ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-25
MEDICAID ELIGIBILITY

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560-X-25-.01 Governing Authorities.

(1) In determining eligibility for Medicaid, the Agency's rules and regulations are governed by the Social Security Act (hereinafter referred to as the Act), Titles XVI and XIX; 20 C.F.R. (Part 416); 42 C.F.R. (Part 435); and the Alabama State Plan for Medical Assistance.

(2) Any part of the Code of Federal Regulations cited herein is adopted by reference as a part of the Rule in which it is cited.
Author:

Statutory Authority: Code of Ala. 1975, §41-22-9.
History: Rule effective October 1, 1982.

560-X-25-.02 Administrative Responsibilities.

(1) The Alabama Medicaid Agency determines eligibility for individuals for the following programs:

(a) All Medicaid programs in accordance with Titles XIX and XXI of the Act except those listed in (2) and (3) below; and,

(b) Low Income Subsidy (LIS) under Medicare Part D in accordance with the rules under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

(2) The Social Security Administration determines the eligibility of individuals for Supplemental Security Income under Title XVI of the Act.

(3) The Alabama Department of Human Resources determines Medicaid eligibility of individuals qualifying for various forms of assistance in accordance with Titles IV-E and XIX of the Act.

(4) The Alabama Department of Public Health determines Medicaid eligibility of individuals qualifying for various forms of assistance in accordance with Titles XIX and XXI of the Act.
Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division
Statutory Authority: Social Security Act, Titles XVI, XIX; and Sections 1860D-14, 1902(a)(66), 1905(p)(3), and 1935(a); 20 C.F.R. 416, 42 C.F.R. 423.774, 423.904, and 42 CFR 435, and the State Plan.
History: Rule effective October 1, 1982. **Amended:** Filed January 11, 2006; effective February 15, 2006. **Amended:** Filed February 11, 2014; effective March 18, 2014. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.03 Coverage Groups.

(1) The following are the general groups of individuals designated as categorically eligible under the State Plan for Medical Assistance, and who as a result are Medicaid eligible:

(a) Aged, blind or disabled persons who receive Supplemental Security Income (SSI) under Title XVI;

(b) Persons who are residents of Title XIX institutions but who are not eligible for SSI, Optional Supplementation or AFDC because their income exceeds $50.00 per month but is not more

than 300 percent of the current SSI benefit amount payable to an individual in his own home who has no income;

(c) Persons who would be eligible for SSI or Optional Supplementation but for the fact that they are residents of a Title XIX institution;

(d) All aged, blind and disabled persons who were residents of a Title XIX institution as of December 31, 1973 and who were converted from the former State program (OAP, APTD, AB). If ineligible under current eligibility rules these individuals are entitled to use the rules for determining eligibility which were in effect under the State's Plan for Medical Assistance in December 1973;

(e) Persons who:

1. are currently receiving Old Age Survivors Disability Insurance (OASDI);

2. are ineligible for SSI due to income;

3. were contemporaneously eligible for both OASDI and SSI in the same month after April 1977; and

4. would be eligible for SSI but for OASDI cost-of-1iving increases received since the last month of contemporaneous OASDI and SSI eligibility.

(f) Individuals receiving mandatory or optional State Supplementation payments;

(g) Individuals who would be eligible for SSI, except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972 or who were eligible for such cash assistance but for the fact that they were residents of a medical institution or intermediate care facility;

(h) Medicaid for Low Income Families: Individuals eligible for Medicaid through the Medicaid for Low Income Families Program or who meet the eligibility criteria for Medicaid for Low Income Families based on policies in effect for the AFDC program as it existed on July 16, 1996 based on Section 1931 of the Social Security Act.

The following individuals are deemed to be eligible for Medicaid for Low Income Families:

1. AFDC qualified pregnant women whose family income and resources fall within the standards for Medicaid for Low Income Families.

2. Individuals under age 18 who would qualify for Medicaid for Low Income Families but do not qualify as dependent children, since they are children for whom public agencies have assumed full or partial financial responsibility and who are in foster homes or private institutions.

(i) All individuals receiving assistance under Title IV-E of the Act, including children for whom adoption assistance or foster care payments are made in Alabama or out of state;

(j) Individuals who are eligible for Medicaid solely because they require and receive services under CMS approved home and community-based services waiver. See Appendix C of the waiver document for a complete description of eligibility groups served by a specific waiver.

(2) Section 1902 (e)(4) of the Social Security Act as amended by the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3, Section 113) mandates that a child born to a woman eligible for and receiving Medicaid on the date of the child's birth be deemed eligible for Medicaid for a period of one year. Under Section 211 of Public Law 111-3, children who are initially eligible for Medicaid as deemed newborns are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States and may not be required to provide further documentation of citizenship or identity at any subsequent Medicaid eligibility determination or redetermination.

(3) The following coverage is mandated by the Consolidated Omnibus Budget Reconciliation Act, Section 9501 of Public Law 99-272.

(a) All pregnant women who otherwise meet Medicaid for Low Income Families income and resource criteria.

(b) sixty-day postpartum coverage to women who were eligible for and receiving Medicaid on the date the pregnancy ended.

(4) The following coverage is mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985, Section 12202 of Public Law 99-272. Coverage is extended to disabled widows or widowers if he or she meets all of the following criteria:

(a) was entitled to a monthly insurance benefit for December 1983 under Title II of the Social Security Act;

(b) was entitled to and received a widow's or widower's benefit for January 1984 based on a disability under Section 202(e) or (f) of the Social Security Act;

(c) became ineligible for SSI/SSP in the first month in which that increase was paid to him or her (and in which a

retroactive payment of that increase for prior months was not made) because of the increase in the amount of the widow's or widower's benefit which resulted from the elimination of the reduction factor for disabled widows and widowers entitled before age 60;

(d) has been continuously entitled to a widow's or widower's benefit under Section 202(e) or (f) of the Act from the first month that increase in the widow's or widower's benefit was received;

(e) would be eligible for SSI/SSP benefits if the amount of that increase, and any subsequent cost-of-1iving adjustments in widow's or widower's benefits provided under Section 215(i) of the Act, were disregarded; and

(f) makes written application for benefits under this provision before July 1, 1988.

(5) The following coverage is mandated by Section 1634(c) of the Social Security Act as amended by Section 6, P.L. 99-643. Individuals who lose eligibility for SSI because of entitlement to, or an increase in Social Security benefits received as a Disabled Adult Child (DAC) shall continue to be eligible for Medicaid if they meet the following criteria:

(a) meet current SSI income and resource limits after a disregard of the entitlement to, or an increase in Social Security benefits.

(b) makes written application for continuation of Medicaid coverage no later than 30 days after notification of possible eligibility by the Medicaid Agency.

(6) The following coverage is provided by state option under the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509):

(a) All pregnant women with a family unit income, as defined by Title IV-A criteria, not in excess of 100 percent of the current federal poverty line;

(b) Pregnant women eligible for Medicaid will continue eligible for prenatal, delivery, and postpartum care, without regard to changes in income, to the end of the 60-day postpartum period;

(c) Infants eligible under SOBRA will be Medicaid eligible up to one year of age while residing in a family unit whose income does not exceed 100 percent of the current federal poverty line.

(7) The following coverage is mandated by the Omnibus Budget Reconciliation Act of 1987, (P.L. 100-203, Section 9116). Disabled

widows and widowers may be eligible for and able to retain Medicaid benefits if they meet all of the following criteria:

(a) have reached 60 but not age 65;

(b) not eligible for Part A Medicare;

(c) eligible for and receiving Title II benefits (OASDI) and,

(d) lost SSI as a result of receiving early widows/widowers benefits.

(8) The following coverage is mandated by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360, Section 301) as amended by P.L. 101-508. This limited coverage is described in the State Plan for Medical Assistance. Individuals may be eligible for Catastrophic Coverage as Qualified Medicaid Beneficiaries alone or may be dually eligible if they meet the criteria of the other categorical eligibility as described in this Chapter. Aged, blind, or disabled individuals may be eligible under these provisions if they meet the following criteria:

(a) Entitled to Part A Medicare.

(b) Have resources that do not exceed three times the resource standard for a recipient of Supplemental Security Income. Resource standards are a federal requirement, but are not an eligibility requirement for Alabama's program.

(c) Have income at or below the following limits:

level Income for 1989 will be 85% of federal poverty

level Income for 1990 will be 90% of federal poverty

level Income for 1991 will be 100% of federal poverty

Income for 1992 and afterwards will be 100% of federal poverty level.

(9) Section 4501(b) of the Omnibus Budget Reconciliation Act of 1990 amended 1902(a)(10)(E) of the Social Security Act to mandate coverage of Specified Low Income Medicare Beneficiaries beginning January 1, 1993. This provision requires medical assistance payment of Medicare Part B premiums for eligible individuals. The Specified Low Income Medicare Beneficiaries (SLMBs) must meet all of the eligibility requirements for Qualified Medicare Beneficiary (QMB) status with the exception of income limits. The SLMBs must have income within the limits listed below:

Income for 1993 cannot be less than 100% and not more than 110% of federal poverty level.

Income for 1994 cannot be less than 100% and not more than 110% of federal poverty level.

Income for 1995 and afterwards cannot be less than 100% and not more than 120% of federal poverty level.

The SLMBs must have resources that do not exceed three times the resource standard for a recipient of Supplemental Security Income. Resource standards are a federal requirement, but are not an eligibility requirement for Alabama's program.

(10) The following coverage is mandated by the Balanced Budget Act of 1997 (Public Law 105-33, Section 4732). Qualifying Individuals (QI-1).

(a) Individuals who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);

(b) Whose income exceeds 120 percent of the federal poverty level but does not exceed 135 percent of the federal poverty level;

(c) Whose resources do not exceed three times the maximum resource standard under SSI; Resource standards are a federal requirement, but are not an eligibility requirement for Alabama's program.

(d) Who is not eligible for any other Medicaid program; and,

(e) Who has been awarded benefits when federal funds are available for the program. Eligibility is awarded on a first-come, first-served basis.

(Medical assistance for the above group is limited to payment of the Medicare Part B premiums under Section 1839 of the Act.)

(11) The following coverage is mandated by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) Section 6401 of P.L. 101-239).

(a) All pregnant women with a family unit income, as defined by Title IV-A criteria, not in excess of 133 percent of the current federal poverty level;

(b) Pregnant women eligible for Medicaid under this provision will continue eligible for prenatal, delivery, family planning, and postpartum care, without regard to changes in income, to the end of the month in which the 60th day of the postpartum period falls; and

(c) Children under age 6 with a family unit income, as defined by Title IV-A criteria, not in excess of 133 percent of the current federal poverty level.

(12) Children under 21, who would be eligible for Medicaid for Low Income Families, ACFC, SSI or otherwise Medicaid eligible if they were in their own home, but who are admitted as inpatients of a psychiatric facility.

(13) Qualified Disabled and Working Individual - A Qualified Disabled and Working Individual is an individual:

(a) under age 65;

(b) who has been entitled to Title II Disability Insurance Benefits (DIB);

(c) whose DIB ended due to earnings exceeding the Substantial Gainful Activity (SGA) level;

(d) who continues to have the same disabling physical or mental condition and not expected to improve;

(e) not otherwise entitled to Medicare;

(f) entitled to enroll in Medicare Part A under the provisions of 6012 (i.e., DIB terminated because of work, still working); and

(g) whose income, based on SSI rules, is under 200% of the Federal Poverty Level (FPL);

(h) whose resources, based on SSI rules, do not exceed twice the SSI resource limit;

(i) who is not otherwise eligible for medical assistance under Title XIX.

