workday.

D. When eligibility under this coverage group ends prior to the end of the twelve month eligibility period, the grace period for premium payment extends to the last day of the month in which coverage under the Working Disabled group ends.

**Example**

An individual granted 10/07 has a review date of 9/08 but his coverage is changed to Medicaid without a premium for 12/07. The grace period for payment of premiums for October and November is November 30th.

E. When eligibility under this coverage group is continued pending a hearing and a premium is due, the grace period is the last day of the month for which coverage is provided.

**Example**

The premium for the month of July is due July 1st. The grace period extends to July 31st.

IV. **Non Payment of Premiums**

A. At the beginning of month twelve of the eligibility period, notification will be given if any premiums for the eligibility period have not been paid when due. The individual will be notified of the penalty to be imposed because of the nonpayment.

B. At the twelve month review a determination will be made as to whether there are any overdue premiums. If so, coverage under the Working Disabled group will end unless there is “good cause” for nonpayment. Coverage as Working Disabled cannot begin again until any unpaid premiums are paid.

V. **Administrative Hearings**

A. Coverage as Working Disabled continues pending a hearing decision if a hearing is timely requested even if the individual is not paying premiums that are due. If the individual was responsible for paying a premium prior to the proposed negative action, this premium will continue to be due.

B. If the individual is upheld at the hearing and they have overpaid any premiums s/he will be issued a refund.

# PART 8

# MEDICARE SAVINGS PROGRAM [BUY-IN])

**SECTION 1: PROGRAM SCOPE**

The Medicare Savings Program (MSP), also known as the Buy-In, provides qualified Medicare eligible individuals with Medicaid coverage that pays for their Medicare premiums. The Department also provides additional benefits for Qualified Medicare Beneficiaries (QMB), which are detailed below.

The Social Security Administration (SSA) enrolls SSI recipients for the Buy-In of Medicare Part B premiums. If the individual needs assistance with payment of Medicare Part A premiums, DHHS enrolls the individual in Qualified Medicare Beneficiaries (QMB). See Section 4.1 of this Part.

**SECTION 2: BASIC ELIGIBILITY REQUIREMENTS**

Individuals may be eligible for Buy-In if they meet the criteria of one of the groups listed in Section 4 of this Part. If not open for or applying for MaineCare, these individuals need to file an application for Buy-In with the Department.

Individuals must meet the basic eligibility requirements for SSI - Related MaineCare described in Part 6, except for individuals who have been diagnosed with end stage renal disease (ESRD). Individuals with an ESRD diagnosis do not need to meet the age or disability requirements.

**SECTION 3: FINANCIAL ELIGIBILITY REQUIREMENTS**

SSI - Related Categorically Needy MaineCare budgeting rules are used to determine Buy-In eligibility.

Buy-In is a separate benefit within Medicaid. As a result, one spouse of an eligible couple can choose to be an ineligible spouse to give Medicaid eligibility to the other, and at the same time the couple will both be considered for Buy-In eligibility.

**Example**

Mr. and Mrs. Mazure apply for MaineCare. Both have Medicare. Mr. Mazure has Social Security income of $920. Mrs. Mazure has Social Security income of $600. Using SSI - Related Categorically Needy budgeting for an eligible couple, both are eligible for Buy-In but over income for Medicaid. Mrs. Mazure has to see a specialist, and Mr. Mazure does not. Mr. Mazure can choose to be counted as an ineligible spouse for MaineCare. We then use the exclusions to deeming found in Part 7, Section 2.2.2, resulting in Mrs. Mazure being eligible for Medicaid, and both of them being eligible for Buy-In.

There is usually a delay between the time an individual is eligible for the Buy-In and the time the Buy-In premium payment begins. During this time, the individual continues to have premiums deducted from their Social Security benefits (See Appendix A).

**Section 3.1: Individual Who Opted Out of Medicare**

Individuals who are not automatically enrolled in Medicare Part A or B, are not entitled to premium-free Medicare Part A (such as those individuals over age 65 but who did not pay enough Medicare taxes), or who opt out of Medicare Part A and/or B coverage when it is first offered, are considered entitled to enroll in Medicare. These individuals are eligible to apply

for Buy-In. The Department will start their coverage without waiting for open enrollment. The Medicare Part A and/or B start date will be the effective date of the Buy-in.

**SECTION 4: COVERAGE TIERS**

 **Section 4.1: Qualified Medicare Beneficiary (QMB)**

1. Eligibility Requirements for QMB

A Qualified Medicare Beneficiary is an individual who:

A. is entitled to Medicare Part A or voluntarily enrolled in Medicare Part A;

B. has income equal to or less than 150% of FPL; and

C. has liquid assets of no more than $50,000 for an individual or $75,000 for a couple. “Liquid Assets” are defined in Part 16.

1. Description of QMB Benefits

A. Medicaid pays the cost of Medicare Part A and/or B premiums, as well as satisfying Medicare Part A and B deductibles and coinsurances (See Appendix A).

B. An individual may be eligible for QMB and Medicaid at the same time.

C. Coverage begins the month after the month in which an eligibility decision is made that the individual is eligible as a QMB. There is no three-month retroactive period.

 **Section 4.2: Specified Low Income Medicare Beneficiary (SLMB)**

1. Eligibility Requirements for SLMB

A Specified Low Income Medicare Beneficiary is an individual who:

A. is entitled to Medicare Part A or is voluntarily enrolled in Medicare Part A;

B. has income over 150% of the Federal Poverty Level (FPL) and equal to or less than 170% of FPL; and

C. has liquid assets of no more than $50,000 for an individual or $75,000 for a couple. “Liquid Assets” are defined in Part 16.

1. Description of SLMB Benefits

A. Medicaid pays the cost of Medicare Part B premium (see Appendix A).

B. An individual may be eligible for SLMB and Medicaid at the same time; and

C. coverage begins the month of application, retroactive to three months (but not prior to 1/1/93).

 **Section 4.3: Qualifying Individual (QI)**

* 1. Eligibility Requirements for QI

A Qualifying Individual is an individual who:

A. is entitled to Medicare Part A or is voluntarily enrolled in Medicare Part A;

B. has income more than 170% of the Federal Poverty Level (FPL) but less than 185% FPL; and

C. has liquid assets of no more than $50,000 for an individual or $75,000 for a couple. “Liquid Assets” are defined in Part 16.

* 1. Description of QI Benefits

A. Medicaid pays the cost of the Medicare Part B premium.

B. The individual cannot receive Medicaid coverage and this benefit at the same time; and

C. coverage begins the month of application up to three months retroactive but no earlier than 1/1/98.

 **Section 4.4: Qualified Disabled and Working Individual (QDWI)**

1. Eligibility Requirements for QDWI

A Qualified Disabled and Working Individual is one who:

A. is entitled to Medicare Part A;

B. is not eligible for Medicaid;

C. has lost entitlement to Social Security disability benefits due to excess income from wages;

D. has countable income equal to or less than 200% of the FPL; and

E. has countable assets less than or equal to $4000.

1. Description of QDWI Benefits

A. Medicaid pays the cost of the Medicare Part A Premium.

B. Coverage begins the month of application, up to three months retroactive.

**PART 9**

**LIMITED BENEFIT GROUPS**

**SECTION 1: BENEFIT FOR PEOPLE LIVING WITH HIV/AIDS**

The Benefit for People Living With HIV/AIDS is a section 1115 health care reform demonstration agreement between the Office of MaineCare Services and the Centers for Medicare and Medicaid Services. The Office for Family Independence determines eligibility for this benefit. This benefit provides limited MaineCare coverage to individuals with an HIV/AIDS diagnosis if they meet the medical and financial requirements identified in this section. This benefit is also known as the Special Benefit Waiver (SBW).

Individuals who do not meet the eligibility requirements for MaineCare, but who are HIV-positive and are at or below 250 percent of the federal poverty level, may be eligible for SBW. If an individual who is eligible for this benefit becomes eligible for full MaineCare coverage, they will be moved to the appropriate MaineCare full coverage group. This contingency includes someone who meets a deductible or has a reduction in income that qualifies them for full MaineCare coverage. If an individual, enrolled in a full MaineCare coverage group, becomes ineligible for that group, including someone who must meet a new deductible, but is eligible for SBW, that individual will be granted coverage through SBW. This enrollment will happen even if SBW has a wait list.

An individual cannot receive SBW coverage and the Maine Rx Plus or Low Cost Drugs for the Elderly and Disabled (DEL) programs at the same time. SBW coverage and DEL coverage can overlap when DEL is supplementing Medicare Part D.

**1. Basic Eligibility Requirements**

Basic Non-Financial eligibility requirements for receiving MaineCare coverage identified in Part 2 apply to this group. This condition includes meeting the requirements for residency, citizenship, social security numbers, assignment of rights to medical payments and support rights, as well as applying for other benefits. SBW has no age requirement.

**A. Medical Eligibility**

The individual must be diagnosed as HIV positive. This diagnosis is confirmed by the Maine Center for Disease Control (MCDC). The individual must also comply with a treatment regimen as defined by their licensed healthcare professional.

If an individual reports a disabling condition and is financially eligible for SSI-Related coverage, eligibility for full MaineCare coverage must be determined first. If the Social Security Administration has not completed a disability determination, this determination will be done by the Medical Review Team.

**B. Assets**

SBW has no asset criteria.

**C. Income**

Individuals must meet the SSI – Related financial eligibility requirements as listed in Part 7 to be financially eligible for SBW. The SSI - Related rules on income exclusions, in Part 17, are applicable to this coverage group. There is no deeming of income from the spouse. There is no cost of care.

Gross income must be equal to or less than 250% of the Federal Poverty Level.

When determining MaineCare coverage for a spouse not applying for, or enrolled in, SBW, the income and assets of both individuals are used to determine eligibility for the spouse.

**2. Premiums**

Premium payments are due on the first day of each month that the individual is open for MaineCare under this coverage group. Some individuals may be exempt from premiums as identified below.

The premium amount is based on gross monthly income projected for the 12-month enrollment period. Premiums are effective the month that coverage begins for the individual and end effective the month that coverage ends under the waiver. See Chart 3.8 for premium amounts due. Premiums, when added to other payments made by the household to Cub Care or MaineCare, will not exceed five percent of that household’s gross annual income.

**A. Payment of Premiums**

(1) Premiums can be paid monthly, in advance for multiple months, or they can be paid in advance for the 12-month enrollment period. Payments will be credited to the earliest months of coverage first, during the current 12-month enrollment period.

**Example:** A monthly premium of $35.93 is due during a 12-month enrollment period from January through December, and the first payment of $395.23 is received on December first. Months one through 11 will be credited with a premium paid. The December payment is overdue.

(2) When a premium is not paid by the first of the month in which it is due the Department shall send notice of nonpayment to the individual.

(3) There is a grace period for nonpayment of premiums. The grace period extends through the last day of the 12-month enrollment period, or 60 days from the first day of the month for which a payment is due, whichever is later.

**Example A**: If the enrollment period is January through December and an individual fails to pay the premium due for March, the individual has until December 31st to pay the March premium.

**Example B**: If the enrollment period is January through December and an individual fails to pay the premium due for December, the individual has until 60 days from December first to pay the December premium.

If the last day of the grace period falls on a weekend or holiday, the premium is due on the next business day.

(4) If eligibility under this coverage group ends prior to the close of the 12-month enrollment period, the grace period for premium payment extends to the last day of the month in which coverage under this group ends, or 60 days from the first day of the month for which a payment is due, whichever is later.

**Example**: An individual is granted coverage for January through December. In March, coverage is changed to full MaineCare without a premium. The grace period for payment of the January premium is 60 days after January first. The grace period for payment of the February premium is 60 days after February first.

(5) If eligibility under this coverage group is continued pending a hearing and a premium is due, the grace period is 60 days from the first day of the month for which coverage is provided.

**Example**: The premium for the month of July is due July first. The grace period extends to 60 days after July first.

**B**. **Exemptions from Premium Payment**

An individual is exempt from a premium if any one of the following conditions apply:

(1) Gross income is less than or equal to 150% of the Federal Poverty Level.

(2) Any one of the following reasons constitutes good cause for premiums not paid or not paid when due:

(a) Mail delay,

(b) Illness of the individual or illness of the person responsible for the individual’s premium payments, or

(c) Unanticipated emergency beyond the control of the individual or their responsible relative.

(3) During periods of retroactive coverage.

**C. Changes in Premium Amount**

If the individual’s income changes so that no premium is due, or the amount of premium increases or decreases, this change will be made as follows:

(1) The change in income must be expected to last at least a full calendar month;

(2) The change of the premium will be effective for the month the income changed if the change is reported within ten days of its occurrence. Otherwise, the change of premium is effective the month the change in income is reported; and

(3) The premium amount will be changed no more than once every six months.

**D. Non-Payment of Premiums**

(1) At the beginning of the last month of the enrollment period, notification will be sent if any premiums for the enrollment period are still due. The individual will be notified of the non-payment penalty to be imposed.

(2) At the 12-month review a determination will be made as to whether any premiums are overdue. If so, coverage for this benefit will end unless “good cause” for non-payment exists. Coverage cannot begin again until any unpaid premiums are paid. When the unpaid premiums are paid, and the individual is otherwise eligible, the individual is re-enrolled regardless of the existence of a wait list or the individual’s place on that list.

**3. Administrative Hearings**

A. Coverage for this benefit continues pending a hearing decision if a hearing is requested at any time during the Adverse Action Notice Period, even if the individual is not paying premiums that are due. If the individual was responsible for paying a premium prior to the proposed negative action, this premium will continue to be due. For complete rules regarding administrative hearings, see Part 1, Section 7 of this manual.

B. If the individual is upheld at the hearing and they have overpaid any premiums, a refund will be issued.

**4. Wait List**

Enrollment for this benefit is capped based on expenditures. If enrollment is frozen, individuals who have been determined to be medically and financially eligible will be placed on a wait list that is maintained by the Maine Center for Disease Control and Prevention (MCDC). The rules for the wait list are in the *MaineCare Benefits Manual*.

When the Office for Family Independence is informed by the MCDC that an individual’s coverage can start, financial eligibility will be updated before coverage for this benefit can start.

**SECTION 2: BREAST AND CERVICAL CANCER**

Medicaid is provided to women who are under age 65 and otherwise meet the eligibility guidelines set forth in DHHS Rules for the Maine Breast and Cervical Health Program (MBCHP), 10-144, Chapter 707 *et seq*. MaineCare coverage is also available for women diagnosed with breast or cervical cancer, or a pre-cancerous condition and who meet the eligibility guidelines set forth in DHHS Rules relating to the Breast & Cervical Cancer Prevention and Treatment Act (BCCPTA), 10-144 C.M.R. Ch. 708 *et seq*.

Individuals are initially authorized coverage under these groups based on data collected by the Maine Center for Disease Control and Prevention (MCDC) and transferred electronically to the Office for Family Independence (OFI). Coverage is continuous for one year or as long as the individual is in need of treatment, whichever is longer. When eligibility under these groups ends, the individual will be reviewed by OFI for continued coverage under another MaineCare coverage group.

Basic Non-Financial eligibility requirements for getting Medicaid coverage identified in Part 2 also apply to these groups. This includes the rules on residency, citizenship, social security numbers, and assignment of rights to medical payments.

**SECTION 3: NON-CATEGORICAL ELIGIBILITY**

*(Repealed effective December 31, 2013, filing 2013-321)*

**SECTION 4: LIMITED FAMILY PLANNING BENEFIT (LFPB)**

This coverage group is effective October 1, 2016.

The Limited Family Planning Benefit is a limited Medicaid benefit that provides coverage to individuals, regardless of gender, for family planning and related services.

Coverage is available only to individuals who have not been determined otherwise eligible for any Categorically Needy or Medically Needy coverage group. If an individual, who is eligible for this benefit, is determined eligible for any Categorically Needy or Medically Needy coverage group, they shall be moved to that coverage group. This change in coverage includes individuals who newly meet a deductible.

If an individual, enrolled in a full coverage group, becomes ineligible for that coverage (including someone who must meet a new deductible), but is eligible for Family Planning benefits, that individual can be enrolled in Family Planning coverage.

**1. Basic Eligibility Requirements**

Basic Non-Financial eligibility requirements for receiving MaineCare coverage identified in Part 2 apply to this group. This stipulation includes meeting the requirements for residency, citizenship, social security numbers, and assignment of rights to medical payments and support rights, as well as applying for other benefits. The Limited Family Planning Benefit has no gender or age requirements.

Pregnant individuals are not eligible for coverage under this benefit.

**A. Assets**

LFPB has no asset criteria.

**B. Income**

Individual income must be equal to or less than 209% of the Federal Poverty Level.

**C. Budgeting**

MAGI-based budgeting rules for Medicaid are used to determine countable income. The assistance unit only consists of the individual applying for coverage.

**2. Presumptive Eligibility for the Limited Family Planning Benefit**

Presumptive eligibility provides immediate, short term access to family planning services for individuals who are not otherwise enrolled in MaineCare. Eligibility for coverage is determined by qualified entities. Pursuant to a State Plan Amendment, these changes are effective October 1, 2020.

**A. Limited Family Planning Benefit Provider Qualification Requirements**

To become qualified to make presumptive eligibility determinations for Medicaid, a provider must—

(1) Participate as a Medicaid provider under the State of Maine’s State Plan;

(2) Notify the Office for Family Independence (OFI) in writing of its intention to make presumptive determinations under this Part;

(3) Accept training, administered by OFI, for all applicable staff on relevant MaineCare eligibility rules and regulations; and

(4) Receive approval from the Department to make presumptive eligibility determinations.

**B. Eligibility for Presumptive Eligibility Determinations by Qualified Providers**

Limited Family Planning Benefit Presumptive Eligibility determinations must be limited to persons who meet all eligibility requirements for LFPB as listed in Section 4 of this Part.

Additionally, LFPB presumptive eligibility is limited to no more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

**C. Limited Family Planning Benefit Presumptive Eligibility Determination Process**

A qualified provider must use a Limited Family Planning Benefit presumptive application to establish the applicant’s financial and non-financial eligibility. Applications may be accessed at the Department’s website; or by contacting the MaineCare Eligibility Program Manager by mail, phone, or e-mail. If the provider determines the applicant meets all the eligibility requirements for coverage under the LFPB, the provider shall determine that the applicant is presumptively eligible for the LFPB.

If eligible the provider must—

(1) Notify the Department of the determination within five business days after the date on which the determination is made if no application for Medicaid has been filed by that date;

(2) Provide the applicant with an approved standard MaineCare application; and

(3) Inform the individual at the time the determination is made that they must complete a full application with the Department no later than the last day of the month following the month in which the presumptive determination is made to see if benefits can continue.

For individuals determined not to be presumptively eligible, the provider must notify the applicant in writing, and orally if appropriate, of the reason for the determination.

**D. Limited Family Planning Benefit Presumptive Eligibility Coverage Period**

Once a provider determines an individual is presumptively eligible, Limited Family Planning Benefit coverage begins immediately and continues until the later of—

1. If a full application for Medicaid is filed prior to the last day of the month following the month presumptive eligibility was determined, the date on which the Department makes the final eligibility decision; or
2. The last day of the month following the month in which the presumptive eligibility determination was made if no application for Medicaid has been filed by that date.

**SECTION 5: COVID-19 TESTING FOR UNINSURED INDIVIDUALS**

The *Families First Coronavirus Response Act* (FFCRA) H.R. 6201, 116 Cong. (2019-2020), P.L. No. 116-127 (3/18/2020), 134 STAT 178 *et seq*. specified in Division F, Section 6004(a)(3) that State Medicaid programs were authorized to create an optional coverage group to ensure services related to testing and diagnosis of COVID-19 are available in response to the pandemic, pursuant to Section 1902(a)(10)(A)(ii)(XXIII) of the *Social Security Act*, 42 U.S.C. 1396a(a)(10) as amended. This is a limited coverage benefit that is effective March 18, 2020 and ends on the last day of the month within which the federal public health emergency (PHE) ends unless otherwise directed by CMS. Coverage under this group is available to individuals who are without health insurance, or whose health insurance coverage does not meet the requirements for minimum essential coverage.

On April 28, 2020 the Governor’s Executive Order 48, FY19/20 suspended and modified the relevant provisions of the *Maine Administrative Procedure Act* in order for these rule changes to: (1) remain in effect until the later of the end of the Federal Proclamation of Emergency or the end of CMS’s approval of the MaineCare program changes, even if that period exceeds ninety days; and (2) automatically repeal upon termination of the Federal Proclamation of Emergency or the end of CMS’s approval of the MaineCare program changes (whichever is later), without further rulemaking by the Department.

In the event of a conflict between this emergency rule and any other MaineCare rule, the terms of this rule supersede other rules and shall apply.

**Section 5.1: Basic Eligibility Requirements**

Basic Non-Financial eligibility requirements for getting full MaineCare coverage, identified in Part 2 apply to this coverage group. This includes the rules on residency, citizenship, social security numbers, and assignment of rights to medical payments and support rights, as well as applying for other benefits.

In order to receive benefits under this category, an individual must not be:

A. Eligible to receive coverage under a mandatory Medicaid eligibility group.

B. Enrolled in Medicaid health care coverage, except that individuals who are enrolled in a limited benefit Medicaid eligibility group will not be considered to be enrolled in health coverage as a

 result of such enrollment and therefore may meet the definition of uninsured individual. Limited coverage groups include individuals infected with tuberculosis, individuals eligible for the Limited Family Planning Benefit, and individuals eligible as Medically Needy.

C. Enrolled in another health care program funded by the federal government, including CHIP, Basic Health Program, Medicare, TRICARE and Veterans Administration, and federal employee plans.

D. Enrolled in a group health plan or health insurance coverage offered by a health insurance issuer (as defined in section 2791 of the Public Health Service Act), including: a qualified health plan through the federally facilitated marketplace, employer-sponsored health insurance, retiree health plans and COBRA continuation coverage.

**Section 5.2: Assets**

There is no asset test for this coverage group.

**Section 5.3: Income**

There is no income limit for this coverage group.

**PART 10**

**MEDICALLY NEEDY COVERAGE**

The Medically Needy option provides coverage to those who meet categorical eligibility requirements, and who would be otherwise eligible for Medicaid but that their income exceeds the income standard for the applicable coverage groups.

Under Medically Needy coverage, the Department quotes a deductible amount and eligibility period. The individual needs to incur medical expenses greater than or equal to the deductible amount before coverage can begin.

**SECTION 1: MEDICALLY NEEDY COVERAGE GROUPS**

**Section 1.1: Eligible Medically Needy Groups**

The Medically Needy coverage groups are available to individuals who meet the categorical criteria of a Medical coverage but are ineligible because of excess income. Individuals eligible for the Medically Needy coverage groups include:

1. Persons who are aged, blind, or disabled (as defined in Part 6, Section 4)
2. Children under age 21
3. Pregnant Women
4. Parent/Caretaker Relatives (as defined in Part 3, Section 2.2)

**Section 1.2: Ineligible Coverage Groups**

Medically Needy coverage is not available to people in the following coverage groups:

1. Expansion Adults (as defined in Part 3, Section 2.4)
2. Medicare Savings Program (Part 8)
3. Limited coverage groups (as defined in Part 9)

**SECTION 2: MEDICALLY NEEDY ELIGIBILITY PERIOD**

**Section 2.1: The Prospective Period**

The Medically Needy eligibility period is the time period during which the individual or family is assigned a deductible. This time period begins the first day of the month the individual first applied for Medicaid (See Part 2 Section 11), or the first day of the month after the date Medicaid ended because of excess income. The time period lasts six consecutive months.

An applicant may choose to withdraw their application for the month of submission and start the Medically Needy period for the following month, which would alter the retroactive period. (See 2.2 below.)

The six-month deductible period is shorted if:

1. The individual will turn age 21 in less than six months;
2. The individual dies
3. The individual becomes eligible for categorical coverage; or
4. The individual voluntarily withdraws from the program.

**Section 2.2: Retroactive Periods**

The applicant may request a retroactive Medically Needy period of one, two, or three months preceding the month of application if they have incurred medical expenses.

When multiple months of retroactive Medically Needy coverage are requested, coverage will not be provided for the second or third month prior to the application month without including the preceding months (first or second) unless the individual is ineligible due to basic eligibility requirements. A single retroactive deductible period is quoted to cover all requested months. See Part 2 Section 13.4 for more details.

**SECTION 3: FINANCIAL ELIGIBILITY REQUIREMENTS**

**Section 3.1: Medically Needy Assets**

Assets must be under the following limits on at least one day of the month to be eligible for that month.

For SSI - Related coverage groups:

$2000 for an individual not married or not living with a spouse, including an individual who is a child.

$3000 for an eligible couple or an individual living with an ineligible spouse

There is no asset limit for MAGI-based coverage groups.

**Section 3.2: Medically Needy Income**

Treatment of income varies depending on whether the person is receiving Medically Needy coverage in an SSI-Related or MAGI-based coverage group.

1. For SSI-Related groups**,** budgeting rules in Part 7 are used to determine countable income.
2. For MAGI-based groups, budgeting rules in Part 4 are used to determine the assistance unit and countable income, except that income of a non-responsible relative is not counted when determining the deductible. A responsible relative is defined as a spouse or a biological or adoptive parent of a child under age 19.

The countable income is compared to the Protected Income Level (PIL). The PIL is based on family size and can be found in Chart 5. When the individual or family’s net countable income is above the PIL a deductible must be met. Due to differences in income counting methodology applicable to categorically needy and Medically Needy coverage groups, an individual may be ineligible for coverage in a categorically needy coverage group but have countable income under the PIL for Medically Needy coverage. An individual in this situation receives Medically Needy coverage without first having to incur any medical costs.

**SECTION 4: DEDUCTIBLE PROCESS**

Individuals who are ineligible under Categorically Needy and whose income is above the appropriate Protected Income Level (PIL) are not eligible for Medicaid until they meet a deductible. The deductible is met by applying incurred costs for necessary medical services to the deductible amount.

**Section** **4.1: Calculating the deductible amount**

1. Determine the countable income.
2. Subtract the PIL for the appropriate assistance unit size (See Chart 5) from the countable income.
3. Multiply the result by the number of months in the eligibility period (usually six months).

The result is the deductible amount the individual or family must meet by applying incurred medical costs before coverage can begin.

