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October 22, 2025

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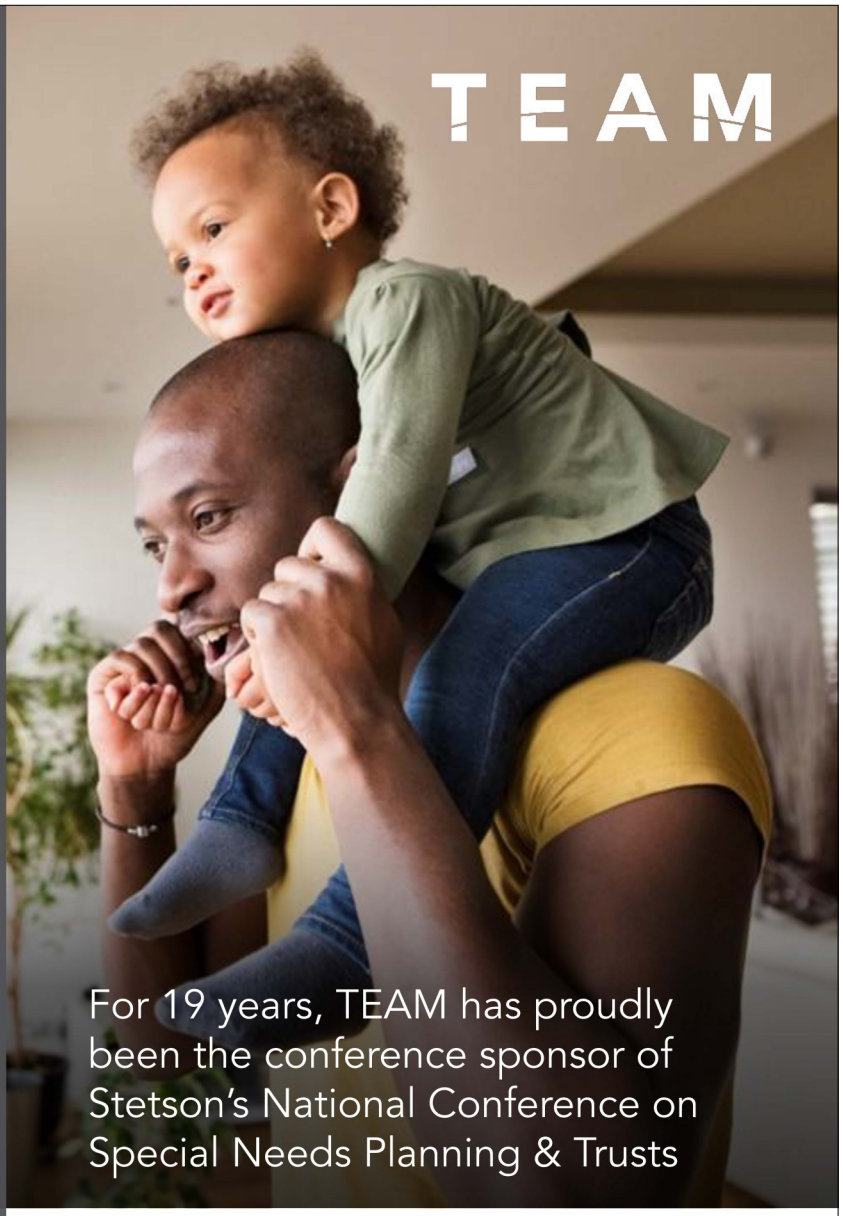

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LTSS Boot Camp

October 22, 2025

LTSS Update:
What's New, What's Next

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Long-Term Services & Supports: What's New & What's Next

Stetson SNT Conference - October 2025

Marielle F. Hazen, Esq., CELA

1

Introduction & Objectives

Long-Term Services and Supports (LTSS) are services assisting individuals with daily living over an extended period, supporting aging, chronic illness, or disability.

Presentation Objectives:

- Current Landscape and the Impact of the Reconciliation Bill
- Trends and Policy Outlook

2

The Clients We Serve

Aging and Disability Demographics

Examining the changing landscape of our client populations and how these demographics shape LTSS

3

Aging Demographics

By 2030, one in five Americans will be 65+ as our population continues to age dramatically:

14.2%
Growth Rate
Fastest growing demographic segment from 2025-2030

71.6M
Seniors by 2030
Up from 62.7M in 2025

20.7%
Population Share
Seniors will exceed youth population (20.2%)

For the first time in US history, seniors will outnumber children by 2030, creating unprecedented challenges.

Data from Claritas Pop-Facts 2024

4

Disability Demographics

Disability rates increase dramatically with age. Americans with disabilities face unique legal and financial challenges, including higher poverty rates (22% vs. 11% for those without disabilities) and increased healthcare needs, highlighting the importance of disability-focused elder law advocacy.

46%
Ages 75+
Nearly half of elderly Americans report having a disability, presenting significant elder care challenges

24%
Ages 65-74
One in four Americans in early retirement years face disability-related needs

12%
Ages 35-64
Working-age adults show lower but still significant disability rates

8%
Under 35
Youngest adult demographic has the lowest disability prevalence

Data source: Census Bureau's 2021 American Community Survey (ACS)

5

Long-Term Care Cost Trends - Nationwide

The 2024 Genworth Cost of Care Survey reveals significant increases in long-term care expenses, creating additional financial pressure on aging Americans and their families:

$111,325
Semi-Private Nursing Home
7% increase from 2023

$127,750
Private Nursing Home
9% increase from 2023

$70,800
Assisted Living
10% increase from 2023

$297,840
24/7 Home Care
3% increase from 2023

Assisted living occupancy rates jumped from 77% to 84%, potentially driving costs higher as demand outpaces available facilities. These rising costs highlight the critical importance of proactive long-term care planning for aging clients.

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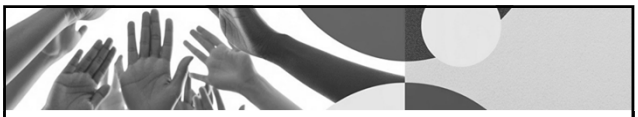


What are Long-Term Services and Support?

7

Understanding Long-Term Service & Supports (LTSS)

LTSS encompasses a wide range of medical and non-medical services for people with disabilities or chronic conditions who need assistance with daily activities over an extended period. These services help maintain dignity, independence, and quality of life.

Home & Community-Based Services
Support services delivered in private homes or community settings, allowing individuals to maintain independence while receiving necessary care.

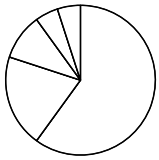
Institutional Care
Comprehensive services provided in nursing homes, assisted living facilities, and other residential settings for those needing 24-hour supervision.

Caregiver Support
Resources and assistance for family members providing unpaid care, including respite services, training, and counseling.

Financing Options
Funding mechanisms including Medicaid, Medicare, private insurance, and personal savings that help cover the rising costs of long-term care.

8

LTSS Funding Sources Nationwide



Long-term services and supports are extremely expensive and not generally covered by Medicare or health insurance. The primary funding for Long-Term Services and Supports (LTSS) in the United States is through public programs like Medicaid, which covers the largest portion. However, a significant burden falls on individuals and families through out-of-pocket payments, highlighting the need for comprehensive financial planning for long-term care. Medicare provides limited coverage, primarily for skilled nursing and rehabilitation, while private long-term care insurance accounts for a smaller percentage of overall funding.

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Medicaid LTSS Eligibility Criteria

Medical Criteria

- **Need for assistance with Activities of Daily Living (ADLs) such as bathing, dressing, eating, toileting, transferring, continence**
- **Cognitive impairment requiring supervision**
- **Nursing home level of care determination**
- **Physician certification of medical necessity**

Financial Criteria

- **Income limits (typically around 300% of SSI federal benefit rate)**
- **Asset limits (usually $2,000 for individuals, varies by state)**
- **Spousal impoverishment protections for married couples**
- **Look-back period for asset transfers (5 years)**
- **Home equity limits**

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Medicaid Key Numbers

- ☐ **SSI and Spousal Impoverishment Standards**
  Updated standards released for 2025 affecting long-term care eligibility and community spouse resource allowances. **Official guidance document available.**
- ☐ **Medicare Premium Updates**
  2025 Medicare Part B premiums and deductibles have been revised. Access the complete **CMS fact sheet** for details on adjustments affecting elder clients.

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State-by-State LTSS Comparison Resources

Medicaid Eligibility Income Chart by State (2025)
Interactive resource with monthly income limits for institutional, HCBS waiver, and regular Aged, Blind, Disabled Medicaid by state, including single and married limits.

KFF Medicaid State Fact Sheets
Kaiser Family Foundation's state fact sheets comparing Medicaid eligibility, enrollment, and coverage details including LTSS for all 50 states.

AARP LTSS State Scorecard
Provides data and narrative comparisons of state LTSS system performance including affordability, access, choice, quality, and family caregiver support with state rankings.

Medicaid.gov State Overviews
Official CMS resource with interactive profiles for each state's Medicaid and CHIP programs including eligibility pathways and program options.

NY NAELA's 50 State Medicaid Chart
Provides essential practice resources for elder law attorneys with comprehensive state-by-state Medicaid comparisons. **Available through NAELA**.

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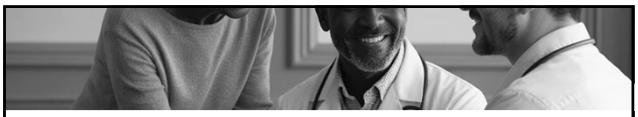

LTSS Models and Delivery Systems

13

Core LTSS Models

Long-Term Services and Supports (LTSS) are delivered through different models, evolving to meet diverse needs while focusing on consumer preference and cost-effectiveness. The sector is undergoing a significant rebalancing trend. **Among the 6 million people who use Medicaid LTSS in the U.S., most are using HCBS (75%) and over half are under 65 (57%). Nationally more than 700,000 people are on waiting lists for HCBS, most of whom have intellectual or developmental disabilities.**

Institutional Settings

Traditional models providing comprehensive care in residential facilities.

- Nursing Homes
- Rehabilitation Centers

Rebalancing Trend

A strategic shift from institution-based care towards Home and Community-Based Services (HCBS), driven by:

- **Cost-efficiency:** Often more affordable than institutional care.
- **Consumer Preference:** Individuals prefer to receive care in their own homes and communities.
- **Policy Evolution:** Government initiatives and funding increasingly favor HCBS.

Home & Community-Based Services (HCBS)

Support services that allow individuals to live independently in their homes or communities.

- In-Home Aides
- Adult Day Care
- Remote Monitoring
- Family Support Programs

This transition emphasizes providing care in the least restrictive environment, aligning with individual autonomy and quality of life.

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Comparison of Institutional v. HCBS

	Institutional LTSS	Home & Community-Based Services (HCBS)
Setting	Licensed residential facilities (e.g., nursing homes, hospitals)	Individual's home, community centers, adult day care facilities
Service Delivery	24/7 medical and personal care in a structured environment	Flexible, personalized care; intermittent or ongoing support
Caregiver Types	Professional staff (nurses, therapists, certified nursing assistants)	Formal (paid aides, therapists) and informal (family, friends) caregivers
Medicaid Spending Share	Historically dominant, but declining	Rapidly increasing, exceeding institutional spending in many states
Cost	Generally higher due to facility overhead and intensive staffing	Generally lower, often more cost-effective for comparable services
Quality/Outcomes	Regulated environment, can sometimes lead to loss of independence; better for acute medical needs	Focus on autonomy, community integration, and higher patient satisfaction; varies by program
Patient Preference	Often considered a last resort; less preferred by most individuals	Strongly preferred by the majority of older adults and individuals with disabilities

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Managed Care Models for LTSS: Introduction

Definition: Managed Long-Term Services and Supports (MLTSS)

MLTSS deliver LTSS through capitated Medicaid managed care contracts instead of traditional fee-for-service models, aiming to improve coordination and cost-efficiency.

Growth & Adoption

24 states now operate MLTSS programs, with the majority integrating these services into broader Medicaid managed care plans, signifying a shift in long-term care delivery.

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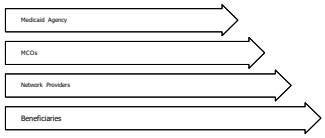
Features of Managed LTSS Models

Key Characteristics

- Capitated payments to managed care organizations (MCOs)
- Service coordination (acute, behavioral, and long-term care)
- Provider network management, quality oversight, outcome reporting
- Operate under federal authorities: Section 1115, 1915(b), 1915(c)



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Why States Use Managed LTSS

Predictable Budgeting

Allows for more stable and forecasted spending within Medicaid programs.

Service Rebalancing

Enables a shift of services from institutional settings to more preferred home and community-based care.

Improved Care & Efficiency

Fosters better care management, coordination, accountability, and overall operational efficiency.

Innovation & Integration

Provides a foundation for new models and integration with Medicare for dually eligible individuals.

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Challenges with Managed LTSS

Access Barriers
Many individuals face difficulties accessing necessary services due to complex eligibility criteria, lack of information, or geographic limitations, particularly in underserved areas.

Provider Network Limitations
Managed LTSS often struggles with an insufficient number of specialized providers and a lack of culturally competent care, leading to gaps in service delivery.

Care Coordination Problems
Fragmentation of services and poor communication among different providers can result in disjointed care, making it challenging to integrate medical and non-medical supports effectively.

Administrative Burden
Both members and providers encounter extensive paperwork, complex authorization processes, and significant delays in service approval, increasing frustration and inefficiency.

Quality Concerns
Ensuring consistent quality and measuring outcomes remain significant challenges, with variability in service standards and difficulties in guaranteeing truly person-centered care.

Member Advocacy Challenges
Members often struggle to navigate the complex system and advocate for their own needs, with limited support available for resolving disputes or ensuring their voice is heard.

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Trends & Future Directions for Managed LTSS

The landscape of Managed Long-Term Services and Supports (LTSS) is continuously evolving, driven by the need for more efficient, integrated, and person-centered care. Several key trends are shaping its future:

Growth of Comprehensive Plans
Managed care plans are increasingly covering the full spectrum of LTSS, moving towards a more holistic approach to member care.

Enhanced Management & Monitoring
There's an expanded focus on robust care management and rigorous outcome monitoring to ensure quality and effectiveness of services.

Evolving Integration & Quality
Statutory and quality measures are continuously evolving, with a trajectory towards further integration of services and improved accountability.

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LTSS Trends and Policy Implications

21

LTSS Rebalancing

Rebalancing Effort

There's a significant national effort to shift LTSS away from institutional care towards HCBS, driven by:

- **Cost-effectiveness:** HCBS often provides care at a lower cost.
- **Consumer Preference:** Most individuals prefer to age in place or receive care in community settings.
- **Policy Evolution:** Federal and state policies increasingly incentivize and fund HCBS.

Impact on the System

This rebalancing aims to create a more person-centered, efficient, and sustainable LTSS system, but it requires:

- Robust workforce development for HCBS.
- Adequate funding and infrastructure for community-based programs.
- Integrated care coordination across settings.

Both institutional and HCBS models deliver similar clinical services but fundamentally differ in their cost structures, promotion of individual autonomy, and inherent risk profiles.

22

Workforce and Provider Challenges

Increasing Demand

LTSS workforce demand is projected to grow significantly, an estimated 39% from 2022 to 2037, necessitating a substantial increase in skilled professionals.

Critical Shortages

Persistent shortages in direct care workers, coupled with high turnover rates and low wages, severely challenge the quality of care delivery and patient access to essential services.

Legal and Fiduciary Risks

Workforce supply issues carry significant legal ramifications, potentially impacting institutions' fiduciary and planning obligations, and increasing liability for LTSS providers.

23

Disparities in LTSS Access

Equitable access to Long-Term Services and Supports (LTSS) is crucial, yet significant disparities persist across various demographics. These disparities, driven by factors such as income, race, and geographic location, exacerbate challenges for vulnerable populations and hinder their ability to receive necessary care.

Income Disparities

Low-income individuals often face substantial barriers to accessing LTSS, including affordability issues, limited insurance coverage, and fewer choices in care providers. This often leads to reliance on less formal, potentially inadequate, support systems.

For instance, 45% of low-income older adults report unmet LTSS needs, compared to 15% of high-income older adults.

Racial & Ethnic Disparities

Racial and ethnic minority groups frequently encounter systemic barriers, such as cultural insensitivity, language barriers, and historical mistrust of healthcare systems. These factors contribute to lower utilization rates of formal LTSS and poorer health outcomes.

Data indicates Black and Hispanic older adults are 50% more likely to rely on informal care compared to white older adults due to access issues.

Geographic Disparities

Access to LTSS can vary significantly based on geographic location, particularly between urban and rural areas. Rural communities often suffer from a shortage of qualified providers, limited transportation options, and fewer diverse care settings, leaving residents with fewer choices.

Rural areas have 60% fewer LTSS providers per capita compared to urban centers, limiting options for residents.

Illustrative statistics based on common trends in LTSS access research.

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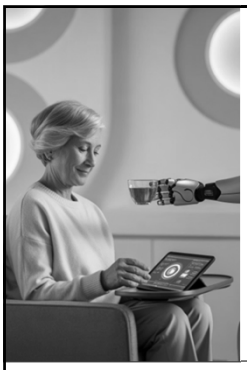

Technology & Innovation in LTSS

Growing Role of Technology
Wearables, telehealth, remote monitoring, digital twins, and home sensors are increasingly integrated into LTSS, transforming care delivery.

Workforce & Care Enhancement with Oversight
Technology can ease workforce shortages and enhance care, but requires robust legal oversight for contracts, privacy, and patient safety protocols.

Elevated Legal Risk & Complexity
Electronic health records (EHRs), interoperability, and cross-system data sharing elevate legal risk and planning complexity for providers and institutions.

25

New and Emerging Trends

Aging in Place Advancements
Integration of health, social services, and community-based support to enable individuals to remain in their homes as they age.

Person-Centered & Integrated Care
Models focused on complex needs, including intellectual and developmental disabilities (IDD) and behavioral health, ensuring holistic support.

Public-Private Partnerships & Housing
New collaborative models and innovative housing solutions are emerging to address long-term care needs effectively.

26

Financing and Sustainability Concerns

Funding Model Debates
Ongoing political debate surrounds funding models, entitlement scope, and solutions for the "middle market" in long-term care.

Advocacy for Sustainable Solutions
There is strong advocacy for expanded public coverage and incentives to encourage private savings for long-term care (LTC).

27

Budget Reconciliation - The OBBA

Key Medicaid & Medicare Provisions affecting long-term care planning, eligibility, and coverage

28

State Funding & Provider Tax Cap: Impacts

Reduced Federal Medicaid Payments

Federal policy changes have lowered the overall Medicaid funding sent to states, tightening LTSS budgets and increasing cost pressures.

Stricter Provider Tax Cap

States now face new limits on how much provider-based taxes can be used for Medicaid matching funds, requiring major updates to state funding models.

Consequences for LTSS

- Fewer provider contracts and service cutbacks
- Longer waitlists and reduced access for clients
- Greater financial strain on individuals and families

☐ **Action Point:** Legal advisors and planners should prepare for possible reductions in LTSS availability and anticipate higher out-of-pocket costs as state budgets adapt to new constraints.

29

Medicaid Expansion Changes

1

Effective January 1, 2026

Elimination of the temporary 5% Federal Medical Assistance Percentage (FMAP) increase for states that adopted Medicaid expansion under the American Rescue Plan

States will need to adjust budgets as this and other federal funding support ends or is reduced

2

Effective October 1, 2028

Introduction of **cost sharing up to $35 per service** for expansion adults with incomes 100-138% of Federal Poverty Level (FPL). The FPL for 2025 is $15,650 for a single person.

- Exemptions for primary care services
- Exemptions for mental health services
- Exemptions for substance use disorder treatments
- Prescription drugs limited to nominal cost sharing amounts

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Medicaid Work Requirements - Timeline & Implications

Effective December 31, 2026

Federal deadline for states to implement mandatory Medicaid work requirements for ACA expansion adults (ages 19-64)

Implementation Timeline

States can implement requirements earlier at their discretion, potentially creating a patchwork of implementation dates across the country

Coverage Impact

Beneficiaries denied or disenrolled due to work requirements will also be ineligible for subsidized Marketplace coverage, creating significant coverage gaps

Individuals must work or participate in qualifying activities for **at least 80 hours monthly** to maintain Medicaid eligibility

Work Requirement Exemptions:

- Pregnant individuals
- People with disabilities
- Medically frail individuals
- Caretakers of dependents f13 years

Vulnerable populations at highest risk include low-wage workers with variable schedules, rural residents with limited employment opportunities, and those with undiagnosed or undocumented health conditions.

31

Home Equity Limits Reduced

New $1M Cap

Maximum home equity limit capped at **$1,000,000** regardless of inflation, eliminating automatic adjustments that previously protected seniors' primary residences.

Agricultural Exemption

Special provisions allow states to implement different requirements for homes located on farms.

Implementation: January 1, 2028

32

Prohibits Enforcement of Important Access Rules

Eligibility and Enrollment Final Rule

Two-part rule aimed at streamlining Medicaid processes and reducing barriers to enrollment for Medicaid and Medicare Savings Programs.

Implementation Stopped

Variable deadlines across provisions with many already in effect. This Bill prohibits the Secretary from implementing, administering or enforcing certain provisions until October 1, 2034.

Delayed enforcement creates uncertainty for beneficiaries and advocates

These rules were designed to improve transitions between Medicaid, CHIP, and Marketplace coverage while eliminating enrollment barriers, but enforcement restrictions significantly limit their effectiveness for vulnerable populations.

33

Enhanced Verification Requirements for Medicaid

1. **Bi-Annual Redeterminations**
   States must conduct eligibility redeterminations for Medicaid expansion adults **at least every 6 months** rather than annually, significantly increasing administrative burden and potential coverage disruptions.
   Effective: For renewals scheduled on or after December 31, 2026

2. **Enhanced Address Verification**
   States must implement robust systems to regularly update enrollee address information using "reliable data sources" to reduce returned mail and improper disenrollments.
   Managed care entities must promptly forward updated address information to the state.
   Effective: January 1, 2027

3. **National SSN Verification System**
   States must submit each enrollee's Social Security Number to a new federal verification system, creating additional administrative requirements.
   Effective: October 1, 2029

4. **Deceased Beneficiary Checks**
   States must review the death master file **at least quarterly** to identify and remove deceased beneficiaries from Medicaid rolls.
   Implementation timeline not specified

34

Not So Beautiful - Impact on Retroactive Coverage

This reduction in retroactive eligibility significantly narrows the financial safety net for those who delay applying for Medicaid while receiving medical care, potentially increasing uncompensated care and medical debt.

Traditional Enrollees
Retroactive coverage limited to **two months** prior to application date

Impacts vulnerable populations including children, pregnant women, elderly, and disabled individuals

Expansion Enrollees
Retroactive coverage limited to **only one month** prior to application date

Affects adults ages 19-64 with incomes up to 138% of federal poverty level

Implementation
Effective Date: January 1, 2027
Gives states approximately 3 years to update systems and procedures

35

Impact of the Bill on Nursing Home Care

Staffing Requirements Delayed
Prohibits HHS from implementing minimum staffing levels required by final rule until **October 1, 2034** 4 a decade-long pause affecting quality of care for nursing home residents. The rule required 3.5 nursing hours per patient per day.

State Requirements Still Apply

These changes could significantly impact quality of care and access to nursing home services for vulnerable seniors.

36

LTCCC's Nursing Home Staffing Reports

The **Long-Term Care Community Coalition's reports** provide information on nursing home staffing, five-star ratings, special focus facilities, ombudsman programs, and more

- **Comprehensive Staffing Data**
  Detailed nurse staffing levels including administrative positions and contract staff ratios - statewide and for individual nursing homes
- **Beyond Nursing Coverage**
  Important non-nursing positions tracked, including administrators and activities staff
- **Multi-Level Analysis**
  Summary data at state, CMS region, and national levels with turnover rates and weekend staffing metrics

37

IDD Providers Increasingly Acquired by Private Equity

Major Shift in Ownership

Intellectual Developmental Disability (IDD) service providers across the nation are increasingly being acquired by investment firms raising serious questions about implications for care quality.

Traditionally, providers of residential care, home health, personal assistance, and other services for people with intellectual and developmental disabilities were nonprofit or religious organizations.

Concerning Trends

Between 2013 and 2023 alone, there were more than 1,000 private equity acquisitions of disability and elder care providers.

Multiple private equity firms now employ tens of thousands of people serving those with disabilities, often operating under subsidiaries with various names that obscure their ownership.

Source: ***Private Equity Stakeholder Project***

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Private Equity Firms Buying Nursing Homes

5-13% **5%** **100%**

Ownership Range
The percentage of American nursing homes now owned by private equity firms ranges from 5% to 13%, with the upper range more likely due to complex ownership structures.

Confirmed Minimum
The Government Accountability Office reported that federal data shows at least 5% of nursing homes nationwide are owned by private equity firms.

Data Reliability
The GAO noted that federal ownership data is flawed, and the true number of private equity-owned facilities is likely higher than reported.

A new national study by the Private Equity Stakeholder Project found that private equity firms continue to purchase and then bankrupt nursing homes around the nation, raising serious concerns about quality of care and financial stability.

Related: **Deadline for Nursing Home Ownership Disclosure** delayed until August 1, 2025

Source: Private Equity Stakeholder Project

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Legal Considerations for Fiduciaries

Exploring the legal issues and responsibilities for individuals managing long-term care decisions.

40

Key Fiduciary Duties in LTSS Decision-Making

01

Loyalty

Act solely in the best interests of the beneficiary, placing their needs above those of the fiduciary or other parties, especially when selecting or changing LTSS providers and programs.

02

Care and Prudence

Exercise the diligence, skill, and reasonable care of a prudent professional when researching, recommending, and securing appropriate LTSS options (e.g., facility-based, home care, managed models).

03

Stay Informed

Remain up-to-date on federal and state LTSS eligibility rules, funding changes, local service availability, and emerging best practices to inform recommendations and avoid coverage/ineligibility issues.

04

Impartiality

Balance the divergent interests and needs of all trust beneficiaries4such as those desiring home-based versus institutional care4and make fair, unbiased decisions.

05

Documentation

Maintain detailed, transparent records of LTSS-related research, communications, decision rationales, and applications to show compliance and defend actions if challenged.

06

Avoid Conflicts of Interest

Exclude any arrangements or recommendations that could benefit the fiduciary personally or otherwise compromise the beneficiary's interests (e.g., steering to affiliated providers).

07

Facilitate Access

Ensure timely and effective support for applications, transitions between care levels, benefit enrollment, and appeals, so beneficiaries receive needed services without avoidable delay.

41

Financial Planning Tools for LTSS Qualification

Asset Protection Trusts

Establish irrevocable trusts to protect assets from being counted towards Medicaid eligibility, ensuring they are preserved for beneficiaries while still qualifying for long-term care services.

Spend-Down Strategies

Strategically reduce countable assets by paying for legitimate expenses, such as home modifications, medical bills, or purchasing exempt assets, to meet Medicaid's financial thresholds.

Medicaid-Compliant Annuities

Convert countable assets into an income stream through a specialized annuity that complies with Medicaid rules, allowing an applicant to qualify for benefits while providing for a spouse.

Caregiver Agreements

Formalize agreements to pay family members for caregiving services. This allows for fair compensation and can help spend down assets in a Medicaid-compliant manner.

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Medical Assistance Estate Recovery and LTSS

MERP requires states to seek repayment from the estates of deceased Medicaid beneficiaries for certain medical expenses paid by Medicaid on their behalf. This includes costs associated with nursing facility services, home and community-based services (HCBS), and related hospital and prescription drug services for individuals aged 55 or older, or for those of any age who received services in a nursing facility.

Assets Subject to Recovery

The assets subject to recovery primarily include those that pass through probate. However, states have the option to expand their definition of "estate" to include non-probate assets. Common assets subject to recovery include:

- **Probate Assets:** Real property (e.g., a home) and personal property (e.g., bank accounts, vehicles) held solely in the deceased beneficiary's name.
- **Non-Probate Assets (depending on state law):** In some states, MERP can extend to assets that avoid probate, such as joint tenancy property, assets in a living trust, life estates, or certain annuities. It is essential to understand your state's specific rules regarding estate definition.

Hardship Waivers

States must establish procedures for waiving estate recovery if it would cause an "undue hardship" for the heirs. The criteria for an undue hardship waiver vary by state.

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Thank You!

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October 22, 2025

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GOVERNMENT BENEFITS AND ITS ROLE IN PAYING FOR LONG-TERM CARE SUPPORTS AND SERVICES

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I. OVERVIEW

A. WHY IS THIS SO COMPLICATED?

In theory, access to government-funded long-term supports and services is simple – "get Medicaid." However, while obtaining Medicaid may seem simple, it is anything but. Why is it so complicated?

- **Medicaid is both a federal and state program**. Medicaid's "original" sin is that it is a federal and state system. While the federal government creates the general rules and provides over half of Medicaid's funding, each state administers its own Medicaid program and is allowed significant flexibility in its rules and administration. Unlike Medicare, which is easily discussed as a national program, Medicaid exhibits considerable variation from state to state, making it challenging to discuss at a national conference.

  > ***Assume that everything discussed about Medicaid at this conference comes with the caveat: Please check your state's rules and programs.***

- **States, through their state plans and waivers, are given broad flexibility in their Medicaid programs**. Depending on the federal authority, states use various combinations of state plan amendments and waivers to deliver home and community-based services.

A Medicaid State Plan is a formal agreement between a state and the federal government that outlines how the state administers its Medicaid program. For our purposes, state plan amendments under § 1915(i) Home and Community-Based Services and §1915(k) Community First Choice Option are the most common.

In our field, Medicaid waivers are frequently utilized to design programs that enable our clients to live outside institutional settings. The most common waivers for our clients are §1915(c) Home and Community-Based Services (HCBS) Waivers, §1915(b) Managed Care Waivers, and §1115 Demonstration Waivers.

States get federal approval for the financial eligibility requirements for their Medicaid programs through state plan amendments and waivers. It can be beneficial to read your state's waiver applications. Attached as Appendix 1 is Michigan's waiver application for its Habilitation and Supports Waiver 1915(c). Looking at this waiver application can be very helpful in understanding many of the concepts discussed below.

- **You cannot assume your state will follow the federal minimum guidelines**. While most states must not be more restrictive than the minimum SSI guidelines in their Medicaid financial eligibility requirements, it is frighteningly familiar for states to create their own rules and dare advocates to challenge them. Because initial legal challenges often occur through the state administrative system, the cost is rarely worth the fight, and states frequently get away with breaking the rules.

