Title 10 MARYLAND DEPARTMENT OF HEALTH

Subtitle 09 MEDICAL CARE PROGRAMS

Chapter 24 Medical Assistance Eligibility

Authority: Estates and Trusts Article, §14.5-1002; Health-General Article, §§2-104(b), 2-105(b), 15-103, 15-105, 15-121, and 15-401—15-407; Annotated Code of Maryland

10.09.24.01

.01 Purpose and Scope.

A. This chapter governs the determination of eligibility for the Maryland Medical Assistance Program.

B. Eligibility may be established for the following coverage groups:

(1) The MAGI coverage groups whose income standard is based on the modified adjusted gross income methodology specified in the Affordable Care Act of 2010, effective January 1, 2014; and

(2) The MAGI Exempt coverage groups whose income standard is based on Title XIX of the Social Security Act.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Aged" means a person who is 65 years old or older.

(2) "Aid to the Permanently and Totally Disabled" means a former category of public assistance mandated under Title XIV of the Social Security Act, 42 U.S.C. §1351 et seq., and replaced by Title XVI of the Social Security Act, 42 U.S.C. §1381 et seq.

(3) "Appeal" means a process by which an applicant, recipient, or representative obtains review of a decision, action, or inaction of the Department or the local department of social services.

(4) "Applicant" means a person whose written application for Medical Assistance has been submitted to the local department of social services but has not received final action. This includes a person, who need not be alive at the time of application, whose application is submitted through a representative.

(5) "Application" means the filing of a written and signed application form for Medical Assistance at the local department of social services or its designee.

(6) "Application date" means the date on which a written, signed application is received by the local department of social services.

(7) "Application form" means the form designated by the Department to be completed, signed, and submitted to the local department of social services, or a designee, as an official application for Medical Assistance.

(8) "Assistance unit" means one person, or a group of persons whose eligibility for Medical Assistance benefits is determined in conjunction with each other.

(9) "Blindness" means a condition in which a person is certified by an ophthalmologist as having either central visual acuity of 20/200 or less in the better eye with correcting glasses, or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of the visual field subtends an angular distance of no greater than 20 degrees.

(10) Caretaker Relative.

(a) "Caretaker relative" means a parent or other person related by blood, marriage, or adoption and living with and caring for an unmarried child younger than 21 years old who is deprived of parental support due to death, continued absence from the home, incapacitation of a parent, or unemployment of the principal wage earner parent. A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed service of the United States is not considered absent from the home. The following relatives and their spouses meet this definition: father, mother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew or niece, and persons of preceding generations as denoted by the prefix of grand, great, and great-great; persons who legally adopt a child or his parent as well as the natural and other legally adopted children of these persons; and other relatives of adoptive parents in accordance with State law. A caretaker relative retains his status as a caretaker relative when the only child or children in his custody receives SSI benefits. This is the only instance when a caretaker relative without children in an assistance unit qualifies as a caretaker relative.

(b) "Continued absence from the home" means that the parent is out of the home, the nature of the absence either interrupts or terminates the parent's functioning as a provider of maintenance, physical care, or guidance for the child, and the known or indefinite duration of the absence precludes counting on the parent's performance of his function in planning for the present support or care of the child.

(c) "Incapacitation" means that a parent has a mental or physical defect, illness, or impairment which eliminates the parent's ability to support or care for the child and is expected to last for a period of at least 30 days.

(d) "Principal wage earner parent" means whichever parent, in a home in which both parents of a child are living, earned a greater amount of income in the period specified below:

(i) For initial eligibility, the 24 months immediately preceding the month in which application is filed on the basis of the unemployment of a parent;

(ii) For eligibility for each subsequent month of the certification period, the 24 months immediately preceding the current month.

(e) Unemployed Parent.

(i) "Unemployed parent" means the principal wage earner parent who:

(aa) Has been unemployed for at least 30 days before the receipt of Medical Assistance; and

(bb) Has not left a job or refused to seek or accept employment without good cause within 30 days of the date of application.

(ii) The condition of unemployment is met when the parent is employed less than 100 hours per month; or is employed 100 hours or more per month, if the parent's work is intermittent and the excess hours are of a temporary nature, as evidenced by the fact that the work hours were under the standard for the two previous months and are expected to be under the standard during the next month.

(10-1) "Carrier" means a:

(a) Health insurer;

(b) Non-profit health service plan;

(c) Health maintenance organization;

(d) Dental plan organization; and

(e) Any other person included as a third party in Section 1902(a)(25)(A) of the Social Security Act, as amended by the Federal Deficit Reduction Act of 2005.

(11) "Categorically needy" means aged, blind, or disabled persons, or families and children, who are otherwise eligible for Medical Assistance and who meet the financial eligibility requirements for FIP, SSI, or Optional State Supplement.

(12) "Child" means an unmarried person younger than 21 years old.

(13) "Chronic hospital" means an institution which falls within the jurisdiction of Health-General Article, §19-307(a)(1), Annotated Code of Maryland, and is licensed pursuant to COMAR 10.07.01.

(14) "Comprehensive care facility" means a nursing facility licensed as a comprehensive care facility pursuant to COMAR 10.07.02.

(14-1) "Continuing care retirement community (CCRC)" means an entity that obtains certificate of registration issued by the Maryland Department of Aging in accordance with COMAR 32.02.01 and pursuant to its authority under Article 70B, Annotated Code of Maryland.

(15) "Corrective Managed Care Program" means the program administered by the Division of Utilization and Eligibility Review of the Medical Care Compliance Administration which limits recipients who have abused or misused Medical Assistance benefits to access most covered services through a single primary medical provider and a single pharmacy.

(16) "Department" means the Maryland Department of Health, the single State agency designated to administer the Medical Assistance Program.

(17) "Department of Human Services" means the department of State government which administers the FIP program.

(18) "Determination" means a decision regarding an applicant's eligibility for Medical Assistance.

(19) "Disabled" means the inability to perform any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months.

(20) "Eligibility technician" means an employee of the local department of social services responsible for determining eligibility of applicants and recipients.

(20-1) "Emergency services" means services provided by a licensed medical practitioner after the onset of a medical condition manifesting itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by

a prudent layperson, possessing an average knowledge of health and medicine, to result in:

(a) Placing health in jeopardy;

(b) Serious impairment to bodily functions;

(c) Serious dysfunction of any bodily organ or part; or

(d) Development or continuance of severe pain.

(20-2) "Entrance fee" means a sum of money or other consideration, other than a surcharge that:

(a) Is paid by a resident to a CCRC initially or in deferred payments, pursuant to a written continuing care agreement between the CCRC and the resident, which governs the use, treatment, and refund of the entrance fee;

(b) Assures a resident of continuing care in the CCRC facility for a term of more than 1 year or for life; and

(c) Is at least three times the weighted average of the monthly cost of the periodic fees charged to independent living and assisted living units.

(21) "Extended care facility" means a nursing facility licensed as an extended care facility pursuant to COMAR 10.07.02.

(21-1) "Family Investment Program (FIP)" means a category of public assistance mandated under Title IV-A of the Social Security Act, 42 U.S.C. §601 et seq.

(21-2) "Guardian of the person" means a guardian appointed by a court pursuant to Estates and Trusts Article, Title 13, Subtitle 7, Annotated Code of Maryland, to serve the interests of a minor or disabled person under that subtitle.

(21-3) "Guardian of the property" means a guardian appointed by a court pursuant to Estates and Trusts Article, Title 13, Subtitle 2, Annotated Code of Maryland, to serve the interests of a minor or disabled person under that subtitle.

(22) "Hospital" means an institution which falls within the jurisdiction of Health-General Article, §19-307(a)(1), Annotated Code of Maryland, and is licensed pursuant to COMAR 10.07.01, or is licensed according to applicable standards established by the state in which the hospital is located.

(23) Income.

(a) "Income" means any property or service received by a person in cash or in-kind which can be applied directly, or by sale or conversion, to meet basic needs for food, shelter, and medical expenses.

(b) "Earned income" means payment received by a person in cash or in-kind as a result of employment, including self-employment. Earned income consists of wages, salaries, commissions, tips, and profit from self-employment.

(c) "In-kind income" means support or benefits in the form of food or shelter, or both, received by a person.

(d) "Unearned income" means all income which does not meet the definition of earned income.

(24) "Family Investment Administration" means the administrative unit of the Department of Human Services and its affiliated local departments responsible for determining an applicant's or recipient's eligibility for Public Assistance, Medical Assistance, and Medical Assistance, State-Only.

(25) "Incurred medical expenses" means those paid or unpaid bills for medical care which are recognized under State law and are or will be the obligation of the applicant.

(26) "Intermediate care facility" means a nursing facility which meets the standards for certification and participation in Title XIX and has entered into a provider agreement with the Department pursuant to COMAR 10.09.11.

(27) "Intermediate care facility for individuals with intellectual disabilities or persons with related conditions (ICF/IID)" means a nursing facility for the intellectually disabled which meets the standards for certification and participation in Title XIX and has entered into a provider agreement with the Department pursuant to COMAR 10.09.11.

(28) "Living together" means sharing a common household.

(29) "Local department of social services (LDSS)" means the Baltimore City or a county social services department under the supervision of the Department of Human Services.

(30) "Long-term-care facility" means a skilled nursing facility, intermediate care facility, intermediate care facility for individuals with intellectual disabilities or persons with related conditions (ICF/IID), chronic hospital, tuberculosis hospital, or mental hospital.

(31) "Mandatory State Supplement" means a cash payment a state is required to make under Section 212, P.O. 93-66 to an aged, blind, or disabled person to provide him with the same amount of cash assistance he was receiving under Old Age Assistance, Aid to the Permanently and Totally Disabled, or Public Assistance to the Needy Blind if his SSI payment is less than that amount.

(31-1) "Maryland Medicaid Managed Care Program" means the Medicaid reform program established under COMAR 10.67.01 —.10, as authorized by Health-General Article, Title 15, Subtitle 1, Annotated Code of Maryland.

(32) "Medicaid" means Medical Assistance provided under the State Plan approved under Title XIX of the Social Security Act.

(33) "Medical Assistance (MA)" means the program administered by the State under Title XIX which provides comprehensive medical and other health-related care for eligible categorically and medically needy persons.

(34) "Medical Care Compliance Administration" means the administrative unit of the Department responsible for ensuring that health care services provided to recipients are appropriate and effectively utilized.

(35) "Medical Care Operations Administration" means the administrative unit of the Department responsible for maintaining a file of all eligible persons and paying providers of service.

(36) "Health Systems Financing Administration" means the administrative unit of the Department responsible for establishing regulations, policies, and procedures for the Medical Assistance program.

(37) "Medical institution" means an institution that:

(a) Is organized to provide medical care, including nursing and convalescent care;

(b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;

(c) Is authorized under State law to provide medical care; and

(d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

(38) "Medically needy" means persons who are otherwise eligible for Medical Assistance, who are not categorically needy, and whose income and resources are within the limits set under the State Plan.

(39) "Medicare" means the medical insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. §§1395 et seq.

(40) "Mental hospital" means an institution which falls within the jurisdiction of Health-General Article, §19-307(a)(1), Annotated Code of Maryland, and is licensed pursuant to COMAR 10.07.04.

(41) "Migrant worker" means a person who moves from place to place to harvest or process seasonal crops.

(42) "Old Age Assistance" means a former category of public assistance mandated under Title I of the Social Security Act, and replaced by Title XVI of the Social Security Act, 42 U.S.C. §1381 et seq.

(43) "One-time-only" means a time-limited certification.

(44) "Optional State Supplement" means a cash payment made by a state to an aged, blind, or disabled person, under §1616 of the Social Security Act.

(45) "Period under consideration" means the specified months which are assessed for determination of eligibility.

(45-1) "Postpartum period" means the period of time beginning on the date a pregnancy ends and ending on the last day of the second month following the end of pregnancy.

(46) "Public Assistance" means cash assistance payments, including state supplementary payments, made to persons who are eligible for programs administered under Title IV-A or Title XVI of the Social Security Act.

(47) "Public Assistance to the Needy Blind" means a former category of public assistance mandated under Title X of the Social Security Act and replaced by Title XVI of the Social Security Act, 42 U.S.C. §§1381 et seq.

(48) Public Institution.

(a) "Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(b) "Institution" means an establishment that furnishes, in single or multiple facilities, food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

(c) "Public institution" does not mean a medical institution, a skilled nursing facility, or a publicly operated community residence that serves no more than 16 residents.

(49) Publicly Operated Community Residence that Serves No More Than 16 Residents.

(a) "Publicly operated community residence that serves no more than 16 residents" means a facility that is publicly operated, serves no more than 16 residents, and offers services beyond food and shelter.

(b) "Publicly operated community residence that serves no more than 16 residents" does not mean:

(i) Residential facilities located on or adjacent to any large institution or multipurpose center;

(ii) Educational or vocational institutions that primarily provide an approved or accredited program to some or all of their residents;

(iii) Medical treatment facilities which provide medical care or remedial service on an inpatient basis; or

(iv) Correctional or holding facilities which provide for persons who are prisoners, have been arrested or detained, or are held under court order as material witnesses or juveniles.

(49-1) "Qualified alien" means an alien who:

(a) Has been fully admitted for permanent residence under the Immigration and Nationality Act (INA);

(b) Has been granted asylum under §208 of the INA;

(c) Has been admitted into the United States as a refugee under §207 of the INA;

(d) Has been paroled into the United States under §212(d)(5) of the INA for a period of at least 1 year;

(e) Has had deportation withheld under §243(h) of the INA; or

(f) Has been granted conditional entry under §203(a)(7) of the INA in effect before April 1, 1980.

(50) "Recipient" means a person who is certified as eligible for Medical Assistance.

(51) "Redetermination" means a determination regarding continuing eligibility of a recipient.

(52) "Remedial service" means any service, other than a physician's service, provided within the scope of practice as defined by State law by a person licensed as a practitioner under State law.

(53) "Resources" means accumulated personal wealth over which a person has the authority or power to liquidate his interest, including cash savings, savings accounts, certificates of deposit, money market certificates, checking accounts, stocks, bonds, cash value of life insurance, burial plots, prepaid burial plans, real property, personal property, mortgages, and mutual funds.

(54) "Retroactive coverage" means the availability of coverage for incurred medical expenses covered under the State Plan for a period not to exceed 3 months before the month of application.

(55) "Skilled nursing facility" means a nursing facility which:

(a) Is licensed as a comprehensive care facility (SNF/CCF), or as an extended care facility (SNF/ECF), or both;

(b) Meets the requirements for certification and participation in Title XIX of the Social Security Act as a skilled nursing facility; and

(c) Has entered into a provider agreement with the Department pursuant to COMAR 10.09.10.

(56) "Social Security Administration" means the administrative unit in the United States Department of Health and Human Services responsible for administering programs under Titles II, IV-A, IV-D, and XVI of the Social Security Act.

(57) "Spend-down" means a procedure by which an applicant who is ineligible for Medical Assistance due to excess income becomes eligible by deducting incurred medical expenses from excess income.

(58) "Spouse" means a person who has been determined to be the husband or wife of another person under State law or for the purposes of determining eligibility for Social Security benefits.

(59) "State Plan" means a comprehensive written commitment by a Medicaid agency, submitted under §1902(a) of the Social Security Act, to administer or supervise the administration of a medical assistance program in accordance with federal requirements.

(60) "Supplemental Security Income (SSI)" means a federally administered program providing benefits to needy aged, blind, and disabled individuals under Title XVI of the Social Security Act, 42 U.S.C. §§1381 et seq.

(61) "Third party" means a person, institution, corporation, public or private agency or organization who is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient.

(62) "Title XIX" means the title of the Social Security Act, 42 U.S.C. §§1396 et seq., which governs establishment of a medical assistance program for low income persons.

(63) "Tuberculosis hospital" means an institution which falls within the jurisdiction of Health-General Article, §19-307(a)(1), Annotated Code of Maryland, and is licensed pursuant to COMAR 10.07.01.

.02-1 MAGI Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010 (Pub.L.111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub.L.111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub.L.112-56).

(2) Authorized Representative" has the meaning stated in COMAR 10.01.04.12.

(3) "Designee" means any entity designated to act on behalf of the Department such as:

(a) Baltimore City or a county social services department under the supervision of the Department of Human Services;

(b) Baltimore City Health Department and its subgrantees, or a county health department; and

(c) The Maryland Health Benefit Exchange.

(4) "Insurance Affordability Program" means a program that is one of the following:

(i) The Maryland State Medicaid program;

(ii) The Maryland Children's Health Insurance Program (CHIP), including the program known as Maryland Children's Health Program (MCHP) Premium;

(iii) An optional State basic health program established under §1331 of the Affordable Care Act;

(iv) A program that makes available to qualified individuals coverage in a qualified health plan through the Maryland Health Benefit Exchange with advance payments of the premium tax credit established under §36B of the Internal Revenue Code; and

(v) A program that makes available coverage in a qualified health plan through the Maryland Health Benefit Exchange with cost-sharing reductions established under §1402 of the Affordable Care Act.

(5) "MAGI" means modified adjusted gross income, as calculated for purposes of determining eligibility for insurance affordability programs under the Affordable Care Act.

(6) "MAGI exempt coverage group" means a coverage group as described under Regulation .03 of this chapter whose eligibility is not determined by MAGI or by the Maryland Health Benefit Exchange.

(7) "Maryland Health Benefit Exchange" means the unit of State government that determines initial and continuing eligibility for the MAGI based insurance affordability programs, including, by delegation, certain eligibility in the program.

.03 Coverage Groups.

A. The following individuals, including recipients of Temporary Cash Assistance, may be determined eligible for the MAGI coverage groups:

(1) Parents and other caretaker relatives whose household income is:

(a) Greater than 123 percent of the federal poverty level and equal to or less than 133 percent of the federal poverty level; or

(b) Equal to or less than 123 percent of the federal poverty level.

(2) Pregnant and postpartum women of any age whose household income is equal to or less than 250 percent of the federal poverty level;

(3) Childless adults 19 years old or older and younger than 65 years old whose household income is equal to or less than 133 percent of the federal poverty level:

(4) Children younger than 21 years old and whose household income is equal to or less than 133 percent of the federal poverty level; and

(5) Former Foster Care individuals who:

(a) Are younger than 26 years old;

(b) Are not eligible and enrolled for coverage under a mandatory Medicaid group other than childless adult; and

(c) Were in a Maryland out-of-home placement, including categorical Medicaid:

(i) On attaining age 18 and leaving out-of-home placement, or

(ii) On attaining age 19—21 during extended out-of-home placement under COMAR 07.02.11.04B.

B. An individual receiving SSI, Mandatory State Supplement, or Optional State Supplement is eligible for the MAGI Exempt coverage groups without having to file a separate application and covered as Categorically Needy.

C. Transitional Medical Assistance.

(1) If a family loses Medical Assistance solely because of increased income from employment of the caretaker relative as defined under Regulation .02B(10)(a) of this chapter, all members of the family shall be eligible for Medical Assistance during the immediately succeeding 12-month period if the parents or caretaker relatives were eligible for Medical Assistance under §A(5) of this regulation in 3 or more months of the 6-month period immediately preceding the month in which they became ineligible for Medical Assistance.

(2) Termination of Transitional Medical Assistance.

(a) Transitional Medical Assistance during the 12-month period described under §C(1) of this regulation shall terminate at the close of the first month in which the family ceases to include a child younger than 21 years old.

(b) Termination of assistance may not become effective until the Department has provided the family with notice of the grounds for the termination.

(3) Continuation in Certain Cases until Redetermination. With respect to a person who would cease to receive Medical Assistance under §C(2) of this regulation but who may be eligible for Medical Assistance under this chapter, the Department may not discontinue Medical Assistance until the Department has determined that the person is not eligible for Medical Assistance under this chapter.

D. The following individuals may be determined eligible for a MAGI Exempt coverage group after filing a separate application for Medical Assistance and, if determined eligible, are covered as Categorically Needy:

(1) An individual who would be eligible for SSI, or Optional State Supplement benefits except for a requirement of those programs that is specifically prohibited under Title XIX.

(2) A person who in December, 1973, was eligible for Medical Assistance as an essential spouse. Medical Assistance will continue if this person:

(a) Continues to meet the December, 1973, criteria of the State's approved Old Age Assistance, Aid to the Permanently and Totally Disabled, or Public Assistance to the Needy Blind plans to be considered an essential spouse; and

(b) Lives with an aged, blind, or disabled spouse who continues to meet the December, 1973, criteria of the State's approved Old Age Assistance, Public Assistance to the Needy Blind, or Aid to the Permanently and Totally Disabled plans.

(3) A person who in the month of December, 1973, was eligible for Medical Assistance and was an inpatient in a long-term care facility qualified to receive Medical Assistance payments, and, if not institutionalized, would have been eligible for Old Age Assistance, Public Assistance to the Needy Blind, or Aid to the Permanently and Totally Disabled. Medical Assistance will continue if this person:

(a) Needed and received inpatient care continuously since December, 1973;

(b) Continues to need and receive inpatient care; and

(c) Continues to meet the eligibility criteria of the Old Age Assistance, Public Assistance to the Needy Blind, or Aid to the Permanently and Totally Disabled plan for December, 1973.

(4) A person who:

(a) Meets all current requirements for Medical Assistance eligibility except the criteria for blindness or disability;

(b) Was eligible for Medical Assistance in December, 1973, as a blind or disabled person, whether or not he was receiving cash assistance in December, 1973; and

(c) For each consecutive month after December, 1973, continues to meet the criteria for blindness or disability and the other conditions of eligibility used under the Medical Assistance plan in December, 1973.

E. The following individuals may be determined eligible for a MAGI Exempt coverage group after filing a separate application, and if determined eligible, are covered as Medically Needy;

(1) A pregnant woman who has been denied AFDC solely because her income or resources exceed the cash assistance level;

(2) A person younger than 21 years old;

(3) A caretaker relative (and spouse);

(4) An aged, blind, or disabled person; and

(5) A person who was eligible as Medically Needy in December, 1973, on the basis of the blindness or disability criteria of Aid to the Permanently and Totally Disabled or Public Assistance to the Needy Blind and who continues to meet current requirements except for blindness or disability criteria.

F. Continuous Eligibility for Pregnant Women. The Department will provide Medical Assistance through the last day of the month in which the 60-day post-partum period ends for a pregnant woman who:

(1) Was eligible and enrolled under §A(2) of this regulation; and

(2) Because of a change in household income, will not otherwise remain eligible.

.03-1 Coverage Group for Women with Breast or Cervical Cancer — Purpose, Definitions, and Eligibility Criteria.

A. Purpose.

(1) The purpose of Regulations .03-1 and .03-2 of this chapter is to exercise the State's option under Title XIX of the Social Security Act to create a new Medical Assistance optional categorically needy coverage group for women who need treatment for breast cancer, cervical cancer, or precancerous conditions, in accordance with the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354).

(2) Applications submitted under Regulations .03-1 and .03-2 of this chapter shall no longer be accepted after December 31, 2013.

(3) An individual who has submitted an application in accordance with §A(1) of this regulation and who has been determined eligible will receive benefits under Regulations .03-1 and .03-2 of this chapter after December 31, 2013.

B. Definitions. In Regulations .03-1 and .03-2 of this chapter, the following terms have the meanings indicated:

(1) "Applicant" means an individual whose application for the Medical Assistance eligibility under the women's breast and cervical cancer coverage group has been submitted to the Department or its authorized representative, but has not received final action.

(2) "Application date" means the date on which a written, signed application for Medical Assistance eligibility under the women's breast and cervical cancer coverage group is received by the Department or its authorized representative.

(3) "Breast and Cervical Cancer Diagnosis and Treatment Program" means the State-funded program of cancer diagnosis and treatment services, which is:

(a) Governed by COMAR 10.14.02; and

(b) Administered by the Department's Center for Cancer Surveillance and Control.

(4) "Cancer treatment services" means active medical treatment for breast cancer, cervical cancer, or a precancerous condition, not including palliative care.

(5) "Categorically needy coverage group" means a category of Medical Assistance eligibility defined at Regulation .03A of this chapter.

(6) "Creditable health insurance coverage" means having one or more of the following types of coverage:

(a) A group health plan;

(b) Health insurance coverage with medical care benefits provided directly or through insurance, reimbursement, or otherwise and including items and services paid for as medical care, under any:

(i) Hospital or medical service policy or certificate;

(ii) Hospital or medical service plan contract; or

(iii) Health maintenance organization contract offered by a health insurance issuer;

(c) Medicare Part A or Part B;

(d) Medical Assistance;

(e) Armed forces insurance; or

(f) A state health risk pool.

(7) "Enrollee" means a woman who is determined eligible and is receiving Medical Assistance benefits under Regulations .03-1 and .03-2 of this chapter.

(8) "Health professional" means a licensed physician or certified registered nurse practitioner.

(9) "Institutionalized person" has the meaning specified at Regulation .08B of this chapter.

(10) "Mandatory Medical Assistance categorically needy coverage group" means a Medical Assistance categorically needy coverage group which the federal government requires a state to cover under the State Plan, in accordance with the Code of Federal Regulations.

(11) "Maryland Breast and Cervical Cancer Screening Program" means the National Breast and Cervical Cancer Early Detection Program in Maryland which:

(a) Is funded by the State or federal government;

(b) Is administered by the Department's Center for Cancer Surveillance and Control through the local jurisdictions; and

(c) Has income and other eligibility requirements.

(12) "National Breast and Cervical Cancer Early Detection Program (NBCCEDP)" means the program of the Centers for Disease Control (CDC), established under Title XV of the Public Health Service Act.

(13) "Needs treatment" means that, according to a written certification by a health professional, the individual needs cancer treatment services, such as chemotherapy, radiation, or surgery.

(14) "Precancerous condition" means for:

(a) Cervical cancer, a condition diagnosed as cervical intra-epithelial neoplasia I, II, or III; or

(b) Breast cancer, a condition diagnosed as atypical ductal hyperplasia or lobular carcinoma in-situ.

(15) "Screening services" means services provided by the Maryland Breast and Cervical Cancer Screening Program to screen for breast or cervical cancer, including clinical breast examinations, mammograms, pelvic examinations, Papanicolaou (Pap) tests, and diagnostic services such as breast ultrasound or colposcopically directed biopsy, to ensure that all women with abnormal screening results receive timely and adequate diagnostic and treatment services.

(16) "Uninsured" means:

(a) Not otherwise having creditable health insurance coverage for cancer treatment services; or

(b) Having creditable health insurance coverage, but the cancer treatment services ordered by a health professional are not covered due to one of the following reasons:

(i) The services are not included among the benefits covered by the individual's health insurance plan;

(ii) A period of exclusion has been applied to the individual's health insurance coverage, such as for a preexisting condition; or

(iii) The individual has exhausted the health insurance plan's covered benefits.

(17) "Women's breast and cervical cancer coverage group" means the Medical Assistance optional categorically needy coverage group covered under Regulations .03-1 and .03-2 of this chapter.

C. Eligibility.

(1) The Department shall determine that an applicant or enrollee is eligible for Medical Assistance coverage under Regulations .03-1 and .03-2 of this chapter if the individual:

(a) Is a woman;

(b) Is 40—64 years old;

(c) Is uninsured, with the Department not requiring a waiting period of prior uninsurance;

(d) Received screening services, in accordance with Regulation .03-2A of this chapter;

(e) Had a biopsy through the:

(i) Maryland Breast and Cervical Cancer Screening Program which resulted in a diagnosis of cervical cancer or a precancerous condition; or

(ii) Breast and Cervical Cancer Diagnosis and Treatment Program which resulted in a diagnosis of breast cancer or a precancerous condition;

(f) Needs treatment;

(g) Is not an institutionalized person;

(h) Meets the nonfinancial eligibility requirements for Medical Assistance, as specified in Regulation .05 of this chapter; and

(i) Is not eligible for a mandatory Medical Assistance categorically needy coverage group.

(2) The requirements in this chapter related to financial eligibility, income, and resources:

(a) Shall apply for assessing eligibility for a mandatory Medical Assistance categorically needy coverage group; and

(b) May not apply for determining eligibility for the WBCCHP under Regulations .03-1 and 03-2 of this chapter.

.03-2 Coverage Group for Women with Breast or Cervical Cancer — Eligibility, Determination, and Covered Services Process.

A. Screening. A woman is considered to have received screening services if the:

(1) NBCCEDP funded all or part of the woman's screening services; or

(2) NBCCEDP did not fund all or part of the woman's screening services, but the screening services were rendered by a provider or entity funded at least in part by the NBCCEDP and the:

(a) Screening services were within the scope of a grant, subgrant, or contract under the State's NBCCEDP; or

(b) NBCCEDP grantee elected to include such screening services by that provider as screening services pursuant to the NBCCEDP.

B. Assistance Unit. An applicant or enrollee shall be considered as an assistance unit of one person, including only the applicant or enrollee.