(14) The following coverage is mandated by Section 5103 of P.L. 101-508, the Omnibus Budget Reconciliation Act of 1990, (OBRA '90) and is applicable to disabled widows/widowers and disabled surviving divorced spouses.

Effective January 1, 1991, individuals who lose SSI because of receipt of a Title II benefit resulting from the change in the definition of disability will be deemed to be receiving SSI if:

(a) They were receiving SSI for the month prior to the month they began receiving the Title II benefit;

(b) They would continue to be eligible for SSI if the amount of the Title II benefit were not counted as income; and

(c) They are not entitled to Medicare Part A.

(15) The following coverage is mandated by Section 4601 of P.L. 101-508, the Omnibus Budget Reconciliation Act of 1990 and is effective July 1, 1991. This provision requires a year-by-year phase in of children born after September 30, 1983 and is applicable to children who:

(a) Have attained age six;

(b) Are under nineteen years of age; and

(c) Have family incomes below 100% of the federal poverty level.

(16) Children who are Medicaid eligible as determined by the State Department of Human Resources, receive state adoption subsidies and have a special need for medical or rehabilitative care.

(17) The following coverage is mandated by the Balanced Budget Act of 1997 (Public Law 105-33, Section 4913). Exempted children. Children who were receiving Supplemental Security Income (SSI) as of August 22, 1996 and who were terminated from SSI due to the change in definition of disability by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. These children will remain eligible for Medicaid as long as they continue to meet the eligibility requirements of SSI but for the change in definition of disability.

(18) Emergency services, as defined by the Alabama Medicaid Agency, will be covered for illegal aliens who would be otherwise eligible for Medicaid except for enumeration, citizenship and alienage requirements.

(19) The following coverage is allowed by PL 106-354, the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000. Medicaid coverage is available to women who:

(a) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix:

(b) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act.

(c) are not eligible for Medicaid under any mandatory categorically needy eligibility group;

(d) meet Medicaid citizenship and alienage status; and,

(e) have not attained age 65.

(20) The Plan First waiver extends Medicaid eligibility for family planning services to all women of childbearing age 19 through 55 and males age 21 and over (who have not had a sterilization procedure performed) with incomes at or below 141% of the federal poverty level that would not otherwise qualify for Medicaid.

(21) Under the Affordable Care Act (ACA) of 2010, the law requires that Medicaid determine financial eligibility for a specific group of individuals based on Modified Adjusted Gross Income (MAGI). This methodology redefines the financial household by eliminating the use of certain disregards and utilizing the tax filing status of an applicant.

Effective January 1, 2014, Alabama Medicaid Agency will apply the MAGI methodology to determine the financial eligibility for the following group:

(a) Pregnant women with income at or below 141% of the federal poverty level,

(b) Children under age 19 with income at or below 141% of the federal poverty level,

(c) Women of childbearing age 19 through 55 with income at or below 141% of the federal poverty level, and

(d) Parents and Other Caretaker Relatives with income at or below 13% of the federal poverty level.

NOTE: A standard income disregard of 5% of the federal poverty level is applied if the individual is not eligible for coverage due to excess income.

The ACA of 2010 expanded coverage for children who are aging out of foster care. Beginning in 2014, eligibility for full Medicaid coverage will be available to former foster care children who were enrolled in foster care and Medicaid when they turned 18 or aged out of foster care and are not yet 26 years old. The former foster care children will be treated as a non-modified adjusted gross income group since eligibility is not based on income.

(22) The following coverage is provided by state option under the American Rescue Plan Act of 2021 (P.L. 117-2 Section 9812 and 9822). This option expanded postpartum coverage from 60 days to 12 months.

(a) Individuals who are eligible for and enrolled in Mediaid or CHIP while pregnant (including during a period of retroactive eligibility) are eligible for extended coverage

through the last day of the month in which their 12-month postpartum period ends.

(b) Individuals eligible for extended postpartum coverage are entitled to continuous eligibility regardless of any changes in circumstances through the last day of the month in which the 12-month postpartum period ends.

(c) Individuals covered under the 12-month postpartum will receive full Medicaid and CHIP benefit coverage.

Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division

Statutory Authority: Social Security Act, Titles XVI, XIX; 20 C.F.R. Part 416; 42 C.F.R. Part 435; §§2361, 2362 Deficit Reduction Act of 1984; State Plan for Medical Assistance, Attachment 2.2A; §9501, Public Law 99-272 and §§1905(n)(1)(c) and 1902(e)(5) Social Security Act and §12202 Consolidated Omnibus Budget Reconciliation Act of 1985; Social Security Act §1634(c), P.L. 99-643, 99-509, SSI Improvement Act of 1986; P.L. 100-203, §§9108, 9116, 9119; Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360, §301); Omnibus Budget Reconciliation Act of 1989 §6401 of P.L. 101-239; §6408(d) OBRA 1989; 42 C.F.R. §§435.231, 1611(b)(1); Omnibus Budget Reconciliation Act of 1990(P.L. 101-508), §§4501, 4601, 4603, 5103; P.L. 99-272, §9529. Section 4501(b) of OBRA '90 and 42 CFR 435.222. Section 1903(v) of the Social Security Act. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (PL 106-354). Patient Protection and Affordable Care Act (P.L. 111-148). American Rescue Plan Act of 2021 (P.L. 117-2, Sections 9812 and 9822).

History: Rule effective October 1, 1982. **Emergency rule** effective July 1, 1985. **Amended:** effective July 9, 1985. **Emergency rule** effective July 22, 1985. **Amended:** effective October 9, 1985. **Emergency rule** effective July 1, 1986. **Amended:** effective September 8, 1986; February 9, 1987; June 10, 1987; August 10, 1987. **Emergency rule** effective January 8, 1988. Amended effective April 12, 1988. **Emergency rule** effective July 1, 1988. **Amended:** effective July 12, 1988; September 9, 1988. **Emergency rule** effective October 1, 1988; January 1, 1989. **Amended:** effective January 10, 1989; April 14, 1989. **Emergency rule** effective April 2, 1990; June 1, 1990; July 2, 1990. **Amended:** effective July 14, 1990; September 13, 1990. **Emergency rule** effective October 9, 1990. **Amended:** effective January 15, 1991. **Emergency rule** effective January 9, 1991. **Amended:** effective April 17, 1991; July 13, 1991; October 12, 1991; June 12, 1992; November 12, 1992; January 13, 1993; March 13, 1993. **Amended:** June 8, 1993; effective July 13, 1993. **Amended:** Filed July 7, 1993; effective August 11, 1993. **Amended:** Filed December 8, 1997; effective January 12, 1998. **Emergency rule** effective February 26, 1998. **Amended:** Filed March 9, 1998; effective April 13, 1998. **Amended:** Filed August 4, 1998; effective September 9, 1998. **Amended:** Filed February 19, 1999; effective March 26, 1999; operative April 1, 1999. **Amended:** Filed August 10, 2001; effective September 14, 2001. **Amended:** Filed January 9, 2004;

effective February 13, 2004. **Amended:** Filed December 12, 2008; effective January 16, 2009. **Amended:** Filed June 11, 2010; effective July 16, 2010. **Amended:** Filed February 11, 2014; effective March 18, 2014. **Amended:** Filed September 11, 2018; effective October 26, 2018. **Amended:** Published May 31, 2023; effective July 15, 2023.

560-X-25-.04 Application, Initial Determination Or Denial Of Eligibility, And Redetermination Of Eligibility.

(1) An application is a specific written request on the designated agency application form which has been completed, dated and signed (including State acceptable electronic signatures) by the applicant and/or applicant's representative or guardian to have eligibility for categorical assistance determined. Application is required before an individual may be determined eligible for Medicaid benefits.

(2) Any person completing an application for Medicaid benefits on behalf of another must have written authority to do so. If the person being represented is unable to sign an authorization, it must be signed by his or her legal guardian, if there is one, or if there is none, then by his or her sponsor. A form entitled, "Appointment of Representative," available from the Alabama Medicaid Agency must be completed and signed by the applicant's representative. A copy of the form is in Rule 560-X-28-.01(16) of this code.

(3) A determination of eligibility is the process by which the Medicaid Agency's worker obtains the facts of the situation of the individual applying for Medicaid or Low-Income Subsidy (LIS) as related to each factor of eligibility. In the eligibility determination process, all facts and information related to eligibility which are alleged by the applicant must be substantiated, verified, and documented.

(4) A redetermination of eligibility must be made by the Medicaid Agency, the Department of Human Resources, Alabama Department of Public Health Child Health Insurance Program (CHIP), or the Social Security Administration for every Medicaid or LIS recipient at least once every twelve months. More frequent redeterminations are necessary for recipients whose circumstances are likely to change or from whom information indicates conditions have changed.

(5) When an applicant/recipient fails or refuses to provide needed information within his/her capacity, he/she may be denied or terminated from Medicaid or LIS; because eligibility cannot be determined or redetermined.

(6) Submission of an application for benefits containing a material misstatement, a material omission, or a material false

statement shall result in a denial or termination of eligibility as appropriate, under such application for reapplication.

(7) Any Medicaid eligible child under age 19 who has been correctly determined Medicaid eligible is deemed to be eligible for a total of 12 months regardless of changes in circumstances other than attainment of the maximum age stated above, as long as the child remains a resident of Alabama.
Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division
Statutory Authority: Social Security Act, Titles XVI, XIX; Sections 1935(a), 1902(a)(66), 1860D-14, and 1905(p)(3); 20 CFR 416; 42 CFR 423.774 and 423.904, and 42 CFR 435.
History: Rule effective October 1, 1982. **Amended:** effective April 15, 1983; July 9, 1985; January 8, 1986; January 14, 1987. **Amended:** Filed August 4, 1998; effective September 9, 1998. **Amended:** Filed January 11, 2006; effective February 15, 2006. **Amended:** Filed March 13, 2008; effective April 17, 2008. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.05 General Categorical Eligibility Criteria.

(1) In order to qualify for Medicaid, AFDC-related and MAGI-related individuals must meet the nonfinancial eligibility criteria of the AFDC programs.

(2) SSI - related individuals must meet general categorical criteria of age, disability or blindness, residence, and citizenship for the appropriate coverage groups:

(a) Age Requirements -- To be eligible, the individual must be 65 years of age or older. This factor is based on SSI policy and must be verified based on evidence requirements stated in SSI policy.

(b) Disability -- If under age 65, an individual must be blind or disabled. Disability is defined as the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment(s) which can be expected to last for a continuous period of not less than 12 months.

(c) Blindness -- An individual meets blindness criteria when his central vision acuity is 20-200 or less (even with glasses) or a limited visual field of 20 degrees or less in the better eye. A person determined to be blind for purposes of SSI benefits also qualifies as blind for purposes of Medicaid.