- **Everything is political**. You must look no further back than the fight over Medicare expansion as part of Obamacare to understand that politics enters every part of Medicaid. Politics is why states have so much flexibility in Medicaid programs, and politics is almost always a key driver of each state's decision on its eligibility requirements.

In fairness to each state, Medicaid expenditures are significant, averaging $20,644 per person with disabilities in 2021. But this can range from $49,015 in Minnesota to $10,838 in Tennessee.[1]

B. STATES "WERE" GIVEN GREAT FLEXIBILITY IN THEIR FINANCIAL ELIGIBILITY REQUIREMENTS.

On December 7, 2021, the Centers for Medicare and Medicaid Services issued a letter to State Medicaid Directors entitled "State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services" (included as Appendix 2). The letter emphasized that, due to the Sustaining Excellence in Medicaid Act of 2019, states have considerable flexibility in determining income and resource disregards for individuals eligible for, or seeking coverage under, certain Medicaid authorities, such as sections 1915(c), (i), (k), and 1115. This option allows states to raise income and resource standards for HCBS recipients through state plan amendments and waivers. The goal is to achieve greater flexibility, which should help states rebalance their Medicaid programs from institutional to community-based care.

It would seem that the new presidential administration might have a different interpretation. As of the time of this writing, there is no known rescission of this letter. In February 2025, Michigan increased its Medicaid asset limits (to match the Medicare Savings Program asset limits) with a state plan amendment approved under the new administration. But this will be something to watch.

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[1] CMS Medicaid and CHIP 2023 Scorecard located at: https://www.medicaid.gov/state-overviews/scorecard/measure/Medicaid-Per-Capita-Expenditures?measure=EX.5&measureView=state&stratification=463&dataView=pointInTime&chart=map&timePeriods=%5B%222021%22%5D.

State Medicaid Director Letter (SMD #21-004) created even greater differences in the financial eligibility requirements for HCBS services between states.

II. SSI MEDICAID

A. SSI ELIGIBILITY EQUALS MEDICAID ELIGIBILITY IN MOST STATES.

In most states, SSI eligibility equates to Medicaid eligibility. But even here, there is some variation.

- **Section 1634 States**. Section 1634 of the Social Security Act (42 USC §1383c(a)) allows states to enter into agreements with the Social Security Administration (SSA), which will then determine eligibility for medical assistance. In these "1634 States," if an individual is eligible for $1 of Supplemental Security Income (SSI), that individual is automatically qualified for Medicaid in that state. If a client resides in a 1634 state, you should verify if the individual is eligible for SSI and, if so, apply for SSI with the Social Security Administration. Once the individual has SSI, there will be no need for a separate Medicaid application.

  Thirty-four states are currently 1634 States: Alabama, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, New Mexico, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

- **SSI Criteria States**. In SSI Criteria States, SSI eligibility should equate to Medicaid eligibility, but each state manages its own Medicaid eligibility processes. So, while a client who is SSI eligible should get Medicaid, you may be required to file a separate Medicaid application in SSI Criteria States.

***Eight states are currently SSI Criteria States: Alaska, Idaho, Kansas, Nebraska, Nevada, Oklahoma, Oregon, and Utah*.**
POMS SI 07115.010(A)(1).

Section 209(b) States. Section 209(b) (42 U.S.C. §1396a(f)) allows states to use more restrictive eligibility criteria for Medicaid than those used for the Supplemental Security Income (SSI) program. In 209(b) States, SSI eligibility does not equate to automatic Medicaid eligibility. While Medicaid financial eligibility standards may be more restrictive in 209(b) states, clients must still have some way to "spenddown" income on medical expenses to become eligible for Medicaid. This is referred to as a Medicaid spenddown or, in some states, having a Medicaid deductible. Thus, if you are in a Section 209(b) State, you must also know your state's specific Medicaid financial eligibility requirements.

***Eight states are currently 209(b) States: Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, and Virginia*.**
POMS SI 0715.010(A)(1).

B. GETTING SUPPLEMENTAL SECURITY ELIGIBILITY.

Again, one dollar ($1.00) of Supplemental Security Income automatically qualifies that individual for Medicaid in most states.

i. Medical Eligibility.

Social Security uses a five-step process for disability criteria, summarized here from attorney Avram Sacks' materials for Stetson SSA Mechanics Boot Camp held in 2023:[2]

[2] *See* Avram Sacks, The Nuts and Bolts of SSI and SSDI, Stetson Law 2023 SSA Mechanics Boot Camp.

1. Substantial Gainful Activity (SGA):

- The claimant must not be engaged in substantial gainful activity. In 2025, the substantial gainful activity threshold is $1,620/month, which increases to $2,700/month for blind individuals.

- If earnings exceed the monthly threshold, the claim is denied, unless there are special circumstances (e.g., impairment-related work expenses, special accommodations).

2. Severity of Impairment:

- The claimant must have a severe impairment that significantly limits their ability to perform basic work tasks (e.g., walking, sitting, lifting, etc.).

- Minor health issues do not qualify. The combined impact of all impairments is taken into consideration.

3. Listed Impairment:

- The claimant may qualify if their impairment matches or equals a listed impairment in Social Security regulations at https://www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm.

- If an impairment does not meet the exact listing criteria, it can still be considered equivalent if its medical significance is similar.

4. Past Relevant Work (PRW):

- If the claim is not established by this stage, the claimant must prove they cannot perform any past relevant work done in the last 15 years.

- This includes both full-time and part-time work that meets the SGA level.

5. Vocational Adjustment to Other Work:

- If the claimant cannot perform past relevant work, the determination shifts to whether they can adjust to other work given their age, education, and residual functional capacity (RFC).

- At step 5, the burden of proof shifts to the Social Security Administration to demonstrate that the claimant can perform other jobs.

ii. <u>Income Eligibility</u>.

The SSA assesses all income types, but treats earned and unearned income differently:

- **Earned Income**. For earned income, meaning income earned while working, Social Security excludes the first $20 a month, plus disregards an additional $65 of the earned income. Then, Social Security counts only half of the remaining earned income.

Example: John earns $1,000 per month in *earned* income. He would still get $509.50 in SSI, calculated as follows:

1. **Earned income:** $1,000
2. **Apply the $20 general income exclusion** (which applies to both earned and unearned income):
    - $1,000 - $20 = $980
3. **Apply the $65 *earned* income exclusion**:
    - $980 - $65 = $915
4. **Divide the remaining income by 2** (since only half of the earned income counts):
    - $915 ÷ 2 = $457.50
5. **Subtract the countable income from the federal benefit rate**:
    - In 2025, the SSI federal benefit rate for an individual is $967.
    - $967 - $457.50 = $509.50. John's SSI payment would be $509, as SSI payments are rounded down to the nearest dollar.

- **Unearned Income**. Unearned income includes gifts, annuities and pensions, inheritances, dividends from investments, rental income, child or spousal support, and so forth. Unearned income reduces SSI benefits dollar-for-dollar. Social Security's table of contents on unearned income can be found at POMS SI 00830.000 Unearned Income.

Example: John earns $1,000 per month in *unearned* income. He would be ineligible for Supplemental Security Income, calculated as follows:

1. **Unearned income:** $1,000
2. **Apply the $20 general income exclusion**:
    - $1,000 - $20 = $980
3. **Subtract the countable income from the federal benefit rate**:
    - In 2025, the SSI federal benefit rate for an individual is $967.
    - $967 - $980 = $0 in SSI (since the countable unearned income exceeds the federal benefit rate).

Importantly, Social Security Retirement and Disability benefits are considered unearned income. It is relatively common for our clients to receive some non-SSI Social Security and SSI benefits, as long as their non-SSI Social Security

income is under $987 ($967 federal benefit rate plus $20 income disregard). This can be a terrific situation for a client because it not only entitles the client to automatic Medicaid eligibility in most states but also makes the client eligible for Medicare.

Cash distributions from a special needs trust will also be considered unearned income for SSI purposes, which is a common mistake in trust administration.

iii. <u>Asset Eligibility</u>.

To qualify for SSI, individuals must have a countable income of less than $2,000 for an individual and $3,000 for a couple. Countable resources include cash, bank accounts, stocks, bonds, and real estate. It does not include specific resources such as the individual's primary residence, one vehicle, personal belongings, certain funeral expenses, ABLE Accounts, and certain special needs trusts. A complete list of exempt resources is discussed in Section V, Strategies for Asset Eligibility below.

III. <u>NON-SSI MEDICAID</u>

A. COMMON MEDICAID INCOME ELIGIBILITY TERMS.

To make income rules even more confusing, many income levels are set at either a percentage of the Federal Poverty Level (FPL) or the Federal Benefit Rate (FBR).

- **<u>Federal Poverty Level</u>**. The Federal Poverty Level (FPL) is calculated annually by the Department of Health and Human Services, using data provided by the U.S. Census Bureau. Income limits for numerous Medicaid programs are determined as a percentage of the FPL. The FPL is uniform throughout the 48 contiguous states, but differs in Alaska and Hawaii. **For the 48 continuous states, the federal poverty level is $1,305/month in 2025 for an individual.**

- **Federal Benefit Rate**. The Federal Benefit Rate (FBR) is the maximum monthly Supplemental Security Income benefit. Each year, increases to the FBR are tied to the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), the same index used for all Social Security benefits. Historically, the FBR typically runs at about 75% of the Federal Poverty Level (discussed above), but the FBR is not technically keyed to the FPL. **In 2025, the FBR is $967/month for individuals and $1,450/month for couples.**

- **Medically Needy Income Level (a.k.a., Protected Income Level)**. For medically needy programs, the Medically Needy Income Level "is the amount remaining after spend-down that permits an individual to qualify for Medicaid."[3] In Michigan, this is called the protected income level and can vary by geography depending on where you live in the state (and has not been changed in over 40 years). For illustrative purposes, if the Medically Needy Income Limit is $500 and an individual's income is $1,500, the individual must spend down $1,000 in medical expenses in a given month before being eligible for Medicaid.

B. NON-SSI MEDICAID CATEGORIES

If a client is not eligible for SSI, they may still qualify for Medicaid under different financial eligibility criteria. However, it would be impossible to discuss all the Medicaid categories and each state's eligibility criteria for each category in an hour-long presentation.[4] Understanding

[3] Instructions, Technical Guide and Review Criteria for a §1915(c) Home and Community-Based Waiver, Center for Medicare and Medicaid Services, page 319 (January 2019).

[4] Kaiser Family Foundation has several useful resources for state-by-state comparisons.

some general financial eligibility criteria that states generally use when applying for Medicaid waivers can be very helpful in understanding your own state's Medicaid eligibility criteria.

For example, I have included in Appendix 4 a sample from my law firm and select passages from Michigan's operations manual to demonstrate how complicated navigating all the Medicaid programs is in just one sample state.

- **Other "Categorically Needy" Financial Criteria**. A client with a disability is "categorically needy" if the client meets income and asset limits set by the state. A categorically eligible beneficiary is automatically eligible for Medicaid without a spenddown. As discussed above, an SSI recipient is "categorically needy" in most states. However, states can use financial criteria more generous than SSI for categorical eligibility. Eligibility will vary by state. In these states, the more "generous" income eligibility level is commonly set at 100% of the federal poverty level (currently $1,305/month), which is $338/month higher than SSI.

According to the Kaiser Family Foundation, in 2025, 28 states allowed Medicaid eligibility for seniors and people with disabilities at some amount above the federal SSI rate: Alaska, Arizona, Arkansas, California, Connecticut, the District of Columbia, Florida, Hawaii, Idaho, Illinois, Indiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont, Virginia, and Wisconsin..[5]

- **Medically Needy**. States can create an optional "medically needy" Medicaid category where an individual's income is otherwise too high for categorically needy coverage. Instead, "these individuals qualify for coverage by spending down (i.e., reducing their income by incurring medical expenses). States that elect to cover the medically needy

[5] Kaiser Family Foundation, Medicaid Eligibility Levels for Older Adults and People with Disabilities (Non-MAGI) in 2025 (April 7, 2025).

populations do not have to offer the same benefit package to them as they offer to the categorically needy."[6] An individual qualifies for Medicaid in a medically needy category after "spending down" their income on certain medical expenses below the medically needy income level in a given state.

Medically Needy Eligibility occurs when Income – Medical Expenses < Medically Needy Income Level.

According to the Kaiser Family Foundation, in 2025, 34 states have medically needy programs for individuals with disabilities. These states include Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.[7]

- **Special Income Group ("300% of SSI Group")**. This category is for individuals who need home- and community-based services and would otherwise require institutional care but have too much income to qualify as categorically eligible for Medicaid. There is no spenddown for this group. States can have lower income rates, but almost every state with the program has capped income at 300% of SSI (i.e., the federal benefit rate). In 2025, this is $2,901/month.

The Special Income Rule is most commonly applied to home- and community-based programs targeted at keeping older adults who would otherwise be in a nursing home at home. However, as advocates, it is sometimes essential to remind agencies that individuals with disabilities may qualify for Medicaid services under numerous categories. This can sometimes be problematic, however, as the agencies charged with providing services to older adults are

[6] Instructions, Technical Guide and Review Criteria for a §1915(c) Home and Community-Based Waiver, Center for Medicare and Medicaid Services, page 319 (January 2019).

[7] Kaiser Family Foundation, Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings From A 50-State Survey (June 14, 2019).

often different than the agencies charged with providing services to individuals with disabilities. Coordinating between those different agencies can be a nightmare. To address this, Michigan just released a letter explaining how that coordination should work, which is included as Appendix 3.

- **Adult Disabled Child (formerly DAC) Medicaid Disregard**. Under 42 USC §1383c(c), states must disregard any increase in Social Security benefits in determining Medicaid eligibility when a child transfers from being an SSI recipient to receiving adult disabled child benefits on a parent's Social Security record.

Depending on the state, this can be highly problematic if a child was never able to receive SSI because a parent died, became disabled, retired, or never had a child apply for SSI. In certain states, this can cause a child to be ineligible for SSI-related Medicaid because the increase in income due to the Social Security increase is not disregarded. This is highly unfair, and the Special Needs Alliance is attempting to make a legislative change. Other common issues can occur when a child works above the substantial gainful activity level, and when a child receiving the ADC benefit gets married.

- **Medicaid Buy-In Programs**. If a beneficiary has earned income (i.e., income from working), they may be eligible for a Medicaid Buy-In program. These programs typically have higher Medicaid asset and income limits to encourage individuals with disabilities to participate in the workforce. They may require participants to pay premiums or cost-sharing based on their income. These return-to-work programs can vary significantly from state to state (if available at all).

The Kaiser Family Foundation keeps a list of income and asset limits for Medicaid Buy-In programs at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-4. **Only three states (plus the District of Columbia) do not have some buy-in program for individuals with disabilities: Alabama, Oklahoma, and Tennessee.[8]**

[8] *Id.*

IV. STRATEGIES FOR OBTAINING INCOME ELIGIBILITY

Clients with incomes exceeding the income eligibility limits are typically more challenging than those with assets exceeding the limits, which is discussed in the next section (Section V below). However, there can still be successful strategies.

- **Can you irrevocably assign income to a special needs trust?**

  In any case involving excess income, your first question should be if the income can be irrevocably assigned to a special needs trust – almost always a first-party (d)(4)(A) trust. According to Social Security POMS SI 01120.200(G)(1)(d):

  > **Assignment of income**
  >
  > A legally assignable payment that is assigned to a trust or trustee is income for SSI purposes, to the individual entitled or eligible to receive the payment, unless an SSI income exclusion applies or the assignment is irrevocable. We consider assignment of payment by court orders to be irrevocable. For example, child support or alimony payments paid directly to a trust or trustee because of a court order are considered irrevocably assigned and thus not income. Also, U.S. Military Survivor Benefit Plan (SBP) payments assigned to a special needs trust are not income because the assignment of an SPB annuity is irrevocable. For more information on SPB annuities, see SI 01120.201J.1.e.

  An irrevocable assignment of income to a first-party special needs trust must be made before age 65. POMS SI 01120.203(B)(3). Whether you can assign income to a pooled trust at age 65 or older is a state-specific question. Assigning income to an ABLE Account generally will not work because the individual owns the ABLE Account. As such, for income purposes, it is usually treated the same as if the income hit the individual's bank account.

  Common examples of income regularly irrevocably assigned to special needs trusts:

  - **Child or spousal support** is *court-ordered* to be paid to the SNT.
  - **Survivor Benefit Plans** through the military (made possible by the 2015 Howard P. "Buck" McKeon National Defense Authorization Act, thanks to many attendees of this conference).
  - **Annuities**, particularly structured settlement annuities, that are irrevocably assigned by court order.

Pension assignment is a state-by-state, pension-by-pension question. The Special Needs Alliance is collaborating with various states to advocate for legislation that would enable government pensions to be assigned to a special needs trust. If you would like to work on this issue in your state, please email me.

The Social Security POMS are also very explicit as to what *cannot be assigned*. The following cannot be assigned:

- Temporary Assistance to Needy Families (TANF)/Aid to Families with Dependent Children (AFDC);
- Railroad Retirement Board-administered pensions;
- Veterans' pensions and assistance;
- Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management;
- Social Security Title II and SSI payments; and
- Private pensions under the Employee Retirement Income Security Act (ERISA) 29 U.S.C.A. § 1056(d).

It will almost always be better to assign income to a special needs trust rather than using a Miller Trust if you can. You can use the trust money in more ways to improve the client's quality of life.

Is a Miller Trust an option in your state and the Medicaid program you need?

A Miller Trust (also known as a Qualified Income Trust or Income Assignment Trust) is a type of trust used in certain income cap states when an individual's income exceeds the income cap. This is the (d)(4)(B) trust if you were ever wondering why special needs trusts jump from (d)(4)(A) to (d)(4)(C)!

With a Miller Trust, if an individual's income exceeds the income cap, the additional funds can be deposited into the Miller Trust. The Miller Trust can then generally only be used to pay medical expenses not covered by Medicaid. Upon the individual's death, it must be paid over to the state's Medicaid agency.

Before you embark on using a Miller Trust, you must understand your state's rules regarding Miller Trusts! Only about half the states allow the use of Miller Trusts.

According to the Kaiser Family Foundation, in 2018, 22 state allow the use of Miller Trusts for individuals with disabilities who need Home and Community-Based Services (HCBS) under Medicaid: Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Mississippi, Missouri, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, and Texas.

- **Can the client work enough to get into your state's buy-in program with higher income/asset limits?**

  As mentioned above, the Kaiser Family Foundation indicates that forty-seven states have a Medicaid buy-in program for individuals with disabilities, which usually comes with higher income/assets limits. If your client can work – sometimes just a few hours – you may be able to get Medicaid eligibility even with higher incomes.

In Michigan, the buy-in program has been instrumental in circumventing the otherwise draconian and burdensome spenddowns associated with medically needy eligibility.

If you think a client's work experience could be a pathway to eligibility, but there is no obvious employment, consider working with a disability organization (e.g., a local Arc) to see if they would be willing to hire for the minimum work required.

- **Advocate or move to another state?**

As discussed above, CMS is giving states extreme flexibility to adjust their income limits for home and community-based services. It is an ideal time to advocate for higher limits in your state.

And yes, a client could always establish residency in another state with higher income limits.

V. STRATEGIES FOR OBTAINING ASSET ELIGIBILITY

Depending on your state, the following checklist outlines options to consider if a client has assets exceeding the Medicaid eligibility limits.

- **Are these services available in a non-asset-tested Medicaid program?**

While this may have limited value in seeking long-term care and support services, it is worth noting that, due to Medicaid expansion and the Affordable Care Act, many state Medicaid programs now use a modified adjusted gross income (MAGI) test, without considering assets. These MAGI-only programs can encompass Medicaid expansion, children's Medicaid, coverage for pregnant women, parents and caretaker relatives, and the CHIP program. As always, the availability of these programs will vary from state to state. Caution: If work requirements in the Big Beautiful Bill are implemented, this option will likely become less attractive.

> ***An individual will generally not be eligible for MAGI-based Medicaid programs if they have Medicare.***

- **For inheritances, evaluate whether there is a way to convert first-party money to third-party money. See if you can decant the trust if there is problematic language.**

If a beneficiary received an inheritance and there are significant assets to justify doing so, scour any will or trust for boilerplate language that might allow the inheritance to be considered third-party funds. If boilerplate language in the will or trust gives the trustee or executor authority to apply a discretionary standard to a beneficiary with a disability, utilize that language.

If the language of the trust contains problematic language or the use of the boilerplate clause might cause issues, it is helpful to know your state's decanting statute (if any). Often, you can decant the trust into a trust that will be acceptable to your state Medicaid agency.

Decanting is a valuable tool if you have a discretionary trust drafted in a state other than your own, which contains problematic language for your state.

Finally, remember that probate courts are generally courts of equity. As courts of equity, probate courts can sometimes use their equitable powers to fix a missed beneficiary designation or correct problematic trust provisions. This is particularly true if the settlors' intent is known and nobody objects to the requested change.

You must do a cost-benefit evaluation before you go to court. First, familiarize yourself with your probate court and state agency to determine if this is a possible form of relief. Second, particularly if the client is under the age of 65 and the sum is modest, the cost-benefit analysis could weigh in favor of establishing a first-party trust and avoiding the expense of court.

- **Can you convert countable resources to exempt resources?**

Particularly for small sums, you should determine if you can easily convert countable resources to exempt resources.

Below is a list of some of the major categories of exempt assets for SSI purposes. **Despite this list, there are *huge* variations from state to state**. You must be familiar with your state's rules and policy manual. Also, remember this does not need to apply to Section 209(b) States.

Start here:

- Paying down debt!

Exempt resources as found in c:

- Home serving as the principal place of residence, including associated land (SI 01130.100). Note: There is an equity limit for long-term care Medicaid and home and community-based waivers, but not for SSI or other Medicaid categories. The equity limit varies by state.

- Jointly-owned real property that cannot be sold without undue hardship to other owners (SI 01130.130)
- Real property, while reasonable efforts to sell it are unsuccessful (SI 01130.140)
- Restricted, allotted Indian land (SI 01130.150)
- One vehicle used for transportation (SI 01130.200)
- Burial space or plot for eligible individuals and their family (SI 01130.400)
- Household goods and personal effects (SI 01130.430)
- Stock held by native Alaskans in Alaska regional or village corporations (SI 01120.105)
- Dedicated accounts for benefits (SI 01130.601)
- Radiation Exposure Compensation Trust Fund payments (SI 01130.680)
- German reparations payments to Holocaust survivors (SI 00830.710, SI 01130.610)
- Austrian social insurance payments (SI 00830.715, SI 01130.615)
- Japanese-American and Aleutian restitution payments (SI 00830.720)
- Federal disaster assistance (SI 00830.620, SI 01130.620)
- Agent Orange settlement payments (SI 00830.730, SI 01130.660)
- Ricky Ray Hemophilia Relief Fund payments (SI 01130.695)
- Payments to Veterans' Children with Certain Birth Defects (SI 01130.681)
- State annuities for certain veterans (SI 01130.662)
- Funds in an ABLE account (SI 01130.740). As noted below, there is a $100,000 cap for SSI purposes, but no cap for Medicaid eligibility.

Exclusions with Limits on Value/Length of Time.

- Funds from the sale of a home, if reinvested in a replacement home within three full calendar months. (SI 01130.110)
- Life insurance up to $1,500 face. If the face value exceeds $1,500, and then the cash value surrender value is considered pending on face value (SI 01130.300)
- Burial funds for an individual and/or their spouse (SI 01130.410)

- Certain prepaid burial contracts (SI 01130.420)
- Property essential to self-support (SI 01130.500–SI 01130.504)
- Resources of a blind or disabled person necessary to fulfill a Plan for Achieving Self-Support (PASS) (SI 00870.000, SI 01130.510)
- Retained retroactive SSI or RSDI benefits for 9 months (SI 01130.600)
- Restitution payments for misused Title II, VIII, or XVI benefits (SI 01130.602)
- Cash and in-kind replacement for lost, damaged, or stolen excluded resources (SI 00815.200, SI 01130.630)
- Victims' compensation payments (SI 00830.660, SI 01130.665)
- State or local relocation assistance payments (SI 00830.655, SI 01130.670)
- Tax refunds related to Earned Income Tax Credits (SI 00830.060, SI 01130.676)
- Grants, Scholarships, Fellowships, and Gifts (SI 01130.455)

Again, despite the POMS's straightforward language on these exemptions, states put their spin on these exempt assets. While in most SSI states, you may face legal challenges if your state applies a stricter standard, it is a rare client who would want to take on that challenge, particularly if there are other avenues for Medicaid qualification.

Certain retirement assets may be exempt depending on your state and program. This topic is too complex for this presentation. Again, know your state.

First-Party Special Needs Trust under 42 USC § 1396p(d)(4)(A)?

A first-party special needs trust is a standalone trust established under 42 U.S.C. § 1396p(d)(4)(A). Assets in a first-party special needs trust are exempt from Medicaid purposes. To be exempt, a first-party special needs trust must:

- Be established for individuals with disabilities *under* the age of 65;
- A parent, grandparent, legal guardian, or a court must set it up; and

- Must contain a payback clause, whereby after the beneficiary's death, the remaining assets are used to reimburse any state that provided Medicaid benefits to the beneficiary before any were received.

> ***In many, if not most, states, Medicaid paybacks cover Medicaid expenditures back to the beneficiary's birth, not the date the Trust was established. Thus, for a critically ill individual (particularly one receiving Medicare), some consideration should be given to whether establishing a trust with a payback makes sense.***

Pros of a First-Party Special Needs Trust:

- A beneficiary, or the beneficiary's family, can choose the Trustee, which will often be more responsive to the beneficiary's needs and have lower ongoing administration costs.
- Trustees can also choose investment advisors and will have a broader range of investment options.
- More individualized drafting opportunities.
- Better able to manage non-cash assets.
- Allows for customized residuary distributions if residuary funds exceed a Medicaid payback.

Cons of a First-Party Special Needs Trust

- Legal fees for drafting the Trust can be expensive, and administration can be costly if using a professional trustee.
- First-party special needs trusts tend to get frequently scrutinized by government agencies, sometimes years (or decades) later.
- Trust administration can be too complicated for an unsophisticated (e.g., family member) Trustee.
- Investment diversification may be difficult with smaller trust sizes.

Pooled Trust under 42 USC 1396p(d)(4)(C)?

A pooled trust, as defined under 42 U.S.C. § 1396p(d)(4)(C), is the traditional alternative to a first-party special needs trust. Each beneficiary has a separate account in a pooled trust, though funds are pooled for investment purposes. A pooled trust must:

- Be managed by a nonprofit association.
- The account must be set up for the sole benefit of an individual with disabilities under Social Security's meaning.
- Remaining funds upon the beneficiary's death must either be retained by the nonprofit or go to pay back Medicaid for the beneficiary's Medicaid expenditures.

> ***States and even individual pooled trusts vary in their rules regarding retained funds. In some states, pooled trusts can retain all remaining funds after a beneficiary's death, while other states require at least some percentage of the funds to go to the state for a Medicaid payback. Pooled trusts also vary in their policies regarding whether a beneficiary can designate where funds are allocated if the Medicaid lien is less than the subaccount amount.***

> ***Under 42 USC § 1396p(d)(4)(C), there is no age limit for funding a pooled trust. Yet there is significant variation among states as to whether funding a pooled trust at age 65 or over will incur a divestment penalty. But when we are talking about Medicaid programs for individuals with disabilities, many of these programs do not have divestment penalties. Funding a pooled trust at age 65 and over may be a viable strategy, but it must be done with considerable care.***

Pros of a Pooled Trust

- Professionally managed by a nonprofit, which should be adept at advising on government benefits.
- Cost-effective to set up, particularly for smaller trusts.
- Economies of scale allow for greater investment diversification.

Cons of a Pooled Trust

- Limited control over distribution and investment decisions. A pooled trust's bureaucratic requirements can be frustratingly burdensome for some individuals.
- Pooled trusts vary significantly in quality.
- Ongoing administration fees can be surprisingly expensive.

ABLE Accounts?

An ABLE (Achieving a Better Life Experience) account is an exempt resource for Medicaid eligibility. An ABLE account allows the individual (if competent) to remain in control of the funds, and the funds in the ABLE Account will grow tax-free if used for qualifying disability expenses. The disability must have begun before age 26 (to be increased to 46 in 2026). ABLE accounts may have a Medicaid payback requirement upon the beneficiary's death, although current enforcement of Medicaid paybacks varies significantly by state. Contributions to an ABLE Account are limited to the annual gift tax exclusion, which is $19,000 in 2025.

A first-party special needs and pooled trust can contribute to an ABLE account. For competent trust beneficiaries who can manage their assets but require Medicaid, special needs trusts that regularly contribute to ABLE accounts can significantly lower trust administration costs and promote independence.

Remember, the disability must have simply begun before the age of 26 (46 in 2026), and you can use a doctor's certification to certify this if you do not have a Social Security Disability determination before these ages.

Pros of ABLE Accounts

- ABLE accounts offer the most independence for beneficiaries. A competent beneficiary can maintain control of their own money by managing their own ABLE account.
- ABLE Accounts are cheap, with annual fees usually $60 or under and investment fees usually around .3-.6%. This is far cheaper than pooled trusts.
- Practically, most any expenditure can qualify as a qualified disability expense. Additionally, distributions made from an ABLE account do not count as in-kind support and maintenance (ISM) for SSI.
- ABLE accounts grow tax-free if distributions are made for qualified disability expenses. This is comparable to a Roth IRA.
- Like pooled trusts, ABLE accounts allow for greater investment diversification for small sums of money.
- You can use an ABLE account in any state giving you a variety of programs to choose from (although significant consolidation of ABLE programs is occurring).

- Most ABLE programs use a TrueLink or similar type debit card, and the cost for the card is usually significantly cheaper than getting a card through a special needs trust.

Cons of ABLE Accounts

- ABLE accounts are only available to beneficiaries whose disabilities began before age 26 (46 is 2026).
- ABLE accounts are not a good option if a beneficiary is a spendthrift or vulnerable to exploitation.
- The $18,000 annual limit makes ABLE accounts a limited option for most resource planning.
- As ABLE account administrators face tight budgets, customer service with specific ABLE programs can be spotty, and many are increasingly challenging to work with, particularly for legal representatives.
- Consolidation of state ABLE programs is limiting the variety of ABLE programs to choose from.
- ABLE accounts can only handle cash.

An ABLE account is exempt from SSI purposes up to $100,000, but there is no asset limit for Medicaid purposes. In these instances, an individual is not supposed to lose SSI eligibility – SSI benefits are suspended. But be careful – this is likely a ripe area for agency error.

Is a Medicaid Buy-In Program an option?