The deductible amount must be reviewed prior to opening coverage. When changes occur that impact Medically Needy eligibility (e.g. changes in income or household composition), eligibility is redetermined and the deductible amount is recalculated. If the Medically Needy period ends or the deductible amount increases, the Eligibility Specialist must give the individual timely and adequate notice of the change. (See Part 2 Section 15.)

**Section 4.2 Applying Incurred Costs**

Bills or other acceptable verification of incurred medical expenses must be submitted within one year of the application date to be applied to the deductible.

To be counted toward the deductible, a bill must be for medical services that are medically necessary and for which the individual is legally liable. The cost of necessary medical services for individuals in the assistance unit and for individuals whose income or assets are or would be used in determining eligibility may be applied against the deductible.

For individuals who are included in more than one assistance unit, the cost of necessary medical services can be applied toward each deductible.

When an individual or family has sufficient costs to meet the deductible, but an accurate start date cannot be determined due to missing bills or pending insurance payments, eligibility begins for the first full month of eligibility. Eligibility is back dated when all information is provided.

The deductible may be met by using medical costs that were incurred prior to the deductible period. When the deductible is met in this manner, the individual is eligible for MaineCare effective the first day of the eligibility period. Otherwise, coverage will begin when the deductible is met.

**Section 4.3 Medical Cost Responsibility**

The medical expenses used to meet the deductible are the individual’s obligation and cannot be billed to Medicaid.

On the day the deductible is met, the individual may be partially responsible for the bills incurred on that date. When this occurs, the Department will inform the provider in writing that the individual is eligible for Medicaid on the day the deductible was met. The notice will also include the amount of the bill the individual is responsible for paying.

If bills from multiple providers were applied on the date the deductible was met, the individual’s responsibility must be distributed equally to each provider. To determine the individual’s responsibility for each provider:

1. Divide the remaining deductible amount by the total sum of charges for all providers with a bill on the day the deductible was met. Round the result to the 4th decimal place.
2. Multiply each individual provider’s bill by the result.
3. The result is the amount the individual is responsible for.

If medical bills that could have been used to meet the deductible are received for a period prior to the date the deductible was met, but between the first date of eligibility and the start of the Medically Needy period, a notice will be sent to the client and provider showing a zero responsibility for the client. These bills will be covered if they are submitted within one year of the date of the eligibility decision.

**SECTION 5: APPLICABLE MEDICAL COSTS**

Medical costs are applied in the following order:

I. Verified medical insurance premiums, including Medicare.

**Note**: Indemnity insurance premiums are not allowed. These are policies that pay for length of stay or a condition (such as cancer) but not for a specific service.

II. Verified actual costs incurred during the eligibility period for medical or remedial care costs not covered under Medicaid such as eyeglasses, dental services and hearing aids for individuals over age 21.

III. Medical costs incurred during the eligibility period by individuals who are part of the assistance unit but not eligible for coverage (such as an ineligible spouse or deeming parent in an SSI - Related unit or the parents of an individual whose eligibility is based on being under age 21).

IV. The unpaid balance on a loan taken out to pay for an old medical bill which was incurred prior to the eligibility period provided:

1. The proceeds of the loan were used to pay the medical bill. Only the amount of the loan actually used to pay the old medical bill may be deducted. Any portion used for another purpose may not be deducted.
2. Neither the medical bill nor the unpaid balance of the loan was previously applied against another deductible.
3. Only the principal part of the unpaid balance may be used in the deductible - not the interest.

This provision allows the individual to use the liability to the lender in place of the liability to the provider.

V. Medical costs incurred prior to the eligibility period and not applied toward another deductible, and which are unpaid on the first day of the eligibility period, which resulted in eligibility.

**Example**

Individual has a medical bill of $5000. He has a deductible for January through June of $4500. He meets the deductible and in July incurs another $4500 deductible. The $500 remaining from the $5000 medical bill can be used towards the new deductible if it was not paid.

VI. Additional services or items necessary for medical treatment such as transportation, long distance telephone calls to medical providers, cost of lodging to receive treatment away from home and nonprescription items or drugs incurred during the eligibility period.

VII. Medicaid coverable costs, paid or unpaid, incurred during the eligibility period in order of service date, including the following medical costs:

A. Medical costs incurred during the eligibility period as long as they have not been written off by the provider during the eligibility period.

B. Medical costs paid with all state or local funds such as General Assistance, DEL and some payments by Vocational Rehabilitation (VR).

Once the deductible has been met, the eligible individuals in the assistance unit will be eligible for Medicaid for the remainder of the eligibility period or until information is provided which would change the eligibility.

**SECTION 6: NON-APPLICABLE MEDICAL COSTS**

The following types of medical bills cannot be considered toward a deductible:

I. Medical costs incurred and paid prior to the eligibility period.

II. Portions of medical costs applied toward a previous deductible, if the deductible is met.

III. Portions of medical costs paid by insurance, including Medicare adjustments.

IV. Medical costs paid by individuals or groups outside the assistance unit for which the individual has no obligation to repay. The exception is medical costs paid with all state or local funds such as General Assistance, DEL and some payments by Vocational Rehabilitation (VR).

V. Medical costs incurred by individuals who are not members of the assistance unit and whose income and assets are not used in determining eligibility.

VI. Payments on old medical bills incurred prior to the eligibility period.

VII. Medical costs incurred during a penalty period.

VIII. Unpaid costs of care to a medical institution or waiver agency during periods of eligibility.

**Example**

This example shows how medical expenses are applied to a deductible and the order in which they must be applied.

An individual, age 22, determined disabled in April, submits the following bills to meet a deductible of $3820 for April through September.

Determine that there are no changes to the deductible amount and that all of the bills submitted can be used toward the current remaining deductible:

**Total Deductible**: $3820.00

I. **Medical Insurance premium** ($79.05 monthly X 6) - $ 474.30

Remaining deductible $3345.70

II. **Items not covered by Medicaid**

Eyeglasses (purchased 4/12) - $ 125.00

Remaining deductible $3220.70

III. **Old unpaid medical bills**

Doctor’s statement shows an outstanding balance

as of 3/31 of $650.00 - $ 650.00

Remaining deductible $2570.70

IV. **Medicaid coverable costs paid or unpaid incurred** **during the eligibility period**

The hospital bill for 4/3 through 4/6 ($3500) was not itemized for insurance payments ($1200). To determine the daily portion of the hospital bill the client is responsible for - divide the total insurance payment by the total hospital bill to the 4th decimal place ($1200 ÷ $3500 = .3428).

**4/3 Charges**

Multiply 4/3 hospital bill by .3428 ($1500 x .3428 = $514.20)

Subtract the result from the 4/3 hospital bill

($1500 – $514.20 = $985.80)

4/3 hospital charge used against the deductible - $ 985.80

Remaining deductible $1584.90

**4/4 Charges**

Multiply 4/4 hospital bill by .3428 ($1000 x .3428 = $342.80)

Subtract the result from the 4/4 hospital bill

($1000 – $342.80 = $657.20) $ 657.20

Physician’s bill after insurance + $ 65.00

Prescription + $ 46.25

Total charges for 4/4 - $ 768.45

Remaining deductible $ 816.45

**4/5 Charges**

Multiply 4/5 hospital bill by .3428 ($900 x .3428 = $308.52)

Subtract the result from the 4/5 hospital bill

($1000 – 308.52 = $691.48) $ 691.48

Physician’s bill after insurance + $ 200.00

Radiology services after insurance + $ 400.00

Total charges for 4/5 $1291.48

The charges for 4/5 are greater than the remaining deductible of $816.45.

The applicant met the deductible on 4/5. The first full day of coverage is 4/6.

The applicant is responsible for the remaining deductible of $816.45 and there are a number of bills on 4/5.

To determine the applicant’s share for each provider for bills incurred on 4/5:

I. Divide remaining deductible by total charges for 4/5 to the 4th decimal place.

($816.45 ÷ $1291.48 = .6322)

II. Multiply each provider's bill by .6322. This is the amount the applicant is responsible for.

Hospital $691.48 x. 6322 = $ 437.13

Physician $200.00 x .6322 = $ 126.44

Radiology $400.00 x .6322 = $ 252.88

Applicant responsibility for 4/5 $ 816.45

**SECTION 7: VERIFICATION OF MEDICAL COSTS**

All costs applied to the deductible must be verified. For each item, with the exception of transportation costs, the applicant must provide a dated bill or receipt showing the name of the provider, date of service, type of service, costs and any insurance payments. If the applicant does not provide an appropriate bill or receipt, the cost cannot be applied.

For transportation, the individual's record must show the reason the cost was incurred, the place visited and the date. A receipt is required if the applicant paid someone else for the transportation. If the applicant's car was used, the actual cost of gas and oil may be calculated or a mileage cost allowed (using current allowance authorized by State Employees Contract). The individual should be given the opportunity to choose whichever option they prefer.

# PART 11

# STATE SUPPLEMENT

In 1974 the Maine Legislature established the State Optional Supplement Program to provide an allowance for basic needs. To receive a State Supplement, the individual must be receiving SSI or would be eligible except for income or citizenship (22 M.R.S.A. §3271).

**Note**: SSI counts income-in-kind. State Supplement does not. If an individual is ineligible for SSI when counting income-in-kind they may be eligible for State Supplement.

If the individual is financially eligible for SSI, the individual must apply for and receive SSI. The month of SSI entitlement is the first month that SSI eligibility exists. The first SSI payment is issued for the month following the month of entitlement.

The State Supplement is effective the same month as the SSI payment.

If the individual is not eligible for SSI but is eligible for a State Supplement payment, this benefit will be authorized without a referral to SSI. The payment will be effective the month following the month of eligibility.

## SECTION 1: NON-FINANCIAL CRITERIA

When determining eligibility for the State Supplement only, the individual must comply with Medicaid rules for assignment of rights (See Part 2, Section 6) and residency (See Part 2, Section 4).

## SECTION 2: INDIVIDUALS INELIGIBLE FOR SSI DUE TO THE 8/96 CITIZENSHIP RULES

When individuals have been denied SSI due to the 8/96 citizenship rules they may be eligible for a State Supplement payment. Upon application to the Department they must meet all other eligibility criteria in this section. This excludes individuals eligible for emergency services only.

State Supplement budgeting rules, found in Part 7, Section 2, are used to determine countable income. The payment is the difference between countable income and the maximum SSI payment plus the State Supplement amount for the living arrangement.

**Example:**

Barb Doyle is a 70 year old individual who is not eligible for SSI due to 8/96 citizenship rules. She is receiving a pension of $300 and lives in the community.

Her countable income is:

 $ 300 Pension

 - $ 20 Federal Disregard

 - $ 55 State Disregard

 $ 225 Countable Income

Her payment amount is:

 $ 674 Max SSI payment level (eff. 1/09)

 + $ 10 State Supplement payment level

 $ 684

 - $ 225 Countable Income

 $ 459 Payment Amount

If we know the individual is not eligible for SSI due to citizenship rules described above, there is no need for a separate SSI eligibility determination.

## SECTION 3: SUBSTANTIAL GAINFUL ACTIVITY (SGA)

"Substantial Gainful Activity" (SGA) is full or part time work that involves physical or mental activities which are usually done for pay or profit, although there may not be a profit.

Applicants who have average monthly earnings of more than $980 a month are considered to be engaging in SGA. (see Appendix B for calculation of this application pretest).

Applicants who are determined to be engaged in Substantial Gainful Activity are not eligible for State Supplement.

Applicants who have stopped work in the month of application do not have to meet the SGA test. Any income from the terminated employment is countable income.

Recipients who are working must continue to meet the definition of disability.

The following are examples of activities that would not be considered Substantial Gainful Activity:

I. A job is made for an individual out of sympathy or compassion, or which can be performed only because others provide more assistance or supervision than would be characteristic of a bona fide employment situation or a market for the goods or services is created more out of sympathy than intrinsic value received.

II. A job that is part of occupational therapy prescribed and supervised by a physician.

III. An activity which is in the nature of a hobby and does not provide a bona fide job opportunity from the standpoint of genuine economic demand and remuneration.

IV. Activity which is part of an active Vocational Rehabilitation program constituting training and supervised by a rehabilitation agency.

## SECTION 4: MONTH OF FIRST PAYMENT

I. For those living alone/with others or residing in a Flat Rate Boarding Homes or Adult Foster Homes, the State Supplement benefit starts the month following the month of application or the month of eligibility, whichever is later.

For example, if an individual applies for and is eligible for SSI in 3/08, the first month for which the SSI and State Supplement benefits are authorized will be 4/08.

II. For Cost Reimbursed Boarding Homes, Adult Family Care Homes and Residential Care Facilities, the State Supplement benefit will be effective the month following the month a decision is made.

For example, if the State Supplement is being authorized on June 2nd, July will be the first month a check is issued.

## SECTION 5: TYPES OF LIVING ARRANGEMENTS

The amount of the State Supplement benefit depends on an individual's living arrangement.

If an individual is eligible for part of a month, they are eligible for a full month benefit.

Codes used by SSI and adopted for State Supplement use:

A. **Individuals in living arrangement A are living alone or with others**. This includes an individual living with their ineligible spouse. It also includes minor children living with their parents. Individuals in this living arrangement receive a State Supplement benefit of $10.00. For a couple, the benefit is $7.50 per individual. This amount does not vary. If eligible for a State Supplement, the benefit amount is $10.00/$7.50.

If an individual in this living arrangement is eligible for a Spousal Living Allowance (SLA), see Part 12, Section 5, the Living Allowance is a State Supplement.

\* Instead of $10.00, when the individual is getting SSI, the SLA benefit amount is found in Chart 3.8.

\* Instead of $10.00, when the individual gets a State Supplement only, the amount of the benefit is determined according to Part 12, Section 5.

B. *[Not in use]*

C. **Individuals in this living arrangement are living in the household of another**. They receive a benefit of $8.00. A couple receives $6.00 per person. This benefit amount does not vary. If eligible for a State Supplement, the benefit amount is $8.00/$6.00.

\* If an individual in this living arrangement is eligible for a Spousal Living Allowance (see Part 12, Section 5), the Living Allowance is a State Supplement. Instead of $8.00, when the individual is getting SSI, the SLA benefit amount is found in Chart 3.8.

\* Instead of $8.00, when the individual gets a State Supplement only, the amount of the benefit is determined according to Part 12, Section 5.

D. **Living in a State or Waiver State Adult Foster Home**: The maximum benefit is $49.00. If the individual is eligible for SSI, the maximum is authorized. If the individual is over income for the SSI but under income for the State Supplement, the State Supplement will vary depending upon the individual’s countable income.

E. **Living in a Flat Rate Boarding Home**: These facilities are licensed by the State to provide care for up to six individuals. The maximum benefit for an individual is $217.00. If the individual is eligible for SSI, the maximum is authorized. If the individual is over income for SSI, but under income for the State Supplement, the State Supplement will vary depending upon the individual’s countable income.

F. **Living in an Adult Family Care Home**: These facilities are licensed by the State to care for up to five people. The maximum State Supplement for individuals is $234.00. If the individual is eligible for SSI, the maximum is authorized. If the individual is over income for SSI but under income for the State Supplement, the State Supplement will vary depending upon the individual’s countable income.

G. **Living in a Cost Reimbursed Boarding Home**. These facilities are licensed by the State to care for seven or more individuals. The maximum State Supplement benefit for an individual in this living arrangement is $234.00. If the individual is eligible for SSI, the maximum is authorized. If the individual is over income for SSI but under income for the State Supplement, the State Supplement will vary depending upon the individual’s countable income.

H. **Living in a medical institution**: Residing in a medical institution means that the individual is living there for more than thirty consecutive days and is expected to remain. The State Supplement for individuals in this living arrangement is $10.00. For a couple, it is $20.00. This amount does not vary.

I. **Residential Care Facility**: These facilities are licensed by the State to care for seven or more individuals. The State Supplement benefit is $10.00. For a couple the benefit is $7.50 per individual. The amount does not vary.

For those in living arrangements A/C/H, the benefit amount is fixed. Once the individual is eligible for the State Supplement, they get the appropriate State Supplement benefit.

For living arrangements D/E/F/G, the amount of the State Supplement will vary with countable income when the individual is not eligible for SSI. When is eligible for SSI, the individual receives the maximum State Supplement amount.

## SECTION 6: CHANGES IN LIVING ARRANGEMENT

If an individual is receiving a State Supplement in one living arrangement and moves to a different arrangement, any increase in benefit will be made effective the month the individual is in the new living arrangement up to three months retroactive to the month the move is reported to the Department.

Any decrease in benefits will be given timely notice of adverse action.

For example, the individual moves from a Cost Reimbursed Boarding Home to his own home and reports this on 7/2. The August State Supplement payment will be reduced to $10.00. If this had been reported on 7/22, the September payment would be reduced to $10.00.

## SECTION 7: SSI CLOSINGS

When the individual is receiving a State Supplement and SSI and the SSI is subsequently closed, the State Supplement payment will be ended unless the individual is eligible for a State Supplement only payment or the SSI closing is timely appealed with SSI and the individual meets all other eligibility rules.

## SECTION 8: REPRESENTATIVE PAYEE

A Representative Payee for an SSI or SSA payment may be used for the State Supplement check.

If not receiving an SSI or SSA benefit, the State Supplement check may be received by other than the individual if that person is the individual’s legal guardian, conservator or has power of attorney.

## SECTION 9: LOST, STOLEN, DESTROYED, OR RETURNED CHECKS

When an individual reports a check has been lost, stolen or destroyed prior to cashing, the agency has the responsibility to replace it. In the instances when there is reason to believe there has either been a forgery or duplicate checks have been received and cashed by the recipient, the following procedures have been established.

I. **Forgeries**

When the photocopy of the original check is sent to the OFI office, staff must meet face-to-face with the individual or Representative Payee to determine whether or not the signature is theirs. If the individual or Representative Payee states it is not, then a Forgery Affidavit will be completed (SWIM-052) and the original sent to FIR with a copy to Division of Financial and Personnel Services and a copy for the record. This initiates an investigation to determine who cashed the check.

If the individual or Representative Payee agrees that the signature on the original check is theirs, OFI staff may refer for fraud.

II. **Replacing a Check**

When a household presents a damaged check, which a bank refuses to cash, the worker will take the following steps:

A. Complete a SWIM-050 (Stop Payment).

B. Complete a SWIM-051 (Application for a Duplicate Check).

C. Void the damaged check.

D. Forward the original forms and the damaged check to the Division of Financial and Personnel Services. A copy is retained for the record.

## SECTION 10: EBT METHOD OF PAYMENT; PERMISSIBLE USE

When expended using an Electronic Benefits Transfer (EBT) card, State Supplement benefits are subject to the same purchase restrictions as those described in 22 M.R.S. §3763(11) and 10-144 C.M.R. 331, Ch. VI, governing Temporary Assistance for Needy Families (TANF) benefits. These restrictions do not apply to federal SSI benefits. When the recipient chooses to have funds distributed to them as direct deposit or check, State Supplement benefits are not subject to the above purchase restrictions.

**PART 12**

**RESIDENTIAL CARE**

The rules in this Part are used for individuals who reside in any of the following living arrangements. Individuals residing in these living arrangements are not considered to be “institutionalized” as described in Part 14.

**SECTION 1: LIVING ARRANGEMENTS**

**Adult Foster Home (AFH):**

Each AFH usually serves one to three individuals who are usually being served by the Office of Aging and Disability Services (OADS). OADS groups AFH into:

\* Private AFH or “Foster Waiver Homes” where residents are also enrolled in the OADS Home & Community Based Waiver Program, and

\* State Assisted AFH where residents are enrolled in SSI/State Supplement and/or OADS Home & Community Based Waiver Program. This distinction is used for OADS purposes only. Medicaid eligibility is determined using the same rules for all AFH but the State Supplement amount is different for each group (See Part 11 for information on the State Supplement).

**Flat Rate Boarding Home (FRBH)**

Each FRBH usually serves up to five individuals who are usually being served by OADS.

**Cost Reimbursed Boarding Home (CRBH**)

CRBH serve six or more individuals. These facilities are classified as Private Non-Medical Institutions (PNMI).

**Residential Care Facility (RCF)**

RCF serve six or more individuals. These facilities are classified as Private Non-Medical Institutions (PNMI).

**Adult Family Care Home (AFCH)**

AFCH serve up to five individuals. Residents of AFCH receive a greater level of care than is provided in a CRBH or RCF but less than that provided in a nursing facility. These facilities are classified as a Private Non-Medical Institutions (PNMI).

Eligibility for coverage requires that the individual:

\* has a coverable group.

\* meets asset criteria.

\* meets income criteria

For individuals residing in a CRBH, RCF, or AFCH above it is necessary to determine the amount that the individual is expected to pay toward the cost of their care if they are found to be eligible for coverage.

**SECTION 2: COVERABLE GROUPS**

For all living arrangements individuals must have a Medicaid coverable group. This can be any coverable group including Non-Categorical. The individual need not be in an elderly or disability coverage group.

**SECTION 3: RESIDENTIAL CARE ASSET CRITERIA**

For all living arrangements, when determining eligibility for Medicaid “countable assets” are assets after exclusions (see Part 16).

For all facilities in this Part, countable assets must be under $2000 for an individual or $3000 for a couple.

Countable assets, exclusions and deductions are identified in Part 16. Apply these rules based on the coverable group the individual is in.

Transfer of asset rules found in Chapter 336 of this Manual apply to individuals residing in a CRBH, RCF, or AFCH.

**SECTION 4: RESIDENTIAL CARE INCOME CRITERIA**

For all living arrangements, when determining eligibility for Medicaid “countable income” is gross income minus exclusions (See Part 17) and disregards (See Part 7, Section 2.1 ).

**Section 4.1: Adult Foster Homes (AFH)**

Residents are considered to be individuals ‘living with others”. If a married couple resides in the facility, at the option of the couple, eligibility may be determined as a couple if either member of a couple is not eligible when treated as an individual. The countable income of each spouse is totaled. Each spouse is deemed to receive one-half of this total and each is compared to 100% FPL.

I. If countable income is under the income limit for SSI/State Supplement the individual needs to apply for SSI/State Supplement in order to get help with their costs for residing in the AFH. When eligible for SSI/State Supplement, Medicaid coverage is also provided.

**Note**: Residents of “State Assisted” AFH are potentially eligible for a $49.00 State Supplement. Residents of “Private AFH” are potentially eligible for $10.00 State Supplement.

II. If countable income is equal to or over the State Supplement income limit for this living arrangement the individual is eligible for Medicaid if countable income is equal to or under 100% FPL.

III. If countable income is over 100% FPL the individual may be eligible for Medicaid under Medically Needy (See Part 10).

IV. If countable income is over 100% FPL and the individual is applying for a Home and Community Based Waiver Program (See Part 13), Medicaid eligibility is determined using the rules of that program.

**Section 4.2: Flat Rate Boarding Homes (FRBH)**

Residents of FRBH are considered to be individuals “living with others”. If a married couple resides in the facility, at the option of the couple, eligibility may be determined as a couple if either member of a couple is not eligible when treated as an individual. The countable income of each spouse is totaled. Each spouse is deemed to receive one-half of this total and each is compared to 100% FPL.

I. If countable income is under the income limit for SSI/State Supplement the individual needs to apply for SSI/State Supplement in order to get help with their costs for residing in the FRBH. When eligible for SSI/State Supplement, Medicaid coverage is also provided.

II. If countable income is equal to or over the State Supplement income limit for this living arrangement the individual is eligible for Medicaid if countable income is equal to or under 100% FPL.

III. If countable income is over 100% FPL the individual may be eligible for Medicaid under Medically Needy (See Part 10).

IV. If countable income is over 100% FPL and the individual is applying for a Home and Community Based Waiver Program, Medicaid eligibility is determined using the rules of that program (See Part 13).

**Section 4.3: Cost Reimbursement Boarding Homes (CRBH), Residential Care Facilities (RCF) and Adult Family Care Homes (AFCH)**

Residents of these facilities are considered to be individuals “living with others”. If a married couple resides in the facility, at the option of the couple, eligibility may be determined as a couple if either member of a couple is not eligible when treated as an individual. The countable income of each spouse is totaled. Each spouse is deemed to receive one-half of this total and each is compared to the private rate for the CRBH and RCF or the income limit in Chart 3.9 for AFCH.

I. If countable income is under the income limit for SSI/State Supplement the individual needs to apply for SSI/State Supplement in order to get help with the cost of their care. When eligible for SSI/State Supplement, Medicaid coverage is also provided.

II. If countable income is equal to or over the State Supplement income limit for this living arrangement, the individual is eligible for coverage if countable income is equal to or under the thirty-one day private rate for the CRBH and RCF, or the income limit in Chart 3.9 for the AFCH in which they reside.

III. If countable income is over the private rate, the individual may become eligible if they meet a deductible (See Part 10 for the rules on Medically Needy).

Medical services provided by the facility are medical costs incurred by the individual. They are used before other medical expenses to determine if the individual meets the deductible. These medical services are projected over a six month period. They are identified by the Office of MaineCare Services and are

assigned a daily rate (cost). The daily rate is multiplied by thirty-one days to determine the monthly amount.

IV. If countable income is over 100% FPL and the individual is applying for a Home and Community Based Waiver Program (See Part 13), Medicaid eligibility is determined using the rules of that program. The rules in this section are used to determine the cost of care. The cost of care is paid to the facility.

**Section 4.3.1: Determining the Cost of Care for an Individual**

I. A cost of care or assessment is determined for all individuals. The cost of care is the monthly amount the individual is expected to contribute toward the cost of his/her care in the facility.

II. The individual has a zero cost of care for the month they are admitted to the facility. There is a cost of care for the month of discharge.

III. **Cost of Care for an Individual**

A. **Determine gross monthly income**. Total gross monthly income includes the State Supplement benefit:

1. If the individual has elected an option under his or her retirement plan that results in a reduced benefit to the individual in exchange for a continued benefit to the spouse upon the individual’s death, (e.g. a joint and survivor annuity option), then that reduced amount will be considered to be gross income. However, the reduced amount may be used only if both the election is irreversible and the reduction amount does not exceed $1,000 per month.

2. If income is garnished due to a court order for child support the reduced amount of the income is used. The maximum reduction allowed is up to and including $1,000 per month per child.

B. From total gross monthly income, subtract:

1. Earned income disregard (See Part 7, Section 2.1),

2. Current federal, state or local income tax deductions,

An adjustment may be made if there are current federal, state or local income tax deductions from the individual’s gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed.