(d) Citizenship -- To be eligible for Medicaid, a person must be a citizen of the United States, or, if an alien, must be a

qualified alien. For qualified aliens arriving before 8/22/1996, they must be a lawful permanent resident, American Indian born in Canada, refugee, asylee, Cuban/Haitian entrant, battered immigrant, Amerasian, person whose deportation has been withheld, honorably discharged veteran, active duty U.S. military, person granted parole for 1 year by INS, or person granted conditional entry under 203 of the immigration law in effect before 4/1/1980. For qualified aliens arriving on or after 8/22/1996, they must be a refugee, asylee, person whose deportation has been withheld, Cuban/Haitian entrant (proceeding groups are eligible for 7 years from date of entry), honorably discharged veteran, active duty U.S. military, Amerasian (eligible for 5 years from date of entry) or lawful permanent resident in U.S. at least 5 years. Aliens should have records to establish naturalization or lawful admission. Non-qualifying aliens are eligible only for emergency services for treatment of emergency medical conditions.

(e) State Resident -- A person must be a resident of Alabama during the period covered by application, must indicate intent to remain, and must be capable of indicating such intent.

(f) Interstate residency Agreements -- The only time the above residency rule is not applicable is where the state has entered into a residence agreement with another state. Where this occurs, the state where the person physically resides is his residence for Medicaid purposes. A list of states with which Alabama has entered into residency agreements may be obtained from the Alabama Medicaid Agency.

(g) Eligibility for Other Benefits -- An individual is required to apply for any payments or benefits from other sources for which he may be eligible. If an individual is already receiving or is entitled to receive benefits from other sources which are in excess of agency standards or is receiving benefits under a VA contract, the individual is not eligible for Medicaid benefits.

(h) Assignment of Third Party Payments -- To be eligible for Medicaid, an individual must assign all third-party benefits to the State. Third Party benefits are any benefits for which an entity is or may be liable to pay all or part of the medical cost of an applicant or recipient.

(i) Eligibility for Medicaid benefits ends with the month in which the individual dies.

(j) Social Security Account Number -- An individual is required to furnish his Social Security Account Number or verification that he has made application for one.

Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division

Statutory Authority: Social Security Act, Titles XVI, XIX; 42 C.F.R., §§401, et seq.; 20 C.F.R. §§401, et seq.; State Plan. **History:** Rule effective October 1, 1982. **Amended:** effective March 15, 1983; September 8, 1983. **Emergency rule** effective April 1, 1985. **Amended:** effective July 9, 1985. **Amended:** Filed August 5, 1997; effective September 9, 1997. **Amended:** Filed November 8, 2001; effective December 13, 2001. **Amended:** Filed September 10, 2002; effective October 15, 2002. **Amended:** Filed October 10, 2003; effective November 14, 2003. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.06 Financial Eligibility Criteria-Resources.

(1) General - In order for an AFDC-related individual to be eligible for Medicaid, he or she must meet the AFDC financial criteria in effect in 1996. An SSI-related individual or couple must not have total countable resources in excess of $2,000 for an individual or $3,000 for a couple. An individual covered under the Qualified Medicare Beneficiary Program created by the Medicare Catastrophic Coverage Act of 1988, the Specified Low Income Medicare Beneficiary Program created by the Omnibus Budget Reconciliation Act of 1990, or the Qualifying Individual Programs created by the Balanced Budget Act of 1997 must not have total countable resources in excess of three times the SSI resource limit. Resource standards for Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries and Qualifying Individuals are a federal requirement but are not an eligibility requirement for Alabama's Medicare Savings Programs.

(a) Liquid vs. Non-1iquid Resources. Resources are those assets including both real and personal property which an individual or couple possess. It includes all liquid (spendable) assets, as well as non-1iquid assets. Non-1iquid resources are assets which are neither cash nor financial instruments. They are resources which cannot be converted to cash within 20 days.

(b) Income vs. Resources. Income is anything of value an individual/couple receives during a month. Resources are the assets such as those described above, which the individual/ couple already has at the beginning of a month in which eligibility for Medicaid is being determined. An item cannot be counted as both income and a resource in the same month.

(2) Minimum exclusions of Non-1iquid Resources - The following types of assets may be excluded from countable resources under certain conditions:

(a) Motor vehicles. An automobile may be excluded to the extent that its value does not exceed the amount specified in 20 CFR §416.1218.

(b) Life Insurance. Life insurance owned by an individual (and spouse, if any) may be excluded to the extent provided in 20 CFR §416.1230.

(c) Household Goods and Personal Effects. Household goods and personal effects are totally excluded from countable resources.

(d) Burial Funds and Burial Spaces.

1. Burial Funds. In determining the resources of an individual (and spouse, if any) there shall be excluded an amount not in excess of $1500 each of funds designated for burial arrangements of the individual or individual's spouse and which are to be used for no other purpose. The applicant/recipient must submit documented evidence of the specific designation of burial funds. Each person's $1500 exclusion must be reduced by:

(i) the face value of insurance policies on the life of an individual owned by the individual or spouse if the face value is $1500 or less and the cash surrender value of those policies has been excluded from the countable resource limit and

(ii) amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial expense.

2. Burial spaces. In determining the resources of an individual, the value of burial spaces for the individual, the individual's spouse, or any member of the individual's immediate family will be excluded from resources. The opening and closing of the grave and headstones are considered as burial space items.

(e) Real Property.

1. Home. If the home is the individual's principal place of residence, and if the individual's or his representative's signed statement identifies the reason for being away from home and the intent to return to the home, it will be excluded as a resource. If an eligible or ineligible spouse resides in what was the individual's principal place of residence prior to institutionalization, it will be excluded as long as the spouse continues to live there. Individuals whose equity interest in the home exceed the Home Equity Limit published annually by U.S. Department of Health and Human Services (HHS) are ineligible for Medicaid long-term care services unless the individual’s spouse, child under 21, or child who is blind or permanently and totally disabled resides in the home.

2. The home may be excluded if a dependent relative is living in the home. (For this purpose a relative is defined as: son, daughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, grandmother, grandfather, grandson, granddaughter, aunt, uncle, sister, brother, stepsister, stepbrother, half-sister, half-brother, niece, nephew, cousin.) Dependency may be of any kind; e.g., financial medical, etc. If a relative, other than a spouse, is living in the home and is not dependent upon the claimant, he or she is not a dependent relative, then the home cannot be excluded on this basis. The dependency must have been immediately prior to the applicant's admission to the nursing home, and the dependent's situation must be checked periodically to determine if the dependency continues to exist.

3. Jointly-Owned Home Property. Jointly-owned home property will be excluded from resources if the sale would cause the other owner undue hardship due to the loss of housing. Undue hardship is defined as when; the property serves as the principal place of residence for one of the owners; the sale of the property would result in the loss of that residence; and no other housing would be readily available for the other owner.

4. Income-Producing Property. Income-producing property is excluded from resources when the equity in the property does not exceed $6000 and the property produces net annual return of at least 6 percent of equity.

(i) Where the value of the property is in excess of $6000, the amount in excess can be counted toward the resource limitation as long as the individual remains eligible and the property nets at least 6 percent of its equity value per annum.

(ii) Where the property is not excluded because the net annual return is less than 6 percent of the equity value, the total value is an includable resource.

(iii) Where the home is associated with self-support activities, the value of the home, contiguous land, and buildings on the land will be excluded. Total equity in other assets used for producing income must be $6,000 or less and the activity must produce at least 6 percent on the equity. Where the equity value of assets for producing income is in excess of $6,000, the amount in excess will be applied to the resource limitation. Resources used to produce items only for home consumption or tools required by employer are assumed to be netting reasonable rate of

return. Property does not have to be utilized if it, in combination with other resources, does not exceed the liquid resource limit.

5. Bona Fide Effort to Sell Interest in Real property. Real property may be excluded as long as a bona fide effort is being made to sell the property. A bona fide effort to sell is defined as an attempt to sell through listing with a real estate agent or by attempt to sell by the owner. A period in excess of 7 days during which no attempt is made to sell voids this exclusion. To qualify for this exclusion, the property must have been listed for sale as of the first moment of the month that eligibility is being sought. Applicant must agree to reimburse the Agency for expenses incurred during the effort to sell and make prompt repayment after sale. Bona fide effort to sell will be reviewed periodically to verify a continuing effort.

6. Property that is specifically designated for a Plan of Self-Support for the Blind or Disabled, as provided in 20 C.F.R. (Part 416), may be excluded.

(3) Valuation of Resources -- The value of an individual's resources for Medicaid eligibility purposes is based upon the individual's equity interest in the resource. Equity is defined as the current market value (or fair market value) of the resource less any recorded indebtedness against the resource, such as a mortgage or lien. A lien taken by the Medicaid Agency under the provisions of 42 U.S.C. §1396p and Chapter 33 of this Code does not operate to reduce the current market value of the property until such lien becomes enforceable in accordance with the terms of the above-cited authorities.

(a) In the case of real property, the current market value of the property, for Medicaid eligibility purposes, is the appraised value of the property established by the current tax assessment notice from the tax assessor's office in the county in which the property is located.

1. This appraised value will be used unless the tax assessment:

(i) Is more than one year old;

(ii) Is a special purpose assessment;

(iii) Is under appeal;

(iv) Is based on a fixed rate per acre method;

(v) Does not provide an appraised value or an assessment ratio for determining such value;

2. Only if one of the above conditions exists, other evidence, such as appraisals or estimated from knowledgeable sources, may be used to establish current market value.

(b) In the case of a life estate or remainder interest in real property, the value of the individual's interest is determined by first establishing the current market value of the property and then multiplying that value by the appropriate life estate or remainder factor, based upon the age of the individual, set forth in the Life Estate and Remainder Tables, 26 CFR §20.2031.7.

1. The value obtained shall be presumed correct unless the individual furnishes clear and convincing evidence establishing a lower value. Such evidence includes, but is not limited to:

(i) efforts to sell the property interest, as evidenced by such factors as the price at which the property interest is offered for sale, marketing and advertising exposure given and offers and negotiations;

(ii) appraisals of the property interest by knowledgeable and experienced sources;

(iii) extent and results of negotiations with owners of other interests in the property or owners of adjoining property.

(c) In the case of entrance fees in a continuing care retirement community or life care community the value of the entrance fee shall be considered a resource available to the individual to the extent that:

1. The individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used to pay for care should other resources or income of the individual be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the continuing care community or life care community.

(4) The following are more liberal resource requirements than SSI for determining the eligibility of individuals as Qualified

Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries, Qualifying Individuals-1:

(a) All resources of the applicant and the resources of the applicant's spouse are excluded.

(b) All interest and dividend income is excluded.

(5) The following are more liberal resource requirements than SSI for determining the eligibility of individuals eligible under the institutional Medicaid program:

(a) The required net annual income of six percent is waived for the excluded $6,000.00 in equity value for income-producing property essential to self-support.

(b) The consideration of a life estate interest in real property is waived.

(c) Cash value of life insurance policies with combined face value less than $5,000.00 is excluded.

(d) The burial fund exclusion is increased to $5,000.00

(e) Commingling of burial funds is allowed.

(f) Long-Term Care Insurance Policies issued before March 1, 2009

1. Medicaid will not consider resources of a person equal to the amount of long-term care insurance benefit payments in determining Medicaid eligibility when the long-term care insurance policy has paid at least the first three years of nursing home care and/or home health care services.

2. The exclusion shall be for the life of the purchaser provided he or she maintains obligations pursuant to the long-term care insurance policy.

3. Insurance benefit payments made on behalf of a claimant, for payment of long-term care services, shall be considered to be expenditure of resources as required for eligibility for medical assistance to the extent that the payments are all of the following:

(i) For services Medicaid approves or covers for its recipients.