C. Application Process. The requirements of Regulation .04 of this chapter shall apply, except for the following differences for the women's breast and cervical cancer coverage group:

(1) For the initial eligibility application, an individual shall apply through the Maryland Breast and Cervical Cancer Screening Program in the local jurisdiction;

(2) The applicant's or enrollee's written application for an initial determination or a redetermination shall be on the form designated by the Department for the women's breast and cervical cancer coverage group;

(3) The Department shall:

(a) Determine initial eligibility, retroactive or current, based on:

(i) A signed application received from the applicant;

(ii) A form signed by a health professional, certifying that the enrollee needs treatment and, for a redetermination, specifying the anticipated length of treatment;

(iii) Confirmation from the Maryland Breast and Cervical Cancer Screening Program that the applicant received screening services in accordance with §A of this regulation;

(iv) Confirmation from the Maryland Breast and Cervical Cancer Screening Program or the Breast and Cervical Cancer Diagnosis and Treatment Program that the applicant had a biopsy which resulted in a diagnosis of breast cancer, cervical cancer, or a precancerous condition; and

(v) Additional information obtained by the Department to verify the applicant's eligibility in accordance with Regulation .03-1C of this chapter;

(b) Redetermine an enrollee's eligibility at least every 12 months, before the end of the certification period, based on the following:

(i) An application completed by the enrollee, verifying continuing eligibility under Regulations .03-1 and .03-2 of this chapter; and

(ii) A certification form completed by a health professional, verifying that the enrollee needs treatment and specifying the expected length of treatment;

(c) Verify, before determining or redetermining eligibility, that the applicant or enrollee is not:

(i) Currently covered by Medical Assistance and does not have an application under consideration in a coverage group which covers all State Plan services without requiring spend down or payment of a premium; or

(ii) Eligible for a mandatory Medical Assistance categorically needy coverage group;

(d) Determine or redetermine eligibility within 45 days after receipt of a signed application;

(e) Refer the applicant or recipient to the local department of social services or local health department for an eligibility determination or redetermination if the individual may be eligible for a mandatory Medical Assistance categorically needy coverage group; and

(f) Notify the applicant or enrollee of the eligibility decision and the rights for appeal and fair hearing, in accordance with Regulation .13 of this chapter; and

(4) Based on the application date, the Department shall establish a period under consideration, which shall be:

(a) For retroactive eligibility for an initial application, not more than 3 months immediately preceding the month of application, if as of this earlier date the applicant would have met the requirements at Regulation .03-1C of this chapter;

(b) For current eligibility for an initial application, a 12-month period beginning with the month of application; or

(c) For current eligibility for a redetermination, the lesser of:

(i) A 12-month period; or

(ii) The number of months that the individual needs treatment.

D. Certification Period.

(1) An enrollee's certification period shall begin:

(a) For retroactive eligibility with the initial determination, the first day of the month which is up to 3 months preceding the month of the application date if, as of this earlier date, the applicant would have met the requirements of Regulation .03-1C of this chapter, including having been screened for and diagnosed with breast cancer, cervical cancer, or a precancerous condition;

(b) For current eligibility with the initial determination, the first day of the month of the application date; or

(c) For a redetermination, the first day of the month immediately following the month in which the previous certification period ended.

(2) The effective date for retroactive or current coverage under Regulations .03-1 and .03-2 of this chapter shall be April 1, 2002 or later.

(3) An enrollee's eligibility under Regulations .03-1 and .03-2 of this chapter shall end as of the:

(a) End of a certification period for a:

(i) 12-month period; or

(ii) A period less than 12 months, based on how long the enrollee needs treatment; or

(b) Date when the enrollee is no longer eligible under Regulations .03-1 and .03-2 of this chapter due to:

(i) Death;

(ii) Establishment of residency in another state;

(iii) Becoming 65 years old;

(iv) Becoming an institutionalized person; or

(v) No longer being uninsured, such as becoming eligible for another Medical Assistance coverage group which covers all State Plan services without requiring spend down or payment of a premium.

E. Redetermination.

(1) Scheduled Redeterminations.

(a) The Department shall issue a redetermination package to an enrollee at least 60 days before the end of the certification period.

(b) Based on the information presented, the Department shall determine whether the enrollee:

(i) Qualifies for continuing eligibility under the women's breast and cervical cancer coverage group with a new 12-month certification period, because the enrollee needs treatment for at least 12 more months;

(ii) Qualifies for continuing eligibility under the women's breast and cervical cancer coverage group with a new certification period of less than 12 months, based on the length of time that the enrollee needs treatment;

(iii) Does not qualify for continuing eligibility under the women's breast and cervical cancer coverage group because the required information was not received by the Department by the specified deadline, but shall be considered for continuing eligibility under the women's breast and cervical cancer coverage group if the necessary information is received by the Department within 6 months of the date of termination;

(iv) Does not qualify for continuing eligibility under the women's breast and cervical cancer coverage group and does not appear to qualify for a mandatory Medical Assistance categorically needy coverage group; or

(v) Does not qualify for continuing eligibility under the women's breast and cervical cancer coverage group because the enrollee may qualify for a mandatory Medical Assistance categorically needy coverage group, and shall be referred for an eligibility determination at the local department of social services.

(2) Unscheduled Redeterminations.

(a) An enrollee shall inform the Department within 10 days of a change in circumstances, which may impact the enrollee's eligibility under Regulations .03-1 and .03-2 of this chapter.

(b) If the Department receives notice of a change in circumstances which may impact the enrollee's eligibility under Regulations .03-1 and .03-2 of this chapter, the Department shall follow the procedures in §E(1)(b) of this regulation for redeterminations.

(3) If the Department determines as part of a scheduled or unscheduled redetermination that an enrollee does not qualify for continuing eligibility under the women's breast and cervical cancer coverage group, the Department shall determine whether the individual qualifies for any other coverage groups under this chapter or COMAR 10.09.11.

F. Covered Services. Enrollees shall be entitled to full coverage for all services covered under the State Plan, not limited to cancer treatment services, except for enrollment in:

(1) The HealthChoice Maryland Medicaid Managed Care Program, in accordance with COMAR 10.67.01—.06;

(2) Rare and Expensive Case Management (REM), in accordance with COMAR 10.09.69;

(3) A home and community-based services waiver under §1915(c) of Title XIX of the Social Security Act;

(4) Medicare buy-in for Medical Assistance payment of Medicare premiums, copayments, and deductibles for Medicare eligible persons;

(5) Program of All-Inclusive Care for the Elderly; or

(6) Coverage for services in a long-term care facility exceeding 30 consecutive days.

.03-3 Medicare Savings Program Coverage.

A. Non-Financial and Resource Eligibility for the Medicare Savings Programs. In order to be eligible for the Medicare savings program under §§E—H of this regulation, an individual:

(1) May not be enrolled in Medical Assistance or the Maryland Children's Health Program under this chapter or under COMAR 10.09.11;

(2) Shall be entitled to hospital insurance benefits under Medicare Part A, or medical insurance benefits under Medicare Part B, or both, with or without payment of premiums;

(3) Shall meet the non-financial eligibility requirements for Medical Assistance under this chapter; and

(4) Shall be part of an assistance unit whose countable resources do not exceed:

(a) For individuals eligible under §§E—G of this regulation, 3 times the maximum amount allowed by the Supplemental Security Income program, as adjusted from time to time by the Social Security Administration, for the number of persons in the assistance unit; or

(b) For individuals eligible under §H of this regulation, 2 times the maximum amount allowed by the Supplemental Security Income program for the number of persons in the assistance unit.

B. Medicare Savings Program.

(1) The Medical Assistance benefits for individuals eligible under §§E—H of this regulation are limited to the Medicare savings program benefits described under those sections of this regulation.

(2) Current eligibility for Medicare savings program benefits shall continue until the recipient is determined ineligible.

C. Application and Redetermination Procedures.

(1) The requirements under this chapter for applications and redeterminations shall apply for §§E—H of this regulation except as described in §C(2)—(5) of this regulation.

(2) Applications and re-applications for eligibility under this regulation shall be filed at:

(a) The Department or its designee;

(b) The Maryland Department of Aging;

(c) An area agency on aging; or

(d) A surrogate organization approved by the Department.

(3) The initial application may be made at a face-to-face interview or by mail with an agency defined under §C(2) of this regulation, as authorized by the Department.

(4) Redeterminations.

(a) Applications for redetermination of eligibility shall be mailed by the Department or its designee to the recipient or representative for completion at least once every 12 months.

(b) The recipient or representative shall return the application to the Department or its designee and indicate:

(i) Any changes that have occurred since the prior redetermination of eligibility, such as a new address; or

(ii) That there is no new information to report, by marking "NO CHANGE" on the front of the application.

(c) Upon notice of a change in circumstances, a redetermination of eligibility under §§E—H of this regulation shall be completed by the Department or its designee.

(5) Eligibility under §§E—H of this regulation shall be initially determined and redetermined by the Department or its designee.

D. Income and Resource Consideration.

(1) Assistance Unit. When financial eligibility is determined for an applicant or recipient under §§E—H of this regulation, the countable income and resources of the following individuals shall be considered and measured against the income and resource standards specified in this regulation for the number of persons in the assistance unit:

(a) The applicant or recipient; and

(b) The applicant's or recipient's spouse when living in the same household, whether or not the spouse is eligible for the same benefits under this regulation.

(2) Determining Countable Income and Resources.

(a) Income and resources shall be evaluated for §§E—H of this regulation in accordance with the provisions for aged, blind, or disabled adults residing in the community, as described under this chapter, in addition to the following resource exclusions:

(i) The cash value of life insurance; and

(ii) An amount up to $1,500 for burial or funeral funds, unless included in the annual resource limit for the full Medicare Part D Low-Income Subsidy (LIS) program.

(b) Cost of Living Disregard. The annual cost of living increase in Social Security income under Title II of the Social Security Act shall be disregarded through the month following the month in which the annual federal poverty level update is published in the Federal Register.

E. Qualified Medicare Beneficiary (QMB).

(1) An individual is eligible for QMB benefits if:

(a) All of the requirements of §A of this regulation are satisfied; and

(b) The assistance unit's net countable income does not exceed 100 percent of the federal poverty level for the number of persons in the assistance unit.

(2) Current eligibility for QMB benefits shall be effective the first day of the month after the month in which QMB eligibility is determined.

(3) Retroactive coverage before the month of application is not available for QMB benefits.

(4) Medicare savings program benefits for a QMB-eligible person shall include coverage of the following expenses by the Medical Assistance program:

(a) Monthly premium for Medicare Part B;

(b) Monthly premium for Medicare Part A, if the individual, due to insufficient working quarters, is not entitled to free coverage by the Social Security Administration; and

(c) Medicare Part A and Part B deductibles and co-insurance for services covered by Medicare, regardless of whether the services are covered under the Medical Assistance State Plan.

F. Specified Low-Income Medicare Beneficiary (SLMB).

(1) An individual is eligible for SLMB benefits if:

(a) All of the requirements of §A of this regulation are satisfied; and

(b) The assistance unit's net countable income is greater than 100 percent but less than 120 percent of the federal poverty level for the number of persons in the assistance unit.

(2) Current eligibility for SLMB benefits shall be effective the first day of the month of application.

(3) An individual may qualify for retroactive SLMB benefits for up to 3 calendar months before the month of application, if the person meets the SLMB eligibility criteria for each of those prior months.

(4) Medicare savings program benefits for a SLMB-eligible person shall consist of coverage by the Medical Assistance program of the monthly premium for Medicare Part B.

G. Qualifying Individual QI.

(1) An individual is eligible for QI benefits if:

(a) All of the requirements of §A of this regulation are satisfied;

(b) The assistance unit's net countable income is at least 120 percent but less than 135 percent of the federal poverty level for the number of persons in the assistance unit; and

(c) The individual is not otherwise eligible for Medical Assistance under this chapter.

(2) Current eligibility for QI benefits shall be effective the first day of the month of application.

(3) An applicant may qualify for up to 3 calendar months before the month of application for retroactive QI benefits if:

(a) The individual meets the QI eligibility criteria for each of those prior months under consideration; and

(b) Each retroactive month is no earlier than January 1 of the calendar year in which the individual applied for QI benefits.

(4) Medicare savings program benefits for a QI eligible individual shall consist of coverage by the Medical Assistance program of the monthly premium for Medicare Part B.

H. Qualified Disabled and Working Individual (QDWI).

(1) An individual is eligible for QDWI benefits if:

(a) The individual:

(i) Meets all of the requirements under §A of this regulation;

(ii) Is younger than 65 years old;

(iii) Was determined disabled by the Social Security Administration (SSA) but lost Social Security benefits solely due to employment;

(iv) Is entitled to enroll in Medicare Part A under §1818A of the Social Security Act; and

(v) Is not otherwise eligible for Medical Assistance under this chapter; and

(b) The assistance unit's net countable income does not exceed 200 percent of the federal poverty level for the number of persons in the assistance unit.

(2) SSA shall establish the effective date of QDWI coverage based on the:

(a) Individual's date of application for QDWI benefits;

(b) Date of potential QDWI eligibility, as specified in a letter from SSA to the individual; and

(c) Dates of the next Medicare open enrollment period.

(3) Medicare savings program benefits for a QDWI-eligible person shall consist of coverage by the Medical Assistance program of the monthly premium for Medicare Part A.

(4) Only the individual who is identified by SSA as potentially eligible may be eligible for QDWI benefits in a QDWI assistance unit.

(5) Retroactive coverage before the month of application is not available for QDWI benefits.

(6) If an individual delays in applying for QDWI benefits after notification of potential QDWI eligibility by SSA, the individual may be required by SSA to pay a premium surcharge for Medicare Part A, unless the individual is covered by an employer-based group health plan.

(7) Eligibility for QDWI benefits shall continue until the earliest of the following dates:

(a) The end of the month after the Department:

(i) Determines that the individual is no longer eligible for QDWI benefits in accordance with this regulation; and

(ii) Sends the recipient a notice of termination at least 10 days before the effective date;

(b) The end of the month before the month that the individual becomes:

(i) Re-entitled to premium-free Medicare Part A; or

(ii) 65 years old;

(c) The date of death; or

(d) The end of the month following the month that the individual:

(i) Is notified by SSA that the individual no longer has a disabling impairment; or

(ii) Files a request for termination of QDWI enrollment.

.03-4 Medicare Buy-In Coverage for Medical Assistance Recipients.

A. If a recipient, who is determined federally eligible and enrolled in Medical Assistance or the Maryland Children's Health Program according to the requirements of this chapter or COMAR 10.09.11, is entitled to hospital insurance benefits under Medicare Part A, or medical insurance benefits under Medicare Part B, or both, with or without payment of premiums, the Medical Assistance program shall provide the same coverage of Medicare savings program expenses as specified for a Qualified Medicare Beneficiary under Regulation .03-3E of this chapter.

B. A qualified recipient is automatically made eligible by the Department or its designee for the Medicare buy-in benefits effective the first day of the:

(1) Second month after the month in which the individual is determined eligible for Medical Assistance or the first day of the third month of Medicare entitlement, whichever date is later, if the individual is eligible in a long-term care or spend down coverage group; or

(2) Month that the individual is eligible for both Medical Assistance and Medicare, if the individual is eligible under COMAR 10.09.24 or COMAR 10.09.11 for Medical Assistance in any coverage groups other than long-term care or spend down.

C. A recipient's eligibility for Medicare buy-in benefits shall continue until the recipient is determined ineligible.

.04 Application — General Requirements.

A. The Department or its designee shall determine initial (retroactive and current) and continuing eligibility.

B. The Department or its designee shall give oral, written, or electronic information about the Medical Assistance Program such as:

(1) Requirements for eligibility;

(2) Available services;

(3) An individual's rights and responsibilities;

(4) Information in plain English, supported by translation services; and

(5) Information accessible to disabled individuals requesting an application.

C. An individual requesting health coverage from an Insurance Affordability Program shall be given an opportunity to apply.

D. The Department or its designee shall make the application available to the individual without delay, by telephone, mail, in-person, internet, other available electronic means and in a manner accessible to disabled individuals requesting an application.

E. A resident temporarily absent from the State but intending to return may apply for health coverage from an Insurance Affordability Program by telephone, mail, in-person, internet, and other available electronic means to the Department or its designee in any jurisdiction. The individual shall:

(1) Demonstrate continued residency in the State; and

(2) Meet all nonfinancial and financial requirements in order to be determined eligible.

F. Application Filing and Signature Requirements.

(1) An individual who wishes to apply for health coverage under an Insurance Affordability Program shall submit a written, telephonic, or electronic application signed under penalty of perjury to the Department or its designee in any jurisdiction. An applicant shall be responsible for completing the application but may be assisted in the completion by an individual of the applicant's choice.

(2) A signed application is required for all individuals for whom assistance is requested. If, after the completion of an eligibility determination, assistance is requested for additional family members, a signed application is required for those individuals.

(3) An exception to §F(2) of this regulation is that a child born to a mother eligible for and receiving Medical Assistance on the date of the child's birth shall be considered to have applied for Medical Assistance and to have been found eligible for Medical Assistance on the date of his birth, and to remain eligible for Medical Assistance for a period of 1 year.

(4) A deemed newborn is eligible for receiving Medical Assistance if, at the time of birth, the child's mother was covered by Medicaid in another state, as a child under CHIP, or under an 1115 waiver.

(5) For the purpose of establishing eligibility, the applicant or an authorized representative shall complete and sign the application.

(6) In the case of a child applicant younger than 18 years old, a parent of the child shall sign the application, except in the following situations:

(a) When the child does not live with a parent, or the parent with whom the child lives is an unmarried minor younger than 18 years old, the caretaker relative other than parent shall sign the application form;

(b) An authorized representative who is 18 years old or older shall complete and sign the application form for an unmarried child younger than 18 years old who is not living with a parent or caretaker relative other than the parent.

(7) The date of application shall be the date on which a written, telephonic, or electronic signed application is received by the Department or its designee.

G. An individual who has filed a written, telephonic, or electronic application may voluntarily withdraw that application; however, the application shall remain the property of the Department or its designee, and the withdrawal may not affect the requirements for

establishing periods under consideration specified in §H of this regulation.

H. Period under Consideration.

(1) The Department or its designee shall establish a current period under consideration based on the date of application established pursuant to §F(6) of this regulation.

(2) The period under consideration shall be for retroactive eligibility, the 1, 2, or 3 months immediately preceding the month of application for Medical Assistance, except as specified in §H(3) and §N of this regulation.

(3) For a deceased individual, the retroactive and current periods under consideration shall begin as stated in §H(1) and (2) of this regulation and may not extend beyond the month of death.

I. Processing Applications — Time Limitations.

(1) When a written, telephonic, or electronic application is filed, a decision shall be made promptly but not later than:

(a) 10 days from the date of application when filed with the local health department; or

(b) 30 days from the date of application when filed with the Department or its designee, with the exception of the local health department.

(2) The time standards specified in §I(1) of this regulation cover the period from the date of application to the date the Department or its designee sends a written or electronic notice of its decision to the applicant.

(3) Information Required.

(a) The applicant shall report all required information. When there is evidence of inconsistency with attested information given by the applicant and reported by the state and federal databases, the applicant shall be required to offer an explanation and appropriate verification to reconcile the inconsistency.

(b) The Department or its designee shall inform the applicant or authorized representative in a written or electronic notice of the required information and verifications needed to determine eligibility, and the applicable pending time limit.

(c) The applicant or authorized representative shall provide all information and requested verification for the determination of nonfinancial and financial eligibility, including information relating to health insurance coverage or potential third-party payments, early enough for the Department or its designee to meet time limitations.

(d) When an applicant completes the application form and requests coverage for:

(i) The current period, verification of all elements of eligibility may be required for the current period;

(ii) The retroactive period, verification of all elements of eligibility may be required for the retroactive period; or

(iii) Both the retroactive and current periods, verification of all elements of eligibility may be required for both the retroactive and current periods.

(e) When an applicant fails to complete the application form, or fails to provide the required information and verification to determine eligibility within the applicable time frame, the applicant shall be determined ineligible.

(4) Extension of Time Standards.

(a) The time standards specified in §I(1) of this regulation shall be extended to allow the applicant sufficient time to complete provision of information when:

(i) The applicant is actively attempting to establish his eligibility but has been unable to provide the required information through no fault of his own; or

(ii) There is an administrative or other emergency beyond the control of the Department or its designee.

(b) The Department or its designee shall document the reason for the delay in the applicant's written or electronic record. The extension of time will continue as long as the requirements of §I(4)(a) of this regulation are met. The Department or its designee shall deny Medical Assistance when these requirements cease to be met. When a subsequent application is made, eligibility and period under consideration shall be determined under §I(7), (8), (9), or (10) of this regulation.

(5) The standards of promptness for acting on applications may not be used to deny assistance except as provided in §I(4)(b) of this regulation.

(6) The standards of promptness for acting on applications may not be used as a waiting period for granting assistance to eligible persons.

(7) Disposition of Application Following a Decision of Ineligibility. If an applicant is determined ineligible for the current period under consideration:

(a) Due to a nonfinancial factor, the application shall be disposed of and the application date may not be retained. If the applicant reapplies, the process and the period under consideration shall be established under §I(9) of this regulation.

(b) Solely because of excess income, the application shall be preserved for the period under consideration. The applicant may subsequently establish eligibility for the period under consideration under the "spend-down" process described under Regulations .09C(4) and .10D(5) of this chapter.

(c) Solely because of failure to complete the application requirements, including voluntary withdrawal of the application, the application shall be disposed of. If the applicant reapplies, the process and period under consideration shall be established under §I (8), (9), or (10) of this regulation.

(8) Reactivation of an Application Following a Decision of Ineligibility for Reasons Other than Nonfinancial Factors or Excess Income.

(a) A request for current eligibility following the rejection of an application for reasons other than nonfinancial factors or excess income shall be considered a reactivation of the appropriate earlier application.

(b) The reactivation period shall:

(i) Apply to the earliest rejected application for which the period under consideration has not expired;

(ii) Include the retroactive period associated with the current period.

(c) The applicant may establish eligibility for the current period, the retroactive period, or both, at any time during the reactivation period.

(9) Reapplication Following a Decision of Ineligibility Due to a Nonfinancial Factor.

(a) When an applicant reapplies following a decision of ineligibility due to a nonfinancial factor, a new period under consideration shall be established based on the date a new application is submitted. Coverage may not be provided for any month in which the applicant has not overcome the prior factor of ineligibility.

(b) The incurred medical expenses from a past period during which nonfinancial ineligibility or excess resources existed may be applied to excess income, if any, for the current period.

(10) Reapplication After the Period Under Consideration Has Expired.

(a) A request for eligibility and application filed after the expiration of the period under consideration shall be considered a new application, and a new period under consideration shall be established.

(b) A part of the expired current period under consideration may not be converted to a retroactive period for purposes of determining eligibility. A part of the expired current period under consideration may constitute part or all of the 3 months before the month of application for purposes of post-eligibility deductions.

(c) The incurred unpaid expenses from the expired period may, with the written consent of the applicant, be applied to excess income, if any, for the current period.

(d) The written consent shall be obtained on a form designated by the Department.

J. An applicant or recipient may be assisted by an individual or individuals of the applicant's or recipient's choice in the application process and may be accompanied by this individual or individuals when in contact with the Department or its designee.

K. Required Application for Income Benefits.

(1) Applicants and recipients shall apply for all income benefits to which there may be entitlement, except as specified in §K(3) of this regulation.

(2) Income benefits include, but are not limited to, Social Security, Unemployment Compensation, Railroad Retirement, Veterans' Administration, Civil Service annuities, federal, state, or local government and private pensions, and Workers' Compensation.

(3) Applicants and recipients determined by the Department or its designee to be unable to perform the required activity because of the applicant's or recipient's physical or mental condition and for whom there is no other individual to perform the activity are not required to apply for income benefits.

(4) Determination of initial eligibility may not be delayed pending the results of the application filed for income benefits.

(5) At the time of redetermination or reapplication, eligibility will be determined on the basis of the applicant's or recipient's documented reasonable and continuous efforts to establish entitlement to income benefits.

L. Social Security Number.

(1) Eligibility may not be established until the applicant or recipient furnishes or applies for a Social Security number for any individual whose income is considered in determining financial eligibility.

(2) Assistance may not be denied, delayed, or discontinued pending the issuance or verification of the number if the applicant or recipient complies with §L(1) of this regulation.

(3) If an applicant or recipient is physically or mentally incapable of acting for himself or herself or lacks the resources to meet the requirements, the Department or its designee shall assist the applicant or recipient in obtaining the necessary evidentiary documents required for application for a Social Security number, and any costs incurred by the Department or its designee shall be paid out of administrative funds.

M. Third-Party Liability.

(1) Applicants and recipients shall notify the Department or its designee within 10 working days when medical treatment has been provided as a result of a motor vehicle accident or other occurrence in which a third party might be liable for their medical expenses.

(2) Applicants and recipients shall cooperate with the Department or its designee in completing a form designated by the Department to report all pertinent information and in collecting available health insurance benefits and other third-party payments.

(3) In accident situations, applicants and recipients shall notify the Department or its designee of the time, date, and location of the accident, the name and address of the attorney, the names and addresses of all parties and witnesses to the accident, and the police report number if an investigation is made.

N. Retroactive Eligibility for Applicants or Recipients. An applicant or recipient who desires Medical Assistance coverage for a past period shall apply for retroactive coverage. The date of application for retroactive coverage shall be established in accordance with the requirements of Regulation .09B of this chapter.

O. The Department or its designee shall explain the spend-down provision to an applicant determined ineligible because of excess income.

P. The Department or its designee shall maintain a written or electronic record including documentation of all required elements of eligibility.

Q. The Department or its designee shall restrict disclosures of information concerning applicants and recipients to purposes directly connected with the administration of the Program, including:

(1) Establishing eligibility;

(2) Determining the extent of coverage under the Program;

(3) Providing services for recipients; and

(4) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Program.

R. The Department or its designee shall conduct a wage-screening inquiry to determine wages, benefits, and claimant history for each of the following applicants or recipients of Medical Assistance:

(1) Childless, adults older than 19 years old and younger than 65 years old;

(2) Parents and other Caretaker Relatives;

(3) Pregnant and postpartum women;

(4) Children younger than 21 years old; and

(5) Former Foster Care Children younger than 26 years old.

S. An applicant or recipient shall give consent to verify information needed to establish eligibility to the Department or its designee, by submitting a written, telephonic or electronic application.

.04-1 Specific Application Requirements for MAGI Exempt Coverage Groups.

A. All of the requirements of Regulation .04 of this chapter shall apply with the exceptions stated in this chapter.

B. Application Filing and Signature Requirements.

(1) An individual who wishes to apply for Medical Assistance shall submit a signed application to the Department or its designee in the jurisdiction where his residence is located.

(2) A deemed newborn is eligible for receiving Medical Assistance if at the time of birth the child's mother was covered in another state as a child under CHIP or under a 1115 waiver.

(3) An individual who has filed an application may voluntarily withdraw that application; but the withdrawal may not affect the requirements for the penalty period associated with the transfer of a resource specified under Regulation .08I of this chapter.

C. Period Under Consideration. Current eligibility shall have a period of consideration of a 6-month period beginning with the month of application for Medical Assistance, except as specified in Regulation .04H(3) of this chapter.

D. Processing Applications. When a written or electronic application is filed, a decision shall be made promptly but not later than:

(1) 45 days from the date of application in the case of determination of aged and blind individuals; or

(2) 60 days from the date of application in the case of determination of disability.

E. Extension of Time Standards.

(1) The time standards specified in Regulation .04I(1) of this chapter shall be extended to allow the applicant sufficient time to complete provision of information when the examining physician delays or fails to take a required action.

(2) Reactivation of an Application Following a Decision of Ineligibility for Reasons Other than Nonfinancial Factors, Excess Resources, or Excess Income.

(a) A request for current eligibility following the rejection of an application for reasons other than nonfinancial factors, excess resources, or excess income shall be considered a reactivation of the appropriate earlier application.

(b) The reactivation period shall:

(i) Apply to the earliest rejected application for which the period under consideration has not expired; and

(ii) Include the retroactive period associated with the current period.

(c) The applicant may establish eligibility for the current period, the retroactive period, or both, at any time during the reactivation period.

(3) Disposition of Application Following a Decision of Ineligibility. If an applicant is determined ineligible for the current period under consideration due to a nonfinancial factor or excess resources, the application shall be disposed of and the application date may not be retained. If the applicant reapplies, the process and the period under consideration shall be established under Regulation .04I(9) of this chapter.

F. Interview.

(1) A face-to-face interview may be conducted at the request of the applicant or the Department or its designee.