**Examples**

\* Last year $600 was the tax liability. $80.00 per month is withheld for income tax. Only $50.00

per month can be allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

\* Last year $600 was the tax liability. $25.00 per month is being withheld for income tax. A deduction of $50.00 per month is allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

**Note**: If an individual is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

3. $70 (personal needs and federal disregard);

4. Medicare premium for the individual;

5. HUD Standard - The HUD Standard is a monthly subsidy given to a facility by the Department of Housing and Urban Development on behalf of residents of the facility; and

6. health insurance premiums incurred by the individual for the individual and/or the individual’s spouse if the spouse is covered by Medicaid and is residing in a CRBH, RCF, Nursing Facility or covered by a Home and Community Based Waiver,

Premiums must be incurred by the individual residing in the specified facility. If the health insurance is provided by the individual’s spouse through his/her coverage, this is not considered to be a cost incurred by the individual who resides in a facility. It is a cost incurred by the individual’s spouse.

**Note**: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

C. The result is the cost of care.

**Note**: If there is a partial month transfer of asset penalty, the individual may be responsible for an amount in addition to his or her cost of care (see Chapter 336 of this Manual).

**Section 4.3.2: Determining the Cost of Care for a Couple**

I. Determine gross monthly income of the couple. Total gross monthly income includes the State Supplement benefit.

A. If the individual has elected an option under his or her retirement plan that results in a reduced benefit to the individual in exchange for a continued benefit to the spouse upon the individual’s death, (e.g. a joint and survivor annuity option), then that reduced amount will be considered to be gross income. However, the reduced amount may be used only if both the election is irreversible and the reduction amount does not exceed $1,000 per month.

B. If income is garnished due to a court order for child support the reduced amount of the income is used. The maximum reduction allowed is up to and including $1,000 per month per child.

II. From total gross monthly income, subtract:

A. Earned income disregard (Part 7, Section 2.1);

B. Current federal, state or local income tax deductions;

An adjustment may be made if there are current federal, state or local income tax deductions from the individual’s gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed. tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed.

**Examples**

\* Last year $600 was the tax liability. $80.00 per month is withheld for income tax. Only $50.00 per month can be allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

\* Last year $600 was the tax liability. $25 per month is being withheld for income tax. A deduction of $50 per month is allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

**Note**: If an individual is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

B. $120 (personal needs and federal disregard);

C. Medicare premium for the individual;

D. HUD Standard - The HUD Standard is a monthly subsidy given to a facility by the Department of Housing and Urban Development on behalf of residents of the facility; and

E. health insurance premiums incurred by either or both spouses for either or both spouses.

**Note**: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

III. Divide the result by two. The result is the cost of care for each spouse.

**Note**: If there is a partial month transfer of asset penalty, the individual may be responsible for an amount in addition to his or her cost of care (see Chapter 336 of this Manual).

**Section 4.3.3: Determining the Cost of Care for an Individual or Couple open on SSI**

1. For an individual or a couple receiving only an SSI benefit, the cost of care is the maximum SSI and State Supplement benefit for an individual/couple (see Chart 3.6) minus the following deductions:
2. Personal needs of $50.00 for an individual/$100 for a couple;
3. health insurance premiums incurred by the individual for the individual and/or the individual’s spouse if the spouse is covered by Medicaid and is residing in a CRBH, RCF, Nursing Facility or covered by a Home and Community Based Waiver
4. the HUD Standard - The HUD Standard is a monthly subsidy given to a facility by the Department of Housing and Urban Development on behalf of residents of the facility.
5. For an individual or a couple open for an SSI benefit and receiving another income, the cost of care is determined by deducting the following from gross monthly income:
6. Personal needs of $50.00 for an individual/$100 for a couple;
7. Federal Disregard of $20.00 for those with income in addition to SSI/State Supplement as long as their income is not based on need (for example, VA pension does not get this disregard, but VA compensation does);
8. health insurance premiums incurred by the individual for the individual and/or the individual’s spouse if the spouse is covered by Medicaid and is residing in a CRBH, RCF, Nursing Facility or covered by a Home and Community Based Waiver; and
9. the HUD Standard - The HUD Standard is a monthly subsidy given to a facility by the Department of Housing and Urban Development on behalf of residents of the facility.

**Section 4.3.4: Changes in the cost of care are made in the following situations**

I. The individual paid a cost of care that was more than what was actually due. When this was due to Department error, the individual cost of care is adjusted retroactively up to one year from the date the error is discovered by the Department. When this was due to error by the individual, no adjustment is made.

II. The individual paid a cost of care that was less than what was actually due. Whether this is due to error by the Department or the individual, the individual’s cost of care is adjusted retroactively up to three months from the date the error is discovered by the Department without advance notice. This includes an adjustment for a lump sum payment.

**SECTION 5: SPOUSAL LIVING ALLOWANCE (SLA)**

I. A spousal living allowance can be given to the spouse of an individual who is residing in a Cost Reimbursed Boarding Home (CRBH)/Adult Family Care Home AFCH)/Residential Care Facility (RCF).

II. In this section, the term “individual” refers to the spouse residing in a CRBH, AFCH, or RCF. The term “at home spouse” refers to the spouse applying for or receiving the spousal living allowance. The “at home spouse” must be legally married under State of Maine law to the individual.

III. When an individual is getting help from Medicaid with their expenses in a CRBH, AFCH, or RCF, the at home spouse may be eligible for a spousal living allowance. This is a payment that is made directly to the at home spouse.

The living allowance starts the month of application by the at home spouse or the first full calendar month the individual is residing in a CRBH, AFCH, or RCF, whichever is later.

**Example**

The at home spouse applies in 10/08 but 11/08 is the first full calendar month his/her spouse is residing in a Residential Care Facility. 11/08 is the first month of payment.

IV. An application is considered to be filed for the living allowance when:

A. the individual residing in the CRBH/AFCH/RCF files an application for help to pay for their residential care expenses or;

B. the at home spouse requests a spousal living allowance and s/he is receiving assistance through the Food Supplement Program, Medicaid, SSI or the State Supplement.

If none of the above applies, the at home spouse must file a separate application with OFI.

**Section 5.1: Eligibility**

I. **Non-Financial Criteria**

A. The at home spouse must be living alone or with others (living arrangement A) or living in the household of another (living arrangement C). The spouse cannot be living in a residential care facility or medical institution. Living arrangements are further defined in Part 11, Section 5.

B. If the at home spouse is not otherwise covered by Medicaid s/he must meet the basic eligibility requirements identified in Part 2 regarding citizenship, residency and providing a Social Security Number.

C. The at home spouse does not need to meet the SSI - Related rule of being aged, blind or disabled.

II. **Financial Criteria**

A. countable assets must be less than $2,000. The rules on treatment of assets are the same as the SSI - Related rules that are outlined in Part 7, Section 1 and Part 16;

B. countable income of the at home spouse must be less than 100% of the Federal Poverty Level for one; and

C. countable income is determined using the SSI - Related rules that are identified in Part 7, Section 2 and Part 17.

**Section 5.2: Benefits**

I. The at home spouse may be eligible for a payment of up to 100% of the Federal Poverty Level for one. There are no partial month benefits. If eligible for part of the month, then benefits will be authorized for the entire month.

A. If the at home spouse is receiving an SSI payment, the monthly living allowance for SSI recipients is the amount listed in Chart 3.8. This amount is authorized in place of the $10.00/$8.00 State Supplement and is considered a State Supplement.

B. If the at home spouse is receiving the State Supplement only (not SSI) the living allowance will be the difference between countable income and 100% of the Federal Poverty Level for one. This will be authorized in place of the $10.00/$8.00 State Supplement and is considered a State Supplement.

C. If the at home spouse is receiving Medicaid but not SSI or State Supplement, the living allowance will be the difference between the spouse’s countable income and 100% of the Federal Poverty Level for one.

D. If the at home spouse is not receiving SSI, State Supplement or Medicaid, the living allowance will be the difference between the spouse’s countable income and 100% of the Federal Poverty Level for one.

**Example**

Mr. Komart enters a Residential Care Facility in 7/08. Mrs. Komart meets all non-financial and financial rules to receive a spousal living allowance effective 8/08. Her only income is Social Security Retirement of $775 monthly. Her spousal living allowance is determined as follows:

Step 1 $ 775 (gross income)

 - $ 20 (federal disregard)

 - $ 55 (state disregard)

 $ 700 (countable income

Step 2 $ 867 (100% FPL for one)

 - $ 700 (countable income)

 $ 167 (spousal living allowance)

II. The Spousal Living Allowance continues as long as the at home spouse is financially and otherwise eligible and as long as s/he has a spouse residing in a CRBH, AFCH, or RCF who is being helped with their expenses by Medicaid.

**PART 13**

**HOME AND COMMUNITY-BASED WAIVER**

**SECTION 1: DEFINITIONS**

Individuals can get Medicaid coverage and special services if they meet the medical and financial requirements of one of the following coverage groups:

I. **Home and Community Benefits for the Elderly and for Adults with Disabilities Waiver**: This is for individuals (age 18 or older) who meet nursing facility level-of-care requirements and choose to remain at home. Some of the services include: care coordination, personal support services, home health services, adult day health services, transportation, emergency response system, environmental modifications and respite services. The program rules are in Section 19 of the *MaineCare Benefits Manual*, (10-144 CMR Chapter 101)

II. **Support Services for Members with Intellectual Disability or Autistic Disorders**: This benefit provides support services to members who most commonly live on their own or with families; there are occasionally individuals living in group homes who are also eligible. The major support services are community support and work support. This waiver does not provide any residential services. The program rules are in the *MaineCare Benefits Manual*, Section 29.

III. **Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder Waiver**: This waiver offers a comprehensive mix of services to members age 18 or older. The major services offered are: home support—including support to live alone or in settings with others (i.e. group homes), community support, and work support. The program rules are in the *MaineCare Benefits Manual*, Section 21.

These individuals are residing in the community, and have been classified as needing nursing facility level-of-care requirements or meeting the ICF-IID level of care.

IV. **Home and Community Based Waiver Benefit for Children with Intellectual Disabilities and/or Pervasive Developmental Disorders (ID and/or PDD):** This waiver provides an alternative to institutional care to children aged five through twenty with ID and /or PDD who would otherwise require services in an ICF-IID or a psychiatric hospital. The services offered through this waiver and other program rules are specified in the *MaineCare Benefits Manual*, Section 32.

V. **Home and Community Based Waiver Benefit for Adults with Other Related Conditions Aged 21 and Over:** This waiver provides an alternative to institutional care to adults aged 21 and older with a “related condition,” as defined at 42 C.F.R. §435.1010. The services offered through this waiver and other program rules are specified in the *MaineCare Benefits Manual*, Section 20.

VI. **Home and Community Based Waiver Benefit for Adults with Brain Injury:** This waiver provides an alternative to institutional care to adults aged 18 and older with brain injury. The services offered through this waiver and other program rules are specified in the *MaineCare Benefits Manual*, Section 18.

An individual eligible for waiver may live with family members eligible for community MaineCare. The waivered individual’s income and assets are used in the eligibility determination for the remaining family members.

**Example**

Mr. Clooney lives with his wife, Wendy. They meet SSI - Related criteria as a married couple. Mr. Clooney’s eligibility for community MaineCare will be based on the combined income and resources of the couple, with an income limit for a household of two. Wendy’s eligibility for waiver services is based on income and resources owned solely by her.

Eligibility for the Medicare buy-in is determined using community rules for a couple. Eligibility for waiver does not affect how the Medicare Buy-In is determined.

**SECTION 2: COVERABLE GROUPS**

Individuals applying for Waivers must have a coverable group.

**SECTION 3: CLASSIFICATION**

Individuals must be eligible for nursing facility, ICF-IID, or psychiatric hospital level of care, depending on the medical criteria of the specific waiver program. This determination is done by the Department of Health and Human Services or a designated agency.

**SECTION 4: WAIVER ASSETS**

The waivered individual's assets must not exceed the SSI - Related asset limit for an individual (See Part 7, Section 1).

Countable assets are defined in Part 16 with the following exceptions:

I. Assets of a non-waivered spouse are not deemed when determining eligibility for the spouse applying for the Waiver as of the first day of the month in which the individual is considered to be in nursing facility or ICF-IID level care status.

II. Assets that are owned jointly are considered wholly owned by the waivered individual.

III. If both eligible individuals are in a waiver status, the asset limit is $2000 for each.

IV. There is no computation of the community spouse's protected share of assets.

**Section 4.1: Transfer of Assets**

Transfers by the individual or their spouse may be subject to a penalty. Follow the procedures outlined in Part 15. Individuals who are Medicaid eligible under the following coverage groups are not subject to the transfer of asset penalty:

I. any MAGI-based group;

II. an SSI - Related group with an income limit of 100% FPL.

**SECTION 5: WAIVER INCOME**

Income guidelines for individuals under the Waiver Programs follow the definitions in Part 17 with the following exceptions:

I. Gross income of an individual must be less than or equal to the Categorical Nursing Care limit (See Chart 4.1). If income exceeds this amount, determine eligibility using the Medically Needy process in Part 10.

II. There is no deeming of income from the non-waivered spouse.

III. If the income of the individual is being reduced due to previous overpayments by government agencies, the reduced payment amount is used.

IV. VA pensions that are Aid and Attendance or based on unusual medical expenses are not counted as income.

**SECTION 6: WAIVER COST OF CARE**

A cost of care is determined for any month in which eligibility exists.

Cost of care is determined by the budgeting process for that waiver and paid to the appropriate agency.

The cost of care is due for each month for which services are provided even if services are not provided for a full calendar month.

The cost of care may be adjusted without timely notice and may be adjusted retroactively (See Part 14, Section 6.2).

Individuals who are Medicaid eligible under the following coverage groups do not have a cost of care:

I. any MAGI-based group;

II. an SSI - Related group with an income limit of 100% FPL.

**Note**: If there is a partial month transfer of asset penalty the individual may be responsible for an amount in addition to their cost of care (See Part 15, section 1.8).

**Section 6.1: Budgeting**

**Note**: VA pensions that are Aid and Attendance or based on unusual medical expenses are not used to determine the cost of care in the Home and Community Based Waivers.

I. Determine the individual's gross monthly income. If this figure is over the Categorical Nursing Care limit (see Chart 4.1), use the SSI-Related budget for an individual (Part 7) and the deductible process (Part 10) to determine eligibility.

Once the individual is Medicaid eligible, use the following steps to determine the individual’s cost of care.

A. If the individual has elected an option under his or her retirement plan that results in a reduced benefit to the individual in exchange for a continued benefit to the spouse upon the individual’s death (e.g. a joint and survivor annuity option), then that reduced amount will be considered to be gross income. However, the reduced amount may be used only if the election is irreversible and the reduction amount does not exceed $1,000 per month.

B. If income is garnished due to a court order for child support the reduced amount of the income is used. The maximum reduction allowed is up to and including $1,000 per month, per child.

C. An adjustment may be made if there are current federal, state or local income tax deductions from the individual’s gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed.

**Examples**

1. Last year $600 was the tax liability. $80.00 per month is withheld for income tax. Only $50.00 per month can be allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

2. Last year $600 was the tax liability. $25.00 per month is being withheld for income tax. A deduction of $50.00 per month is allowed as a deduction as this is the current tax liability

($600 ÷ 12 = $50.00).

**Note**: If an individual is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

D. When a husband and wife are living together and are both covered by a Waiver, they each may have a cost of care. However, they may allocate income to each other to reduce or eliminate the cost of care.

**Example**

Husband and wife are both eligible for Waiver. The husband has SSA of $1,400. The wife has SSA of $700. We allocate $350 to the wife so each will have $1,050 used in the calculation of their individual costs of care.

II. Subtract 200% Federal Poverty Level for a single-person household. This is the Personal Needs Allowance for the individual.

III. Subtract the cost of:

A. Medicare payments for the individual.

B. Health insurance premiums incurred by the individual for the individual and/or the individual’s spouse if the spouse is covered by Medicaid and is residing in a CRBH, RCF, AFCH, Nursing Facility or covered by a Home and Community-Based Waiver.

**Notes**

Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the non-waivered spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the non-waivered spouse.

Indemnity insurance premiums are not allowed. These are policies that pay for length of stay or a condition but not for a specific service. Third Party Liability should be contacted to assess cost effectiveness. If cost-effective, TPL will arrange for premium payment.

C. **Certain Medical Expenses**

1. Unpaid medical expenses incurred by the individual for necessary medical services. This includes payment on the unpaid balance of a loan taken out to pay for medical expenses incurred prior to Medicaid coverage provided the proceeds of the loan were used to pay the medical bill. Only the amount of the loan actually used to pay the medical bill may be deducted and only the principal (and not the interest) part of the unpaid balance may be used as a deduction.

2. Disability related expenses that are not payable by the waiver, the Medicaid program, or a third-party payer. Disability related expenses include:

a. Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening.

b. Communication devices: adaptations to computers for communication or environmental control, speaker telephone, teletext devices.

c. Wheelchair (manual or power) accessories: accessories, lab tray, seats and back supports.

d. Adaptations to transportation vehicles: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving.

e. Hearing aids.

f. Glasses and adapted visual aids.

g. Environmental control units: devices that substitute for touch control such as a voice activated device to adjust lighting.

h. Assistive animals (purchase only).

i. Personal emergency response systems.

3. A medical expense or disability related expense will not be deducted from the cost of care if:

a. the expense was covered by insurance (including Medicare).

b. the expense was not covered due to a Medicaid penalty period of ineligibility.

c. the Department has determined that the expense was not the responsibility of the individual because a medical assessment was not timely and requested by the facility or because the facility did not timely and adequately assist the individual with filing a Medicaid application. This determination is made by the Office of Aging and Disability Services (OADS).

d. the expense is the cost of care to a medical institution or a waiver agency during periods of Medicaid coverage.

e. the expense was for a Medicaid covered service and the individual was covered by Medicaid.

4. Verified medical expenses are deducted from the cost of care in the month following the month in which the bills are received in the regional office.

IV. Subtract any spousal allocation. To determine this:

A. Determine the spouse's gross monthly income, including SSI and TANF payments.

B. Subtract the gross monthly income from the maximum spousal allowance (see Chart 4.2).

C. The balance is the spousal allocation.

V. Subtract any dependent allocation. When an individual eligible under the Waivers has dependents living at home, an allocation may be allowed for their needs. For purposes of this section, a dependent is defined as a minor or dependent child, dependent parents, or dependent siblings of the waivered individual or non-waivered

 spouse. These dependents are individuals who may be claimed for tax purposes under Internal Revenue Code. To determine the allocation:

 A. determine the dependent(s) gross monthly income, including SSI and TANF payments.

B. subtract the gross monthly income from the appropriate maximum dependent allowance (See Chart 2). The balance is the dependent allocation.

VI. The remainder is the individual's cost of care.

**Example**

Don Renoir is 75 years old. He has applied for the Elderly Waiver. Assets in his name only are under $2,000. He receives Social Security and a pension totaling $1,500 per month.

His spouse, Claudette, has Social Security of $500 per month.

The 19-year old son, who is the couple’s dependent, lives with them. He has zero monthly income.

 $1,500.00 Mr. Renoir’s gross monthly income

 - 1,945.00 personal needs allowance for Mr. Renoir (200% of FPL)

 $ -445.00

 - 96.40 Medicare Part B premium

 $ Not applicable

 - 123.00 spousal allocation

 $ not applicable

 - 154.00 dependent allowance

 $ 0.00 Mr. Renoir’s cost of care

Spousal allocation is determined as follows:

 $ 623.00 maximum spousal allocation

 - 500.00 spouse’s gross income

 $ 123.00 spousal allocation

Dependent allocation is determined as follows:

 $ 154.00 maximum dependent allowance

 - 0.00 income of Mr. Renoir’s son

 $ 154.00 dependent allocation

**PART 14**

**INDIVIDUALS IN MEDICAL INSTITUTIONS**

The rules in this Part are used for individuals who are institutionalized. An institutionalized individual is one who applies for or receives Medicaid and is expected to stay at least thirty days in a hospital or nursing facility.

A Community Spouse is a person who, according to Maine state law, is married to an institutionalized spouse.

A spouse living in a AFH, FRBH, CRBH, RCF, or AFCH (as defined in Part 12, Section1), or receiving Home and Community Based Waiver services (see Part 13) is considered a Community Spouse.

Eligibility for an institutionalized individual requires that the individual:

\* Meets the definition of Institutionalization

\* Has a coverable group

\* Has a medical need classification

\* Meets asset criteria

\* Meets income criteria

If eligible, a cost of care will be determined based on the individuals income.

Individual who are changing from institutionalized status to community status must be given advanced notice if coverage is ending.

**SECTION 1: INSTITUTIONALIZED**

**Institutionalization**: A person is considered institutionalized when he/she resides in a hospital or nursing facility and is expected to remain for thirty consecutive days. A hospital is one that is primarily for the care and treatment of patients with disorders other than tuberculosis or mental disease.

Individuals who die prior to the end of the thirty day period are considered to be institutionalized.

Special income and asset rules are triggered for the person who is institutionalized. These special rules are effective on the first day of the month in which the thirty days of institutionalization starts.

**Example**

The individual enters a hospital or nursing facility on March 20th and remains for at least thirty consecutive days. Special income and asset rules are effective March 1st.

**Section 1.1: Special income and asset limits**

The special income and asset limits for institutionalization are as follows:

I. **Residing in a Hospital**

A. Gross income of the individual must be equal to or less than the Categorically Needy Income Limit in Chart 4.1. If the individual’s gross income exceeds the Categorically Needy Income Limit in Chart 4.1, eligibility is determined using Medically Needy rules. See Part 7.

B. Countable assets of the individual must be under $2,000. If there is a community spouse, the Community Spouse Share of Assets is determined as defined in Section 4.3 of this Part.

C. The cost of care for the individual starts in the first full calendar month residing in a hospital. If there is a community spouse, a Community Spouse Monthly Income Allowance and Income Allocation is determined, as defined in this Part.

II. **Residing in a Nursing Facility or skilled section of a hospital**

A. Gross income of the individual must be less than the private rate for a semi-private room in the facility where the individual resides. If the income of the individual is over the Categorically Needy Income Limit in Chart 4.1 but under the private rate for the facility, a deductible must be met (See Section 5 of this Part).

B. Countable assets of the individual must be under $2,000. If there is a community spouse, the Community Spouse Share of Assets is determined as defined in Section 4.3 of this Part.

C. The cost of care for the individual starts in the first full calendar month they reside in a nursing facility or skilled level of care. Cost of care is determined as defined in this Part.

If there is a community spouse, a Community Spouse Monthly Income Allowance and Income Allocation is determined, as defined in Section 6.1.1 of this Part.

D. If the gross income of the individual exceeds the private rate for a semi-private room in the facility where the individual resides:

1. the individual may be eligible under Medically Needy, but no nursing care costs are covered;

2. a Community Spouse Asset Allocation is given (See Section 4.3 of this Part); and

3. no cost of care is determined and as a result no Community Spouse Monthly Income Allowance is given.

**SECTION 2: COVERABLE GROUPS**

Individuals applying for nursing facility coverage must have a Medicaid coverable group. This can be any coverable group including Family - Related. The individual need not be in an elderly or disability coverage group.

If the individual only qualifies for a coverage group that does not pay for nursing care services the individual is not given a cost of care since nursing care services are not being paid. This includes Non-Categorical, HIV Waiver and Breast and Cervical Cancer groups (See Part 9).

**SECTION 3: MEDICAL NEED CLASSIFICATION**

In order for Medicaid to pay for nursing facility care the person must be in medical need of that level of care. This decision is made by the Department of Health and Human Services or its designee.

**Section 3.1: Individuals ineligible due to a transfer of assets**

If the individual meets the medical need criteria but is ineligible for help with long term care costs due to a transfer of assets, the Categorically Needy Income Limit in Chart 4.1 is used to determine Medicaid eligibility.

**Section 3.2: Individuals who are not in need of nursing facility level of care**

I. If an individual in a Nursing Facility does not meet the medical need criteria, that person may still be eligible for Medicaid coverage if the individual would be eligible if they were living in the community. Coverage is determined using the rules in Parts 6, 7 and 10 for an individual in the living arrangement, "living alone or with others". In this situation, Medicaid will not pay for nursing care costs nor can they be used toward meeting a deductible.

II. Awaiting Placement for Residential Care (DAP or APRC). If an individual is in need of residential care but there are no beds available the individual may remain in the nursing facility as awaiting placement to a residential care facility. This coverage is for individuals converting from private pay including Medicare to Medicaid and found not in need of nursing facility level of care. MaineCare may help the individual with the cost of care if they meet eligibility criteria below. The Office of MaineCare Services sets the APRC rates (Chart 3.8).

A. The Office of Aging and Disability Services (OADS) must establish that the individual meets non-financial criteria as identified in the *MaineCare Benefits Manual*.

B. The following financial criteria must be met:

1. the asset and all non-financial criteria are the same as for an individual residing in a Residential Care Facility (RCF). See Part 12;

2. countable income is determined using the same rules as for an individual residing in a RCF; and

3. the individual's countable income must be less than the APRC amount. A cost of care to be paid to the nursing facility is determined using the same rules as for an individual in a RCF. SSI and State Supplement benefits are counted when determining the cost of care.

If countable income is equal to or over the APRC amount, the daily rate can be used as the cost incurred for medical expenses in determining a “spend-down” (deductible).

C. If countable income is equal to or less than the Community Medicaid income limit for the individual’s coverable group, they can get Medicaid coverage in addition to help with the cost of room and board under APRC.

D. If countable income is over this amount, but less than the APRC amount, the individual is eligible for APRC only (not Medicaid).

E. Coverage under APRC ends when:

1. the Office of Aging and Disability Services (OADS) determines the individual no longer meets the non-financial criteria as identified in the *MaineCare Benefits Manual*; or

2. the individual becomes financially ineligible.

**SECTION 4: INSTITUTIONAL ASSET CRITERIA**

Individuals must use their assets to meet their needs. Specific types and amounts may be retained by the individual and community spouse to meet current and future needs.

All available assets are to be used in determining eligibility. Countable assets are defined in Part 16. Asset limits are defined in Part 7, Section 1.

Unless exempt, a transfer of assets by the individual is subject to a penalty. Refer to Part 15 to assess if a transfer has occurred and if a penalty needs to be applied.

Countable assets of the individual must be under $2000 on any day of the month for which eligibility is determined.

**Section 4.1: Long Term Care Partnership Program**

This program provides incentives to Maine’s citizens to purchase long term care insurance by disregarding some assets of the person, if they must apply for financial assistance for help with their long term care needs.