As discussed in the income section above, Medicaid Buy-In Programs enable individuals to maintain Medicaid coverage while working. These programs typically have asset limits (and other asset rules) that are more generous than SSI's. Thus, if your client can work at least some, that could give them a greater asset cushion.[9]

[9] The Kaiser Family Foundation keeps a list of income and asset limits for Medicaid Buy-In programs at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-4.

Again, in many states, the amount of work does not have to be substantial. It can be as low as a few hours a month in Michigan.

- **Does it make sense to divest assets as a last resort option?**

While this would usually be the last option to consider, many Medicaid waiver programs for individuals with disabilities may not have a divestment penalty. It could be a risky last resort option.

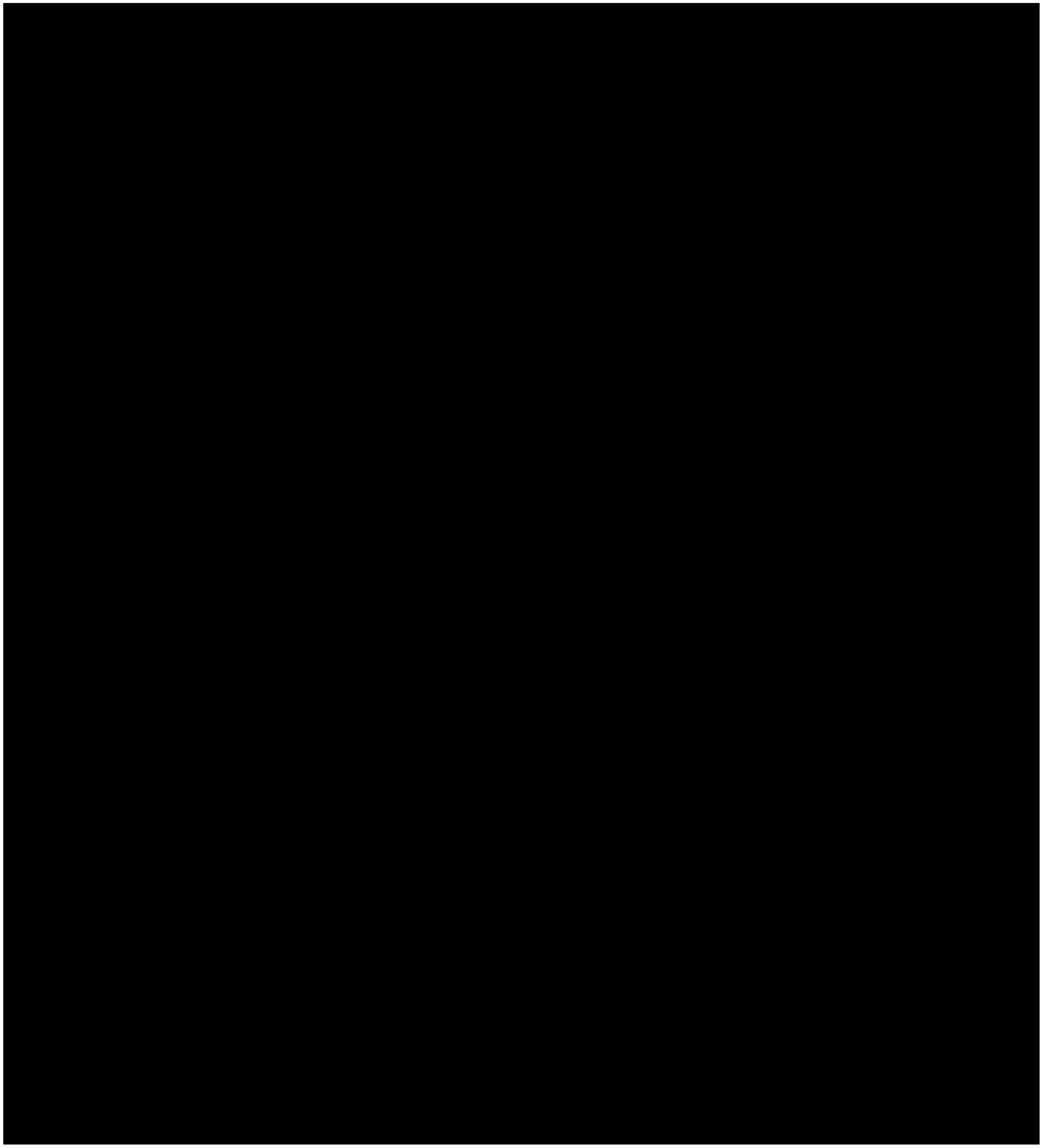
You must check your state's waiver and plan before advising. And, of course, SSI has a 3-year divestment penalty, Home and Community-Based Services 1915(c) Waivers have a 5-year divestment penalty, and HUD Housing generally has a 2-year divestment rule. Even if a current Medicaid program does not have a divestment penalty, a client may need Medicaid services in the future where a divestment would apply.

In addition to being a last resort option, it is clearly an option you never want to take with someone who has little or questionable capacity without obtaining court approval.

- **Move to California?**

This is mostly facetious, but a central point of this presentation is the broad flexibility that states now have in setting financial eligibility criteria for home and community-based services. California went so far as to eliminate any asset test for its Medi-Cal program. Thus, while it is probably not practical, another last resort option could be establishing residency in a different state.

APPENDIX 1



Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

◉ **§1634 State**

○ **SSI Criteria State**

○ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

◉ **No**

○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

◉ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Parents & caretaker relatives
42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

Pregnant Women
42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

Infants and Children
42 CFR 435.118
1902(a)(10)(A)(i)(III)(IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- (●) **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ( ) **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

  - ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
  - ( ) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

    Check each that applies:

    - [ ] **A special income level equal to:**

      Select one:

      - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
      - ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

        Specify percentage: [ ]
      - ( ) **A dollar amount which is lower than 300%.**

        Specify dollar amount: [ ]
    - [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
    - [ ] **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
    - [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
    - [ ] **Aged and disabled individuals who have income at:**

      Select one:

      - ( ) **100% of FPL**

APPENDIX 2

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD# 21-004

RE: State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services

December 7, 2021

Dear State Medicaid Director:

This letter provides guidance to states on a "rule of construction" of the Medicaid Act under section 3(b) of the Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, which has been included in several subsequent federal laws (hereafter the "construction rule").[1] The construction rule provides that states have the option to target and tailor income and resource disregards at individuals who are eligible for, or seeking coverage of, home and community-based services (HCBS) authorized under section 1915(c), (i), (k) and 1115 authorities.[2]

This new option permits states to adopt higher effective income and resource eligibility standards for people who need HCBS, either for all such individuals or for a particular cohort of such individuals. The option affords states with broad discretion in selecting the cohorts of individuals needing HCBS for whom the state will apply higher effective income or resource standards. States could, for example, effectively raise the resource standard for all individuals eligible for HCBS, or for individuals eligible for a particular 1915(i) or 1915(k) benefit approved under a state's plan, or for individuals eligible for one or more of the eligibility groups covered under a state's section 1915(c) waiver. This option presents states with a critical tool to use in their efforts to "rebalance" their Medicaid coverage of long-term services and supports (LTSS)

[1] *See* The Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Division N, Title I, Section 204(b); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, Division A, Title III, Subtitle E, Part II, Section 3812(b); Continuing Appropriations Act, 2021, Pub. L. No. 116-159, Division C, Title III, Section 2302(b); Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, Division B, Title I, Section 1105(b); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Division H, Title II, Section 205(b). CMS does not interpret the construction rule in these provisions or the Sustaining Excellence in Medicaid Act rule of construction provision to be time-limited, notwithstanding its inclusion in multiple federal laws.

[2] The construction rule in the Sustaining Excellence in Medicaid Act provision and in the provisions described in footnote 1 reads: "Nothing in section 2404 of Public Law 111-148, section 1902(a)(17) or 1924 of the Social Security Act shall be construed as prohibiting a State from applying an income or resource disregard under a methodology authorized under section 1902(r)(2) of such Act (1) to the income or resources of an individual described in section 1902(a)(10)(A)(ii)(VI) of such Act (including a disregard of the income or resources of such individual's spouse); or (2) on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act."

from institutional to community-based care. The purpose of this letter is to provide information on how states can utilize the construction rule to expand coverage of HCBS under their Medicaid programs.

Background

In order to understand the new flexibility under the construction rule to expand eligibility for individuals seeking HCBS, it is helpful to review certain requirements and state options regarding the financial methodologies applied in determining eligibility for individuals seeking Medicaid based on their need for long term services and supports, eligibility groups for individuals seeking coverage of HCBS, and spousal impoverishment protections for married individuals receiving institutional care or HCBS.

Section 1902(r)(2)-based disregard authority

Section 1902 of the Social Security Act (the Act) contains two broad mandates for state Medicaid agencies in their determinations of financial eligibility for individuals who are excepted from the use of modified adjusted gross income (MAGI) methodologies.[3] First, section 1902(a)(17) of the Act requires that states use comparable financial methodologies in determining eligibility for categorical populations (e.g., individuals who are 65 years old and older, 21 years old or younger, or who have disabilities).[4] Second, section 1902(r)(2)(A) of the Act requires that states use financial methodologies in Medicaid that are no more restrictive than those applied in the most closely related cash assistance program.[5] However, section 1902(r)(2)(A) of the Act allows states to adopt income and/or resource methodologies which are less restrictive than the applicable cash assistance program. Typically, less restrictive methodologies adopted by states involve disregarding a certain amount or type of income or resources in determining applicants' and beneficiaries' countable income or resources.

CMS regulations implementing the states' authority to apply less restrictive methodologies than the corresponding cash assistance program's methodologies under section 1902(r)(2)(A) of the

[3] Section 1902(e)(14)(A) of the Act requires that states use MAGI-based methodologies in determining financial eligibility for Medicaid, subject to the exceptions described in subparagraph (D) of the same provision. Populations excepted from MAGI-based methodologies generally include, but are not limited to, individuals who seek Medicaid on the basis of being 65 years old or older, or having blindness or a disability, individuals who seek coverage for long-term services and supports, and individuals who seek Medicaid on the basis of being "medically needy." *See* 42 C.F.R. §435.603(j).

[4] *See* section 1905(a).

[5] Certain states have elected the authority provided under section 1902(f) of the Act to apply financial methodologies more restrictive than the SSI program in determining eligibility for individuals 65 years old or older or who have blindness or a disability, subject to certain conditions. *See* 42 C.F.R. §435.121. These states are referred to as "209(b)" states, after the provision of the Social Security Act Amendments of 1972, Pub. L. No. 92-603, section 209(b), which enacted what became codified at 1902(f) of the Act.

Act require that such less restrictive methodologies be comparable for all individuals in an eligibility group, consistent with section 1902(a)(17) of the Act.[6] In other words, targeting disregards at selected individuals in the same group is not permitted. For example, if a state elects to disregard $100 in income for individuals seeking coverage under an eligibility group for individuals 65 years old and older, $100 must be disregarded in determining the income eligibility of all 65 and older individuals applying for the group.[7]

Individuals eligible for the "217" group

In operating HCBS programs authorized under section 1915(c) of the Act, states commonly extend eligibility to individuals described in section 1902(a)(10)(A)(ii)(VI) of the Act. This section authorizes Medicaid coverage for individuals who: would be eligible for Medicaid if they were in a medical institution; would require an institutional level of care in the absence of the provision of HCBS; and will receive 1915(c) services. This eligibility group is further described in 42 C.F.R. §435.217 and is commonly referred to as the "217 group."

Determining whether the 217 group applicants satisfy the requirement in section 1902(a)(10)(A)(ii)(VI) of the Act that they "would be eligible . . . if they were in a medical institution" involves the hypothetical assumption that the applicant *is* in an institution and the concomitant identification of an eligibility group under which the individual would be eligible under the state's plan assuming such institutional status.[8] Treating a 217 group applicant as institutionalized can facilitate eligibility because: (1) the income standards of eligibility groups for institutionalized individuals covered under a state's plan may be higher than those serving noninstitutionalized individuals; and (2) the income and resources of other individuals (i.e., a spouse or parent) are not included in an institutionalized individual's eligibility determination.[9]

In order to adopt a 217 group, the state selects a group that is already covered under the state plan. We refer to this group as the "principal group." The principal group is identified in the state's section 1915(c) waiver. [10] In evaluating an applicant's financial eligibility for the 217 group, his or her income and resources are determined based on the hypothetical assumption that the applicant is institutionalized and then compared to the income and resource standards of the principal group.

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[6] *See* 42 C.F.R. § 435.601(d)(4).
[7] Id.
[8] *See* 50 F.R. 10013, 10016-17 (March 13, 1985).
[9] Id., at 10020-21.
[10] "CMS Application for a §1915(c) Home and Community-Based Waiver [Version 3.5, Includes Changes Implemented through November 2014], Instructions, Technical Guide, and Review Criteria," pages 81-83 (Release Date: January 2015).

For example, many states that cover the 217 group also cover the "special income level group" (the SIL group) for institutionalized individuals, described in section 1902(a)(10)(A)(ii)(V) of the Act and 42 C.F.R. § 435.236. States establish the income eligibility for the SIL group, which may be up to 300 percent of the supplemental security income federal benefit rate (SSI FBR) ($2,382 a month in 2021).[11] This means that, for an individual seeking Medicaid through the 217 group in a state that: (1) has selected the SIL group as the principal group in its section 1915(c) waiver, and (2) has elected an income standard of 300 percent of the SSI FBR for the SIL group, the individual can have income up to 300 percent of the SSI FBR and be income-eligible for the 217 group (as the individual would be income-eligible under the principal SIL group if institutionalized). If the individual meets the other eligibility requirements for coverage under the 217 group (e.g., meets the level of care defined by the state and resource standard), then the individual can receive HCBS covered under the state's 1915(c) waiver.

Historically, CMS has required that states use not only the same income and resource standards of the principal group to determine eligibility for a 217 group applicant, but the same financial methodologies as well.[12] In practice, this has meant that states have applied section 1902(r)(2)-authorized disregards to the 217 group only to the extent that the same disregards are applied in determining eligibility for the principal group.

The spousal impoverishment rules

Section 1924 of the Act, commonly referred to as the "spousal impoverishment statute," requires that financial eligibility determinations for "institutionalized" spouses be determined consistent with the spousal impoverishment statute's methodology. Section 1924(h)(1) of the Act defines an "institutionalized spouse" as a married individual who is in a medical institution or, at state option, is eligible for the 217 group, and is married to an individual who is not in a medical institution or nursing facility. However, section 2404 of the Affordable Care Act (ACA), as amended by the Consolidated Appropriations Act, 2021, P.L. 116-260,[13] requires that section 1924(h)(1)'s definition of an "institutionalized spouse" include, through September 30, 2023, married individuals who are in need of HCBS authorized under section 1915(c), (i), or (k) of the Act, or a comparable package of HCBS available under section 1115 authority.

The spousal impoverishment statute generally ensures that the "community spouse" of an institutionalized beneficiary is permitted to keep a share of the couple's combined income and resources to meet the individual's own community needs, up to certain maximum standards established under section 1924(c) of the Act. In determining the amount of the couple's combined resources to set aside for a community spouse (referred to as the "community spouse resource allowance," or CSRA), the spousal impoverishment statute requires that all resources

[11] Sections 1902(a)(10)(A)(ii)(V) and 1903(f)(4)(B) of the Act.
[12] *See* 50 F.R., at 10021.
[13] *See* Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Division H, Title II, Section 205(a) ("Extension of the spousal impoverishment protections").

owned by either spouse, jointly or solely, be pooled. The CSRA is then subtracted from this amount and the remainder is deemed to be available to the institutionalized spouse and counted in determining whether the value of his or her resources is at or below the resource standard for eligibility.

Targeting disregards on the basis of need for certain HCBS

The construction rule directs that nothing in certain statutory provisions, including section 1902(a)(17) of the Act, "shall be construed as prohibiting a state from applying an income or resource disregard" under the authority of section 1902(r)(2)(A) of the Act "on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act."

As described above, CMS's regulation implementing section 1902(r)(2)(A) of the Act requires that income and resource disregards adopted by a state must be comparable for (i.e., applied to all) individuals seeking coverage under a given eligibility group. CMS interprets the construction rule to create a narrow exception to that rule, such that states may target income and resource disregards at individuals within an eligibility group based on their need for certain HCBS described in sections 1915(c), (d), (i) and (k) or authorized under a section 1115 demonstration.

For example, if a state covers the optional categorically needy eligibility group authorized in section 1902(a)(10)(A)(ii)(X) of the Act, which serves individuals who have incomes up to the federal poverty level (FPL) and who are either 65 years old or older or have disabilities ("FPL group for individuals age 65 and older or who have a disability"), a state could apply an income and/or resource disregard in determining financial eligibility for the group exclusively to those individuals 65 or older who have a need for 1915(c), (i), or (k) services, or HCBS authorized under a section 1115 demonstration. Similarly, in a state that covers the medically needy, as authorized in section 1902(a)(10)(C) of the Act, the state could target an income or resource disregard at all prospective medically needy individuals who need the HCBS described in the construction rule, or even more narrowly at medically needy individuals who need HCBS and who are, for example, 65 years old and older, or under the age of 21.

CMS also interprets the construction rule to permit states to target a disregard based on an individual's need for a particular HCBS. For example, in a state that operates a 1915(c) waiver and also offers coverage for both 1915(i) and (k) services, the state could limit application of the disregard to individuals who need 1915(i) services. Furthermore, if a state operates multiple 1915(i) benefits, it could choose to apply a disregard exclusively for individuals who need one of the 1915(i) benefits. We also note that CMS has long permitted states to disregard types of income or resources, income or resources used or set aside for a particular purpose, or the

income and resources of a spouse. Per the construction rule, such disregards also may be targeted to individuals receiving HCBS or particular HCBS.[14]

We note that the construction rule refers to an individual's "need" for HCBS available under various authorities. Generally, CMS would consider it reasonable for a state to define "need" in terms of satisfying the eligibility requirements for these services; i.e., based on an individual meeting the level-of-care and coverage criteria applicable to the relevant HCBS. In the context of 1915(c) services, however, an individual's eligibility to receive such services is contingent not only on the individual meeting the level of care and coverage eligibility criteria, but also on the availability of a slot in the relevant 1915(c) waiver. It would be permissible for states to target a disregard at individuals who need 1915(c) services; i.e., individuals who meet the level-of-care and coverage criteria for a 1915(c) waiver, but may not be enrolled in and receiving those services because of a waiting list for available waiver slots.

For example, in a state that covers the 217 group in a 1915(c) waiver and uses the SIL group as the principal group (and has selected 300 percent of the SSI FBR as the income standard), an individual who meets the financial eligibility requirements for the 217 group and the clinical and coverage requirements for the waiver is ineligible for Medicaid so long as the individual is on a waiting list for the waiver and is not eligible under a separate group. This is because, as noted above, an eligibility requirement for the 217 group is that the individual will receive 1915(c) services; i.e., that there is a slot in a 1915(c) waiver in which the individual will be placed and through which the individual will receive coverage for 1915(c) services that have been included in an individual's approved plan of care.

However, an individual could still qualify for Medicaid coverage under certain circumstances. Specifically, if a state separately covers under its state plan the FPL group for individuals age 65 and older or who have a disability and elect to apply to this group, under the authority of the construction rule, an income disregard above the FPL and below 300 percent of the SSI FBR for all individuals who meet the level-of-care criteria for the relevant 1915(c) waiver. In this instance, individuals who meet such criteria but are on the waiting list for the 1915(c) waiver and who otherwise would be eligible under the 217 group can alternatively qualify for Medicaid in the FPL group for individuals age 65 and older or who have a disability and will receive coverage for other state plan services, possibly including home health care services, personal care services, and 1915(i) services (if otherwise available under the state plan) while the individual is on the waiting list for the 1915(c) waiver.

Targeting less restrictive income and resource disregards at the 217 group

[14] *See* "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers," May 11, 2001, at page 6, 7.

As noted above, CMS has historically required states to apply section 1902(r)(2)-authorized disregards to the 217 group to the same extent they are applied in determining eligibility for the principal group.[15] However, the construction rule directs that nothing in sections 1902(a)(17) or 1924 of the Act or section 2404 of the ACA shall be construed to prohibit a state from applying income or resource disregards to an individual "described in section 1902(a)(10)(A)(ii)(VI) of the Act" (i.e., the 217 group) or such individual's spouse.

Section 1902(r)(2) of the Act authorizes states to apply income or resource disregards to, among others, individuals described in section 1902(a)(10)(A)(ii) of the Act, of which the 217 group is a part. Furthermore, the implementing regulation at 42 CFR 435.601(d)(1)(ii) authorizes the use of less restrictive income and resource methodologies to "[o]ptional categorically needy individuals under groups established under . . . section 1902(a)(10)(A)(ii) of the Act." Neither the statute nor regulation limit application of income or resource disregards in determining eligibility for the 217 group.[16] While it has been the historical CMS policy to limit less restrictive methodologies for the 217 group to the extent of their application to the principal group, this policy was not mandated by the plain language of section 1902(r)(2) of the Act.

While neither sections 1902(a)(17) nor 1924 of the Act have imposed a barrier on a state's targeting of income or resource disregards at the 217 group, we interpret the specific reference in the construction rule regarding the use of section 1902(r)(2)-based disregards and the 217 group to confirm the states' authority to do so. Accordingly, states may now apply less restrictive methodologies, including income and resource disregards, exclusively to individuals seeking eligibility for a 217 group, even if such less restrictive methodologies are not applied to the principal group for which the individual would be eligible if living in an institution.[17]

As noted above, the language in the construction rule relating to the 217 group specifically references the "disregard of the income or resources of [the 217 group enrollee's] spouse." Generally, the income and resources of other third parties are not deemed available to (and therefore would have no need under the authority of section 1902(r)(2) of the Act to be disregarded for) 217 group applicants and enrollees. However, where a married individual who is a 217 group applicant or enrollee is considered an "institutionalized spouse,"[18] as defined under section 1924(h)(1), states must include the community spouse's resources in the married 217 group applicant's financial eligibility determination, consistent with the resource eligibility

[15] *See* "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers," May 11, 2001, at page 22.
[16] 42 C.F.R. § 435.601(d)(1)(ii).
[17] Disregards that apply to a principal group will continue to apply to the 217 group. As noted further in this letter, states will need to submit state plan amendments to exercise the authority provided by the rule of construction provision. However, as it relates to the 217 group, such amendments will only be necessary for disregards that states wish to target exclusively at the 217 group.
[18] *See* footnote 10, above.

formula mandated by section 1924(c) of the Act.[19] In determining resource eligibility under the spousal impoverishment statute, however, for a married 217 group enrollee, CMS interprets the construction rule to permit the disregard of a community spouse's resources. In other words, in pooling the spouses' resources for a 217 group applicant or beneficiary under the spousal impoverishment rules, states can elect to disregard all or a portion of the resources of the community spouse under section 1902(r)(2)(A) of the Act.

The same outcome may now be achieved for married medically needy individuals. Prior to the ACA's mandatory application of the spousal impoverishment rules for married 1915(c) waiver participants, states could permit the spouses of medically needy 1915(c) waiver participants to keep more resources than otherwise permitted under section 1924(c) of the Act. Section 1915(c)(3) permits a waiver of section 1902(a)(10)(C)(i)(III) of the Act, which governs the income and resource methodology rules for the medically needy, and therefore permits states to apply institutional deeming rules to married individuals (i.e., not count the community spouse's income or resources) who seek to participate in 1915(c) waivers as medically needy.[20]

Thus, before the ACA's enactment, if a married individual seeking section 1915(c) services as a medically needy individual in a 1915(c) waiver in which section 1902(a)(10)(C)(iii) of the Act had been waived, only the resources (and income) in the name of the married applicant would be included in his or her financial eligibility determination; resources exclusively in the other spouse's name, even if in total exceeding the CSRA, would not be deemed available to the married applicant.

However, by mandatory application of the spousal impoverishment rules, the resource eligibility determination requires that all of the resources owned by either spouse, separately or jointly, be pooled, and the amount exceeding the CSRA deemed available to the "institutionalized" spouse. CMS is aware that a few states preferred the pre-ACA method of effectively permitting a couple to keep all resources when one spouse needs 1915(c) waiver services, but that options for accomplishing this have generally been unavailable, with both the ACA's spousal impoverishment provision being in effect and there being no exceptions to the comparability mandate in a state's use of 1902(r)(2)-based disregards. Now, however, the construction rule permits the targeting of resource (and income) disregards at married medically needy individuals who are eligible for 1915(c) (or other HCBS) services, such that states may ultimately permit such couples to keep all resources.

---

[19] Section 1924(a)(1) of the Act mandates that its provisions supersede other provisions of the Medicaid statute that are inconsistent with the former. While not relevant here, CMS has opined that section 1924 of the Act does not supersede section 1902(e)(14)(A) of the Act, which mandates the use of MAGI income methodologies for certain Medicaid eligibility populations. *See* SMDL #15-001, "Affordable Care Act's Amendments to the Spousal Impoverishment Statute," pages 5-6.

[20] *See* 50 F.R. at 10021.

Other related provisions of federal law

As noted, the construction rule that is the subject of this letter is contained in several recently-enacted federal laws.[21] Also included as a component of this construction rule in some of these federal laws, and independently in others, is additional language referring to home and community-based services and spousal-related income and asset disregards for individuals who qualify for Medicaid by reducing their income based on their incurred medical or remedial care expenses.[22] This letter does not address those provisions, and CMS continues to review their impact on program policies.

Conclusion

States that are interested in electing the new flexibility authorized by the construction rule must submit a state plan amendment in order to effectuate a new income or resource disregard. CMS is prepared to offer technical assistance to states that are interested. Questions about this letter may be directed to Gene Coffey, Technical Director, Division of Medicaid Eligibility Policy, CMCS, at Gene.Coffey@cms.hhs.gov.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

[21] *See* Footnote 1, above.

[22] *See* Medicaid Extenders Act of 2019, Pub. L. No. 116-3, Section 3(b)(1); Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16, Section 2(b)(1); Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Division N, Title I, Section 204(b)(2); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, Division A, Title III, Subtitle E, Part II, Section 3812(b)(2); Continuing Appropriations Act, 2021, Pub. L. No. 116-159, Division C, Title III, Section 2302(b)(2); Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, Division B, Title I, Section 1105(b)(2); Consolidated Appropriations Act, 2021 Pub. L. No. 116-260, Division H, Title II, Section 205(b)(2).

APPENDIX 3

Michigan Department of Health and Human Services
Program Policy Division PO Box 30809
Lansing MI 48909

Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

September 11, 2024

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<City> <State> zipcode5-zipcode4

Dear MI Choice and Medicaid Behavioral Health Providers:

RE: Guide to Coordinate Services for Medicaid Behavioral Health and MI Choice

The purpose of this document is to clarify when Medicaid Behavioral Health services and MI Choice home and community-based waiver (MI Choice) services can and cannot be provided together. It should be used as a guide to develop a coordinated, person-centered, plan of services for individuals to ensure they get the support they need regardless of which program(s) serve them.

It is important to note, when a service is available through both the Habilitation Supports Waiver (HSW) and the Behavioral Health 1915(i) State Plan Amendment (SPA) service array, it is described in this document as a Community Mental Health (CMH) service. If someone is enrolled in the HSW, they would get services available from the HSW and could receive services from Behavioral Health 1915(i)SPA as long as the individual is enrolled, and medical necessity is met.

For more information on the requirements of any of the programs mentioned in this Letter, please refer to the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. Information on Behavioral Health programs is found in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. Information on the Home Help and MI Choice programs are found in their respective chapters with the program name.

Background

Michigan has several Medicaid programs that offer home and community-based services and supports that allow individuals to live in their own homes and receive assistance. These programs include Medicaid State Plan benefits and Medicaid waivers. Medicaid requires that services and supports be coordinated so there is no duplication of service.

The primary program that provides home and community-based support is the State Plan personal care program, called Home Help. This program is administered by MDHHS. An individual cannot be enrolled in a Medicaid waiver if their service and support needs can be fully met through Home Help services.

There are also several waivers that support people to live in the community. Two waivers, MI Choice and the HSW, serve individuals who could receive services and supports in an institutional setting. Additionally, the Behavioral Health 1915(i)SPA provides supports and services and serves many people who use the community mental health system.

With the exception for Home Help services described below, when someone enrolls in either waiver program, Medicaid rules require that the waiver program assure the services and supports necessary to maintain the individual in their preferred home or community-based setting are authorized without duplication.

The 1915(c) MI Choice and Habilitation Supports Waivers (HSW)

Some Medicaid beneficiaries may be eligible for both the MI Choice waiver and the HSW. These individuals must choose from which waiver to receive services and supports. An individual cannot be enrolled in or receive services from both waivers at the same time. While the array of services on the waivers is similar, it is not identical. For example, Enhanced Pharmacy is not a service through the MI Choice Waiver but is an HSW service. See the crosswalk at the end of this document for a listing of services available in each program. Please refer to the MDHHS Medicaid Provider Manual for a description of services. Individual choice may be based on the services available, access to providers, availability of a waiver slot or other unique factors. For persons who are eligible for both waivers, the waiver selected by an individual is not as important as providing clear communication that the individual must choose only one of the waivers.

The MI Choice Waiver provides home and community-based services and supports to the elderly and adults with disabilities who are otherwise eligible for nursing facility services. Twenty waiver agencies administer the MI Choice Waiver program throughout the state. To be eligible for MI Choice, applicants must meet the nursing facility level of care criteria, be eligible for Medicaid, and have a need for and agree to receive supports coordination and at least one other MI Choice service monthly. MI Choice offers expanded financial eligibility to its participants. The income limit is 300% of SSI ($2,829 per month, gross in 2024), and special asset protections for spouses apply. Persons who enroll in MI Choice do not have a spend-down. When enrolling in MI Choice, participants choose to receive MI Choice services instead of personal care available through the Home Help program.

The HSW provides support to people who have a developmental disability (a severe chronic condition attributable to a mental or physical impairment that has manifested before the age of 22 and impairs three or more major life activities), are Medicaid eligible, require and receive at least one habilitative service each month, reside in a community setting and are eligible to receive services available at an intermediate care facility for individuals with intellectual and developmental disabilities (ICF/IID). The HSW is administered by Prepaid Inpatient Health Plans (PIHPs) through the community mental health system. Habilitation services under the HSW cannot duplicate services that are otherwise available to an individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973. Individuals enrolled in the HSW must have their personal care needs met through the Home Help program up to the limits of that program.

When a beneficiary requires a transition from the HSW to MI Choice or from MI Choice to the HSW the initial step is to contact the MDHHS specialist for the waiver in which the beneficiary is currently enrolled. All HSW enrollments start on the first day of a month and may end on any day of a month. This is different for MI Choice. MI Choice enrollments can start on any day of the month and may end on any day of the month. The coordination of the start date and disenrollment date is essential when transitioning from one 1915(c) waiver to another.