(2) If it is determined that a face-to-face interview is necessary, the interview may be conducted with an individual other than the applicant in the following situations:

(a) When the Department or its designee determines that the applicant cannot participate in the interview because of unusual circumstances such as severely incapacitating disabilities, the interview shall be conducted with an authorized representative or individual acting responsibly on behalf of the applicant; or

(b) When the applicant is an unmarried child younger than 18 years old and is not living with a parent or other caretaker relative, the interview shall be conducted with one or more of the following individuals who is 18 years old or older:

(i) The parent or other knowledgeable relative of the child;

(ii) The nonrelated individual with whom the child is living; or

(iii) Another designated responsible individual who is knowledgeable about the child's circumstances.

G. Required Application for Income Benefits.

(1) Eligibility may not be established until applicants, and recipients furnish proof that they have applied for and taken all other necessary steps to obtain and accept all income benefits to which there may be entitlement, except as specified in §N(3) of this regulation.

(2) Income benefits include, but are not limited to:

(a) Social Security;

(b) Unemployment Compensation;

(c) Railroad Retirement;

(d) Veterans' Administration;

(e) Civil Service annuities;

(f) Federal, state, or local government and private pensions; and

(g) Workers' Compensation.

(3) Applicants and recipients determined by the Department or its designee to be unable to perform the required activity because of the applicant's or recipient's physical or mental condition and for whom there is no other individuals to perform the activity are not required to apply for income benefits.

(4) Determination of initial eligibility may not be delayed pending the results of the application filed for income benefits.

(5) At the time of redetermination or reapplication, eligibility will be determined on the basis of the applicant's or recipient's documented reasonable and continuous efforts to establish entitlement to income benefits.

H. An applicant who is 65 years old or older, or blind or disabled, is not eligible until the applicant furnishes proof that the applicant has applied for or is receiving Part A Medicare. Eligibility determination may not be delayed pending the results of the application filed for Part A Medicare. Periodic reviews of eligibility are necessary for those blind or disabled individuals initially determined ineligible for Medicare because of the required waiting period.

I. Social Security Number.

(1) Eligibility may not be established until the applicant or recipient furnishes or applies for a Social Security number for each member of an assistance unit and any individual whose income and resources are considered in determining the financial eligibility of an assistance unit.

(2) An individual may not be added to an assistance unit until an application is completed for a Social Security number.

J. Retroactive Eligibility for Cash Assistance Applicants or Recipients. A Public Assistance applicant or recipient who desires Medical Assistance coverage for a past period shall apply for retroactive coverage. The date of application for retroactive coverage shall be established as follows:

(1) The Medical Assistance application date shall be the:

(a) Same as that of the Public Assistance application date if the Medical Assistance application is filed within 3 months of the date of the Public Assistance application; or

(b) Date the Medical Assistance application is filed if the filing date is more than 3 months after the date of the Public Assistance application.

(2) Retroactive eligibility shall be determined in accordance with the requirements of Regulation .10C of this chapter.

K. The Department or its designee shall conduct a wage-screening inquiry to determine wages, benefits, and claimant history for an Aged Blind Disabled applicants or recipients that:

(1) Resides in a long term care facility; or

(2) Is chronically ill and non-ambulatory.

L. An applicant shall sign consent forms as needed authorizing the Department or its designee to verify from sources such as an employer, banks, and public or private agencies, information needed to establish eligibility.

M. Obtaining Financial Records from Fiduciary Institutions Doing Business in the State as of October 1, 2017.

(1) The Department or its designee shall inform the applicant or authorized representative in a written or electronic document of the required information and verifications needed to determine financial eligibility for Medical Assistance and the time limit for submitting the required records.

(2) The applicant or authorized representative shall provide all of the required information and verifications needed to determine financial eligibility for Medical Assistance within the time period specified in the notice from the Department or its designee.

(3) The Department or its designee shall request financial records necessary to determine the applicant's eligibility for Medical Assistance on behalf of the applicant when:

(a) The applicant or authorized representative is actively attempting to obtain financial documentation to establish eligibility but has been unable to provide the required financial information through no fault of his own from a certain fiduciary institution conducting business in the State;

(b) The applicant or authorized representative provides documentation to show their efforts to obtain the information; and

(c) The applicant or authorized representative provides a signed consent form designated by the Department or its designee to obtain the records.

(4) If the conditions set forth in §M(3) of this regulation are not met, the applicant or authorized representative remains responsible to provide the information.

(5) Reimbursement Schedule. The Department or its designee shall reimburse a fiduciary institution for providing copies of financial records in accordance with the Banks and Banking regulations found in 12 CFR §219.3, including the Reimbursement Schedule at Appendix A.

.05 Nonfinancial Eligibility Requirements — Citizenship.

A. Eligibility. To be eligible for federal coverage of full Medical Assistance benefits, an individual shall be:

(1) A citizen of the United States, including:

(a) An individual who was born in:

(i) One of the 50 states;

(ii) The District of Columbia;

(iii) Puerto Rico;

(iv) Guam;

(v) The Northern Mariana Islands; or

(vi) The Virgin Islands;

(b) A child born outside of the United States if:

(i) The federal requirements, including the requirements in the Child Citizenship Act of 2000 (Public Law 106-395), are met for the child to automatically acquire United States citizenship upon the child's lawful admission to the United States for permanent residence;

(ii) At least one of the child's natural, adoptive, or stepparents is a United States citizen by birth or naturalization;

(iii) The child is younger than 18 years old;

(iv) The child is residing in the United States in the legal and physical custody of the citizen or naturalized parent; and

(v) The child is a lawful permanent resident of the United States;

(c) An individual who has been naturalized as a United States citizen; or

(d) A national from American Samoa or Swain's Island;

(2) A qualified alien, as specified in §C of this regulation, who is eligible in accordance with the requirements related to the 5-year bar specified at §D of this regulation;

(3) An honorably discharged veteran of the armed forces of the United States;

(4) An alien on active duty in the armed forces of the United States;

(5) The lawfully admitted spouse, including a surviving spouse who has not remarried, or lawfully admitted unmarried dependent child of an:

(a) Honorably discharged veteran of the armed forces of the United States; or

(b) Alien on active duty in the armed forces of the United States; or

(6) An alien who is:

(a) Eligible for and receiving Supplemental Security Income (SSI);

(b) A member of a state or federally recognized Indian tribe, as defined in 25 U.S.C. §450b(e); or

(c) An American Indian born in Canada to whom §289 of the Immigration and Nationality Act (INA) applies.

B. Veterans. Veterans of the following foreign armed forces are considered under this regulation to be veterans of the armed forces of the United States:

(1) Individuals who served in the Philippine Commonwealth Army during World War II or as Philippine scouts following World War II; and

(2) Hmong and other Highland Lao veterans who fought under United States' command during the Vietnam War and who were lawfully admitted to the United States for permanent residence.

C. Qualified Aliens. According to §431 of the Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 (PRWORA), qualified aliens admitted to the United States shall include:

(1) The following types of aliens, who may be subject to the 5-year bar specified at §D of this regulation, depending on their most recent date of entry and their date of qualified alien status:

(a) Aliens who were lawfully admitted to the United States for permanent residence or who since admission were granted lawful permanent resident status in accordance with the INA;

(b) Aliens granted parole for at least 1 year under §212(d)(5) of the INA; and

(c) A documented or undocumented immigrant who was battered or subjected to extreme cruelty by the individual's United States citizen or lawful permanent resident spouse or parent, or by a member of the spouse's or parent's family residing in the same household as the immigrant, if:

(i) The spouse or parent consented to, or acquiesced in, the battery or cruelty;

(ii) The abusive act or acts occurred in the United States;

(iii) The individual responsible for the battery or cruelty no longer lives in the same household as the victim;

(iv) A Violence Against Women Act immigration case or a family-based visa petition has been filed; and

(v) There is a substantial connection between the battery or cruelty and the need for Medical Assistance benefits; and

(2) The following types of aliens, who are not subject to the 5-year bar specified in §D of this regulation:

(a) Alien children and pregnant women who are lawfully residing in the United States, including legal permanent residents who have resided in the United States for less than 5 years as described under §214 of the Children's Health Insurance Program Authorization Act of 2009 (CHIPRA);

(b) Aliens who were lawfully admitted to the United States for permanent residence as Amerasian immigrants under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988;

(c) Refugees admitted under §207 of the INA;

(d) Aliens granted asylum under §208 of the INA;

(e) Aliens whose deportation is being withheld under:

(i) §243(h) of the INA as in effect prior to April 1, 1997; or

(ii) §241(b)(3) of the INA, as amended;

(f) Cuban or Haitian entrants, as defined at §501(e) of the Refugee Education Assistance Act of 1980;

(g) Aliens granted conditional entry under §203(a)(7) of the INA in effect before April 1, 1980;

(h) Children receiving federal payments for foster care or adoption assistance under Part B or E of Title IV of the Social Security Act, if the child's foster or adoptive parent is considered a citizen or qualified alien; and

(i) Victims of a severe form of trafficking, in accordance with §107(b)(1) of the Trafficking Victims Protection Act of 2000, who have been subjected to:

(i) Sex trafficking if the act is induced by force, fraud, or coercion, or the individual who was induced to perform the act was younger than 18 years old on the date that the visa application was filed; or

(ii) Involuntary servitude.

D. Five-Year Bar to Federal Medical Assistance for Qualified Aliens.

(1) Except for coverage of emergency medical services specified at Regulation .05-2 of this chapter, qualified aliens in the categories specified in §C(1) of this regulation who entered the United States on or after August 22, 1996, were not eligible for federally-funded Medical Assistance for 5 years from the date that the qualified alien:

(a) Entered the United States with the status of a qualified alien; or

(b) Obtained the status of a qualified alien, if the individual did not enter the United States as a qualified alien.

(2) The 5-year bar specified in §D(1) of this regulation shall also be applied to qualified aliens who entered the United States before August 22, 1996, but did not remain continuously present in the United States from the last date of entry before August 22, 1996 until the date of qualified alien status.

(3) An alien is not considered to be continuously present in the United States as specified in §D(2) of this regulation if, before the date of qualified alien status, the alien had:

(a) A single absence from the United States of more than 30 days; or

(b) Absences from the United States totaling more than 90 days.

(4) The 5-year bar to eligibility for federal Medical Assistance benefits, specified in §D(1) of this regulation, does not apply to:

(a) Qualified aliens in the categories specified at:

(i) §C(1) of this regulation, who are not subject to the 5-year bar in accordance with §D(1) or (2) of this regulation; or

(ii) §C(2) of this regulation;

(b) A qualified alien who is:

(i) An honorably discharged veteran of the armed forces of the United States;

(ii) On active duty in the armed forces of the United States; or

(iii) The lawfully admitted spouse, including a surviving spouse who has not remarried, or lawfully admitted unmarried dependent child of an honorably discharged veteran or individual on active duty in the armed forces of the United States; and

(c) Lawful permanent residents who:

(i) Entered the United States under another exempt category specified at §D(4)(a)—(b) of this regulation; and

(ii) Converted to lawful permanent resident status.

(5) Effective December 1, 2009, as authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the 5-year bar will no longer apply to Medical Assistance or Children's Health Insurance Program eligibility for pregnant women and children who are qualified aliens.

.05-1 Documentation of Citizenship and Identity.

A. An applicant or recipient shall be required as a condition of eligibility to provide documentary evidence of identity as well as citizenship or nationality, to the Department's satisfaction, based on federal requirements, if the individual is:

(1) Declared to be a citizen or national of the United States; and

(2) Being determined for:

(a) Initial eligibility based on an application filed on or after September 1, 2006; or

(b) Continuing eligibility based on a redetermination with an end date on or after September 30, 2006.

B. The requirements of this regulation shall be met for all Medical Assistance coverage groups except for:

(1) Supplemental Security Income beneficiaries;

(2) Newborns who are deemed eligible, for a period of 1 year, for Medical Assistance based on the mother's Medical Assistance eligibility for the newborn's date of birth;

(3) Newborns deemed eligible who are born to an otherwise eligible non-qualified alien woman meeting the requirements of Regulation .05-2 of this chapter who has filed an application and has been determined eligible for Medical Assistance for the newborn's date of birth;

(4) Individuals who are entitled to Medicare benefits or enrolled in any part of Medicare;

(5) Individuals receiving SSDI disability insurance benefits under §223 of the Social Security Act, or monthly benefits under §202 of the Act, based on the individual's disability;

(6) Children who are receiving foster care or adoption assistance under Title IV-B or Title IV-E of the Social Security Act; and

(7) Other categories of individuals who are considered by the federal government to have previously presented satisfactory documentary evidence of identity as well as citizenship or nationality.

C. An applicant may not be determined eligible for Medical Assistance until the requirements of this regulation are met.

D. An applicant may be determined eligible for Medical Assistance for a period of 90 days to provide requested documents. When an applicant fails to provide documentation of citizenship within the 90 day period, the applicant shall be determined ineligible.

E. Continuing eligibility for a recipient may not be approved at redetermination until the requirements of this regulation are met.

F. If an applicant or recipient fails to meet the requirements of this regulation within the time standards specified at Regulation .04I(1) of this chapter, and the time standards are not extended in accordance with Regulation .04I(4) of this chapter, the Department shall:

(1) Deny eligibility for an applicant; or

(2) Terminate eligibility for a recipient, in accordance with the requirements for timely notice in COMAR 10.01.04.

G. The reactivation requirements in Regulation .04I(8) of this chapter shall apply to applicants and recipients deemed MAGI exempt. The documentation requirements of this regulation are subsequently met within the current period under consideration for the:

(1) Applicant's denied application; or

(2) Recipient's terminated period of continuing eligibility.

H. If there is documentation in an applicant's or recipient's written or electronic record or a state or federal data system that demonstrates that the individual meets the requirements of this regulation, the individual shall be considered to meet the requirements of this regulation, unless the:

(1) Department or its designee has cause to question the documentation previously accepted; or

(2) Federal government requires additional documentation.

.05-2 Nonfinancial Eligibility Requirements — Emergency Medical Services for Ineligible or Illegal Aliens.

A. An alien shall be eligible for federal Medical Assistance coverage of emergency medical services, as specified under §§B and C of this regulation, if the alien is determined by the Department to:

(1) Have received emergency medical services described under §§B and C of this regulation that are necessary for treatment of an emergency medical condition; and

(2) Meet all other requirements of Medical Assistance eligibility as specified in this chapter, including Maryland residency and financial eligibility, except the requirements related to:

(a) Social Security number; and

(b) Alien eligibility and declaration of immigration status.

B. Emergency medical services, including labor and delivery services, are for the treatment of an emergency medical condition that, after a sudden onset, manifests itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention can reasonably be expected to result in:

(1) Placing the individual's health in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

C. Emergency medical services extend from when the individual enters a hospital to receive the emergency medical services until the individual's emergency medical condition or other medical condition requiring the emergency medical services is stabilized, as determined by the Department.

D. Emergency medical services do not include:

(1) An organ transplant and all services related to an organ transplant; or

(2) Routine prenatal or postpartum care.

.05-3 Nonfinancial Eligibility Requirements — Residency.

A. To be eligible for the Maryland Medical Assistance Program, an applicant or recipient shall be a Maryland resident.

B. An individual is a Maryland resident if the individual resides in Maryland with the intent of remaining permanently or for an indefinite period, regardless of whether the individual maintains the residence permanently or at a fixed address.

C. Residency in a state begins on the day that an individual:

(1) Enters the state with the intent to remain permanently or for an indefinite period; or

(2) Decides to remain in the state permanently or for an indefinite period after entering for another purpose.

D. An individual is not a resident of a state if the individual:

(1) Is temporarily residing in or visiting the state without the intent of remaining, except as specified under §I(2)(b)(ii) or §I(3) of this regulation;

(2) Came into the state for a specific, time-limited purpose and does not intend to remain, except as specified under §I(2)(b)(ii) or §I(3) of this regulation; or

(3) Entered the state voluntarily to obtain noninstitutional medical care, such as for acute hospital inpatient services.

E. Residency in a state established on any day in a calendar month shall constitute residency for the full month.

F. Retaining Residency.

(1) Residency is retained until abandoned.

(2) Temporary absence from a state, with the intent to return to the state when the purpose of the absence is accomplished, does not interrupt continuity of residency, unless another state's Medical Assistance program determines that the individual is a resident of the other state.

(3) An individual who is routinely absent from a state for a protracted period of time retains residency in that state if the individual:

(a) Declares the intent to remain a resident of the state;

(b) Has an established residential address in the state; and

(c) Is not certified for Medical Assistance or receiving public assistance in another state.

(4) Residency in a state is not affected by an absence for:

(a) Unanticipated medical care; or

(b) Out-of-state medical treatment preauthorized by the state's Medical Assistance Program.

G. An individual is ineligible for a state's Medical Assistance Program for any month in which the individual is not a resident of the state.

H. State Supplementary Payment for a Recipient of Supplemental Security Income (SSI).

(1) Notwithstanding any other provisions of this regulation, the state of residence for a recipient of a state supplementary SSI payment is the state making the supplementary payment.

(2) An individual receiving a state supplementary payment from another state who moves to Maryland with the intent of remaining in Maryland is not eligible for Maryland Medical Assistance until:

(a) The individual's change of state residence is verified; and

(b) Changes, if any, in the individual's payment amount are made with the Social Security Administration.

I. Additional Residency Criteria for Noninstitutionalized Individuals.

(1) Noninstitutionalized Child.

(a) Except as otherwise specified in this regulation, a noninstitutionalized, unmarried individual younger than 21 years old is considered a resident of the state where the child lives:

(i) With the child's parent or other caretaker relative; or

(ii) In another living arrangement if the child is not living with the child's parent or other caretaker relative, and the child's parent or other caretaker relative is not responsible for the child's day-to-day care and supervision.

(b) For a child receiving federal payments for foster care or adoption assistance under Title IV-E of the Social Security Act, the child's state of residence is the state where the child lives, even if it is not the state making the payments.

(c) If a noninstitutionalized child's Medical Assistance eligibility is determined based on blindness or disability, the child's state of residence is the state where the child lives.

(2) Noninstitutionalized Adult. A noninstitutionalized adult, including an individual younger than 21 years old who is married or otherwise emancipated from the individual's parents, is considered a resident of the state where the individual lives:

(a) Voluntarily with the intent to remain permanently or for an indefinite period; or

(b) At the time of Medical Assistance application, if the individual is:

(i) Determined as incapable of indicating intent, in accordance with §K of this regulation; or

(ii) Not receiving assistance from another state and entered the state with a job commitment or seeking employment, whether or not the individual is currently employed.

(3) The exclusion of Medical Assistance eligibility under §D of this regulation for individuals who temporarily reside in the state without the intent of remaining shall be waived for members of an assistance unit that includes a migrant worker, in MAGI Exempt coverage groups.

(4) Notwithstanding any other provision of this regulation, the state of residence for an individual placed by a state government in another state is the state that arranges or makes the placement for medical or other publicly funded services.

J. Additional Residency Criteria for Institutionalized Individuals.

(1) For an institutionalized adult, including an individual younger than 21 years old who is married or otherwise emancipated from the individual's parents, the state of residence is the state where the individual is institutionalized, if the individual indicates the intent to remain in the long-term care facility indefinitely.

(2) If an institutionalized adult became incapable of indicating intent when the individual was 21 years old or older, the individual's state of residence is the state where the individual is institutionalized.

(3) An institutionalized child younger than 21 years old, or an institutionalized adult who became incapable of indicating intent when younger than 21 years old, is a resident of the state in which the:

(a) Individual's parent or other legal guardian resided at the time of the individual's placement in the long-term care facility;

(b) Individual's parent or other legal guardian currently resides, who applied for Medical Assistance on the individual's behalf; or

(c) Individual is institutionalized if the individual was abandoned by the individual's parents and does not yet have a legal guardian.

(4) Notwithstanding any other provision of this regulation, the state of residence for an individual institutionalized by a state government in an out-of-state facility is the state that arranges or makes the placement.

(5) The Department may not deny Medical Assistance eligibility to an institutionalized individual who satisfies the residency requirements of this regulation, on the grounds that the individual did not establish Maryland residency before entering the long-term care facility.

K. An adult is considered incapable of indicating intent if the individual:

(1) Has an Intelligence Quotient of 49 or less, or a mental age of 7 years old or younger, based on tests acceptable to the Department's Developmental Disabilities Administration;

(2) Is judged legally incompetent; or

(3) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of intellectual disabilities.

.05-4 Nonfinancial Criteria for MAGI Exempt Coverage Groups.

A. Blindness.

(1) To be eligible for Medical Assistance as a blind individual, an applicant or a recipient shall be blind as defined at Regulation .02 of this chapter.

(2) Procedure for Determination of Blindness.

(a) If an applicant's or recipient's eligibility for Medical Assistance is determined on the basis of blindness, an ophthalmologist or a licensed optometrist shall examine the individual, unless:

(i) Both of the individual's eyes are missing; or

(ii) The Social Security Administration has determined that the individual is currently blind.

(b) The ophthalmologist or licensed optometrist shall submit a report of the examination to the local department of social services or other entity designated by the Department.

(c) An ophthalmologist, contracted by the Department or its designee, shall review the report and determine, on behalf of the local department of social services or other entity designated by the Department:

(i) Whether the individual meets the definition of blindness; and

(ii) The need and frequency of reexamination for periodic redetermination of blindness.

(3) Reexaminations for periodic redeterminations of blindness shall be conducted according to the procedures described under §B(2) of this regulation.

(4) The local department of social services or other entity designated by the Department shall accept the Social Security Administration's determination of blindness for an individual receiving a Social Security benefit based on blindness.

B. Disability.

(1) In order to be eligible for Medical Assistance as a disabled individual, an applicant or recipient shall meet the definition of disabled in Regulation .02B of this chapter.

(2) Procedure for Determination of Disability.

(a) The Family Investment Administration shall determine disability.

(b) The local department of social services shall obtain a medical report and other nonmedical evidence for an individual applying for Medical Assistance on the basis of disability. The medical report and nonmedical evidence shall include a diagnosis and other information in accordance with the requirements for evidence applicable to disability determinations under the Supplemental Security Income Program (SSI), specified under 20 CFR Part 416, Subpart I.

(c) A Family Investment Administration review team shall review the medical report and other evidence obtained under §B(2)(b) of this regulation and determine whether the individual's condition meets the definition of disability. The review team shall be composed of a medical or psychological consultant, and another individual who is qualified to interpret and evaluate medical reports and other evidence relating to the individual's physical or mental impairments and, as necessary, to determine the capacities of the individual to perform substantial gainful activity as specified in 20 CFR Part 416, Subpart J.

(3) Disability Determination Made by the Social Security Administration.

(a) The Family Investment Administration may not make an independent determination of disability if the Social Security Administration has made a disability determination within 90 days of the date of the Medical Assistance application on the same issues presented in the Medical Assistance application.

(b) A determination by the Social Security Administration is binding on the Family Investment Administration until it is changed by the Social Security Administration. If the Social Security Administration determination is changed, the new determination is binding on the Family Investment Administration.

(c) The Department or its designee shall refer to the Social Security Administration for reconsideration or reopening of the determination all applicants who allege new information or evidence affecting previous Social Security Administration determinations of ineligibility based on disability, except as specified in §B(4)(d)(i) of this regulation.

(4) Disability Determination made by the Family Investment Administration. The Family Investment Administration shall make a determination of disability if any of the following circumstances exists:

(a) The individual applies for Medical Assistance and has not applied for SSI benefits;

(b) The individual applied for SSI benefits and was found ineligible for a reason other than disability;

(c) The individual has applied for both Medical Assistance and SSI benefits, and the Social Security Administration has not made an SSI determination within 90 days from the date of the individual's application for Medical Assistance;

(d) The individual has applied for Medical Assistance and:

(i) Alleges a disabling condition different from, or in addition to, that considered by the Social Security Administration in making its determinations;

(ii) Alleges more than 12 months after the most recent determination by the Social Security Administration denying disability that the individual's condition has changed or deteriorated since that determination and alleges a new period of disability that meets the durational requirements for disability, and has not applied to the Social Security Administration for a determination with respect to those allegations;

(iii) Alleges less than 12 months after the most recent determination by the Social Security Administration denying disability that the individual's condition has changed or deteriorated and alleges a new period of disability that meets the durational requirements for disability, and has applied to the Social Security Administration for reconsideration or reopening of its disability decision but the Social Security Administration has refused to consider the new allegations; or

(iv) Alleges less than 12 months after the most recent determination by the Social Security Administration denying disability that the individual's condition has changed or deteriorated, alleges a new period of disability that meets the durational requirements for disability, and no longer meets the nondisability requirements for SSI, but may meet the State's nondisability requirements for Medical Assistance eligibility.

.05-5 Nonfinancial Eligibility Requirements — Institutions.

A. Inmate of a Public Institution.

(1) To be eligible for Medical Assistance, an applicant or recipient may not be incarcerated as an inmate of a public institution.

(2) Inmate Status.

(a) An individual is considered incarcerated as an inmate of a public institution if the individual resides in a public institution involuntarily as a result of being accused or found guilty of a criminal offense, including the duration of time in which the individual is involuntarily residing in the public institution in a preadjudication or pretrial status awaiting criminal proceedings, penal dispositioning, or other involuntary detainment procedure.

(b) An individual may not be considered an inmate of a public institution if the individual resides in a public:

(i) Institution voluntarily and not as the result of a legal criminal process;

(ii) Educational or vocational training institution for the purpose of receiving educational or vocational training; or

(iii) Institution for the first partial month of residence or for a temporary period pending other arrangements appropriate to the individual's needs.

(c) Hospitalization as a Result of the Commission of a Crime. An individual who is hospitalized as a result of an injury sustained during the commission of a crime and has not yet been incarcerated because of the hospitalization may not be considered an inmate of a public institution.

(d) Retaining Inmate Status. Except as provided in §A(2)(f) of this regulation, an individual's inmate status continues until the criminal indictment against the individual is dismissed or the individual is released from the public institution.

(e) An individual who is not present at the correctional facility during the day, because the individual is attending a day treatment program or participating in day-time employment, but who resides in a correctional facility at night, shall be considered an inmate of a public institution.

(f) Inmate Admitted to Medical Institution. An inmate may be covered by Medical Assistance during the period when the inmate is admitted as an inpatient of a medical institution, such as a hospital, nursing facility, or juvenile psychiatric facility, and is receiving services covered by Medical Assistance.

(g) Individual Sent to an Institution for Mental Disease (IMD).

(i) Inmate status shall apply to an individual who is accused of a criminal offense and is sent directly to an IMD either for a mental examination or because the individual is determined mentally incompetent to stand trial.

(ii) An individual committed by a court to an IMD based on a verdict of not guilty by reason of insanity may not be considered an inmate of a public institution.

(3) Children Younger than 21 Years Old Committed to a Correctional Facility.

(a) A child committed by a court to a correctional institution due to a violation of the law shall be considered incarcerated as an inmate of a public institution.

(b) A child committed to the custody of the Maryland Department of Juvenile Services shall be considered incarcerated as an inmate of a public institution if the child is placed in a State-owned and State-operated facility, and that status shall continue until the child is released from the facility.

(c) A child committed to the custody of the Maryland Department of Juvenile Services may not be considered an inmate of a public institution if the child is living:

(i) With the child's parent, caretaker relative, or legal guardian;

(ii) In a group home serving no more than 16 residents; or

(iii) In a privately operated facility under the jurisdiction of the Maryland Department of Juvenile Services.

B. Institution for Mental Disease (IMD).

(1) An institutionalized individual younger than 65 years old who is admitted for residence in an institution for mental disease is not eligible for Medical Assistance, unless the applicant or recipient is:

(a) Younger than 22 years old; and

(b) Receiving inpatient psychiatric services for individuals younger than 21 years old.

(2) Inpatient psychiatric services for individuals younger than 21 years old may be provided:

(a) To individuals who are younger than 21 years old; or

(b) Until the earlier of the date that the individual:

(i) No longer requires the services; or

(ii) Is 22 years old, if the individual was receiving the services immediately before reaching 21 years old.

(3) Except as provided in §B(4) of this regulation, when an individual is on conditional release or convalescent leave from an IMD, the individual may not be considered institutionalized in the IMD.

(4) An individual who is receiving inpatient psychiatric services for individuals younger than 21 years old shall be considered an institutionalized individual until the earlier of the date that the individual:

(a) Is unconditionally released from the IMD; or

(b) Is 22 years old.

.06 MAGI Exempt Assistance Unit.

A. Purpose and Scope. This regulation establishes who shall be a member of an assistance unit, who may be excluded from an assistance unit, who will have separate eligibility determinations, and whose income and resources will be considered in determining financial eligibility for MAGI Exempt applicants and recipients of Medical Assistance.