I. **Insurance Policy**

A. To meet the requirements of this MaineCare program, the long term care insurance policy must be a qualified State long term care insurance partnership as certified by the Maine Bureau of Insurance. Certification requires several factors which include:

1. The policy must cover an insured who was a Maine resident when coverage became effective under the policy. If the individual has a long term care partnership policy from another state which also participates in this program and has agreed to provide reciprocal disregards for Medicaid applicants with qualified partnership plans, Maine will provide the same disregards. The individual must still otherwise qualify for MaineCare assistance as detailed in sub‑sections II and III of this section.

2. The policy must meet the definition of a qualified long term care insurance policy in the IRS Code §7702B(b) and 26 U.S.C. §7702B(b), and must meet the Model regulations specified in 42 USC §1396p(b)5.

3. the policy must have been issued or re-issued on or after July 1, 2009 (the effective date of the applicable approved State Plan Amendment.

4. the policy must meet consumer protection standards of inflation protection, and its issuers are subject to training requirements of the Bureau of Insurance (Maine Bureau of Insurance Regulations 02‑031 CMR chapter 425).

B. Prior to making application for MaineCare the individual must have used the available coverage and benefits under the approved Long Term Care Policy.

II. **Eligibility for MaineCare**

A. All non-financial eligibility requirements as detailed in Section 1000 of this manual must be met.

B. Applicant must meet the medical qualifications for assistance.

C. Applicant’s long term care insurance policy will be reviewed to determine if it meets the qualifications stated above, and to determine the extent of benefits paid so far by the terms of the policy.

D. In addition to exempting assets routinely exempted under MaineCare rules, the amount of benefits paid to or on behalf of the insured applicant will be disregarded in the eligibility determination.

III. **Post-Eligibility Considerations**

A. MaineCare benefits will only be paid for those expenses otherwise covered as outlined in the *MaineCare Benefits Manual* and for which the recipient’s insurance policy has exhausted the benefits.

B. The amount of the individual’s assets disregarded under the above provisions continues to be disregarded post-eligibility throughout the lifetime of the individual, even if the disregarded assets have been transferred post-eligibility.

C. If the policy benefits paid exceed the individual’s assets at the time of application, additional assets up to the value of the benefits paid will be disregarded.

**Section 4.2 Assets of Couples Residing in a Nursing Facility**

If the total assets of a couple in the same room in a nursing facility exceed the standard for a couple, they can decide who will be the eligible spouse and assets can be transferred to the ineligible spouse. Each spouse is treated as an individual. Coverage can begin for the eligible spouse effective the month countable assets for the eligible spouse are below the standard for an individual.

If the couple reside in different rooms in the same facility or in different facilities, then each is treated as an individual when determining the asset limit. Coverage can begin for the eligible spouse effective the month countable assets for the eligible spouse are below the standard for an individual.

No spousal allowance of income or assets is determined since the ineligible spouse is not living in the community.

**Section 4.3: Assets of the Institutionalized Individual with a community spouse**

When an institutionalized individual has a community spouse, the couple’s assets are looked at under special rules. These special rules determine how much of the couples assets are attributed to the community spouse and the institutionalized spouse. The amount attributed to

the community spouse is called the Community Spouse Asset Allowance. The amount attributed to the institutionalized spouse is an available asset for the individual.

Determine the Community Spouse Asset Allowance

I. Total all countable assets owned by the community spouse and the institutionalized spouse (his, hers, theirs) on the first day of the month of application.

II. The community spouse is allowed to keep all countable assets owned by the couple up to the Spousal Impoverishment amount in Chart 4.4. This is the Community Spouse Asset Allowance. Any share of the couple's assets over this amount is considered to be available to the institutionalized spouse.

The Community Spouse Asset Allowance may be increased over the Spousal Impoverishment amount of Chart 4.4 if the gross monthly income of the community spouse and the Community Spouse Monthly Income Allocation is less than the Monthly Income Allowance (See Section 6.1.1 in this Part for definitions). This determination is made through the Administrative hearings process described in Section 4.4 of this Part.

III. The $8000 savings exclusion (See Part 16, Section 4.47) is applied to the amount available to the institutionalized spouse. This exclusion is not applied to the total countable assets or to the Community Spouse Asset Allowance.

IV. The result is compared to the asset limit for an individual.

The assets required to meet the Monthly Income Allowance shall be based on the Monthly Income Allowance set at the time of application.

**Section 4.4: Hearing to Increase the Community Spouse Asset Allowance**

Either the community spouse or institutionalized spouse may request a hearing if they have filed an application and they are dissatisfied with the determination of:

I. The Community Spouse Asset Allowance.

II. The amount of assets attributed to the institutionalized individual.

The hearing will be held within thirty days of the request.

The Department will make a determination of whether an amount greater than the Community Spouse Asset Allowance (Chart 4.4) is needed to raise the community spouse income to the Monthly Income Allowance.

If the individual agrees with the Department’s decision, a hearing is requested using the Consent Decree in Appendix F.

If the individual disagrees with the Department’s determination, s/he may request a face-to-face hearing.

A determination is made as follows on whether assets in addition to the Community Spouse Asset Allowance (Chart 4.4) are needed to meet the Monthly Income Allowance:

I. Monthly Income Allowance and the Community Spouse Income Allocation are determined according to Section 6.1.1 of this Part.

II. the community spouse’s gross monthly income and the Community Spouse Monthly Income Allocation (from the institutionalized spouse) are subtracted from the Monthly Income Allowance. This is the income deficit.

III. the Department will get two estimates of the price of a single premium lifetime annuity that will generate a payment equal to the deficit.

IV. the average of these two estimates shall be substituted for the amount of assets attributed to or protected for the community spouse when the Community Spouse Asset Allowance (Chart 4.4) is less than the averaged cost of an annuity.

If the Community Spouse Asset Allowance in Chart 4.4 is greater than the averaged cost of the annuity, there shall be no substitution for the cost of an annuity.;

V. the spouse is not required to purchase this annuity.

**Section 4.5: Transfer of Assets to the Community Spouse**

Once the Community Spouse Asset Allowance has been established, the couple has twelve months to transfer the protected assets to the sole ownership of the Community Spouse.

**Section 4.6: Non-Cooperation from the Community Spouse**

If the community spouse does not make assets available to the institutionalized spouse, eligibility will not be denied if:

I. the institutionalized spouse has assigned to the State any rights to support from the community spouse. A referral will be made to the Third Party Liability Unit (TPL) on behalf of the institutionalized spouse who gains eligibility for nursing care assistance when deemed assets are not made available by the community spouse;

II. the institutionalized spouse is unable to execute an assignment of support due to physical or mental impairment. The State has the right to bring a support proceeding against a community spouse without an assignment under these conditions; or

III. the State determines that denial of eligibility would cause an undue hardship. The consequences of being denied Medicaid for nursing care by itself does not constitute undue hardship.

**SECTION 5: INCOME CRITERIA**

Individuals must use their income to meet their needs.

Gross non-excluded income is used in determining eligibility. Gross non-excluded income is defined in Part 17 with the following exception: If the income of the institutionalized spouse is being reduced due to previous overpayments by government agencies, the reduced payment amount is used.

Income exclusions used for SSI - Related categories are used to determine gross non-excluded income.

Unless exempt, a transfer of income by the individual is subject to a penalty. Refer to Part 15 to assess if a transfer has occurred and if a penalty needs to be applied.

**Section 5.1: Income Ownership**

The income ownership rules for purposes of this Part supersede any State laws relating to community property or the division of marital property. The rules of ownership of income are as follows:

I. Income payments made solely in the name of one spouse are available only to that respective spouse.

II. When an income payment is made in the names of both spouses, one half is considered to be available to each, unless there is documentation to the contrary.

III. If the payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income is available to each spouse in proportion to the spouse's interest. When both spouses' names are on the payment and no interest is specified, one half of the couples' interest is considered available to each spouse.

IV. Income from a trust is counted to the extent it is considered available (Part 16, Section 4.53).

**Section 5.2: Income Limits**

Gross non-excluded income of the individual must be less than the private rate for a semi-private room in the facility where the individual resides.

**Section 5.2.1: Income below the Categorically Needy Income Limit**

If an individual has income below the categorically needy income limit (see Chart 4.1). See Section 6 of this Part to determine the cost of care.

**Section 5.2.2: Income equal to or over the Categorically Needy Income Limit**

If an individual has income equal to or over the categorically needy income limit, but under the private rate for the facility a deductible must be met.

Depending on the gross income the deductible is always met by incurring the Medicaid rate or private rate for the facility. Specifics on which rate to use are explained below. Eligibility occurs on the first day of the month of eligibility for the six month period.

The deductible is met as follows:

A. Combine all gross unearned income.

B. Subtract the $20.00 Federal Disregard, where applicable. The remainder is the net unearned income.

C. Combine all gross earned income.

D. Subtract any remainder of the $20.00 Federal Disregard not deducted for the unearned income.

E. Subtract the earned income disregard of $65.00.

F. Divide the remaining earned income by two. The remainder is the net earned income.

G. Combine the net earned and unearned income.

H. Subtract the Protected Income Level (PIL) for one (See Chart 5).

I. Multiply this figure by six to determine the total for the deductible period. This is the individual's deductible.

J. Subtract the cost of:

1. Medicare payments of the individual.

2. Health insurance premiums incurred by the individual for the individual and/or the individual’s spouse if the spouse is covered by Medicaid and is residing in an AFH, FRBH, CRBH, RCF, or AFCH, (as defined in Part 12, Section1), or receiving Home and Community Based Waiver services (See Part 13).

Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

**Note**: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

3. Outstanding medical bills incurred by the individual for necessary medical services (See Part 10).

K. The balance is the remaining deductible. The deductible is met as follows:

1. If the gross income is in excess of the Categorical Income limit (Chart 4.1) and less than the Medicaid rate, subtract the Medicaid Rate for the six month period.

2. If the gross income is equal to or over the Medicaid rate for the facility but less than the private rate, subtract the private rate for the six month period.

**SECTION 6: COST OF CARE**

Institutionalized individuals are responsible for paying toward their cost of care for stays of a full calendar month. This includes those who may have paid privately for a portion of the month.

If an individual moves from one nursing facility to another the payment goes to the facility where the individual was residing on the first day of the month. If the individual moves from one facility to another on the first day of the month, the facility to which the individual moves is paid the cost of care.

If the individual was institutionalized on the first day of the month for which eligibility is being requested, the cost of care begins with that month.

If an individual was living in the community on the first day of the month for which eligibility is being requested then the first cost of care is owed for the following month.

If the individual was in acute status in a hospital for a full calendar month the individual may not owe anything for hospital costs due to payments from Medicare and/or other insurance. A cost of care is still determined. The hospital will be responsible to collect any portion that is actually owed.

When, after third party payments, the balance owed is less than the individual's cost of care, the lesser amount will be collected by the facility. This also applies when an individual is in a skilled nursing facility and covered by Medicare and QMB. A cost of care will be established. Since QMB covers the Medicare co-insurances and deductibles no cost of care will be collected until the Medicare days end.

There is no cost of care for SSI recipients in a medical institution if the Social Security Administration determines that the individual will be returning home within three months of entering the facility.

Individuals who receive SSI and whose total income is less than $60.00 (based on being in a nursing facility) have no cost of care.

The amount of an individual’s cost of care may be adjusted without advance notice (See Section 6.2 of this Part).

Individuals who are no longer in a nursing facility are to be refunded their cost of care for that month by the facility. If the individual is entering a AFH, FRBH, CRBH, RCF, or AFCH (as defined in Part 12, Section1), or receiving Home and Community Based Waiver services (see Part 13). a cost of care may be owed to the new provider based on the eligibility requirements for this new program.

**Section 6.1 Determining the Individual’s Cost of Care**

The individual’s cost of care is what the individual is expected to pay towards the cost of their care at the institution. The cost of care is determined by considering the individual’s income minus certain expenses and the Community Spouse Monthly Income Allocation.

For individuals who are categorically eligible, there is one determination process to follow. For those who are medically needy the determination process varies, depending on the individual's income.

For any month that an individual is considered to be institutionalized, a community spouse's income is never used in determining the cost of care, including a partial month, except in determining the Community Spouse Monthly Income Allocation.

**Section 6.1.1: Determining the Community Spouse Monthly Income Allocation**

At the time of application a determination is made of the Community Spouse Monthly Income Allocation.

The Community Spouse Monthly Income Allocation is the amount of income the institutionalized spouse is allowed to give to the community spouse before paying the cost of care.

**Definitions**

**Minimum Monthly Income Standard** – This is an amount set by Federal law used in the formula to determine the Monthly Income Allowance (See Chart 4.4).

**Monthly Income Allowance** – This is the Minimum Income Standard plus excess shelter costs.

**Monthly Excess Shelter Standard** – This is an amount set by Federal law. If the community spouse has shelter costs that exceed this amount, the excess can be used in determining the Community Spouse Monthly Income Allowance (See Chart 4.4).

**Maximum Monthly Income Allocation** – This is an amount set by Federal law that establishes the limit on income that can be allocated to the community spouse.

**Community Spouse Monthly Income Allocation** – This is the Monthly Income Allowance minus the community spouse’s income.

The Community Spouse Monthly Income Allocation is determined as follows:

I. Determine if the community spouse has excess shelter costs:

Total the following shelter expenses for the community spouse’s primary residence:

A. rent or mortgage payment (principal and interest);

B. taxes, homeowner's and renter's insurance payments;

C. maintenance charges for condominiums or cooperatives; and

D. the Standard Utility Allowance used by the State in the Food Supplement Program. The utility standard will be reduced to the extent it is included in cooperative or condominium maintenance fees (See Appendix J for the computation of the utility standard).

1. If the countable monthly shelter expenses are less than or equal to the Monthly Excess Shelter Standard (Chart 4.4), no shelter costs are given in the allowance.

2. If the countable monthly shelter expenses are greater than the Monthly Excess Shelter Standard, the difference is the Excess Shelter Cost.

II. Combine the excess shelter cost with the Minimum Monthly Income Standard. This figure may not exceed the Maximum Monthly Income Allocation. This is the Monthly Income Allowance.

III. Determine the gross monthly income of the community spouse including TANF/SSI payments. Include income actually generated from the Community Spouse Asset Allocation.

IV. Subtract gross monthly income from the Monthly Income Allowance amount in II. above. (If the gross monthly income of the community spouse is equal to or greater than the Monthly Income Allowance, no income allocation is made from the institutionalized spouse).

V. The balance is the Community Spouse Monthly Income Allocation. This income is allocated from the institutionalized spouse to the community spouse.

The Monthly Income Allowance must not exceed the Maximum Monthly Income Allocation (See Chart 4.4).

This allocation can only be increased by:

I. a court order specifying a higher amount, or

II. an administrative hearing that establishes that the community spouse needs income above the Minimum Monthly Income Allowance due to exceptional financial circumstances.

**Examples**

 1. Excess Shelter $ 547

 Minimum Monthly Income Standard (Chart 4.4) + $1967

 Monthly Income Allowance $2514

 Community Spouse Gross Income - $ 500

 Community Spouse Monthly Income Allocation $2014

 2. Excess shelter $ 1098

 Minimum Monthly Income Standard (Chart 4.4) + $ 1967

 Monthly Income Allowance $ 3065

The Monthly Income Allowance exceeds the cap set by the Maximum Monthly Income Allocation. This limits the Allowance to the Maximum Monthly Income Allocation.

 Monthly Income Allowance Allowed (Chart 4.4) $ 2931

 Minus Community Spouse gross income - $ 700

 Community Spouse Monthly Income Allocation $ 2231

**Section 6.1.2: Administrative Hearing Process for Income**

The community spouse or institutionalized spouse may request an administrative hearing if they have filed an application and they are dissatisfied with the determination of:

I. the Monthly Income Allowance;

II. the Community Spouse Monthly Income Allocation; and/or

III. the excess shelter cost.

Either spouse may request a revision of the Monthly Income Allowance if they can establish a need, due to exceptional circumstances, which would create a financial hardship if more funds were not made available. This may occur either through the

hearing process or a court order. The circumstances that caused the request are subject to departmental review yearly to determine if continued receipt of the increased allowance is warranted.

If either spouse establishes that the community spouse needs income above the level otherwise provided by the Monthly Income Allowance, due to exceptional circumstances resulting in significant financial duress, there shall be supplemented to the Monthly Income Allowance, an amount adequate to provide such additional income as is necessary. “Financial duress” is defined as the inability of the community spouse to meet current monthly household and/or medical expenses. “Such additional income as is necessary” is defined as the amount by which the community spouse’s actual and necessary household and/or medical expenses exceed the Monthly Income Allowance.

In order to establish exceptional circumstances resulting in significant financial duress, either spouse must establish that the community spouse has made use of resources and income to meet current monthly household and medical expenses, and

that he or she has no other ability to meet those expenses. Exceptional circumstances will not be deemed to exist where application of the Monthly Income Allowance results in a change or inconvenience to the lifestyle of the community spouse if necessary monthly household and medical expenses can nevertheless be met.

Once an application has been filed, either spouse may request an administrative hearing to increase the Community Spouse Asset Allowance (see Section 4.2 of this Part) if the community spouse's monthly income does not meet the Monthly Income Allowance. The additional assets are requested so that they will generate income and raise the community spouse's total available income to meet the Monthly Income Allowance. The additional allocation of assets to the community spouse may be revised as of the month of application. The Community Spouse Asset Allowance may not be revised prior to that month.

**Section 6.1.3: Dependent Allocation**

When an institutionalized individual has dependents living at home, an allocation may be allowed for their needs. The method of determining the allocation amount depends on whether there is a community spouse.

For purposes of this section, a dependent is defined as a minor or dependent child, dependent parent(s), or dependent sibling(s) of the institutionalized individual or community spouse, who are residing with the community spouse. These dependents are individuals who may be claimed by the institutionalized or community spouse for tax purposes under Internal Revenue Code.

I. **Dependent Allocation with a Community Spouse**

To determine the allocation:

A. Determine the gross monthly income of each dependent member including SSI, TANF, and adoption assistance payments. Assets are considered only to the extent of interest or dividend income being generated.

B. Compare the gross income of each individual to the Minimum Monthly Income Standard. (See Chart 4.4)

If the gross monthly income is equal to or greater than the Standard, no allocation is made.

If the gross monthly income is less than the Minimum Monthly Income Standard, subtract the income from the Standard. Divide the remainder by three. The resulting figure is the allocation for each dependent.

II. **Dependent Allocation Without a Community Spouse**

To determine the allocation:

A. determine the gross monthly income of all dependents living together including SSI, TANF and Adoption Assistance payments. Assets are considered only to the extent of income being generated by the assets.

B. compare the gross income of all dependents living together to the Full Need Standard in Chart 2 for the appropriate unit size. For example, three dependents would use the unit size of three.

If gross monthly income is equal to or greater than the standard, no allocation is made.

If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.

**Section 6.1.4: Calculating Cost of Care for Individuals below the Categorical Income Limit**

I. **Determine the individual's gross monthly income**

A. If the individual has elected an option under his or her retirement plan that results in a reduced benefit to the individual in exchange for a continued benefit to the spouse upon the individual’s death (e.g. a joint and survivor annuity option), then that reduced amount will be considered to be gross income. However, the reduced amount may be used only if the election is irreversible and the reduction amount does not exceed $1,000 per month.

B. If income is garnished due to a court order for child support the reduced amount of the income is used. The maximum reduction is $1000/child/month.

II. An adjustment may be made if there are current federal, state or local income tax deductions from the individual’s gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed.

**Examples**

1. Last year $600 was the tax liability. $80.00 per month is withheld for income tax. Only $50.00 per month can be

 allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

2. Last year $600 was the tax liability. $25.00 per month is being withheld for income tax. A deduction of $50.00 per month is allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

**Note**: If an institutionalized individual is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

III. **Subtract the appropriate personal needs allowance**. This is:

A. $40.00 per month, or

B. $130.00 for the following individuals:

1. those receiving the reduced VA pension of $90.00 who are not in a VA facility, or

2. those in VA nursing facilities who receive a VA pension and are single with no dependents or are the surviving spouse with no dependents

C. up to the maximum dependent allowance (Chart 4.2) for an individual who participates in a sheltered workshop. To determine the actual amount:

1. Subtract $40.00 from any unearned income.

2. Subtract any remainder of the $40.00 from earned income.

3. Subtract $50.00 from any remaining earnings.

4. Subtract one-half of any remaining earnings.

The deductions of $40.00 and $50.00 and the one-half remainder figure are added together. This figure is the personal needs allowance. This figure may not exceed the maximum dependent allowance (Chart 4.2).

IV. Subtract the cost of:

A. Medicare payments for the individual.

B. Health insurance premiums incurred by the individual for the individual and/or the individual’s spouse if the spouse is covered by Medicaid and is residing in a RCF, CRBH, Nursing Facility, or covered by a Home and Community Based Waiver.

Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her

coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

**Note**: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability (TPL) should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

C. Certain Medical expenses:

1. Paid or unpaid medical expenses incurred by a Medicaid covered individual, while residing in the facility, for necessary medical services as long as:

a. the service is not covered in the per diem rate of the facility as determined by the *MaineCare Benefits Manual*.

b. the service is not one the facility is expected to provide. The facility is expected to provide services contained in a written order or plan of care established by the individual’s physician.

2. A medical expense will not be deducted from the cost of care if:

a. the expense was covered by insurance (including Medicare).

b. the expense was not covered due to a Medicaid penalty period of ineligibility.

c. the Department has determined that the expense was not the responsibility of the individual because a medical assessment was not timely requested by the facility or because the facility did not timely and adequately assist the individual with filing a Medicaid application. This determination is made by the Office of Elder Services (OES).

d. the expense is the unpaid cost of care to a medical institution or a waiver agency during periods of Medicaid coverage.

e. the expense was for a Medicaid covered service and the individual was covered by Medicaid.

V. Subtract any spouse's and/or dependent's allocation. These figures are determined in Section 6.1.1 or 6.1.3 of this Part.

VI. The remainder is the individual's cost of care.

**Note**: If there is a partial month transfer of asset penalty the individual may be responsible for an amount in addition to their cost of care (See Part 15, Section 1.8).

**Example**

John enters the hospital on 2/17 from home. He moves to a nursing facility on 2/27. He is married and his wife Joan continues to live in their apartment. They have a $13,500 certificate of deposit from which they receive the interest monthly. They also have a checking account with a balance of $738.29. John receives Social Security benefits of $729.50 and Joan receives $529.80. The subsidized rent is $550.00 monthly, including heat and lights.

**Income Allocation**

**Joan's income John's income**

$ 529.80 Social Security $729.50 Social Security

+ 65.26 interest income

$ 595.06

 $ 600.00 Rent

 + 24.00 Telephone

 $ 624.00

 - 590.00 (30% of $1967 – Chart 4.4)

 $ 34.00 Excess shelter

 +1967.00 Minimum Monthly Income Standard (Chart 4.4)

 $2001.00 (<$2931 maximum – Chart 4.4)

 - 595.06 Joan's income

 $1405.94 Income allocation to community spouse

 **Cost of Care**

 $ 729.50 John's income

 - 40.00 personal needs

 $ 689.50

 - 104.90 Medicare premium (Appendix C)

 $ 584.60

 -1405.94 Income allocation to community spouse

 0.00 Cost of care

**Section 6.1.5: Calculating the Cost of Care for Individuals with Income Equal to or Over the Categorical Income Limit and less than the Private Rate**

An individual is not expected to pay more than the Medicaid rate of the facility for a cost of care.

If the individual's gross income is over the Categorical Income limit but under the Private rate of the facility, multiply the daily Medicaid rate of the facility by thirty-one days. Compare the cost of care as calculated in Section 6.1.4 of this Part to the thirty-one day Medicaid rate. The individual is responsible to pay the lesser of the two amounts, either the cost of care or the Medicaid rate.

**Example**

Dick Reel entered a nursing facility on 1/17/08, from home. Dick receives $2972 in Civil Services benefits, $798 in Social Security benefits and a pension of $1800 monthly. The private rate is $200 per day and the Medicaid rate is $100 per day.

**Income**

$2972.00 Civil Service

$ 798.00 Social Security

$1800.00 Pension

$ 5570.00 Total

**Deductible** (See Section 5.2 of this Part)

$ 5570.00 Dick's gross income

- 20.00 Federal disregard

$ 5550.00

- 315.00 PIL (1)

$ 5235.00

X 6 Deductible period

$31410.00 Deductible

- 629.40 Medicare premiums

$30780.60

 18600.00 Medicaid rate for 6 months

$12180.60

Because there is a remaining deductible use the Private rate instead of the Medicaid rate for 6 months.

 $30,780.60

- $37,200.00 Private rate for 6 months

 0.00 Remaining deductible

**Cost of Care**

$ 5570.00 Dick's gross income

- 40.00 Personal needs

$ 5530.00

- 104.90 Medicare premium

$ 5425.10 Cost of Care

Dick’s cost of care will be $3100 monthly. This is the Medicaid rate for the facility and it is less than the cost of care calculated using the rules in section 6.1.4.

**Section 6.2: Changes in the Cost of Care**

I. The individual paid a cost of care that was more than what was actually due. When this was due to Department error, the individual cost of care is adjusted retroactively up to one year from the date the error is discovered by the Department. When this was due to error by the individual, no adjustment is made.

II. The individual paid a cost of care that was less than what was actually due. Whether this is due to error by the Department or the individual, the individual’s cost of care is adjusted retroactively up to three months from the date the error is discovered by the Department without advance notice. This includes an adjustment for a lump sum payment (see Section 6.4 of this Part).

**Section 6.3 Non-Covered Medical Expenses**

Verified medical expenses that can be deducted from the cost of care are deducted for the month following the month the bills are received in the office.

For individuals who die and had incurred non-covered medical expenses, the last cost of care can be adjusted for the month in which they die.

Individuals who only receive $40.00 per month SSI and have a $0 cost of care are not reimbursed for non-covered medical expenses.

**Example**

Jack Snow purchases two bottles of Tylenol at $11.49 each and two hearing aid batteries at $10.00 each. Receipts are submitted on 3/5. Gross Social Security is $891.80.