(ii) In an amount not in excess of the charges of the health services provider.

(iii) For nursing home care and/or home health care services.

(iv) For services delivered after October 1, 1997.

(g) Long-Term Care Insurance Policies issued on or after March 1, 2009.

1. Medicaid will not consider resources equal to the amount of benefits paid (dollar-for-dollar) by an Alabama Long-Term Care Insurance Partnership Policy (Partnership Policy) for long-term care services received in determining Medicaid eligibility and in estate recovery.

2. The amount to be excluded will be above and beyond the standard resource exclusion provided under the Medicaid State Plan. To qualify for this exclusion, the individual must be covered by a Partnership Policy that has been certified by the Alabama Department of Insurance as meeting the following criteria:

(i) The policy covers a person who was a resident of Alabama when coverage first became effective under the policy. Medicaid will provide reciprocity with respect to long-term care insurance policies covered under other state long-term care insurance partnerships. The amount of the resource exclusion will equal the resource exclusion that would apply to a Partnership Policy issued under the Alabama Long-Term Care Partnership Program.

(ii) The policy meets the definition of a "qualified long-term care insurance policy' found in section 7702B(b) of the Internal Revenue Code of 1986.

(iii) The policy meets the specific requirements of the Deficit Reduction Act of 2005 and National Association of Insurance Commissioners (NAIC) Long Term Care Insurance Model Regulations and Model Act, as last amended.

(iv) The policy includes the following inflation protection: for purchasers under 61 years old, compound annual inflation protection; for purchasers 61 to 76 years old, some inflation protection; and for purchasers 76 years or older, inflation protection may be offered but is not required.

3. The issue date is the effective date of coverage under the policy. If a long-term care insurance policy issued before March 1, 2009 is exchanged after that date for a Partnership Policy, the resource exclusion will apply

only with respect to insurance benefits received under the new Partnership Policy.

Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division

Statutory Authority: Social Security Act, Titles XVI, XIX; 1902(r)(2); 20 C.F.R. §§401, et seq.; State Plan; Public Law 100-203, §9103; Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360, §301); 20 C.F.R. §416.1212; 42 C.F.R. §§401, et seq.; 26 C.F.R. §20.2031.7.

History: Rule effective October 1, 1982. **Amended:** effective March 15, 1983; May 15, 1983; September 8, 1983; September 8, 1984. **Emergency rule** effective January 1, 1985. **Amended:** effective March 11, 1985. **Emergency rule** effective September 1, 1985. **Amended:** effective December 9, 1985. **Emergency rule** effective January 1, 1986. **Amended:** effective April 11, 1986. **Emergency rule** effective June 9, 1986. **Amended:** effective August 11, 1986; August 10, 1987. **Emergency rule** effective January 8, 1988. **Amended:** effective February 9, 1988. **Emergency rule** effective August 1, 1988. **Amended:** effective November 10, 1988. **Emergency rule** effective January 1, 1989. **Amended:** effective April 14, 1989; July 13, 1991; January 14, 1992; May 13, 1993. Emergency Rule effective June 1, 1993. **Amended:** effective May 11, 1993. **Amended:** Filed July 7, 1993; effective August 11, 1993. **Amended:** Filed July 7, 1994; effective August 12, 1994. **Amended:** Filed July 6, 1995; effective September 1, 1995. **Amended:** Filed July 9, 1996; effective August 14, 1996. **Amended:** Filed October 6, 1997; effective November 10, 1997. **Amended:** Filed March 9, 1998; effective April 13, 1998. **Amended:** Filed June 5, 1998; effective July 10, 1998. **Amended:** Filed June 8, 1999; effective July 13, 1999. **Amended:** Filed August 19, 2002; effective September 23, 2002. **Amended:** Filed October 12, 2005; effective November 16, 2005. **Amended:** Filed July 12, 2006; effective August 16, 2006. **Amended:** Filed January 7, 2009; effective February 11, 2009. **Amended:** Filed June 11, 2010; effective July 16, 2010. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.07 Development Of Ownership Interest In Nonliquid Resources For SSI-Related Individuals.

(1) Ownership interest in Real Property -- Establishment of ownership interest may be obtained by:

(a) Assessment notice;

(b) Recent tax file;

(c) Current mortgage statement;

(d) Deed;

(e) Report of title search;

(f) Wills, court records, or relationship documents which show rights of an heir to the property after death of the former owner.

(2) The laws of the State of Alabama regarding the validity of deeds, wills, mortgages, and other instruments which convey legal title to real property will govern all such determination.

(3) Types of Ownership -- The type of ownership in real property is determined by the instrument, if any, conveying the real property, and by Alabama law. Ownership interests arising through the death of a spouse or other relative are governed by the Alabama laws of descent and distribution and by those Alabama laws providing for the spouse and family of a decedent.
Author:
Statutory Authority: State Plan; Social Security Act, Titles XVI, XIX; 42 C.F.R. §§401, et seq.; 20 C.F.R. §§401, et seq.
History: Rule effective October 1, 1982.

560-X-25-.08 Development Of Ownership Interest In Liquid Resources For SSI-Related Individuals.

(1) Cash -- Cash on hand is always counted as liquid resource except when it is a business asset necessary to the operation of a trade or business that is excluded as necessary for self-support or under an approved plan for achieving self-support in the case of the blind or disabled.

(2) Checking, Savings, and Other Accounts.

(a) General. These are countable resources if the applicant/recipient has unrestricted legal access to the accounts. This rule applies to individual accounts and joint accounts as well as certificates of deposit, savings certificates, and all forms of time deposits, whether held individually or jointly. This rule applies to accounts, deposits, etc., in any financial institution or being held by any financial or brokerage service or agency.

(b) Joint Accounts.

1. When only one holder of a joint account is an applicant/recipient who has unrestricted access to the funds in the account it is presumed that the applicant/recipient owns the total funds in the account.

2. When two or more eligible individuals or applicants are holders of the same joint account and each has unrestricted access to the funds in the account it is

presumed that the eligible individual or applicant owns an equal share of the total funds in the account, regardless of the source of the funds.

3. Unrestricted access depends upon the legal structure of the account. When the account reads "or" or "and/or" and the applicant/recipient is legally able to withdraw funds from the account, he/she is considered to have unrestricted access to the total funds in the account.

(c) Rebuttal of Presumption. The opportunity to rebut the presumption of ownership shall be afforded all applicants/ recipients. In order for an applicant/recipient to rebut successfully the presumption of full or partial ownership, all of the following documentation is required:

1. A statement by the applicant/recipient on a form 234, giving:

(i) His/her allegation regarding no ownership or partial ownership of the funds documented by a statement from the financial institution, copy of the bank book, account book, certificate of deposit, etc., verifying the language of the account, and a copy of the signature card;

(ii) The reason for establishing the joint account;

(iii) Who made deposits to and withdrawals from the account, and how withdrawals were spent, documented with evidence such as wage statements, deposit slips, and employer's statements verifying source of deposits and cancelled checks; and

(iv) Corroborating statements on form 234 from the other account holder(s), or, if the co-holder of the joint account is incompetent or a minor, a statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint account.

2. If the rebuttal is successful and it is determined that the funds in the account do not belong to the applicant/ recipient and should be excluded as a countable resource, a change in the account designation removing the applicant/ recipient's name from the account or restricting access to the account must be executed and verification of such submitted as evidence before eligibility can be determined. If this change is not made and evidence is not submitted by the applicant/recipient within ten (10) days following notification, the presumption of ownership will apply.

(3) Promissory Notes, Loans, and Property Agreements (Mortgages) -- Promissory notes, loans, and property agreements are considered resources, if the owner had the legal right to sell them. If so, the resources should be counted in the amount of the outstanding principal balance.

(4) Trusts -- Whether the principal of a trust is a resource to the applicant/recipient depends on its availability to the applicant/recipient by the terms of the trust instrument itself.

Trusts, or other similar legal devices may be excluded from consideration as a resource. Medicaid shall determine whether the requirements for exclusion expressed in the current statutory authorities have been meet.

(5) Annuities – A lump sum annuity that can be sold, cashed in, surrendered or revoked will be considered a resource in the amount of the current value of the annuity unless a lesser value is satisfactorily documented.

(6) Stocks, Bonds, and Mutual Fund Shares -- These are considered countable liquid resources according to their market value.

(7) Life Insurance -- The cash surrender value of any life insurance policy owned by the applicant/recipient is a countable resource to the extent provided in 20 C.F.R. §416.1230.

(8) The foregoing are not intended to be an all-inclusive list of liquid resources. Any resource readily convertible into cash may be considered a liquid resource.
Author: Audrey Middleton, Associate Director, Policy Program Implementation Unit, Certification Support Division
Statutory Authority: State Plan; Social Security Act, Titles XVI, XIX; 42 C.F.R. §§401, et seq.; 20 C.F.R. §§401, et seq.
History: Rule effective October 1, 1982. **Amended:** effective August 10, 1988. **Amended:** Filed August 5, 1997; effective September 9, 1997. **Amended:** Filed January 9, 2004; effective February 13, 2004.

560-X-25-.09 Transfer Of Assets Affecting Eligibility.

(1) An individual, or the spouse of such individual, who is an applicant or recipient of either institutional Medicaid or home and community-based waiver services, who transfers an asset at any time on or after the "look-back date", as defined in paragraph (9)(j), for less than fair market value for the purpose of establishing or maintaining eligibility will cause the individual to be charged with the difference between the fair market value of the asset and the amount of any compensation received. The difference is referred to as uncompensated value and is counted

toward the resource limit of the individual for a period of time determined in accordance with paragraph (5).

(a) When there is an institutionalized married couple and only one applies for Medicaid, any transfers of assets for less than fair market value within the "look-back date" made by the applicant and /or non-applying spouse affects the applicant's eligibility. In these situations, the applying spouse will incur the entire penalty period.

(b) If at a later time the applicant's spouse, who initially did not apply, makes an application, the remaining penalty period would be apportioned between them. Any fractional remainder will be served by either spouse.

(2) When a stream of income or the right to a stream of income, such as an annuity, is transferred, Medicaid shall make a determination of the total amount of income expected to be transferred during the owner's life, based on an actuarial projection of the owner's life expectancy as established by federal life expectancy tables, and calculate a penalty period based on the projected total income.

(3) A transfer of an asset for less than fair market value is presumed to have been for the purpose of establishing or maintaining Medicaid eligibility unless the individual presents convincing evidence that the transfer was exclusively for some other purpose, in accordance with paragraph (7).

(4) Any individual who fails to disclose in an application a transfer of assets which occurred on or after the "look-back date" or who fails to report a transfer which occurs after eligibility is awarded, or who receives Medicaid benefits prior to discovery of a transfer of assets in violation of this rule shall be subject to recoupment action and suspension of benefits pursuant to Code of Ala 1975, §22-6-8 and Chapters 4 and 33 of this Administrative Code. Such individual and/or his representative may also be subject to criminal prosecution under Code of Ala. 1975, §22-1-11 and §1128B of the Social Security Act (42 U.S.C. §1320a-7b).

(5) Penalty Period for Transfers of Assets Occurring Within the "Look-Back Date."

(a) This period is applicable to nursing facility services as defined in the State Plan, a level of care in any institution equivalent to that of nursing facility services as defined in the State Plan, and home and community-based waiver services.