A-1. More Than One Assistance Unit Among Individuals Living Together. More than one assistance unit is permissible if:

(1) The parent or other caretaker relative chooses to have a child's eligibility determined as blind or disabled under Regulation .04J of this chapter;

(2) A caretaker relative chooses to have his eligibility determined as aged, blind, or disabled under Regulation .04J of this chapter; and

(3) There are individuals who would have been members of the assistance unit except for their status as automatically eligible Medical Assistance recipients under Regulation .03B of this chapter.

A-2. Separate Eligibility Determinations for Certain Individuals.

(1) An individual eligibility determination shall be conducted for each individual identified in §A-1(1) of this regulation who requests Medical Assistance.

(2) For the aged, blind, or disabled individual identified in §A-1(2) of this regulation:

(a) If the person chooses to have eligibility determined as aged, blind, or disabled and either the person's spouse is non-aged, blind, or disabled or the aged, blind, or disabled spouse chooses to have eligibility determined as a caretaker relative, an individual eligibility determination shall be conducted; or

(b) If the person applies as aged, blind, or disabled and the person's spouse also applies as aged, blind, or disabled, the couple will be considered one unit.

B. Aged, Blind, or Disabled.

(1) This section is applicable to the following:

(a) An aged, blind, or disabled person 21 years old or older who has no unmarried related children younger than 21 years old living with him;

(b) An aged, blind, or disabled person and spouse, with no unmarried related children younger than 21 years old living with the couple;

(c) A blind or disabled child younger than 21 years old who chooses to have his eligibility determined as blind or disabled; and

(d) An aged, blind, or disabled caretaker relative who chooses to have his eligibility determined as aged, blind, or disabled.

(2) Composition—Aged, Blind, or Disabled.

(a) The assistance unit shall include the following persons, except as provided in §B(2)(b)—(c) of this regulation:

(i) The aged, blind, or disabled person; and

(ii) The aged, blind, or disabled spouse of the aged, blind, or disabled person, when living together.

(b) An aged, blind, or disabled caretaker relative who chooses to apply as caretaker relative will not be included in the unit.

(c) A non-aged, blind, or disabled parent or caretaker relative other than parent will not be included in the unit.

(3) Income and Resource Consideration.

(a) In determining financial eligibility, the income and resources of the following persons shall be considered:

(i) All persons included in the assistance unit;

(ii) The spouse of the applicant, when living together, unless the spouse is an SSI recipient; and

(iii) The parent of a blind or disabled child younger than 18 years old, when living together, unless the parent is an SSI recipient.

(b) Treatment of Income and Resources of Persons Not Living Together.

(i) When spouses cease to live together, their income and resources shall be considered available to each other throughout the month in which they cease living together. Beginning with the first full month of separate residence, only actually contributed income and resources from the spouse shall be counted.

(ii) When a blind or disabled child younger than 18 years old ceases to live with his parent, the income and resources of the parent shall be considered available throughout the month in which they cease living together. Beginning with the first full month of separate residence, only actually contributed income and resources from the parents shall be counted.

C. Blind and Disabled Children Living With Parents or Other Caretaker Relatives.

(1) This section applies to blind or disabled children living with a caretaker relative who chooses to have the child's eligibility determined as an individual younger than 21 years old and an aged, blind, or disabled individual who chooses to have his eligibility determined as a caretaker relative.

(2) Persons Living Together. The unit shall be established on the basis of persons living together, including persons who are temporarily absent from the home for purposes of attending school, or pursuing vocational or job training.

(3) Composition — Children Living With Parents or Other Caretaker Relatives. The assistance unit shall include, except as provided in §§A-1 and C(4) of this regulation, the parents, caretaker relatives other than parents, their unmarried children younger than 21 years old, and any other unmarried children younger than 21 years old (including second generation children who are parented by an unmarried person younger than 21 years old) who are related by blood, marriage, or adoption to the parent or caretaker relative other than parent. The relationship between children and caretaker relatives other than parents shall be limited to those specified in Regulation .02B(10)(a) of this chapter.

(4) Exclusion of a Child or Caretaker Relative Other Than Parent.

(a) The provisions of §C(3) of this regulation may not apply when:

(i) A parent or caretaker relative other than a parent chooses to exclude a child from the assistance unit provided at least one child is in the unit and the exclusion does not cause the applicant or recipient to lose Medical Assistance (Title XIX) status as a caretaker relative as defined in Regulation .02B(10)(a) of this chapter.

(ii) A caretaker relative other than a parent chooses to be excluded from the assistance unit. The choice of exclusion includes the caretaker relative's spouse.

(b) An excluded aged, blind, or disabled person retains the option of selecting any federal category in which technical eligibility may be established upon subsequent application.

(c) An excluded non-aged, blind, or disabled person may not have a separate eligibility determination.

(5) Subsequent Application for an Excluded Person.

(a) A person excluded from the assistance unit may apply for Medical Assistance.

(b) If an excluded person applies as aged, blind, or disabled, the following conditions apply:

(i) A separate eligibility determination will be made in accordance with §A-1 of this regulation; and

(ii) Income and resources of a spouse or parent will be considered in accordance with §B(3) of this regulation.

(c) If an excluded person does not apply as aged, blind, or disabled, the following conditions apply:

(i) The period under consideration will be the same as that of the currently eligible assistance unit;

(ii) Eligibility for the new member shall be determined in conjunction with the currently eligible assistance unit established in §C(3) of this regulation;

(iii) The income and resources of the new member shall be added to that of the currently eligible assistance unit beginning with the month for which coverage of the new member is requested;

(iv) The income of the new member may not be averaged to include any months before the month for which coverage is requested;

(v) Certification may not begin earlier than the date the new member becomes eligible; and

(vi) A decision of ineligibility for the new member will not affect the eligibility status of the currently eligible assistance unit for the remainder of the certification period.

(6) Income and Resource Consideration.

(a) In determining financial eligibility, the income and resources of the following persons shall be considered:

(i) All persons included in the assistance unit;

(ii) The spouse of the applicant, when living together, unless the spouse is an SSI recipient; and

(iii) The parent of a child younger than 21 years old, when living together, unless the parent is an SSI recipient.

(b) Treatment of Income and Resources When a Child Leaves the Home. The income and resources of a parent shall be considered throughout the month in which a child leaves the home for the purpose of establishing a new address, when the separation is for reasons other than placement in a foster home, group home, or drug or alcohol abuse treatment center. Beginning with the first full month of separate residence, only actually contributed income and resources from the parent shall be counted.

D. Additions to the Household. A new member of the household will be considered in accordance with all applicable regulations of this chapter.

10.09.24.06-1

.06-1 MAGI Household Unit.

A. Purpose and Scope.

(1) This regulation establishes who shall be a member of the MAGI household and who will be excluded from the MAGI household.

(2) The regulation applies to applicants and recipients of coverage groups described under Regulation .03A of this chapter.

B. Household Composition.

(1) An individual, plus anyone for whom the individual claims a personal exemption, shall be included in the federal tax filing unit in the taxable year in which an initial determination or renewal of eligibility is being made.

(2) For an individual who does not file a federal tax return and is not claimed as a federal tax dependent in the taxable year in which an initial determination or renewal of eligibility is being made, the household size shall consist of the individual and the following individuals:

(a) Spouse; and

(b) Natural, adopted or step children.

(3) For a child applicant the household size shall consist of the child and the following individuals:

(a) Natural, adopted, or step parents; and

(b) Natural, adopted, or step siblings.

(4) In the case of a married couple living together, each spouse shall be included in the household of the other spouse, regardless of whether they expect to file a joint federal tax return.

(5) In the case of determining the household size of a pregnant woman, the pregnant woman shall be counted as herself plus the number of children she is expected to deliver.

.07 Consideration of Income.

A. This regulation contains the rules for considering earned and unearned income of:

(1) Members of the MAGI household unit and those individuals whose income is considered pursuant to Regulation .06-1 of this chapter in determining financial eligibility of individuals for retroactive and current eligibility for the period under consideration; or

(2) Members of the MAGI exempt assistance unit and those individuals whose income and resources are considered pursuant to Regulation .06 of this chapter in determining financial eligibility of an assistance unit for retroactive and current eligibility for the period under consideration.

B. Definitions.

(1) "Disregard" means the amount of money specified by regulation that can be subtracted from countable income.

(2) "Excludable income" means income which is exempt from consideration as countable income.

(3) "Income tax" means federal, state, or local taxes either paid or withheld from income of a self-employed person not to exceed the tax table amount for the number of known dependents.

(4) "Modified Adjusted Gross Income (MAGI) based income" means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in 42 CFR 435.603 , with the following exceptions:

(a) An amount received as a lump sum is counted as income only in the month received;

(b) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income; and

(c) American Indian or Alaska Native exceptions in accordance with 42 CFR 435.603.

C. The applicant shall report all income. When there is evidence of regular expenditures which are inconsistent with reported income, the applicant shall be required to offer an explanation and appropriate verification to reconcile the inconsistency.

D. The Department or its designee shall consider all income in accordance with this regulation.

E. Retroactive Eligibility. The income to be considered is that which was actually available during the retroactive period under consideration.

F. Current Eligibility. In considering income for current eligibility, the following rules apply:

(1) When an individual has regular income in the MAGI coverage group, the amount to be considered is that which is available or can reasonably be expected to be available for a projected period of 12 months, including the month of application;

(2) When an individual has a regular income in the MAGI Exempt coverage group, the amount to be considered is that which is available, or can reasonably be expected to be available, for a projected period of 6 months including the month of application;

(3) When a member of a MAGI exempt assistance unit works for less than 12 months but receives an annual salary, is self-employed, or has irregular or seasonal earning, the amount to be considered is one-half the expected annual income based on the prior year's gross income;

(4) For a deceased individual, the income to be considered is that which was available up to and including the month of death. When there are other individuals in the assistance unit or MAGI household unit, the deceased individual's income will be averaged over the unit's established period under consideration.

G. Treatment of Income.

(1) All earned and unearned income which is not designated as excludable income pursuant to §J of this regulation shall be counted to establish countable gross income.

(2) Countable gross income for MAGI Exempt coverage groups shall be reduced by subtracting appropriate income disregards as specified in §K of this regulation to determine countable net income.

(3) Countable gross income for MAGI coverage groups shall be the household income calculated according to MAGI.

(4) MAGI income limits shall be:

(a) Converted from traditional income limits to account for elimination of income disregards; and

(b) Increased by 5 percentage points of the federal poverty level for the following circumstances:

(i) When an individual's income exceeds the Medicaid income standard; and

(ii) The income standard is the highest income standard under which the individual can be determined eligible.

H. Earned income includes the following:

(1) Wages.

(2) Commissions and fees.

(3) Salaries and tips.

(4) The value of in-kind goods and services received as a result of employment.

(5) Profit from self-employment income of MAGI exempt coverage groups, as described in §K(3)(a)of this regulation.

(6) Remuneration received for work or for activities performed as a participant in a program conducted by a sheltered workshop or activities center.

(7) The Earned Income Tax Credit (EITC) a person receives through the Tax Reduction Act of 1973.

(8) Sick pay which counts as earnings for deduction purposes under Title II of the Social Security Act.

(9) Work study earnings.

I. Unearned income includes the following:

(1) Benefits and income from:

(a) Social Security;

(b) Veterans Administration;

(c) Workmen's Compensation Board;

(d) Black Lung Program;

(e) Railroad Retirement Board;

(f) Government, private, or company pensions and annuities;

(g) Unemployment benefit plans;

(h) Unemployment supplemental benefit plans;

(i) Payments from oil or mineral rights (leases);

(j) Government payments on land;

(k) Insurance benefits paid directly to a person;

(l) Trust funds;

(m) Individual Retirement Accounts (IRA's);

(n) Keogh Plans;

(o) Military allotments.

(2) Alimony, court-ordered and voluntary support payments received from an absent spouse, or an absent natural or adoptive parent.

(3) Financial contributions received from persons or public or private agencies.

(4) In-kind Support—Aged, Blind, or Disabled.

(a) One-third the appropriate medically needy income level for the number of persons in an aged, blind, or disabled assistance unit, when:

(i) A person receives in-kind support in the form of food and shelter while living in the household of another, and

(ii) The person pays less than his pro rata share of the total household expenses for food and shelter, unless he documents otherwise.

(b) The value of actual payments for food, shelter, or both made by other persons on behalf of the assistance unit.

(c) The fair market value of free shelter received while living in an independent dwelling unit. When the person fails to present evidence of the fair market value of the dwelling unit, the presumed value shall be 1/3 the appropriate medically needy income level for the number of persons in the assistance unit.

(d) This provision may not apply to persons residing in public or private institutions, foster homes, group homes, or commercial establishments.

(5) Interest, dividends, royalties, or other income accrued to stocks, bonds, insurance, and savings certificates if the income is available to the person on a regular basis.

(6) Interest or dividends accrued to savings accounts.

(7) Mortgage payments.

(8) Lump sum benefits or other amounts of income received on a one-time-only basis including gifts, inheritances, retroactive benefit payments, lottery winnings, damage claims unless specifically excluded by other regulations, or any other lump sums or portions of them that are not excluded under §J or K of this regulation.

(9) Profit from Rental Income as described in §§L(3)(b) and M(2)(c)(ii) of this regulation.

(10) Cash assistance received from nongovernmental social agencies unless excluded under the provisions of §J or §K of this regulation.

(11) Grants, loans, scholarships, and fellowships for educational purposes, except as specified in §J(3) and (9) of this regulation.

(12) Cash assistance, including Public Assistance grants and SSI benefits, except as specified in Regulation .06B(3)(a)(ii) and .06C(4)(a)(ii) of this chapter.

(13) Sick pay which does not count as earnings for deduction purposes under Title II of the Social Security Act.

J. Excludable Income—Aged, Blind, or Disabled. Income from the following sources shall be excluded in determining countable gross income:

(1) The value of the coupon allotment under the Food Stamp Program.

(2) Payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, 42 U.S.C. §4601 et seq., excluding compensation received for the fair market value of the acquired real property.

(3) Grants or loans to an undergraduate student for educational purposes made or insured under any program administered by the Secretary, U.S. Department of Education.

(4) Work-study earnings, work-study stipends, and reimbursement for out-of-pocket expenses of a student.

(5) Benefits received under Title III C Nutrition Program for the Elderly of the Older Americans Act of 1965, as amended.

(6) Stipends, compensation, or expenses received by volunteers from a program existing or to be set up under the "Domestic Volunteer Service Act of 1973" sponsored by ACTION, such as but not limited to:

(a) (PLS) Demonstration Project Program for Local Services;

(b) VISTA (Volunteers in Service to America);

(c) UYA (University Year for Action);

(d) RSVP (Retired Senior Volunteer Program);

(e) Foster Grandparents;

(f) Older American Community Service Program;

(g) SCORE (Service Corps of Retired Executives); and

(h) ACE (Action Corps of Executives).

(7) The value of supplemental 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.

(8) The value of livestock and home produce used for own consumption.

(9) Educational Expenses.

(a) The portion of educational grants, loans, scholarships, and fellowships that is designated and used solely for undergraduate and graduate educational pursuits such as tuitions, books, mandatory fees, transportation to and from educational institutions, and the cost of child care while in attendance.

(b) These expenses may be allowed to the extent that there are insufficient funds from those grants and loans specified under §J(3) of this regulation to cover these expenses.

(10) The earned income of a blind or disabled child who is younger than 22 years old and regularly attending school, including a college, university, or vocational training school, not to exceed $1,620 a calendar year.

(11) Payments received from providing foster care or subsidized adoption services to a child placed in the home by a public or private nonprofit child placement or child care agency.

(12) Assistance provided in cash or in-kind under the Emergency Energy Conservation Services Program, including plans for crisis intervention to prevent fuel cut-offs and assistance provided under the Low-Income Home Energy Assistance Act.

(13) The value of rent subsidies or other assistance received by a person for his dwelling unit under:

(a) The U.S. Housing Act of 1937, 42 U.S.C. §§1400 et seq.;

(b) The National Housing Act, 12 U.S.C. §§1701 et seq.;

(c) Section 101 of the Housing and Urban Development Act of 1965, 42 U.S.C. §§1400 et seq.;

(d) Title V of the Housing Act of 1949, 12 U.S.C. §§1601 et seq.; 42 U.S.C. §§1400 et seq.

(14) Infrequent or Irregular Earned Income. Infrequent or irregular earned income shall be excluded if:

(a) The total gross amount does not exceed $30 per quarter; and

(b) It is received less frequently than twice per quarter or cannot be reasonably anticipated.

(15) Infrequent or Irregular Unearned Income. Infrequent or irregular unearned income shall be excluded if:

(a) The total amount does not exceed $200 per 6 months; and

(b) It is received less frequently than twice per quarter or cannot be reasonably anticipated.

(16) The value of earned and unearned in-kind income.

(17) Third-party payments for food, clothing, shelter, or other goods and services made on behalf of an assistance unit or other persons whose income and resources are considered in determining eligibility, if the payment is not reimbursement for services

rendered by a member of the assistance unit or other persons whose income and resources are considered.

(18) The Earned Income Tax Credit (EITC) a person receives through the Tax Reduction Act of 1973.

(19) Reparation payments made by the Federal Republic of Germany.

(20) For recipients of a VA pension who have neither spouse nor child, the VA payment not to exceed $90 per month beginning the month after the month of admission to a long-term care facility.

(21) Cash, including interest earned on the cash, or in-kind replacement received from any source for purposes of repairing or replacing an excluded resource that is lost, damaged, or stolen is not income but continues to be considered as an excluded resource in accordance with the provisions of Regulation .08G(7) of this chapter.

(22) Assistance, including any interest earned on the 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 not income but an excluded resource.

(23) Support and Maintenance (In-Kind Income) Provided as Replacement for an Excluded Home Because of a Casualty Loss or a Presidentially Declared Major Disaster.

(a) When an excluded home is damaged or destroyed and temporary housing is furnished to a person who owned an excluded home, the in-kind support and maintenance is not counted as income. This temporary housing is intended to replace the home pending repair or replacement of the excluded home.

(b) When an excluded home is damaged or destroyed as a result of a presidentially declared major disaster, the value of support and maintenance (in cash or in-kind) received by a person, or couple, is excluded, if:

(i) The person, or couple, was residing in the household as a home when a catastrophe occurred in the area in which the home was located;

(ii) The catastrophe was declared by the President to be a major disaster for purposes of the Disaster Relief Act of 1974;

(iii) The person, or couple, stopped living in the home because of the catastrophe and, within 30 days after the catastrophe, began to receive the support and maintenance; and

(iv) The person, or couple, received the support and maintenance while living in a residential facility, including a private home, maintained by another person.

(24) Any amount refunded from any public agency, if paid on the purchase of food or the satisfaction of real property levies.

(25) One-third of support payments made to or for a blind or disabled child by an absent parent.

(26) Interest income accrued to a:

(a) Bank account during the period under consideration, such as a checking, savings, or money market account;

(b) Dedicated bank or other financial institution account that is considered an excludable resource because it is unavailable, such as an escrow account for a security deposit; or

(c) Keogh account, individual retirement account (IRA), or other private retirement account that is countable as a resource.

(27) Interest payments received for a mortgage, promissory note, or other loan.

(28) Refund of taxes on income, property, food, or other items already paid.

(29) Proceeds of a loan received by an individual as the borrower.

(30) Payments received from a trust, if the trust is countable as a resource.

(31) Income from the sale of an assistance unit member's blood or plasma.

(32) Cash donations based on need received from one or more charitable organizations.

(33) All income excluded by federal statute for medical assistance programs.

K. Disregards — Aged, Blind, or Disabled. In order to determine countable net income, the following disregards shall be deducted from the countable gross income of an aged, blind, or disabled assistance unit:

(1) A general disregard of $20 per month for a person or a couple.

(2) An earned income disregard of $65 per month plus one-half of the remainder of the earned income of a person or a couple.

(3) A disregard of one-half of the gross income amount for the following types of income:

(a) Profit from self-employment income, unless an applicant or recipient can document a cost to produce in excess of the disregard of one-half of gross income; and

(b) Profit from rental property income and other income-producing property.

(4) The amount of earned income used to meet any expenses reasonably attributable to earning of income of a blind person younger than 65 years old in accordance with 20 CFR §416.1112(c)(5).

(5) Any wages, allowances, or reimbursement for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by a blind or disabled handicapped person employed in a project under Title VI of the Rehabilitation Act of 1973 as added by Title II of Pub. L. No. 95-602 (92 Stat. 2992, 29 U.S.C. §795(b)(c)).

L. Schedule MA-1.

Persons Dependent	Medical Assistance Standards	
on Income	Annual	Monthly
1	$ 4,200	$ 350
2	4,700	392
3	5,200	434
4	5,700	475
5	6,252	521
6	6,876	573
7	7,740	645
8	8,508	709
9	9,192	766
10	9,912	826
11	10,632	886
12	11,352	946
13	12,048	1,004
14	12,756	1,063
15	13,488	1,124
16	14,208	1,184
Each Additional Person	732	61

.08 Consideration of Resources for MAGI Exempt Coverage Groups.

A. This regulation contains the rules for considering resources of members of the MAGI exempt assistance unit and those individuals whose income and resources are considered pursuant to Regulation .06 of this chapter in determining financial eligibility of an assistance unit for retroactive and current eligibility for the period under consideration.

B. Definitions.

(1) "Account" means cash savings or any other form of liquid resource in a bank, credit union, savings and loan association, or any other financial institution in which the resource is subject to withdrawal by the owner or owners of the account.

(2) Automobile.

(a) "Automobile" means a passenger car or any other vehicle used to provide necessary transportation.

(b) "Automobile" does not mean an airplane, farm machinery, or a vehicle used solely for recreational purposes.

(3) "Burial funds" means a revocable burial contract, burial trust, or other burial arrangement or any other separately identifiable fund which is clearly designated as set aside for a person's burial expenses.

(4) "Burial spaces" means conventional gravesites, crypts, mausoleums, urns, and other repositories which are customarily and traditionally used for the remains of deceased persons.

(5) "Equity value" means the fair market value of property less any legal debt on the property.

(6) "Fair market value" means the amount for which property can be sold on the open market in a particular geographical area.

(7) "Funds in an irrevocable trust or other irrevocable arrangement that are available to meet burial expenses" means funds which are held in an irrevocable burial contract, an irrevocable burial trust, or an amount in an irrevocable trust which is specifically identified as available for burial expenses.

(8) "Home" means any shelter in which a member of the assistance unit or any person whose income and resources are considered in determining the financial eligibility of the assistance unit, has an ownership interest and uses as his principal place of residence. The home includes the parcel of land on which the shelter is situated and any related outbuildings necessary to its operation. Only one residence may be considered home property.

(9) "Immediate family" means a person's spouse or a person's minor and adult children, including adopted children and stepchildren, or a person's brothers, sisters, parents, adoptive parents, and the spouses of these persons. Neither dependency nor living in the same household are factors in determining whether a person is an immediate family member.

(10) "Institutionalized person" means a person who is:

(a) An inpatient in a nursing facility;

(b) An inpatient in a medical institution and with respect to whom payment is made based upon a level of care provided in a nursing facility; or

(c) Receiving services under a home and community-based services waiver under COMAR 10.09.27 or 10.09.31.

(11) "Joint account" means an account in which two or more persons are named as owners of the account and the funds in the account are subject to withdrawal by any of the persons named as owners.

(12) "Medicaid qualifying trust" means a trust or similar legal device established on or before August 10, 1993, other than by will, by an individual or an individual's spouse, under which the individual or the individual's spouse may be the beneficiary of all or part of the payments from the trust, and the distribution of payment is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

(13) "Nonapplicant" means a person who is neither an applicant nor the spouse of an applicant.

(14) Property.

(a) "Property" means any thing or things in which a person has a legal or equitable interest.

(b) "Personal property" means all property that is not real property.

(c) "Real property" means property which is fixed or immovable such as land or a building.

(15) "Uncompensated value" means the difference between the fair market value of a person's interest in a resource at the time it was disposed of and the amount of compensation received for the resource.

C. The applicant shall report all resources to the Department or its designee with the exception of non-disabled children and their caretaker relatives who are not being considered as medically needy.

D. Countable income that is retained at redetermination or reapplication shall be considered a resource unless specifically excluded by other regulations.

E. The Department or its designee shall require an accounting and reasonable documentation, consisting of convincing testimony or other evidence, of the disposal of previously held resources within 30 months before the month of application to assure that the resources are no longer available and the disposal meets the requirements of this regulation.

F. Excludable Resources for Aged, Blind, or Disabled Noninstitutionalized Individuals and Aged, Blind, or Disabled Institutionalized Individuals Who Intend to Return Home. The following resources are excluded in determining financial eligibility for aged, blind, or disabled noninstitutionalized individuals and for an aged, blind, or disabled institutionalized individual who intends to resume living in the individual's home:

(1) The home, as defined under §B(7) of this regulation, unless the person is institutionalized and has a life estate interest with full powers in the home.

(2) Income-Producing Property.

(a) Income-producing property associated with the home includes farm machinery, business equipment, vehicles, special tools, farm animals, and livestock related to self-support activities. The property shall be excluded if the total equity value of these resources does not exceed the limit set forth in §F(2)(c) of this regulation and the resource produces a net annual return of at least 6 percent of the equity.

(b) Income-producing property not associated with the home includes land, buildings, farm machinery, business equipment, vehicles, special tools, farm animals and livestock related to self-support activities. This property shall be excluded if the total equity value of these resources does not exceed the limit set forth in §F(2)(c) of this regulation and the resource produces a net annual return of at least 6 percent of the equity.

(c) $6,000 Equity Value Exclusion. A $6,000 equity value exclusion applies to the combined equity value of resources in §F(2) (a) and (b) of this regulation. The exclusion does not apply to each individual property.

(d) Limitations on Equity Value Exclusion.

(i) The full equity value of each property not producing a net annual return of 6 percent will be a countable resource.

(ii) The combined equity value in excess of $6,000 of all properties producing an individual net annual return of 6 percent will be a countable resource.

(3) Household Goods and Personal Effects.

(a) Household Goods.

(i) Household goods include those items of personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home and in the functions and activities of home and family life, as well as those items which are for comfort and accommodation.

(ii) Household goods necessary for the maintenance, use, and occupancy of the home shall be excluded regardless of value. The equity value of nonessential items shall be added to other countable resources and measured against the applicable resource standard.

(b) Personal Effects.

(i) Personal effects include those items of personal property which are worn or carried by a person or have an intimate relation to him.

(ii) Personal effects shall be excluded except as specified in §F(3)(b)(iii) of this regulation.

(iii) The equity value of nonessential personal effects of considerable value such as furs, and jewelry which is not excluded in §F(3)(c) of this regulation, shall be added to other countable resources and measured against the applicable resource standard.

(c) A wedding ring and an engagement ring shall be excluded from consideration as resources.

(d) Prosthetic devices, dialysis machines, hospital beds, wheelchairs, and similar equipment required because of a person's physical condition shall be excluded from consideration as resources.

(e) For an institutionalized person, household goods and personal effects remaining in the possession of the person at the long-term care facility shall be excluded from consideration as resources.

(4) Livestock and farm produce that is used only for home consumption.

(5) Automobiles.

Any automobile owned by a member of the assistance unit shall be excluded regardless of its value or purpose.

(6) Life Insurance with a Maximum Face Value of $1,500 for Each Person.

(a) Life insurance policies such as term or burial insurance which do not have a cash surrender value may not be used in determining the total face value of all policies.

(b) Whenever the total face value of all policies on any person exceeds the allowable maximum face value, the entire cash surrender value of these policies shall be counted as a resource. Cash surrender value includes available accrued dividends and interest.

(7) Cash and In-Kind Replacement Received for Casualty Losses of Excluded Resources.

(a) Cash, including interest earned on the cash, or in-kind replacement received from any source for the purpose of replacing an excluded resource that is lost, damaged, or stolen, shall be an excluded resource for a period of 9 months, beginning with the date the cash or in-kind replacement was received.

(b) The initial 9-month exclusion period specified in §F(7)(a) of this regulation shall be extended for a reasonable period up to an additional 9 months if circumstances beyond the control of the individual prevent him from repairing, replacing, or contracting for the repair or replacement of the resource.

(c) Any of the cash and interest or in-kind replacement that is not used to repair or replace the excluded resource shall be counted as a resource beginning with the period under consideration after expiration of the initial 9-month period, or the extended period, if any.

(d) If an extension of the time period is made pursuant to §F(7)(b) of this regulation and the individual changes his intent to repair or replace the excluded resource, cash and interest, or in-kind replacement previously excluded, shall be counted as resources effective with the month the individual reports his change of intent.

(8) Assistance Received Because of a Major Disaster.

(a) Assistance, including any interest earned on the 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 shall be excluded in determining countable resources for a period of 9 months from the date of receipt.

(b) The initial 9-month period for not counting the assistance specified in §G(8)(a) of this regulation shall be extended for a reasonable period up to an additional 9 months if circumstances beyond the control of the person prevented him from repairing, replacing, or contracting for repair or replacement of damaged or destroyed property.

