

PART 9 SPECIAL GROUPS – HIV/AIDS WAIVER, BREAST AND CERVICAL, NON-CATEGORICAL

SECTION 1 HIV/AIDS Waiver

Individuals can get limited benefits under Medicaid for people with HIV/AIDS if they meet medical and financial requirements identified in this section.

If an individual who is eligible for this benefit becomes eligible for any Categorically Needy or Medically Needy coverage group s/he will be moved to that coverage group. This includes someone who meets a deductible or spend down or, for example, an individual who has a reduction in income so that s/he qualifies for Family - Related coverage with income under 150% of the Federal Poverty Level (See Chart 6). This individual's coverage group is then changed from the HIV/AIDS Benefit to the Categorical coverage group.

If an individual who is enrolled in a Categorical coverage group becomes ineligible including someone who must meet a new deductible or spend down, but is eligible for HIV/AIDS Benefits, that individual will be changed to HIV/AIDS Benefit. This will happen even if there is a wait list for HIV/AIDS Benefits.

An individual cannot get coverage for the HIV Benefit and the Maine Rx Plus or Low Cost Drugs for the Elderly and Disabled (DEL) at the same time unless DEL is supplementing Medicare Part D.

Section 1.1 Basic Eligibility Requirements

Individuals must meet all the basic eligibility requirements for getting MaineCare coverage identified in Part 2. This includes the rules on residency, citizenship, social security numbers, assignment of rights to medical payments and support rights as well as applying for other benefits. There is no age requirement.

Section 1.1.1 Medical Eligibility

The individual must be diagnosed as HIV positive. This diagnosis is confirmed by the Maine Center for Disease Control (MCDC). The individual must also comply with the treatment regimen as identified in the MaineCare Benefit Manual.

Section 1.1.2 Financial Eligibility

If an individual is financially eligible for SSI - Related coverage, a disability decision will be done by the Medical Review Team if a disability decision has not been made by Social Security and the individual agrees to cooperate with this determination.

Section 1.2 Income

The SSI - Related rules on income exclusions in Part 17 are applicable to this coverage group.

Gross income must be equal to or less than 250% of the Federal Poverty Level (See Chart 6).

There is no deeming of income from the spouse. There is no cost of care.

When determining MaineCare coverage for a spouse not applying for or enrolled in the HIV Benefit, the income/assets of both spouses are considered under the rules for the spouse's coverable group. For example, if the spouse is being considered for SSI - Related coverage, the income and assets of both spouses are considered when determining eligibility for the spouse.

Section 1.3 Assets

There are no asset criteria.

Section 1.4 Premiums

A premium payment is due for each month the individual is open for Medicaid under this coverage group unless s/he is exempt from a premium as identified below.

Premiums are due on the first day of each month of coverage.

The premium amount is based on gross monthly income projected for the twelve month enrollment period. A premium is effective the month an individual is added for coverage under this group and ends effective the month coverage under this coverage group ends. See Chart 3.10 for premium amounts due.

Section 1.4.1 Payment of Premiums

- I. Premiums can be paid monthly, for multiple months, or they can be paid in advance for the twelve month enrollment period. Payments will be credited to the earliest months of coverage first, during the current twelve month enrollment period.

For example: A monthly premium of \$20.00 is due during a twelve month enrollment period from January through December and the first payment of \$220 is received on December 1st. Months one through eleven will be credited with a premium paid. The December payment is overdue.

- II. When a premium is not paid by the first of the month in which it is due the Department will give notice of nonpayment.
- III. There is a grace period for nonpayment of premiums. The grace period extends through the last day of the twelve month enrollment period.

For example: If the enrollment period is January through December, the individual has until December 31st to pay his or her premiums for the period January to December.

If the last day of the month falls on a weekend or holiday the premium is then due on the next workday.

- IV. If eligibility under this coverage group ends prior to the close of the twelve month enrollment period, the grace period for premium payment extends to the last day of the month in which coverage under this group ends.

For example: an individual granted 10/07 has a review date of 9/08 but his coverage is changed to Medicaid without a premium for December. The grace period for payment of premiums for October and November is November 30th.

- V. If eligibility under this coverage group is continued pending a hearing and a premium is due, the grace period is the last day of the month for which coverage is provided.

For example: the premium for the month of July is due July 1st. The grace period extends to July 31st.

Section 1.4.2 Exemptions from Premium Payment

An individual is exempt from a premium:

- I. If gross income is less than or equal to 150% of the Federal Poverty Level (See Chart 6) .
- II. If there is good cause for premiums not paid or not paid when due because of one of the following reasons:
 - A. Mail delay;
 - B. Illness of the individual or their responsible relative; or
 - C. Unanticipated emergency beyond the control of the individual or their responsible relative.
- III. During periods of retroactive coverage.

Section 1.4.3 Changes in Premium Amount

If the individual's income changes so that no premium is due or the amount of premium increases or decreases, this change will be made as follows:

- I. the change in income must be expected to last a full calendar month;
- II. the change will be effective for the month the income changed as long as the change is reported within 10 days of it's occurrence; otherwise, the change is effective the month the change is reported; and
- III. the premium amount will be changed no more than once every 6 months.

Section 1.4.4 Non-Payment of Premiums

- I. At the beginning of month twelve of the enrollment period, notification will be given if any premiums for the enrollment period have not been paid when due. The individual will be notified of the penalty to be imposed because of the non-payment.
- II. At the twelve month review a determination will be made as to whether there are any overdue premiums. If so, coverage for this

benefit will end unless there is “good cause” for non-payment. Coverage cannot begin again until any unpaid premiums are paid. When the unpaid premiums are paid and the individual is otherwise eligible, the individual is re-enrolled even if there is a wait list and regardless of the individual's place on the waiting list.