Steps to follow to transfer between HSW and MI Choice:

1. The MI Choice waiver agency or PIHP must contact the MDHHS specialist for the waiver in which the beneficiary is currently enrolled. The purpose of this contact is to provide justification for a transfer and supporting documentation for MDHHS review.
2. If the MDHHS specialist agrees that a transfer is appropriate, the MDHHS specialist for the current waiver program will contact the specialist for the receiving waiver program.
3. If the MDHHS specialist does not agree that a transfer is appropriate, they will contact the MI Choice waiver agency or PIHP to discuss their concerns and next steps.
4. To proceed with program transfer, MDHHS will coordinate a teleconference with the MI Choice waiver agency or PIHP.
5. The MDHHS specialist of the receiving program will notify the appropriate MI Choice waiver agency or PIHP of the potential transition.
6. The receiving MI Choice waiver agency or PIHP completes the evaluation of eligibility.
7. Upon confirmation of the individual's eligibility and their approval to transfer to the new program, the MI Choice waiver agency and PIHP coordinate the individual's disenrollment and enrollment dates.
8. Disenrollment from the current waiver must occur on the last day of a month, with the start date of the new waiver occurring on the 1st of the following month.
9. Once known, the disenrollment date and start date must be communicated to the MDHHS waiver specialist to ensure a smooth transition between waivers.

Coordination with the Behavioral Health 1915(i)SPA

People who are eligible for either MI Choice or HSW may be eligible for Behavioral Health1915(i)SPA and additional State Plan services available through the community mental health system. These services are available to people with intellectual disabilities, developmental disabilities, or serious mental illness. Some people with serious mental illness may be eligible for MI Choice Waiver services because of a physical disability and for Behavioral Health 1915(i)SPA services because of their serious mental illness.

MI Choice participants may receive Behavioral Health 1915(i)SPA and State Plan services that do not duplicate MI Choice services. This includes services such as Skill-Building and Supported Employment. A person with an intellectual or developmental disability or serious mental illness who is enrolled in the MI Choice Waiver could access Behavioral Health State Plan and Behavioral Health 1915(i)SPA services through the community mental health system.

Since Behavioral Health State Plan, HSW and the Behavioral Health 1915(i)SPA services are administered through the community mental health system, coordination of those services is common. Coordination of Behavioral Health State Plan and Behavioral Health1915(i)SPA services with the MI Choice waiver is more challenging since they are administered by different agencies. Such coordination involves regular communication between the two agencies. MI Choice enrollees must receive supports coordination from MI Choice as a condition of enrollment. However, it may be necessary for a MI Choice participant to also have a CMH case manager to help them access and manage the behavioral health services they require.

Coordination of CLS and Personal Care

Coordination of services and supports issues also arise for people on the HSW and people only receiving Behavioral Health 1915(i)SPA and State Plan services who need more personal care than is available through the Home Help program or other programs. The MDHHS Medicaid Provider Manual has addressed how the CLS services are coordinated with State Plan personal care services for individuals served by the mental health system:

> "For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help services when MDHHS has determined the individual's needs for this assistance exceeds Home Help service limits. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help."
>
> "If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision."
>
> See the MDHHS Medicaid Provider Manual for more information.

Clarification of Similar Services

- **Individual or Group Therapy (CMH service) versus Counseling (MI Choice service)**

  CMH offers Individual or Group Therapy while MI Choice offers counseling services. Individual or Group Therapy is more intense and focused on treatment whereas Counseling is less intense and focused on assisting the person with adjusting to life changes.

Individual or Group Therapy is defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Service chapter under the Covered Services section of the MDHHS Medicaid Provider Manual as:

> "Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships.
>
> Evidence based practices such as integrated dual disorder treatment for co- occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker."

Counseling is defined in the MI Choice chapter of the MDHHS Medicaid Provider Manual as:

> "Counseling services seek to improve the participant's emotional and social well- being through the resolution of personal problems or through changes in a participant's social situation. Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral or mental health needs."

- **Community Living Supports**

Both HSW and MI Choice offer Community Living Supports (CLS), which is also a Behavioral Health 1915(i)SPA service.[1] These services are similar in many ways, but often delivered differently because of the differing emphases among the programs. Both programs provide guidelines for the provision of the CLS services, without being too descriptive, to allow individuals some flexibility.

When both the CMH and MI Choice waiver agency are providing CLS services to the same person, it is essential to have a coordinated person-centered service plan that specifically delineates exactly what each entity is doing for the individual to avoid any duplication of services. The person-centered service plan should also describe why the service is not available from the other entity. For instance, the CMH may provide CLS that includes transportation to and from community classes as well as assistance during the class while the MI Choice waiver provides CLS in the morning to assist with bathing, dressing, and meal preparation to get the individual ready to attend the class. MI Choice cannot provide CLS during the class because skill building is not a MI Choice service.

It is also important to note that the CMH service cannot duplicate nor replace personal care services available through the Home Help Services program. Individuals enrolled in MI Choice cannot also use Home Help Services. Therefore, it may be necessary for the MI Choice program to cover services such as assistance with ADLs that would otherwise be covered through the Home Help program.

- **Services in Residential Settings**

Both the HSW and MI Choice programs can offer services in Residential Settings. According to Section 11 of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of the MDHHS Medicaid Provider Manual, the CMH can only authorize personal care services in a "licensed foster care setting with a specialized residential program certified by the state." MI Choice may provide services in licensed Adult Foster Care Homes or Homes for the Aged and in unlicensed Assisted Living Facilities. Section 4.1 of the MI Choice chapter of the MDHHS Medicaid Provider Manual states that services in a licensed setting "cannot be provided in circumstances in which they would duplicate services available elsewhere or are available under the State Plan." Therefore, MI Choice services are not available to persons who are being served by CMH in a specialized residential program certified by the state.

CMH provides "Personal Care in Licensed Specialized Residential Settings" and offers additional assistance to meet the ADL and IADL needs of the individual. The MI Choice program offers Community Living Supports or Residential Services to provide additional services to participants who live in a residential setting and require more services and supports than would be normally offered to a resident.

- **Environmental Modifications (Environmental Accessibility Adaptations or Home Modifications)**

The Environmental Modifications are also known as Environmental Accessibility Adaptations and Home Modifications. Regardless of the title of the service, the definitions are very similar for both CMH and MI Choice. One notable difference is that MI Choice will never cover central air conditioning, but CMH will under certain well-defined circumstances. If a participant is using the services of the CMH and those services are meeting their needs, it is not appropriate to make a referral to the MI Choice program solely because the person requires an environmental modification.

- **Respite Care Services**

The Respite Care Services definitions are very similar for both CMH and MI Choice. Both provide intermittent services to relieve a family member or other (unpaid) caregiver. The CMH will allow a licensed nurse to provide respite. In the MI Choice program, only non-licensed persons furnish respite services. If a nurse is providing services, then the service is called either Private Duty Nursing or MI Choice Nursing services. Additionally, the CMH definitions allow respite to be provided at a Licensed Camp, which is not allowed in MI Choice.'

Services that CANNOT Be Used Simultaneously

- Persons can never be enrolled in both the MI Choice Waiver program and the HSW at the same time. The process to transition from one 1915(c) waiver to another is explained above and requires careful planning and coordination.

- When respite is needed, a single agency (either the CMH or the Waiver Agency) should authorize all respite services.

- Persons living in a licensed foster care setting with a specialized residential program certified by the state cannot also enroll in the MI Choice program.

- Persons receiving CMH Therapy services should not also have MI Choice counseling services authorized. MI Choice counseling is NOT a replacement for CMH Therapy.

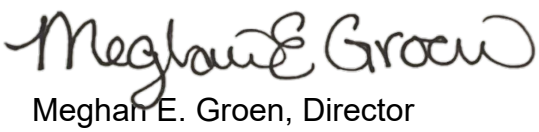
Conclusion

To ensure individuals with long-term services and supports needs can address those needs and access the full array of services and supports available, coordination between service systems is crucial. Refer to the table below to learn more about the services offered in each program. Coordination is key to implementing the individual's person-centered service plan that clearly delineates the services and supports authorized by each program or system, how those services differ from similar services available elsewhere, and why each system must furnish the services authorized. The goal is to assure individuals receive the services and supports he or she needs to have a full life in the community within each programs' requirements and parameters without duplication.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

NOTE: For current service definitions, please refer to the appropriate policy bulletins and MDHHS Medicaid Provider Manual chapters.

Sincerely,



Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration

MI Choice, Habilitation Supports Waiver (HSW) and Behavioral Health 1915(i)SPA Crosswalk

	MI Choice 1915(c)	Habilitation Supports Waiver 1915(c)	Behavioral Health 1915(i)SPA
Program Eligibility ***Can only be enrolled in one 1915(c) Waiver at a time**	• Meets Nursing Facility Level of Care Criteria • Eligible for Medicaid (expanded eligibility rules apply) • Is either elderly (aged 65+) or aged 18 or older and has a disability. • Needs and agrees to receive at least one MI Choice service, in addition to supports coordination monthly • Resides in a home and community-based setting • Can be concurrently enrolled in Behavioral Health 1915(i)SPA services	• Has an intellectual or developmental disability (as defined by Michigan law) • Eligible for Medicaid • If not for HSW services, would require ICF/IID level of care services; and chooses to participate in the HSW in lieu of ICF/IID services. • Resides in a community setting • Must require and receive at least one HSW habilitative service per month • Can be concurrently enrolled in Behavioral Health 1915(i)SPA services	• Eligible for Medicaid • Available to beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability who are currently residing in a HCBS setting and meet the needs-based criteria. **Needs based criteria:** • Have a substantial functional limitation in one or more areas of major life activity AND • Without Behavioral Health §1915(i)SPA services, at risk of not increasing or maintain a sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity, and/or community inclusion and participation.
Private Duty Nursing	Available for qualified participants aged 21+	Available for qualified adults with IID age 21+	N/A
Level of Care	Nursing Facility	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	N/A
Medicaid Health Plan Enrollment	Exempt	Exempt	Exempt

Services Requirement	Must receive at least one MI Choice waiver service in addition to supports coordination per month	Must receive one habilitative service each month. Habilitative services include the following: 1. Community Living Supports 2. Out of Home Nonvocational Habilitation 3. Prevocational Services 4. Supported Employment	Must receive at least one Behavioral Health 1915(i)SPA service every three months, in addition to monthly monitoring, as documented in the person-centered service plan
Available Services	• Adult Day Care • Assistive Technology • Chore Services • Community Health Worker • Community Living Supports • Community Transportation • Counseling • Environmental Accessibility Adaptations • Fiscal Intermediary • Goods and Services • Home Delivered Meals • Nursing Services • Personal Emergency Response System • Private Duty Nursing/Respiratory Care • Residential Services • Respite • Specialized Medical Equipment & Supplies • Supports Brokerage • Supports Coordination • Training • Vehicle Modifications	• Community Living Supports • Enhanced Medical Equipment & Supplies • Enhanced Pharmacy • Environmental Modifications • Family Training • Fiscal Intermediary • Goods and Services • Non-Family Training • Out-of-Home Nonvocational Habilitation • Overnight Health and Safety Supports • Personal Emergency Response Systems • Prevocational Services • Private Duty Nursing • Respite Care • Supports Coordination • Supported Employment	• Community Living Supports • Enhanced Pharmacy • Environmental Modifications • Family Support & Training • Fiscal Intermediary • Housing Assistance • Respite • Skill Building • Specialized Medical Equipment & Supplies • Supported/Integrated Employment • Vehicle Modification

Home Help Program	Cannot receive Home Help Services when enrolled in MI Choice. The MI Choice service of Community Living Supports will fulfill personal care service needs.	Must use Home Help (through MDHHS) as eligible.	Must use Home Help (through MDHHS) as eligible.
Other	• If aging out of State Plan private duty nursing services, usually enroll on 21st birthday. (May enroll sooner if you need MI Choice services other than private duty nursing.) • Cannot enroll before the initial assessment by a waiver agency. • Can still receive all Medicaid State Plan services including mental health services, however careful coordination must occur.	• May enroll at any age if eligibility criteria are met and a slot is available • May back-date enrollment under specific circumstances • Can still receive all Medicaid State Plan services • Must use Home Help for personal care services • Can choose an agency to deliver services or hire your own workers (self- determination)	• Can still receive all Medicaid State Plan services • Must use Home Help for personal care services • Can choose an agency to deliver services or hire your own workers (self- determination) • Can be enrolled in a C-Waiver and the BH 1915(i)SPA

NOTE: For current service definitions, please refer to the appropriate policy bulletins and MDHHS Medicaid Provider Manual chapters.

APPENDIX 4

MEDICAID PROGRAM SCREENING QUESTIONS:

Who Can Qualify for Medicaid in Michigan?

	Is the person age 19-64 *and* not qualified for and not enrolled in Medicare or Medicaid with modified adjusted gross income at or below 138% of the Federal Poverty Level ($20,120 in 2023)?	If YES, eligible under the Healthy Michigan Plan BEM 137
If NO,	Is the person on SSI?	If YES, eligible under BEM 150
If NO,	Is the person a former SSI recipient who lost SSI eligibility due to receipt of or an increase in RSDI benefits in the past?	If YES, possible eligibility under BEM 155 (503 Individuals) BEM 157 (Early Widow(er)s) BEM 158 (Disabled Adult Children)
If NO,	Is the person under 65 with a disability?	If YES, possible eligibility under BEM 170 (Home Care Children) BEM 171 (Children's Waiver) BEM 174 (Freedom to Work) BEM 163 (AD-CARE) BEM 164 (Extended Care - LTC, MI Choice & PACE) BEM 166 (Group 2 "Medically Needy")
If NO,	Is the person under age 65 and blind, but with no determination of disability?	If YES, possible eligibility under BEM 164 (Extended Care - LTC, MI Choice & PACE) BEM 166 (Group 2 "Medically Needy")
If NO,	Is the person age 65 or over?	If YES, possible eligibility under BEM 163 (AD-CARE) BEM 164 (Extended Care - LTC, MI Choice & PACE) BEM 166 (Group 2 "Medically Needy")

Is the person a Medicare beneficiary who needs help paying for Medicare premiums, coinsurances and deductibles?	Possible eligibility under BEM 165 for the Medicare Savings Programs (QMB, SLMB, ALMB or NMB) or BEM 169 for Qualified Disabled Working Individuals (QDWI)

MEDICAID PROGRAM TERMINOLOGY

503 Individuals **BEM 155**	Former SSI recipients who lost SSI eligibility due to an increase in Social Security Retirement Survivors Disability Insurance (RSDI) benefits. Medicaid eligible if the person would be eligible for SSI if the RSDI cost-of-living increases paid since SSI eligibility ended were excluded.
AD-CARE **BEM 163**	People age 65 or over and people under age 65 with a disability. Net countable monthly income cannot exceed 100% of the Federal Poverty Level (in 2024, $1,275 for one person).
Children's Waiver **BEM 171**	A child under age 18 who requires care in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/ID) but can be cared for at home for less cost.
Disabled Adult Children (DAC) **BEM 158**	A person age 18 or older who received SSI and ceased to be eligible for SSI on or after July 1, 1987 because she or he became entitled to receive DAC RSI benefits or because of an increase in such RSI benefits and is currently receiving DAC RSI benefits and would be eligible for SSI without such RSI benefits.
Early Widower(s) **BEM 157**	A person entitled to Medicare Part A and who receives RSDI benefits some or all of which are early Social Security widow(er)'s benefits and was terminated from SSI because of the receipt of those benefits and was receiving SSI in the month the early widow(er)'s benefits began and would be eligible for SSI if all the widow(er)'s benefits were excluded.
Extended Care **BEM 164**	A Medicaid eligibility category available to nursing home patients and persons seeking MI Choice waiver program and PACE services who are age 65 or older or who are under age 65 and have a disability. If the person has too much income to qualify for AD-CARE, Medicaid eligibility may be secured if gross monthly countable income does not exceed 300% of the SSI Federal Benefit Rate ($2,829 in 2024).

Freedom to Work **BEM 174**	Available to a person with a disability (according to Social Security's disability standards) who is aged 16 through 64 and who is employed with earned income. The asset and income standards for eligibility are more generous than other categories of Medicaid eligibility.
Group 2 Medically Needy **BEM 166**	Available to persons age 65 or older, persons who are blind or persons with a disability who have too much countable income to qualify for other categories of Medicaid. Eligibility for Medicaid is secured in any month in which a person incurs health care costs that equal or exceed a person's excess income, *a.k.a.* "the deductible".
Healthy Michigan Plan **BEM 137**	Available to persons age 19-64 who do not qualify for and are not enrolled in Medicare or Medicaid and have a modified adjusted gross income of 138 percent of the Federal Poverty Level ($20,782 in 2023). There is no asset test.
Home Care Children **BEM 170**	Available to a child under age 18 who is unmarried and has a disability who requires institutional care but can be cared for at home for less cost.
Medicare Savings Programs **BEM 165**	Programs that pay for a Medicare beneficiary's premiums, deductibles and coinsurances. The asset limits are more generous than other Medicaid programs.
MI Choice Waiver **BEM 106**	A program for persons age 65 or older and for persons with a disability that pays for home and community-based services to prevent an individual's admission to a nursing facility. To qualify a person's monthly gross income cannot exceed 300 percent of the federal SSI benefit level ($2,829 in 2024).
PACE **BEM 167**	The Program for All Inclusive Care for the Elderly. A managed care program for persons age 65 or older and for persons under age 65 with a disability that pays for home and community-based services to prevent an individual's admission to a nursing facility. To qualify a person's monthly gross income cannot exceed 300 percent of the federal SSI benefit level ($2,829 in 2023).

EXHIBIT I - LIST OF SSI-RELATED MA CATEGORIES

MA Category	BEM Item	Unique Nonfinancial Eligibility Factor	Program Code	Financial Eligibility Group	Automatic MA Eligibility
SSI Recipients	150	Aged, blind or disabled	A, B, E	1	Yes
Appealing SSI Termination	150	Appealing SSI termination	M, O, P	1	No
503 Individuals	155	Aged, blind or disabled	M, O, P	1	No
Early Widow(er)s	157	Blind or disabled	O, P	1	No
DAC	158	Aged, blind or disabled	M, O, P	1	No
AD-Care	163	Aged or disabled	M, P	1	No
Extended-Care	164	Aged, blind or disabled	M, O, P	1	No
Medicare Savings Programs	165	Medicare Part A	M, O, P	-	No
Group 2 Aged, Blind and Disabled	166	Aged, blind or disabled	M, O, P	2	No
QDWI	169	Type of Medicare	P	-	No
Home Care Children	170	Disabled	P	1	No
Children's Waiver	171	Disabled	P	1	No
Breast and Cervical Cancer Prevention and Treatment Program	173	Health department cancer screening	O	1	No

EXHIBIT II - SSI-RELATED MA CODING

Eligible for:			Case		Recipient	
Regular MA	BEM	MSP	PT *	SC *	PT *	ES *
AD-Care	163	Full QMB	0	1F	4	4
AD-Care	163	None	0	1F/1E	5	4
Extended-Care	164	Full QMB	8	1F	0	4
Extended-Care	164	Limited QMB (SLMB)	1	1F	1	4
Extended-Care	164	None	1	1F/1E	0	4
Group 2	166	Full QMB	9	2F	0	3
Group 2	166	Limited QMB (SLMB)	0	2F	2	3

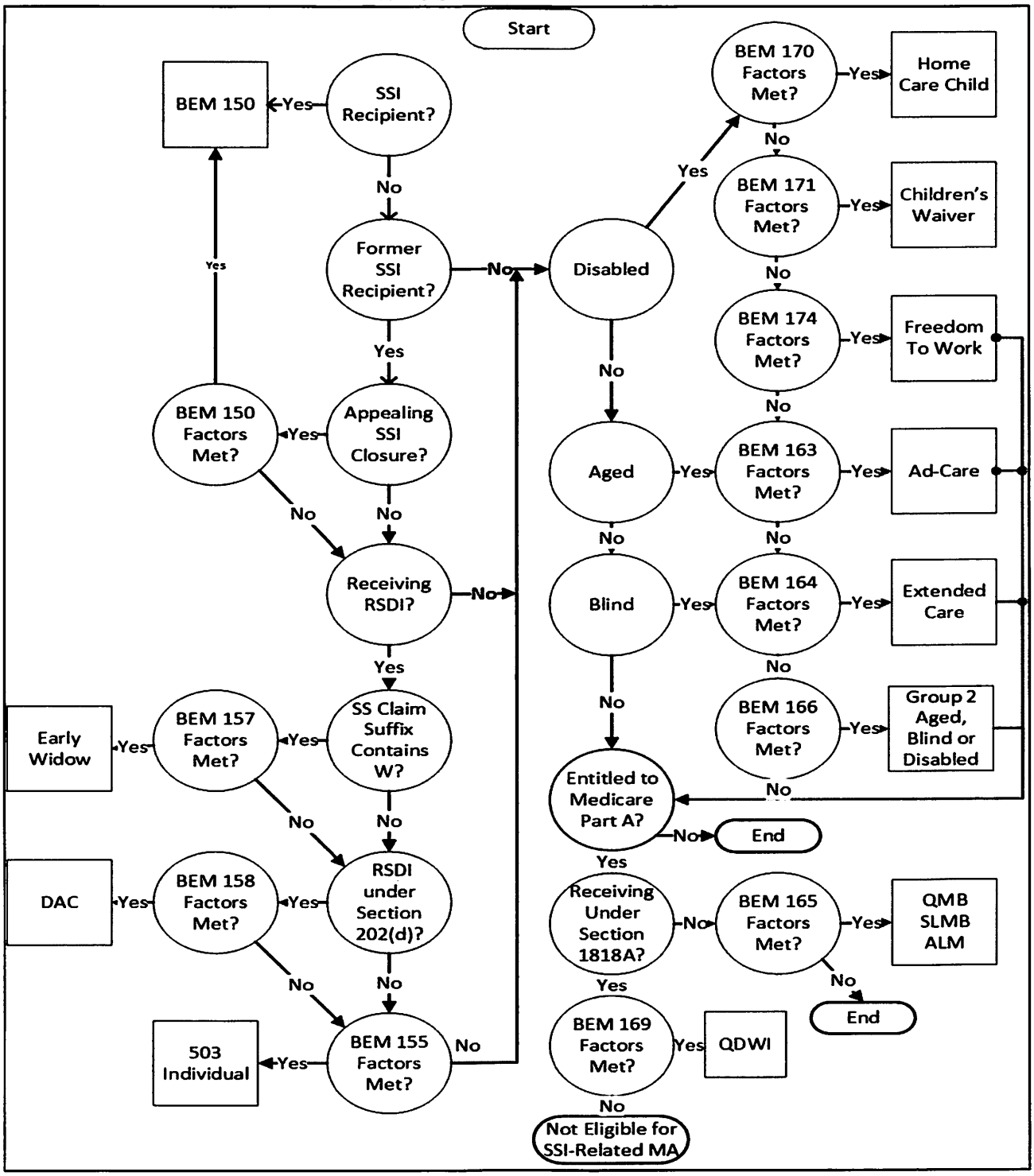
Eligible for:			Case		Recipient	
Regular MA	BEM	MSP	PT *	SC *	PT *	ES *
Group 2	166	None	0	2F/2E	0	3
Active Deductible	545	Full QMB	9	2B	0	7
Active Deductible	545	Limited QMB (SLMB)	0	2C	2	7
Active Deductible	545	None	0	20	0	7
Active Deductible	545	Full ALMB	0	2H	0	7
None	**NA**	**Full QMB**	**9**	**2B**	**0**	**3**
None	**NA**	**Limited QMB** (SLMB)	**0**	**2C**	**2**	**3**
Appealing SSI termination	150	**	0	1F	0	4
503 Individual	**155**	**	**5**	**1F**	**0**	**4**
Early Widow(er)	**157**	**None**	**7**	**1F**	**0**	**4**
DAC	**158**	**	**4**	**1F**	**0**	**4**
Home Care Child	**170**	**	**0**	**1F**	**0**	**4**
Children's Waiver	**171**	**	**0**	**1F**	**0**	**4**
QDWI	**169**	**None**	**0**	**1Q**	**0**	**4**
Freedom to Work (FTW)	174	None	0	1D	0	4
Freedom to Work (FTW)	174	Full QMB	8	1D	0	4
Freedom to Work (FTW)	174	Limited QMB (SLMB)	0	1D	2	4
Freedom to Work (FTW) premium level	174	None	0	1K	0	4
None	NA	Full ALMB	0	2H	0	3

DATA ELEMENT KEY

- **Case level Program Type (PT) on format page one.**
- **Scope/Coverage (SC).**
- **Recipient level Program Type (PT) starting on format page two.**
- **Eligibility Status (ES).**

Note: When adding coverage to an active deductible case, the ES remains 7.

EXHIBIT I - SSI-RELATED MA CATEGORIES



LEGAL BASE

MA

CHALGIAN & TRIPP LAW OFFICES PLLC

Government Benefits and Its Role in Paying for Long-term Care Supports and Services

Christopher W. Smith
LTSS Boot Camp Stetson University SNT Conference

October 22, 2025

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1

GET MEDICAID!

02

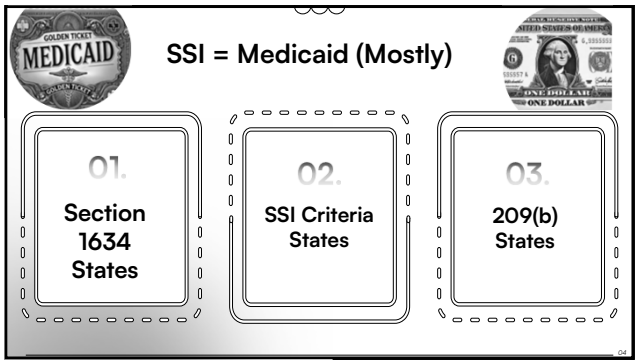
2

Why Is This So Complex?

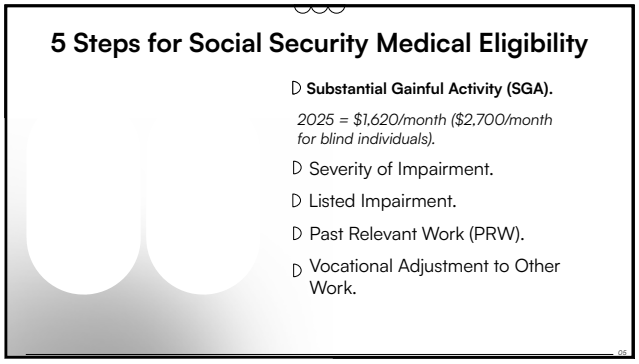
- Medicaid's Original Sin:
  A Dual Federal / State System
- State Flexibility Through State Plans and Waivers
- State's Not Doing What They Should
- Politics

03

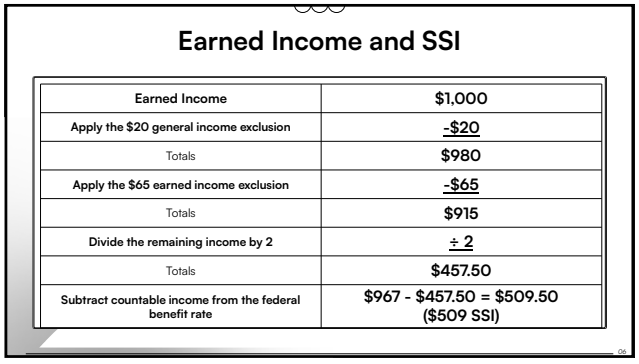
3


GOLDEN TICKET
MEDICAID
SSI = Medicaid (Mostly)
ONE DOLLAR
01.
Section 1634 States
02.
SSI Criteria States
03.
209(b) States
04

4


5 Steps for Social Security Medical Eligibility
Substantial Gainful Activity (SGA).
2025 = $1,620/month ($2,700/month for blind individuals).
Severity of Impairment.
Listed Impairment.
Past Relevant Work (PRW).
Vocational Adjustment to Other Work.
05

5


Earned Income and SSI
Earned Income $1,000
Apply the $20 general income exclusion -$20
Totals $980
Apply the $65 earned income exclusion -$65
Totals $915
Divide the remaining income by 2 ÷ 2
Totals $457.50
Subtract countable income from the federal benefit rate $967 - $457.50 = $509.50 ($509 SSI)
06

6

Unearned Income and SSI

Earned income	$1,000
Apply the $20 general income exclusion	-$20
Totals	$980
Subtract countable income from the federal benefit rate	$967-$980 = $0 SSI

Other Social Security Benefits = Unearned Income

07

7

SSI Asset Eligibility

$2,000 Individual

$3,000 Couple

Exempt Assets

08

8

Com
Medi

9

Common Medicaid Income Eligibility Terms

01. Federal Poverty Level (FPL): $1,305/month (2025) in 48 states in 2025.

02. Federal Benefit Rate (FBR): Maximum SSI benefit: $967/month (2025) for individuals.

03. Medically Needy Income Level (MNIL) Varies by state/geography. Example: Spend down $1,000 if income is $1,500 and MNIL is $500.

10

Categorically Needy

01. No Income Spend Down.

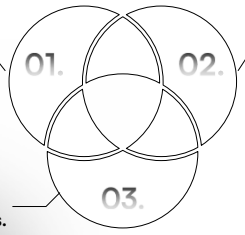
02. Slightly higher income limit than SSI. Usually 100% FPL / $1,305 in 2025.

03. ~28 States.

11

Medically Needy

Must spend down on medical expenses until the medically needy income level is reaches.



Income — Medical Expenses < Medically Needy Income Level.

~34 States.

12

Special Income Group

("300% of SSI Group").

01

Individuals who would otherwise require institutional care.

02

300% of the Federal Benefit Rate $2,901/month

13

Medicaid Buy-In Programs

- **Higher Medicaid Income / Asset Limits if the individual receives *earned income*.**

14

Childhood Disability Benefit (formerly DAC)

- **Medicaid disregards additional Social Security income when child goes from SSI to Childhood Disability Benefits off a parent's benefit record.**

15

Strateg
Inc

16

Can You Assign Income To SNT?

- Child or spousal support
- Annuities
- Military Survivor Benefit Plans
- Other Pensions?

Assignment Must Be Irrevocable and Before Age 65 (for standalone Trust!)

017

17

Is A Miller Trust An Option?

- aka, Qualified Income Trust.
- Available in ~22 States.
- Income in excess of income cap is put into trust.
- Payback requirement.

018

18

Other Income Eligibility Strategies

- Can client get into buy-in program?
- Can you get creative with medical expenses in a medically needy state?
- Advocate for higher limits in your state?
- Move?