(9) Burial spaces for a person and the person's immediate family.

(10) Proceeds from Sale of a Home. Proceeds from the sale of a home shall be excluded from consideration as a resource for a period not to exceed 3 months from the date the proceeds are received if the:

(a) Person indicates he intends to replace the home during that period;

(b) Home is in fact replaced during that period; and

(c) Replaced home itself was an excluded resource under the provision of §F(1) of this regulation.

(11) Payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, 42 U.S.C. §4601 et seq. Compensation received for the fair market value of the acquired real property is not subject to this regulation.

(12) Assistance provided in cash or in-kind under the Emergency Energy Conservation Services Program, including plans for crisis intervention to prevent fuel cut-offs and assistance provided under the Low-Income Home Energy Assistance Act.

(13) Burial Funds.

(a) In determining the resources of a person and the person's spouse, if any, there shall be excluded an amount up to $1,500 per person of funds specifically set aside for burial arrangements of the person or the person's spouse.

(b) Interest earned on excluded burial funds and appreciation on the value of excluded burial arrangements shall be excluded from resources if left to accumulate and become a part of the burial fund.

(c) Funds or interest earned on funds and appreciation in the value of burial arrangements, which have been excluded from resources because they are burial funds, shall be used solely for that purpose.

(d) If any excluded funds, interest, or appreciated value set aside for burial expenses are used for any purpose other than the burial arrangements of the person or the person's spouse for whom the funds were set aside, the unit shall be determined ineligible until the unit spends for medical services an amount which is equal to the amount of burial funds used for some other purpose.

(e) §F(13)(d) of this regulation may not apply if countable resources, when added to the total excluded burial funds, including the amount misspent, were within the applicable amount in Schedule MA-2 during the month in which the use of burial funds for some other purpose occurred.

(f) An individual's $1,500 exclusion as described under §F(13)(a) of this regulation shall be reduced by:

(i) The face value of life insurance policies owned by the individual or the individual's spouse if the cash surrender value of those policies has been excluded from resources; and

(ii) Amounts in an irrevocable burial fund as described under §F(14) of this regulation.

(14) An irrevocable burial fund of any amount, which has been set aside for the burial of the individual or the individual's spouse.

G. Excludable Resources for Aged, Blind, or Disabled Institutionalized Individuals Who Do Not Intend to Return Home. The following resources are excluded in determining financial eligibility for an aged, blind, or disabled institutionalized individual who does not intend to resume living in the individual's home:

(1) The home as defined in §B(4) of this regulation, if it is occupied by the institutionalized person's spouse or any one of the following relatives who are medically or financially dependent:

(a) Son;

(b) Daughter;

(c) Grandson;

(d) Granddaughter;

(e) Stepson;

(f) Stepdaughter;

(g) In-laws;

(h) Mother;

(i) Father;

(j) Stepmother;

(k) Stepfather;

(l) Half sister;

(m) Half brother;

(n) Niece;

(0) Nephew;

(p) Grandmother;

(q) Grandfather;

(r) Aunt;

(s) Uncle;

(t) Sister;

(u) Brother;

(v) Stepbrother;

(w) Stepsister.

(2) Household Goods and Personal Effects Remaining in the Possession of the Person at the Long-Term Care Facility.

(a) Household goods include those items of personal property which are customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home and in the functions and activities of home and family life, as well as those items which are for comfort and accommodation.

(b) Personal effects include those items of personal property which are worn or carried by a person or have an intimate relation to him.

(c) Household goods and personal effects include, but are not limited to, items of personal clothing, toilet articles, prosthetic devices, an engagement ring, and a wedding ring.

(3) Life Insurance with a Maximum Face Value of $1,500 for Each Person.

(a) Life insurance policies such as term or burial insurance which do not have a cash surrender value may not be used in determining the total face value of all policies.

(b) Whenever the total face value of all policies exceeds the allowable maximum face value, the entire cash surrender value of these policies shall be counted as a resource. Cash surrender value includes all available accrued dividends and interest.

(4) Burial spaces for a person and the person's immediate family.

(5) Income-Producing Property.

(a) Income-producing property associated with the home includes farm machinery, business equipment, vehicles, special tools, farm animals, and livestock related to self-support activities. This property shall be excluded if the total equity value of these resources does not exceed the limit set forth in §G(5)(c) of this regulation and the resource produces a net annual return of at least 6 percent of the equity.

(b) Income-producing property not associated with the home includes land, buildings, farm machinery, business equipment, vehicles, special tools, farm animals, and livestock related to self-support activities. This property shall be excluded if the total equity value of these resources does not exceed the limit set forth in §G(5)(c) of this regulation and the resource produces a net annual return of at least 6 percent of the equity.

(c) $6,000 Equity Value Exclusion. A $6,000 equity value exclusion applies to the combined equity value of resources in §G(5)(a) and (b) of this regulation. The exclusion does not apply to each individual property.

(d) Limitations on Equity Value Exclusion.

(i) The full equity value of each property not producing a net annual return of 6 percent will be a countable resource.

(ii) The combined equity value in excess of $6,000 of all properties producing an individual net annual return of 6 percent will be a countable resource.

(6) Burial Funds.

(a) In determining the resources of a person and the person's spouse, if any, there shall be excluded an amount up to $1,500 per person of funds specifically set aside for burial arrangements of the person or the person's spouse.

(b) Interest earned on excluded burial funds and appreciation on the value of excluded burial arrangements shall be excluded from resources if left to accumulate and become a part of the burial fund.

(c) Funds or interest earned on funds and appreciation in the value of burial arrangements, which have been excluded from resources because they are burial funds, shall be used solely for that purpose.

(d) If any excluded funds, interest, or appreciated value set aside for burial expenses are used for any purpose other than the burial arrangements of the person or the person's spouse for whom the funds were set aside, the unit shall be determined ineligible until the unit spends for medical services an amount which is equal to the amount of burial funds used for some other purpose.

(e) Section G(6)(d) of this regulation may not apply if countable resources, when added to the total excluded burial funds, including the amount misspent, were within the applicable amount in Schedule MA-2 during the month in which the use of burial funds for some other purpose occurred.

(f) An individual's $1,500 exclusion as described under §G(6)(a) of this regulation shall be reduced by:

(i) The face value of life insurance policies owned by the individual or the individual's spouse if the cash surrender value of those policies has been excluded from resources; and

(ii) Amounts in an irrevocable burial fund as described under §G(7) of this regulation.

(7) An irrevocable burial fund of any amount, which has been set aside for the burial of the individual or the individual's spouse.

H. Exclusion of the home under §§F(1) and G(1) of this regulation and exclusion of income-producing property under §§F(1) and G(5) of this regulation do not prevent a lien being attached to or executed on the home or property except as provided in Regulation .15A-2(3) of this chapter.

I. Treatment of Joint Accounts.

(1) If a joint account exists between an applicant and a nonapplicant, all of the funds in the account are considered available to the applicant.

(2) If a joint account exists between the spouse of an applicant and a nonapplicant, all of the funds in the account are considered available to the spouse of the applicant.

(3) If a joint account exists between an applicant, the spouse of an applicant, and a nonapplicant, all of the funds in the account are considered available to the applicant and the spouse of the applicant.

(4) Rebuttal of Presumption of Full Ownership Interest.

(a) If the nonapplicant owner can demonstrate, to the Department's satisfaction, that the nonapplicant made regular and proportionate contributions of the nonapplicant's own funds to the account, a pro rata share of the funds is considered available to the nonapplicant.

(b) If either the applicant, the spouse of the applicant, or the nonapplicant owner of a joint account believes that the ownership interest attributed to him or her by the Department under §I(1)—(3) or (4)(a) of this regulation is incorrect and can demonstrate, under §I(5)(b) of this regulation, to the satisfaction of the Department, an ownership interest other than that attributed to him or her by the Department, the Department shall consider the amount established through rebuttal as the correct amount for the purpose of determining eligibility for Medical Assistance.

(5) Declaration of Ownership Interests.

(a) The applicant and the nonapplicant of a joint account shall declare their ownership interests on a form designated by the Department.

(b) The applicant shall provide adequate documentation to substantiate the declared ownership interests.

(6) If the nonapplicant owner withdraws funds from the account during or after the 30-month period immediately before the month of application, the withdrawal is considered a disposal by the applicant or the spouse of the applicant to the extent that the remaining funds are less than the amounts considered available to the applicant under §I(1)—(4) of this regulation.

J. Medicaid Qualifying Trust.

(1) In the case of a Medicaid qualifying trust as defined under §B(12) of this regulation, the amount from the trust considered available to the person or the person's spouse establishing the trust is the maximum amount of payments that may be permitted under the terms of the trust to the beneficiary, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the beneficiary.

(2) Section J of this regulation shall apply whether or not the:

(a) Medicaid qualifying trust is irrevocable or has been established for purposes other than to enable a person to qualify for Medical Assistance; or

(b) Discretion described under §J of this regulation is actually exercised.

(3) If the beneficiary of a trust is an intellectually disabled person who resides in an intermediate care facility for the intellectually disabled, the trust may not be considered a Medicaid qualifying trust if it was established before April 17, 1986 and is solely for the benefit of the intellectually disabled person.

(4) The Department may waive the application of §J of this regulation if the Department determines that to do so would work an undue hardship.

K. Disposal of Resources for Less than Fair Market Value.

(1) In determining eligibility for Medical Assistance for any period under consideration beginning before October 1, 1993, an institutionalized individual shall be determined ineligible for nursing facility services, for a level of care in a medical institution equivalent to that of nursing facility services, and for waiver services under COMAR 10.09.27 and 10.09.31 if the individual or the individual's spouse:

(a) Disposes of a resource for less than fair market value at any time during or after the 30-month period immediately before or after the date the person becomes an institutionalized person if the person is entitled to Medical Assistance on that date; or

(b) If not entitled to Medical Assistance on that date, then on the date the person applies for Medical Assistance while an institutionalized person.

(2) If a person disposes of a resource for less than fair market value while in a period of ineligibility for an earlier disposal, the later disposal is considered a part of the earlier disposal for purposes of computing the total period of ineligibility.

(3) The period of ineligibility shall begin with the month in which the resource was transferred and the number of months in the period shall be equal to the lesser of:

(a) 30 months; or

(b) The total uncompensated value of the transferred resource, divided by the average cost, to a private patient at the time of application, of nursing facility services in the state in which the person is institutionalized.

(4) An institutionalized person may not be determined ineligible for Medical Assistance under §K(1) of this regulation if the resource transferred was a home and title to the home was transferred to:

(a) The spouse of the person;

(b) The person's child as defined under Regulation .02B(12) of this chapter or who is blind or disabled as determined under Regulation .05D and E of this chapter;

(c) A sibling of the person who has an equity interest in the home and who was residing in the home for a period of at least 1 year immediately before the date the person became an institutionalized person; or

(d) A son or daughter of the person other than the person's child described under §K(4)(b) of this regulation, who:

(i) Is lawfully residing in the home,

(ii) Was residing in the home for a period of at least 2 years immediately before the date the person became an institutionalized person, and

(iii) Can establish, to the Department's satisfaction, that the son or daughter provided the care that permitted the person to reside at home rather than in an institution.

(5) A person may not be determined ineligible for Medical Assistance by reason of the transfer of any resource, excluded or nonexcluded, if the resource was transferred under any one of the conditions below:

(a) The resource was transferred to the community spouse, or to another for the sole benefit of the community spouse, as defined under Regulation .10-1B(1) of this chapter;

(b) The resource was transferred to the person's son or daughter who is blind or disabled as defined under Regulation .05D and E of this chapter;

(c) The resource was transferred to the person's spouse, or to another for the sole benefit of the person's spouse, if the spouse does not transfer the resource to another person for less than fair market value;

(d) The person furnishes convincing evidence, consisting of testimony or other corroborative evidence, that the person intended to dispose of the resource at fair market value or for other valuable consideration;

(e) The person furnishes convincing evidence that the resource was transferred exclusively for a purpose other than to qualify for Medical Assistance; or

(f) The Department determines that the denial of eligibility would work an undue hardship.

L. A unit shall be ineligible for any month in which countable resources exceed the applicable standard, but may reapply for any following month in which countable resources are less than or equal to the applicable standard.

M. Schedule MA-2.

Individuals	Medically Needy Resource Standard (ABD)
1	2,500
2	3,000
3	3,100
4	3,200
5	3,300
6	3,400
7	3,500
8	3,600
9	3,700
10	3,800
Each Additional Individual	100

N. Schedule MA-2A.

Categorically Needy Resource Standard		
Effective	Individual	Couple
January 1, 1987	$1,800	$2,700
January 1, 1988	1,900	2,850
January 1, 1989	2,000	3,000

.08-1 Disposal of Assets for Less Than Fair Market Value.

A. Definitions. In this regulation, the following terms have the meanings indicated:

(1) "Assets" means all income and resources of an individual and of an individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

(a) The individual;

(b) The individual's spouse;

(c) A person, including a court or administrative body:

(i) With legal authority to act in place of or on behalf of the individual or the individual's spouse, or

(ii) Acting at the direction or upon the request of the individual or the individual's spouse.

(2) "Trust" means a legal instrument, which is either revocable or irrevocable, created, other than by will, by a grantor for the benefit of designated beneficiaries under the laws of the State and subject to the management of a trustee or trustees who have a fiduciary responsibility to manage the trust's resources and income for the benefit of the beneficiaries.

B. Disposal of Assets.

(1) In determining eligibility for Medical Assistance for any period under consideration beginning on or after October 1, 1993, in the case of assets disposed of after August 10, 1993, a penalty period shall be established during which an individual is determined ineligible for nursing facility services, for a level of care in a medical institution equivalent to that of nursing facility services, and for home and community-based waiver services provided for under the authority of §1915(c) and (d) of the Social Security Act if the individual or the individual's spouse disposes of an asset for less than fair market value at any time during or after the time periods specified under §B(2) of this regulation.

(2) Time Periods for Evaluating Disposals.

(a) For assets other than trusts, the time period for evaluating disposals is the following:

(i) For disposals earlier than February 6, 2006, the 36-month period immediately before the date as of which the individual both is an institutionalized individual and has applied for Medical Assistance.

(ii) For disposals on or after February 6, 2006, the 60-month period immediately before the date as of which the individual both is an institutionalized individual and has applied for Medical Assistance.

(b) In the case of payments from a trust or portions of a trust that are treated as a disposal of assets under Regulation .08-2B(4)(c), (5)(a)(ii), or (5)(b) of this chapter, the time period for evaluating disposals is the 60-month period immediately before the date as of which the individual both is an institutionalized individual and has applied for Medical Assistance.

(3) The penalty period begins:

(a) For a transfer before February 6, 2006, with the later of:

(i) The first day of the month in which the asset was transferred; or

(ii) The date on which the individual is eligible for Medical Assistance and, but for the transfer, would be receiving institutional level of care; and

(b) For a transfer on or after February 6, 2006, with the later of:

(i) The first day of the month in which the individual is eligible for Medicaid and would be receiving Medicaid nursing facility services but for the application of this penalty; or

(ii) The month during or after which assets have been transferred for less than fair market value.

(4) If the transfer occurs while the individual is in a penalty period for an earlier disposal, the penalty period begins on the first day of the first month following the end of the earlier penalty period.

(5) The number of months in the penalty period are equal to the total, cumulative, uncompensated value of all assets transferred, divided by the average monthly cost, to a private patient at the time of application for Medical Assistance, of nursing facility services in the State.

(6) Asset Transfers For Less Than Average Monthly Cost of Care.

(a) If the amount of a transfer is less than the average monthly cost of nursing facility services in the State, the length of the penalty period is calculated based on the proportion of the average monthly cost of nursing facility services that was transferred.

(b) If a series of transfers is made, each of which is less than the average monthly cost of nursing facility services, the penalty period is calculated based on the total, cumulative, uncompensated value of all assets transferred.

(7) Transfers Not Equally Divisible. If the amount of a single transfer or the amount of the total, cumulative, uncompensated value of all assets transferred is not equally divisible by the average monthly cost of nursing facility services in the State, the length of the penalty period is calculated based on the proportion of the average monthly cost of nursing facility services that was transferred.

(8) An institutionalized individual may not be determined ineligible for Medical Assistance under §B(1) of this regulation if the asset transferred was a home, and title to the home was transferred to:

(a) The spouse of the individual;

(b) The individual's child as defined under Regulation .02B of this chapter or who is blind or disabled as determined under Regulation .05-4 of this chapter;

(c) A sibling of the individual who has an equity interest in the home and who was residing in the home for a period of at least 1 year immediately before the date the individual became an institutionalized individual; or

(d) A son or daughter of the individual other than the individual's child described under §B(8)(b) of this regulation, who:

(i) Is lawfully residing in the home,

(ii) Was residing in the home for a period of at least 2 years immediately before the date the individual became an institutionalized individual, and

(iii) Can establish, to the Department's satisfaction, that the son or daughter provided the care that permitted the individual to reside at home rather than in an institution.

(9) An individual may not be determined ineligible for Medical Assistance by reason of the transfer of any asset, excluded or countable, if the asset was transferred under one of the following conditions:

(a) The asset was transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

(b) The asset was transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

(c) The asset was transferred to, or to a trust established for the sole benefit of, the individual's son or daughter who is blind or disabled as defined under Regulation .05-4 of this chapter;

(d) The asset was transferred to a trust established for the sole benefit of a disabled individual, as defined under Regulation .05-4B of this chapter, younger than 65 years old;

(e) The individual furnishes convincing evidence, consisting of testimony or other corroborative evidence, that the individual intended to dispose of the asset at fair market value or for other valuable consideration;

(f) The individual furnishes convincing evidence that the asset was transferred exclusively for a purpose other than to qualify for Medical Assistance; or

(g) The full value of the asset transferred by an individual for less than fair market value has been returned to the individual.

(10) In the case of an asset held by an individual in common with another individual or individuals in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered a transfer when any action is taken, either by the individual or by any other individual, that reduces or eliminates the individual's ownership or control of the asset.

.08-2 Treatment of Trust Amounts.

A. For the purpose of this regulation, "trust" has the meaning defined under Regulation .08-1A of this chapter.

B. Treatment of Trusts Established after August 10, 1993.

(1) In determining eligibility for Medical Assistance for any period under consideration beginning on or after October 1, 1993, in the case of trusts established after August 10, 1993, an individual shall be considered to have established a trust if assets of the individual as defined under Regulation .08-1A of this chapter were used to form all or part of the corpus of the trust and if any of the following persons established the trust other than by will:

(a) The individual;

(b) The individual's spouse;

(c) A person, including a court or administrative body:

(i) With legal authority to act in place of or on behalf of the individual or the individual's spouse, or

(ii) Acting at the direction or upon the request of the individual or the individual's spouse.

(2) In the case of a trust, the corpus of which includes assets of one of the individuals described under §B(1)(a) or (b) of this regulation and assets of any other individual or individuals, the provisions of this regulation apply to the portion of the trust attributable to the assets of the individual described under §B(1)(a) or (b) of this regulation.

(3) The provisions of this regulation apply without regard to:

(a) The purposes for which a trust is established;

(b) Whether the trustees have or exercise any discretion under the trust;

(c) Restrictions on when or whether distributions may be made from the trust; or

(d) Restrictions on the use of distributions from the trust.

(4) Revocable Trusts. In the case of a revocable trust:

(a) The corpus of the trust shall be considered resources available to the individual;

(b) Payments from the trust to, or for the benefit of, the individual shall be considered income of the individual; and

(c) Other payments from the trust shall be considered assets disposed of by the individual.

(5) Irrevocable Trust. In the case of an irrevocable trust, if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual:

(a) The portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income:

(i) To or for the benefit of the individual, shall be considered income of the individual, and

(ii) For any other purpose, shall be considered a transfer of assets; and

(b) A portion of the trust from which, or any income on the corpus from which, a payment could not, under any circumstances, be made to the individual shall be considered to be assets disposed of by the individual, as of the date of establishment of the trust or, if later, the date on which payment to the individual was foreclosed. The value of the trust shall be determined, for purposes of evaluating the disposal, by including the amount of any payments made from that portion of the trust after the date of establishment or foreclosure.

(6) The following trusts may not be counted in determining eligibility for Medical Assistance:

(a) Special needs trusts as defined in §C of this regulation; and

(b) A pooled special needs trust containing the assets of an individual who is disabled, and which meets all of the following conditions:

(i) The trust is established and managed by a nonprofit association,

(ii) 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,

(iii) Accounts in the trust are established solely for the benefit of disabled individuals by the parent, grandparent, or legal guardian of the individuals, by the individuals, or by a court, and

(iv) 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 Department from the amounts remaining in the account an amount equal to the total amount of Medical Assistance paid on behalf of the beneficiary.

(7) A nonprofit association that establishes and manages a trust consistent with the requirements of §B(6)(b) of this regulation may establish accounts for individuals for whom no governmental entity has made a determination of disability, provided that:

(a) The beneficiary of the account has submitted, or is actively engaged in preparing to submit, an application to:

(i) The Social Security Administration for Supplemental Security Income or Social Security Disability Insurance; or

(ii) The Department of Human Services State Review Team for a disability determination using the Social Security Administration rules; and

(b) The account is closed immediately upon a determination, exclusive of appeals, by any State or federal governmental agency that the beneficiary of the account is not disabled.

C. Special Needs Trust. The following criteria shall define a single, stand-alone special needs trust that is funded with assets that belonged to the beneficiary:

(1) The trust is irrevocable;

(2) The trust states that the beneficiary is disabled under Regulation .05-4B of this chapter;

(3) The beneficiary of the trust is younger than 65 years old at the time the trust is established and funded;

(4) The trust has been established by:

(a) The beneficiary;

(b) The beneficiary's parent;

(c) The beneficiary's grandparent;

(d) The beneficiary's legal guardian; or

(e) A court;

(5) The trust does not contain provisions that conflict with the policies set forth under this regulation;

(6) The trust provides that all states which have provided medical assistance benefits to the beneficiary shall be paid their proportionate share of the total amount of medical assistance benefits paid on behalf of the beneficiary by all states, up to the amount of assets remaining in the trust upon the death of the beneficiary;

(7) If the trust allows for the termination of the trust before the death of the beneficiary, the trust shall provide that:

(a) All states which have provided medical assistance benefits to the beneficiary shall be paid their proportionate share of the total amount of medical assistance benefits paid on behalf of the beneficiary by all states, up to the amount of assets remaining in the trust at the time of termination, after administrative expenses related to the termination of the trust;

(b) Other than amounts paid to the states under §C(7)(a) of this regulation and payment of administrative expenses and reasonable compensation to the trustee for trust management, along with reasonable costs associated with investment, legal, or other services, no entity other than the trust beneficiary may benefit from early termination of the trust; and

(c) The power to terminate shall be held by someone other than the trust beneficiary;

(8) The trust does not permit distribution of trust assets upon termination of the trust that would hinder or delay reimbursement to the states under §C(6) and (7) of this regulation;

(9) The trust does not place time limits, or any other limits, on the states' claim for reimbursement under §C(6) and (7) of this regulation;

(10) The trust contains the following provisions:

(a) Additions may not be made to the trust after the beneficiary is 65 years old;

(b) Expenditures from the trust shall be used for the sole benefit of the beneficiary and shall be directly related to the beneficiary's health care, education, comfort, or support;

(c) The trust beneficiary may not serve as trustee, cotrustee, trust protector, trust advisor, or in any other capacity that would allow the beneficiary to influence or exercise authority or control over distributions from the trust;

(d) The trustee shall administer the trust in accordance with the provisions of Estates and Trusts Article, §15-502, Annotated Code of Maryland, and may not:

(i) Except for the beneficiary's relative, limited to the relatives defined at COMAR 10.09.24.02B(10)(a), who may have a contingent future interest in any trust funds remaining in the trust after the requirements of §C(6) of this regulation have been met, have an interest in trust assets;

(ii) Have discretion to use trust assets for the trustee's own benefit;

(iii) Self-deal by selling trust assets to the trustees or buying trust assets from the trustee; or

(iv) Loan trust assets to the trustee;

(e) Compensation to the trustee shall be limited in accordance with the provisions of Estates and Trusts Article, §14.5-708, Annotated Code of Maryland;

(f) Any leases or mortgages that the trust may hold shall contain a provision that they either terminate or become due and payable upon the death of the beneficiary or termination of the trust;

(g) If the trust owns titled property that is valued at more than $500, the property shall be titled in the name of the trust, except for securities, which may be held in the name of a nominee;

(h) If the trust owns an asset jointly with another, the ownership shall be as tenants in common, and the ownership agreement shall provide that, upon termination of the trust, the property shall either be sold for fair market value or the other owners shall purchase the trust's interest in the property for fair market value;

(i) Trust assets may not be held as an ongoing business or enterprise, or as investments in new or untried enterprises;

(j) Trust distributions may not be used to supplement Medical Assistance payments to any health care provider delivering goods or services to the beneficiary;

(k) Trust assets may not be used to purchase gifts;

(l) Trust assets may not be used to purchase a life insurance policy on the life of the beneficiary;

(m) Trust assets may only be used to purchase a life insurance policy on the life of someone other than the trust beneficiary if the trust is the only beneficiary of the life insurance policy;

(n) Trust assets may not be used to purchase an annuity on the life of the beneficiary unless, upon the beneficiary's death, all states which have provided medical assistance benefits to the beneficiary are paid, out of any remaining annuity payments, their proportionate share of the total amount of medical assistance benefits paid on behalf of the beneficiary by all states.

(o) The trust may not loan trust assets without security, which may include an interest in real or personal property of at least equivalent value;

(p) The trust may only make loans if the loan agreement provides for immediate repayment in the event of the death of the beneficiary or termination of the trust for any other reason;

(q) The only real property in which the trust may invest is in a single home property, which is used as the residence of the beneficiary and is titled in the name of the trust;

(r) The trust may not disburse more than $100,000 for the purchase of property without the approval of the State circuit court in the jurisdiction in which the beneficiary resides;

(s) An annual accounting of the trust, including a listing of current assets, income, and itemized distributions during the previous year, shall be sent to the Maryland Medical Assistance Program, Division of Recoveries and Financial Services;

(t) Trust assets may not be used to pay funeral expenses of the beneficiary but may be used to purchase an irrevocable burial contract for the beneficiary to cover the beneficiary's funeral and burial expenses;

(u) The trust may not receive payments from a structured settlement or an annuity that was purchased by funds that are not part of the trust unless:

(i) Upon the beneficiary's death, all states which have provided medical assistance benefits to the beneficiary are paid, out of any remaining annuity or settlement payments, their proportionate share of the total amount of medical assistance benefits paid on behalf of the beneficiary by all states; and

(ii) The beneficiary's right to receive payments from the annuity or structured settlement has been assigned irrevocably to the trust and such assignment was made before the trust beneficiary attains the age of 65;

(11) A copy of the trust shall be sent to the Maryland Medical Assistance Program, Division of Recoveries and Financial Services, and if any amendments are made to the trust, the amendments shall comply with this section and a copy of the amendments shall be sent to the Division of Recoveries and Financial Services;

(12) If the trust agreement fails to comply with any provision of this section, the full value of the assets of the trust shall be considered available resources of the trust beneficiary for Medical Assistance eligibility purposes.

.08-3 Resource Consideration of Entrance Fees for Continuing Care Retirement Communities.

A. Treatment of Entrance Fees before January 1, 2006. For Medical Assistance applications or requests for spousal resource assessments filed before January 1, 2006, the entrance fee shall be considered in accordance with the policies for exclusion of home property in this chapter.

B. Treatment of Entrance Fees On or After January 1, 2006.

(1) For Medical Assistance applications or requests for spousal resource assessments filed on or after January 1, 2006, an entrance fee shall be considered available to the owner as a countable resource if the CCRC provides written verification, based on CCRC practice or policy, which satisfies the Department that all of the following criteria are met:

(a) The applicant or recipient or a designated beneficiary is eligible for a full refund of any amount remaining in the entrance fee, after subtracting any payments or transfers made by the individual in accordance with §B(1)(c)—(e) of this regulation, when the individual:

(i) Dies; or

(ii) Terminates the continuing care agreement and leaves the CCRC facility;

(b) The entrance fee does not confer on the applicant or recipient a real property interest in the CCRC facility, in which case the entrance fee would be considered as excludable home property;

(c) The applicant or recipient has the ability to obtain funds from the entrance fee, without moving from the CCRC facility, to pay the CCRC or another entity for support and maintenance if the individual's income and other resources are insufficient to pay for the support and maintenance;

(d) If the Medical Assistance applicant or recipient has a son or daughter who is blind or disabled as defined under this chapter, the applicant or recipient has the ability to transfer unconditionally all or part of the entrance fee to the individual's blind or disabled son or daughter; and

(e) If the Medical Assistance applicant or recipient is institutionalized and married to a community spouse the:

(i) CCRC's entrance fee, if it is considered a countable resource in accordance with the requirements in §B of this regulation, shall be included in the assessment for the attribution of spousal resources, in accordance with Regulation .10-1 of this chapter; and

(ii) CCRC shall permit the recipient to transfer unconditionally all or part of the entrance fee to the sole ownership of the community spouse according to the amount that is needed, after totaling other resources owned singly or jointly by the couple, for the community spouse resource allowance to total the protected amount calculated by the Department, in accordance with Regulation .10-1 of this chapter.