(b) The total, cumulative uncompensated value of the assets transferred on or after the "look-back date" will be divided by the average monthly cost to a private patient for nursing facility services in the state (at the time of application) as determined by Medicaid. This quotient, minus the fractional

remainder, shall be the number of months the uncompensated value is counted. The fractional remainder shall be converted to a dollar figure and added to the individual's liability. This penalty period shall begin the month of transfer, or the first month in which the individual is eligible for medical assistance under the State Plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this Rule.

(6) Transfers Not Considered. An individual shall not be ineligible for medical assistance to the extent that:

(a) The assets transferred were a home and title to the home was transferred to:

1. the individual's spouse;

2. the individual's child who is under age 21, or who is blind or permanently and totally disabled;

3. the individual's sibling who has an equity interest in such home and who has been residing in such individual's home for a period of at least one year immediately before the date such individual becomes an institutionalized individual; or

4. the individual's son or daughter (other than a child described in paragraph (6)(a)2. above) who was residing in such individual's home for a period of at least two years immediately before the date such individual becomes an institutionalized individual, and who (as determined by Medicaid) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility.

(b) The assets—

1. were transferred:

(i) to the individual's spouse or to another for the sole benefit of the individual's spouse;

(ii) from the individual's spouse to another for the sole benefit of the individual's spouse; or

(iii) to the individual's child who is blind or permanently and totally disabled or to another for the sole benefit of the individual's child who is blind or permanently and totally disabled.

2. All assets transferred must be spent only for the sole benefit of the individual's spouse or the individual's child who is blind or permanently and totally disabled within a time frame actuarially commensurate with the life expectancy of the beneficiary of the transferred assets.

(c) A satisfactory showing is made to Medicaid that the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, or the assets were transferred exclusively for a purpose other than to qualify for Medicaid.

(d) Medicaid determines that denial of eligibility would work an undue hardship.

(e) The assets were transferred to a trust which is determined to be exempt from consideration under § 1917(d) of the Social Security Act.

(f) All assets transferred on or after the "look-back date" for less than fair market value have been returned to the individual. A return of the assets may cause ineligibility based on excess resources.

(7) Rebuttal. The burden is upon the individual to rebut the presumption that a transfer of an asset was made for the purpose of establishing or maintaining Medicaid eligibility by furnishing Medicaid with convincing evidence that the asset was transferred exclusively for some other purpose. Convincing evidence may be pertinent documentary or non-documentary evidence which shows, for example, that the transfer was ordered by a court, or that at the time of transfer the individual could not have anticipated becoming eligible due to the existence of other circumstances which would have precluded eligibility. A subjective statement of intent or ignorance of the provisions of this Rule is not sufficient, by itself, to rebut the presumption raised.

(8) Undue Hardship

(a) In situations where an individual has admitted that an asset has been transferred for less than fair market value for the purpose of obtaining Medicaid benefits, the Agency may still grant an exemption from the penalty period where the individual demonstrates by clear and convincing evidence that the imposition of such a penalty will cause the individual to suffer undue hardship. Undue hardship will only be considered in extreme cases where the individual has been denied admission to or discharged from an institutional facility or denied home and community-based waiver services under circumstances which would deprive the individual of medical care such that the individual's health or life would be endangered, or of food, clothing, shelter, or other

necessities of life. Undue hardship does not exist where a transfer penalty causes an individual or the individual's family to experience inconvenience or would cause an individual to restrict his/her lifestyle.

(b) In determining the existence of "undue hardship" Medicaid will consider all circumstances involving the transfer and the situation of the individual, including but not limited to, the following:

1. Whether the individual has been determined to be a person in need of care and protection pursuant to the Adult Protective Services Act, Code of Alabama 1975, § 38-9-1, et seq.;

2. Whether the individual or his representative has exhausted all reasonable efforts to obtain a return of, or compensation for, the transferred asset, including voiding the transfer pursuant to Code of Alabama 1975, § 35-1-2 or § 8-9-12, or diligently prosecuting other criminal or civil action available to recover the asset;

3. Whether the individual was deprived of an asset by fraud or misrepresentation. Such claims must be documented by official police reports or civil and/or criminal legal actions against the perpetrator;

4. Whether the individual or his representative has exhausted all reasonable efforts to meet the individual's needs from other available sources.

(c) When a penalty period is imposed, the Notice of Action will include notice that the individual or authorized representative may, as part of the review process, request an undue hardship exemption. The written request for an undue hardship exemption must be received be Medicaid within 60 days from the date the notice of action is mailed. A denied request may be appealed in accordance with Chapter 3 of this Code.

(9) Definitions. As used in this rule:

(a) "Transfer" is, and occurs at the time, when an individual or spouse (or a parent, guardian, court or administrative body, or anyone acting in place of or on behalf of or at the request or direction of the individual or spouse), by either affirmative act or failure to act, loses or relinquishes all rights of legal access to an asset or interest therein.

(b) "Compensation" is all money, real or personal property, food, shelter or services received by the individual or spouse at or after the time of transfer in exchange for the asset in question. Money, real or personal property, food, shelter or services received prior to the transfer are compensation only

if they were provided pursuant to a legally enforceable agreement (i.e., personal service agreement, etc.) to provide such items in exchange for the asset in question. Services provided pursuant to a personal service agreement are compensation only if all the criteria set forth in paragraph (9)(k) of this rule are met. Payment or assumption of a legal debt owed by the individual or spouse in exchange for the asset is also compensation.

(c) "Fair market value" is the current market value of an asset at the time of the transfer or contract of sale, if earlier. Current market value shall be determined in accordance with Rule 560-X-25-.06(3), except that if a remainder interest in property is transferred, whether or not a life estate is retained, the uncompensated value will be based on the fair market value of the entire property at the time of the transfer or contract of sale, if earlier.

(d) "Uncompensated value" is the fair market value of the asset minus the amount of any compensation received by the individual or eligible spouse in exchange for the asset.

(e) A "home" is any shelter in which the individual (and spouse, if any) has an ownership interest and which is used by the individual (and spouse, if any) as his principal place of residence. The home includes any land that appertains thereto and any related outbuildings necessary to the operation of the home.

(f) The "month of application" is the month in which the original, initial application of an individual is received and accepted by the Medicaid Agency.

(g) "Assets" are all income or resources of the individual or the individual's spouse. This term includes income or resources which the individual or individual's spouse is or was entitled to but does not receive. With respect to transfer of assets, the term "assets" also includes the following:

1. An annuity purchased by or on behalf of the individual and will be treated as a disposal of assets for less than fair market value unless:

(i) the annuity is—

(I) an annuity described in subsection (b) or (q) of § 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from--

A. an account or trust described in subsection (a), (c), (p) of §408 of such Code;

B. a simplified employee pension (within the meaning of §408(k) of such Code); or

III. a Roth IRA described in § 408A of such Code; or

(ii) the annuity—

(I) is irrevocable and non-assignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made; and,

(iii) in the annuity—

(I) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or

(II) the State is named as such beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value

2. The purchase of a life estate interest in another individual's home will be treated as a disposal of assets for less than fair market value unless:

(i) the purchase—

(I) was made by the individual who resides in the home continuously for a period of at least one (1) year after the date of the purchase; and

(II) price is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration).

(ii) Any purchase price less than the actuarially sound purchase price will be treated as a transfer of assets for less than fair market value under the provisions of this Rule.

3. Funds used to purchase a promissory note, loan, or mortgage will be treated as disposal of assets for less than fair market value unless:

(i) such promissory note, loan, or mortgage—

(I) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(II) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(III) prohibits the cancellation of the balance upon the death of the lender.

(ii) In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (I) through (III), the value of such promissory note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for institutional or home and community-based waiver services.

(h) A transfer is considered to be "for the sole benefit of" a spouse, or a blind or disabled child, if the transfer is arranged in such a way that no individual or entity, except the spouse or the blind or disabled child, can benefit from the assets transferred in any way, whether at the time of the transfer or any time in the future.

(i) "Institutionalized individual" is an individual who is:

1. An inpatient in a nursing facility;

2. An inpatient in a medical institution (including an intermediate care facility for individuals with intellectual disabilities (ICF/IID), as defined in 42 C.F.R. § 435.1009) for whom payment is based on a level of care provided in a nursing facility; or

3. Determined eligible for home and community-based services and who would otherwise require the level of care provided in a nursing facility or medical institution.

(j) "Look-back date" for an institutionalized individual is the date that is 60 months immediately prior to the later of the first day of the month of the original, initial application. For individuals receiving home and community-based waiver services, the “look-back date” is the date that

is 60 months immediately prior to the later of the first day of the month of the original, initial application or the first day of the month in which the individual disposes of assets for less than fair market value. For transfers relating to trusts, annuities, or similar legal instruments, the "look-back date" is 60 months.

(k) "Personal Service Agreement" is a legally enforceable written agreement for personal care services to be provided in exchange for anything of value. A transfer of assets is presumed to have occurred at the time of the exchange and a transfer penalty shall be imposed unless all of the following are met:

1. At the time of the receipt of the services, the services were recommended in writing and signed by the applicant's physician, as necessary to prevent the admission of the applicant to a nursing facility. Such services may not include the providing of companionship and related services;

2. At the time of the receipt of the services, the applicant was not residing in a nursing facility;

3. At the time of the receipt of the services, the transfer of the consideration (money and/or property) to the provider/relative occurred; and

4. At the time of the receipt of the services there already existed a written and signed agreement executed between the applicant and provider for the specific service(s) rendered.

(i) The agreement executed between the applicant and provider/relative must fully describe the type, frequency and duration of the services being provided to the applicant in such a way that they can be documented when provided; and the amount of consideration (money and/or property) being received by the provider/relative.

(ii) The agreement executed between the applicant and provider/relative must provide that the amount of consideration (money and/or property) cannot exceed the fair market value for that rendered service(s). Rates for these services must be shown to be comparable to the usual and customary rates in the local area. The fair market value of the services may be determined by consultation with an area business which provides such services.

(iii) Services that are provided pursuant to a valid personal services agreement must be documented with

time sheets and attendance logs for each hour of services provided. Contracts cannot provide for a "lump sum" payment regardless of the services that are to be provided, as each service must be individually documented to be justified.

(iv) Payment must only be for actual services rendered. Any reimbursement for out-of-pocket expenses incurred by the caregiver must be documented by a receipt.

Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division

Statutory Authority: Social Security Act, §§1613, 1917; 20 C.F.R. §416.1246; Code of Ala. 1975, §§35-1-2, 8-9-12; State Plan; Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360, Section 303); §608(d) Family Support Act; and Section 13611 of the Omnibus Budget Reconciliation Act of 1993; and 42 C.F.R. 430 Subpart B.

History: Rule effective October 1, 1982. Repealed and New Rule adopted in lieu thereof effective June 9, 1986. **Amended:** effective January 14, 1987. **Emergency rule** effective September 30, 1988. Repealed and New Rule adopted in lieu thereof effective January 10, 1989. **Amended:** June 16, 1989; May 14, 1991. Emergency Rule effective June 1, 1993. Filed: July 7, 1993; effective August 11, 1993. **Amended:** Filed June 6, 1995; effective July 11, 1995. **Amended:** Filed December 6, 1995; effective January 11, 1996. **Amended:** Filed January 9, 2004; effective February 13, 2004. **Amended:** Filed May 27, 2004; effective July 1, 2004. **Amended:** Filed July 12, 2006; effective August 16, 2006. **Amended:** Filed May 12, 2008; effective June 16, 2008. **Amended:** Filed July 12, 2012; effective August 16, 2013. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.10 Income Criteria For Individuals In Institutions And Home And Community-Based Waivers.