**Cost of Care**

$ 891.50 Gross Social Security

- 40.00 Personal needs

- 104.90 Medicare premium

- 20.00 Uncovered medical expenses (see note below)

$ 726.60 Cost of care

**Note**: Cannot allow Tylenol - (generic brand for Tylenol is supplied by the facility. If Tylenol is prescribed by a physician and included in the plan of care, it is supplied by the facility and the cost is not allowed as an uncovered medical expense).

**Section 6.4: Lump Sums**

All lump sum payments, with the exception of SSI, are treated as income in the month received.

Any portion of a lump sum remaining the following month is an asset. Social Security and SSI retroactive payments are an excluded asset for nine months.

**Section 6.5: Medicare Buy-In for Institutionalized Individuals**

Medicare Buy-In is determined the same as for those who live in the community. See Part 8 for a description of the Buy-In programs.

If a couple is residing in the same room they are considered to be living together. If they are residing in separate rooms they are considered to be living apart.

Aid and Attendance is not used in this process.

**PART 15**

**TRANSFER OF ASSETS**

**SECTION 1: TRANSFER OF ASSETS FOR INSTITUTIONALIZED INDIVIDUALS**

When an individual disposes of assets for less than fair market value on or after the look back period they may have to serve a penalty period before coverage can begin for institutional level of care services. The services are:

\* Nursing facility services

\* Nursing facility services in a medical institution

\* Home and Community Based Waiver Services

The individual may be eligible for all other Medicaid services.

**Section 1.1: Definition of the look back period**

The look back period for all transfers is sixty months prior to the month in which the individual is institutionalized and applies for Medicaid.

If the individual has had multiple periods of institutionalization and/or applications, the look back period starts with the first date on which the individual was institutionalized and applied for Medicaid.

**Section 1.2: Definition of “Individual”**

In establishing whether a transfer of assets has taken place, the term “individual” includes the individual him/herself as well as:

I. the individual’s spouse; or

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

**Section 1.3: Definition of Assets Subject to Transfer**

For transfer purposes, an asset includes all income and resources of the individual and the individual's spouse. This includes any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action or lack of action by the individual as defined above, including but not limited to renouncing an inheritance or failing to exercise a spousal share in a challenge to a will.

To determine the effect that the transfer has on eligibility, several questions must be answered:

I. What was transferred?

II. Who was the transfer made to?

III. When was the transfer made?

IV. What did the individual or couple receive in exchange?

V. Why was the transfer made?

**Section 1.4: Exempt Transfers**

The following may be transferred without penalty:

I. The home, if it is transferred to:

A. a child who is under age 21 or who does or would meet SSI criteria of total and permanent disability or blindness;

B. a sibling who has an equity interest in the home and was residing in the home for at least one year prior to the individual going to the medical institution.

**Example**

A brother and sister have joint ownership of a home in which they both lived for the last five years prior to the brother going into a nursing facility. The brother may transfer his interest in the home to his sister without penalty.

A penalty would be established if:

1. the sister was not a joint owner or had no equity interest in the home, or

2. the sister had not lived in the home one year prior to the institutionalization of her brother.

C. a child over age 21 who does not meet the SSI criteria of blindness or disability if the child was residing in the home for at least two years prior to the individual's entering the medical institution and was providing care which enabled the institutionalized individual to live at home rather than a medical institution for this time; or

D. a spouse.

II. Any asset transferred to the individual's child who does or would meet SSI criteria of total and permanent disability or blindness. This exemption also applies to the transfer of assets by the individual or the individual's spouse to a trust established solely for the benefit of the individual's child who does or would meet the SSI criteria total and permanent disability or blindness.

III. Assets transferred to a trust established solely for the benefit of an individual under 65 years of age who does or would meet the SSI criteria of total and permanent disability.

IV. Assets which the owner intended to dispose of at fair market value or for other valuable consideration but, without being at fault, the owner did not obtain full fair market value.

V. Assets transferred exclusively for a purpose other than to qualify for Medicaid either at the time of the transfer or at some future date. "Exclusively" means, transferred for that reason only and solely. It is not enough to prove that there was a reason to

 transfer in addition to gaining Medicaid eligibility. The reason for transferring must be exclusive of gaining Medicaid eligibility.

VI. Assets transferred for less than fair market value once all the assets have been returned to the individual. There is no penalty as of the month in which all the assets are returned to the individual. When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. A penalty remains in effect for the past time period during which the asset had been transferred.

VII. Assets transferred to (or for the sole benefit of) the spouse.

VIII. Assets transferred (sixty months) prior to the month in which the individual is institutionalized and applies for Medicaid. When a transfer involved assets of a trust of any type, the look back period is sixty (See Part 16, Section 4.53).

IX. Assets transferred for Fair Market value.

X. Irregular or infrequent gifts provided the cumulative amount of the gifts do not exceed $500 per calendar quarter. Each gift is analyzed separately. This provision does not mean that the first $500 per quarter is excluded when the cumulative amount of those gifts is more than $500.

A transfer is considered to be for the "sole benefit of" a spouse, blind or disabled child or disabled individual when no individual or entity except the spouse, blind or disabled child or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any other time in the future.

**Section 1.5: Fair Market Value**

A transfer for fair market value incurs no penalty. Fair market value may be received in cash by the individual.

Fair Market Value is an amount that can be expected to be received for selling a similar article on the open market in the geographic area involved.

The compensation received for the asset must be in a tangible form with intrinsic value that is equivalent to or greater than the value of the transferred asset. A transfer for love and consideration is not a transfer for fair market value.

Fair market value may be received by the individual in the form of payment of the individual's past medical expenses and debts if measurable and verified. Fair market value must be received by the individual and not delivered at a future date.

Fair market value may also be received in the form of past support for basic necessities if such support is measurable and verified. A reasonable value must be placed on the support provided and the specific time period must be substantiated for which it was given.

Past support for basic necessities does not include any items given as a gift or any services provided by relatives. Past support for basic necessities may include clothing, transportation or personal care provided by a relative only if this clothing, transportation or personal services were provided as part of a legally written enforceable agreement whereby the individual would transfer the asset in payment for clothes, transportation or personal services once those services have been received.

An Individual may only transfer assets for services provided by a relative if the transfer takes place at the time the service is rendered and:

I. the services must be performed after a written agreement has been executed between the applicant and provider. Other provisions stated above continue to apply.

II. at the time of the receipt of the services, the applicant may not be residing in a nursing facility or a CRBH, AFCH, or RCF.

III. at the time of the receipt of the services, the services must have been recommended in writing and signed by the applicant's physician, as necessary to prevent the transfer of the applicant to residential care or nursing facility care. Such services may not include the mere providing of companionship.

IV. at the time of application, the Department will verify the agreement by reviewing the written contract between the applicant and the provider / relative which must show the type, frequency and duration of the services being provided to the applicant and the amount of consideration (money or property) being received by the provider / relative. If the amount paid for the services is above the fair market value of the services at the time the services were delivered, then the applicant will be considered to have transferred the assets for less than fair market value. If in question, fair market value of the services may be determined by consultation with an area business which provides such services.

**Section 1.6: Disproving the Presumed Transfer**

Any transfer taking place will be presumed to have been made for the purpose of becoming or remaining eligible for Medicaid, unless the individual furnishes clear and convincing evidence that the transaction was for some other purpose and that there was no intent at the time to apply for Medicaid within the foreseeable future. It is the Department's responsibility to demonstrate that a transfer took place and to establish the date of the transfer. It is the individual's responsibility to prove that the transfer took place for reasons other than to gain eligibility for Medicaid.

If the individual wants to disprove the presumption that the transfer was made to establish Medicaid eligibility, the burden of proof rests with the individual. The individual must demonstrate that the transfer was specifically and solely for some other purpose than to receive Medicaid. Statements and evidence to disprove the transfer must be contained in the individual's record.

The statement should cover, but not necessarily be limited to the individual's:

I. purpose for transferring the asset;

II. attempts to dispose of the asset for fair market value;

III. reasons for accepting less than the fair market value for the asset;

IV. plans for and ability to provide financial support after the transfer;

V. relationship, if any, to the persons to whom the asset was transferred; and

VI. belief that the fair market value was received.

In addition to the individual having to prove that the transfer was made specifically and solely for a purpose other than to be Medicaid eligible, other factors to be considered include:

I. a sudden onset of a disability or blindness after the asset was transferred;

II. the diagnosis of a previously undetected disabling condition after the transfer occurred;

III. unexpected loss of other assets following the transfer;

IV. unexpected loss of income after the transfer occurs; and

V. court ordered transfers.

**Section 1.7: Establishing Date and Value of a Transfer**

This will depend on the type of asset transferred.

I. For assets other than bank accounts a transfer of assets occurs when:

A. title (ownership) or legal interest to property has passed from the individual to another individual. For example: Sole ownership of a home valued at $100,000 is transferred to another. The value of the transfer is $100,000.

B. the individual establishes a joint ownership, tenancy in common, joint tenancy or other similar arrangement, such as adding a name to stocks, bonds, or real property. In addition to legally transferring part ownership, the individual has taken action which reduced or eliminated their ownership or control of the remainder of the asset. The date of the transfer is the date that the joint ownership was established. The amount of the transfer is the total uncompensated value of the asset. For example: In 10/05 the individual establishes joint ownership of their home valued at $100,000. The value of the transfer is $100,000. The date of the transfer is 10/05.

C. the asset is converted from an accessible to an inaccessible asset. An example is when assets are placed in an irrevocable trust.

D. the individual takes action to refuse the receipt of assets.

E. unless otherwise exempt, when real property is sold and the individual holds a promissory note, a transfer of assets must be assessed as follows:

1. if the individual sold property for less than fair market value (see Section 1.5 of this Part), a transfer of assets has occurred amounting to the difference between the sale price (the presumed value of the note) and the value of the property. To determine the sale price the presumed value of the note is used.

2. if the current value of the note is less than the presumed value, the difference between the two amounts is a transfer of assets.

The total amount of assets transferred due to (1) and (2) above incurs a penalty, and the date of the transfer is the date the real property is sold.

F. As of 2/8/06, funds used to purchase a promissory note, loan or mortgage can be considered a transfer of assets unless the note, loan or mortgage:

1. has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Social Security Administration, found online at: http://www.ssa.gov/OACT/STATS/table4c6.html).

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

3. prohibits the cancellation of the balance upon death of the lender.

If the conditions in 1, 2, and 3 above are not met, the value of the transfer is the outstanding balance due on the note, loan or mortgage as of the date of the individual's application for Medicaid.

G. The individual transfers ownership in real property and retains a life estate. In order to determine the value of the transfer penalty refer to Appendix E – Life Estate and Remainder Interest Table. Using the age of the individual at the time of transfer, find the amount in the column of Chart, "Remainder", and multiply it by the fair market value of the property at the time of the transfer. This is the value of the transfer.

H. The individual transfers a life estate interest in real property. In order to determine the value of the transfer penalty refer to Appendix E – Life Estate and Remainder Interest Table. Using the age of the individual at the time of transfer, find the amount in the column, "Life Estate" and multiply it by the fair market value of the property at the time of the transfer. This is the value of the transfer.

I. Purchase of a life estate after 2/8/06. The money used to purchase a life estate interest in another individual's home is considered a transfer of assets, unless the applicant resides in the other individual's home for at least one full and consecutive year beginning on the date of purchase. The value of the life estate must still be calculated in order to determine if the applicant received fair market value for the purchase, regardless of how long the applicant lived in the home. If the applicant paid more than the life estate is worth, then the difference is a transfer for less than fair market value and is subject to a penalty.

II. With bank accounts, a transfer of funds in an account is determined to take place when:

A. funds, owned by the individual (see Part 16, Section 2.5), are withdrawn by the other joint owner(s) from an account and used for other than the sole benefit of the individual; or

B. another person's name is added to the individual's account, the money in the account is owned by the individual, and the intent of the individual in giving access is to convey ownership of those funds. Intent to convey ownership must be documented with a clearly written statement of intent to transfer the funds in the account to the joint owner. This statement must be:

1. duly executed in the presence of the notary public; and

2. signed by the individual at the time the account was made joint or within a reasonable period of time, usually one week but maybe longer due to circumstances beyond the control of the client.

**Note**: Evidence of an intent to transfer the funds in the account at the time that the name was added to the account will be rebutted by evidence that the individual continued to use the funds.

**Section 1.8: Establishing a Penalty**

Once it has been determined that a transfer of assets has occurred for less than fair market value, the penalty period must be determined.

When a penalty is imposed, it is only the long term care services that cannot be paid. The individual may be eligible for all other MaineCare services.

I. The penalty period is determined as follows:

A. Determine the date that each transfer occurred.

B. Determine the amount of the transfer.

C. Divide the amount of the transfer by the average monthly private rate for a semiprivate room for a nursing facility at the time of application (see Chart 4.3). This determines the number of whole months of ineligibility based on the transfer.

D. When the value of the transfer is less than the average monthly private rate for a semi-private room for a nursing facility in Chart 4.3, or the penalty calculation includes a partial month, the partial month shall be counted and implemented as a period of ineligibility using the following method:

1. After determining the amount of transfer and dividing that amount by the average monthly private rate for a semiprivate room for a nursing facility, impose a period of ineligibility for the whole months.

2. Convert the remaining partial month into a dollar amount by multiplying the number of whole months by the monthly private rate used in the calculation above, and subtracting that figure from the total amount of the transfer.

3. This remainder is added to the cost of care for the first month of eligibility after imposing the penalty period.

**Example**

If the monthly private rate is $6,000 and the transfer amount is $56,400, this would result in a transfer penalty of 9.4 months. To determine the remainder amount, you would take $6,000 X 9 months = $54,000. $56,400 minus $54,000 = $2,400. You would add $2,400 to the cost of care for one month. If the penalty period begins March 1st,

it would end November 30th $2,400 would be added to the cost of care for December.

In an instance where the penalty period is less than a full month the partial month penalty will be added to the cost of care in the first month a cost of care is due.

**Example**

Individual enters nursing facility November 27th. There is a partial month transfer penalty of $3000. The first month a cost of care is due is December. The $3000 partial month transfer penalty will be added to the December cost of care.

II. If there has been more than one transfer in the same month, the penalty period is determined as follows:

A. Determining the total, cumulative, value of all transfers in the same month.

B. Divide the amount by the average monthly private rate for a semiprivate room for a nursing facility at the time of application (see Chart 4.3). This determines the number of whole months of ineligibility.

C. When the value of the transfer is less than the average monthly private rate for a semi-private room for a nursing facility in Chart 4.3, or the penalty calculation includes a partial month, the partial month shall be counted and implemented as a period of ineligibility using the following method:

1. After determining the amount of transfer and dividing that amount by the average monthly private rate for a semiprivate room for a nursing facility, impose a period of ineligibility for the whole months.

2. Convert the remaining partial month into a dollar amount by multiplying the number of whole months by the monthly private rate used in the calculation above, and subtracting that figure from the total amount of the transfer.

3. This remainder is added to the cost of care for the first month of eligibility after imposing the penalty period. In an instance where the penalty period is less than a full month the partial month penalty will be added to the cost of care in the first month a cost of care is due.

III. If there have been multiple transfers occurring in more than one month during the look-back period, all transfers can be added together into one penalty period using the following method:

A. Accumulate all transfers.

B. Divide the amount by the average monthly private rate at the time of application for a semiprivate rate for a nursing facility (See Chart 4.3). This determines the number of whole months of ineligibility.

C. The transfer is treated as one transfer and is treated as if it occurred on the earliest date of the multiple transfers.

D. When the value of the transfer is less than the average monthly private rate for a semi-private room for a nursing facility in Chart 4.3, or the penalty calculation includes a partial month, the partial month shall be counted and implemented as a period of ineligibility using the following method:

1. After determining the amount of transfer and dividing that amount by the average monthly private rate for a semiprivate room for a nursing facility, impose a period of ineligibility for the whole months.

2. Convert the remaining partial month into a dollar amount by multiplying the number of whole months by the monthly private rate used in the calculation above, and subtracting that figure from the total amount of the transfer.

3. This remainder is added to the cost of care for the first month of eligibility after imposing the penalty period. In an instance where the penalty period is less than a full month the partial month penalty will be added to the cost of care in the first month a cost of care is due.

IV. The penalty period for transfers begins with the later of:

A. the first day of a month in which the transfer for less than fair market value occurred; or

B. the first day of the month the individual is eligible for Medicaid and would otherwise be receiving help with the cost of long term care services based on an approved MaineCare application were it not for the Department imposing an asset transfer penalty period; and

C. the first day which does not occur during any other period of ineligibility.

V. At the time both spouses become institutionalized, have applied for and are otherwise eligible for MaineCare and there is a penalty period in effect for either spouse, the remaining penalty period can be divided between the spouses into any combination of full months. Whether there is a division of the penalty and, if so, how it will be divided, is a decision of the spouses.

When, for some reason, one spouse is no longer subject to a penalty (for example, no longer lives in a nursing facility or dies), the remaining period applicable to both spouses must be served by the remaining spouse.

**Section 1.9: Hardship Waiver**

The individual applying for help with the cost of nursing facility services or home and community based waiver services may be able to get the period of ineligibility waived if they can show that the transfer penalty places them in an undue hardship situation. It is the responsibility of the individual to prove the claim of undue hardship.

I. Determine if undue hardship exists. An undue hardship exists if this denial would:

A. deprive the individual of medical care such that the individual’s health or life would be threatened; or

B. deprive the individual of food, clothing, shelter, or other needs of life.

II. Determine whether to waive the penalty when undue hardship exists. The penalty can be waived if:

A. the individual was exploited as assessed by the Office of Aging and Disability Services; or

B. the individual can prove all of the following:

1. Neither the individual nor the spouse have the means to pay for the cost of nursing facility or home and community based waiver services, taking into consideration all exempt and non-exempt income and assets.

2. The recipient of the transferred asset is unable or unwilling to make the value of the transfer or any part of it available to pay for the individual’s cost of nursing facility or home and community based waiver services.

3. The individual has made all reasonable efforts to recover the transferred asset or its equivalent value. The individual must cooperate with the Department in any recovery activity that is undertaken.

4. The individual must agree in writing that if the transferred assets or equivalent value are recovered, the individual will reimburse Medicaid for funds expended as a result of the approved claim of undue hardship.

III. The result of being denied Medicaid for nursing facility services or home and community based waiver services, by itself, is not considered undue hardship.

IV. The Department will use the following process for undue hardship determinations:

A. All denials/closures due to a transfer of assets will include a written notice that an “undue hardship” provision exists and can be considered according to the criteria indicated above if the applicant/recipient requests it.

B. A claim of undue hardship must be made no later than thirty days from the date of the denial/closure notice. With the individual’s written permission, an authorized representative or the facility in which the individual resides can claim undue hardship on the individual’s behalf.

C. A decision on a claim of undue hardship will be made and the applicant notified in writing within thirty days of the claim being made.

D. An appeal from any adverse action including a denial of a claim of undue hardship must be made within thirty days of the notice of denial. Applicants/recipients will be given written notice of this right to a hearing.

E. In II. B.1. above, the Department will not use income and assets provided to the community spouse to prevent impoverishment in determining whether

 the individual or the spouse have the means to pay the cost of long term care services in the facility.

**PART 16**

**ASSETS**

**SECTION 1: DEFINITIONS**

**ANNUITIZED ANNUITY:** An annuity under which the individual is receiving a benefit payment under a payment option (life only, ten year certain, etc.) which they have selected.

**ANNUITY:** An annuity is an investment on which an individual receives fixed payments for a lifetime or a specified period of time.

**ASSETS**: Cash, other liquid resources or real or personal property.

**AVAILABLE ASSET:** An asset that has a value which is legally obtainable by the individual. If there is a penalty for early or late withdrawal to get the asset, the available asset is the amount after the penalty is taken.

**DEFERRED ANNUITY:** An annuity under which the benefit payment will begin at some future date. The individual has not yet selected a payment option (life only, ten year period certain, etc.)

**EQUITY VALUE**: The fair market value of real or personal property minus any encumbrances. Examples of encumbrances are: mortgages, liens, and other debts on or attached to the property.

Any asset which has no saleable value will not be used in determining eligibility because it has no equity value.

**Examples**

* Homes that, due to structural damage, and their location on leased property, have no resale value.
* Vacant property not large enough to be sold due to changes in zoning laws.
* Vehicles, which cannot be sold due to mechanical or other problems.

**FAIR MARKET VALUE**: Amount that can be expected to be received for selling a similar article on the open market in the geographic area involved. The individual may refute the fair market value determined by the Department by providing statements from two credible sources.

**LIQUID ASSETS**: Cash or other resources that can be converted into cash on demand.

**NON-LIQUID ASSETS**: Real or personal property that cannot be converted into cash on demand.

**OWNERSHIP:** Power, authority or title to sell, exchange, convert or redeem any property. Property in the name of a child is available to both child and parent, as the parent can make it available.

**REAL ESTATE AND OTHER NON-LIQUID ASSETS:**

In determining the value of this countable asset, the type of ownership must be established.

If the owners have "joint tenancy", each owner has an equal interest in the total value of the property.

If the owners are "tenants in common", each owner has a share in the property. Generally, each owner can sell that share without the consent of the other owners. If the terms of ownership prohibit sale of one owner's portion or the other owner(s) refuses to agree to sell, the real estate is excluded.

**UNAVAILABLE ASSET:** An asset that has a value which is legally unobtainable to the individual.

**SECTION 2: USE OF ASSETS**

Individuals must use their assets to meet their needs before MaineCare will be available. Specific types and amounts may be retained to meet current and future needs. See explanation of specific assets that follow.

If assets are potentially available, applicants, recipients or others acting on their behalf must take action to make them available.

All available assets are to be used in determining eligibility.

Unavailable assets are not to be used in determining eligibility.

**SECTION 3: TREATMENT OF ASSETS**

**Section 3.1: Eligibility Groups for Which MAGI-based Methodology Applies**

All assets are excluded for eligibility groups for which MAGI-based methodology applies.

**Section 3.2: All Other Eligibility Groups**

Unless specifically indicated as excluded or unavailable, all assets are counted toward the appropriate limit (Part 7) whether listed in Section 4 of this Part or not.

For the purpose of this Part, SSI - Related categories refer to Parts 6, 9. 11, 12, 13, and 14.

**SECTION 4: TYPES OF ASSETS**

**Section 4.1: Agent Orange -** *excluded for SSI-Related categories*

All Agent Orange settlements as provided for under PL 100- 687 and 101-201 are excluded.

**Section 4.2: Alaskan Native Claims *-*** *excluded for SSI-Related categories*

The tax-exempt portions of payments made pursuant to PL 92-203, the *Alaskan Native Claims Settlement Act* are excluded.

**Section 4.3: Annuities** *- partially excluded for SSI-Related categories*

A. Policy applicable to all MaineCare including residential care and long term care

An annuity may be purchased by the individual or a third party. If the annuity is purchased by other than the individual, the payments are counted as income. There is no countable resource nor is there a transfer of assets.

(1) Annuities purchased before 2/8/06

(a) The current cash value of the annuity available to the individual, including the principal and interest earned on the principal, minus any penalty fees for withdrawal, is a countable resource.

(b) Payments from annuities are considered income to the individual for whom the payments are designated.

(2) Annuities Purchased on or after 2/8/06

(a) Payments from annuities are considered income to the individual for whom the payments are designated.

(b) The current cash value of the annuity available to the individual including the principal and interest earned on the principal minus any penalty fees for withdrawal is a countable resource.

B. Policy applicable to long term care –

Applicants for and recipients of Medicaid long term care or residential care coverage must disclose a description of any interest the individual or community spouse has in an annuity regardless of whether the annuity is irrevocable or is treated as an asset. This must be disclosed at the time of initial application and at re-determination.

(1) Annuities purchased before 2/8/06

If the individual has purchased other than a straight life annuity, a transfer of assets has occurred. This is because the individual has purchased not only a benefit for him/herself but also payments to a beneficiary. The value of the transfer is equal to the difference between the cost of the annuity purchased and the cost of a straight life annuity providing the same monthly benefit. The date of the transfer is the date the payment option is selected and the funds cannot be returned to the individual. To determine if the transfer is subject to a penalty, refer to Part 15.

(2) Annuities Purchased on or after 2/8/06

(a) An annuity purchased by or on behalf of an annuitant who has applied for Medicaid with respect to long term care services will be treated as a transfer of assets unless:

(i) the annuity is an Individual Retirement Annuity (26 U.S.C. §408(b,q); or

(ii) the annuity is purchased with proceeds from

an Individual Retirement Account or a simple retirement account (26 U.S.C. §408(a), (c), or (p) ;

a simplified employee pension (26 U.S.C. §408(k); or

a Roth IRA (26 U.S.C. §408); or

(iii) the annuity is:

* + - irrevocable and non-assignable; and
		- actuarially sound (as determined in the Social Security Administration Life Expectancy Table. This table can be found on the internet at <http://www.ssa.gov/OACT/STATS/table4c6.html>); and
		- provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(b) The purchase of an annuity by the individual or the community spouse shall be treated as the disposal of an asset for less than fair market value unless:

(i) the State of Maine is named as the remainder beneficiary in the first position for the total amount of Medicaid paid on behalf of the individual; or

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

**Section 4.4: Assets being converted –** *excluded for SSI - Related categories*

Assets which are in the process of being converted are exempt during the period they are unavailable.

**Examples**

* insurance policies which have been sent to the insurance company,
* property which is being probated and
* stocks which have been submitted for redemption.

**Section 4.5: Bank accounts (including savings, checking, money market and certificates of deposit) -**

Included are individual and jointly owned bank accounts and other jointly owned liquid assets:

A. Individual Accounts - the funds in these accounts areto be totally available to the individual.

B. Joint Accounts:

(1) Funds in these accounts are considered to be owned by the individual unless there is proof that funds in the account were contributed by another joint owner of the account.

If the individual claims that s/he does not own the money in the account s/he must provide evidence that this money belongs to the other joint owner(s). Any money in that account which the individual can show was contributed by one of the other joint bank account owners is excluded.

Verification of ownership of the funds may be shown through bank statements, written statement from the source that provided the fundsto the account, letters of award showing proof of ownership, or other clear and convincing evidence satisfying the Eligibility Specialist that the money in the account is not available to the applicant or recipient

Any money in the account which, even though contributed by the joint owner, is intended for use by the applicant/recipient (such as a gift) is countable to the individual. The Department will presume this portion is considered as any other available asset unless credible evidence is given showing this was not a gift.

(2) When evidence is provided that funds in the account belong to another joint owner, the individual must remove her name from the account or establish a separate account with the funds she does own. This must be done within thirty days of successful presentation of ownership evidence.