(2) The Department shall grant the applicant or recipient the opportunity to rebut the CCRC's written verification that all of the conditions in §B of this regulation are met for consideration of the entrance fee as a countable resource.

(3) If the applicant or recipient submits a rebuttal to the Department, the Department shall request additional documentation and evidence from the CCRC that support the basis for the CCRC's written verification of the availability of the entrance fee.

(4) The entrance fee may not be considered as a countable resource for determining the applicant's or recipient's Medical Assistance eligibility if the:

(a) Requirements in §B(1) of this regulation are not met;

(b) CCRC imposes limitations, conditions, penalties, or otherwise restricts the individual's right to reside in the CCRC facility when the individual uses funds from the entrance fee to make payments or transfers in accordance with §B(1)(c) — (e) of this regulation; or

(c) Applicant or recipient successfully rebuts, as determined by the Department in accordance with §B(2) of this regulation, the CCRC's written verification that all of the conditions in §B(1) of this regulation are met.

.08-4 Resource Consideration of Long-Term Care Partnership Policies.

A. This regulation establishes the rules for applicants and recipients who:

(1) Own a long-term care (LTC) partnership policy; and

(2) Meet all factors of Medicaid eligibility in accordance with MAGI Exempt coverage groups described in this chapter.

B. Definitions.

(1) In this regulation, the following terms have the meanings indicated.

(2) Defined Terms.

(a) "Benefit payment amount" means the dollar value of LTC benefits which an insurance carrier has furnished on behalf of a partnership policyholder and which is disregarded from the resource amount when determining eligibility.

(b) "Insurance carrier" means an insurer who issues an insurance policy and makes benefit payment amounts on behalf of a partnership policyholder.

(c) "Partnership policy" means a LTC insurance policy that meets the requirements as described under COMAR 31.14.03.02 and whose benefit payment amount is disregarded from the resource amount when determining eligibility.

(d) "Partnership policyholder" means an individual who owns a partnership policy under the federal LTC partnership program.

(e) "Reciprocity compact" means an agreement among states having partnership programs that are approved under section 6021(b) of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA).

C. Partnership Policyholder Requirements.

(1) An applicant or recipient shall meet all factors of Medicaid eligibility in accordance with rules for MAGI Exempt coverage groups set forth in this chapter.

(2) An applicant or recipient shall have:

(a) A Maryland partnership policy approved on or after January 1, 2009, that meets all certification requirements, as described in COMAR 31.14.03; or

(b) A partnership policy approved in another state that has joined the national reciprocity compact under the federal LTC partnership program.

(3) An applicant or recipient shall provide documentation of the partnership policy benefit payments that have been issued by an insurance carrier.

(4) Subject to Regulation .10-2E of this chapter, an applicant or recipient who applies for LTC Medical Assistance in a nursing facility or through a waiver program shall be ineligible for payment for nursing facility services, or services under a home and community based waiver program, when the individual's equity interest in home property exceeds the maximum allowable home equity amount as set forth in Regulation .10-2 of this chapter.

D. Eligibility Determination for a Partnership Policyholder.

(1) When determining the resources of an individual in accordance with Regulation .08 of this chapter, there shall be disregarded a dollar value equal to the benefit payment amount.

(2) The benefit payment amount for purposes of the disregard set forth in §D(1) of this regulation shall:

(a) For purposes of initial application, equal the dollar amount of benefits paid to or on behalf of the partnership beneficiary at the time of application; and

(b) For purposes of redetermination, equal the benefit payment amount in §D(2)(a) of this regulation and the value of any additional benefits paid to or on behalf of the partnership beneficiary up to the time of redetermination, until all benefits under the

partnership policy are exhausted.

(3) At the time of application and at each redetermination, the Department shall request documentation of the benefit payment amount.

E. With the exception of an amount equal in value to the benefit payment amount applied at the most recent redetermination period, partnership policyholders will continue to be subject to a penalty for asset transfers for less than fair market value in accordance with Regulation .08 of this chapter.

F. Estate recovery by the Department is limited as set forth in Regulation .15A-3(5) of this chapter.

.09 Determining Financial Eligibility for Noninstitutionalized Individuals.

A. Basis.

(1) Financial eligibility is determined on the basis of the countable net income and resources of members of the MAGI exempt assistance unit and those individuals whose income and resource are considered pursuant to Regulations .06, .07, and .08 of this chapter for the period under consideration. For current eligibility under spend-down, a review to identify changes in the unit's financial and nonfinancial eligibility status shall be made before spend-down eligibility is established.

(2) The appropriate medically needy income level shall be the amount specified in Schedule MA-1 for the number of persons whose income is considered in determining financial eligibility.

(3) The appropriate medically needy resource level shall be the amount specified in Schedule MA-2 for the number of persons whose resources are considered in determining financial eligibility.

(4) Financial eligibility is determined on the basis of the countable income for members of the MAGI household unit and those individuals whose income are considered pursuant to Regulations .06-1 and .07 of this chapter for the period under consideration. For current eligibility under spend-down, a review to identify changes in the unit's financial and nonfinancial eligibility status shall be made before spend-down eligibility is established.

B. Retroactive Eligibility.

(1) When the countable net income and resources are equal to or less than the medically needy income and resource levels, eligibility exists as medically needy.

(2) When the countable net income is greater than the medically needy income level and the countable resources are equal to or less than the medically needy resource level, retroactive eligibility may exist under the spend-down provision as specified in §B(4) of this regulation.

(3) Excess Resources. Retroactive eligibility does not exist when the countable resources are greater than the medically needy resource level.

(4) Retroactive Spend-Down Eligibility.

(a) In determining retroactive spend-down eligibility, documented medical and remedial expenses incurred during the 3 months before the month of application of any person whose income and resources are considered in determining eligibility shall be considered if the incurred expenses:

(i) Have not been paid for by any third party, including a family member or an insurer; and

(ii) Are not required to be paid for by any third party, such as an insurer.

(b) The incurred medical expenses shall be considered on a month-by-month basis beginning with the earliest month in the period under consideration and shall be deducted from excess income in the following order:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges;

(ii) Expenses incurred for necessary medical care or remedial services that are recognized under State law but are not covered under the State Plan;

(iii) Expenses incurred for necessary medical care or remedial services that are covered under the State Plan.

(c) Retroactive spend-down eligibility is established when the incurred medical expenses exceed the excess income.

(d) The medical expense used to establish retroactive spend-down eligibility may not be:

(i) Reimbursed by the Medical Assistance Program; or

(ii) Used for any subsequent eligibility determination.

(e) Retroactive spend-down eligibility is not established when the incurred medical expenses are equal to or less than the excess income.

C. Current Eligibility.

(1) When the countable net income and resources are equal to or less than the medically needy income and resource levels, eligibility exists as medically needy.

(2) When the countable net income is greater than the medically needy income level and the countable resources are equal to or less than the medically needy resource level, eligibility may exist under the spend-down provision as specified in §C(4) of this regulation. Spend-down eligibility is established when the amount of the incurred medical expenses equals or exceeds the excess income.

(3) Excess Resources. Eligibility does not exist when the countable resources are greater than the medically needy resource level.

(4) Spend-Down Eligibility.

(a) In determining spend-down eligibility, documented medical expenses incurred during the time periods and meeting the conditions specified in §C(4)(b)—(d) of this regulation shall be considered.

(b) Medical expenses incurred before the month of application shall be considered if:

(i) The expenses were not considered in any retroactive certification;

(ii) The expenses were not used to establish spend-down eligibility for a prior certification; and

(iii) The expenses are not paid for by any other person, remain the obligation of the person whose income and resources are considered in determining eligibility, and have not been forgiven by the provider of the services as evidenced by account statements dating up to 3 months before the month of application.

(c) Medical expenses incurred at any time during or after the month of application and before the end of the period under consideration by any person whose income and resources are considered in determining eligibility shall be considered if the medical expenses:

(i) Have not been paid for by any third party, including a family member or an insurer; and

(ii) Are not required to be paid for by any third party, such as an insurer.

(d) Each medical bill verifying expenses shall include a statement of the service and the date the service was rendered. For purchases of medicines and medical supplies or equipment, the statement from the provider shall include the item purchased and the date and cost of the purchase.

(e) Medical expenses incurred during the time periods specified in §C(4)(b) and (c) of this regulation shall be deducted from the excess income beginning with the earliest time period and in the following order:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges;

(ii) Expenses incurred for necessary medical care or remedial services that are recognized under State law but are not covered under the State Plan;

(iii) Expenses incurred for necessary medical care or remedial services that are covered under the State Plan.

(f) Spend-down eligibility is established for the remainder of the period under consideration when the incurred medical expenses equal or exceed the amount of excess income. The medical expenses used to establish spend-down eligibility may not be:

(i) Reimbursed by the Medical Assistance Program; or

(ii) Used for any subsequent eligibility determination.

(g) When spend-down eligibility is not established during the application process, the applicant shall be notified of his ineligibility and advised of the spend-down provision. The application date shall be preserved for possible spend-down eligibility at any time during the established period under consideration.

(h) When the incurred medical expenses do not equal the amount of excess income during the period under consideration, eligibility does not exist. A new application date and period under consideration will be established when the applicant reapplies after

the expiration of the established period under consideration.

.10 Determining Financial Eligibility for Institutionalized Persons.

A. Scope.

(1) This section applies to persons who are institutionalized throughout a calendar month.

(2) Institutional status is presumed to begin on the first day of the first full calendar month in which the person is institutionalized and ends on the last day of the last full calendar month before discharge.

(3) Institutional status is not interrupted by a transfer from one long-term care facility to another or by a transfer from a long-term-care facility to a hospital.

(4) Presumed institutional status changes on the first day of the month of discharge to the community.

(5) Eligibility for noninstitutionalized persons shall be determined separately under Regulation .09 of this chapter.

B. Basis.

(1) Financial eligibility shall be determined on the basis of the countable resources and income of members of the assistance unit.

(2) A person is categorically needy if his total income before deductions does not exceed 300 percent of the current SSI payment standard and his countable resources are within the applicable amount in Schedule MA-2A.

(3) A person is medically needy if his total income before deductions exceeds 300 percent of the SSI payment standard or if countable resources exceed the applicable amount in Schedule MA-2A.

(4) When calculating an institutionalized recipient's available income for the cost-of-care in a long-term care facility, in accordance with Regulations .10 and .10-1 of this chapter, guardianship fees may not be allowed as an income deduction, whether or not the recipient has a community spouse.

C. Retroactive Eligibility.

(1) A retroactive eligibility determination shall be made for services incurred by an institutionalized person within 3 months before the month of application. Eligibility will be considered only for the month, or months, in which the expenses were incurred.

(2) The period under consideration shall be the month, or months, for which coverage is requested.

(3) Excess Resources. When the countable resources are greater than the medically needy resource standard, retroactive eligibility does not exist.

(4) Determination of Available Income for the Retroactive Period. The following amounts shall be deducted from the total income in the following order:

(a) For dates of service beginning July 1, 2003, a personal needs allowance of:

(i) $50 a month for an institutionalized person other than a person who meets the requirements of §C(4)(a)(iii) of this regulation.

(ii) $100 a month for an institutionalized couple.

(iii) $100 a month for a person who resided in an ICF/IID or mental hospital, participated in therapeutic work activities, and received remuneration for participation in these activities. An amount greater than $100 a month but not to exceed the MNIL may be deducted based on additional documented work-related need.

(b) For dates of service beginning July 1, 2004, a personal needs allowance of:

(i) $60 a month for an institutionalized person other than a person who meets the requirements of §C(4)(b)(iii) of this regulation;

(ii) $120 a month for an institutionalized couple; and

(iii) $100 a month for a person who resides in an ICF/IID or mental hospital, participates in therapeutic work activities, and received remuneration for participation in these activities, and an amount greater than $100 a month but not to exceed the MNIL which may be deducted from available income based on additional documented work-related need.

(c) For dates of service beginning July 1, 2005, a personal needs allowance adjusted annually by an amount not exceeding 5 percent to reflect the percentage by which social security benefits are increased by the federal government to reflect changes in the cost of living.

(d) Spousal or Family Allowance or Both. For an institutionalized spouse as defined under Regulation .11B(6) of this chapter, an amount equal to the community spouse monthly income allowance as defined under Regulation .11B(2) of this chapter and, if applicable, an amount equal to the family allowance as determined under Regulation .11C(3)(c) of this chapter. For an institutionalized person without a spouse in the community, the amount needed to maintain an unmarried child or children younger than 21 years old living at home at a level which, based on verified need, equals the applicable medically needy income level.

(e) Residential Maintenance Allowance for a Single Person.

(i) For a person with no spouse or unmarried child younger than 21 years old at home, the amount not to exceed the medically needy income level that was needed to maintain the person's residence during the retroactive period shall be deducted beginning with the person's earliest first full month of institutionalization if, based on a medical review process established by the Department, it is determined that the person will be able to resume living in his community residence and that the person intends to do so.

(ii) Institutional status is not interrupted by a transfer from one long-term care facility to another or by a transfer to a hospital.

(f) Incurred expenses for medical care or remedial service that have not been paid for by any third party, including a family member or an insurer, and are not required to be paid for by any third party, such as an insurer, including:

(i) Medicare and other health insurance premiums, deductibles or co-insurance charges;

(ii) In the case of eligibility determinations before August 1, 2005, necessary medical care or remedial service recognized under State law but not covered under the State Plan; and

(iii) In the case of eligibility determinations on or after August 1, 2005, unless a court of competent jurisdiction issues a contrary ruling in a final unappealable order, necessary medical care or remedial service recognized under State law but not subject to Medical Assistance reimbursement.

(g) Incurred expenses for necessary medical care or remedial service described under §C(4)(f)(iii) of this regulation as follows:

(i) For eligibility determinations on or after August 1, 2005, unless a court of competent jurisdiction issues a contrary ruling in a final unappealable order, incurred expenses may not include medical expenses for dates of service more than 3 months before the month of the Medical Assistance application; and

(ii) Incurred expenses shall be limited to the fees reimbursed by Medical Assistance in effect on the date of service and shall be for actual charges if no Medical Assistance fee exists.

(h) The maximum deduction for unpaid nursing facility bills incurred during a penalty period resulting from a transfer of assets shall be zero.

(5) Subject to the requirements of §C(6) of this regulation, effective October 1, 2016, the personal needs allowance set forth in §C(4) of this regulation shall be increased as follows:

(a) For a Medicaid recipient who has been assigned a guardian of the person, $50 per month;

(b) For a Medicaid recipient who has been assigned a guardian of the property, $50 per month;

(c) For a Medicaid recipient who has been assigned a single guardian serving all purposes, $50 per month; and

(d) For a Medicaid recipient who has been assigned one individual to serve as guardian of the person and one different individual to serve as guardian of the property, $100 per month.

(6) A guardian shall submit a monthly bill to the Medicaid recipient or authorized representative in order for a guardianship fee to be added to the recipient's personal needs allowance set forth in §C(4) of this regulation.

(7) If the effective date cited in §C(4)(f)(ii) and (iii), and (g)(i) of this regulation is invalidated by final unappealable order of a court of competent jurisdiction, the effective date shall be April 1, 2009.

(8) When the available income as determined under §C(4) of this regulation is equal to or less than the person's incurred cost-of-care to the facility and countable resources are equal to or less than the medically needy resource standard, retroactive eligibility exists and begins on the first day of the period under consideration. Certification is established under Regulation .11D of this chapter.

(9) When the available income as determined under §C(4) of this regulation is greater than the person's incurred cost-of-care to the facility and countable resources are equal to or less than the medically needy resource standard, retroactive eligibility may exist under §C(10) of this regulation.

(10) Retroactive Spend-Down Eligibility.

(a) In determining retroactive spend-down eligibility, documented medical expenses incurred more than 3 months before the month of the Medical Assistance application shall be considered if the incurred expenses:

(i) Have not been paid for by any third party, including a family member or an insurer;

(ii) Are not required to be paid for by any third party, such as an insurer;

(iii) Were not incurred during a penalty period; and

(iv) Were not forgiven by the provider.

(b) The incurred medical expenses shall be considered on a month-by-month basis beginning with the earliest month in the period under consideration and shall be deducted from excess available income in the following order:

(i) Medicare and other health insurance premiums, deductibles, or co-insurance charges;

(ii) Expenses incurred for necessary medical care or remedial services that are recognized under State law but are not covered under the State Plan;

(iii) Expenses incurred for necessary medical care or remedial services that are covered under the State Plan.

(c) The medical expenses used to establish retroactive spend-down eligibility may not be:

(i) Reimbursed by the Medical Assistance Program;

(ii) Used for any subsequent eligibility determination; or

(iii) Incurred before the period for which retroactive eligibility is requested.

(d) Retroactive spend-down eligibility is established on the day the incurred medical expenses considered under §C(10)(b) of this regulation equal or exceed the excess available income. Certification is established under Regulation .11D of this chapter.

(e) Retroactive spend-down eligibility is not established when the incurred medical expenses are less than the excess available income.

D. Current Eligibility.

(1) Excess Resources. When the countable resources are greater than the medically needy resource level, eligibility does not exist.

(2) Determination of Available Income. The following amounts shall be deducted from total income in the following order:

(a) For dates of service beginning July 1, 2003, a personal needs allowance of:

(i) $50 a month for an institutionalized person other than a person who meets the requirements of §D(2)(a)(iii) of this regulation.

(ii) $100 a month for an institutionalized couple.

(iii) $100 a month for a person who resides in an ICF/IID or mental hospital, participates in therapeutic work activities, and receives remuneration for participating in these activities. An amount greater than $100 a month but not to exceed the MNIL may be deducted based on additional documented work-related need.

(b) For dates of service beginning July 1, 2004, a personal needs allowance of:

(i) $60 a month for an institutionalized person other than a person who meets the requirements of §D(2)(b)(iii) of this regulation;

(ii) $120 a month for an institutionalized couple; and

(iii) $100 a month for a person who resides in an ICF/IID or mental hospital, participates in therapeutic work activities, and received remuneration for participation in these activities, and an amount greater than $100 a month but not to exceed the MNIL which may be deducted from available income based on additional documented work-related need.

(c) For dates of service beginning July 1, 2005, a personal needs allowance adjusted annually by an amount not exceeding 5 percent to reflect the percentage by which social security benefits are increased by the federal government to reflect changes in the cost of living.

(d) Spousal or Family Allowance or Both. For an institutionalized spouse as defined under Regulation .11B(6) of this chapter, an amount equal to the community spouse monthly income allowance as defined under Regulation .11B(2) of this chapter and, if applicable, an amount equal to the family allowance as determined under Regulation .11C(3)(c) of this chapter. For an institutionalized person without a spouse in the community, the amount needed to maintain an unmarried child or children younger than 21 years old living at home at a level which, based on verified need, equals the applicable medically needy income level.

(e) Residential Maintenance Allowance for a Single Person.

(i) For a person with no spouse or unmarried child younger than 21 years old at home, an amount not to exceed the medically needy income level needed to maintain the person's residence during institutionalization shall be deducted for a period of up to 6 months beginning with the person's first full month of current institutionalization if, based on a medical review process established by the Department, it is determined that the person will be able to resume living in his community residence during this period and that person intends to do so.

(ii) The maximum 6-month period is not interrupted by a transfer from one long-term care facility to another or by admission to a hospital.

(f) The following incurred medical expenses that are not subject to payment by a third party:

(i) Medicare and other health insurance premiums, deductibles or co-insurance charges;

(ii) For eligibility determinations before August 1, 2005, necessary medical care or remedial service recognized under State law but not covered under the State Plan; and

(iii) For eligibility determinations on or after August 1, 2005, unless a court of competent jurisdiction issues a contrary ruling in a final unappealable order, necessary medical care or remedial service recognized under State law but not subject to Medical Assistance reimbursement.

(g) Incurred expenses for necessary medical care or remedial service described under §D(2)(f)(iii) of this regulation as follows:

(i) For eligibility determinations on or after August 1, 2005, unless a court of competent jurisdiction issues a contrary ruling in a final unappealable order, incurred expenses may not include medical expenses for dates of service more than 3 months before the month of the Medical Assistance application; and

(ii) Incurred expenses shall be limited to the fees reimbursed by Medical Assistance in effect on the date of service and shall be for actual charges if no Medical Assistance fee exists.

(h) The maximum deduction for unpaid nursing facility bills incurred during a penalty period resulting from a transfer of assets shall be zero.

(3) Subject to the requirements of §D(4) of this regulation, effective October 1, 2016, the personal needs allowance is increased as follows:

(a) For a Medicaid recipient who has been assigned a guardian of the person, $50 per month;

(b) For a Medicaid recipient who has been assigned a guardian of the property, $50 per month;

(c) For a Medicaid recipient who has been assigned a single guardian serving all purposes, $50 per month;

(d) For a Medicaid recipient who has been assigned one individual to serve as guardian of the person and one different individual to serve as guardian of the property, $100 per month.

(4) A guardian shall submit a monthly bill to the Medicaid recipient or authorized representative in order for a guardianship fee to be added to the recipient's personal needs allowance set forth in §D(2) of this regulation.

(5) If the effective date cited in §D(2)(f)(ii) and (iii) and (g)(i) of this regulation is invalidated by final unappealable order of a court of competent jurisdiction, the effective date shall be April 1, 2009.

(6) If, after application of the disregards in §D(2) of this regulation, the person's income equals or is less than the projected cost-of-care, eligibility exists and may begin on the first day of the period under consideration. The amount remaining after application of the disregards in §D(2) of this regulation is available income to be applied to the person's cost-of-care. Certification is established under Regulation .11D of this chapter.

(7) If, after application of the disregards in §D(2) of this regulation, the person's income exceeds the projected cost-of-care, eligibility may be established under §D(8) of this regulation.

(8) Spend-down Eligibility.

(a) In determining spend-down eligibility, documented medical expenses incurred during the time periods and meeting the conditions specified in this section shall be considered.

(b) Medical expenses incurred before the month of application shall be considered if the expenses:

(i) Were not considered in any retroactive certification;

(ii) Were not used to establish spend-down eligibility for a prior certification;

(iii) Have not been paid for by any third party, including a family member or an insurer, and are not required to be paid for by any third party, such as an insurer;

(iv) Were not incurred during a penalty period;

(v) Remain the obligation of any person whose income and resources are considered in determining eligibility; and

(vi) Have not been forgiven by the provider of the services, as evidenced by account statements dating up to 3 months before the month of application.

(c) Medical expenses incurred at any time during or after the month of application and before the end of the period under consideration shall be considered if they:

(i) Were not paid for by any third party, including a family member or an insurer;

(ii) Are not required to be paid for by any third party, such as an insurer;

(iii) Were not incurred during a penalty period; and

(iv) Have not been forgiven by the provider.

(d) Each medical bill verifying expenses shall include a statement of the service and the date the service was rendered. For purchases of medicines and medical supplies or equipment, the statement from the provider shall include the item purchased and the date and cost of the purchase.

(e) Medical expenses incurred during the time periods specified in §D(8)(b) and (c) of this regulation shall be deducted from the excess available income beginning with the earliest time period and in the following order:

(i) Medicare and other health insurance premiums, deductibles, or co-insurance charges;

(ii) Expenses incurred for necessary medical care or remedial services that are recognized under State law but are not covered under the State Plan;

(iii) Expenses incurred for necessary medical care or remedial services that are covered under the State Plan.

(f) Spend-down eligibility is established for the remainder of the period under consideration on the day the incurred medical expenses, considered under §D(8)(e) of this regulation, including projected private cost-of-care obligations, equal or exceed the amount

of excess available income. Certification is established under Regulation .11D of this chapter.

(g) The medical expenses used to establish spend-down eligibility may not be:

(i) Reimbursed by the Medical Assistance Program; or

(ii) Used for any subsequent eligibility determination.

(h) Eligibility exists on the day that incurred medical expenses equal or exceed the amount of excess available income.

(i) When spend-down eligibility is not established during the application process, the applicant shall be notified of his ineligibility and advised of the spend-down provision. The application date shall be preserved for possible spend-down eligibility at any time during the established period under consideration.

(j) Eligibility exists on the day during the preserved spend-down period that incurred medical expenses equal or exceed the amount of excess available income. Certification is established under Regulation .11D of this chapter.

(k) When the incurred medical expenses do not equal the amount of excess available income during the period under consideration, eligibility does not exist. A new application date and period under consideration will be established when the applicant reapplies after the expiration of the established period under consideration.

.10-1 Treatment of Income and Resources of Certain Institutionalized Spouses.

A. Basis.

(1) Except as this regulation specifically provides, the provisions of this regulation may not affect:

(a) The determination of what constitutes income or resources;

(b) The methodology and standards for determining and evaluating income and resources;

(c) The criteria and standards for determining financial and nonfinancial eligibility for Medical Assistance; or

(d) Any other provision of this chapter.

(2) In determining the eligibility for Medical Assistance of an institutionalized spouse as defined under §B(6) of this regulation, the provisions of this regulation shall supersede any other provisions of this chapter which are inconsistent with them.

(3) Sections D and E of this regulation, which concern the treatment of resources, shall apply to a person who begins a continuous period of institutionalization on or after September 30, 1989. Section C of this regulation, which concerns the treatment of income, shall apply to a person who begins a continuous period of institutionalization before or after September 30, 1989 and who remains institutionalized for a continuous period on or after September 30, 1989. Continuity is broken by absence from an institution for 30 consecutive days.

B. Definitions.

(1) "Community spouse" means a person who lives in the community outside an institution and who is married to an institutionalized spouse.

(2) "Community spouse monthly income allowance" means the amount by which the minimum monthly maintenance needs allowance established under §C(5) of this regulation exceeds the amount of monthly income otherwise available to the community spouse.

(3) "Community spouse resource amount" means the greatest of the amounts under §E(2)(a)—(d) of this regulation.

(4) "Continuous period of institutionalization" means 30 consecutive days of institutional care in a medical institution or nursing home.

(5) "Excess shelter allowance" means the amount by which the sum of the community spouse's expenses for shelter exceeds 30 percent of the amount described under §C(5)(a) of this regulation. Expenses for shelter include rent or mortgage payment, taxes and insurance for the community spouse's principal residence and the standard utility allowance used by the State under §5(e) of the Food Stamp Act of 1977. If the community spouse's principal residence is a condominium or cooperative, the required maintenance charge for the condominium or cooperative shall be included in the sum of the community spouse's expenses for shelter, and the standard utility allowance shall be reduced to the extent the required maintenance charge includes utility expenses.

(6) "Family member" means minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(7) "Institutionalized spouse" means a person who is an inpatient in a nursing facility or who is an inpatient in a medical institution and with respect to whom payment is made based upon a level of care provided in a nursing facility, whose average length of stay exceeds 30 days and who is married to a person who is not in a medical institution or nursing facility.

C. Treatment of Income.

(1) Separate Treatment of Income. During any month in which an institutionalized spouse is in the institution, except as provided under §C(2) of this regulation, income of the community spouse may not be deemed available to the institutionalized spouse.

(2) Attribution of Income. In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined to be eligible for Medical Assistance, the following apply:

(a) Non-Trust Property. Except as provided under §C(2)(c) and (d) of this regulation, unless the instrument providing the income otherwise specifically provides, if payment of income is made:

(i) Solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) In the name of the institutionalized spouse and the community spouse, 1/2 of the income shall be considered available to each of them; and

(iii) In the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest or, if payment is made with respect to both spouses and no such interest is specified, 1/2 of the joint interest shall be considered available to each spouse.

(b) Trust Property. In the case of a trust, income shall be considered available to each spouse as provided in the trust or, in the absence of a specific provision in the trust, if payment of income is made:

(i) Solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) To both the institutionalized spouse and the community spouse, 1/2 of the income shall be considered available to each of them; and

(iii) To the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest; or

(iv) To both spouses and if the interest is not specified, 1/2 of the joint interest shall be considered available to each spouse.

(c) In the case of income not from a trust in which there is an instrument establishing ownership, except as provided under §C(2)(d) of this regulation, 1/2 of the income shall be considered to be available to the institutionalized spouse and 1/2 to the community spouse.

(d) Section C(2)(a) and (c) of this regulation shall be superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under these sections.