(1) The income limit for the institutional Medicaid program and certain home and community-based waiver programs is determined by the Agency and published in the State Plan for Medical Assistance. The income limit is equal to 300 percent of the current SSI benefit amount payable to an individual in his own home who has no income.

(2) The income limit for certain recipients of home and community-based waiver services who are eligible for Medicaid solely because they require and receive services under a home and community-based services waiver is the SSI federal benefit rate plus the $20.00 general disregard.

(3) Rules in 20 C.F.R. 416 Subpart K govern types of countable income and income exclusions except as further limited by §36-27-21.1, Code of Ala. 1975.

(4) In determining the amount of income an individual has to apply to his cost of care in an institution, the following are deducted:

(a) amounts of income protected for personal needs subject to the limits as set forth in the Agency State Plan, Attachment 2.6-A.

(b) amounts of income protected for the maintenance needs of the ineligible spouse and dependents living outside the facility.

(c) amounts of income protected for health insurance premiums that are paid by the applicant/recipient.

(d) amounts of income for incurred necessary medical or remedial care recognized under state law but not covered under the State's Medicaid Plan, nor subject to payment by Medicare or any other third-party health insurance including Medicare premiums, deductibles and coinsurance.

1. The incurred necessary medical or remedial care must be determined to be medically necessary. All verification needed to make the determination of medical necessity and to allow the deduction must be furnished to the agency within six months of the date of the service.

2. A deduction for expenses incurred for medically necessary non-covered medical or remedial care will be allowed based on the lesser of the Medicaid rate, the Medicare rate, or reasonable and customary charges.

3. A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of current application.

4. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

5. A deduction for initial or replacement dentures will be allowed for those meeting Agency established medical necessity criteria.

6. A deduction for hearing aids will be allowed for those meeting Agency established medical necessity criteria.

7. A deduction from the individual's income for incurred necessary medical or remedial care is only applicable when the individual has available income to allow for an offset (liability amount to the nursing home is greater than zero).

(5) The following are more liberal income requirements than SSI for determining the eligibility of individuals as Qualified Medicare Beneficiaries and Specified Low Income Medicare Beneficiaries, and Qualifying Individuals-1:

(a) The consideration of in-kind income support and maintenance in the income calculation is waived.

(b) Fluctuating income may be averaged for the past six months and projected for twelve months.

(c) Interest and dividend income is excluded.

Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division
Statutory Authority: State Plan; Social Security Act, Titles XVI, XIX; 1902(r)(2); 42 C.F.R. §§401, et seq.; Code of Ala. 1975, §36-27-21-.1; 42 C.F.R. §435.725; 42 C.F.R. §§435.231, 1611(b)(1); §§1915(c), §1902(a)(10)(A)(ii)(VI).
History: Rule effective October 1, 1982. **Emergency rule** effective August 4, 1983. **Amended:** effective November 10, 1983; July 9, 1984; July 9, 1985. **Emergency rule** effective January 8, 1988. **Amended:** effective April 12, 1988; July 14, 1990. **Emergency rule** effective October 9, 1990. **Amended:** effective January 15, 1991; July 13, 1991; November 12, 1992. Emergency Rule effective May 1, 1993. **Amended:** Filed July 7, 1993; effective August 11, 1993. **Amended:** Filed April 11, 2006; effective May 16, 2006. **Amended:** Filed July 12, 2006; effective August 16, 2006. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.11 Additional Criteria For Institutional Care.

(1) In addition to the rules covered in Rules 560-X-25-.05 through .11 the following criteria must also be met for an individual to qualify for Medicaid in a Title XIX institution:

(a) The individual must be certified as needing the level of care received in an institution and as having a continuing need for institutionalized care.

(b) The individual must be in a facility certified to participate in the Medicaid program and which has a current provider agreement with the Medicaid Agency.

(2) In order for an individual institutionalized in a hospital or nursing home to qualify for the maximum income limit allowed for institutionalized Medicaid recipients, as described in Rule No. 560-X-25-.10, the individual must have been a resident of a Title XIX medical institution for 30 consecutive days or longer. Being a resident of an institution for 30 consecutive days means being a resident for the period beginning with day one until the last instant of the 30th consecutive day.
Author: Arthur Miller, John H. Ziegler
Statutory Authority: Social Security Act, Title XIX; 42 C.F.R. §§401, et seq.; State Plan; Chapter 10 this Code; Social Security Act §1902(a)(10)(A)(ii)(V) as amended by §9510 of COBRA 1985.
History: Rule effective October 1, 1982. **Amended:** effective March 15, 1983. **Emergency rule** effective July 1, 1987. **Amended:** effective August 10, 1987.

560-X-25-.12 Periods Of Entitlement.

(1) The earliest date of entitlement for Medicaid is the first day of the month of application for assistance under one of the categorical programs, provided the individual meets all factors of eligibility for that month. The individual who is eligible on the first day of the month is entitled to Medicaid for the full month.

(2) An exception to (1), above, is Retroactive Medicaid Coverage. Individuals who have incurred medical expenses for the three months immediately preceding the month of application for Medicaid or the three months prior to the receipt of the first SSI check (for SSI cases), may become eligible for Medicaid benefits during that time provided all eligibility requirements are met for each month.
Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division
Statutory Authority: Social Security Act, Titles IV-A, XVI, XIX; 42 C.F.R. §435.914; State Plan.
History: Rule effective October 1, 1982. **Amended:** effective March 11, 1986; January 14, 1987; September 13, 1990. **Amended:** Filed October 7, 1993; effective November 12, 1993. **Amended:** Filed December 8, 1997; effective January 12, 1998. **Amended:** Filed February 11, 2014; effective March 18, 2014. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.13 Adults In Need Of Protective Services.

For adults in need of protective services (as defined by Code of Ala. 1975, §§38-9-2, et seq.), property may be excluded during the period from the date the petition is filed to the date of the court order, but in no event for a period to exceed 120 days.

Author: Aljanetta C. Rugley, Policy/Research Specialist, Policy Program Implementation, Certification Support Division
Statutory Authority: Code of Ala. 1975, §§38-9-2, et seq.
History: Rule effective October 1, 1982. **Amended:** Filed July 12, 2001; effective August 16, 2001.

560-X-25-.14 Pregnant Women And Children Age 0 - 18 With Income Equal To Or Below 141%.

(1) Pregnant women are defined as "women who are pregnant or post-partum, with household income at or below 141% of the Federal Poverty Level (FPL)". Medicaid coverage under MAGI-related coverage groups is available for pregnant women meeting the requirements listed below:

(a) The household income must be equal to or less than 141% of the current federal poverty level. A standard income disregard of 5% of the federal poverty level is applied if the individual is not eligible for coverage due to excess income.

(b) Self-attestation must be accepted for pregnancy unless there is information that is not reasonably compatible with such attestation.

(c) The individual must be pregnant or post-partum.

(d) The person to be covered must be living in Alabama and must be a United States citizen or meet alienage requirements.

(e) Any private insurance benefits must be assigned to the State.

(f) Application must be made for any other benefits for which the person's family appears eligible.

(g) Changes in income and/or living arrangements must be reported at annual review.

(h) The person to be covered must furnish or apply for a Social Security number.

(2) Children age 0 -18 are defined as "infants and children under age 19 with household income at or below 141% of the Federal Poverty Level".

Medicaid coverage under poverty provisions is available to children age 0 -18 with income at or below 141% of the Federal Poverty Level meeting the requirements listed below:

(a) The household income must be equal to or less than 141% of the current federal poverty level. A standard income disregard

of 5% of the federal poverty level is applied if the individual is not eligible for coverage due to excess income.

(b) The child must be 0 - 18 years old.

(c) Children's eligibility will continue through the month of their 19th birthday.

(d) The child to be covered must be living in Alabama and must be a United States citizen or meet alienage requirements.

(e) Any private insurance benefits must be assigned to the State.

(f) Application must be made for any other benefits for which the person's family appears eligible.

(g) Changes in income and/or living arrangements must be reported at annual review.

(h) The person to be covered must furnish or apply for a Social Security number.

Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division
Statutory Authority: Section 6401 of P.L. 101-239, Omnibus Budget Reconciliation Act of 1989 (OBRA 89). Section 4601 of P.L. 101-508, Omnibus Budget Reconciliation Act of 1990 (OBRA 90).
History: **Emergency rule** effective September 1, 1991. **Permanent rule** effective December 12, 1991. **Amended:** Filed December 12, 2001; effective January 16, 2002. **Amended:** Filed June 12, 2002; effective July 17, 2002. **Amended:** Filed June 11, 2003; effective July 16, 2003. **Amended:** Filed February 11, 2014; effective March 18, 2014. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.15 Parents And Other Caretaker Relatives And Transitional Medical Assistance.

(1) **Parents and Other Caretaker Relatives (POCR)**

(a) Parents and Other Caretaker Relatives is a Medicaid eligibility coverage group available to parents and other caretaker relatives of dependent children with household income at or below 13% of the federal poverty level (FPL). POCR also includes qualified pregnant women without other children whose family income falls within the standards for POCR. A standard income disregard of 5% of the federal poverty level is applied if the individual is not eligible for coverage due to excess income.

(b) The POCR must be related to the dependent child by blood, adoption, or marriage, with whom the dependent child lives, and who has primary responsibility for the dependent child's care. An all-inclusive list of POCR relationships includes:

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

2. The spouse of such POCR, even after the marriage ends due to divorce or death.

(c) A "dependent child" is defined as a child who is under the age of 19.

(d) Self-attestation must be accepted to verify the POCR relationship for caretaker relatives unless there is information that is not reasonably compatible with such attestation. In such cases, the following documents are acceptable to verify POCR relationship:

1. Primary sources: Birth record, school records, sworn, notarized or witnessed statement of applicant/recipient, affidavit of paternity, hospital birth record, court orders signed by the judge where the relationship is acknowledged as claimed and there is no evidence to the contrary. If there are no primary sources to verify the POCR relationship, then the combination of both a Declaration of Natural Relationship Form made by the applicant/recipient or other persons with knowledge of the relationship and a secondary source to verify the POCR relationship

2. Secondary sources: Insurance policy, other agency records, (example Red Cross, SSA, Census records, VA, Department of Senior Services records, Department of Human Resources), bible records, income tax records, official records, (example school report card, juvenile court), other hospital records, clinic or Health Department records, church records, military records, statement from a minister, priest or rabbi, baptismal certificate or other.

(e) Technical Requirements:

1. The dependent child must be living in the home of the POCR.

2. The dependent child must be under age 19.

3. The dependent child must be a U.S. citizen or an alien in satisfactory immigration status.

4. The POCR caretaker must cooperate with the Department of Human Resources and Alabama Medicaid Agency in Medical Support Enforcement Activities and in Third Party Medical Liability Activities unless good cause for not cooperating is determined.

5. When application is made for a dependent child the POCR who cares for the dependent child automatically assigns to the State all medical insurance or medical support benefits to the extent medical assistance is provided to both the dependent child and the POCR.