If it is necessary to obtain guardianship, conservatorship or power of attorney for one of the joint owners, the thirty day count will not begin until the process of obtaining guardianship, etc., is completed. If the Department determines that there is no active pursuit of the appointment, the thirty day count will begin.

The account will be considered owned in equal portions when the two or more joint holders are eligible individuals or couples.

When a joint name is added to the account, funds are considered to be transferred to the joint name added if conditions in Part 15, Section 1.7 (II) are met.

**Examples**

(a) Mr. and Mrs. Jones have a 33 year old son, John. Because John has to travel a great deal to work he added his parents' names to his savings and checking accounts so they could pay his bills if needed. The Jones' were able to verify that John had deposited from his own money all of the funds in the account and that all of the transactions were for his benefit. They were given thirty days to remove their names from the accounts.

(b) Martha Thompson has a joint checking account with her daughter, Jane. Jane has POA for her mother. Jane's paychecks ($1400 monthly) and Martha's Social Security check ($600) both go into this account. They live together and split expenses. Jane does not need to invoke her POA to access the money in the account. Since only 30% of the money going into the account is from Martha's income, only this percentage of the total balance is considered to be hers. Martha will have thirty days to remove Jane's name or to establish an account of her own, with her portion of the funds.

C. Other jointly owned liquid assets –

A distinction is made between jointly owned bank accounts and other jointly owned liquid assets, such as stocks and bonds.

For other types of jointly owned liquid assets, each joint owner owns an equal share of the asset. For example, if there were 3 joint owners each would own a one-third interest in the asset.

**Example**

Two sisters are applying for assistance. They have stocks left to them by their brother. This is verified by a copy of his will. Instead of the entire value being counted by each, one half of the value counts for each sister.

If the individual or couple establish that other joint owners refuse to sell jointly owned property, the value of the asset is excluded. This exclusion does not apply if any joint owner has the ability to convert the jointly owned asset to cash without the permission of the other owners or if the joint owners are a couple. See the policy on transfers for a possible transfer penalty the individual has established joint ownership.

**Section 4.6: Burial Contracts/Spaces/Funds**

A. Excluded for SSI-Related categories:

(1) Prepaid burial contracts (mortuary trusts) set up before 3/1/06, regardless of value.

(2) Prepaid burial contracts (mortuary trusts) set up on or after 3/1/06, are excluded so long as either the contract is less than or equal to the statewide average for burial and funeral costs of $12,000. If the contract is for more than $12,000 then the estate of the Medicaid recipient must be named the beneficiary of any funds remaining after payment of funeral and burial charges.

(3) Burial spaces intended for the use of the individual, spouse or other member of the immediate family, are an excluded asset

B. For SSI - Related categories:

(1) Separate identifiable account for their burial expenses.

(a) For each individual exclude up to $1500 set aside in a separate identifiable account for their burial expenses as long as the individual does not have a total of $1500 in all of the following funds:

* prepaid burial
* excluded face value of whole life insurance
* cash value of counted whole life insurance policies
* prepaid burial contract

(b) In order to be excluded as "funds designated for burial", funds held as cash, (i.e., bank accounts or certificates of deposit), must be separately identifiable as a different account and cannot be co-mingled with non-burial related funds.

(c) The funds are excluded as burial funds effective the month in which they are separated.

(d) Once this money is considered a designated burial fund certain conditions must be met:

(i) there must be documentation in the case to show that no transactions are made to the asset except for the posting of interest and the addition of funds.

(ii) any interest accrued is excluded as income or asset as long as the individual remains continuously eligible for MaineCare and no withdrawals are made from the fund. Interest on these funds is excluded even if the total amount of the original designated funds plus the accumulated interest exceed the $1500 limit.

**Examples**

* + - The individual indicates that a savings account of $1450 has been set aside for burial. At the time of the next review, the savings account has increased due to accumulated interest to $1563. The entire savings account continues to be an excluded asset and the interest is not considered income.
		- Several months later, the individual becomes ineligible for MaineCare. If the individual reapplies and continuous coverage does not exist, up to $1500 of the designated burial funds and accumulated interest since the original designation can be excluded as an asset.

(e) At time of review, if burial funds have been co-mingled with non-burial related funds, the individual must be given an opportunity to separate the funds before they are counted as a resource. The funds must be separated by the end of the month that is two months after the month of review in which the individual is advised of the need to separate the funds.

**Example**

If the review is due 9/07 the individual should be advised that funds must be separated by 11/30/07. If they are not, the exclusion does not apply unless the reason for non-separation is beyond the control of the individual.

(f) Determine whether the separate identifiable account can total $1500 as follows:

(1) Term insurance is excluded as an asset and does not count against the $1500 limit.

(2) For each individual deduct the amount of any prepaid burial contracts from the $1500 limit.

(3) If the face value of whole life insurance has been excluded, deduct the amount of the face value from the $1500 limit (See Section 2.27 of this Part).

(4) If an individual's whole life policies are not excluded then deduct the cash value from the $1500 limit. If there is a loan against the policy, deduct the net cash value from the $1500 (See Section 2.27 of this Part).

**Examples**

* The individual has one insurance policy with a face value of $1600 and a cash value of $1300. There are no prepaid burials. The policy can be considered a $1300 designated burial fund.
* The individual has one insurance policy with a face value of $1600 and a cash value of $1800. There are no prepaid burials. The policy can be considered a $1500 designated burial fund. The remaining $300 cash value is added to the other countable assets.
* The individual has one insurance policy with a face value of $1600 and a cash value of $1700. There is a prepaid burial plan for $500 as well. Only $1000 of the cash value can be considered a designated burial fund as the allowable limit of $1500 is offset by the $500 prepaid burial. The remaining cash value of $700 is added to other countable assets.

 $ 1700 Cash surrender value of whole life insurance policy

+ $ 500 Add: Prepaid burial contract

 $ 2200 Total

- $ 1500 Maximum exclusion

 $ 700 Countable asset

**Section4.7: Certificates of Deposit** *- countable for SSI-Related categories*

The amount of the countable asset is the proceeds available to the individual or couple if they were to cash in the certificate now, minus penalties for early withdrawal. Taxes are not treated as a penalty.

**Section 4.8: Commercial Transportation Tickets** *- excluded for SSI-Related categories*

The value of a domestic commercial transportation ticket received as a gift by an individual (or his or her spouse) and not converted to cash will be excluded in the determination of the individual's assets. Domestic travel is defined as travel among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

**Section 4.9: Continuing Care Retirement Communities (CCRC) / Life Care Community (LCC)** *partially excluded for SSI - Related categories*

Admission contracts offer a range of housing and health care services to serve older persons as they age and as their health care needs change over time. CCRC’s generally offer independent living units, assisted living, and nursing facility care for persons who can afford to pay the entrance fees. These facilities are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. In order to operate in the State of Maine, this type of facility must have permission from the Bureau of Insurance and be licensed by the Department of Health and Human Services.

The CCRC and LCC facilities that accept Medicaid payment are allowed to require in their admissions contracts that residents spend their resources, declared for the purposes of admission, on their care before they apply for Medicaid. With this in mind, an applicant for Medicaid who has resided in such a community must provide a copy of their admission contract as part of their Medicaid application. If there is an additional contract related to their entrance fee, that must be provided also. If the contract provides for a lifetime care agreement, the applicant will be ineligible for Medicaid.

The individual's entrance fee in a CCRC or LCC shall be considered an available asset for the purposes of Medicaid eligibility to the extent that:

A. the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care.

B. the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the contract and leaves the facility; and the entrance fee does not confer an ownership interest in the CCRC or LCC.

For applicants with community spouses, only that part of the entrance fee that is not protected for by the community spouse's resource allowance would be considered a countable asset.

**Section 4.10: Disaster Relief Act** *- excluded for SSI - Related categories*

Assistance received under the *Disaster Relief Act of 1974* (PL 93-288), or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States, is excluded in determining countable resources:

A. for a period of nine months from the date of receipt;

B. interest earned on the assistance is excluded from resources for a period of nine months beginning on the date the assistance is received; and

C. the initial nine month period will be extended for a reasonable period up to an additional nine months when it is found the individual has good cause for not having necessary repairs or replacement of damaged or destroyed property completed. Good cause exists when circumstances beyond an individual's control prevented the repair or replacement of such property within the nine month time period.

**Section 4.11: Disaster Unemployment Assistance –** *excluded for SSI-Related categories*

Disaster Unemployment Assistance authorized in P.L. 100-707, U.S.C. Section 5155(d) (1988) is excluded. This is paid to an individual unemployed as a result of a major disaster.

**Section 4.12: Earned Income Tax Credit (EITC) –** *excluded for SSI-Related categories*

Excluded for the month of receipt and the following month.

**Section 4.13: Energy Assistance (Other than HEAP)** *- excluded for SSI-Related categories*

Any other benefits paid through federal laws to eligible households for the purpose of providing energy assistance is excluded.

**Section 4.14: Escrow Accounts** *- excluded for SSI-Related categories*

Escrow accounts set up by the U.S. Department of Housing and Urban Development (HUD) for families who are participating in the Family Self Sufficiency Program are not considered a countable resource.

Any interest paid on these accounts is not countable income. As long as the individual is receiving any state, federal or other public assistance for housing they cannot access this amount.

This program is a five year program open to all Section 8 housing participants which aims to help the family to become self-sufficient at the end of the five year period.

When the account becomes available, it is counted as a resource and/or interest income.

**Section 4.15: Experimental Housing Allowance Payments** *– included for SSI-Related categories*

Payments made under Annual Contributions Contracts entered into prior to 1/1/75, under Section 23 of the *US Housing Act of 1937*, as amended.

**Section 4.16: Food Produced for Home Consumption** *– exclude for SSI-Related categories*

Food produced in home farming for consumption by the assistance unit is excluded.

**Section 4.17: Governor Baxter School for the Deaf Compensation -** *excluded for SSI-Related categories*

One time cash payment from the Governor Baxter School for the Deaf Compensation Authority. Interest on this compensation is excluded as income and any accrued interest is excluded as an asset.

**Section 4.18: Grants, Loans, and Scholarships**

A. Administered by Commissioner of Education – PL 90-575 – Title V –

The grants and loans are:

* Basic Education Opportunity Grant Program (Pell Grants)
* National Direct Student Loan program (Perkins Loans)
* Supplemental Education Opportunity Grant Program (SEOG)
* Guaranteed Student Loan Program
* State Student Loan Program

SSI - Related categories – *exclude for all undergraduates and exclude only tuition and fees for graduate students*

B. All other grants/loans/scholarships:

SSI - Related categories – *exclude tuition and fees for undergraduates and count for all other students*

**Section 4.19: Home Energy Assistance Program (HEAP) –** *excluded for SSI-Related categories*

Benefits paid to eligible households under the *Home Energy Assistance Act of 1980*, Title III of PL 96-223 (LIHEAP) is excluded.

**Section 4.20: Household Goods –** *excluded for SSI-Related categories*

Items used in day-to-day living such as clothing, household furnishings, utensils, home and property maintenance tools and equipment, heirlooms, wedding and engagement rings, basic jewelry.

**Section 4.21: Housing Act Assistance** *– excluded for SSI - Related categories*

Effective 10/1/76 the value of any assistance paid with respect to a dwelling unit under the *United States Housing Act of 1937*, the *National Housing Act*, section 101 of the *Housing and Urban Development Act of 1965*, or Title V of the *Housing Act of 1949* as provided by section 2(h) of PL 94‑375.

**Section 4.22: HUD Community Development Block Grant** *– included for SSI-Related categories*

HUD community development block grant funds received to finance the rehabilitation of privately owned residences. Individuals receiving a grant are precluded by HUD regulations from using grant monies for purposes other than major property repairs or capital improvements. Payment is by check made payable either directly to the contractor or jointly to the contractor and property owner.

**Section 4.23: Income Remaining After the Month of Receipt** *- included for SSI-Related categories*

Any portion of income (including, but not limited to: lump sums for wages, inheritances, and lottery winnings) that remains following the month the income was received is counted with

all other assets. This provision pertains to all types of income including lump sums from wages, inheritances and lottery winnings.

**Section 4.24: Individual Development Accounts (IDA) -** *excluded for SSI-Related categories*

An IDA is a special bank account that is set up by or for the individual to allow the individual to accumulate funds for specific purposes.

There are two types of IDA's in Maine: a Family Development Account (FDA) for TANF recipients and a Demonstration Project IDA which is available to anyone. The Demonstration Project IDA is also known as *Assets for Independence Act* (AFIA) IDA. Individual contributions to either IDA are matched by state and/or federal funds.

A. Family Development Account (FDA for TANF recipients):

(1) Any income used by the individual to fund this account is excluded as income.

(2) Any asset used by the individual to fund this account is excluded as an asset including up to $10,000 of lump sum income remaining in the month following receipt.

(3) Any individual contributions that are matched are excluded as income or asset.

(4) Accrued interest on FDA funds is excluded as income or asset.

(5) Withdrawals from these accounts at any time must be used for the following purposes in order for the fund to remain an exempt asset. When withdrawals are used for any other purpose this will result in the fund being considered a countable asset effective the month of the withdrawal. The TANF Program determines if this condition is met.

(a) expenses for education or job training to attend an accredited or approved post-secondary education or training institution;

(b) the purchase or repair of a home that is the primary residence;

(c) the purchase or repair of a vehicle used for transportation to work or to attend an education or training program;

(d) capital to start a small business for any member of the assistance unit 18 years of age or older;

(e) health care costs of a member of the assistance unit that are medically necessary and that are not covered by public or private insurance;

(f) to address an emergency that may cause the loss of shelter, employment or other basic necessities; or

(g) to address other essential family needs approved by the Department.

B. Demonstration Project Account (AFIA):

(1) any income used by the individual to fund an AFIA is excluded as income.

(2) any individual contributions that are matched are excluded as income or assets.

(3) accrued interest on AFIA funds is excluded as income or assets.

(4) withdrawal from these accounts is allowable only for certain reasons as determined by the agency authorizing this IDA. These reasons include post- secondary educational expenses, acquiring a residence, or expenditures for operating a business.

**Section 4.25: Insurance Settlements** *– partially excluded for SSI-Related categories*

Portions of insurance settlements earmarked and used, or intended to be used for specific purposes, are exempt for 6 months from date of receipt. Examples are back medical bills and attorney and legal fees associated with the settlement.

Verification of use, or intent to use, may be shown through verbal or written statements from those providers to whom the individual owes money associated with the settlement. For example, unpaid medical bills or attorney fees.

Portions of insurance settlements not specifically earmarked and used or intended to be used for specific purposes are income in the month received and any remaining portion is an asset in the following month.

For specific information regarding accident and injury settlements when the individual was on MaineCare see Part 2, Section 6.

For settlements associated with the replacement of an excluded asset, see Section 2.43 of this Part.

**Section 4.26: Job Corps** *– included for SSI-Related categories*

All Job Corps payments except on-the-job training income of an individual, at least 19 years old, who is not a dependent child.

**Section 4.27: Life Estate** *- included for SSI-Related categories*

A "life estate" is ownership of real property. Ownership is limited to the term of life, usually that of the owner of the life estate, and may have other conditions attached such as occupancy.

Life estates can be acquired by inheritance or by purchase, or can be retained when property is sold, such as when the individual sells the right to ownership after death and retains the right to ownership during their lifetime.

The monetary value of a "life estate" and the "remainder" must be established so that the applicant's assets or transfer of assets can be properly valued.

To establish the value of the property rights, refer to Appendix E.

Using the individuals’ age, find the amount in the first column, “Life Estate”, and multiply it by the current fair market value of the property. The result is the current value of the life estate owned by the individual. This is a countable asset but can be exempted with an intent to return if the real property is the primary residence.

**Section 4.28: Life Insurance**

Term life insurance is an excluded asset since it has no cash value.

Life insurance is excluded as long as the combined face value of all whole life policies owned by the individual on the same insured does not exceed $1500. If the total face value of all whole life policies owned by the individual on the same insured exceeds $1500, then the cash values, minus any outstanding loans, is counted against the asset limit. A portion of the cash value may be excluded for burial purposes (See Section 2.6 of this Part).

**Examples:**

A. An individual has a face value life insurance policy of $1000 and one for $500. Even if the cash value exceeds $1500, these are excluded.

B. An individual has a $2000 face value whole life policy. The cash value is $1790. This results in assets of up to $1790 counted against the asset level. Also see Section 4.6 of this Part for potential exclusions for burial purposes.

C. An individual has a $2000 face value whole life policy. The cash value is $1790 but there is a $500 outstanding loan against the policy. This could result in an asset of up to $1290 ($1790 minus the $500 loan) counted against the asset limit (See Section 4.6 of this Part regarding exclusions for burial purposes).

D. An individual owns a policy on himself that has a $1000 face value and owns a policy on his wife with the same face value. Even though both policies are owned by the individual they are exempt because the total face value on each insured is under $1500.

**Section 4.29: Life Lease (Tenancy)** *- excluded for SSI-Related categories*

This is a contract arrangement to live in a certain place, usually for the term of life. It is not ownership and therefore is not a countable asset.

**Section 4.30: Loans** *– excluded for SSI-Related categories*

Money borrowed by an individual is not counted as either an asset or income for the month received. Any remainder is considered an asset in the following month.

Written statements from both the individual and the party lending the money must be obtained indicating that the funds are a loan, the amount and the plan for repayment. Without verification of the loan the funds will be considered a gift and treated as a lump sum (See Section 4.31 of this Part).

**Section 4.31: Lump Sum Payments** *– partially excluded for SSI-Related categories*

Income that has accumulated and is received in one payment by the individual is considered a lump sum. This includes Worker's Compensation, Retroactive Social Security payments, Unemployment Benefits received retroactively due to the result of a hearing, and Veteran's

Benefits. Gifts, inheritances, lottery winnings and insurance settlements are also considered to be a lump sum payment.

Lump sum payments are counted as income in the month received, and any remaining the next month are counted as an asset. SSI lump sum payments are excluded income.

SSI or Social Security retroactive payments are excluded as an asset for nine months. After that, any portion remaining becomes a countable asset.

**Section 4.32: Native American payments** *- excluded for SSI-Related categories:*

A. Any payments distributed per capita to or held in trust for members of any Indian tribes under PL 92-524, 93-134, 94-540, 97-458 or 98-64.

B. Receipts distributed to members of certain Indian tribes referred to in Section 5 of PL 94-114, effective 10/17/75, and PL 98-123 and 98-124, effective 10/13/83.

C. Any income or assets accruing to members of the Passamaquoddy Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians pursuant to PL 96-420 (the *Maine Indian Claims Settlement Act of 1980*).

D. The tax exempt portions of payments made pursuant to PL 93-203, the Alaskan Claims Settlement Act.

E. Native American payments as detailed in Title 20 CFR, Part 416 Appendix to Subpart K (IV)(b) and (c).

F. Per capita distribution payments, receipts from trust lands and dividend payments to members of various native American and Indian tribes such as Blackfeet, Gros Ventre, Grand River Band, *Alaskan Native Claims Settlement Act* under the provisions of Distribution and Judgment Funds (PL 92-254 Sections 4, 6, and 7), Receipts from Lands Held in Trust for Indian Tribes (PL 94114, Section 6).

G. Any assets accruing to members of the Passamaquoddy Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians pursuant to PL 96-420, the *Maine Indian Claims Settlement Act of 1980*.

**Section 4.33: Nazi Persecution Payments** *– excluded for SSI-Related categories*

Payments made to victims of Nazi persecution under Public Law 103-286 (Nazi Persecution Victims Eligibility Benefits).

**Section 4.34: Nutrition and Food Assistance** *– excluded for SSI-Related categories*

The value of food assistance received under the *Child Nutrition Act of 1966*, as amended, and the special food service program for children under the *National School Lunch Act*, as amended (PL 92-433 and PL 93-150). Any benefits received under Title VII, Nutrition Program for the Elderly, of the *Older Americans Act of 1965*, as amended.

The value of benefits received under the Food Supplement Program (formerly Food Stamps) or Donated Commodities is excluded.

**Section 4.35: Pension Plans (Individual and Employee)**

Funds are a countable asset at the point they are made available.

For example, a retirement fund owned by an individual is included if he/she has the option of withdrawing a lump sum even though he/she is not eligible for periodic payments. The value of the asset equals the amount that is currently available (i.e., the total fund value less any penalties and/or applicable fees.

If an individual is eligible for periodic retirement benefits, the fund is excluded. Payments may be counted as unearned income.

**Section 4.36: Promissory Notes and Mortgages** *– countable for SSI-Related categories*

A. Policy applicable to all SSI-Related categories including residential care and long term care -

A mortgage is a pledge of property to a creditor as security for the obligation or repaying a debt (note).

A note is a written promise to pay or repay a specific amount of money at a stated time. The note specifies conditions such as the amount to be paid, frequency of payments and interest rate.

The note, to be enforceable, and therefore to be of any value, needs to be signed by the debtor and needs to identify, in a complete and precise manner, the obligations to repay.

The presumed value of the note is the principal to be repaid minus any repayments on principal that have been made.

The presumed value can be refuted by obtaining a statement from two sources in the business of buying notes, such as a mortgage company. The statement should identify the amount the source would presently pay for the note and describe the basis for that amount.

The current value of the note then becomes the current sale value. If different sale values are obtained, the higher amount will be used.

B. Policy applicable to long term care:

A transfer of assets occurs when the current sale value of the note is established at less than the presumed value. The amount of the transfer is the amount by which the presumed value exceeds the current sale value. The date of the transfer is the date the note was signed by the debtor. (See Part 15 for treatment of asset transfers.)

Funds used to purchase a promissory note, loan or mortgage can be considered a transfer of assets (see Part 15) unless the note, loan or mortgage:

(1) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Social Security Administration, found online at: <http://www.ssa.gov/OACT/STATS/table4c6.html>).

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

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

In the case of a promissory note, loan or mortgage that does not meet the conditions in (1), (2), and (3). above, the value of the note, loan or mortgage to be considered in determining the amount of the asset transfer shall be the outstanding balance due as of the date of the individual's application for Medicaid.

**Section 4.37: Property used for home consumption** *- excluded for SSI Related categories*

All property and equipment used to produce goods or services for home consumption. This includes garden plots, wood lots and livestock.

**Section 4.38: Property used to produce income** *- excluded for SSI-Related categories*

Property and equipment used in the production of income includes real property, boats, trucks, machinery and livestock. This also includes garden plots, wood lots and rental property that are income producing and liquid assets used as part of a business or trade.

A. With eligibility decisions effective 3/1/06, income producing property and equipment can be excluded as a countable asset as long as, after three years of operation, the property produces countable income that equals or exceeds .22%, which is the average interest rate for a twelve month Certificate of Deposit (CD) at banks in Maine

(1) Countable income is income that is produced by the property and/or equipment as determined by the MaineCare rules for treating income (See Part 17, Section 3.4.46).

(2) To determine if the countable income equals or exceeds .22%:

(a) Multiply .22% by the fair market value of the property and/or equipment minus encumbrances.

(b) Countable income must at least equal the result in (A(2)(a)) in order for the property and/or equipment to be excluded as an asset.

(3) If the countable income has changed considerably in any year, countable income is averaged for the last three years.

(4) The test for income producing property to be an excluded asset is applied only after the property and/or equipment has three years of operation.

B. Income producing property is excluded as a countable asset regardless of the annual rate of return if:

(1) The property cannot be used due to circumstances beyond the control of the individual and resumption of income production is likely.

(2) The property cannot be used due to the inability of the individual to use the property for up to twenty-four months.

(3) The individual is temporarily disabled and resumption of income production is likely.

(4) The property has not been in operation or production for three years or more.

(5) The owner is making good faith efforts to sell the property at a reasonable price.

**Section 4.39: Radiation Exposure Compensation Act –** *included for SSI-Related categories*

Money received under the *Radiation Exposure Compensation Act* for injuries or death resulting from radiation due to nuclear testing and uranium mining.

**Section 4.40: Real Property**

With the exception of the exclusions below real property is a countable asset.

A. All real property may be excluded if:

(1) it is up for sale at fair market value with a Realtor or actively being advertised by the owner in the geographic area of the property. If reasonable offers are turned down, no exclusion will be given. A reasonable offer is one, which reflects the price on the open market given the condition and location of the property.

(2) two different knowledgeable sources in the geographic area agree that the property cannot be sold due to a specific condition.

(3) it is held in Joint Tenancy or Tenants in Common with others who refuse to sell the property. A statement from the joint owner is required or documented evidence that such a statement was asked for but not provided.

(4) it meets the criteria of Income Producing Property defined in Section 4.38 above.

B. Primary Residence

(1) Policy applicable to SSI-Related MaineCare categories, including residential care and long term care:

The home which the individual considers their primary residence and the land and all buildings on that land are exempt. This exemption also applies to any adjoining land as long as it is not separated by real property owned by others. Presence of any easement, road, waterway or other natural boundary does not change the exemption.

The home is exempt during periods of temporary absences of the individual, spouse or dependent as long as they indicate their intent to return. (i.e. nursing home care, boarding home, hospitalization, visiting, etc.) Except for visiting, a written statement of intent to return must be submitted. If the client is unable to make this statement, someone acting on the individual's behalf, such as the individual's guardian, conservator or holder of Power of Attorney may do so.

Once a declaration of intent is made it is valid until an intent not to return home is declared. At that time the home would become a countable asset on the first day of the month after the month in which the declaration is made.

The home may also be exempt if an individual moves out of his or her primary residence, without the intent to return, if he/she is fleeing the home due to domestic violence.

**Note:** Except for migrant workers (Part 2, Section 4), when a primary residence is located out of state, it cannot be exempted as a countable asset on the basis of an intent to return home. This intent to return to an out of state residence is inconsistent with the residence requirement which is that the individual be living in Maine and intend to remain here.

The home is exempt if occupied by the spouse or dependent of the individual. A dependent is someone who is financially or medically dependent on the individual. This person is or could be claimed as a dependent for IRS purposes.

(2) Policy applicable to Long Term Care

An individual shall not be eligible for long term care assistance if the individual's equity interest in their primary residence exceeds $750,000. This rule is also effective for re-determinations of eligibility made for those applicants whose initial application was on or after 1/1/06.

To determine the equity interest an individual has in their primary residence, consider the following:

(a) The Department needs to see a statement of fair market value such as a recent appraisal from an individual or company licensed to do so.