19

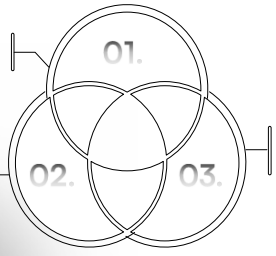
Strateg
As

20

Asset Eligibility Strategies

Is there a MAGI-related Medicaid program that would work?

Can you convert countable assets to exempt assets?



For inheritances, is there a way to convert into 3rd Party money?

21

Special Needs Trust?

- First-Party Standalone Special Needs Trust
  - Drafted by Attorneys.
  - Trustee / Asset Flexibility.
- Pooled Trusts
  - Managed by Nonprofits.
  - Professional management / investment diversification.

022

22

ABLE Accounts

Pros of ABLE Accounts

- Independence/beneficiary control.
- Cheap.
- Tax-free growth.
- Investment diversification.
- Wide distribution discretion.
- Cheap TrueLink card.

Cons of ABLE Accounts

- Disability began before 26 (46 is 2026).
- The $18,000 annual limit (tied to gift tax exemption).
- Spotty customer service.
- ABLE accounts can only handle cash.

023

23

Other Asset Eligibility Requirements

01. Is a Medicaid Buy-In Program an option?

02. Divest assets?

03. Move?

024

24

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25

STETSON LAW

LTSS Boot Camp

October 22, 2025

Federal Medicaid Waivers

STETSON LAW

Center for Elder Justice

Access and Justice For All®

Federal Medicaid Waivers

Kandace E. Rudd, JD, MSW
Florida Bar Board Certified in Elder Law
Florida Supreme Court Certified Circuit-Civil Mediator

- **Federal Authority**
    - Social Security Act
        - 42 U.S. Code Chapter 7 – Social Security
            - Subchapter XVI – Supplemental Security Income for Aged, Blid, and Disabled § 1381 – 1385
            - Subchapter XVIII – Health Insurance for the Aged and Disabled (Medicare) § 1395 – 1395III
            - Subchapter XIX – Grants to States for Medical Assistance Programs (The Medicaid Act) § 1396 – 1396w-8
    - States Medicaid programs are subject to requirements in 42 USC 1396a(a) -State Plan, if States chooses to participate in Medicaid
        - Joint Federal/State funded (42 USC 1396a(a)(2)); federal match depends on state's per capita income (Federal Medical Assistance Percentage (FMAP) not less than 50%)
        - Fair hearing rights (42 U.S.C. 1396a(a)(3))
        - Single State agency to administer program (42 U.S.C. 1396a(a)(5))
        - "Reasonable promptness" for applications (42 U.S.C. 1396a(a)(8))
        - Mandatory eligible groups (42 U.S.C. 1396a(a)(10)(A)(i))
        - Optional eligible groups (42 U.S.C. 1396a(a)(10)(A)(ii))
    - State Plan is implemented through state statute and administrative regulation
- **Types of Medicaid Waivers**
    - Research and Demonstration Waiver
        - §1115 Medicaid Demonstration Waiver

- States can develop experimental, pilot, or demonstration projects that are approved by the Health and Human Services Secretary that will likely promote the objective of Medicaid (provide medical assistance to low-income individuals), such as expanding eligibility, delivery system reforms payment experiments

  - Program Waivers
    - §1915(b) Waiver
      - Waivers to promote cost-effectiveness and efficiency
      - Allows use of Managed Care Organizations
    - §1915(c) Waiver
      - Home and Community Based Services (HCBS) waivers for states without HCBS in their state plans
      - Waivers respecting medical assistance requirement in State plan; scope, etc.; "habilitation services" defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants

- **§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver**
  - Waives certain federal requirements, but cannot waive federal-state fund matching system or fair hearing rights
  - The Secretary may waive requirements under section 1902 such as statewidness (1902(a)(1)); property and efficient administration (1902(a)(4)); comparability of

services (1902(a)(10)(B)-€); payment of services outside the State(1902(a)(16)); freedom of choice of providers ((1902(a)(23));

- Sec. 1115(a)(1) – the Secretary may waive compliance with any of the requirements of section 2, 402, 454, 1002, 1402, 1602, or 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project.
- 42 U.S.C. 1315(a)(1) – the Secretary may waive compliance with any of the requirements of section 302, 602, 654, 1202, 1352, 1382, or 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project
- Common 1115 Waivers Include:
    - Statewideness – Sec. 1902(a)(1)
        - "[P]rovide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;"
    - Comparability of Services – Sec. 1902(a)(10)(B)
        - [T]hat the medical assistance made available to any individual described in subparagraph (A)—
            - (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

        - (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

- Freedom of Choice of Providers Sec. 1902(a)(23)
    - [P]rovide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a 5ermissi managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C), except as provided in subsection (g), in section 1915, and in section 1932(a), except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under

Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of the moratorium;

- The Secretary may approve the use of federal Medicaid funds on generally impermissible expenditures.
  - Sec. 1903 outlines the payments to states that are federally matched, allowable sources of non-federal share of expenditures, and managed care requirements
  - Sec. 1115(a)(2)(A) costs of such project which would not otherwise be included as expenditures under section 3, 455, 1003, 1403, 1603, or 1903, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate, and (B) costs of such project which would not otherwise be a 6ermissible use of funds under part A of title IV and which are not included as part of the costs of projects under section 1110, shall to the extent and for the period prescribed by the Secretary, be regarded as a 6ermissible use of funds under such part.
  - 42 U.S.C. 1315(a)(2)(A) costs of such project which would not otherwise be included as expenditures under section 303, 655, 1203, 1353, 1383, or

1396b of this title, as the case may be, and which are not included as part of the costs of projects under section 1310 of this title, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate, and (B)costs of such project which would not otherwise be a permissible use of funds under part A of subchapter IV and which are not included as part of the costs of projects under section 1310 of this title, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissible use of funds under such part.

- Budget Neutrality Required for 1115 Waivers
  - Federal spending would be equal to that without the demonstration project
    - Budge neutrality is not defined under federal statute or regulations but has been in practice for numerous years
    - CMS must approve spending of budget neutrality savings, included in the agreed terms and conditions, to fund federal share of costs not otherwise allowed
  - CMS provides instructions for calculating budget neutrality. Most recent guidance provided in SMD #24-003 dated August 22, 2024.
    - Budget neutrality test that results in limits on federal Medicaid funding the state may receive over the course of the demonstration project period known as that budget neutrality expenditure limit set forth in the terms and conditions

- Applies to demonstration projects under Section 1115(a)(1) and 1115(a)(2)(A).
- Budge neutrality is monitored throughout the demonstration period and a final determination is made by CMS at the conclusion of the approval period.
    - If the state exceeds budget neutrality expenditure limit at the end of the period it must return the excess funds to CMS
    - Monitoring template on CMS website

- Affordable Health Care Act (Sec. 10201(i)) instituted changes to Section 1115 regarding transparency, public input, and evaluation by adding sub section (d) and. (Sec. 1115(d) and 42 U.S.C. 1315(d))
    - 42 C.F.R. pt. 431, subpt. G added to implement requirements under ACA
        - State public notice process (42 C.F.R. §431.408) requires a minimum 30-day public notice and comment period regarding the application for §1115 Waiver application or extension to comprise:
            - Comprehensive description of the application/extension with "sufficient level of detail to ensure meaningful input." See 42 C.F.R. §431.408(a)(1)(i).
            - Location/website where copies of the application are available for review and comment
            - Postal address/website where written comments may be submitted by the public and the 30-day time period when comments will be accepted

    - Location, date, and time of at least two (2) public hearings on separate dates by the State to seek public input on the application at least 20 days prior to the submission of the application.
- Requirements for the contents of the application and extensions can be found at 42 C.F.R. §431.412. These requirements include documentation of the public process conducted by the state, the issues raised by the public comments, and how the state considered these issues in development of the final application.
- Federal public notice process (42 C.F.R. §431.416)
    - Within 15 days of receipt of application (new or extension) CMS will the State a notice of receipt that will include the start date for the 30-day federal comment period. CMS will also publish the notice receipt, complete application with supporting information submitted by the State, proposed effective date of demonstration waiver, and addresses (mail/email) for submission of comments. To its website within the same 15-day timeframe.
    - CMS will provide continued public disclosure by publishing on its website status updates and listings issues raised during public notice process
    - CMS must publish the written comments online (primary or alternative website) and review and consider all comments

by deadline; written response by CMS to public comments will not be provided.

- CMS cannot make a final decision on the application until 45 days after the notice of receipt. However, 42 C.F.R. §431.416(g) provides exceptions to the federal public notice process and CMS may "expedite a decision on a proposed demonstration or demonstration extension request that addresses a natural disaster, public health emergency, or other sudden emergency threats to human lives."

- Monitoring, Compliance, and Evaluation
  - Implementation
    - The terms and conditions agreed to between the Secretary and the State to implement the demonstration project require the State to conduct period reviews of the implementation, CMS to review documented complaints of the State's failure to comply with the agreed terms and conditions and the implementation of the waiver, and CMS will promptly share complaints with the State that CMS has received and provide notice of any monitoring or compliance issues.
    - States must hold public forum within 6 months of implementation date and annually thereafter to

solicit comments on the progress of the demonstration project

- Terminations/Suspensions
  - Secretary may terminate or suspend the demonstration project at any time in whole or part whenever the Secretary has determined the State "materially failed to comply with the terms of the demonstration project." See 42 C.F.R. §431.420(d)(1)
  - Secretary may withdraw waiver/expenditure authorities on finding the project "is not likely to achieve the statutory purposes." See 42 C.F.R. §431.420(d) (2)
- Evaluation 42 C.F.R. §431.424
  - States must publicly publish their approved evaluation strategy for the demonstration project within 30 days CMS approval.
    - Evaluation plan must include the demonstration hypotheses, the data that will utilized and baseline value, data collection methods, isolation of the effect of the project from outside factors through use of control or comparison groups, proposed date of final

report, and any other information significant to the State's research.

- Reporting 42 C.F.R. §431.428
  - State must submit annual reports to CMS that include:
    - Policy/administrative difficulties in operation; issues and/or complaints by beneficiaries of the health care delivery system; impact in providing insurance coverage to beneficiaries and uninsured; outcomes of care, quality of care, cost of care, and access to care; results of beneficiary surveys, grievances, and appeals; results of any audits, investigations, or lawsuits that impact the project; financial performance of project; status of progress in achieving demonstration evaluation criteria; State legislative developments that may impact project; results/impact of any project programmatic area that is unique to design or hypothesis of project; summary of annual post-award public forms (comments).

        - Draft annual reports must be submitted no later than 90 days after the end of the demonstration year or as specific in the agreed terms and conditions.
            - Draft annual report must be published by the State within 30 days of submission to CMS
        - Final annual report must be submitted within 60 days of the receipt of comments from CMS
            - State must publish the approved final report with 30 days of approval
- §1115 Waiver Application Process
    - Draft Application
        - CMS preprint form
    - State 30-day public comment period and minimum 2 public hearings
    - Submit application to CMS
    - Federal 30-day public comment period
    - CMS review (Health and Human Services and Office of Management and Budget)
        - Budget neutrality required
    - Approval
        - Waivers are generally approved for a 5-year period with)
    - Implementation
    - Monitoring/Evaluation
        - Annual state reports and evaluations

- Amendments/Renewals
    - Extensions are generally approved for three (3) years and five (5) years when the beneficiary population includes those dually eligible in Medicare and Medicaid

- Extensions of 1115 Waivers
    - CMS has "fast track" process to extend demonstrations projects for states meeting the following criteria
        - (1) have had one full extension cycle of the demonstration without substantial programs changes; (2) in compliance with reporting deliverables, positive monitoring and evaluation results indicating objectives of project and Medicaid have been achieved; (3) not proposing major or complex changes; and (4) use streamlined extension application templates
    - Section 1115(a) Extensions
        - States with targeted or compressive demonstration projects may submit an attestation, streamlined extension template application, and if needed reline of term and conditions to outline changes to effectuate any requested program changes.
        - CMS reviews monitor and evaluation information to determine progress on meeting Medicaid objectives and a specific program component the state has requested to change
        - Fast track review offers five (5) year extension period
        - Example provided by CMS

    - CMS successfully piloted this fast track process with the extension of a section 1115(a) demonstration in Colorado. The demonstration has been operating since 2002 and maintains federal funding for uninsured pregnant women with family incomes from 141 percent to 195 percent of the federal poverty level. Colorado submitted an extension application with no changes requested and showed positive outcomes in meeting the objectives of the demonstration. CMS' review focused on whether the demonstration had been operating successfully and that the demonstration would meet its future goals. CMS approved the demonstration extension for a 5-year period on July 24, 2015; completing federal review in 98 days.
- CMS does not offer fast track review for complex policy areas such as
    - Medicaid Expansion Programs with enhanced Federal Medical Assistance Percentage (FMAP);
    - Delivery system reform, financing, and payments arrangements that cannot be authorized under state plan authority, including delivery system reform incentive pools;
    - Designated State Health Programs;
    - Demonstrations with dual eligible Medicare and Medicaid populations;

        - Establishing Home and Community-Based Services (HCBS), including those discussed in the 2014 HCBS final rule;
        - Enrollment caps and eligibility limitations;
        - Uncompensated care pools

- Section 1115€ Extensions
    - Available to states with comprehensive demonstration projects proposing no program changes
    - Limited to three (3) year extension unless waiver qualifies for five years for dual eligible enrollees
    - States submit attestation, streamlined extension template application, and abbreviated set of supporting documents
    - CMS required to provide decision within six (6) months of submission by state; deemed granted if no response provided
- Section 1115(f) Extensions
    - States with 1115€ extensions may submit 1115(f) extensions under an expedited process with proposed program changes
    - 120-day extension review period
        - Within 45 days after receipt of application CMS notifies the State of intent to review of the terms and conditions; failure to notify deemed approval of application

        - Within 45 days after notification CMS informs State of proposed changes in terms and conditions; failure to provide deemed approval of application
        - During 30-day period following notification of proposed changes CMS And State negotiate revised terms and conditions
    - Limited to three (3) year extension unless waiver qualifies for five years for dual eligible enrollees
    - States submit attestation and streamlined extension template application
- **§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers to promote cost-effectiveness and efficiency**
    - Purpose of this waiver is to utilized managed care delivery system to increase cost-effectiveness and efficiency in the delivery of health care
        - See §1915(b); 42 U.S.C. 1396n(b); and 42 CFR pt. 438
    - Typically used by states to waiver requirements for comparability, statewidenss, and freedom of choice to implement a managed care delivery system for Medicaid
        - Managed Care is a delivery system to provide health care and additional services through contractual arrangement between state Medicaid agencies and managed care organizations that accept a set number of enrollees per month payments (capitation) for services.
            - 42 C.F.R. 438.2 defines capitation payment as “a payment the State makes periodically to a contractor on behalf of each beneficiary

enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment."

- Capitation payments can only be made by State and retained by the Managed Care Organization (MCO) for Medicaid eligible enrollees

- CMS must review and approval all contracts, proposed final contracts must be submitted no later than 90 days prior to the effective date of contract. See 42 CFR 438.3
- Contracts are publicly available and should be reviewed

- Managed care programs may also be implemented under state plan authority §1932(a) and §1115 as a demonstration project waiver.
  - May also have concurrent §1915(b) and §1915(c) waivers such as Florida's Long-Term Care Waiver
- Key differences between a managed care §1915(b) waiver program and managed care state plan are:
  - under §1915(b) states are able to require dual eligibles, American Indians, and children with special health care needs to enroll in a managed care delivery system; State must demonstrate the deliver system is cost-effective, efficient, and consistent with objectives of Medicaid; and approval is limited to 2 years

        - Four types of waivers listed in §1915(b)
            - (1) Freedom of Choice - restricts enrollees from receiving services within the managed care network
            - (2) Enrollment Broker – use a central broker to assist enrollees in selecting plan
            - (3) Non-Medicaid Services - uses cost savings to provide additional services to beneficiaries that are not included in federal match funding
            - (4) Selective Contracting - restricts the provider from whom the Medicaid eligible may obtain services
    - Cost Effectiveness Required
        - Spending is equal to or less than the cost of the same services without the waiver
        - Measurement is the projected estimate of the cost of the services provided without the waiver compared to the cost of services under the waiver program
        - States must demonstrate that the waiver is cost effective and efficient in the application and quarterly after implementation
    - Enrollee Rights
        - State must ensure that MCO enrollees is guaranteed the rights outlined in 42 CFR 438.100(b)(2) and (3).
    - Grievance and Appeals
        - All MCOs must have a grievance and appeal system in place

- Filing Requirements
    - Enrollee may file a grievance or appeal with MCO. Enrollee may request a State Fair Hearing only after receiving notice that an adverse benefit determination was upheld or if MCO failed to adhere to notice and timing requirements.
        - 42 CFR 438.400 - Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (2) The reduction, suspension, or termination of a previously authorized service. (3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter is not an adverse benefit determination. (4) The failure to provide services in a timely manner, as defined by the State. (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.(6) For a resident of a rural area with only one MCO, the denial of an enrollee's

request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network. (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

- Timing
    - Enrollee may file a grievance at any time
    - Enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.

- Timely and adequate notice of an adverse benefit determination in writing
    - Notice must explain: determination made or intended to be made; reason for determination; right of enrollee to information; enrollee's right and procedures to request appeal and a fair hearing; circumstances to expedite appeal process; and enrollee's right to continuance of benefits
    - Review 42 CFR for specific time frames of notices
- General Requirements
    - MCOs must give beneficiaries any reasonable assistance in completing the forms and procedural steps.
    - Process for grievances must: acknowledge receipt of each grievance and appeal; ensure decision makers are qualified, do not have conflicts, and consider all information submitted by

beneficiary; oral inquires seeking appeal are treated as an appeal; beneficiary has opportunity to present evidence and testimony and to make legal and factual arguments, provide beneficiary with a copy of their case file and other documents in connection with the appeal of the adverse benefit determination free of charge; and include enrollee, authorized representative or legal representative of deceased enrollee's estate.

- Resolution of Grievance
    - MCO must resolve each grievance and provide notice to the beneficiary
    - Timeframes
        - For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.
        - For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended.
        - For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no

longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended.

- Timeframe may be extended for up to 14 calendar days if the beneficiary requests extension or MCO documents need for additional information and how delay is in the beneficiary's interest
- MCO must make reasonable efforts to give beneficiary prompt oral notice of delay; give written notice of reason for the extension to beneficiary; and resolve the appeal expeditiously

- Fair Hearing
  - Enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination or if the MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's appeals process. The enrollee may initiate a State fair hearing.
  - The enrollee must have no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's notice of resolution to request a State fair hearing.
- Recordkeeping

- States must require MCOs to maintain records of all grievances and review the information as part of ongoing monitoring procedures and be available upon request by CMS.
- Records must include: general description of the reason for grievance/appeal; date received; date of each review/review meeting; resolution; date of resolution; and name of beneficiary

- Continuation of Benefits
  - MCO must continue the enrollee's benefits if all of the following occur:
    - The enrollee files the request for an appeal timely; appeal involves the termination, suspension, or reduction of previously authorized services; services were ordered by an authorized provider; period covered by the original authorization has not expired; and enrollee timely files for continuation of benefits
      - Timely filed means on or before the later of the following: (i) Within 10 calendar days of the MCO sending the notice of adverse benefit determination (ii) The intended effective date of the MCO's proposed adverse benefit determination.
  - Duration
    - If continued or reinstated by MCO, benefits must be continued until one of following occurs:

        - The enrollee withdraws the appeal or request for state fair hearing
        - The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO sends the notice of an adverse resolution to the enrollee's appeal.
        - A State fair hearing office issues a hearing decision adverse to the enrollee.
    - If allowed under MCO's contract, the MCO can recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely under the continuation of benefits request and the final decisions was adverse to the enrollee (upholding the adverse benefit determination)
- Effectuation of reversed appeal resolutions.
    - If the MCO or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
    - If the MCO or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the

disputed services while the appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations.

- Waiver Application Process
  - Preprinted form must be used for initial requests, amendments, and renewals
  - Application Includes
    - Program Overview
      - States must describe how Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (required)
      - Program Description, Wavier Services, Statutory Authority, Delivery Systems, Restriction on Freedom of Choice, and Populations Affect and/or Excluded
    - Access, Provider Capacity, and Utilization Standards
      - Timely Access to Contracted Services, Provider Capacity to Supply Sufficient Contracted Providers, Utilization Standards Specific to Selective Contracting Program
    - Quality
      - Quality Standards and Contract Monitoring
      - Coordination and Continuity-of-Care Standards
    - Program Operations

        - How beneficiaries will get information about selective contracting program and processes in place for individuals with special needs
    - Cost-Effectiveness and Efficiency
        - Projected waiver expenditures for waiver period (two - five years)
            - Pre-waiver costs, projected waiver costs and difference
    - CMS has 90 days from submission of application to make decisions unless CMS requests additional information in writing Section 1915(f)(2)
        - New 90-day time period begins upon submission of additional information by State
- Annual Reporting
    - State must submit a Medicaid managed care quality rating system report in a form and manner determined by CMS. See 42 CFR 438.535

- **§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers for Home and Community Based Services**
    - Goal of 1915(c) Waivers is to provide an array of services sufficient to allow the enrollee to avoid or delay institutionalization
        - See Section 1915(c); 42 U.S.C. 1396n(c); and 42 CFR pt. 441 subpt. G
    - Section 1915(c) allows states to obtain waiver of statewideness (§1902(a)(1), comparability (§1902(a)(10)(B)), and income/resources rules (§1902(a)(10)(C)(i)(III)) to provide home and community-based services to

individuals who without such services would require services in an institutional setting

- Waiver of income and resources rules
    - Exclusion of community spouse's income and allows states to use spousal impoverishment rules in determining eligibility for applicant spouse
    - State can establish eligibility criteria for HCBS Waiver as long as it is no more restrictive than SSI rules for single applicant
    - §1902(a)(10)(C)(i)(III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;
- Number of enrollees in HCBS can be capped by the State and the creation of a waitlist for services. See §1915(c)(4)(A).
    - State's estimated number of enrollees must include those that will replace beneficiaries who leave the waiver, die, or lose eligibility.

        - Model waivers limited to 200 beneficiaries at a time
    - Enrollees must be determined to need a level of care provided in a hospital, nursing facility, or intermediate care facility (ICF) which would be reimbursed under the state plan (institutional level of care)
- Cost Neutrality required
    - §1915(c)(2)(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted
    - Expenditures must be reasonably estimated and documented
    - Estimates must be on annual basis for each year of the waiver period
- Services under HCBS Waiver may include:
    - Case management; homemaker (chores/light housekeeping); home health aid; personal care; adult day programs; habilitation services; respite care; supported employment; day treatment or partial hospitalization for individual with chronic mental illness; educational services; prevocational services; other services approved by CMS "as cost effective and necessary to avoid institutionalization." 42 CFR 440.180
    - Room and board are excluded except when part of respite care services in a facility approved by State that is not a private residence or waiver that "allow personal caregivers as providers of approved waiver services, a

portion of the rent and food that may be reasonably attributed to the unrelated caregiver who resides in the same household with the waiver beneficiary." 42 CFR 441.310(a)(2)(ii)

- Written Person-Centered Plan
  - Planning process for the person-centered plan should include:
    - The individual (beneficiary), individual's authorized representative, those the individual has chose to include, and the case manager qualified to develop an individual care plan. If case manager is same as HCBS provider the State must have conflict of interest protections approved by CMS.
      - "Individuals must be provided with a clear and accessible alternative dispute resolution process." 42 CFR 441.301(c)(1)(vi)
    - Time at date/time/locate convenience for individual
    - Process should be directed by the individual and the individual should be provided with information and support to ensure the individual directs the process and allows them to make an informed choice.
    - Offers informed choices regarding services and supports and from whom.
    - Cultural considerations, plain language, and in a manner accessible to individual.

- Provides clear conflict-of-interest guidelines and strategies for resolving conflict during planning
- Provide individual with process to request update to plan as needed
- Record of alternative settings that were considered during planning

- Person-Centered Service Plan
  - 42 CFR 441.301(c)(3) Plan must reflect services and supports that are important to the individual to meet the needs identified through an assessment of functional needs… Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:
    - Residential setting chosen by individual that is fully integrated and supports full access to the community;
    - Individual's strength and preferences;
    - Clinical and support needs identified in functional needs assessment;
    - Individual's goals and desired outcomes;
    - Paid and unpaid services and supports to achieve goals and provider of services and supports "including natural supports." "Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports."
    - Risk factors and methods to minimize them

- Understandable written plan to the individual and naturals supports
- Identify individual/entity that will monitor plan
- Finalized and agreed to with informed consent in writing and signed by individual/authorized representative and provider
- Distributed to individual and those involved in plan
- Self-directed services included
- Prevent inclusion of unnecessary or inappropriate services and supports; and
- Document that any modification of the additional conditions, under paragraph 42 CFR 441.301(c)(4)(vi)(A)-(D)

- Review of Person-Centered Plan
  - Plans must be reviewed and revised: at least every 12 months; significant change in needs or circumstances of individual; or at the individual's request
  - State are required to complete reassessment of functional needs assessment and review and revise person-centered service plan based on reassessment at least every 12 months for no less than 90% of one-year continuous enrollees

        - Compliance with this standard begins three years after 7/9/24

- Home and Community Based Services Settings Rule
    - Detailed set of rules adopted to prevent placement of HCBS Waiver enrollees into institutional-like settings. See 42 CF 431.301(c)(4)-(6).
    - HCBS Settings must have all the following qualities:
        - Integrated in and supports full access of individuals to the greater community;
        - Selected by the individual. "The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;"
        - Ensures rights to privacy, dignity, and respect, and freedom from coercion and restraint;
        - Enhances individual initiative, autonomy, and independence in making life choices (ADLs, IADLS, physical and social environment);
        - Facilitates individual choice regarding services and supports, and who provides them; and
        - Provider owned settings have additional requirements under 42 CFR 441.301(c)(4)(vi).
    - Settings that are not considered HCBS

- Nursing facility, mental health facility, intermediate care facility (ICF), hospital, and any other locations that have qualities of an institutional setting, as determined by the Secretary
- 42 CFR 441.301(c)(5)(v) - Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

- Compliance and Transition
    - State assurance on initial application of compliance with HCBS settings requirements
    - CMS requires transition plans to bring states into compliance with HCBS settings rule; timeframe for transition plans was based on renewal date and effective date of regulation.
        - 30-day public notice and comment period at the State level for proposed transition plans

        - State required to submit proof public notice and summary of comments received, reasons why comments were not adopted, and any modifications to plan based on comments.

- Grievance
    - States must have a system for beneficiaries to file a grievance related to the State's or provider's performance of activities under 42 CFR 441.301(c)(1)-(6).
        - Grievance is defined as an expression of dissatisfaction or complaint related to the State's or a provider's performance of the activities described in paragraphs (c)(1) through (6) of this section, regardless of whether remedial action is requested.
        - Compliance required two years after 7/9/24
    - General Requirements
        - The beneficiary/authorized representative may file a grievance at any time. Another individual or entity may file on behalf of, assist, and represent the beneficiary with written consent. Providers are not permitted to file a grievance.
        - State must have written grievance policies and procedures; provide assistance to beneficiaries to access and use grievance system; ensure punitive or retaliatory action is not threatened or taken; accept grievances and requests for extension of timeframes; provide beneficiary with notices and information; review resolution with which the beneficiary is dissatisfied; and provide

information about grievance system to all providers and subcontractors approved to deliver services.

- Process for grievances must: allow either oral or written grievance to be filed; acknowledge receipt of each grievance; ensure decision makers are qualified, do not have conflicts, and consider all information submitted by beneficiary; beneficiary has opportunity to present evidence and testimony and to make legal and factual arguments, provide beneficiary with a copy of their case file free of charge and "sufficiently in advance of the resolution timeframe"; and provide beneficiaries language services free of charge..

- Resolution of Grievance
    - State must resolve each grievance and provide notice to the beneficiary
    - Timeframe not exceed 90 calendar days from the date the State receives the grievance
    - Timeframe may be extended for up to 14 calendar days by the State if the beneficiary requests extension or State documents need for additional information and how delay is in the beneficiary's interest
        - State must make reasonable efforts to give beneficiary prompt oral notice of delay; give written notice of reason for the extension to beneficiary; and resolve the grievance expeditiously

- Recordkeeping
    - States must maintain records of all grievances and review the information as part of ongoing monitoring procedures and be available upon request by CMS.
    - Records must include: general description of the reason for grievance; date received; date of each review/review meeting; resolution; date of resolution; and name of beneficiary.

- Application for Waiver
    - CMS preprinted form recommended but not required
        - Applications are extensive (hundreds of pages)
    - 42 CFR 443.301 outlines the content requirements for waiver requests including State assurances described in §441.302, supporting documents required by §441.303, specific waivers requested, cost neutrality, services provide through person-centered service plan, eligibility, number of enrollees (cap on enrollment), service areas, etc.
        - State Assurances must include: safeguards to protect health and welfare of beneficiaries; financial accountability; evaluation of level of care need of beneficiary (initial and periodic); alternatives of care under waiver (institutional or home and community-based services); average per capita expenditures; actual total expenditures; Institutionalization absent waiver; reporting to CMS of waiver's impact; habilitation services correctly furnished; day

treatment/partial hospitalization services are correctly furnished; and HCBS payment adequacy to ensure sufficient direct care staff;

CMS has 90 days from submission of application to make decisions unless CMS requests additional information in writing Section 1915(f)(2)

- New 90-day time period begins upon submission of additional information by State

- Approval for three years (five years for programs that include dually eligibility beneficiaries). Extensions are generally for five years.
  - Public notice is required if "any significant" proposed changes to the State's methods and standards for setting payment rates for services

- Reporting
  - Compliance Reporting
    - Incident management system every 24 months, CMS may reduce frequence up to once every 60 months
    - Critical incidents, as defined in 42 CFR 441.302(a)(6)(i)(A), in the form and manner, and at a time, specified by CMS
    - Person-Centered Planning annual report
    - Annually the State will provide CMS with information on the waiver's impact on the type, amount, and cost of services provided under the State plan, in the form and manner, and at a time, specified by CMS

        - Compliance begins 3 years after 7/9/24; managed care delivery system compliance begins the first rating period for contracts with the MCO, PIHP, or PAHP beginning on or after the date that is 3 years after July 9, 2024.
- Home and Community-Based Services Quality Measure Set
    - Home and Community-Based Services Quality Measure Set are required to be used by States with section 1915(c) waiver programs to promote public transparency related to the administration of Medicaid-covered HCBS
    - States must report every other year on all measures in the Home and Community-Based Services Quality Measure Set that are identified by the Secretary pursuant to 42 CFR 441.312(d)(1)(ii)
    - Compliance begins 4 years after 7/9/24; managed care delivery system compliance begins the first rating period for contracts with the MCO, PIHP, or PAHP beginning on or after the date that is 4 years after July 9, 2024.
- Access Reporting Annually
    - Waiting Lists
        - Description of how State maintains waiting list including if the State screens individuals on waitlist for eligibility, if the State periodically rescreens individuals on waitlist for eligibility, and the frequency of rescreening.
        - Number of people on the waitlist

        - Average amount of time on waitlist for individuals newly enrolled in past 12 months
    - Access to homemaker, home health aide, personal care, and habilitation services.
        - Average amount of time from when homemaker services, home health aide services, personal care services, and habilitation services initially approved for individuals newly receiving services in past 12 months
        - Percent of authorized hours for homemaker services, home health aide services, personal care services, and habilitation services provided within past 12 months.
    - Compliance begins 3 years after 7/9/24; managed care delivery system compliance begins the first rating period for contracts with the MCO, PIHP, or PAHP beginning on or after the date that is 3 years after July 9, 2024.
- Payment Adequacy Reporting Annually
    - States must report percentage of total payments (not including excluded costs) for furnishing homemaker services, home health aide services, personal care, and habilitation services, that is spent on compensation for direct care workers
        - Exclude payments provided under self-directed
    - Compliance begins 4 years after 7/9/24; managed care delivery system compliance begins the first rating period for contracts with

the MCO, PIHP, or PAHP beginning on or after the date that is 4 years after July 9, 2024.