6. The POCR must furnish all Social Security numbers for everyone in the household or apply for a Social Security number for anyone who does not have a number and furnish the number upon receipt. (These numbers will be used in addition to any other means of identification in the administration of the program as provided for in Section 402(a)(25) of the Social Security Act). The number provided will be used in computer matches, program reviews and audits. Eligibility and income information will be requested regularly from the Internal Revenue Service, Social Security Administration, Alabama Department of Industrial Relations and other public and private organizations.

7. The POCR must apply for any other benefits for which they or other members of the household appear to be eligible, such as Veteran Benefits, Social Security, Unemployment Compensation, etc.

(f) The Agency uses less restrictive income and resource methodologies than those in effect as of July 16, 1996, as follows:

1. Resources are excluded.

2. Gifts and inheritance are considered excluded income.

(2) **Transitional Medical Assistance (TMA)**

(a) When a household loses eligibility for Medicaid benefits under the POCR coverage group due wholly or partly to the collection of increased earnings or hours of employment, the household is entitled to twelve (12) continuance months of Transitional Medical Assistance (TMA), provided that:

1. Medicaid benefits under the POCR coverage group were terminated due wholly or partly to the POCR's increased earnings or hours of employment;

2. The household correctly received Medicaid benefits under the POCR coverage group in Alabama for at least

three (3) of the six (6) months immediately prior to the first month of ineligibility; and

3. There is a child under 19 in the home.

(b) When a household loses eligibility for Medicaid benefits under the POCR coverage group due wholly or partly to the collection or increased collection of spousal support, the household is entitled to four (4) continuous months (and children are eligible for twelve (12) continuous months) of Extended Medicaid coverage, provided that both:

1. Medicaid benefits under the POCR coverage group were terminated due wholly or partly to the POCR's collection or increased collection of spousal support; and

2. The household (or any member of the household) correctly received Medicaid benefits under the POCR coverage group in Alabama for at least three (3) of the six (6) months immediately prior to the first month of ineligibility.

Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division
Statutory Authority: Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
History: **Emergency rule** effective September 1, 1991. **Permanent rule** effective December 12, 1991. **Amended:** Filed February 19, 1999; effective March 26, 1999; operative April 1, 1999. **Amended:** Filed December 12, 2001; effective January 16, 2002. **Amended:** Filed June 12, 2002; effective July 17, 2002. **Repealed and New Rule:** Filed June 11, 2003; effective July 16, 2003. **Amended:** Filed February 11, 2014; effective March 18, 2014. **Amended:** Filed June 11, 2015; effective July 16, 2015. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.16 Income And Resources Of A Married Couple For Institutional Care.

(1) The Medicare Catastrophic Coverage Act (MCCA) of 1988 provides for the special treatment of income and resources of a married couple. The special treatment is to protect the income and resources for the maintenance needs of the community spouse while the spouse is in a medical institution or nursing facility. In determining Medicaid eligibility for an institutionalized spouse, the provisions of this section supersede any other inconsistent provisions of this chapter, including the determination of income and resources.

(2) For purposes of this section, the following definitions apply:

(a) SPOUSE - Person legally married to another under State law. The SSI definition as applied to the QMB/SLMB cases is not applicable to spousal cases. Legal marriage is a traditional marriage conducted by legal authority or a common law marriage recognized by a court and entered into prior to January 1, 2017.

(b) INSTITUTIONALIZED SPOUSE (IS) - Legally married person who resides in a medical institution or nursing facility and can reasonably be expected to continue to reside in the medical institution or nursing facility for a continuous period.

(c) COMMUNITY SPOUSE (CS) - Legally married person who is not living in a medical institution or nursing facility, and has a spouse residing in a medical institution or nursing facility for a continuous period.

(d) CONTINUOUS PERIOD OF INSTITUTIONALIZATION - At least 30 consecutive days of institutionalization in qualified medical institutions and/or nursing facilities.

(e) OTHERWISE AVAILABLE INCOME - Income that would be used to determine eligibility without benefit of disregards (including federal, state and local taxes) - gross income as defined by SSI.

(f) MAINTENANCE NEEDS STANDARDS - Income standards against which community spouses' and other family members' incomes are compared for purposes of determining the amount that can be allocated in the post-eligibility calculation.

(g) MONTHLY MAINTENANCE NEEDS ALLOWANCE - The minimum income the community spouse is entitled to have each month. This is an amount deducted in the post-eligibility calculation of income for maintenance needs of the community spouse (if both spouses agree to the allocation) or other dependent family members to meet their needs in the community.

(h) SPOUSAL SHARE - The set total value amount of resources protected for the community spouse. The Spousal Share is the greater of the Minimum Protected Resource Amount or one-half of the total value of the married couple’s combined countable resources, not to exceed the Maximum Protected Resource Amount.

(3) Protecting Income and Resources for the Community Spouse.

(a) A monthly maintenance needs allowance can be protected for the community spouse and family dependents at home.

(b) Spousal Impoverishment - To determine eligibility for an institutionalized spouse who has a community spouse, all resources, whether owned jointly or individually by either

spouse, must be "pooled" beginning with the point that a spouse was institutionalized to perform a Spousal Assessment. A Spousal Assessment must be conducted at both the beginning of the first continuous period of institutionalization and at the time of application for Medicaid benefits. A Spousal Assessment will calculate the total value amount of both the resources available to the institutionalized spouse and the protected Spousal Share of the community spouse. A Spousal Assessment is to be completed at the request of either of the married couple, an authorized representative acting on behalf of either spouse, or at the time of application for Medicaid benefits. A Spousal Assessment is to be accomplished in a prompt manner.

(c) When a married couple is both institutionalized and both apply, each is treated as individuals rather than as a couple. Treatment as individuals begins as of the first day of the month following the month both are institutionalized. Spousal impoverishment rules do not apply and an assessment of resources shall not be conducted.

(d) If a married couple is institutionalized and only one applies for Medicaid, they are treated as individuals as of the beginning of the first full month of separation. Income and assets of the ineligible spouse must be deemed during the partial month.

(e) Spousal impoverishment rules apply to legally married couples when one enters a medical institution or nursing facility while the other remains in the community. The institutionalized spouse must remain in an institution for 30 continuous days or longer.

(f) Spousal impoverishment does not apply if a claimant is not legally married at the time he/she enters the medical institution or nursing facility, unless he or she subsequently marries.

(g) If there is a change in circumstances such that there is no community spouse or institutional spouse, spousal impoverishment provisions cease to apply. The effective date of the cessation is the first full month following the change in status, for example, the community spouse enters a medical institution or nursing facility; or if the marriage is ended by death, divorce or annulment.

(h) In order for spousal impoverishment rules to apply there must be a community spouse both at the point of institutionalization and at the point of application.

(i) If the claimant marries after the initial determination of eligibility, spousal rules apply. The resource assessment is computed based on the assets owned by the couple, individually

or jointly, at the beginning of the institutionalized spouse's most recent continuous period of institutionalization even though that point precedes the point in time where there is a known community spouse.

(j) If both spouses enter an institution at the same time, but one spouse returns to the community, an assessment must be completed. The assessment is computed based on the resources owned by the couple (individually or jointly) at the beginning of the institutionalized spouse's most recent continuous period of institutionalization, even though both spouses were institutionalized at that point.

(4) When a claimant for Medicaid was divorced during the look-back period (60 months), the district office should review the divorce settlement. If the claimant did not receive an equal share of the marital estate, it may be considered a transfer of resources.

(5) Treatment of Income - The following rules apply in determining ownership of income for eligibility purposes:

(a) Consider available to each spouse one-half of any income paid in the name of both spouses,

(b) Consider any income paid solely to each spouse as income to that spouse,

(c) Consider income paid in the name of another party and both spouses, or one spouse, available to each spouse in proportion to each spouse's interest (or one-half of the total amount to each when payment is made to both spouses),

(d) Consider available to each spouse, one-half of any income that has no instrument establishing ownership. The institutionalized spouse is allowed to submit evidence to Medicaid to rebut the determination of available income (other than trust income). Prenuptial agreements are not binding nor considered for Medicaid eligibility purposes or for spousal impoverishment.

(e) If the institutionalized spouse is the grantor of a trust providing for payment of income to him or her, the maximum amount payable by the terms of the trust will be counted as available. No income paid only to a community spouse shall be counted in determining eligibility or amount of the payment to the nursing home for the institutionalized spouse for any month of institutionalization. The rule on trust income incorporates Section 1902(k) of the Social Security Act, the Medicaid Qualifying Trust provision.

(6) Compare the institutionalized spouse's countable income to the institutional income limit.

(a) After the institutionalized spouse has been determined income and resource eligible, determine the amount of income, if any, to be applied toward the cost of institutional care (i.e., liability amount) by deducting the following from the institutionalized spouse's income in the following order:

1. Personal Needs Allowance,

2. Community Spouse Monthly Maintenance Needs Allowance, if applicable,

3. Family Maintenance Needs Allowance, if applicable,

4. Amount for Health Insurance premiums, if applicable.

(b) The remainder should be the amount the claimant must pay to the nursing facility. In the case of a divorced couple, alimony is not considered to be an income deduction for decreasing the liability amount to be paid to the nursing facility.

(7) The minimum monthly maintenance needs standard for the community spouse is recalculated each year. Changes, if any, in this amount are effective in July. The community spouse monthly maintenance needs allowance is determined as follows: Deduct the community spouse's monthly income from the minimum monthly maintenance needs standard. This amount is published each year by the U. S. Department of Health & Human Services (HHS) and is 150 percent of the federal poverty level for a couple. Available income of the community spouse includes income that would be used to determine eligibility for the claimant, without benefit of disregards (including federal, state, and local taxes)(gross income according to SSI standards). Any remaining amount is the monthly maintenance needs allowance (if allocated to the spouse). This amount is used in the post-eligibility calculation for allocation to the community spouse. If in excess, an allowance is not made available. When allowances are not made available to (or for the benefit of) the community spouse, Medicaid will not deduct the allowance. The following are mandated deductions for the institutionalized spouse and may reduce the monthly maintenance needs allowance for the community spouse:

(a) personal needs allowance,

(b) Veterans Administration aid and attendance allowance,

(c) Veterans Administration payments for unusual medical expenses, and

(d) Veterans Administration continuing medical expenses.

(8) A maintenance needs allowance may be provided from the institutionalized spouse to other dependent family members. The

dependent family member is defined as: a minor child, dependent adult child, dependent parent, or dependent sibling of either spouse, who is living with the community spouse and who is listed on the federal tax forms as a dependent (Internal Revenue Service tax dependent) of the community spouse.

(a) Allowances for each family member are determined as follows:

1. Step 1. Deduct the gross income of the family member from the community spouse minimum monthly maintenance standard;

2. Step 2. Divide the remainder in Step 1 by 3.

3. Step 3. The remainder in Step 2, rounded down to the nearest dollar, is the minimum family monthly maintenance needs allowance used in the post-eligibility calculation to be allocated to the family member. If in excess, an allowance is not made available, deduct allowances for other family members, regardless of whether institutionalized spouses make their income available to such persons.

(b) When there is no community spouse and there are other family members, the current AFDC payment standard will be used. The total number of family members at home will be computed against this table. This standard will be used when there are other family members, even though in some instances the needs allowance will be less than that of a spouse only. Any income of the family at home will be deducted from the standard to determine allocation. If the family at home has no income, the standard will be allocated. If the income of the institutionalized spouse is below the standard, the entire income will be allocated except for the protected personal needs allowance and the veterans aid and attendance allowance, veterans reimbursement for continuing unusual medical expenses. The current AFDC definition of family units will be used in determining who is a family member.