(b) The amount of an individual's equity interest in their home is equal to the current market value of the home minus any encumbrances, such as a mortgage or other loan that is secured by the home. (Not including a home equity line of credit that has not been utilized.)

(c) A reverse mortgage or a home equity loan outstanding on the property would decrease the equity, but The Department must examine the mortgage or home equity note to see if there has been a transfer of assets.

(d) The Department must see loan documentation to verify that it is a valid transaction with a company in the business of providing home loans or a private individual.

(e) This rule does not affect an individual's eligibility for community MaineCare services if otherwise eligible.

The rule does not apply if the spouse of the individual, or dependent, or disabled child of the individual is lawfully residing in the home.

C. For real property not exempted above the equity value of that property is counted. The value of real property is established by statements from two real estate appraisers or town tax valuation adjusted to 100% valuation rate. If jointly owned the countable asset is the proportion of ownership interest in the real property.

D. Proceeds from the sale of an excluded home will be excluded for up to 3 months from the date of receipt, provided all the proceeds are intended to be used and are, in fact, used to purchase another home, which is similarly excluded.

**Example**

A piece of land is left to an individual and his two sisters. Although there are three owners, the will indicated that one half of the property is owned by the individual. Therefore, one half of the equity becomes a countable asset unless otherwise excluded.

**Section 4.41: Relocation assistance -** *excluded for SSI-Related categories*

Payments made under Title II of the *Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970*.

**Section 4.42: Reparation Payments –** *exclude for SSI - Related categories*

Japanese Restitution Payments and German Reparation Payments are excluded.

**Section 4.43: Replacement of an excluded asset** *– excluded for SSI - Related categories*

Cash received or in-kind replacement received to replace or repair an excluded asset that is lost, stolen or damaged is excluded for a period of nine months. An additional nine months can be given when circumstances beyond the individual's control prevented the replacement or repair of the asset.

**Example**

The individual has a motor vehicle that was excluded as his primary vehicle under Section 4.54 of this Part. The vehicle was involved in an accident. The insurance company gives the individual a check to replace the vehicle. The individual has nine months in which to purchase another vehicle or repair the damaged one. If at the end of the nine month period the individual still has the money, it will be counted against the asset limit.

**Section 4.44: Reverse Mortgage –** *excluded for SSI Related categories*

Proceeds from a reverse mortgage are treated as proceeds of a loan and are not income. Any proceeds available in the month following the month of receipt are a countable resource. This arrangement allows the homeowner to borrow, via a mortgage contract, a percentage of the appraised value of his/her home equity.

The homeowner receives a periodic payment (or a line of credit) which does not have to be repaid as long as the borrower lives in the home. In most reverse mortgages the original loan does not have to be repaid until the homeowner dies, sells the home, or moves.

**Section 4.45: Ricky Ray Hemophilia Relief Fund Act –** *excluded for SSI-Related categories*

Payments received under the *Ricky Ray Hemophilia Relief Fund Act of 1998*. Interest income generated on these payments is countable income and any accrued interest is excluded as an asset. These payments are not subject to special rules on trusts or transfer of resource penalty. Payments are not counted in determining cost of care.

**Section 4.46: Savings Bonds –** *countable for SSI-Related categories*

These are countable to the extent of their current cash value. New bonds have no cash value for six months from the date of issue.

If they are jointly owned, the amount to be counted is based on the proportion of ownership interest. If the joint owners (indicated by "and" on the bonds) refuse to sell, then the bonds are unavailable as an asset to the assistance unit.

**Section 4.47 Savings Exclusion -** *excluded for SSI-Related categories, except State Supplement*

**Up to $8,000 of savings for an individual, $12,000 for an assistance unit of two or more. Any** amount over the excluded amount is counted toward the asset limit. Savings is defined as an account which earns interest or dividends except that a checking account does not need to earn interest/dividends. "Savings" includes:

* savings or checking account including those in a credit union;
* IRA;
* Keogh;
* available cash value of an annuity;
* stocks;
* bonds;
* mutual funds; and
* cash surrender value of life insurance.

The $8,000/$12,000 exclusion applies to all accounts subject to the exclusion. The exclusion is not applied to each account.

**Section 4.48; Self-Support Plans for Blind or Disabled Individuals -** *excluded for SSI Related categories*

Any asset necessary to carry out an approved plan for achieving self-support for a blind or disabled individual is excluded. The plan must be approved by the Bureau of Rehabilitation Services or the Social Security Administration.

**Section 4.49: Stepparent Assets –** *excluded for SSI-Related categories*

Assets owned solely by the stepparent are excluded.

**Section 4.50: Stocks, Bonds and Mutual Fund Shares -** *included in SSI-Related categories*

The value of these assets is determined by multiplying the number of shares by the current value per share. Since the amount indicated on the certificates may be less than actually owned (due to stock splits and reinvestment of dividends) it is important to establish, with the company or broker, the actual number of shares.

If the shares are owned jointly with others (other than the spouse) then the amount of the countable asset is based on the proportion of ownership interest the individual or couple has.

If signatures are required by the other joint owners, in order for the shares to be sold and the joint owners refuse to sell, then the value of these shares is unavailable as an asset to the assistance unit.

If a decision is made to sell the shares, the value is excluded from the time a formal request is made until the proceeds of the sale are dispersed to the individual or couple by the company or broker.

**Section 4.51: Supplemental assistance –** *included for SSI-Related categories*

Assistance such as General Assistance, provided by public or private agencies to help recipients and applicants meet emergency situations.

**Section 4.52: Susan Walker Settlement –** *excluded for SSI-Related categories*

Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et al, and payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement.

When payments are made in lieu of a class settlement, the agreement must be signed by all parties on or before 12/31/97 or 270 days after the date on which a release is first sent to the persons to whom the payment is to be made.

**Section 4.53: Trusts –** *partially excluded for SSI-Related categories*

A "trust" includes any legal instrument or device that is similar to a trust.

There are special provisions for the treatment of assets placed in a trust. The term "asset" includes income as well as resources. Application of the trust provisions govern the treatment of assets in the trust.

A payment from a trust is any disbursal from the corpus of the trust or from income generated by the trust. A payment may include cash as well as non-cash or property disbursements, such as, the right to use and occupy real property.

For trusts established on or before 8/10/93 for services provided on or before 4/30/94 refer to Appendix H.

The following rules are effective for trusts established on or after 8/11/93 for Medicaid provided on or after 5/1/94.

A. Trusts established by the individual:

(1) Special rules apply to the treatment of trusts established by the individual. These rules apply without regard to:

(a) the purposes for which the trust is established;

(b) whether the trustees have or exercise any discretion under the trust;

(c) any restriction on when or whether distributions may be made from the trust; or

(d) any restrictions on the use of distributions from the trust.

(2) A trust is considered to be established by an individual if the assets of the individual were used to form all or part of the corpus of the trust and if any

 of the following entities and/or individuals established the trust other than by will:

(a) the individual;

(b) the individual's spouse;

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

When a trust corpus includes assets of someone other than the individual, these rules apply only to the individual's portion of the trust assets. The individual's countable income and resources must be prorated based on the proportion of the individual's assets in the trust to those other persons.

(3) When a trust is set up as of 3/1/06 as part of a negotiated settlement of the individual or his/her spouse, the trust is considered to be set up by the individual and is not a third party trust. A 'negotiated settlement' is one in which the individual as defined above and others confer, bargain, or discuss with the view of reaching an agreement. Examples of a negotiated settlement are: a divorce or an insurance settlement. Any funds transferred to a trust as a result of a negotiated settlement, are considered to be funds that are owned by and transferred by the individual.

(4) Revocable Trusts - are trusts which can, under state law, be revoked by the individual or an entity in A(2) of this section or a court. It includes a trust which ends if some action is taken by the individual.

In the case of a revocable trust:

(a) the entire corpus and the income produced by the corpus of the trust is considered a resource available to the individual;

(b) payments from the trust to or for the benefit of the individual are considered income to the individual; and

(c) any other payments from the trust are considered to be assets that are transferred. The look back period for transfers is sixty months (See Part 15, Section 1.1).

When real property is transferred to a revocable trust, it is considered to be available to the individual because it is accessible.

Effective with transfers on or after 9/1/02, a primary residence, while an available asset, cannot be exempted on the basis of an "intent to return" or as the residence of the community spouse because the property is not owned by the individual.

Similarly, property used to produce income is an available asset but is not exempted as income producing property because it is not owned by the individual.

(5) Irrevocable Trusts - are trusts which cannot in any way be revoked by the individual or entity in A(2) of this section.

In the case of irrevocable trusts:

(a) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual including a payment at a future date, the following rules apply:

(i) the portion of the corpus that could be paid to or for the benefit of the individual is a countable resource to the individual. The income produced by this portion of the corpus is also a countable resource to the individual.

(ii) payments actually made from the corpus (or from income produced by the corpus) to or for the benefit of the individual are income to the individual.

(iii) payments actually made from the corpus (or from income produced by the corpus), but not to or for the benefit of the individual, are a transfer of assets. All payments made on or after 2/8/06 are subject to a sixty month look back period (See Part 15).

(b) if no payment could be made under any circumstances to or for the benefit of the individual the following rules apply:

(i) the portion of the corpus from which no payment could be made to or for the benefit of the individual is considered to be an asset that has been transferred.

Income on this portion of the corpus from which no payment could be made to or for the individual is also considered to be an asset that has been transferred. The look back period is sixty months (See Part 15).

(ii) the date of the transfer is the date of the establishment of the trust or, if later, the date on which payment is unavailable to the individual.

(iii) the value of the transfer includes any payments made after the trust is established or payment to the individual is unavailable.

6. Exemptions

The following trusts are exempt from the provisions of A(5) of this section. No transfer is considered to take place as a result of establishing the trust, except as indicated in (b) below relating to pooled trusts. The income and resources considered available to the individual are those made available by the trust.

(a) a trust containing the assets of an individual under age 65 who does or would meet the SSI criteria for disability if:

(1) the trust is established for the sole benefit of the individual by the individual's parent, grandparent, legal guardian or a court; and

(2) the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total Medicaid paid on behalf of the individual after due payment of any legal obligations of trust.

This trust is considered to be established for the "sole benefit of" the individual if no other individual or entity can benefit from the assets transferred in any way whether at the time the trust is established or at any time in the future. A trust may provide for reasonable compensation to trustees to manage the trust and for beneficiaries after Medicaid has been reimbursed.

The trust may contain assets of individuals other than the disabled individual.

This exemption remains once the individual turns age 65 as long as there are no changes in the terms of the trust once the individual attains age 65. Any assets added as of age 65 are not subject to exemptions under (E) above.

(b) a trust containing the assets of an individual who does or would meet the SSI criteria for disability if:

(1) the trust is established and managed by a non-profit association;

(2) a separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds, the trust pools these accounts;

(3) the accounts in the trust are established solely for the benefit of the disabled individual by the individual or the individual's parent, grandparent, legal guardian or by a court; and

(4) to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the state an amount equal to the total amount of Medicaid paid on behalf of the beneficiary after due payment of any legal obligations of the trust.

However, any assets added to the trust as of age 65 may be subject to a transfer penalty (see Part 15).

A trust is considered to be established for the "sole benefit of" the individual if no other individual or entity can benefit from the assets transferred in any way whether at the time the trust is established or at any time in the future. A trust may provide for reasonable

compensation to trustees to manage the trust and for beneficiaries after Medicaid has been reimbursed.

An individual age 65 or older is not automatically considered to meet the SSI criteria for disability. This must be determined as in Part 6, Section 4.3.

(c) trusts that are set up with retroactive SSI benefits awarded under the Sullivan v. Zebley, 493 U.S. 521 (1990) decision.

B. Trusts Established for the Individual by Someone Else

With trusts that are set up for the individual by someone else including those that are set up by will, trust funds are available assets unless the terms of the trust make them unavailable.

If the trust is irrevocable, that is, no member of the assistance unit or any responsible relative residing in the home has the power to revoke the trust arrangement or change the name of the beneficiary, what is available to the client is what is made available according to the terms of the trust.

1. The terms of the trust may specify the amount/frequency and/or purposes for which the funds may be used or this may be left to the discretion of the trustee(s). The terms of the trust may use a combination of both trustee discretion and specific fund usage.

2. Of the funds left to trustee discretion, what is available to the client is whatever the trustee makes available.

3. Funds made available are considered as income or assets in accordance with applicable Medicaid eligibility rules for the situation.

4. If the terms of the trust restrict withdrawal by written approval of a judge of the courts, regular withdrawals will be treated as any other income. Irregular withdrawals, in order to be disregarded, must be used to supplement the needs of the person for whom the trust is drawn up.

**Examples**

(a) An individual has a trust fund that was established upon the death of his parents based on their will. From this he is to receive $500 from the interest each month and $10,000 every three years to buy a new vehicle. The monthly payments are income. The $10,000 is used to purchase an excluded asset (the old vehicle is traded in to purchase the new one).

This trust is irrevocable in accordance with the provisions above. The terms of the trust specify the amount, frequency and for part of the payments (the $10,000) the purpose. Medicaid policy treats interest payments as income and excludes the vehicle as an asset.

(b) A trust was set up for the individual by his father who is deceased. The individual is to receive $200 per month for

as long as the fund lasts. The fund currently has $140,000. The individual can get all the funds in the trust if there is an emergency.

The $200 per month is considered income as long as this represents interest income. The remainder of the fund is considered an asset (currently $140,000) since it can be accessed by the individual.

(c) A trust is set up for the individual by her grandmother. It is irrevocable and the trustee has full discretion in disbursement of the funds (totaling $75,000) based on the needs of the individual.

Since the trust is irrevocable, what is considered available to the individual is whatever the trustee, in her discretion, makes available.

**Section 4.54: Vehicles**

The following exclusions are applied in the manner most advantageous to the individual:

* 1. Exclude one vehicle which is used to provide transportation for the household, such as passenger cars, trucks, boats and special vehicles such as motorcycles, snowmobiles, animal drawn vehicles and even animals. This includes vehicles that are unregistered, inoperable or in need of repair.
	2. A second vehicle is totally excluded regardless of value if it is:

1. needed for employment or to seek employment;

2. needed to secure medical treatment;

**Note**: This exclusion does not apply to individuals residing in a nursing or residential care facility. These facilities are required to provide Medicaid eligible individual with any transportation needed to secure medical treatment.

3. modified for operation by a person with a disability or is modified for the transportation of a person with a disability; or

4. necessary because of climate, terrain, distance, or other similar factors, or to provide transportation to perform essential daily activities.

In order for an individual to have a second vehicle for reasons 1-4 above, they must show a need for two separate vehicles.

**Examples**

* An individual lives on an island, leaves one car on the island and one car on the mainland to avoid having to transport a car on the ferry.
* An elderly applicant has two cars. An adult (or minor) child who lives with her uses one of the vehicles for work. The applicant needs the other vehicle to secure medical treatment.

C. If no vehicle is totally excluded, the fair market value in excess of $4500 is counted as an asset. The fair market value is established by using the "trade-in value" listed in the "National Automobile Dealers Association's (NADA) Used Car Guide". The individual may prove that the vehicle is worth less than the value listed by NADA by providing verification from two reliable sources.

**Note**: This exclusion involves the fair market value and not the equity in the vehicle. For this reason the individual may wish to exclude the vehicle with the highest value and not the one with the most equity.

D. Unless excluded, the equity value of any other vehicle is counted. For business vehicles see Section 4.37 of this Part.

**Examples**

* + - 1. Sally and Jim have two vehicles that are not excluded. They have a Buick worth $7000 (FMV) on which they owe $6000. They also have a Ford worth $5000 (FMV) that they own free and clear.

If the Buick is partially excluded they would be over assets.

$7000 (FMV/$1000 equity) - $4500 exclusion = $2500

$5000 (FMV and equity) Ford = $5000 countable

This results in countable assets of $7500 from these two vehicles.

If the Ford is partially excluded only $1500 would be counted against the asset limit.

$5000 (FMV and equity) Ford - $4500 exclusion = $500

$7000 (FMV/$1000 equity) Buick = $1000 countable

2. Mrs. Johnson has a five year old car that is not totally or partially excluded. The fair market value (FMV) is $6000. She still owes $5000 on this.

$6000 (FMV) - $4500 exclusion = $1500 countable asset

Even though the equity is only $1000, $1500 is counted as an asset, because of the fair market value.

**Section 4.55: Veterans Payments for Vietnam Veterans’ natural children:** *excluded for SSI-Related categories*

VA monthly payments made to or on behalf of Vietnam veterans' natural children regardless of their age or marital status for any disability resulting from spina bifida suffered by such children are excluded from income and resources. Interest earned on unspent payments is not excluded.

**Section 4.56: Volunteer Service Programs –** *excluded for SSI-Related categories*

Any payment whether cash or in-kind made under the *Domestic Volunteer Service Act*Public Laws (93-113)

A. Title I - Corporation for National and Community Service (CNCS)(formerly ACTION)

* + AmeriCorps State and National, AmeriCorps NCCC, and AmeriCorps\* VISTA
	+ University Year for Action (UYA)
* Special and Demonstration Volunteer Programs

B. Title II - National Older American Volunteer Programs which now include

* Foster Grandparent Program
* Senior Companion Program
* Retired Senior Volunteer Program (RSVP)

C. Title III - **(**repealed and now contained within the *Small Business Act*)

* Service Corps of Retired Executives (SCORE)
* Active Corps of Executives (ACE)

**PART 17**

**INCOME**

Income is divided into two categories, earned and unearned. Earned income is received from employment or self-employment. It may be received as wages, salaries, commissions or profits. Goods and services received in return for work are also known as bartering income or in-kind income. Unearned income is cash income received from sources other than employment or self-employment. Within each category there are many types of income.

The source of income and the time frame in which it is received must be considered in determining the countable income for a particular month. All income is counted in the month it is received, except for contract income, whether it is for a previous, current or future period. This provision pertains to all types of income including lump sums from wages, inheritances and lottery winnings.

Income received through direct deposits and other electronic transfers of funds is counted for the month they were intended to be received even if they are posted early or late.

The current monthly income reported at the time of initial application will be presumed to continue throughout the remainder of the eligibility period. Any increased or additional income must be reported within ten days of receipt in order to determine continued eligibility.

The actual income received for the period to be covered must be used to determine eligibility for retroactive coverage.

**SECTION 1: DEFINITIONS**

**Attributed Income:** Attributed income means the amount of tips reported to IRS by large restaurants. It is based on a formula and may not reflect the amount actually received by the employee. The attributed tips are shown on the W-2. It is the responsibility of the employer to keep a daily log of tips actually received. The log of tips will be used to determine the amount of tips countable as income. If there is reason to believe that tips are being underreported, the individual and, with the individual's permission, the employer or collateral sources should be contacted.

**Contract Income:** Contract income means income received by employees for a set period of time. It may be a full year or for a shorter term, such as school teachers. Divide the most recent contract income by the length of the term of the contract to determine the monthly average.

**Corporation – C:** C Corporation means a business that has been incorporated as a C corporation. The income of the corporation is owned by the corporation and is not countable to the individual unless it is distributed to the individual as income.

**Corporation – LLC, Sub-S or S:** LLC, Sub-S or S Corporation means a business that has been incorporated as an LLC, Sub-S or S corporation. The income of these corporations is owned by the individual.

**Earned Income:** Earned income means income received in payment for the labor or services of an individual. It includes cash payments, wages, salaries, commissions, sheltered workshop wages, and profits from self-employment, severance, contractual payments and deferred compensation.

**Fluctuating Income:** Fluctuating income means income received by an employee in different amounts each pay period or at irregular intervals. The differences may be due to the number of hours worked, hourly wage rate, output (such as piecework and some types of commissions) or the number of employers (such as baby sitting). In these cases, the individual's income must be examined over the broadest period of time possible. If the "year to date" (YTD) figure is an accurate reflection of the current situation, divide the amount by the number of weeks the YTD covers and budget this average as regular weekly income. If the YTD is not accurate, the average weekly income should be based on a review of income

representative of the current situation. If there are unusually high or low weeks, then an exploration of how likely they are to continue must be made and their inclusion or exclusion documented.

**Lump Sum Income:** Lump sum income means a non-recurring payment received as a result of an accumulation of income or windfall income. Some examples are: retroactive portions of Social Security, Workers’ Compensation, Unemployment, Disability, VA or other benefits, pay raises, inheritances, and lottery winnings. Lump sum income is treated as income in the month of receipt and as an asset (if applicable) in the following month. See Section 4.40 of this Part for SSI-Related eligibility group exclusions to income and Part 16, Section 4.31 for SSI-Related eligibility group exclusions as an asset.

**Partnership:** Partnership means an agreement between two or more individuals who share profit and loss in a business. The specific terms of a partnership determine whether income and assets are owned by the individual unless the business is a C, LLC, Sub-S or S Corporation.

**Regular Income:** Regular income means income received by an employee at regular intervals and in the same amount each pay period. This includes income of salaried employees and hourly wage earners who work the same number of hours at the same hourly pay each week. The amount of income to be used is based on the frequency it is received.

**Seasonal Income:** Seasonal income means income that is not received year round. During the off-season, no income is received from the seasonal occupation. Seasonal income is budgeted for the period that the individual is actually working. To determine an anticipated amount, use the income received for the most recent season of employment, taking into consideration any expected increases or decreases in income.

**Self-Employment Income:** Income received by a self-employed individual who is engaged in a business enterprise. This includes independent contractors, franchise holders, owners / operators, farmers, people who produce and sell a product, and service-type businesses. If the most recent tax return is available showing the profit or loss, and there have been no major changes, then the monthly gross income is determined by dividing the net profit or loss amount by twelve. The net profit or loss can be found on the appropriate IRS schedule such as the Schedule C. If a tax return is unavailable, the profits have changed considerably, or the business was started after the beginning of the tax year, the most detailed records showing the net profit should be used. The records may include ledger sheets, receipt books, self-employment work sheets, or any reasonable form of documentation. All deductions allowed by the Internal Revenue Service, including depreciation, may be used.

Some sources of income, though exempt from taxation, are counted in MaineCare. An example is Difficulty of Care payments. The amount that is counted will be the gross receipt minus expenses associated with the production of this income. The net loss from one source of self-employment is deducted against other earnings including other sources of self-employment income of the individual, his/her spouse or other members of the assistance unit. This applies whether a couple filed a joint income tax return or separate returns, and regardless of which member of the assistance unit incurred the loss. This includes, in SSI - Related categories, the ineligible spouse and parents of disabled children.

**Sole Proprietorship**: Sole Proprietorship means a business owned by the individual. The business is not incorporated under IRS rules. The individual owns all the assets and income of the business.

**Unearned Income:** Unearned income means income received for something other than payment for the labor or services of an individual. It includes Social Security, Veteran's Benefits, pensions, dependent's allotments, maintenance agreements, contributions, support payments, annuities, dividends, interest, or unemployment compensation. Service charges are not deductible in determining dividend or interest income.

**SECTION 2: INCOME FOR ELIGIBILITY GROUPS FOR WHICH MAGI-BASED METHODOLOGY APPLIES**

**Section 2.1: MAGI-based Income**

MAGI-based income is defined as income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section36B(d)(2)(B) of the Internal Revenue Code, [“Modified adjusted gross income” means adjusted gross income increased by – (a) Any amount excluded from gross income under section 911 of the Internal Revenue Code; (b) Any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax; and (c) An amount equal to the portion of the taxpayer’s social security benefits (as defined in the Internal Revenue Code Section 86(d) which is not included in gross income under section 86 for the taxable year”], with the following exceptions:

1. An amount received as a lump sum is counted as income only in the month received;
2. Scholarships, awards, or fellowship grants used for education purposes and not for

living expenses are excluded from income;

1. American Indian/Alaska Native exceptions. The following are excluded from income:
2. Distributions from Alaska Native Corporations and Settlement Trusts;
3. 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;
4. Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(a) Rights of ownership or possession in any lands located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior; or

(b) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

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

(a) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(b) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

1. 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;
2. Student financial assistance provided under the Bureau of Indian Affairs education programs.

**Section 2.2 Income Conversion Methodology**

When income is received once a month, the taxable income is the amount to be counted.

When income is received twice a month (usually the first and fifteenth of each month), multiply the taxable wages by two.

When income is received biweekly, multiply the taxable wages by 2.15.

When income is received weekly, multiply the taxable wages by 4.3.

**SECTION 3: INCOME FOR OTHER (NON-MAGI) ELIGIBILITY GROUPS**

**Section 3.1 Non-MAGI-Based Income**

This is defined asthe gross amount of income before any deductions (including but not limited to payroll deductions).

**Section 3.2 Income Conversion Methodology**

When income is received once a month, that is the monthly gross income.

When income is received twice a month (usually the first and fifteenth of each month), multiply the gross income by two.

When income is received biweekly, multiply the gross income by 2.15.

When income is received weekly, multiply the gross income by 4.3.

**Section 3.3 Garnishment**

Garnishment is when income is withheld by administrative or court order to pay a creditor or overpayment by a government agency.

Income is counted even if it is garnished, unless the garnishment was premised on an overpayment of governmental benefits and the individual was receiving Medicaid at the time of the overpayment occurred. In such case the garnished amount is excluded in determining the amount of income.

**Section 3.4: Treatment of Income**

**Section 3.4.1: Adoption Assistance – included**

 Adoption Assistance Payments

**Section 3.4.2: Agent Orange Settlements – excluded**

Agent Orange Settlements as provided for under PL 100-687 and 101-201.

**Section 3.4.3: ASPIRE Payments – excluded**

Exclude all payments made by the ASPIRE-TANF Program.

**Section 3.4.4: Burial Funds – excluded**

Interest on funds designated for burial or interest earned on the value of agreements representing the purchase of burial spaces (provided the burial spaces are excluded from assets and provided the interest is left to accrue) as long as there is no break in the receipt of assistance. (See Part 16, Section 4.6).

**Section 3.4.5: Cafeteria Plans – partially excluded**

Portions of IRS Section 125 payments retained by the employer as payment for benefit items chosen by the employee from the Section 125 menu or “cafeteria plan” are excluded.

**Section 3.4.6: Child Support *–* included**

Child support payments are income to the child(ren) for whom the payments are intended. This rule applies even if the child does not reside with the parent receiving the payment or if the payments include arrearages (past due amounts) or if the "child" for whom the payments are intended is now over age 18.