- Medicaid Enrollee Rights
    - Constitutional Due Process
        - Goldberg v. Kelly, 397 U.S. 254 (1970)
            - Procedural due process applies to welfare benefits. Pre-termination evidentiary hearing is necessary to provide due process. Benefit recipients must be provided timely and adequate notice detailing reasons for termination and opportunity to defend by confronting adverse witnesses and present arguments and evidence before an impartial decisionmaker.
    - Notice
        - 42 CFR 431.210 - Notice required under 42 CFR 431.206 (c)(2), (c)(3), or (c)(4) must contain (a) A statement of what action the agency, skilled nursing facility, or nursing facility intends to take and the effective date of such action; (b) A clear statement of the specific reasons supporting the intended action; (c) The specific regulations that support, or the change in Federal or State law that requires, the action; (d) An explanation of (1) The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

        - State or local agency must send notice at least 10 days before date of action except as permitted under 42 CFR 431.213 (death, voluntary withdrawal, etc) and 431.214 (probable fraud).
    - Fair Hearing
        - Hearing is required as outlined 42 CFR 431.220
            - 42 CFR 431.220(b) The agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all beneficiaries.
        - Request for Fair Hearing
            - Agency must establish procedures to allow individual and authorized representative to submit hearing requests, including a request for an expedited fair hearing, via website, telephone, mail, in person, and common electronic means.
            - Agency cannot interfere or limit an applicant's or beneficiary's freedom to make a request for a hearing. Agency can assist with submitting and processing request.
            - Agency allow reasonable time, not to exceed 90 days from date of notice of action is mailed, to request a hearing.
        - Continuation of Benefits
            - 42 CFR 431.230 - beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless (1) It is determined at the hearing that the sole issue is one of Federal or State law or

policy; and (2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

- Agency may recover costs of continued services if agency action is upheld by hearing decisions.

- Hearing Decisions
  - Review 42 CFR 431.244 for detailed description of hearing decision requirements.
- Corrective Action
  - The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility if hearing decision is favorable to the applicant or beneficiary; or agency decides in the applicant's or beneficiary's favor before the hearing. See 42 CFR 431.246

- Federal Rights
  - Provisions of the Medicaid Act have been determined to be enforceable as individual civil rights under 42 U.S.C. §1983 (Civil Action for Deprivation of Rights). See Gonzaga Univ. v. Doe, 536 U.S. 273 (2002) and Blessing v. Freestone, 520 U.S. 329 (1997).
    - Enrollees be provided medical assistance with reasonable promptness. 42 USC 1396a(a)(8); 42 CFR 435.930(a).
    - Enrollees be provided a fair hearing. 42 USC 1396a(a)(3);

        - That services to children meet the requirements of Early & Periodic Screening, Diagnosis and Treatment (EPSDT). 42 USC 1396a(a)(43)
- Americans with Disabilities Act 42 USC 12132
    - Olmstead v. LC, 527 U.S. 582 (1999), Supreme Court decision found that unnecessary institutionalization of persons with disabilities was a violation of the Americans with Disabilities Act of 1990. States must provide services in the "most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR 35.130(d)

Federal Medicaid Waivers

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1

Federal Authority

- Social Security Act
  - Social Security Amendments of 1965 – The Medicare and Medicaid Act
- States Medicaid programs are subject to requirements in 42 USC 1396a(a) -State Plan, if States chooses to participate in Medicaid
  - Joint Federal/State funded (42 USC 1396a(a)(2)); federal match depends on state's per capita income (Federal Medical Assistance Percentage (FMAP) not less than 50%)
  - Fair hearing rights (42 U.S.C. 1396a(a)(3))
  - Single State agency to administer program (42 U.S.C. 1396a(a)(5))
  - "Reasonable promptness" for applications (42 U.S.C. 1396a(a)(8))
  - Mandatory eligible groups (42 U.S.C. 1396a(a)(10)(A)(i))
  - Optional eligible groups (42 U.S.C. 1396a(a)(10)(A)(ii))
- State Plan is implemented through state statute and administrative regulation

2

Medicaid Waivers

- §1115 Medicaid Demonstration Waiver
  - States can develop experimental, pilot, or demonstration projects that are approved by the Health and Human Services Secretary that will likely promote the objective of Medicaid (provide medical assistance to low-income individuals), such as expanding eligibility, delivery system reforms payment experiments
- §1915(b) Waiver
  - Allows use of Managed Care Organizations (MCOs)
- §1915(c) Waiver
  - Home and Community Based Services (HCBS) waivers for states without HCBS in their state plans

3

§1115 [42 U.S.C. 1315]

Medicaid Demonstration Waiver

4

§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver

- Waives certain federal requirements (Sec. 1115(a)(1) and 42 U.S.C. 1315(a)(1))
  - Most common waivers seek to waive requirements under
    - Sec. 1902(a)(1) Statewideness
    - Sec. 1902(a)(10)(B) Comparability
    - Sec. 1902(a)(23) Freedom of Choice
  - Cannot waive the federal-state matching system or the right to fair hearing
  - Waivers may be broad or narrow in scope and population
- Generally approved for 5-year period with extensions of 3 – 5 years
  - CMS can withdrawal approval at anytime

5

§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver

- The Secretary may approve the use of federal Medicaid funds on generally impermissible expenditures
  - Sec. 1115(a)(2)
  - 42 U.S.C. 1315(a)(2)
- "Budget Neutral" Required
  - Federal spending would be equal to that without the demonstration project
  - Budget neutrality is not defined under federal statute or regulations but has been in practice for numerous years
  - Budget neutrality is monitored throughout the demonstration period and a final determination is made by CMS at the conclusion of the approval period

6

§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver

- Affordable Health Care Act (Sec. 10201(i)) instituted changes to Section 1115 regarding transparency, public input, and evaluation
  - Sec. 1115(d)
  - 42 U.S.C. 1315(d)
  - 42 C.F.R. pt. 431, subpt. G
- State public notice process (42 C.F.R. §431.408) requires a minimum 30-day public notice and comment period
- Requirements for the contents of the application and extensions
- Federal public notice process (42 C.F.R. §431.416)
- Monitoring, Compliance, and Evaluation

7

§1115 [42 U.S.C. 1315] Medicaid Demonstration Waiver

- Waiver Process
  - Draft Application
  - State 30-day public comment period and minimum 2 public hearings
  - Submit application to CMS
  - Federal 30-day public comment period
  - CMS review (Health and Human Services and Office of Management and Budget)
  - Approval
  - Implementation
  - Monitoring/Evaluation
  - Amendments/Renewals

8

§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

- Purpose of this waiver is to utilized managed care delivery system to increase cost-effectiveness and efficiency in the delivery of health care
- Typically used by states to waiver requirements for comparability, statewidenss, and freedom of choice
- Managed Care
  - Contractual arrangement between state Medicaid agencies and MCOs that accept a set number of enrollees per month payments (capitation) for services
- Capitation "a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment."
  - 42 C.F.R. 438.2

9

§1915(b) [42 U.S.C. 1396n(b)]

Medicaid Waivers for Medicaid Managed Care

10

§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

- Managed care programs may also be implemented under state plan authority §1932(a) and §1115 as a demonstration project waiver.
- May have concurrent §1915(b) and §1915(c) waivers
  - Example: Florida's Statewide Medicaid Managed Care Long-Term Care Waiver (SMMC-LTC)
- State Plan vs. Waiver
  - Under §1915(b) States
    - Able to require dual eligibles, American Indians, and children with special health care needs to enroll in a managed care delivery system
    - State must demonstrate the delivery system is cost-effective, efficient, and consistent with objectives of Medicaid
    - Approval is limited to 2 years
- §1915(a) Waiver
  - Voluntary managed care program by executing contract with MCOs using competitive procurement process. CMS must approve in order to make payment

11

§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Cost Effectiveness Required

- Spending is equal to or less than the cost of the same services without the waiver
- Measurement is the projected estimate of the cost of the services provided without the waiver compared to the cost of services under the waiver program
- States must demonstrate that the waiver is cost effective and efficient in the application and quarterly after implementation

12

§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Enrollee Rights Guaranteed by State

- Receive information as required in 42 CFR § 438.10
- Be treated with respect and consideration for their dignity and privacy
- Receive information on available treatment options and alternatives
- Participate in health care decision (including refusing treatment)
- Free from restraint or seclusion as a means of coercion, discipline, convenience or retaliation
- Request and receive copy of medical records and request to amened or correct
- Furnished with health care services in accordance with §§ 438.206 through 438.210.

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§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Grievance and Appeals

- Adverse Benefit Determination Notice
  - Notice must include certain information
  - Review 42 CFR for specific time frames of notices
- Timing
  - Grievance may be filed with MCO at anytime
  - File appeal within 60 calendar days of adverse notice
- Resolution of Grievance
- State Fair Hearing
  - Only after receiving notice that an adverse benefit determination was upheld or if MCO failed to adhere to notice and timing requirements
  - No less than 90 calendar days and no more than 120 calendar days to request fair hearing

14

§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Continuation of Benefits

- Enrollee may request a continuation of benefits on or before
  - 10 calendar days of notice
  - Effective date of proposed adverse benefit determination
- MCO must continue benefits when certain conditions are met
- Duration of benefits
- MCO can recover cost if under contract, provided solely under continuation, and final decision upheld MCOs decision

15

§1915(b) [42 U.S.C. 1396n(b)] Medicaid Waivers - MCOs

Waiver Application

- Preprinted form must be used
- Application
  - Program Overview
  - Access, Provider Capacity, Utilization Standards
  - Quality
  - Program Operations
  - Cost-Effectiveness and Efficiency
- Approval
  - CMS has 90 days to make a decisions unless additional information is requested in writing
  - Two years (five years for programs that include dually eligibility beneficiaries).
- Annual Reporting

16

§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers for Home and Community Based Services

- Goal of 1915(c) Waivers is to provide services sufficient to avoid or delay institutionalization
  - See Section 1915(c); 42 U.S.C. 1396n(c); and 42 CFR pt. 441 subpt. G
- Waiver of statewideness (§1902(a)(1), comparability (§1902(a)(10)(B)), and income/resources rules (§1902(a)(10)(C)(i)(III))
- Waiver of income and resource rules
  - §1902(a)(10)(C)(i)(III) the single standard to be employed in determining income and resource eligibility
  - States can exclude community spouse's income
  - Allows states to use spousal impoverishment rules to determine eligibility
  - States may establish eligibility for criteria for HCBS (no more restrictive than SSI rules for single applicant)

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§1915(c) [42 U.S.C. 1396n(c)]

Medicaid Waivers for Home and Community Based Services

18

§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

- Institutional Level of Care
  - hospital, nursing facility (SNF), or intermediate care facility (ICF)
- Enrollment capped and the creation of waitlist for services
  - State provide an estimated number of enrollee
  - Model waivers limited to 200 beneficiaries at a time
- Cost Neutrality Required
  - Average per capita expenditure estimated "does not exceed 100 percent of the average per capita expenditure" for fiscal year under State plan for such individuals
  - Expenditures are reasonable estimated and documented

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Services May Include

- Case management
- Homemaker (chores/light housekeeping)
- home health aid
- personal care
- adult day programs
- habilitation services
- respite care
- supported employment
- day treatment or partial hospitalization for individual with chronic mental illness
- educational services
- prevocational services
- other services approved by CMS "as cost effective and necessary to avoid institutionalization."

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Person-Centered Service Plan

- Planning process for written person-centered plan
- Services and support that are important to individual and meeting needs (functional needs assessment)
- Written plan must include certain elements outlined in 42 CFR 441.301(c)(2)
  - Goals and desired outcomes
  - Natural Supports
  - Clinical and support needs identified in functional needs assessment
  - Residential setting
  - Finalized and signed
- Reviewed and revised
  - Every 12 months
  - Significant change in needs/circumstances
  - At request

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

HCBS Settings Rule

- Detailed set of rules adopted to prevent placement of HCBS Waiver enrollees into institutional-like settings.
  - See 42 CF 431.301(c)(4)-(6)
- Setting must be:
  - Integrated in and supports full access to greater community
  - Selected by individual
  - Right to privacy, dignity, respect, and freedom from coercion/restraint
  - Enhances individual initiative, autonomy, and independence in making life choices
  - Facilitates individual choice regarding services and supports, and who provides them
- Provider owned settings have additional requirements under 42 CFR 441.301(c)(4)(vi)

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

HCBS Settings Rule

- Settings that are not considered HCBS
  - Nursing facility, mental health facility, intermediate care facility (ICF), hospital, and any other locations that have qualities of an institutional setting, as determined by the Secretary
- Compliance with settings rule is part state assurances on initial application
- CMS requires transition plan to bring states into compliance
  - Timeframe based on renewal date and effective date of regulation
  - 30-day public comment period for proposed transition plan

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Grievance

- Grievance is defined as an expression of dissatisfaction or complaint related to the State's or a provider's performance of the activities described in paragraphs (c)(1) through (6) of this section, regardless of whether remedial action is requested
  - 42 CFR 441.301(c)(1)-(6).
- May file at any time (oral or written)
- States must have written grievance policies and procedures
- Allow beneficiary an opportunity to present evidence/testimony and make legal/factual arguments
- Provide beneficiary with a copy of their case file free of charge

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Grievance

- Resolution of Grievance
  - Not to exceed 90 calendar days
  - May be extended 14 calendar days
  - Expeditious resolution
  - Notice must be provided to beneficiary
- Recordkeeping
  - States must maintain records of all grievances
    - general description of the reason; date received; date of each review/review meeting/resolution; resolution; and name of beneficiary

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Waiver Application

- CMS forms recommended but not required
- Applications are extensive and detailed
  - State assurances
  - Supporting documents
  - Specific waiver requests
  - Cost neutrality
  - Services
  - Eligibility
  - Number of enrollees
  - Service areas
- Approval
  - CMS has 90 days to make a decisions unless additional information is requested in writing
  - Three years (five years for programs that include dually eligibility beneficiaries).

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§1915(c) [42 U.S.C. 1396n(c)] Medicaid Waivers - HCBS

Reporting

- Compliance Reporting
  - Incident management systems
  - Critical incidents see 42 CFR 441.302(a)(6)(i)(A)
  - Person-Centered Planning annual report
  - Annual report on impact on services (type, amount, cost)
- HCBS Quality Measure Set
  - To promote public transparency related to the administration of Medicaid-covered HCBS
- Annual Access Reporting
  - Waiting Lists
  - Access to homemaker, home health aide, personal care, and habilitation services
- Annual Payment Adequacy Reporting

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Enrollee Rights

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Medicaid Enrollee Rights

- Constitutional Due Process
  - Goldberg v. Kelly, 397 U.S. 254 (1970) - Procedural due process applies to welfare benefits
- Notice
  - Must contain:
    - Statement of what action the is being taken and effective date
    - Specific reason supporting action
    - Regulations support or chang in law requiring action
    - Explanation of rights
    - Continuation of benefits
  - State or local agency must send notice at least 10 days before date of action except as permitted under 42 CFR 431.213 (death, voluntary withdrawal, etc) and 431.214 (probable fraud).

29

Medicaid Enrollee Rights

- Fair Hearing
  - Required as outlined in 42 CFR 431.220
  - Request for Fair Hearing
    - Procedures
    - Agency cannot interfere or limit in the request for hearing
    - Agency may assist in submitting and processing request
    - Must allow reasonable time to request hearing (not to exceed 90 days from date of notice)
  - Continuation of benefits
    - Agency may recover costs of continued services if agency action is upheld by hearing decisions
  - Decisions
    - recommendations or decisions must be based exclusively on evidence introduced at the hearing.
  - Corrective action if favorable decision for beneficiary

30

Medicaid Enrollee Rights

- Federal Rights
  - Provisions of the Medicaid Act have been determined to be enforceable as individual civil rights under 42 U.S.C. §1983 (Civil Action for Deprivation of Rights).
    - See Gonzaga Univ. v. Doe, 536 U.S. 273 (2002) and Blessing v. Freestone, 520 U.S. 329 (1997).
    - Enrollees be provided medical assistance with reasonable promptness. 42 USC 1396a(a)(8); 42 CFR 435.930(a).
    - Enrollees be provided a fair hearing. 42 USC 1396a(a)(3);
    - That services to children meet the requirements of Early & Periodic Screening, Diagnosis and Treatment (EPSDT). 42 USC 1396a(a)(43)
  - Americans with Disabilities Act 42 USC 12132
    - Olmstead v. LC, 527 U.S. 582 (1999), Supreme Court decision found that unnecessary institutionalization of persons with disabilities was a violation of the Americans with Disabilities Act of 1990.
      - States must provide services in the "most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR 35.130(d)

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Questions?

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October 22, 2025

Trust Me: Ensuring Long-Term Planning Aligns with Medicaid and Managed Care Requirements

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National Conference on Special Needs Planning and Special Needs Trusts
Boot Camp: Understanding and Accessing Long-Term Supports & Services
Wednesday, October 22, 20254 | 11:20 a.m. – 12:10 p.m.

Elizabeth A. Moran, JD
Executive Director
The Arc of Colorado
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720.660.9794

1

Why Alignment *Matters*

Poor alignment can result in:

- ✓Service and support denials
- ✓Unnecessary and sometime dangerous delays
- ✓Financial ineligibility and subsequent instability
- ✓Jeopardizing a client's care and housing stability
- ✓Depletion of financial resources
- ✓Heavy tax consequences when accessing retirement funds

2

Common Legal Problem Areas

- Medicaid Financial Eligibility & Trust Misalignment
- Service Authorization & Medical Necessity Disputes under MCOs
- MLTSS Person-Centered Planning & Case Management Failures
- Appeals, Notices, and Due Process Issues
- Transitions Between Systems or Programs Failures
- Person-Centered Planning Failures

3

What do Managed Care Organizations (MCOs), well… *do?*

- Contract & Administrative Functions
- Care Delivery and Coordination
- Financial & Payment Functions
- Enrollee Services & Rights
- Quality Assurance & Improvement
- Special Roles in LTSS/MLTSS States

Sources: 42 CFR Part 438; CMS Managed Care Guidance; MACPAC Managed Care Overview.

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4

LTSS and MLTSS

- **Managed Long-Term Services and Supports (MLTSS) Goal:** Improve coordination and integrated medical/behavioral, and long-term supports to improve outcomes and fragmentation, expand HCBS options, and support aging in place.
- **States pay MCOs a capitated rate**; MCOs manage authorization, payment, and coordination of LTSS.
- **Operates under federal waiver authority** with CMS oversight.

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5

HCBS are *Optional* Benefits under Medicaid

Challenge	Implication for Planning
HCBS are optional under Medicaid	States may not offer, may limit, or may change HCBS programs at any time.
Waitlists and caps are common	Clients may face delays before receiving in-home services.
Institutional care is mandatory	Nursing home care may be the only immediate Medicaid option.
Legal documents need flexibility	POAs, trusts, and care directives should address both home and facility scenarios.
Financial planning must bridge gaps	Clients may need private funds or insurance to cover interim care.
State-specific policies differ	Attorneys must tailor strategies to *local* Medicaid rules and program availability.

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The Flow of Managed Care Service Delivery

Enrollee → MCO network → referrals/authorization

Utilization review → appeals → external review

Ongoing monitoring & care coordination

7

How Services Are Authorized Under Medicaid Managed Care

- **Assessment and service planning** by care coordinators or case managers employed or contracted by the MCO
- **Prior authorization** review
- **Medical necessity** review
- **Regulated Timeframes** (14 calendar days/72 hours)
- **Approval or denial:** *Who* makes the decision any why its important
- **Service plan implementation**
- **Notice and appeals rights** and **state fair hearing rights** (42 CFR §438.400–438.424)
- **State oversight**

8

Role of Care Coordinators

The Good

- Point of contact for members
- Develop and monitor person-centered plans
- Communicate among client, providers, and MCO
- Advocate for medically necessary services
- Bridge between long-term planning and managed care

The (*perhaps*) Not-so Good

- High caseloads, turnover, training gaps, limited authority, variation by program area
- Shape service plan…also employed by MCO so may face cost-control incentives
- Person-centered planning requirements (42 CFR 441.301)…effective communication services and supports(?)
- Not legal experts

9

Who Makes Decisions & Appeals

- First-level: MCO utilization review staff / medical directors
- Internal reconsideration (appeals) required
- External review options vary by state
- State agency oversight is critical
- Legal recourse through admin/judicial appeals

Source: Medicaid Managed Care Entity Checklist; Medicaid.gov

10

Decision-Making Supports & Person-Centered Planning

WHO makes decisions?

- Client (if competent)
- Legal representative (POA, SDM Team/Agreement, Guardian)
- MCO care coordinators (advocate, gatekeeper)
- State oversight agencies (e.g., fair hearings)

Reminders…

- Supported decision-making and POAs preserve autonomy.
- Guardians/representatives must be recognized by the MCO.
- Federal regulations require person-centered service planning in HCBS waivers.
- Decisions should reflect the individual's will and preference, not just what's expedient.
- Role of care coordinators and legal representatives (e.g., POA, guardian).

042 C.F.R. § 441.301(c)(1) – HCBS person-centered planning requirements

11

Key Requirements for the Person-Centered Service Plan (42 C.F.R. § 441.301(c)(1))

Must be developed through a person-centered planning process that:

(i) Includes people chosen by the individual.
(ii) Provides necessary information and support to the individual to ensure they can direct the process as much as possible.
(iii) Is timely and occurs at times and locations convenient to the individual.
(iv) Reflects cultural considerations and uses plain language.
(v) Includes strategies for resolving disagreements.
(vi) Offers choices about services and supports and who provides them.
(vii) Provides a method for the individual to request updates.
(viii) Includes informed consent and is signed by all responsible parties.
(ix) Ensures that decisions made by the individual are honored and documented.

Additional Key Principles Embedded in § 441.301(c)

- Conflict-free case management
- Review and updates
- Community integration

12

Medicaid Eligibility: Income & Asset Considerations (*generally)*

- Strict limits on income *and* countable assets
- Key Eligibility Thresholds
  - **Asset Limits:** Vary by state, but typically around $2,000 in countable assets for an individual. Certain assets (e.g., primary residence up to a set equity limit, one vehicle, personal belongings) are exempt.
  - **Income Limits:** There are caps for eligibility, which may trigger the use of Miller trusts (Qualified Income Trusts) in some states to qualify.
  - **Lookback Period:** Medicaid reviews asset transfers within a 60-month (5-year) lookback period to detect disqualifying gifts or transfers.

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Special Needs Trusts (SNTs), ABLE Accounts & Medicaid Eligibility

- First-Party SNTs
- Third-Party SNTs.
- Medicaid Asset Protection Trusts (MAPTs)
- ABLE Accounts
- Conflicts Between Trust Distributions & Medicaid Covered Services

14

Real Property & Home Planning

- **Medicaid Home Exemption**
- **Estate Recovery**
- **Life Estates & Deeds**

15

Look Back and Transfer Penalties

Transfers for less than fair market value during the 5-year lookback can result in penalty periods during which the individual is ineligible for Medicaid.

- Track the date and amount of transfers carefully.
- Avoid last-minute gifting, except in structured crisis planning strategies
- Explain implications to clients

16

Spousal Impoverishment Protections

- **Community Spouse Resource Allowance (CSRA):** Allows the spouse to keep a portion of the couple's assets (varies by state, often between ~$30,000 and ~$154,000).
- **Monthly Maintenance Needs Allowance (MMNA):** Allows diversion of some income to the community spouse.
- **Spousal Refusal**: In some states, the community spouse can refuse to contribute to care costs, shifting the obligation to Medicaid (with potential state recovery later).

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POA & Advance Directives

Durable Power of Attorney (DPOA)

- Include gifting powers that are broad enough to execute Medicaid planning strategies (e.g., funding trusts, transferring assets, executing deeds).
- Authorize creation and funding of SNTs or MAPTs.
- Provide authority for long-term care planning decisions, not just financial transactions.

Advance Directive

- Healthcare Power of Attorney (or Proxy)
- Living Will: Specifies your preferences for medical treatments, including:
  - Life-sustaining treatments
  - Comfort care
  - Cardiopulmonary Resuscitation (CPR)
- Instructions for End-of-Life Care:

18

Common Pitfalls

- Failing to update trust usage with evolving managed care policies.
- POAs or trustees authorizing payments inconsistent with MCO-covered services.
- Lack of communication between attorneys, MCOs, and trustees.
- Failure to confirm allowable expenses.
- Assuming all MCOs have the same coverage rules.

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Effective Advocacy That Honors Client's Will and Preference

- **Presume capacity**
- **Elicit the client's preferences early**.
- **Separate will and preference from others' opinions**
- **Provide effective communication and support:**
  - Use plain language and accessible formats
  - Allow extra processing time and repeat key points without rushing the client.
  - Involve interpreters, augmentative and alternative communication tools, or support persons if needed to facilitate understanding.
  - Document communication preferences and use them consistently.
  - Confirm understanding by asking the client to explain decisions in their own words rather than relying on yes/no answers.
- **Use Supported Decision-Making** rather than substituted decisionomaking whenever possible.

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20

Best Practice & Advocacy Strategies

- **Document client preference.** Consider informal tools: Stoplight Tool, Trajectory, SDM Agreements, etc.
- **Early alignment:** Incorporate Medicaid & MLTSS considerations at the planning stage, not after eligibility or service issues arise.
- **Track authorizations & renewals**: MLTSS plans often require frequent reauthorizations; missing these can lead to service gaps.
- **Collaborate with care coordinators:** Build relationships with MCO care managers and state Medicaid contacts.
- **Document *everything*** (and encourage your client to do so, too): Notices, service plans, MCO communications — critical for appeals.
- **Educate clients & families:** Empower them to recognize and respond to improper denials or reductions.
- **Know your state's managed care grievance and appeal processes.**

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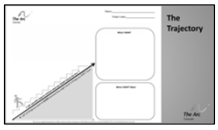
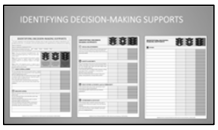
21

Tools: Honoring Client Will & Preference





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Key Takeaways & Best Practices

- Confirm trust distributions complement, *not* duplicate, Medicaid-covered services.
- Build collaborative relationships *early* with:
  - Care coordinators
  - Trust administrators
  - Families & support networks
- Ensure SNTs reflect managed care realities — review language annually.
- Advocate for the client's will and preference within regulatory frameworks and flexibility for managed care changes.
- Train fiduciaries – or provide state specific resources – on how Medicaid and managed care intersect.
- Keep documentation and communication transparent across all teams.
- Escalate when:
  - Services are denied despite medical need.
  - Care plan is not person-centered.

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Additional Resources and References

- Medicaid.gov – https://www.medicaid.gov
- 42 U.S.C. § 1396p – Medicaid Trust Rules
- Social Security POMS – SI 01120.199
- Kaiser Family Foundation – Medicaid MCO Tracker
- National Health Law Program – https://healthlaw.org
- Justice in Aging – https://justiceinaging.org
- *Your* state's Medicaid manual / MCO contracts

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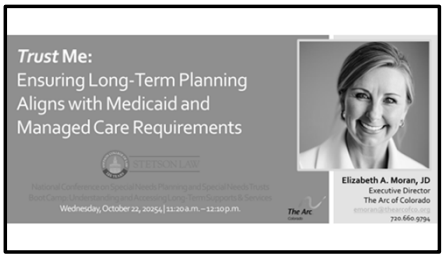
Thank You!



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The Intersection of Long-Term Care and Housing Options

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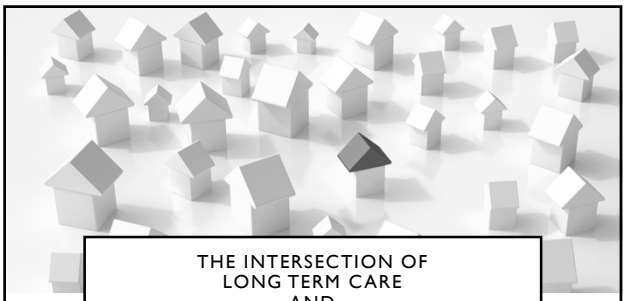

THE INTERSECTION OF LONG TERM CARE AND HOUSING OPTIONS

Roxanne J. Chang, JD, MS LLP

October 22, 2025

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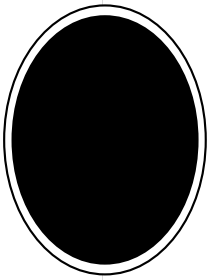
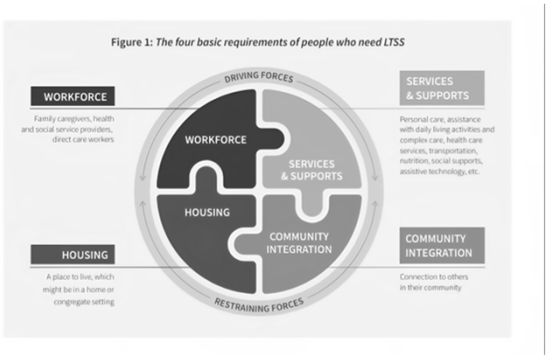


- Unjustified segregation of persons with disabilities constitutes discrimination in violation of the Americans with Disabilities Act (ADA)
- Public entities must provide community-based services to persons with disabilities when
  - (1) such services are appropriate;
  - (2) the affected persons do not oppose community-based treatment; and,
  - (3) community-based services can be reasonably accommodated.