(9) Treatment of Resources - Medicaid shall "pool" the resources of an institutionalized and community spouse when:

(a) Either spouse requests an assessment at the beginning of the institutionalized spouse's first continuous period of institutionalization; and

(b) Although the married couple may not have requested a Spousal Assessment at the time one of the spouses was institutionalized, Medicaid shall determine the total combined resources existing at the point of institutionalization when the initial Medicaid application is filed. At the time of application, Medicaid computes the total combined value of the

resources of the married couple and a Spousal Share. A Spousal Assessment will be conducted both at the time and date of institutionalization, and at the time of initial eligibility determination (i.e., eligibility or ineligibility). All the resources owned by either the institutionalized spouse or the community spouse, or both, shall be considered a countable resource available to the institutionalized spouse, except for the community spouse's Spousal Share.

(c) At the beginning of a continuous period of institutionalization of a spouse, Medicaid shall to determine the total value amount of both the Spousal Share of the community spouse and Medicaid eligibility for the institutionalized spouse for the first month of a continuous period of institutionalization as follows:

1. Step 1. List all combined countable resources owned individually or jointly by the married couple at the date and time of entry to the medical institution or nursing facility. The following types of otherwise excluded resources shall be included in a Spousal Assessment:

(i) equity value of real property normally excluded from assets due to a bona fide effort to sell;

(ii) equity value of real property normally excluded from assets because it is jointly owned, and the sale of the property would cause the other owner undue hardship because of the loss of housing;

(iii) equity value of real property normally excluded because of a legal impediment; and/or

(iv) equity value of real property normally excluded because it is income producing.

2. Step 2. Determine the total value of items listed in Step 1 above. If the total in Step 2 is less than the Minimum Protected Resource Amount (published annually by HHS), stop here. All resources may be protected as the Spousal Share. If the amount in Step 2 is greater than the Minimum Protected Resource Amount, go to Step 3.

3. Step 3. Determine 1/2 of the total value in Step 2.

4. Step 4. Compare the amount in Step 3 with the Maximum Protected Resource Amount (published annually by HHS). If the amount in Step 3 is less than the Maximum Protected Resource Amount, protect the amount in Step 3 as the Spousal Share. If the amount in Step 3 is greater than the Maximum Protected Resource Amount, protect the Maximum Protected Resource Amount as the Spousal Share.

5. Step 5. Subtract the amount in Step 4 from the total amount in Step 2 above. The remaining amount is a countable resource to be used for the institutionalized spouse. If this remaining amount exceeds the current resource limit for an institutionalized case, the claimant is ineligible until those assets and assets accumulated during the spend-down period are spent down to the appropriate level.

6. During the continuous period of institutionalization, after the month in which an institutionalized spouse is determined to be eligible, no resources of the community spouse shall be deemed to the institutionalized spouse.

7. Once an assessment has been made, a new assessment can only be made if the claimant is discharged from the nursing facility or medical institution for 30 continuous days and then readmitted for another 30-continuous day period. The assessment can be reevaluated if it is determined that inaccurate information was provided during the original assessment. Only the resources on hand at the point of continuous institutionalization of the institutionalized spouse, and the value of those resources can be used in the reevaluation of the assessment. After the assessment is completed, the amount attributed to the institutionalized spouse and any additional money accumulated or acquired by either spouse, must be spent down to $2,000.00 on the institutionalized spouse in order to be eligible. Gifts and resource exclusions that are otherwise available when determining an individual's eligibility do not qualify as an appropriate spend down. The institutionalized spouse may spend the money on nursing home care, items he or she needs in the nursing home, to pay legitimate debts belonging solely to him or her, maintenance on property in proportion to the ownership interest, or other appropriate expenses. If the community spouse or institutionalized spouse acquires additional resources during the spend-down period, those additional resources must be spent down also. The only amount that the community spouse can retain, prior to and at the time of the effective date of eligibility for institutionalized Medicaid benefits, is the protected amount determined in the assessment. After the effective date of eligibility for institutionalized Medicaid benefits, no resources of the community spouse shall be deemed available to the institutionalized spouse.

(10) Undue Hardship

(a) If information is available to make a determination that excess resources exist and the institutionalized spouse or sponsor claims an undue hardship exists, the case will be sent

to the Beneficiary Services East or West Division to determine whether an undue hardship exists. If it is determined that an undue hardship exists, the institutionalized spouse may be awarded eligibility.

(b) An undue hardship exists under this section when Medicaid determines by clear and convincing evidence that the institutionalized spouse lacks the right, authority, or power to access the excess countable resources attributed to such spouse under 1924 (c)(2) of the Social Security Act, and ineligibility for Medicaid benefits will result in non-receipt of necessary medical services. In determining the existence of "undue hardship," Medicaid will consider all circumstances involving the situation of the institutionalized spouse, including but not limited to the following:

1. Whether the institutionalized spouse (or authorized representative) has exhausted all reasonable efforts to obtain and utilize the resources in question; or

2. Whether the institutionalized spouse (or authorized representative) has exhausted all reasonable efforts to meet his/her needs from all other available sources; or

3. Whether the institutionalized spouse has been determined to be a person in need of care and protection pursuant to the Adult Protective Services Act, Code of Ala. 1975, §38-9-1, et seq.

(11) In situations when the community spouse cannot be located, is alleged deceased, or refuses to cooperate with the institutionalized spouse:

(a) The record shall contain a sworn statement completed by the institutionalized spouse or other person with knowledge of the whereabouts of the community spouse and must show the following:

1. last known name;

2. last known address;

3. forwarding address at the post office;

4. last known employment;

5. circumstances surrounding disappearance;

6. health of the individual at time of disappearance;

7. state of mind of the individual at time of disappearance;

8. efforts to locate;

9. SSN/VA claim number/other identifying information on the individual; and

10. if alleged to be deceased, obtain death certificate from the Department of Public Health.

(b) The eligibility specialist must follow up on any leads noted above and must verify the following: financial accounts, property, and employment.

(12) Transfers by the community spouse to a person or persons other than the institutionalized spouse may result in a period of ineligibility for nursing home payments for the institutionalized spouse. The institutionalized spouse will need to actually transfer (within 12 months) sufficient resources to equal the amount protected as the Spousal Share so that such resources do not continue to cause ineligibility.

(13) All countable resources in excess of the amount protected for the Spousal Share shall be countable resources to the institutionalized spouse whether they are in the name of the institutionalized spouse or community spouse.
Author: Denise Banks, Associate Director, Policy and Training, Beneficiary Services Division
Statutory Authority: 42 USC 1396r-5. Social Security Act, Section 1924(a) through (g).
History: New Rule: Filed August 4, 1998; effective September 9, 1998. **Amended:** Filed October 12, 2005; November 16, 2005. **Amended:** Filed April 11, 2014; effective May 16, 2014. **Amended:** Filed September 11, 2018; effective October 26, 2018.

560-X-25-.17 Low Income Subsidy (LIS).

(1) The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to Medicare beneficiaries. The MMA also provides extra help in the form of a Low-Income Subsidy (LIS) to apply to the premium cost associated with Medicare Part D. Individuals qualifying for LIS will receive full or partial assistance with the monthly Medicare Part-D premium, the yearly deductible, and prescription co-payments depending on the income, family size, and resources of the beneficiary.

(2) Medicare beneficiaries with full Medicaid, SSI recipients, and Medicare beneficiaries participating in the Medicare Savings Programs (QMB, SLMB, QI) will be deemed to be eligible for LIS, and do not have to make a separate application. Medicare beneficiaries with limited income and resources who do not fall

into one of the deemed subsidy groups must make application for the LIS Program through the Social Security Administration or the Medicaid Agency. If an individual or couple completes the Social Security Administration's LIS application at a Medicaid site, or forwards a completed Social Security Administration LIS application to a Medicaid site, the Medicaid Agency will forward the completed application to the Social Security Administration's LIS processing center. If an applicant insists upon a formal LIS determination by Medicaid, the applicant must complete a Medicaid LIS application and submit the required verification to the Medicaid Agency.

(3) Individuals must be entitled to Medicare Part A (Hospital Insurance) and/or Part B (Medicare Insurance) and enroll in a prescription drug plan that services their area.

FPL & Assets	**Percentage of Premium Subsidy Amount (1)**	**Deductible**	**Copayment up to out of-pocket limit**	**Copayment above out of-pocket limit**
Full-benefit dual eligible individual - institutionalized individual	100%*	$0	$0	$0
Full-benefit dual eligible individual - Income at or below 100% FPL (non-institutionalized individual)	100%*	$0	The lesser of: (1) an amount that does not exceed $1- generic/ preferred multiple source and $3- other drugs, or (2) the amount charged to other individuals below 135% FPL and with assets that do not exceed $6,000 (individuals) or $9,000 (couples)	$0
Full-benefit dual eligible individual - Income above 100% FPL	100%*	$0	An amount that does not exceed	$0

(non-institutionalized individual)			$2-generic/ preferred multiple source and $5-other drugs	
Other low-income beneficiary with income below 135% FPL and with assets that do not exceed $6,000 (individuals) or $9,000 (couples)	100%*	$0	An amount that does not exceed $2-generic/ preferred multiple source and $5-other drugs	$0
Other low-income beneficiary with income below 135% FPL and with assets that exceed $6,000 but do not exceed $10,000 (individuals) or with assets that exceed $9,000 but do not exceed $20,000 (couples)	100%*	$50	15% coinsurance	An amount that does not exceed $2-generic/ preferred multiple source drug or $5-other drugs
Other low-income beneficiary with income at or above 135% FPL but below 150% FPL, and with assets that do not exceed $10,000 (individuals) or $20,000 (couples)	Sliding scale premium subsidy (100%-0%)	$50	15% coinsurance	An amount that does not exceed $2-generic/ preferred multiple source drug or $5-other drugs

(4) The following eligibility criteria must be met:

(a) Resource limits are effective using SSI criteria

1. Individual at or below $10,000 plus $1,500 burial exclusion

2. Couples at or below $20,000 plus $3,000 burial exclusion

(b) Income limits are effective using SSI criteria

1. Full subsidy - income at or below 135% of the FPL

2. Partial subsidy - income above 135% but below 150% of the FPL

(c) Poverty level standards for income will be based on household size which will include the applicant, his/her spouse, and all relatives for whom the applicant provides support and could claim for income tax purposes, and who are living with the applicant.

(d) Income and resources will be verified

(e) Reviewed annually

(5) LIS eligibility is as follows:

(a) For calendar year 2006, eligibility is effective as of the first day of the month of application, but not earlier than January 1, 2006, and remains in effect for a period not to exceed one year.

(b) For any calendar year after 2006, eligibility is effective as of the first day of the month of application and remains in effect for a period consistent with the State Plan, but not to exceed one year.

(c) LIS determination is not a determination for eligibility for Medicaid services.

(d) LIS is subject to Medicaid administrative rules and policies regarding application processing and redeterminations

Author: Audrey Middleton, Associate Director, Policy and Program Implementation Unit, Certification Support Division
Statutory Authority: Social Security Act 1935(a), 1860D-14, 1905(p)(3); and 42 CFR 423.774 and 423.904.
History: New Rule: Filed January 11, 2006; effective February 15, 2006.