**Section 3.4.7: Children eligible for SSI - Related Eligibility Groups**

The following exclusions from the child’s income apply:

1. The first $1640 per month of earned income, not to exceed $6600 per calendar year, for a student attending school regularly as defined by the learning institution.
2. One-third of child support, including a military allotment. The payment may be voluntary or court ordered.

**Section 3.4.8: Combat Pay – excluded**

Hostile fire allotment paid by the Uniformed Services.

**Section 3.4.9: Commercial Transportation Tickets – excluded**

The value of a domestic commercial transportation ticket received as a gift by an individual (or his or her spouse) and not converted to cash will be excluded in the determination of the individual's income. Domestic travel is defined as travel among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

**Section 3.4.10: Compensated Work Therapy Program – excluded**

Earnings received under the Compensated Work Therapy Program established by Title 38 U.S.C. Section 1718 and administered by the Department of Veteran Affairs. Monies received under this program are considered a social service benefit and not to be considered countable income.

**Section 3.4.11: Cost of Living Adjustment (COLA) – excluded for most purposes – see (B) below**

There are two types of income exclusions associated with annual Cost of Living Adjustments. One exclusion is used for any COLA taking effect in January, February

and March (See Section 4.11.1 below), while the other only applies to Social Security and Railroad Retirement benefits (See Section 4.11.2 below).

1. **Cost of Living Adjustments taking effect January, February and March** *excluded*

All annual Cost of Living Adjustments (COLA) that take effect in January, February or March, will be excluded for any individual in a Medicaid coverable group whose income limit is based on the FPL. This exclusion will remain in effect until the month following the month that the new annual Federal Poverty Levels (FPL) are published in the Federal Register. This exclusion also applies to individuals covered by DEL, Maine Rx, Cub Care, and Medicare Buy-In.

**Examples**

(1) An individual is an ongoing MaineCare recipient. He received a Social Security COLA in January. The Federal Poverty Levels are published in February. The COLA is excluded until March. The cost of living increase is counted in the budget as of April.

This exclusion also applies in determining retroactive coverage.

(2) An individual applies in April. The poverty levels were published in February. The Social Security COLA received in January will be excluded for the retroactive months of January, February and March.

This exclusion does not apply to individuals covered under Home and Community Bases Waivers and Medically Needy since the Federal Poverty Levels are not used in determining their eligibility.

1. **Social Security and Rail Road Retirement Cost of Living Adjust. (COLA) -** *excluded for SSI - Related eligibility groups (not excluded for State Supplement)*

If the COLA results in ineligibility for individuals covered under SSI - Related eligibility groups, the amount of SSA / RR received prior to the most recent COLA is used to determine eligibility.

1. This applies to individuals:

(a) covered under SSI – Related eligibility groups using the Federal Poverty Level as an income limit.

(b) covered under Medicare Buy-In.

1. This applies to individuals in the following living arrangements when comparing their income to the Medicaid rate for the facility:
2. Awaiting Placement for Residential Care,
3. residing in Cost Reimbursed Boarding Homes
4. in Residential Care Facilities, and
5. in Adult Family Care Homes whose income goes over the Medicaid rate.

This exclusion is not used to determine the cost of care for these facilities.

**Example**

A disabled individual is eligible and receiving Medicaid. In January he receives his SSDI COLA of $35.00. This increase puts him over the FPL in effect for that month.

The increase will not be counted until the month following the month the new FPL’s are published.

In February the new FPL’s are published. The individual’s countable income is still greater than the new FPL level because of the COLA received in January. The COLA of $35.00 received in January will be excluded to determine the individual’s countable income.

1. This exclusion ends if:

(a) individual loses Medicaid coverage for any reason for three consecutive months.

To determine if an individual has lost Medicaid coverage for three consecutive months the retroactive period of a reapplication must be taken into account. If including the retroactive months the individual was not closed for three consecutive months, the disregard will continue.

**Example**

An individual with a COLA disregard closes in June. He reapplies in November. By applying the COLA disregard in the retroactive month of August, September and October the individual is eligible. The individual will keep the COLA disregard for retroactive and prospective months.

1. the individual’s countable income, including the disregarded SSA/RR COLA, is below the FPL.

 The individual may again be eligible for the disregard in later years if they again become ineligible due to COLA changes in SSA / RR and FPL.

 If the individual receives added or increased income from a source other than SSA / RR at the time of the COLA adjustments, this disregard can be used only if ineligibility is caused by the change in SSA/RR income.

 When budgeting for a couple this disregard applies to the SSA / RR of both individuals even though disregarding the COLA increase of only one member of the couple would result in keeping Medicaid coverage for the couple.

**Section 3.4.12: Difficulty of Care Payments – included**

A source of income that although is exempt from taxation is included.

**Section 3.4.13: Disability Insurance Payments – excluded**

All payments made on behalf of an individual under a credit life or credit disability insurance policy (i.e. payment of car payments or mortgage when you become disabled).

**Section 3.4.14: Disabled Widowers Benefits – excluded**

Social Security benefits received by some disabled widow(er)s who are not receiving Medicare (See Part 6, Section 5.2.9).

**Section 3.4.15: Disaster Relief – excluded**

In-kind or cash assistance received as the result of a disaster declared by the President of the United States.

**Section 3.4.16: Disaster Unemployment Assistance – excluded**

Disaster Unemployment Assistance authorized in P.L. 100-707,42 U.S.C. Section 5155(d) (1988). This is paid to an individual unemployed as a result of a major disaster.

**Section 3.4.17: Earned Income Exclusions – partially excluded**

 **Excluded only for persons who are blind**

Earned income which is used to meet expenses of producing income by a person who is blind is excluded. This includes earnings excluded by SSI as part of a PASS plan. These expenses include transportation to and from work (in accordance with IRS guidelines or actual cost if not using own car), cost of caring for a guide dog, child-care, licenses, lunches, Braille instruction, professional association dues, income taxes, tools, union dues and computer training.

**Excluded for individuals with a disability**

Earned income which is used to meet expenses of producing income as part of a PASS plan by a person who is disabled is excluded.

**Section 3.4.18: Emergency Assistance – excluded**

**Section 3.4.19: Emergency Conservation Services Program – excluded**

Any assistance provided in cash or in-kind under the Emergency Conservation Services (ECS) Program (PL 93-644, Sections 222 and 95-568) including cash to prevent fuel cut-offs.

**Section 3.4.20: Experimental Housing Allowance Program – excluded**

Payments made under Annual Contribution Contracts entered into prior to 1/1/75, under Section 23 of the *U. S. Housing Act of 1937*, as amended.

**Section 3.4.21: FmHA Utility Reimbursement – excluded**

**Section 3.4.22: Food produced for personal consumption by members of the household – excluded**

**Section 3.4.23: Food Supplement Program (FSP) – excluded**

The value of benefits under the Food Supplement Program or food distributed by the Department of Agriculture are excluded.

**Section 3.4.24: Foster Care Payments**

**Included** IV-E Foster Care Maintenance Payments – Payments received from the Department or other agencies for foster children in licensed or approved homes who are not part of the assistance unit.

**Excluded** Foster care payments to a provider of foster care for a child or adult who is not an eligible individual but who is living with an eligible individual and who was placed there by a public or private agency.

**Section 3.4.25: General Assistance – excluded**

**Section 3.4.26: Goods and services – Included**

Goods and services not included in the list of basic requirements (See Chart 1.)

**Section 3.4.27: Governor Baxter School Compensation – excluded**

One time cash payment from the Governor Baxter School for the Deaf Compensation Authority. Interest on this compensation is excluded as income and any accrued interest is excluded as an asset.

**Section 3.4.28: Grants, Loans Scholarships**

A. **Administered by Commissioner of Education – PL 90-575 – Title V**

(1) The grants and loans are:

 Basic Education Opportunity Grant Program (Pell Grants)

National Direct Student Loan program (Perkins Loans)

Supplemental Education Opportunity Grant Program (SEOG)

Guaranteed Student Loan Program

State Student Loan Program

**All excluded for undergraduates, only tuition and fees excluded for graduate students**

(2) All other grants/loans/scholarships – exclude tuition and fees and other necessary educational expenses for undergraduates and count for all other students (educational expenses include lab fees, student activity fees, transportation, stationary supplies, books, technology fees, and impairment related expenses necessary to attend school or perform school work.)

(B) **Federal College Work Study Program – excluded**

**Section 3.4.29: Home Based Care Funds – excluded**

**Section 3.4.30: Home Energy Assistance Program (HEAP) – excluded**

Assistance with fuel bills or weatherization assistance received through the Home Energy Assistance Program (HEAP).

**Section 3.4.31: Housing – excluded**

* + - 1. Value of relocation assistance under the *Uniform Relocation and Real Property Acquisition Policies Act of 1970* (PL 91-646 Title II). This does not include payment for the fair market value of the property.
			2. Any interest paid on HUD escrow accounts is not countable income as long as a family is receiving any state, federal or other public assistance for housing and they cannot access this amount. The "Family Self-Sufficiency Program" is a five year program open to all section 8 housing participants which aims to help the family become self-sufficient at the end of the five years. When the account becomes available, it is countable as a resource and/or interest income.
			3. Value of assistance for housing under the *Housing Authorization Act of 1976* (PL 94-375) or *Housing Act of 1937* as amended by PL 92-213.

**Section 3.4.32: HUD Utility Reimbursement – excluded**

**Section 3.4.33: Individual Development Accounts – excluded**

Contributions to an Individual Development Account (IDA). See the asset rule (Part 16) for a definition of an IDA.

1. **Family Development Account (FDA for TANF recipients)**
2. any income used by the individual to fund this account excluded as income.
3. any asset used by the individual to fund this account is excluded as an asset including up to $10,000 of lump sum income remaining in the month following receipt.
4. any individual contributions that are matched are excluded as income.
5. accrued interest on FDA funds is excluded as income or asset.
6. Withdrawals from these accounts at any time must be used for the following purposes in order for the fund to remain an exempt asset:
7. expenses for education or job training to attend an accredited or approved post-secondary education or training institution;
8. the purchase or repair of a home that is the primary residence;
9. the purchase or repair of a vehicle used for transportation to work or to attend an education or training program;
10. capital to start a small business for any member of the assistance unit 18 years of age or older;
11. health care costs of a member of the assistance unit that are medically necessary and that are not covered by public or private insurance;
12. to address an emergency that may cause the loss of shelter, employment or other basic necessities; or
13. to address other essential family needs approved by the Department.

When withdrawals are used for any other purpose this will result in the fund being considered a countable asset effective the month of the withdrawal. The TANF Program determines if this condition is met.

1. **Demonstration Project Account (AFIA)**
2. any income of the individual deposited in an AFIA are excluded as income.
3. any individual contributions that are matched by another party are excluded as income or assets.
4. accrued interest on AFIA funds are excluded as income or assets.
5. withdrawal from these accounts is allowable only for certain reasons as determined by the agency authorizing this IDA. These reasons include post- secondary educational expenses, acquiring a residence, or expenditures for operating a business.

**Section 3.4.34: Income of those who could be in the household except they are in a medical facility – Included**

Income of persons who could be members of the assistance unit except that they are in a hospital, intermediate care facility (ICF) or skilled nursing facility (SNF). In most situations, the income of the individual in the hospital or nursing home is used to determine nursing home eligibility. This also takes place when the individual is in an acute care facility for a period of more than sixty days or immediately upon entering a hospital for a kidney transplant.

**Section 3.4.35: Income tax refunds – excluded**

**Note**: Income tax refunds are excluded as assets for 12 months from receipt.

**Section 3.4.36: Irregular or Infrequent Income – excluded**

Earned or unearned income, from a single source, which is received irregularly (receipt cannot reasonably be expected) or infrequently (no more than once during a calendar quarter). This amount is not to exceed $60.00 per calendar quarter for unearned income and $30.00 per calendar quarter for earned income. This includes small gifts of income such as those received at Christmas, graduation, birthdays or anniversaries.

**Section 3.4.37: Job Corp Payments – excluded**

Payment by Job Corp for supportive services such as child-care, transportation, medical care, meals and other reasonable expenses are excluded.

**Note**: All other payments from Job Corp are considered income.

**Section 3.4.38 Job Related Expenses – excluded**

 Reimbursement for job related expenses such as travel or uniforms to the extent that they do not represent a gain or exceed actual expenses.

**Section 3.4.39: Loans – excluded**

Money borrowed by an individual providing there is clear evidence of an agreement to repay. The proceeds of the loan are not income in the month borrowed, however, they are considered countable assets in the following month.

Written statements from both the individual and the party lending the money must be obtained indicating that the funds are a loan, the amount and the plan for repayment. Without verification of the loan the funds will be considered a gift and treated as a lump sum (See Section 4.41 below).

**Section 3.4.40: Lump Sum Income– partially excluded**

SSI lump sum payments are excluded income.

SSI or Social Security retroactive payments are excluded as an asset for nine months. After that, any portion remaining becomes a countable asset.

The exception to the month received rule is direct deposits and other electronic transfers of funds. These are counted for the month they were intended to be received even if they are posted early or late.

**Section 3.4.41: Native American payments– excluded**

1. Any payments distributed per capita to or held in trust for members of any Indian tribes under PL 92-524, 93-134, 94-540, 97-458 or 98-64.
2. Receipts distributed to members of certain Indian tribes referred to in Section 5 of PL 94-114, effective 10/17/75, and PL 98-123 and 98-124, effective 10/13/83.
3. Any income or assets accruing to members of the Passamaquoddy Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians pursuant to PL 96-420 (the *Maine Indian Claims Settlement Act of 1980*).
4. The tax exempt portions of payments made pursuant to PL 93-203, the Alaskan Claims Settlement Act.
5. Native American payments as detailed in Title 20 CFR, Part 416 Appendix to Subpart K (IV).
6. Per capita distribution payments, receipts from trust lands and dividend payments to members of various native American and Indian tribes such as Blackfeet, Gros Ventre, Grand River Band, *Alaskan Native Claims Settlement Act* under the provisions of Distribution and Judgment Funds (PL 92-254 Sections 4, 6, and 7), Receipts from Lands Held in Trust for Indian Tribes (PL 94114, Section 6).

**Section 3.4.42: Nazi persecution payments – included**

Payments made to victims of Nazi persecution under Public Law 103-286 (Nazi Persecution Victims Eligibility Benefits).

**Section 3.4.43: Nutrition and Food Assistance – excluded**

1. The value of supplemental food assistance under the *Child Nutrition Act of 1966* (WIC), as amended and the special food services program for children under the *National School Lunch Act*, as amended (PL 92-422, PL 90-302 and PL 93-150).
2. Any benefit received under Title VII Nutrition Program for the Elderly, of the *Older Americans Act of 1965*, as amended by PL 95-478.

**Section 3.4.44: Payments to replace income – excluded**

All payments made to replace income that has been lost, destroyed or stolen.

**Section 3.4.45: Radiation Exposure Compensation – excluded**

Money received under the *Radiation Exposure Compensation Act* for injuries or death resulting from radiation due to nuclear testing and uranium mining.

**Section 3.4.46: Rent rebates – excluded**

Rebates by any public agency of taxes or rent rebate on real property.

**Section 3.4.47: Rental Property Income – included**

Net income from rental property is treated as earned income when Income Tax is filed on a Schedule C. It is treated as unearned income if filed in a Schedule E.

**Section 3.4.48: Repayment of a loan – excluded**

Money received as the repayment of the principal of a loan (including a promissory note) is not income in the month received. Any amount retained in the following

month is considered a countable asset. Money received as interest payments is considered income in the month received.

**Example**

A couple sells their home and holds a mortgage at 10%. They receive $315 per month as a mortgage payment. Of that amount, $200 is interest and must be counted as income in the month received. The remaining $115 is repayment of the principal and is excluded income for the month. Any portion of the principal remaining in the following month is a countable asset for that month.

**Section 3.4.49: Ricky Ray Hemophilia Fund – excluded**

Payments received under the *Ricky Ray Hemophilia Relief Fund Act of 1998*. Interest income generated on these payments is countable income and any accrued interest is excluded as an asset. These payments are not subject to special rules on trusts or a transfer of resource penalty. Payments are not counted in determining a cost of care.

**Section 3.4.50: Roomers and Boarders – included**

Net income from roomers and boarders is treated as unearned income.

**Section 3.4.51: Savings bonds – excluded**

Interest on Series E, EEE and H Savings Bonds is not counted as income at any time. When these bonds are redeemed, the interest is a countable asset.

Interest on Series HH Savings Bonds is paid by direct deposit, semi-annually. The interest would be considered unearned income in the month received.

**Section 3.4.52: Self Support Plans – excluded**

That portion of earned or unearned income needed to fulfill a plan for self-support approved by Vocational Rehabilitation or the Social Security Administration (including PASS plans) for an individual who is disabled or blind.

**Section 3.4.53: Selling, replacing or exchanging an asset – excluded**

Money received as a result of selling, replacing or exchanging an asset is excluded as income. They are assets that have changed their form.

**Section 3.4.54: Senior Community Service Employment Program (SCSEP) – excluded**

Community Service Employment is a Program for older Americans authorized under Chapter 35, Title 42 of U.S. Code.

**Section 3.4.55: SSI Payments – excluded**

SSI benefits received by a spouse, parent or other family member when determining non-nursing care assistance.

**Section 3.4.56: Susan Walker Settlement – excluded**

Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et al, and payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement.

When payments are made in lieu of a class settlement, the agreement must be signed by all parties on or before 12/31/97 or 270 days after the date on which a release is first sent to the persons to whom the payment is to be made.

**Section 3.4.57: TANF – excluded**

TANF benefits received by a spouse, parent or other family member are excluded. These people are also not counted as members of the assistance unit during the budgeting process.

**Section 3.4.58: VA Benefits for Vietnam veterans’ children with spina bifida – excluded**

VA monthly payments made to or on behalf of Vietnam veterans’ natural children regardless of their age or marital status for any disability resulting from spina bifida suffered by such children are excluded from income and resources. Interest earned on unspent payments is not excluded.

**Section 3.4.59: VA Benefits that have special treatment – partially excluded**

1. Excluded as income is that portion of a VA benefit (Pension or Compensation) which is paid to disabled veterans, their spouses, widows or parents as an Aid and Attendance, Housebound Allowance or payments resulting from Unusual Medical Expenses.

There are two exceptions to this rule:

1. Benefits in excess of $90.00 per month are counted in determining the cost of care for a resident of a State Veteran’s Nursing Home if the resident is a veteran with no dependents or surviving spouse with no dependents.
2. There is no exclusion of benefits when determining the cost of care in a RCF, CRBH, or AFC.
3. **VA benefits for dependents**. VA may increase the amount of a benefit if the veteran or surviving spouse has a dependent.
4. When the increase is included in the payment to the veteran or surviving spouse and the dependent resides with the veteran or surviving spouse. This is called an “augmented benefit." The share attributed to a dependent is income to the dependent only. If the dependent does not live with the veteran or surviving spouse, the dependent’s share is not income to anyone.
5. When the dependent of a veteran or surviving spouse does not live with the veteran or surviving spouse VA may pay the increase directly to the dependent. This is called an “apportionment” or

“apportioned benefit”. This payment is unearned income to the dependent.

**Section 3.4.60: Vendor Payments – excluded:**

Vendor payments (payments for goods or services provided to an eligible individual or couple which are made directly to a vendor by a third party).

**Section 3.4.61: Volunteer Service Programs – excluded:**

Any payment whether cash or in-kind made under the *Domestic Volunteer Service Act* Public Laws (93-113)

1. **Title I** - Corporation for National and Community Service (CNCS) (formerly ACTION):
	* + - 1. AmeriCorps State and National, AmeriCorps NCCC, and AmeriCorps\* VISTA,
				2. University Year for Action (UYA), and
				3. Special and Demonstration Volunteer Programs.
2. **Title II** - National Older American Volunteer Programs which now include:
3. Foster Grandparent Program
4. Senior Companion Program
5. (Retired Senior Volunteer Program (RSVP)
6. **Title III** *- (repealed and now contained within the Small Business Act)*
7. Service Corps of Retired Executives (SCORE)
8. Active Corps of Executives (ACE)

**PART 18**

**PRESUMPTIVE ELIGIBILITY DETERMINED BY HOSPITALS**

Presumptive eligibility allows a qualified hospital to determine certain individuals “presumptively eligible” for MaineCare temporarily while eligibility is being determined for ongoing Medicaid coverage. The hospital determines that the individual is likely eligible for coverage under the eligibility guidelines established in Parts 2, 3, and 4 of this manual based on preliminary information obtained from the applicant. If the hospital determines that the individual is presumptively eligible, the individual is eligible to receive Medicaid coverage. This coverage is called hospital presumptive eligibility (HPE).

**SECTION 1:** **Hospital Qualification Requirements**

To become qualified to make presumptive eligibility determinations, a hospital must do the following:

1. Participate as a Medicaid provider under the State of Maine’s State Plan;

2. Notify the Office for Family Independence (OFI) in writing of its intention to make presumptive eligibility determinations under this Part;

3. Accept training, administered by OFI, for all applicable staff on relevant MaineCare eligibility rules and regulations;

4. Be certified by OFI and agree to make presumptive eligibility decisions according to state and federal policies; and

5. Not currently be disqualified from performing presumptive eligibility as result of failing to meet the performance requirements outlined in Section 8.

**SECTION 2: HPE Coverage Groups**

Hospital presumptive eligibility determinations must be limited to persons who meet all eligibility requirements for coverage under any one of the following eligibility groups:

1. Children (Part 3, Section 2.1),

2. Parent/Caretaker Relative (Part 3, Section 2.2),

3. Pregnant Women (Part 3, Section 2.3),

4. Expansion Adults (Part 3, Section 2.4),

5. Former Foster Care Children (Part 3, Section 3.1(C)),

6. Family Planning Coverage (Part 9, Section 4); or Coverage for women who are in treatment for breast and cervical cancer under Maine Title 10-144 C.M.R. Ch. 708.

**SECTION 3:** **HPE Determination Process**

A qualified hospital must use a Hospital Presumptive Eligibility application (HPE-App) provided by the Department to establish the applicant’s household size and income. Applications may be accessed at the Department’s website; or by contacting the MaineCare Eligibility Program Manager by mail, phone, or e-mail.

Hospitals are prohibited from requiring individuals to provide verification of any of the eligibility factors used in the Medicaid determination. Hospitals must accept the individual’s attestation for all factors of eligibility.

If the hospital determines the applicant meets all the eligibility requirements for coverage in one of the coverage groups listed in Section 2, the hospital shall determine that the applicant is presumptively eligible for MaineCare coverage.

**SECTION 4: HPE Coverage Period**

Once a hospital determines an individual is presumptively eligible, Medicaid coverage begins on the date the hospital determines eligibility and continues until the later of the following:

1. If a full MaineCare application is filed prior to the last day of the month following the month presumptive eligibility was determined, the date on which a final eligibility decision is made; or

2. The last day of the month following the month in which presumptive eligibility was determined if no application for Medicaid has been filed by that date.

For pregnant women, one period of presumptive eligibility is allowed per pregnancy. Otherwise, applicants are only allowed one HPE period in a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

**SECTION 5: Hospital Responsibilities**

It is the responsibility of the hospital to do the following:

1. Accept the individual’s attestation of all eligibility factors including income, citizenship status, immigration status, and State residency status. The hospital cannot require verification;

2. Provide presumptive eligibility applicants with a full MaineCare application, or as appropriate, an application for breast and cervical cancer treatment with the Maine CDC Breast and Cervical Health Program – and information about how to complete it;

3. Notify the presumptive eligibility applicant of the presumptive determination in writing (and orally if appropriate), at the time the determination is made; and

4. Take the following action based on whether the applicant was found eligible or ineligible:

A. For a presumptive eligibility applicant determined not presumptively eligible, notify the applicant in writing at the time of the determination (and orally if appropriate) of the reason for the denial and that the applicant may file an application for MaineCare with OFI; or

B. For a presumptive eligibility applicant determined to be eligible the hospital must:

(1) Complete a MaineCare Hospital Presumptive Eligibility Card (HPE-Card) for the individual;

(2) Notify OFI of each presumptive eligibility determination within five working days from the date the determination was made including submitting a copy of the HPE-Card;

(3) Provide a copy of the HPE-Card to the applicant; and

(4) notify the applicant (in writing and orally if appropriate) of the following:

(a) that if the applicant does not file a full MaineCare application with OFI, or an application for breast and cervical cancer treatment with the Maine CDC Breast and Cervical Health Program, before the last day of the following month, presumptive eligibility coverage will end on that last day; and

(b) that if the applicant files a full MaineCare application with OFI or an application for breast and cervical cancer treatment with the Maine CDC Breast and Cervical Health Program before the last day of the following month, presumptive eligibility coverage will continue until an eligibility determination is made on the application that was filed.

**SECTION 6: OFI Responsibilities**

OFI is required to provide appropriate notices regarding eligibility decisions made on a full MaineCare application filed by or on behalf of the individual determined to be presumptively eligible. OFI is not required to send any notice regarding the discontinuance of the presumptive eligibility period and the individual has no rights of appeal in regard to that discontinuance.

**SECTION 7: Performance Standards for Qualified Hospitals**

1. **Performance Standard**

Qualified hospitals must maintain performance standards in order to continue performing presumptive eligibility determinations. In a rolling six-month period and based on a statistically significant sample of cases, no less than 80% of applicants granted presumptive eligibility by a hospital must file a regular MaineCare application with OFI before the last day of the month following the month of a presumptive eligibility determination.

1. **Corrective Action**

A. The first time OFI determines that a qualified hospital has failed to meet the Performance Standards established in Section 7(1), OFI will notify the hospital in writing within five business days from when OFI determined the hospital did not meet the standard. The written notice will include the following:

(1) A description of the standard that was not met and an explanation of how the determination was made; and

(2) A request for confirmation that all applicable hospital staff will participate in mandatory training on hospital presumptive eligibility rules and regulations. Such training will be conducted by OFI.

B. When OFI determines that a qualified hospital has failed to meet any of the Performance Standards established in Section 7(1) within 24 months of issuance of a written notice under Section 7(2)(A), OFI will notify the hospital in writing within five business days of determining the hospital did not meet the standard. The written notice will include the following:

(1) A description of the standard that was not met and an explanation of how the determination was made; and

(2) Confirmation that if the hospital fails to meet the standard established in Section 7(1) again within the subsequent 24-month period, the hospital will be disqualified from making presumptive eligibility determinations for a period of 12 months and until the hospital becomes requalified pursuant to Section 1.