2



Reinhard, Susan. LTSS Choices: A Series on Transforming Long-Term Services & Supports. Washington, DC: AARP Public Policy Institute, December 4, 2020. https://doi.org/10.26419/ppi.00124.001

3

LTC HOUSING OPTIONS

- Independent/Community Based
- Congregate Living (rooms or apartments)
- Assisted Living & Memory Care
- Institutional Care
- Continuing Care Retirement/Life Plan Communities

4

INDEPENDENT/ COMMUNITY-BASED HOUSING

- Living in a relative's home (e.g., parents, siblings)
- Owning and living in one's own home
- Renting property
- Living with roommate(s)
- Services and supports
  - Informal (e.g., family members)
  - Formal supports and services (e.g., Medicaid funded services, paid caregivers/staff)

5

[redacted]

- Generally defined as separate living quarters/rooms with shared spaces and additional supports, such as:
  - Independent Living Communities
  - Group Homes
  - Intergenerational Housing
  - Intentional Communities

6

INDEPENDENT LIVING COMMUNITIES

- Often apartments or stand-alone living quarters
- With communal areas, such as:
  - Dining room
  - Community center
  - Fitness center
- Additional services and supports, such as:
  - Meal prep;
  - Housekeeping;
  - Recreational activity programming
  - Personal care/medication administration services via independent home care agency

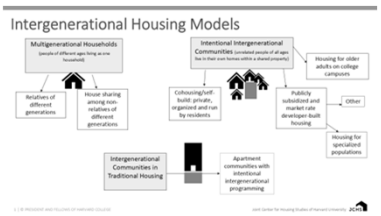
7

GROUP HOMES

- Single family residence
- Residential neighborhood
- Unrelated residents
- 24/7 staff
  - Provide supervision and safety
  - Assist with personal care & housekeeping
  - Provide access to the community
- Target populations (dementia, intellectual disabilities, older adults)
- State-specific licensing requirements

8

[redacted]



9

INTENTIONAL COMMUNITIES FOR PEOPLE WITH DISABILITIES (AKA NEUROINCLUSIVE COHOUSING COMMUNITIES)

Designed to accommodate those with disabilities/neurodivergent but also inclusive for non-disabled/neurotypical residents

Independent living quarters (homes, condos).

Communal space and community building and amenities programming

Services and supports provided within the community along with other external, state funded services and supports.

10

EXAMPLES OF INTENTIONAL COMMUNITIES FOR PEOPLE WITH DISABILITIES/ NEUROINCLUSIVE HOUSING

Sample Communities

- Heartbeet Lifesharing https://heartbeet.org/
- Intentional Communities of Washtenaw County

Additional Resources

- Autism Housing Network: https://www.autismhousingnetwork.org/create/neuro-inclusive-framework/
- Neuroinclusive Housing Solutions https://www.neuroinclusivehousingsolutions.com/
- Neuroinclusivity in Housing https://nihouse.ca/

11

ASSISTED LIVING

Room and board

Assistance with:

- Activities of daily living (ADLs) (e.g, personal hygiene, dressing, bathing)
- Instrumental activities of daily living (IADLs) (e.g., Shopping, transportation)
- Some medical oversight (e.g., medication administration, access to nurse)
- Some supervision
- Therapeutic activities

12

MEMORY CARE

Room and board

- Structural design for people with dementia;
- Secured living quarters

Assistance with:

- Activities of daily living (ADLs)Instrumental activities of daily living (IADLs) (e.g., Shopping, transportation)
- Some medical oversight (e.g., medication administration, access to nurse)
- Therapeutic activities
- By staff trained in dementia care

13

INSTITUTIONAL CARE

- ICF/IDD or ICF/DD
- Nursing Facility

14

ICF/ID

- Intermediate care facilities for people with intellectual disabilities
- Medicaid funded program
- Residential facility licensed by the state
- Aggressive, consistent treatment and rehabilitative health services in a controlled environment
- Level of care criteria established by the state

15

NURSING FACILITIES	• Room and board • Custodial care • 24-hour supervision • Skilled nursing care • Constant medical monitoring

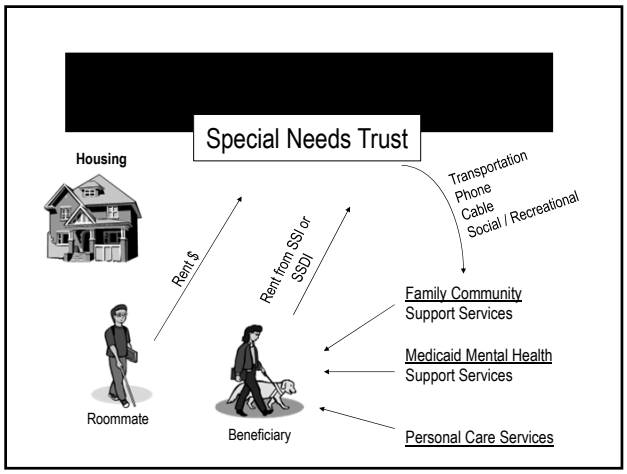
16

CONTINUING CARE RETIREMENT COMMUNITIES	• "Aging in place" • Campus includes all levels of care independent living, assisted living, memory care, skilled nursing

17

PAYING FOR HOUSING	Government benefits (SSI, SSDI) Earnings ABLE Accounts Housing Choice Voucher Program ("Section 8") Special Needs Trusts

18



19

- Least restrictive setting
- Person-centered/directed supports
- Sufficient funding for home and community-based services and supports
- Affordable housing
- Community programming and inclusion

20

STETSON LAW

LTSS Boot Camp

October 22, 2025

Ten Medicaid Regulations You'll Want to Know

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Access and Justice For All®

Ten-*ish* Medicaid Regulations You'll Want to Know

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Littman Krooks LLP

New York

Medicaid is the primary source of funding for long-term care in the United States, yet its rules are often complex, counterintuitive, and ever-changing. For attorneys, advisors, and professionals working with older adults and individuals with disabilities, a solid grasp of key Medicaid regulations is essential to effective planning and advocacy. Importantly, these rules do not exist in isolation, many intersect with other benefits and supports, including Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). This presentation highlights approximately ten regulations governing long-term care supports and services, rules that shape eligibility, asset protection, and benefits. By understanding these regulations, practitioners can better guide their clients through the maze of requirements and help them secure the care and financial protection they need.[1]

20 CFR § 404.350: Who is entitled to child's benefits?

20 CFR § 404.350 outlines the criteria under which an individual may be entitled to child's benefits under Title II of the Social Security Act. In a special needs practice, the most common benefit is the Disabled Adult Child or DAC benefit. These benefits are payable to the child of an insured person who is either entitled to old-age or disability benefits or has died. The regulation specifies several conditions that must be met for entitlement.

[1] This presentation does not cover any regulations related to federal Medicaid waivers as this is provided for in another segment.

To qualify for child's benefits, the applicant must (1) be the insured person's child which includes biological children, adopted children, and in some cases, stepchildren, as defined in §§ 404.355 through 404.359; (2) meet the dependency requirements outlined in §§ 404.360 through 404.365; (3) apply for benefits; (4) be unmarried; and (5) be under age 18, or between ages 18 and 19 and a full-time student, or age 18 or older with a disability that began before age 22.

20 CFR § 416.202: Who may get SSI benefits?

20 CFR § 416.202 outlines the fundamental eligibility criteria for receiving SSI benefits. To qualify, an individual must meet all specified requirements, encompassing age, disability status, residency, citizenship, income, and resource limits. The applicant must be aged 65 or older, blind, or disabled. The individual must also be a resident of the United States and either a U.S. citizen or national, an alien lawfully admitted for permanent residence, an alien permanently residing under color of law, or, in certain cases, the child of U.S. armed forces personnel living overseas. In addition, the applicant's income and resources cannot exceed the established limits.

20 CFR § 416.1202: Deeming of resources

20 CFR § 416.1202 outlines the rules for deeming resources in the SSI program. Deeming refers to the process by which the Social Security Administration (SSA) considers the resources of certain individuals, including spouses and parents, as available to the SSI applicant, potentially affecting their eligibility and benefit amount.

If an SSI applicant is married to someone who is not eligible for SSI benefits and they live in the same household, the SSA counts the value of the ineligible spouse's resources as part of the applicant's resources. This includes money and property, minus certain exclusions.

For children with disabilities under the age of 18 who live with their parents, the SSA generally counts the parents' resources as available to the child. This means that the financial resources of the parents can affect the child's eligibility for SSI benefits. However, there are some limited exceptions to this rule. If the child previously received a reduced SSI benefit while residing in a medical treatment facility, is eligible for medical assistance under a Medicaid State home care plan, and would otherwise be ineligible due to parental deeming, the SSA may not apply the deeming provisions.

20 CFR §§ 416.1802 through 416.18035 (Who is considered your spouse):

These regulations explain how the SSA decides whether someone is considered married for SSI purposes. If SSA determines that a person is married, it affects whether they are treated as part of a couple or as an individual for SSI eligibility and payment amounts. The rules look at both legal marriages and certain living arrangements that SSA treats like a marriage, even if the couple is not legally wed.

The SSA accepts marriages recognized under state law, including common-law marriages where applicable. SSA also has “deemed marriage” rules: if two people present themselves as spouses and live together in the same household, they may be considered married for SSI purposes, even if the marriage isn’t valid under state law.

These regulations also explain how the SSA determines whether someone is the spouse of another person when state law is unclear. For example, if a marriage would have been valid except for a legal technicality, the SSA may still treat the individuals as married. The SSA may also look at other evidence—such as joint tax returns, shared property, or statements from the couple or others—to decide if a marital relationship exists.

If the SSA decides two people are married, they may be required to apply as a couple, and their income and resources are combined for determining eligibility and benefit amounts. This can reduce the SSI payment compared to what each might receive if counted individually, because SSI provides a lower combined rate for couples than for two individuals. The rules also note that marriage can affect whether someone is considered a child for SSI purposes; once someone is married, they are no longer treated as a child when SSA decides eligibility.

20 CFR §§ 416.1130 through 416.1141 (In-Kind Support and Maintenance):

The regulations provided for in 20 CFR §§ 416.1130 through 416.1141 govern how the SSA evaluates in-kind support and maintenance (ISM) for SSI recipients. ISM refers to shelter[2] received for free or at less than fair market value, which the SSA counts as unearned income and may reduce the SSI benefit. These regulations provide detailed guidance on determining the value of ISM.

Section 416.1130 introduces the concept of ISM and explains that both earned and unearned income can include items received in kind. The SSA generally values in-kind items at their current market value. For example, if an SSI recipient's relative paid for their utility bill, the SSA may treat this payment as unearned income.

Section 416.1131 outlines the one-third reduction rule, which applies when an individual lives in another person's household and receives shelter. Instead of valuing each room individually, the SSA counts one-third of the Federal Benefit Rate (FBR) as additional income. For example, if the FBR is $967 per month, $322.33 would be counted as income for ISM

[2] The regulations still provide for food in the definition of ISM. However, effective September 30, 2024, the SSA updated their SSI regulations to remove food from the calculations of ISM. In your materials are the proposed changes to the regulations.

purposes (minus a $20 disregard). This rule simplifies the calculation and provides a standardized method for counting the value of shelter.

Section 416.1132 defines what constitutes living in another person's household. A household is generally the personal residence of one or more individuals who provide support. Living in a commercial establishment, such as a hotel or boarding house, does not automatically constitute living in someone else's household. However, if an individual resides in a boarding house where shelter is provided without direct payment, that arrangement could be considered a household for ISM purposes.

Section 416.1133 explains how to determine a pro rata share of household operating expenses. If an SSI recipient pays a fair portion of household expenses—such as rent, utilities, or groceries—they are considered to be living in their own household, and the one-third reduction rule does not apply. For example, if two individuals share an apartment and one pays half of the rent and utilities, that person is not receiving ISM from the other resident.

Section 416.1140 introduces the presumed value rule, which applies when the one-third reduction rule is not applicable. Under this rule, the SSA assigns a maximum value to shelter received in kind rather than attempting to determine the exact market value. The presumed value is set at one-third of the FBR plus $20, which aligns with the general income exclusion. For example, if the FBR is $967, the maximum presumed value of ISM would be $342.33 ($322.33 + $20) per month, even if the actual cost of the meals or shelter is difficult to calculate.

Section 416.1141 specifies when the presumed value rule applies for determining in-kind support and maintenance (ISM) for SSI recipients. This rule is used when the one-third reduction rule does not apply, and it establishes a maximum presumed value for ISM, which is one-third of the Federal Benefit Rate (FBR) plus $20.

The presumed value rule applies when an individual receives ISM and is living in their own household or in a household where not all members receive public assistance. In such cases, the SSA presumes a maximum value for the ISM received. However, if the individual can demonstrate that the actual value of the ISM is less than the presumed value, the SSA will use the actual value to determine the unearned income.

In contrast, if the individual lives in a public assistance household, where all members receive public assistance, the presumed value rule does not apply. In this situation, the SSA considers that the individual is not receiving ISM from members of the household, and thus, the presumed value rule is not used. This distinction ensures that individuals in public assistance households are not unfairly penalized by ISM calculations.

20 CFR § 416.1212 (Exclusion of the Home):

20 CFR § 416.1212 establishes the rules governing the treatment of a home under the SSI program. It defines what property qualifies as a "home" and provides criteria for when the home is excluded from SSI resource calculations, as well as circumstances under which it may become a countable resource. Under the regulation, a home is any property in which the individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This includes the dwelling itself, the land on which it is situated, and related outbuildings. The regulation recognizes the home as the individual's primary living space, distinguishing it from other property or assets.

The home is excluded from SSI resource calculations regardless of its value[3], provided it is the individual's principal place of residence. However, if there are income-producing structures or property on the same land that do not qualify under the home exclusion, those portions may be considered countable resources.

If the individual no longer resides in the home or moves without intent to return. In such circumstances, the home ceases to be the individual's principal place of residence and becomes a countable resource. If the individual sells the home and reinvests the proceeds into a new home within three months, the new home may be excluded from resources, provided it qualifies as the principal place of residence and meets the regulatory requirements. This three-month reinvestment period allows for a transition while maintaining the home exclusion, preventing temporary disqualification from SSI due to the sale and replacement of the primary residence.

20 CFR § 416.1231 (Burial Spaces and Certain Funds Set Aside for Burial Expenses):

20 CFR § 416.1231 specifies how certain burial-related resources are treated under the SSI program. It establishes exclusions for burial spaces and funds specifically designated for burial expenses, provided certain conditions are met.

Under this regulation, one burial space per individual is excluded from SSI resource calculations. This exclusion applies to burial plots, crypts, mausoleums, urns, and related items necessary for the burial of the individual or their immediate family members. Immediate family includes the individual's spouse, children, and parents. The exclusion is not limited by the value of the burial space and is not subject to the $2,000 individual or $3,000 couple resource limit.

[3] Under The One Big Beautiful Bill Act (P.L. 119-21), signed into law on July 4, 2025 it establishes a $1 Million ceiling, regardless of inflation for home equity values for enrollees who qualify for Medicaid to receive long-term supports and services.

SSI also excludes up to $1,500 per person in funds set aside for burial expenses. These funds must be clearly designated for burial purposes and kept separate from other resources. Acceptable forms of burial funds include revocable burial contracts, burial trusts, and other financial instruments with a definite cash value. If these funds are commingled with non-burial resources, the exclusion does not apply to any portion of the funds.

Funds placed in irrevocable burial arrangements are excluded from resources without a dollar limit provided they are in an irrevocable trust or arrangement. An irrevocable arrangement means that the funds cannot be refunded or used for any purpose other than burial expenses.

If excluded burial funds are used for purposes other than the burial arrangements of the individual or their spouse, future SSI benefits may be reduced. The reduction is equal to the amount of excluded burial funds used for other purposes. This penalty applies only if, at the time of use, the individual would have had resources exceeding the SSI resource limit without the burial fund exclusion.

20 CFR § 1.529A-0 through 20 CFR § 1.529A-8 (Qualified ABLE Programs):

These regulations establish the rules for Qualified ABLE Programs, which allow individuals with disabilities to create tax-advantaged savings accounts, known as ABLE accounts. These accounts are designed to help eligible individuals save for expenses related to their disability while protecting their eligibility for means-tested federal programs such as Medicaid and SSI. The regulations provide detailed guidance on eligibility, contributions, distributions, and program administration, ensuring both the integrity of the program and the protection of beneficiaries.

To open an ABLE account, the designated beneficiary must meet specific eligibility criteria. The individual must have a significant disability that occurred before the age of 26[4] and is expected to last at least 12 months or result in death. The ABLE program must verify eligibility at the time the account is established and may require periodic recertification.

The regulations define several terms. The "designated beneficiary" is the individual for whom the account is established. "Qualified disability expenses" (QDEs) are costs incurred to maintain health, independence, and quality of life, including education, housing, transportation, employment training, assistive technology, health care, financial management, legal fees, and funeral or burial expenses. For instance, a beneficiary could use ABLE funds to pay for specialized computer software to facilitate remote work or for occupational therapy sessions.

Contributions to ABLE accounts may be made by the designated beneficiary, family members, friends, or other third parties. Contributions are subject to both annual limits (currently $19,000) and aggregate limits tied to the state's 529 college savings plan maximum. Contributions are treated as gifts for federal tax purposes and may be subject to gift tax rules.

The regulations also clarify how ABLE accounts interact with other federal programs. Balances in an ABLE account are generally disregarded for SSI and Medicaid eligibility. However, if an account balance exceeds $100,000, SSI benefits may be suspended until the balance drops below the limit.

Distributions from ABLE accounts are tax-free if used for QDEs. If funds are used for non-QDEs, the earnings portion of the distribution is subject to federal income tax and may incur

[4] On January 1, 2026 individuals whose disability was diagnosed before age 46 will be eligible for ABLE accounts allowing millions of more people to qualify. *See* https://www.congress.gov/bill/117th-congress/senate-bill/331

an additional penalty tax. For instance, if a beneficiary used ABLE funds to purchase a vacation unrelated to their disability, the earnings portion of that distribution would be taxable, and a 10% penalty could apply. The regulations provide rules to calculate the earnings portion and tax consequences for non-qualified distributions.

Upon the death of the designated beneficiary, remaining ABLE funds may be used to reimburse the state for Medicaid benefits provided to the individual, after payment of funeral and burial costs and any remaining QDEs. Any remaining funds may then be distributed to the beneficiary's estate or a successor beneficiary, provided the beneficiary is a sibling or stepsibling.

42 CFR § 433.36 (Liens and Recoveries):

42 CFR § 433.36 provides states the authority to place liens on a Medicaid recipient's property or to recover funds from their estate in order to recoup the cost of the Medicaid services provided. The rationale is to ensure that Medicaid dollars are used appropriately and that the state can be reimbursed when assets are available.

Liens may be imposed in two main situations. First, if Medicaid payments were made in error or obtained improperly, the state can place a lien to recover those funds. Second, when payments were correctly made, a lien may be placed on the real property of an institutionalized person who is not reasonably expected to return home. Before doing so, however, the state must provide notice and hearing rights to protect the recipient's due process.

The regulation places limitations on when a lien may be placed against a Medicaid recipient's home. In order to protect certain family members, the liens are not permitted if certain

relatives are still residing in the home. These include a spouse, a child under the age of 21, or a child who is blind or disabled, regardless of age. In addition, a lien cannot be placed if the recipient's sibling has an equity interest in the home and is living in the home for a period of a least one year immediately before the Medicaid recipient was institutionalized.

The regulation further requires that liens be removed if circumstances change and the Medicaid recipient is able to return home.

Estate recovery is also addressed in this regulation. States may recover costs for Medicaid services from the estate of a deceased recipient, but recovery is generally delayed until the death of a surviving spouse, or unless there are no surviving minor, blind, or disabled children. States may also enforce liens by recovering from the sale of property after the recipient's death, again subject to these protections.

A lien is also barred if the recipient's son or daughter has resided in the home for at least two years prior to institutionalization, has lived there continuously since that date, and can demonstrate to the state agency that he or she provided care that enabled the individual to remain at home rather than entering an institution.

Finally, recovery cannot be made by reducing or withholding payments from other benefit programs, such as Social Security, SSI, or SSDI. In other words, Medicaid recovery efforts must be limited to property interests and estates, not to ongoing federal benefit payments.

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 404 —Federal Old-Age, Survivors and Disability Insurance (1950-)
Subpart D —Old-Age, Disability, Dependents' and Survivors' Insurance Benefits; Period of Disability

Authority: Secs. 202, 203(a) and (b), 205(a), 216, 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 403(a) and (b), 405(a), 416, 423, 425, and 902(a)(5)).

Source: 44 FR 34481, June 15, 1979, unless otherwise noted.

Child's Benefits

CHILD'S BENEFITS

§ 404.350 Who is entitled to child's benefits?

(a) ***General.*** You are entitled to child's benefits on the earnings record of an insured person who is entitled to old-age or disability benefits or who has died if—

(1) You are the insured person's child, based upon a relationship described in §§ 404.355 through 404.359;

(2) You are dependent on the insured, as defined in §§ 404.360 through 404.365;

(3) You apply;

(4) You are unmarried; and

(5) You are under age 18; you are 18 years old or older and have a disability that began before you became 22 years old; or you are 18 years or older and qualify for benefits as a full-time student as described in § 404.367.

(b) ***Entitlement preclusion for certain disabled children.*** If you are a disabled child as referred to in paragraph (a)(5) of this section, and your disability was based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535) and your benefits ended after your receipt of 36 months of benefits, you will not be entitled to benefits based on disability for any month following such 36 months regardless of the number of entitlement periods you have had if, in such following months, drug addiction or alcoholism is a contributing factor material to the later determination of disability (as described in § 404.1535).

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 60 FR 8146, Feb. 10, 1995; 61 FR 38363, July 24, 1996]

§ 404.351 Who may be reentitled to child's benefits?

If your entitlement to child's benefits has ended, you may be reentitled on the same earnings record if you have not married and if you apply for reentitlement. Your reentitlement may begin with—

(a) The first month in which you qualify as a full-time student. (See § 404.367.)

(b) The first month in which you are disabled, if your disability began before you became 22 years old.

(c) The first month you are under a disability that began before the end of the 84th month following the month in which your benefits had ended because an earlier disability had ended; or

(d) With respect to benefits payable for months beginning October 2004, you can be reentitled to childhood disability benefits at anytime if your prior entitlement terminated because you ceased to be under a disability due to the performance of substantial gainful activity and you meet the other requirements for reentitlement. The 84-month time limit in paragraph (c) in this section continues to apply if your previous entitlement to childhood disability benefits terminated because of medical improvement.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 61 FR 38363, July 24, 1996; 71 FR 66865, Nov. 17, 2006]

§ 404.352 When does my entitlement to child's benefits begin and end?

(a) We will find your entitlement to child's benefits begins at the following times:

(1) If the insured is deceased, with the first month covered by your application in which you meet all other requirements for entitlement.

(2) If the insured is living and your first month of entitlement is September 1981 or later, with the first month covered by your application throughout which you meet all other requirements for entitlement.

(3) If the insured is living and your first month of entitlement is before September 1981, with the first month covered by your application in which you meet all other requirements for entitlement.

(b) We will find your entitlement to child's benefits ends at the earliest of the following times:

(1) With the month before the month in which you become 18 years old, if you are not disabled or a full-time student.

(2) With the second month following the month in which your disability ends, if you become 18 years old and you are disabled. If your disability ends on or after December 1, 1980, your entitlement to child's benefits continues, subject to the provisions of paragraphs (c) and (d) of this section, until the month before your termination month (§ 404.325).

(3) With the last month you are a full-time student or, if earlier, with the month before the month you become age 19, if you become 18 years old and you qualify as a full-time student who is not disabled. If you become age 19 in a month in which you have not completed the requirements for, or received, a diploma or equivalent certificate from an elementary or secondary school and you are required to enroll for each quarter or semester, we will find your entitlement ended with the month in which the quarter or semester in which you are enrolled ends. If the school you are attending does not have a quarter or semester system which requires reenrollment, we will find your entitlement to benefits ended with the month you complete the course or, if earlier, the first day of the third month following the month in which you become 19 years old.

(4) With the month before the month you marry. We will not find your benefits ended, however, if you are age 18 or older, disabled, and you marry a person entitled to child's benefits based on disability or person entitled to old-age, divorced wife's, divorced husband's, widow's, widower's, mother's, father's, parent's, or disability benefits.

(5) With the month before the month the insured's entitlement to old-age or disability benefits ends for a reason other than death or the attainment of full retirement age (as defined in § 404.409). Exception: We will continue your benefits if the insured person was entitled to disability benefits based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of his or her disability (as described in § 404.1535), the insured person's benefits ended after 36 months of payment (see § 404.316(e)) or 12 consecutive months of suspension for noncompliance with treatment (see § 404.316(f)), and the insured person remains disabled.

(6) With the month before the month you die.

(7) With the month in which the divorce between your parent (including an adoptive parent) and the insured stepparent becomes final if you are entitled to benefits as a stepchild and the marriage between your parent (including an adoptive parent) and the insured stepparent ends in divorce.

(c) If you are entitled to benefits as a disabled child age 18 or over and your disability is based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535), we will find your entitlement to benefits ended under the following conditions:

(1) If your benefits have been suspended for a period of 12 consecutive months for failure to comply with treatment, with the month following the 12 months unless you are otherwise disabled without regard to drug addiction or alcoholism (see § 404.470(c)).

(2) If you have received 36 months of benefits on that basis when treatment is available, regardless of the number of entitlement periods you may have had, with the month following such 36-month payment period unless you are otherwise disabled without regard to drug addiction or alcoholism.

(d)

(1) Your benefits may be continued after your impairment is no longer disabling if—

(i) You are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services, as described in § 404.327(a) and (b);

(ii) You began participating in the program before the date your disability ended; and

(iii) We have determined under § 404.328 that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls.

(2) We generally will stop your benefits with the earliest of these months—

(i) The month in which you complete the program; or

(ii) The month in which you stop participating in the program for any reason (see § 404.327(b) for what we mean by "participating" in the program); or

(iii) The month in which we determine under § 404.328 that your continuing participation in the program will no longer increase the likelihood that you will not have to return to the disability benefit rolls.

Exception to paragraph (d) : In no case will we stop your benefits with a month earlier than the second month after the month your disability ends, provided that you meet all other requirements for entitlement to and payment of benefits through such month.

(e) If, after November 1980, you have a disabling impairment (§ 404.1511), we will pay you benefits for all months in which you do not do substantial gainful activity during the reentitlement period (§ 404.1592a) following the end of your trial work period (§ 404.1592). If you are unable to do substantial gainful activity in the first month following the reentitlement period, we will pay you benefits until you are able to do substantial gainful activity. (Earnings during your trial work period do not affect the payment of your benefits during that period.) We will also pay you benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity during those succeeding months. After those three months, we cannot pay you benefits for any months in which you do substantial gainful activity.

[68 FR 4707, Jan. 30, 2003, as amended at 70 FR 36506, June 24, 2005; 75 FR 52621, Aug. 27, 2010]

§ 404.353 Child's benefit amounts.

(a) ***General.*** Your child's monthly benefit is equal to one-half of the insured person's primary insurance amount if he or she is alive and three-fourths of the primary insurance amount if he or she has died. The amount of your monthly benefit may change as explained in § 404.304.

(b) ***Entitlement to more than one benefit.*** If you are entitled to a child's benefit on more than one person's earnings record, you will ordinarily receive only the benefit payable on the record with the highest primary insurance amount. If your benefit before any reduction would be larger on an earnings record with a lower primary insurance amount and no other person entitled to benefits on any earnings record would receive a smaller benefit as a result of your receiving benefits on the record with the lower primary insurance

amount, you will receive benefits on that record. See § 404.407(d) for a further explanation. If you are entitled to a child's benefit and to other dependent's or survivor's benefits, you can receive only the highest of the benefits.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 48 FR 21928, May 16, 1983; 51 FR 12606, Apr. 14, 1986; 61 FR 38363, July 24, 1996]

§ 404.354 Your relationship to the insured.

You may be related to the insured person in one of several ways and be entitled to benefits as his or her child, *i.e.*, as a natural child, legally adopted child, stepchild, grandchild, stepgrandchild, or equitably adopted child. For details on how we determine your relationship to the insured person, see §§ 404.355 through 404.359.

[63 FR 57593, Oct. 28, 1998]

§ 404.355 Who is the insured's natural child?

(a) ***Eligibility as a natural child.*** You may be eligible for benefits as the insured's natural child if any of the following conditions is met:

(1) You could inherit the insured's personal property as his or her natural child under State inheritance laws, as described in paragraph (b) of this section.

(2) You are the insured's natural child and the insured and your mother or father went through a ceremony which would have resulted in a valid marriage between them except for a "legal impediment" as described in § 404.346(a).

(3) You are the insured's natural child and your mother or father has not married the insured, but the insured has either acknowledged in writing that you are his or her child, been decreed by a court to be your father or mother, or been ordered by a court to contribute to your support because you are his or her child. If the insured is deceased, the acknowledgment, court decree, or court order must have been made or issued before his or her death. To determine whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a), the written acknowledgment, court decree, or court order will be considered to have occurred on the first day of the month in which it actually occurred.

(4) Your mother or father has not married the insured but you have evidence other than the evidence described in paragraph (a)(3) of this section to show that the insured is your natural father or mother. Additionally, you must have evidence to show that the insured was either living with you or contributing to your support at the time you applied for benefits. If the insured is not alive at the time of your application, you must have evidence to show that the insured was either living with you or contributing to your support when he or she died. See § 404.366 for an explanation of the terms "living with" and "contributions for support."

(b) ***Use of State Laws*** —

(1) ***General.*** To decide whether you have inheritance rights as the natural child of the insured, we use the law on inheritance rights that the State courts would use to decide whether you could inherit a child's share of the insured's personal property if the insured were to die without leaving a will. If the insured is living, we look to the laws of the State where the insured has his or her permanent home when you apply for benefits. If the insured is deceased, we look to the laws of the State where the insured had

his or her permanent home when he or she died. If the insured's permanent home is not or was not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, we will look to the laws of the District of Columbia. For a definition of permanent home, see § 404.303. For a further discussion of the State laws we use to determine whether you qualify as the insured's natural child, see paragraphs (b)(3) and (b)(4) of this section. If these laws would permit you to inherit the insured's personal property as his or her child, we will consider you the child of the insured.