(3) Protecting Income for the Community Spouse. After an institutionalized spouse is determined to be eligible for Medical Assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the cost of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(a) A personal needs allowance of:

(i) $50 a month for dates of service beginning July 1, 2003;

(ii) $60 a month for dates of service beginning July 1, 2004; and

(iii) For dates of service beginning July 1, 2005, an amount adjusted annually by an amount not exceeding 5 percent to reflect the percentage by which social security benefits are increased by the federal government to reflect changes in the cost of living.

(b) A community spouse monthly income allowance as defined under §B(2) of this regulation, but only to the extent income of the institutionalized spouse is made available to, or for the benefit of, the community spouse;

(c) A family allowance, for each family member defined under §B(5) of this regulation, equal to 1/3 of the amount by which the amount described under §C(5)(a) of this regulation exceeds the amount of the monthly income of that family member; and

(d) Incurred expenses for medical care or remedial service for the institutionalized spouse that are not subject to payment by a third party, including:

(i) Medicare and other health insurance premiums, deductibles or co-insurance charges, and

(ii) Necessary medical care or remedial service recognized under the State law but not covered under the State plan.

(4) Incurred expenses for necessary medical care or remedial service described under §C(3)(d)(ii) of this regulation shall be limited to the fees reimbursed by Medical Assistance which are in effect on the date of service.

(5) Establishment of Minimum Monthly Maintenance Needs Allowance. The minimum monthly maintenance needs allowance for a community spouse is the sum of:

(a) The applicable percent, described under §C(6) of this regulation, of 1/12 of the income official poverty line for a family unit of two members; and

(b) An excess shelter allowance as defined under §B(5) of this regulation.

(6) Applicable Percent. For purposes of §C(5)(a) of this regulation, the applicable percent, effective as of the following dates, is:

(a) September 30, 1989, 122 percent;

(b) July 1, 1991, 133 percent; and

(c) July 1, 1992, 150 percent.

(7) Cap on Minimum Monthly Maintenance Needs Allowance. The minimum monthly maintenance needs allowance established under §C(5) of this regulation may not exceed $1,500, subject to adjustment under §G of this regulation, except as provided under §F(3) of this regulation.

(8) Court Ordered Support. If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance as defined under §B(2) of this regulation shall be not less than the amount of the monthly income ordered.

D. Treatment of Resources.

(1) Computation of Spousal Share at the Time of Institutionalization.

(a) Total Joint Resources. There shall be computed, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse:

(i) The total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest;

(ii) A spousal share which is equal to 1/2 of the total value.

(b) Assessment. At the request of an institutionalized spouse or community spouse, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse and upon receipt of the relevant documentation of resources, the Department shall:

(i) Promptly assess and document the total value of the resources;

(ii) Provide a copy of the assessment and documentation to each spouse; and

(iii) Retain a copy of the assessment for use under this regulation.

(c) Request for Assessment When Not Part of the Medical Assistance Application. If the request is not part of an application for Medical Assistance, the Department may not include a notice indicating that the spouse has the right to a fair hearing as provided for under §F(1)(c) of this regulation, but shall require payment of a fee not to exceed the reasonable expense of providing and documenting the assessment.

(2) Attribution of Resources at the Time of Initial Eligibility Determination. In determining the resources of an institutionalized spouse at the time of application for benefits under this chapter, regardless of any State laws relating to community property or the division of marital property, all the resources held by either the institutionalized spouse, the community spouse, or both, shall be considered to be available to the institutionalized spouse, but only to the extent that the amount of the resources exceeds the greatest of the amounts computed under §E(2)(a)—(d) of this regulation at the time of application for benefits.

(3) Assignment of Support Rights. The institutionalized spouse may not be ineligible by reason of resources determined under §D(2) of this regulation when:

(a) The resources are unavailable to the institutionalized spouse;

(b) Payments are not being made for the care of the institutionalized spouse;

(c) The institutionalized spouse, or that person's guardian or attorney in fact or representative, agrees to cooperate with the State in bringing a criminal action for nonsupport under Family Law Article, §§10-201 and 10-202, Annotated Code of Maryland; and

(d) The institutionalized spouse, if capable of executing an assignment, has assigned all support rights from the community spouse to the State.

(4) Resources may not be considered to be unavailable to the institutionalized spouse under §D3(a) of this regulation if the institutionalized spouse, or:

(a) That spouse's guardian or attorney in fact has the legal authority to withdraw, liquidate, or otherwise access those resources; or

(b) The institutionalized spouse's guardian or attorney in fact, has assisted in making those resources unavailable unless it can be demonstrated, to the Department's satisfaction, that the:

(i) Action was primarily for a purpose unrelated to Medical Assistance eligibility, and

(ii) Denial of eligibility would work an undue hardship.

(5) Resources shall be considered to be unavailable to the institutionalized spouse under §D(3)(a) of this regulation only if the community spouse has willfully failed to, and refuses to, pay for care of the institutionalized spouse or cannot be located.

(6) Section D(3)(c) or (d) of this regulation may not be considered to be satisfied if the institutionalized spouse, or the institutionalized spouse's guardian or attorney in fact, has taken any action or otherwise assisted in limiting his or her support rights from the community spouse.

(7) The Department shall waive the requirements of §D(3)(c) or (d) of this regulation if the Department determines that denial of eligibility would work an undue hardship.

(8) Separate Treatment of Resources After Eligibility for Benefits Established. During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this chapter, resources of the community spouse may not be deemed available to the institutionalized spouse.

E. Permitting Transfer of Resources to the Community Spouse.

(1) In General. An institutionalized spouse may, without regard to Regulation .08K of this chapter, transfer to the community spouse, or to another for the sole benefit of the community spouse, an amount equal to the community spouse resource allowance as defined under §E(2) of this regulation, but only to the extent the resources of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse. The transfer shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under §E(3) of this regulation.

(2) Community Spouse Resource Allowance Defined. The community spouse resource allowance is the amount by which the greatest of the following amounts exceeds the amount of resources otherwise available to the community spouse:

(a) $12,000, subject to adjustment under §G of this regulation;

(b) The lesser of the spousal share computed under §D(1)(ii) of this regulation or $60,000, subject to adjustment under §G of this regulation;

(c) The amount established under §F(4) of this regulation; or

(d) The amount transferred under a court order under §E(3) of this regulation.

(3) Transfers Under Court Orders. If a court has entered an order against an institutionalized spouse for the support of the community spouse, Regulation .08K of this chapter may not apply to amounts of resources transferred under the order for the support of the spouse or a family member as defined under §B(5) of this regulation.

F. Fair Hearing.

(1) The spouse is entitled to a fair hearing as provided for under Regulation .14 of this chapter if either the institutionalized spouse or the community spouse is dissatisfied with the determination of any of the following:

(a) Minimum monthly maintenance needs allowance as established under §C(5) of this regulation;

(b) Determination of the amount of monthly income otherwise available to the community spouse;

(c) Computation of the spousal share of resources under §D(1) of this regulation;

(d) Attribution of resources under §D(2) of this regulation; or

(e) Determination of the community spouse resource allowance as defined under §E(2) of this regulation.

(2) Any hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing if an application for benefits under this chapter has been made on behalf of the institutionalized spouse.

(3) Revision of Minimum Monthly Maintenance Needs Allowance. If either the institutionalized spouse or the community spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances resulting in significant financial duress, the Department shall substitute, for the minimum monthly maintenance needs allowance established under §C(5) of this regulation, an amount adequate to provide the additional income as is necessary.

(4) Revision of Community Spouse Resource Amount. If either the institutionalized spouse or the community spouse establishes that the community spouse resource amount, in relation to the amount of income generated by that amount, is inadequate to raise the community spouse's income, which shall include the amount of the community spouse monthly income allowance, to the minimum monthly maintenance needs allowance, the Department shall substitute, for the community spouse resource amount, an amount adequate to provide a minimum monthly maintenance needs allowance.

G. For services furnished during a calendar year after 1989, the dollar amounts specified under §§C(7) and E(2)(a) and (b) of this regulation shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers between September, 1988 and the September preceding the calendar year involved.

.10-2 Substantial Home Equity and Exclusion of Long-Term Care Coverage.

A. Subject to §E of this regulation, an institutionalized individual is not covered by Medical Assistance for long-term care services in a nursing facility, medical institution with a level of care equivalent to a nursing facility, or home and community-based services waiver if:

(1) The individual's equity interest in the individual's home property, reduced by any bona fide, legally binding, documented encumbrances secured by the home, exceeds the amount specified in §D of this regulation; and

(2) The individual does not have, lawfully residing in the home, the individual's spouse or the individual's son or daughter who is:

(a) Younger than 21 years old; or

(b) Blind or disabled as determined under Regulation .05-4 of this chapter.

B. For all applications received on January 1, 2007 or after, the Department shall evaluate the institutionalized individual's equity interest in the individual's home property if the individual is determined eligible for Medical Assistance based on:

(1) An initial determination of nursing facility or waiver eligibility;

(2) A reapplication for nursing facility or waiver eligibility after a break in nursing facility or waiver eligibility; or

(3) A redetermination after an initial determination or reapplication in accordance with §B(1) or (2) of this regulation.

C. The institutionalized individual's equity interest in the individual's home property shall be evaluated by the Department, in accordance with §§A and B of this regulation, at:

(1) The determination of nursing facility or waiver eligibility; and

(2) Each subsequent redetermination of nursing facility or waiver eligibility.

D. The maximum allowable equity interest specified at §A(1) of this regulation shall be $543,000 in calendar year 2014, adjusted annually as set forth in section 6014 of the Deficit Reduction Act of 2005, Pub. L. 109-171 (DRA) by the percentage increase in the consumer price index for all urban consumers, rounded to the nearest $1,000.

E. Reductions to Equity Interest.

(1) If the individual has ownership interest in no property other than the home, the benefit payment amount shall be applied to reduce an equal amount of home equity.

(2) A mortgage, reverse mortgage, home equity loan, lien, or other bona fide encumbrance received by the individual and secured by the home property may be considered by the Department to reduce the individual's equity interest in the home.

F. An exclusion of long-term care coverage, in accordance with §A of this regulation, shall be applied even if there is a legal impediment to transferring or selling the home property.

G. The Department may waive the application of §F of this regulation if the Department determines that denial of eligibility for long-term care coverage would work an undue hardship.

.11 Certification Periods.

A. This regulation specifies the time periods for certifying eligible members of an assistance unit. Certification periods for retroactive and current coverage will be based on consideration periods established in accordance with the provisions of Regulations .09 and .10 of this chapter.

B. Certification of Eligible Noninstitutionalized Persons.

(1) The following eligible noninstitutionalized persons shall be certified for a one-time-only period of 6 months or less and scheduled redetermination for continued eligibility may not be made:

(a) Those who are certified for a retroactive period only, including retroactive spend-down;

(b) Those who are certified under the spend-down provision; and

(c) Those whose anticipated circumstances preclude eligibility beyond the current period.

(2) Section B(1)(c) of this regulation is limited to:

(a) A person who dies before the completion of the eligibility determination;

(b) A migrant worker whose date of departure or expected date of departure from the State is known; and

(c) A coverable inmate of a public institution who leaves the institution solely for admission to a medical facility.

(3) Eligible persons not certified under §B(1) of this regulation shall be certified for a one-time-only period of 6 months and scheduled redetermination of eligibility shall be made.

C. Date for Certification to Begin and End for Noninstitutionalized Persons.

(1) Persons Eligible for Retroactive Coverage Under Spend-Down.

(a) Certification begins on the day in the period under consideration on which retroactive spend-down eligibility was met.

(b) Certification ends on the last day of the most recent month in the retroactive period in which coverable expenses were incurred.

(c) Only persons who have coverable medical expenses during the period under consideration shall be certified.

(d) Certification under this provision shall cover only those incurred medical bills that are not subject to third-party payment and remain the liability of persons in the assistance unit.

(2) Persons Eligible for Retroactive Coverage Without Spend-Down.

(a) Certification begins on the first day of the earliest month of the retroactive period under consideration in which coverable medical expenses were incurred.

(b) Certification ends on the last day of the most recent month in the retroactive period in which coverable medical expenses were incurred.

(c) Only persons who have coverable medical expenses during the period under consideration shall be certified.

(d) Certification under this provision shall cover only those incurred medical bills that are not subject to third-party payment and remain the liability of persons in the assistance unit.

(3) Persons Eligible for Current Coverage Under Spend-Down.

(a) Certification begins on the day in the period under consideration on which medical expenses for services already received equal or exceed the amount of excess income. The beginning date of the certification period shall be established to exclude from coverage any full day after the application date and before the certification date for which all expenses for medical services were used to establish spend-down eligibility.

(b) Certification ends on the last day of the period under consideration.

(4) Individuals Eligible for the Maryland Medicaid Managed Care Program.

(a) Initial certification shall be a period of 6 months.

(b) Section C(4)(a) of this regulation applies only if the individual:

(i) Has not been eligible for Medical Assistance any time during the calendar month immediately before the month of application; and

(ii) Has no private health insurance.

(c) An individual certified under §C(4)(a) of this regulation is not subject to the unscheduled redetermination requirements of Regulation .12C(2) of this chapter.

(d) Subsequent certification periods shall be consistent with the provisions of this subsection.

(5) All Other Persons.

(a) Certification begins on the first day of the month of application.

(b) Certification ends on the last day of the period under consideration.

(6) Notwithstanding the provisions of §D(1)—(4) of this regulation, certification of a deceased person may not continue beyond the date of death.

(7) Notwithstanding the provisions of §D(1)—(4) of this regulation, certification of an eligible new member of the assistance unit pursuant to Regulation .06D of this chapter may not precede the date he becomes a member of the household.

D. Date for Certification to Begin and End for Eligible Institutionalized Persons.

(1) Persons Eligible for Retroactive Coverage Under Regulation .10C(5) of this chapter.

(a) Certification begins on the first day of the period under consideration.

(b) Certification ends on the last day of the period under consideration.

(2) Persons Eligible for Retroactive Coverage Under Regulation .10C(7) of this chapter.

(a) Certification begins on the day the incurred medical expenses less health insurance and other third-party coverage equal or exceed the excess available income.

(b) Certification ends on the last day of the period under consideration.

(3) Persons Eligible for Current Coverage Under Regulation .10D(3) of this chapter.

(a) Certification begins on the first day of the period under consideration or, at the option of the person or the person's representative, on the first day of the following month if coverage is not needed in the month of application.

(b) Certification continues until the person is determined ineligible and scheduled redetermination of eligibility shall be made at least once every 12 months.

(4) Persons Eligible for Current Coverage Under Regulation .10D(5) of this Chapter.

(a) Certification begins on the day the incurred medical expenses less health insurance and other third-party coverage equal or exceed the excess available income.

(b) Eligibility ends on the last day of the period under consideration or, if it is known that eligibility should terminate before the end of the period under consideration, on the appropriate earlier date, and scheduled redetermination of eligibility may not be made.

(5) Notwithstanding the provisions of §D(1)—(4) of this regulation, certification of a deceased person may not continue beyond the date of death.

.12 Post-Eligibility Requirements.

A. Notice of Eligibility Determination. The Department or its designee shall inform an applicant of the applicant's legal rights and obligations and give the applicant written or electronic notification of the following:

(1) For eligible individuals in MAGI coverage groups:

(a) The basis and effective date for eligibility;

(b) Instructions for reporting changes that may affect the recipients eligibility; and

(c) The right to request a hearing.

(2) For eligible individuals in MAGI Exempt coverage groups:

(a) A finding of eligibility, the beginning and ending dates for coverage; and

(b) The right to request a hearing.

(3) For ineligible individuals in MAGI coverage groups:

(a) A finding of ineligibility, the reason for the finding, and the regulation supporting the finding;

(b) Information regarding application for MAGI exempt coverage groups; and

(c) The right to request a hearing.

(4) For ineligible individuals in MAGI exempt coverage groups:

(a) A finding of ineligibility, the reason for the finding, and the regulation supporting the finding; and

(b) The right to request a hearing.

B. Recipient Responsibility.

(1) A recipient or his representative shall notify the Department or its designee within 10 working days of changes that may affect eligibility.

(2) A recipient or his representative shall limit use of the Medical Assistance card to the person whose name appears on the card.

(3) Third-Party Liability.

(a) A recipient or his representative shall notify the Department or its designee within 10 working days when medical treatment has been provided as a result of any accident or other occurrence in which a third party might be liable.

(b) Recipients shall cooperate with the Department or its designee in completing a form designated by the Department to report all pertinent information that would assist the Department or its designee in seeking reimbursement.

(c) In accident situations, recipients shall notify the Department or its designee of the time, date, and location of the accident, the name and address of the attorney, the names and addresses of all parties and witnesses to the accident, and the police report number if an investigation is made.

(4) When written notice of cancellation is received, a recipient shall discontinue use of the Medical Assistance card on the first day of ineligibility and return it to the Department or its designee.

(5) Failure to comply with the provisions of §B(1), (2), and (3) of this regulation may result in the termination of assistance.

(6) Failure to comply with the provisions of §B(1)—(4) of this regulation may result in legal action, referral to the Department or its designee for reimbursement, fraud investigation, or both, for illegal use of the Medical Assistance card.

(7) Recipients shall cooperate with the Department's quality control and audit review process, including provision and verification of all information pertinent to eligibility determination. Failure to cooperate may result in the termination of coverage.

C. Redeterminations.

(1) Redetermination for Former SSI Recipients.

(a) The Department or its designee shall promptly redetermine eligibility when notice has been received from the Social Security Administration that an individual's SSI benefits have been terminated.

(b) When notice of SSI termination is received, Department or its designee shall notify the person that redetermination is required to establish continuing eligibility and shall make the application available to him.

(c) When the written or electronic, signed application is received by the Department or its designee, a new period under consideration will be set. The new period will be related to the date the application is received but may not include any months in which the individual was entitled to coverage under the current certification period.

(d) The Department or its designee shall notify the individual or his representative of the required information and verifications needed to determine eligibility and the time standards in acting in the redetermination process.

(e) All non-financial and financial factors for continuing eligibility shall be met.

(f) The following applies when the individual is determined ineligible for Medical Assistance:

(i) When the SSI termination is received by the tenth day of the month, the Department or its designee shall cancel certification effective the end of the month, unless the recipient requests a hearing in accordance with COMAR 10.01.04.

(ii) When the SSI termination notice is received after the tenth day of the month, the Department or its designee shall cancel certification effective the end of the following month unless the recipient requests a hearing in accordance with COMAR 10.01.04.

(h) Notice of Eligibility Decisions.

(i) Eligible Individuals. Individuals who are determined eligible for a new period under consideration shall be sent notice in accordance with §A(1) and (2) of this regulation.

(ii) Ineligible Individuals. Individuals determined ineligible shall be sent notice in accordance with §A(3) and (4) of this regulation.

(i) When ineligibility is due to excess income only, the person will be provided with an explanation of the spend-down provision. Spend-down eligibility may be established at any time during the new period under consideration.

(2) Unscheduled Redetermination.

(a) The Department or its designee shall promptly make unscheduled redetermination when:

(i) The person's circumstances suggest future changes which may affect eligibility before the due date of a scheduled redetermination;

(ii) Relevant facts or changes in circumstances are reported by the recipient or someone on his behalf; or

(iii) Relevant facts or changes are brought to the attention of the Department or its designee from other responsible sources.

(b) The Department or its designee shall notify the recipient that redetermination is required to establish continuing eligibility. Notification will be sent in a timely manner so that a decision of eligibility will be made within 30 days from the date of change.

(c) The Department or its designee shall notify the recipient of the required information and verifications needed to determine eligibility and the time standards in acting in the redetermination process.

(d) The Department or its designee may not require the recipient or his representative to appear in unless the Department or its designee has determined that a face-to-face contact is necessary to make an accurate eligibility determination, or the recipient requests a face to face interview.

(e) All non-financial and financial factors for continuing eligibility shall be met.

(f) Eligibility Decisions.

(i) Eligibility Continued for the Remainder of the Certification Period. Recipients who are determined eligible for the remainder of the certification period will be sent notice in accordance with §A(1) and (2) of this regulation.

(ii) Recipients Determined Ineligible for the Remainder of the Certification Period. Recipients determined ineligible for the remainder of the certification period because of a change in circumstances or failure to establish eligibility following a change in circumstances, shall be sent notice in accordance with §A(3) and (4) of this regulation.

(g) A person may reapply at any time after the cancellation of current eligibility and a new period under consideration will be established.

(3) Scheduled Redetermination.

(a) The Department or its designee shall make scheduled redeterminations at least once every 6 months for noninstitutionalized individuals certified under Regulation .11B(3) of this chapter and at least once every 12 months for institutionalized individuals certified under Regulation .11D(3) of this chapter.

(b) The Department or its designee shall notify the recipient that redetermination is required to establish continuing eligibility. The notice and application will be sent at least 45 days before expiration of the current certification period.

(c) When the written, telephonic, or electronic, signed application is received by the Department or its designee, a new period under consideration will be set. The new period will be related to the date the application is received but may not include any months in which the individual was entitled to coverage under the current certification period.

(d) A recipient shall be treated the same as an applicant at the time of scheduled redetermination.

(e) All nonfinancial and financial factors of eligibility shall be met.

(f) The local Department or its designee shall make timely decisions in accordance with the provisions of Regulation .04H of this chapter.

(g) Eligibility Decisions.

(i) Eligibility Established. Applicants who are determined eligible for a new period under consideration shall be sent notice in accordance with §A(1) and (2) of this regulation.

(ii) Ineligibility Established. Applicants determined ineligible for the new period under consideration shall be sent notice in accordance with §A(3) and (4) of this regulation.

(h) When ineligibility is due to excess income only, the applicant will be provided with an explanation of the spend-down provision. Spend-down eligibility may be established at any time during the new period under consideration.

D. Subsequent Application. A person may reapply when eligibility is not met during the periods established in §C(1) and (3) of this regulation.

.13 Hearings.

The procedures for the Department or its designee granting a hearing to an applicant or a recipient and the status of benefits pending a hearing are set forth in COMAR 10.01.04.

.14 Fraud.

A. "Medicaid fraud" means:

(1) Knowingly and willfully making or causing to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan established by Title XIX of the Social Security Act of 1939;

(2) Knowingly and willfully making or causing to be made any false statement or representation of a material fact for use in determining rights to those benefits or payments;

(3) Having knowledge of the occurrence of any event affecting:

(a) The initial or continued right to those benefits or payments, or

(b) The initial or continued right to those benefits or payments to any other individual in whose behalf an application has been made or in whose behalf benefits or payments are being received, and concealing or failing to disclose that event with an intent to secure fraudulently those benefits or payments either in a greater amount or quantity than is due or when benefits or payments are not authorized;

(4) Having made application to receive or having received any of those benefits or payments for the use and benefit of another, and knowingly and willfully converting any part of the benefit or payment to a use other than for the use and benefit of that other person;

(5) Fraudulently obtaining, attempting to obtain, or aiding another person in obtaining or attempting to obtain any drug product or any medical care, the benefit or payment of any part of which is or may be made from federal or state funds under a state Medical Assistance program, by use of:

(a) Fraud, deceit, misrepresentation, or subterfuge;

(b) Forgery or alteration of a Medical Assistance prescription; or

(c) Concealment of any material fact or by the use of false names or addresses;

(6) Possession of a blank Medical Assistance prescription, unless possession is authorized by:

(a) A contract or other power, right, or permission to manufacture, store, transport, or distribute blank prescriptions;

(b) A grant of a rendering privilege as evidenced by the issuance of a rendering number by a state Medical Assistance program by which one is authorized to prescribe pharmaceutical products for Medical Assistance recipients if the authorization:

(i) To possess a blank Medical Assistance prescription terminates 30 days after notice of suspension or termination of provider status in a state Medical Assistance program or exhaustion of final appeal rights, whichever is later; and

(ii) Does not extend to possession of blank Medical Assistance prescriptions which have been obtained from a source not authorized to distribute blank Medical Assistance prescriptions under §S(6)(a) of this regulation; or

(c) Performance of one's lawful duties as a law enforcement officer or as one employed by a state Medical Assistance program;

(7) Possession of a Medical Assistance card without the authorization of the individual to whom the card is issued, unless:

(a) Possession is obtained by a provider without knowledge that the presenting party lacked authorization; or

(b) Possession is pursuant to one's lawful duties as a law enforcement officer or as one employed by a state Medical Assistance program;

(8) Manufacture, distribution, or possession of a counterfeit Medical Assistance card, or prescription blank except when possession is obtained:

(a) By a provider without knowledge that the card or prescription blank is counterfeit; or

(b) Pursuant to one's lawful duties as a law enforcement officer or as one employed by a state Medical Assistance program; and

(9) Manufacture, distribution, or possession of a provider identification plate used or capable of use to imprint Medical Assistance prescriptions unless authorized by:

(a) A contract or other power, right, or permission to manufacture, transport, distribute, handle, or possess the plates;

(b) Issuance by a state Medical Assistance program to the party in possession; or

(c) Performance of one's lawful duties as a law enforcement officer or as one employed by a state Medical Assistance program.

B. Examples. The following are examples of circumstances that may be Medicaid fraud:

(1) Failure to report income, resources, if applicable, and family composition at the time of application or reapplication;

(2) Failure to report within 10 working days any changes in income, resources, if applicable, and circumstances during any period of eligibility;

(3) Lending a Medical Assistance card to another person;

(4) Using or attempting to use a Medical Assistance card with intent to secure fraudulently benefits which are not authorized.

C. LDSS Reporting. All cases of suspected Medicaid fraud that are discovered by personnel of a local department of social services shall be reported to the Department or its designee.

D. Other Reporting. All cases of suspected Medicaid fraud that are discovered by agencies other than a local department of social services, that is, other state or federal agencies, providers, or concerned citizens, may be reported to the Department or its designee.

E. Review and Investigation. The Department or its designee shall review and, when appropriate, investigate all referrals when an allegation is made that a misrepresentation of a material fact has been made or is suspected to have been made.

F. Disposition of Referrals. Each referral shall be processed by the Department or its designee for appropriate resolution which includes, but is not limited to:

(1) Referral for prosecution;

(2) Filing of charges at District Court;

(3) Recovery of incorrect benefit payments;

(4) A finding that the allegation has not been sustained;

(5) Referral to the appropriate agency; and

(6) Other administrative action.

G. Penalties. A person convicted of the crime of Medicaid fraud is subject to penalties as described in Criminal Law Article, §§8-510—8-512, Annotated Code of Maryland.

.14-1 Recipient Abuse.

A. Forms of Abuse. Recipient abuse exists when:

(1) A recipient utilizes an inappropriate type of provider for care;

(2) A recipient utilizes an appropriate type of provider at an inappropriate frequency for care;

(3) A recipient utilizes an appropriate provider in an inappropriate manner; or

(4) A recipient utilizes a Medical Assistance card in an inappropriate manner.

B. Examples. The following are examples of circumstances that may be recipient abuse:

(1) Misrepresenting to a provider material facts regarding symptoms, circumstances, or treatment by other providers;

(2) Failing to affirmatively disclose to a provider any treatment or services being provided by another provider;

(3) Losing or failing to maintain security sufficient to prevent loss or theft of more than one Medical Assistance card during a certification period;

(4) Utilizing an emergency room of a hospital or a specialty outpatient clinic of a hospital as a primary care provider when primary care providers are available in the service area in which the recipient resides;

(5) Underutilizing the appropriate providers for the proper care and management of an existing health condition;

(6) Obtaining medications that require close physician monitoring while not appropriately using the physician services which could provide the monitoring;

(7) Using or maintaining custody or possession of a Medical Assistance card in such a manner that it is used for an unauthorized or illegal purpose.

C. Procedures.

(1) The Department or its designee, shall determine whether recipient abuse exists using the procedures in §C(2)—(8) of this regulation.

(2) Cases may be reviewed on the basis of statistical reports, outside complaints, referrals from other agencies, or other appropriate sources.

(3) A preliminary review shall be conducted to determine whether the recipient's alleged or noted behavior is of the form specified under §A(1)—(3) of this regulation or is of the form specified under §A(4) of this regulation.

(4) If the alleged or noted behavior is one of the types listed in §A(1)—(3) of this regulation, all relevant and available information shall be forwarded for medical review as specified under §B(5) of this regulation.

(5) If the alleged or likely behavior is of the type listed in §A(4) of this regulation, all relevant and available information shall be forwarded for administrative review as specified under §C(7) of this regulation.

(6) When a case is referred for medical review, a medical professional employed by the Department or its designee shall determine whether the recipient's use of medical services constitutes abuse, as defined under §A(1), (2), or (3) of this regulation. The medical reviewer shall consider all relevant and available information including Medical Assistance payment records and information secured from interviews, if conducted, in making a decision. The reviewer may, when appropriate, obtain records from other sources, including providers of medical services.