Section 1.5 Administrative Hearings

- I. Coverage for this benefit continues pending a hearing decision if a hearing is requested, even if the individual is not paying premiums that are due. If the individual was responsible for paying a premium prior to the proposed negative action, this premium will continue to be due.
- II. If the individual is upheld at the hearing and they have overpaid any premiums s/he will be issued a refund.

Section 1.6 Wait List

Enrollment for this benefit is capped based on expenditures. If enrollment is frozen, individuals who have been determined to be medically and financially eligible will be placed on a wait list that is maintained by the Maine Center for Disease Control and Prevention (MCDC). The rules for the waiting list are in the MaineCare Benefits Manual.

When the Office of Integrated Access and Support is informed by the MCDC that individual's coverage can start, financial eligibility will be updated before coverage for this benefit can start.

SECTION 2 BREAST AND CERVICAL CANCER

Medicaid is provided to women who are under age 65 and otherwise meet the eligibility guidelines set forth in DHHS Rules for the Maine Breast and Cervical Health Program (MBCHP), 10-144, Chapter 707 *et seq.*

Individuals are initially authorized coverage under this group based on data collected by the Maine Center for Disease Control and Prevention (MCDC) and transferred electronically to the Office of Integrated Access and Support (OIAS). Coverage is continuous for one year or as long as the individual is in need of treatment, whichever is longer. When eligibility under this group ends, the individual will be reviewed by OIAS for continued coverage under another MaineCare coverage group.

Basic Non-Financial eligibility requirements for getting Medicaid coverage identified in Part 2 apply to this group. This includes the rules on residency, citizenship, social security numbers, and assignment of rights to medical payments.

SECTION 3 NON-CATEGORICAL ELIGIBILITY

Section 3.1 Basic Eligibility Criteria

The individual must be between the ages of 21 up to and including age 64, not residing as a specified relative with a child under age 18 (or is age 18 and expects to graduate from high school prior to their 19th birthday) and be ineligible under any other coverage group.

If the individual claims to have a disability that would meet the MaineCare requirement, a disability determination will be done. The individual can get temporary coverage, if eligible, until a decision is made.

Basic Non-Financial eligibility requirements for getting MaineCare coverage identified in Part 2 apply to this group. This includes the rules on residency, citizenship, social security numbers, and assignment of rights to medical payments.

Section 3.2 Assets

The countable asset limit is \$2,000 for an individual, \$3,000 for a couple. The rules on the definition of assets and asset exclusions used in SSI - Related Medicaid coverage are used for this group.

Section 3.3 Income

Gross non-excluded monthly income must be equal to or under 100% of the Federal Poverty Level (See Chart 6). The rules on the definition of income and income exclusions used in SSI - Related Medicaid coverage are used for this group. There are no income disregards.

Section 3.4 Budgeting

The rules for Medicaid SSI - Related budgeting are used in determining the size of the assistance unit and whose income to count.

Individuals in this coverage group are not eligible under Medically Needy.

Section 3.5 Wait List - Procedures to Prevent Program Expenditures from Exceeding Budget

- I. DHHS may institute a wait list for this program when DHHS determines that there are insufficient funds with which to add additional individuals.
- II. Individuals on the wait list have no rights to coverage under this program.
- III. Wait List Procedure -
 - A. The wait list will be maintained statewide by the date the Office of Integrated Access and Support receives the application.
 - B. The "application date" for purposes of placement on the wait list is:
 1. The date an application form is received from someone who has not been enrolled in MaineCare coverage for one month.
 2. If an individual who has been enrolled in Medicaid becomes financially eligible under the Non-Categorical coverage group at the time he or she becomes ineligible for another Medicaid coverage group, the date of application is the day following the date the individual's other Medicaid coverage group ends.
 3. If an individual between the ages of 21 and 64 has been getting forty-five day Temporary Coverage (pending an eligibility decision for coverage under another Medicaid group) and the Temporary Coverage ends, the

application date is the date of the original application for coverage under another Medicaid coverage group.

- C. Individuals on the wait list will become eligible for coverage if and when the Department determines that program funding is available. When the Department determines that program funding is available, individuals will be enrolled on the basis of their application date. The earliest applications will be enrolled first. For example, those applying March 15th will be enrolled before those applying March 16th. No retroactive coverage is available for individuals enrolled off the wait list.

If an individual has been on the wait list for over 3 months, his or her financial eligibility will be updated before coverage is authorized. If the individual is then found to be ineligible, he or she will be dropped from the wait list. To get back on the wait list, he or she will need to reapply. If eligible, the new application date will be used to put them on the wait list.

An individual who fails to respond to the financial eligibility update process, but who establishes “good cause” (See Section 3.6 below) for not responding, will be given sixty days from the date he or she is dropped from the wait list to submit an application. If financial eligibility exists, the individual will be authorized coverage the first day of the month he or she returns the completed application.

Section 3.6 Reinstatement Process

When a non-categorical individual’s coverage is closed for failure to respond to a redetermination request, that individual will have sixty days from the date of closure to regain coverage if good cause exists. (Coverage will be retroactive back to the original date of closure, even if a wait list is in effect.) Good cause reasons must be demonstrated by the individual, and can include, but are not limited to;

- I. circumstances beyond the individuals control such as illness, or
- II. non-receipt of notice.

Section 3.7 Discontinuance of the Wait List

When the Commissioner determines that the program expenditures will not exceed the program cap for the current waiver year, then the Department shall enroll eligible individuals to the extent necessary to provide coverage to as many persons as possible within the program budget, in accordance with the above rule.