(7) When a case is referred for administrative review, a determination shall be made by the Department or its designee, regarding whether the recipient's use of benefits constitutes abuse as defined under §A(4) of this regulation.

(8) If a recipient has been convicted of a crime involving use of Medical Assistance benefits, as defined in §A of this regulation, the Department or its designee may consider the recipient to have committed abuse as described under §A(4) of this regulation.

D. Notice. A recipient determined to have abused the Medical Assistance entitlement shall receive notice to that effect. Notice includes the following:

(1) A statement of the reason or reasons why the recipient was found to have abused the Medical Assistance entitlement;

(2) If applicable, a statement that the recipient will be enrolled in the Corrective Managed Care Program and the effective date and duration of that enrollment;

(3) A statement regarding an opportunity to provide additional information which will be considered before enrollment becomes effective;

(4) If applicable, a statement regarding an opportunity to identify a preference for an assigned primary medical care provider or pharmacy; and

(5) A statement of appeal rights under Regulation .13 of this chapter.

E. Consideration of Recipient Information.

(1) Additional information received from the recipient under §D(3) of this regulation is considered relative to the appropriateness of the recipient's enrollment in the Corrective Managed Care Program.

(2) Notice of the determination of the Department or its designee regarding the additional information shall be sent to the recipient. The notice shall either confirm or reverse the decision to enroll the recipient.

(3) Information received from the recipient under §D(4) of this regulation is considered relative to the designation of a primary medical provider or pharmacy in accordance with §G(7) of this regulation.

F. Corrective Managed Care Program.

(1) A recipient determined to have abused the Medical Assistance entitlement shall be enrolled in the Corrective Managed Care Program in which the recipient shall be required to meet the requirements of §F(1)—(3) of this regulation.

(2) The recipient shall obtain all covered physician, hospital outpatient and inpatient, and clinic services, except methadone clinic and all other drug and alcohol abuse services and emergency services, from, or upon written referral by, a single primary medical provider.

(3) The recipient shall obtain prescribed drugs only from a single designated pharmacy provider, except in an emergency or pursuant to hospital inpatient treatment.

G. Provider Selection.

(1) The Department or its designee shall select primary medical and pharmacy providers for the recipient according to the requirements of §G(2)—(7) of this regulation.

(2) The primary medical provider may be any physician who participates in the Medical Assistance Program and whose practice ischiefly in one of the following specialties which include general practice, family practice, pediatrics, obstetrics-gynecology, or internal medicine.

(3) The Department or its designee may also designate a physician group, community health center, or clinic which participates in the Program as a physician provider and which assigns practitioners in one or more of the specialties named under §G(2) of this regulation to be the designated primary medical provider for the recipient.

(4) The Department or its designee may designate a provider which delivers limited or specialty services if the designation is in the recipient's best interest and the provider agrees to deliver or manage the recipient's primary care and refer the recipient for other services as necessary.

(5) The pharmacy provider may be any pharmacy, or any single branch of a pharmacy chain, which participates in the Medical Assistance Program.

(6) The recipient shall be afforded an opportunity to suggest primary medical and pharmacy providers. However, the Department or its designee is not bound by the recipient's suggestion and may designate other providers if, in its sole discretion, the recipient's choice of provider would not serve the recipient's best interest in achieving appropriate use of the health care system and of Medical Assistance benefits.

H. The Program may designate a new primary medical or pharmacy provider if the:

(1) Recipient moves out of the service area of the provider;

(2) Provider originally selected refuses to serve as the recipient's provider;

(3) Program determines that the provider is not reasonably accessible to the recipient or does not meet accepted standards of medical or pharmacy practice;

(4) Recipient has not responded affirmatively to the imposition of restrictions; or

(5) Recipient's best interest in achieving appropriate use of the health care system and of Medical Assistance benefits would, in the Program's sole discretion, be better served by an alternative designation.

I. Time of Period of Enrollment for the Corrective Managed Care Program.

(1) The period of enrollment is 24 months.

(2) A recipient who has completed the period of enrollment and who is subsequently found, through the procedures specified under §C of this regulation, to have resumed abusive practices, shall be enrolled for an additional period of 36 months.

(3) A recipient found to have abused Medical Assistance benefits while enrolled in the Corrective Managed Care Program shall have the enrollment period extended for 24 months.

(4) A recipient who has been found on three separate determinations under §C(5)—(7) of this regulation to have abused Medical Assistance benefits shall be enrolled for a period of 60 months.

J. If an enrolled recipient loses and regains eligibility for Medical Assistance benefits, the recipient shall be re-enrolled at the resumption of eligibility for a full enrollment period.

K. The final determination of abuse, the decision to enroll the recipient for the Corrective Managed Care Program, and the designation of primary medical and pharmacy providers shall be the responsibility of the Department or its designee.

L. The recipient shall be given notice of an opportunity for a hearing in conformity with COMAR 10.01.04.

.15 Liens, Adjustments, and Recoveries.

A. Definitions. In this regulation, the following terms have the meanings indicated:

(1) "Dependent" means a:

(a) Child of the decedent, or the decedent's descendants;

(b) Sibling, including half or step, of the decedent; or

(c) Parent of the decedent, or the decedent's ancestors.

(2) "Discharge from a long-term care facility and return home" means the release of a person from that facility for the purpose of returning to the home for permanent residence.

(3) "Equity interest in the home" means co-ownership of the home which is not the result of a transfer of the property for less than the fair market value within 2 years before institutionalization.

(4) "Estate" means all real and personal property and other assets included within an individual's estate, as defined for purposes of State probate law.

(5) "Group health plan" means any plan, including a self-insured plan, of or contributed to by an employer to provide health care, directly or otherwise, to the employer's employees, former employees, or their families.

(6) "Incorrect payment of benefits" means payment of benefits to which a recipient is not entitled.

(7) "Lawfully residing in the home" means residing in the home with the permission of the owner or, if under guardianship, the owner's legal guardian.

(8) "Real property" means property which is fixed or immovable, such as land or a building.

(9) "Residing in the home on a continuous basis" means using the home as the principal place of residence.

(10) "Substantial hardship" means the Department's estate claim will result in the sale or transfer of the real property owned by the decedent and that the sale or transfer will result in the removal from the property of a dependent who:

(a) Resided in the property on the date of the decedent's death;

(b) Has resided in the property continuously for a period beginning at least 2 years before the decedent's death; and

(c) Cannot provide an alternate residence.

A-1. The Department shall make a claim against income or resources, or both, of a recipient for benefits correctly paid, or to be paid, under the following circumstances:

(1) Under a court order;

(2) In any situation in which a recipient has a cause of action against any person for medical expenses arising from that cause of action; or

(3) As a result of payment by the Department for services for which health care coverage was available to a recipient.

A-2. Liens.

(1) Incorrect Payments. Following a court judgment which has determined that benefits were incorrectly paid for a person, the Department shall impose a lien against the person's property, both personal and real, before the person's death, on account of Medical Assistance claims paid or to be paid on the person's behalf.

(2) Correct Payments. Except as provided under §A-2(3) of this regulation, the Department shall impose a lien against the real property of a person, before the person's death, on account of Medical Assistance claims paid or to be paid on that person's behalf under the following circumstances:

(a) The person owns real property, is a patient in a long-term care facility, and is required, as a condition of receiving Medical Assistance services, to spend for costs of medical care all but a minimal amount of his income required for personal needs; and

(b) The Department has determined, after notice and opportunity for a hearing, that there is no reasonable expectation that the person can be discharged from the long-term care facility and return home.

(3) Restrictions on Placing a Lien. The Department may not impose a lien on the home of an institutionalized individual under §A-2(2) of this regulation if any of the following individuals lawfully reside in the home. The institutionalized individual's:

(a) Spouse;

(b) Child as defined in Regulation .02B of this chapter;

(c) Son or daughter who is blind or disabled as defined in Regulation .05D and E of this chapter; or

(d) Sibling, who has an equity interest in the home and who was residing in the home for a period of at least 1 year immediately before the date of the institutionalized person's admission to a long-term care facility.

(4) Termination of a Lien. Any lien imposed on a person's real property under §A-2(2) of this regulation will dissolve if the person is discharged from a long-term care facility and returns to the home.

(5) Delay in the Imposition of a Lien.

(a) When the imposition of a lien against a person's property is delayed because of the person's mental incompetence, eligibility may be granted pending the appointment of a legal representative for the person.

(b) The effective date of the lien shall be the date eligibility was granted.

A-3. Adjustments and Recoveries.

(1) The Department shall seek recovery of Medical Assistance benefits correctly paid:

(a) From the estate of any individual who was 55 years old or older when the individual received Medical Assistance benefits; and

(b) From the estate or upon sale of the property on which a lien was imposed and which was owned by an individual described under §A-2(2) of this regulation.

(2) The Department shall seek recovery under §A-3(1) of this regulation of Medical Assistance benefits correctly paid only:

(a) After the death of the person's surviving spouse;

(b) When the individual has no surviving child as defined in Regulation .02B of this chapter;

(c) When the person has no surviving son or daughter who is blind or disabled as defined in Regulation .05D and E of this chapter; and

(d) In the case of liens imposed on a person's home under §A-2(2) of this regulation, when there is no:

(i) Sibling of the person lawfully residing in the home, who has resided there for a period of at least 1 year immediately before the date of the person's admission to a long-term care facility and who has lawfully resided there on a continuous basis since that time, or

(ii) Son or daughter of the person lawfully residing in the home, who has resided there for a period of at least 2 years immediately before the date of the person's admission to a long-term care facility, who has lawfully resided there on a continuous basis since that time, and who can establish to the Department's satisfaction that he or she provided the care that permitted the person to reside in the home rather than in the facility.

(3) The Department may not seek recovery from the estate of a deceased individual under §A-3(1) and (2) of this regulation if, in the Department's judgment, substantial hardship exists.

(4) The Department may not seek recovery from the estate of a deceased individual for Medical Assistance payments of Medicare premiums, copayments, or deductibles.

(5) The Department may not seek recovery from the estate of a deceased individual to the extent of the value of LTC partnership policy benefits furnished to the individual up to the time of death.

B. The Department shall accept reimbursement when voluntarily offered by a current or former recipient or someone acting on his behalf.

C. Repealed.

D. Extended Benefits Pending a Hearing Decision.

(1) The Department or its designee shall consider reimbursement in all cases in which:

(a) A recipient received extended benefits pending a hearing and decision by an administrative law judge at the Office of Administration Hearings; and

(b) The administrative law judge affirmed the original decision of the Department or its designee.

(2) The Department or its designee shall institute procedures to recover the cost of any expenditures made on behalf of a recipient in cases identified in §D(1) of this regulation. This provision may not apply to a individual who requested a hearing and extended benefits resulting from a bona fide belief that the Department or its designee has taken an adverse action erroneously.

E. The Department shall investigate and take appropriate action in all cases in which eligibility has been incorrectly established as a result of the action or inaction of a recipient, representative, or person acting responsibly for the recipient.

F. Assignment of Benefits, Release of Information, and Requirement of Cooperation by Recipient in Recovery Procedures.

(1) A recipient of Medical Assistance is deemed to have created an authorization for the release to the Department of all data, records, and information by insurance companies, nonprofit health service plans, providers of medical care, employers, unions, governmental agencies, and any other agencies, organizations, or individuals necessary for the Department's pursuit of third-party reimbursement. The authorization extends to all information relevant to third-party reimbursement or third-party health care coverage.

(2) The local department of social services shall take reasonable measures to identify and report to the Department on a form designated by the Department all possible third-party benefits available to persons determined eligible for Medical Assistance.

(3) The Department shall collect available benefits from third parties determined liable to pay for services received under Medical Assistance.

(4) An individual who receives medical services that was or will be paid for by Medical Assistance is deemed to have made assignment to the Department of:

(a) His own rights to any medical care support available under an order of a court or an administrative agency, and any third-party payments for medical care; and

(b) The rights of any other individual eligible under the plan, for whom he can legally make an assignment.

(5) Assignment of rights to benefits does not include assignment of rights to Medicare benefits.

(6) An applicant or recipient of Medical Assistance shall cooperate in:

(a) Establishing paternity for a child born out of wedlock for whom he can legally assign rights; and

(b) Obtaining medical care support and payments for himself and any other individual for whom he can legally assign rights.

(7) Waiver.

(a) The Department shall waive the requirements in §G(6) of this regulation if the Department, through the local department of social services, determines that the individual has good cause for refusing to cooperate.

(b) With respect to establishing support paternity of a child born out of wedlock or obtaining medical care and payments for a child for whom the individual can legally assign rights, the Department, through the local department of social services, shall find that cooperation is against the best interests of the child if it is reasonably anticipated that cooperation will result in:

(i) Physical harm to the child for whom support is to be sought;

(ii) Emotional harm to the child for whom support is to be sought;

(iii) Physical harm to the parent or caretaker relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(iv) Emotional harm to the parent or caretaker relative with whom the child is living, of such nature or degree that it reduces the person's capacity to care for the child adequately.

(c) If at least one of the following circumstances exists, and the Department, through the local department of social services, believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought, the Department, through the local department of social services, shall find that cooperation is against the best interests of the child:

(i) The child for whom support is sought was conceived as a result of incest or forcible rape;

(ii) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

(iii) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish him for adoption, and the discussions have not gone on for more than 3 months.

(d) If the Department of Human Services has made a finding that good cause for refusal to cooperate does or does not exist, the Department shall adopt that finding as its own for this purpose.

(e) With respect to obtaining medical care support and payments for an individual in any case not covered by §G(7)(b) or (c) of this regulation, the Department, through the local department of social services, shall find that cooperation is against the best interests of the individual or other person to whom Medical Assistance is being furnished, if it is reasonably anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person.

(8) The Department or its designee shall:

(a) Deny or terminate eligibility for any applicant or recipient who refuses to cooperate as required under §G(6) of this regulation unless cooperation has been waived;

(b) Provide Medical Assistance to any individual who:

(i) Cannot legally assign his own rights, and

(ii) Would otherwise be legally eligible for Medical Assistance but for the refusal by a person legally able to assign his rights or to cooperate as required by this regulation.

(9) The assignment created by this regulation shall be effective as long as the recipient is eligible for Medical Assistance and remains effective for all services paid by the Program during this period of eligibility, and for those services which were erroneously provided to ineligible persons and paid for by the Program.

.16 Interpretive Regulation.

Except if the language of a specific regulation indicates an intent by the Department to provide reimbursement for covered services to Program recipients without regard to the availability of federal financial participation, State regulations shall be interpreted in conformity with applicable federal statutes and regulations.

.17 Information from and Liability of Health Insurance Carriers.

A. A carrier shall:

(1) Provide, at the request of the Department, information about individuals who are eligible for benefits under the Program or are Program recipients so that the Department may determine:

(a) Whether an individual, the spouse of an individual, or the dependent of an individual is receiving health care coverage from a carrier; and

(b) The nature of that coverage;

(2) Provide the information required under §A of this regulation in a manner prescribed by the Department; and

(3) Accept the Program's right of recovery and the assignment to the Program of any right of an individual or other entity to payment from the carrier for an item or service for which payment has been made under the Program if the carrier has a legal obligation to make payment for the item or service.

B. Subject to §A of this regulation, a carrier may not reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or otherwise affect a health insurance policy or contract for a reason based wholly or partly on the:

(1) Eligibility of the individual for receiving benefits under the Program; or

(2) Receipt by an individual of benefits under the Program.

C. A carrier shall comply with the provisions of Health-General Article, §15-144, Annotated Code of Maryland, pertaining to health maintenance organizations.

Administrative History

Effective date: May 1, 1983 (10:6 Md. R. 558)

Regulations .01, .02, and .06 amended as an emergency provision effective December 1, 1992 (19:25 Md. R. 2198); amended permanently effective June 1, 1993 (20:10 Md. R. 852)

Regulation .02B amended effective May 1, 1986 (13:8 Md. R. 898); August 8, 1988 (15:16 Md. R. 1914); May 1, 1989 (16:8 Md. R. 910); December 1, 1992 (19:23 Md. R. 2041); March 24, 1997 (24:6 Md. R. 485); June 2, 1997 (24:11 Md. R. 793)

Regulations .02B; .03C; .04; .07B, I, J, L; .08G, H; .09B; .10C, E, F; .11D, E; .12B; .14A; and .15D amended as an emergency provision effective May 1, 1983 (10:11 Md. R. 962); adopted permanently effective September 1, 1983 (10:17 Md. R. 1521)

Regulations .02B and .05A amended as an emergency provision effective October 3, 1997 (24:22 Md. R. 1550); amended permanently effective January 12, 1998 (25:1 Md. R. 16)

Regulation .02B amended effective November 24, 2005 (32:23 Md. R. 1826); December 31, 2007 (34:26 Md. R. 2262); October 14, 2013 (40:20 Md. R. 1652)

Regulation .03 amended as an emergency provision effective May 4, 1990 (17:11 Md. R. 1339); amended permanently effective August 13, 1990 (17:15 Md. R. 1858)

Regulation .03-1 adopted effective April 1, 2002 (29:6 Md. R. 567)

Regulation .03-1B amended effective June 9, 2003 (30:11 Md. R. 735)

Regulation .03-2 adopted effective April 1, 2002 (29:6 Md. R. 567)

Regulation .03-2F amended effective January 6, 2003 (29:26 Md. R. 2027)

Regulation .03-3 adopted effective June 7, 2004 (31:11 Md. R. 856)

Regulation .03-3 amended effective December 27, 2010 (37:26 Md. R. 1787)

Regulation .03-4 adopted effective June 7, 2004 (31:11 Md. R. 856)

Regulation .03-4A amended effective December 27, 2010 (37:26 Md. R. 1787)

Regulation .04 amended effective May 1, 1986 (13:8 Md. R. 898); May 1, 1989 (16:8 Md. R. 910); June 30, 2008 (35:13 Md. R. 1179); April 19, 2010 (37:8 Md. R. 615)

Regulation .04J amended as an emergency provision effective October 1, 2001 (28:24 Md. R. 2125); emergency status expired March 29, 2002

Regulations .04J, .07B, G—N, and .08B, G—L amended as an emergency provision effective March 1, 1984 (11:5 Md. R. 449); emergency status extended at 11:14 Md. R. 1247 (July 6, 1984)

Regulations .04J, .07B, G—N, and .08B, G—L amended effective October 15, 1984 (11:20 Md. R. 1742)

Regulation .04J amended effective September 20, 2010 (37:19 Md. R. 1284)

Regulation .05 repealed and new Regulation .05 adopted effective September 24, 2007 (34:20 Md. R. 1737)

Regulation .05A amended effective April 14, 2003 (30:7 Md. R. 487)

Regulation .05C amended effective April 19, 2010 (37:8 Md. R. 614)

Regulation .05D amended effective March 11, 1985 (12:5 Md. R. 482); April 19, 2010 (37:8 Md. R. 614)

Regulation .05E amended effective March 11, 1985 (12:5 Md. R. 482); March 24, 1997 (24:6 Md. R. 485)

Regulation .05H amended effective June 2, 1997 (24:11 Md. R. 793)

Regulation .05-1 adopted effective September 24, 2007 (34:20 Md. R. 1737)

Regulation .05-1B amended effective April 19, 2010 (37:8 Md. R. 614)

Regulation .05-2 adopted effective September 24, 2007 (34:20 Md. R. 1737)

Regulation .05-2 amended effective April 19, 2010 (37:8 Md. R. 614)

Regulation .05-3 adopted effective September 24, 2007 (34:20 Md. R. 1737)

Regulation .05-3K amended effective October 14, 2013 (40:20 Md. R. 1652)

Regulation .05-4 adopted effective September 24, 2007 (34:20 Md. R. 1737)

Regulation .05-5 adopted effective September 24, 2007 (34:20 Md. R. 1737)

Regulations .06, .07M, .08, .10, .11, .12C, and .15 amended effective May 1, 1986 (13:8 Md. R. 898)

Regulation .07 amended effective April 19, 2010 (37:8 Md. R. 615)

Regulation .07D, M amended effective June 30, 2008 (35:13 Md. R. 1179)

Regulation .07J amended effective October 8, 1991 (18:18 Md. R. 2005)

Regulation .07M amended as an emergency provision effective September 30, 1989 (16:21 Md. R. 2258); adopted permanently effective February 1, 1990 (17:1 Md. R. 69)

Regulation .07N amended as an emergency provision effective July 1, 1984 (11:13 Md. R. 1173); amended permanently effective September 10, 1984 (11:18 Md. R. 1584)

Regulation .07N amended as an emergency provision effective July 1, 1986 (13:14 Md. R. 1628); adopted permanently effective September 8, 1986 (13:18 Md. R. 2020)

Regulation .07N amended effective August 10, 1987 (14:16 Md. R. 1774); July 1, 1988 (15:13 Md. R. 1554)

Regulations .07N and .10E amended as an emergency provision effective July 1, 1985 (12:13 Md. R. 1274); adopted permanently effective November 4, 1985 (12:22 Md. R. 2104)

Regulation .07N amended as an emergency provision effective July 1, 1989 (16:14 Md. R. 1565); amended permanently effective October 30, 1989 (16:21 Md. R. 2261)

Regulation .07N amended as an emergency provision effective July 1, 1990 (17:15 Md. R. 1851); adopted permanently effective November 1, 1990 (17:20 Md. R. 2427)

Regulation .07N amended as an emergency provision effective December 10, 1991 (18:26 Md. R. 2827); amended permanently effective April 1, 1992 (19:5 Md. R. 577)

Regulation .07N amended as an emergency provision effective November 25, 1992 (19:25 Md. R. 2199); amended permanently effective March 29, 1993 (20:4 Md. R. 371)

Regulation .07N amended as an emergency provision effective July 22, 1993 (20:16 Md. R. 1275); amended permanently effective November 1, 1993 (20:21 Md. R. 1654)

Regulation .07N amended as an emergency provision effective August 10, 1994 (21:18 Md. R. 1506); amended permanently effective November 7, 1994 (21:22 Md. R. 1876)

Regulation .08 amended as an emergency provision effective May 15, 1992 (19:11 Md. R. 1012); emergency status extended at 19:19 Md. R. 1702; amended permanently effective September 14, 1992 (19:18 Md. R. 1656)

Regulation .08 amended as an emergency provision effective April 8, 1994 (21:9 Md. R. 744); emergency provision rescinded retroactively to April 8, 1994 (21:14 Md. R. 1226)

Regulation .08 amended effective June 30, 2008 (35:13 Md. R. 1179)

Regulation .08B amended effective September 1, 1993 (20:17 Md. R. 1346); January 12, 1987 (14:1 Md. R. 31); August 22, 1988 (15:17 Md. R. 2049); July 3, 1995 (22:13 Md. R. 967)

Regulation .08G, H amended effective June 2, 1997 (24:11 Md. R. 793)

Regulation .08G, H, and H-1 amended effective January 12, 1987 (14:1 Md. R. 31)

Regulation .08G, H, and I amended effective August 22, 1988 (15:17 Md. R. 2049)

Regulation .08G, H, and K amended effective July 3, 1995 (22:13 Md. R. 967)

Regulation .08G, I amended as an emergency provision effective October 1, 2001 (29:4 Md. R. 413); emergency status extended at 29:8 Md. R. 696; amended permanently effective April 29, 2002 (29:8 Md. R. 700)

Regulation .08J-1 adopted effective September 1, 1993 (20:17 Md. R. 1346)

Regulation .08J-1 amended effective October 14, 2013 (40:20 Md. R. 1652)

Regulation .08L amended effective June 29, 1987 (14:13 Md. R. 1474); January 25, 1988 (15:2 Md. R. 121)

Regulation .08L amended as an emergency provision effective July 1, 1989 (16:14 Md. R. 1565); amended permanently effective October 30, 1989 (16:21 Md. R. 2261)

Regulation .08M amended effective June 29, 1987 (14:13 Md. R. 1474)

Regulations .08 and .10 amended, and new Regulation .10-1 adopted as an emergency provision effective September 30, 1989 (16:21 Md. R. 2259); adopted permanently effective February 1, 1990 (17:1 Md. R. 69) (Regulation .10-1 originally adopted as Regulation .11)

Regulations .08-1 and .08-2 adopted effective July 3, 1995 (22:13 Md. R. 967)

Regulation .08-2 amended effective April 29, 2002 (29:8 Md. R. 700)

Regulation .08-3 adopted effective November 24, 2005 (32:23 Md. R. 1826)

Regulation .09B, C amended effective September 20, 2010 (37:19 Md. R. 1284)

Regulation .10 amended effective November 10, 2003 (30:22 Md. R. 1580)

Regulation .10C and D amended as an emergency provision effective July 1, 1986 (13:14 Md. R. 1628); adopted permanently effective September 8, 1986 (13:18 Md. R. 2020)

Regulation .10C, D amended effective July 1, 1987 (14:13 Md. R. 1474)

Regulation .10C, D amended as an emergency provision effective March 13, 2009 (36:8 Md. R. 591); emergency status expired July 30, 2009

Regulation .10C, D amended effective July 27, 2009 (36:15 Md. R. 1165); September 20, 2010 (37:19 Md. R. 1284); October 14, 2013 (40:20 Md. R. 1652)

Regulation .10E amended as an emergency provision effective May 1, 1983 (10:7 Md. R. 632); adopted permanently effective May 9, 1983 (10:9 Md. R. 791)

Regulation .10-1 amended as an emergency provision effective July 1, 1992 (19:15 Md. R. 1382); amended permanently effective November 1, 1992 (19:21 Md. R. 1891)

Regulation .10-1C amended effective November 10, 2003 (30:22 Md. R. 1580)

Regulation .10-1C, E amended and G adopted effective November 12, 1990 (17:21 Md. R. 2529)

Regulation .10-1D amended effective October 8, 1991 (18:18 Md. R. 2005)

Regulation .11C amended effective September 10, 1994 (11:8 Md. R. 1584) June 2, 1997 (24:11 Md. R. 793)

Regulation .11E amended effective September 10, 1984 (11:18 Md. R. 1584)

Regulation .12B amended effective August 8, 1988 (15:16 Md. R. 1914)

Regulation .12C amended effective September 10, 1984 (11:18 Md. R. 1584)

Regulation .13 repealed and new Regulation .13 adopted effective March 19, 2012 (39:5 Md. R. 382)

Regulation .13C amended effective August 8, 1988 (15:16 Md. R. 1914)

Regulation .14 amended effective August 8, 1988 (15:16 Md. R. 1914)

Regulation .14 amended and recodified to Regulations .14 and .14-1 effective December 1, 1992 (19:23 Md. R. 2041)

Regulation .14B amended as an emergency provision effective May 1, 1984 (11:10 Md. R. 858); emergency status expired August 28, 1984

Regulation .14B amended effective August 29, 1984 (11:17 Md. R. 1492)

Regulation .15 amended effective August 8, 1988 (15:16 Md. R. 1914); July 3, 1995 (22:13 Md. R. 967)

Regulation .15 amended as an emergency provision effective October 13, 1992 (19:22 Md. R. 1979); amended permanently effective February 1, 1993 (20:2 Md. R. 113)

Regulation .15 amended as an emergency provision effective April 8, 1994 (21:9 Md. R. 744); emergency provision rescinded retroactively to April 8, 1994 (21:14 Md. R. 1226)

Regulation .15A-3 amended as an emergency provision effective November 12, 2002 (29:24 Md. R. 1915); amended permanently effective February 17, 2003 (30:3 Md. R. 179)

Regulation .17 adopted effective December 31, 2007 (34:26 Md. R. 2262)

Chapter revised effective January 6, 2014 (40:26 Md. R. 2162)

Regulation .02B amended effective September 11, 2017 (44:18 Md. R. 866); May 20, 2019 (46:10 Md. R. 486)

Regulation .03A, C amended effective May 20, 2019 (46:10 Md. R. 486)

Regulation .03F adopted effective May 20, 2019 (46:10 Md. R. 486)

Regulation .04F amended effective March 28, 2016 (43:6 Md. R. 406)

Regulation .04-1D amended effective December 31, 2018 (45:26 Md. R. 1243)

Regulation .04-1M adopted effective May 7, 2018 (45:9 Md. R. 461)

Regulation .05-4B amended effective July 4, 2016 (43:13 Md. R. 713)

Regulation .08-1B amended effective February 1, 2016 (43:2 Md. R. 127)

Regulation .08-2B, C amended effective April 10, 2017 (44:7 Md. R. 355); May 20, 2019 (46:10 Md. R. 486)

Regulation .08-2C amended effective August 29, 2016 (43:17 Md. R. 954)

Regulation .08-4 adopted effective April 13, 2015 (42:7 Md. R. 568)

Regulation .10C, D amended effective September 11, 2017 (44:18 Md. R. 866)

Regulation .10-2 adopted effective April 13, 2015 (42:7 Md. R. 568)

Regulation .15A-3 amended effective April 13, 2015 (42:7 Md. R. 568)