(2) ***Standards.*** We will not apply any State inheritance law requirement that an action to establish paternity must be taken within a specified period of time measured from the worker's death or the child's birth, or that an action to establish paternity must have been started or completed before the worker's death. If applicable State inheritance law requires a court determination of paternity, we will not require that you obtain such a determination but will decide your paternity by using the standard of proof that the State court would use as the basis for a determination of paternity.

(3) ***Insured is living.*** If the insured is living, we apply the law of the State where the insured has his or her permanent home when you file your application for benefits. We apply the version of State law in effect when we make our final decision on your application for benefits. If you do not qualify as a child of the insured under that version of State law, we look at all versions of State law that were in effect from the first month for which you could be entitled to benefits up until the time of our final decision and apply the version of State law that is most beneficial to you.

(4) ***Insured is deceased.*** If the insured is deceased, we apply the law of the State where the insured had his or her permanent home when he or she died. We apply the version of State law in effect when we make our final decision on your application for benefits. If you do not qualify as a child of the insured under that version of State law, we will apply the version of State law that was in effect at the time the insured died, or any version of State law in effect from the first month for which you could be entitled to benefits up until our final decision on your application. We will apply whichever version is most beneficial to you. We use the following rules to determine the law in effect as of the date of death:

(i) If a State inheritance law enacted after the insured's death indicates that the law would be retroactive to the time of death, we will apply that law; or

(ii) If the inheritance law in effect at the time of the insured's death was later declared unconstitutional, we will apply the State law which superseded the unconstitutional law.

[63 FR 57593, Oct. 28, 1998]

§ 404.356 Who is the insured's legally adopted child?

You may be eligible for benefits as the insured's child if you were legally adopted by the insured. If you were legally adopted after the insured's death by his or her surviving spouse you may also be considered the insured's legally adopted child. We apply the adoption laws of the State or foreign country where the adoption took place, not the State inheritance laws described in § 404.355, to determine whether you are the insured's legally adopted child.

[44 FR 34481, June 15, 1979, as amended at 63 FR 57594, Oct. 28, 1998]

§ 404.357 Who is the insured's stepchild?

You may be eligible for benefits as the insured's stepchild if, after your birth, your natural or adopting parent married the insured. You also may be eligible as a stepchild if you were conceived prior to the marriage of your natural parent to the insured but were born after the marriage and the insured is not your natural parent. The marriage between the insured and your parent must be a valid marriage under State law or a marriage which would be valid except for a *legal impediment* described in § 404.346(a). If the insured is alive when you apply, you must have been his or her stepchild for at least 1 year immediately preceding the day you apply. For purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), you will be considered to meet the one year duration requirement throughout the month in which the anniversary of the marriage occurs. If the insured is not alive when you apply, you must have been his or her stepchild for at least 9 months immediately preceding the day the insured died. This 9-month requirement will not have to be met if the marriage between the insured and your parent lasted less than 9 months under one of the conditions described in § 404.335(a)(2)(i)-(iii).

[48 FR 21928, May 16, 1983, as amended at 64 FR 14608, Mar. 26, 1999; 70 FR 61365, Oct. 24, 2005]

§ 404.358 Who is the insured's grandchild or stepgrandchild?

(a) ***Grandchild and stepgrandchild defined.*** You may be eligible for benefits as the insured's grandchild or stepgrandchild if you are the natural child, adopted child, or stepchild of a person who is the insured's child as defined in §§ 404.355 through 404.357, or § 404.359. Additionally, for you to be eligible as a grandchild or stepgrandchild, your natural or adoptive parents must have been either deceased or under a disability, as defined in § 404.1501(a), at the time your grandparent or stepgrandparent became entitled to old-age or disability benefits or died; or if your grandparent or stepgrandparent had a period of disability that continued until he or she became entitled to benefits or died, at the time the period of disability began. If your parent is deceased, for purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), your parent will be considered to be deceased as of the first day of the month of death.

(b) ***Legally adopted grandchild or stepgrandchild.*** If you are the insured's grandchild or stepgrandchild and you are legally adopted by the insured or by the insured's surviving spouse after his or her death, you are considered an adopted child and the dependency requirements of § 404.362 must be met.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21928, May 16, 1983]

§ 404.359 Who is the insured's equitably adopted child?

You may be eligible for benefits as an equitably adopted child if the insured had agreed to adopt you as his or her child but the adoption did not occur. The agreement to adopt you must be one that would be recognized under State law so that you would be able to inherit a child's share of the insured's personal property if he or she were to die without leaving a will. The agreement must be in whatever form, and you must meet whatever requirements for performance under the agreement, that State law directs. If you apply for child's benefits after the insured's death, the law of the State where the insured had his or her permanent home at the time of his or her death will be followed. If you apply for child's benefits during the insured's life, the law of the State where the insured has his or her permanent home at the time or your application will be followed.

§ 404.360 When a child is dependent upon the insured person.

One of the requirements for entitlement to child's benefits is that you be dependent upon the insured. The evidence you need to prove your dependency is determined by how you are related to the insured. To prove your dependency you may be asked to show that at a specific time you lived with the insured, that you received contributions for your support from the insured, or that the insured provided at least one-half of your support. These dependency requirements, and the time at which they must be met, are explained in §§ 404.361 through 404.365. The terms *living with, contributions for support,* and *one-half support* are defined in § 404.366.

§ 404.361 When a natural child is dependent.

(a) ***Dependency of natural child.*** If you are the insured's natural child, as defined in § 404.355, you are considered dependent upon him or her, except as stated in paragraph (b) of this section.

(b) ***Dependency of natural child legally adopted by someone other than the insured.***

(1) Except as indicated in paragraph (b)(2) of this section, if you are legally adopted by someone other than the insured (your natural parent) during the insured's lifetime, you are considered dependent upon the insured only if the insured was either living with you or contributing to your support at one of the following times:

(i) When you applied;

(ii) When the insured died; or

(iii) If the insured had a period of disability that lasted until he or she became entitled to disability or old-age benefits or died, at the beginning of the period of disability or at the time he or she became entitled to disability or old-age benefits.

(2) You are considered dependent upon the insured (your natural parent) if:

(i) You were adopted by someone other than the insured after you applied for child's benefits; or

(ii) The insured had a period of disability that lasted until he or she became entitled to old-age or disability benefits or died, and you are adopted by someone other than the insured after the beginning of that period of disability.

[64 FR 14608, Mar. 26, 1999]

§ 404.362 When a legally adopted child is dependent.

(a) ***General.*** If you were legally adopted by the insured before he or she became entitled to old-age or disability benefits, you are considered dependent upon him or her. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits during the life of the insured, you must meet the dependency requirements stated in paragraph (b) of this section. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits after the death of the insured, you are considered dependent upon him or her. If you were adopted after the insured's death by his or her surviving spouse, you may be considered dependent upon the insured only under the conditions described in paragraph (c) of this section.

(b) ***Adoption by the insured after he or she became entitled to benefits*** —

(1) ***General.*** If you are legally adopted by the insured after he or she became entitled to benefits and you are not the insured's natural child or stepchild, you are considered dependent on the insured during his or her lifetime only if—

(i) You had not attained age 18 when adoption proceedings were started, and your adoption was issued by a court of competent jurisdiction within the United States; or

(ii) You had attained age 18 before adoption proceedings were started; your adoption was issued by a court of competent jurisdiction within the United States; and you were living with or receiving at least one-half of your support from the insured for the year immediately preceding the month in which your adoption was issued.

(2) ***Natural child and stepchild.*** If you were legally adopted by the insured after he or she became entitled to benefits and you are the insured's natural child or stepchild, you are considered dependent upon the insured.

(c) ***Adoption by the insured's surviving spouse*** —

(1) ***General.*** If you are legally adopted by the insured's surviving spouse after the insured's death, you are considered dependent upon the insured as of the date of his or her death if—

(i) You were either living with or receiving at least one-half of your support from the insured at the time of his or her death; and,

(ii) The insured had started adoption proceedings before he or she died; or if the insured had not started the adoption proceedings before he or she died, his or her surviving spouse began and completed the adoption within 2 years of the insured's death.

(2) ***Grandchild or stepgrandchild adopted by the insured's surviving spouse.*** If you are the grandchild or stepgrandchild of the insured and any time after the death of the insured you are legally adopted by the insured's surviving spouse, you are considered the dependent child of the insured as of the date of his or her death if—

(i) Your adoption took place in the United States;

(ii) At the time of the insured's death, your natural, adopting or stepparent was not living in the insured's household and making regular contributions toward your support; and

(iii) You meet the dependency requirements stated in § 404.364.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 56 FR 24000, May 28, 1991; 57 FR 3938, Feb. 3, 1992]

§ 404.363 When is a stepchild dependent?

If you are the insured's stepchild, as defined in § 404.357, we consider you dependent on him or her if you were receiving at least one-half of your support from him or her at one of these times—

(a) When you applied;

(b) When the insured died; or

(c) If the insured had a period of disability that lasted until his or her death or entitlement to disability or old-age benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

[44 FR 34481, June 15, 1979, as amended at 75 FR 52621, Aug. 27, 2010]

§ 404.364 When is a grandchild or stepgrandchild dependent?

If you are the insured's grandchild or stepgrandchild, as defined in § 404.358(a), you are considered dependent upon the insured if—

(a) You began living with the insured before you became 18 years old; and

(b) You were living with the insured in the United States and receiving at least one-half of your support from him or her for the year before he or she became entitled to old-age or disability benefits or died; or if the insured had a period of disability that lasted until he or she became entitled to benefits or died, for the year immediately before the month in which the period of disability began. If you were born during the 1-year period, the insured must have lived with you and provided at least one-half of your support for *substantially all* of the period that begins on the date of your birth. Paragraph (c) of this section explains when the *substantially all* requirement is met.

(c) The "substantially all" requirement will be met if, at one of the times described in paragraph (b) of this section, the insured was living with you and providing at least one-half of your support, and any period during which he or she was not living with you and providing one-half of your support did not exceed the lesser of 3 months or one-half of the period beginning with the month of your birth.

[44 FR 34481, June 15, 1979, as amended at 73 FR 40967, July 17, 2008]

§ 404.365 When an equitably adopted child is dependent.

If you are the insured's equitably adopted child, as defined in § 404.359, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at the time of his or her death. If your equitable adoption is found to have occurred after the insured became entitled to old-age or disability benefits, your dependency cannot be established during the insured's life. If your equitable adoption is found to have occurred before the insured became entitled to old-age or disability benefits, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at one of these times—

(a) When you applied; or

(b) If the insured had a period of disability that lasted until he or she became entitled to old-age or disability benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

§ 404.366 "Contributions for support," "one-half support," and "living with" the insured defined—determining first month of entitlement.

To be eligible for child's or parent's benefits, and in certain Government pension offset cases, you must be dependent upon the insured person at a particular time or be assumed dependent upon him or her. What it means to be a dependent child is explained in §§ 404.360 through 404.365; what it means to be a dependent parent is explained in § 404.370(f); and the Government pension offset is explained in § 404.408a. Your dependency upon the insured person may be based upon whether at a specified time you were receiving *contributions for your support* or *one-half of your support* from the insured person, or whether you were *living with* him or her. These terms are defined in paragraphs (a) through (c) of this section.

(a) ***Contributions for support.*** The insured makes a contribution for your support if the following conditions are met:

(1) The insured gives some of his or her own cash or goods to help support you. Support includes food, shelter, routine medical care, and other ordinary and customary items needed for your maintenance. The value of any goods the insured contributes is the same as the cost of the goods when he or she gave them for your support. If the insured provides services for you that would otherwise have to be paid for, the cash value of his or her services may be considered a contribution for your support. An example of this would be work the insured does to repair your home. The insured person is making a contribution for your support if you receive an allotment, allowance, or benefit based upon his or her military pay, veterans' pension or compensation, or social security earnings.

(2) Contributions must be made regularly and must be large enough to meet an important part of your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. If the insured person only provides gifts or donations once in a while for special purposes, they will not be considered contributions for your support. Although the insured's contributions must be made on a regular basis, temporary interruptions caused by circumstances beyond the insured person's control, such as illness or unemployment, will be disregarded unless during this interruption someone else takes over responsibility for supporting you on a permanent basis.

(b) ***One-half support.*** The insured person provides one-half of your support if he or she makes regular contributions for your ordinary living costs; the amount of these contributions equals or exceeds one-half of your ordinary living costs; and any income (from sources other than the insured person) you have available for support purposes is one-half or less of your ordinary living costs. We will consider any income which is available to you for your support whether or not that income is actually used for your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. A contribution may be in cash, goods, or services. The insured is not providing at least one-half of your support unless he or she has done so for a reasonable period of time. Ordinarily we consider a reasonable period to be the 12-month period immediately preceding the time when the one-half support requirement must be met under the rules in §§ 404.362(c)(1) and 404.363 (for child's benefits), in § 404.370(f) (for parent's benefits) and in § 404.408a(c) (for benefits where the Government pension offset may be applied). A shorter period will be considered reasonable under the following circumstances:

(1) At some point within the 12-month period, the insured either begins or stops providing at least one-half of your support on a permanent basis and this is a change in the way you had been supported up to then. In these circumstances, the time from the change up to the end of the 12-month period will be considered a reasonable period, unless paragraph (b)(2) of this section applies. The change in your source of support must be permanent and not temporary. Changes caused by seasonal employment or customary visits to the insured's home are considered temporary.

(2) The insured provided one-half or more of your support for at least 3 months of the 12-month period, but was forced to stop or reduce contributions because of circumstances beyond his or her control, such as illness or unemployment, and no one else took over the responsibility for providing at least one-half of your support on a permanent basis. Any support you received from a public assistance program is not considered as a taking over of responsibility for your support by someone else. Under these circumstances, a reasonable period is that part of the 12-month period before the insured was forced to reduce or stop providing at least one-half of your support.

(c) ***"Living with" the insured.*** You are living with the insured if you ordinarily live in the same home with the insured and he or she is exercising, or has the right to exercise, parental control and authority over your activities. You are living with the insured during temporary separations if you and the insured expect to live together in the same place after the separation. Temporary separations may include the insured's absence because of active military service or imprisonment if he or she still exercises parental control and authority. However, you are not considered to be living with the insured if you are in active military service or in prison. If *living with* is used to establish dependency for your eligibility to child's benefits and the date your application is filed is used for establishing the point for determining dependency, you must have been living with the insured throughout the month your application is filed in order to be entitled to benefits for that month.

(d) ***Determining first month of entitlement.*** In evaluating whether dependency is established under paragraph (a), (b), or (c) of this section, for purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), we will not use the temporary separation or temporary interruption rules.

[44 FR 34481, June 15, 1979, as amended at 45 FR 65540, Oct. 3, 1980; 48 FR 21928, May 16, 1983; 52 FR 26955, July 17, 1987; 64 FR 14608, Mar. 26, 1999]

§ 404.367 When you are a "full-time elementary or secondary school student".

You may be eligible for child's benefits if you are a full-time elementary or secondary school student. For the purposes of determining whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a)(2)(i), if you are entitled as a student on the basis of attendance at an elementary or secondary school, you will be considered to be in full-time attendance for a month during any part of which you are in full-time attendance. You are a full-time elementary or secondary school student if you meet all the following conditions:

(a) You attend a school which provides elementary or secondary education as determined under the law of the State or other jurisdiction in which it is located. Participation in the following programs also meets the requirements of this paragraph:

(1) You are instructed in elementary or secondary education at home in accordance with a home school law of the State or other jurisdiction in which you reside; or

(2) You are in an independent study elementary or secondary education program in accordance with the law of the State or other jurisdiction in which you reside which is administered by the local school or school district/jurisdiction.

(b) You are in full-time attendance in a day or evening noncorrespondence course of at least 13 weeks duration and you are carrying a subject load which is considered full-time for day students under the institution's standards and practices. If you are in a home schooling program as described in paragraph (a)(1) of this section, you must be carrying a subject load which is considered full-time for day students under standards and practices set by the State or other jurisdiction in which you reside;

(c) To be considered in full-time attendance, your scheduled attendance must be at the rate of at least 20 hours per week unless one of the exceptions in paragraphs (c) (1) and (2) of this section applies. If you are in an independent study program as described in paragraph (a)(2) of this section, your number of

hours spent in school attendance are determined by combining the number of hours of attendance at a school facility with the agreed upon number of hours spent in independent study. You may still be considered in full-time attendance if your scheduled rate of attendance is below 20 hours per week if we find that:

(1) The school attended does not schedule at least 20 hours per week and going to that particular school is your only reasonable alternative; or

(2) Your medical condition prevents you from having scheduled attendance of at least 20 hours per week. To prove that your medical condition prevents you from scheduling 20 hours per week, we may request that you provide appropriate medical evidence or a statement from the school.

(d) You are not being paid while attending the school by an employer who has requested or required that you attend the school;

(e) You are in grade 12 or below; and

(f) You are not subject to the provisions in § 404.468 for nonpayment of benefits to certain prisoners and certain other inmates of publicly funded institutions.

[48 FR 21928, May 16, 1983, as amended at 48 FR 55452, Dec. 13, 1983; 56 FR 35999, July 30, 1991; 61 FR 38363, July 24, 1996]

§ 404.368 When you are considered a full-time student during a period of nonattendance.

If you are a full-time student, your eligibility may continue during a period of nonattendance (including part-time attendance) if all the following conditions are met:

(a) The period of nonattendance is 4 consecutive months or less;

(b) You show us that you intend to resume your studies as a full-time student at the end of the period or at the end of the period you are a full-time student; and

(c) The period of nonattendance is not due to your expulsion or suspension from the school.

[48 FR 21929, May 16, 1983]

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 416 —Supplemental Security Income for the Aged, Blind, and Disabled
Subpart B —Eligibility
General

Authority: Secs. 702(a)(5), 1110(b), 1602, 1611, 1614, 1619(a), 1631, and 1634 of the Social Security Act (42 U.S.C. 902(a)(5), 1310(b), 1381a, 1382, 1382c, 1382h(a), 1383, and 1383c); secs. 211 and 212, Pub. L. 93-66, 87 Stat. 154 and 155 (42 U.S.C. 1382 note); sec. 502(a), Pub. L. 94-241, 90 Stat. 268 (48 U.S.C. 1681 note); sec. 2, Pub. L. 99-643, 100 Stat. 3574 (42 U.S.C. 1382h *note*).

Source: 47 FR 3103, Jan. 22, 1982, unless otherwise noted.

Editorial Note: Nomenclature changes to part 416 appear at 68 FR 53509, Sept. 11, 2003.

§ 416.202 Who may get SSI benefits.

You are eligible for SSI benefits if you meet all of the following requirements:

(a) You are—

(1) Aged 65 or older (subpart H);

(2) Blind (subpart I); or

(3) Disabled (subpart I).

(b) You are a resident of the United States (§ 416.1603), and—

(1) A citizen or a national of the United States (§ 416.1610);

(2) An alien lawfully admitted for permanent residence in the United States (§ 416.1615);

(3) An alien permanently residing in the United States under color of law (§ 416.1618); or

(4) A child of armed forces personnel living overseas as described in § 416.216.

(c) You do not have more income than is permitted (subparts K and D).

(d) You do not have more resources than are permitted (subpart L).

(e) You are disabled, drug addiction or alcoholism is a contributing factor material to the determination of disability (see § 416.935), and you have not previously received a total of 36 months of Social Security benefit payments when appropriate treatment was available or 36 months of SSI benefits on the basis of disability where drug addiction or alcoholism was a contributing factor material to the determination of disability.

(f) You are not—

(1) Fleeing to avoid prosecution for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which you flee (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State);

(2) Fleeing to avoid custody or confinement after conviction for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which you flee (or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of that State); or

(3) Violating a condition of probation or parole imposed under Federal or State law.

(g) You file an application for SSI benefits (subpart C).

[47 FR 3103, Jan. 22, 1982, as amended at 58 FR 4897, Jan. 19, 1993; 60 FR 8149, Feb. 10, 1995; 61 FR 10277, Mar. 13, 1996; 65 FR 40495, June 30, 2000]

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 416 —Supplemental Security Income for the Aged, Blind, and Disabled
Subpart L —Resources and Exclusions

Authority: Secs. 702(a)(5), 1602, 1611, 1612, 1613, 1614(f), 1621, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, 1383, and 1383b); sec. 211, Pub. L. 93-66, 87 Stat. 154 (42 U.S.C. 1382 note).
Source: 40 FR 48915, Oct. 20, 1975, unless otherwise noted.

Editorial Note: Nomenclature changes to part 416 appear at 68 FR 53509, Sept. 11, 2003.

§ 416.1202 Deeming of resources.

(a) ***Married individual.*** In the case of an individual who is living with a person not eligible under this part and who is considered to be the husband or wife of such individual under the criteria in §§ 416.1802 through 416.1835 of this part, such individual's resources shall be deemed to include any resources, not otherwise excluded under this subpart, of such spouse whether or not such resources are available to such individual. In addition to the exclusions listed in § 416.1210, we also exclude the following items:

(1) Pension funds that the ineligible spouse may have. *Pension funds* are defined as funds held in individual retirement accounts (IRA), as described by the Internal Revenue Code, or in work-related pension plans (including such plans for self-employed persons, sometimes referred to as Keogh plans);

(2) For 9 months beginning with the month following the month of receipt, the unspent portion of any retroactive payment of special pay an ineligible spouse received from one of the uniformed services pursuant to 37 U.S.C. 310; and

(3) For 9 months beginning with the month following the month of receipt, the unspent portion of any retroactive payment of family separation allowance an ineligible spouse received from one of the uniformed services pursuant to 37 U.S.C. 427 as a result of deployment to or service in a combat zone (as defined in § 416.1160(d)).

(b) ***Child*** —

(1) ***General.*** In the case of a child (as defined in § 416.1856) who is under age 18, we will deem to that child any resources, not otherwise excluded under this subpart, of his or her ineligible parent who is living in the same household with him or her (as described in § 416.1851). We also will deem to the child the resources of his or her ineligible stepparent. As used in this section, the term “parent” means the natural or adoptive parent of a child, and the term “stepparent” means the spouse (as defined in § 416.1806) of such natural or adoptive parent who is living in the same household with the child and parent. We will deem to a child the resources of his or her parent and stepparent whether or not those resources are available to him or her. We will deem to a child the resources of his or her parent and stepparent only to the extent that those resources exceed the resource limits described in § 416.1205. (If the child is living with only one parent, we apply the resource limit for an individual. If the child is living with both parents, or the child is living with one parent and a

stepparent, we apply the resource limit for an individual and spouse.) We will not deem to a child the resources of his or her parent or stepparent if the child is excepted from deeming under paragraph (b)(2) of this section. In addition to the exclusions listed in § 416.1210, we also exclude the following items:

(i) Pension funds of an ineligible parent (or stepparent). *Pension funds* are defined as funds held in IRAs, as described by the Internal Revenue Code, or in work-related pension plans (including such plans for self-employed persons, sometimes referred to as Keogh plans);

(ii) For 9 months beginning with the month following the month of receipt, the unspent portion of any retroactive payment of special pay an ineligible parent (or stepparent) received from one of the uniformed services pursuant to 37 U.S.C. 310; and

(iii) For 9 months beginning with the month following the month of receipt, the unspent portion of any retroactive payment of family separation allowance an ineligible parent (or stepparent) received from one of the uniformed services pursuant to 37 U.S.C. 427 as a result of deployment to or service in a combat zone (as defined in § 416.1160(d)).

(2) ***Disabled child under age 18.*** In the case of a disabled child under age 18 who is living in the same household with his or her parents, the deeming provisions of paragraph (b)(1) of this section shall not apply if such child—

(i) Previously received a reduced SSI benefit while a resident of a medical treatment facility, as described in § 416.414;

(ii) Is eligible for medical assistance under a Medicaid State home care plan approved by the Secretary under the provisions of section 1915(c) or authorized under section 1902(e)(3) of the Act; and

(iii) Would otherwise be ineligible because of the deeming of his or her parents' resources or income.

(c) ***Applicability.*** When used in this subpart L, the term *individual* refers to an eligible aged, blind, or disabled person, and also includes a person whose resources are deemed to be the resources of such individual (as provided in paragraphs (a) and (b) of this section).

[40 FR 48915, Oct. 20, 1975, as amended at 50 FR 38982, Sept. 26, 1985; 52 FR 8888, Mar. 20, 1987; 52 FR 29841, Aug. 12, 1987; 52 FR 32240, Aug. 26, 1987; 60 FR 361, Jan. 4, 1995; 62 FR 1056, Jan. 8, 1997; 65 FR 16815, Mar. 30, 2000; 72 FR 50875, Sept. 5, 2007; 73 FR 28036, May 15, 2008; 75 FR 7554, Feb. 22, 2010]

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 416 —Supplemental Security Income for the Aged, Blind, and Disabled
Subpart L —Resources and Exclusions

Authority: Secs. 702(a)(5), 1602, 1611, 1612, 1613, 1614(f), 1621, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, 1383, and 1383b); sec. 211, Pub. L. 93-66, 87 Stat. 154 (42 U.S.C. 1382 note).

Source: 40 FR 48915, Oct. 20, 1975, unless otherwise noted.

Editorial Note: Nomenclature changes to part 416 appear at 68 FR 53509, Sept. 11, 2003.

§ 416.1212 Exclusion of the home.

(a) ***Defined.*** A home is any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.

(b) ***Home not counted.*** We do not count a home regardless of its value. However, see §§ 416.1220 through 416.1224 when there is an income-producing property located on the home property that does not qualify under the home exclusion.

(c) ***If an individual changes principal place of residence.*** If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, we still consider the home to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

(d) ***If an individual leaves the principal place of residence due to domestic abuse.*** If an individual moves out of his or her home without the intent to return, but is fleeing the home as a victim of domestic abuse, we will not count the home as a resource in determining the individual's eligibility to receive, or continue to receive, SSI payments. In that situation, we will consider the home to be the individual's principal place of residence until such time as the individual establishes a new principal place of residence or otherwise takes action rendering the home no longer excludable.

(e) ***Proceeds from the sale of an excluded home.***

(1) The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within 3 months of the date of receipt of the proceeds.

(2) The value of a promissory note or similar installment sales contract constitutes a “proceed” which can be excluded from resources if—

(i) The note results from the sale of an individual's home as described in § 416.1212(a);

(ii) Within 3 months of receipt (execution) of the note, the individual purchases a replacement home as described in § 416.1212(a) (see paragraph (f) of this section for an exception); and

(iii) All note-generated proceeds are reinvested in the replacement home within 3 months of receipt (see paragraph (g) of this section for an exception).

(3) In addition to excluding the value of the note itself, other proceeds from the sale of the former home are excluded resources if they are used within 3 months of receipt to make payment on the replacement home. Such proceeds, which consist of the downpayment and that portion of any installment amount constituting payment against the principal, represent a conversion of a resource.

(f) ***Failure to purchase another excluded home timely.*** If the individual does not purchase a replacement home within the 3-month period specified in paragraph (e)(2)(ii) of this section, the value of a promissory note or similar installment sales contract received from the sale of an excluded home is a countable resource effective with the first moment of the month following the month the note is executed. If the individual purchases a replacement home after the expiration of the 3-month period, the note becomes an excluded resource the month following the month of purchase of the replacement home provided that all other proceeds are fully and timely reinvested as explained in paragraph (g) of this section.

(g) ***Failure to reinvest proceeds timely.***

(1) If the proceeds (e.g., installment amounts constituting payment against the principal) from the sale of an excluded home under a promissory note or similar installment sales contract are not reinvested fully and timely (within 3 months of receipt) in a replacement home, as of the first moment of the month following receipt of the payment, the individual's countable resources will include:

(i) The value of the note; and

(ii) That portion of the proceeds, retained by the individual, which was not timely reinvested

(2) The note remains a countable resource until the first moment of the month following the receipt of proceeds that are fully and timely reinvested in the replacement home. Failure to reinvest proceeds for a period of time does not permanently preclude exclusion of the promissory note or installment sales contract. However, previously received proceeds that were not timely reinvested remain countable resources to the extent they are retained.

Example 1. On July 10, an SSI recipient received his quarterly payment of $200 from the buyer of his former home under an installment sales contract. As of October 31, the recipient has used only $150 of the July payment in connection with the purchase of a new home. The exclusion of the unused $50 (and of the installment contract itself) is revoked back to July 10. As a result, the $50 and the value of the contract as of August 1, are included in a revised determination of resources for August and subsequent months.

Example 2. On April 10, an SSI recipient received a payment of $250 from the buyer of his former home under an installment sales contract. On May 3, he reinvested $200 of the payment in the purchase of a new home. On May 10, the recipient received another $250 payment, and reinvested the full amount on June 3. As of July 31, since the recipient has used only $200 of the April payment in connection with the purchase of the new home, the exclusion of the unused $50 (and of the installment contract itself) is revoked back to April 10. As a result, the $50 and the value of the contract as of May 1 are includable resources. Since the recipient fully and timely reinvested the May payment, the installment contract and the payment are again excludable resources as of June 1. However, the $50 left over from the previous payment remains a countable resource.

(h) ***Interest payments.*** If interest is received as part of an installment payment resulting from the sale of an excluded home under a promissory note or similar installment sales contract, the interest payments do not represent conversion of a resource. The interest is income under the provisions of §§ 416.1102, 416.1120, and 416.1121(c).

[50 FR 42686, Oct. 22, 1985, as amended at 51 FR 7437, Mar. 4, 1986; 59 FR 43285, Aug. 23, 1994; 75 FR 1273, Jan. 11, 2010]

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 416 —Supplemental Security Income for the Aged, Blind, and Disabled
Subpart L —Resources and Exclusions

Authority: Secs. 702(a)(5), 1602, 1611, 1612, 1613, 1614(f), 1621, 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, 1383, and 1383b); sec. 211, Pub. L. 93-66, 87 Stat. 154 (42 U.S.C. 1382 note).

Source: 40 FR 48915, Oct. 20, 1975, unless otherwise noted.

Editorial Note: Nomenclature changes to part 416 appear at 68 FR 53509, Sept. 11, 2003.

§ 416.1231 Burial spaces and certain funds set aside for burial expenses.

(a) ***Burial spaces*** —

(1) ***General.*** 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.

(2) ***Burial spaces defined.*** For purposes of this section "burial spaces" include burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

(3) ***An agreement representing the purchase of a burial space.*** The value of an agreement representing the purchase of a burial space, including any accumulated interest, will be excluded from resources. We do not consider a burial space "held for" an individual under an agreement unless the individual currently owns and is currently entitled to the use of the space under that agreement. For example, we will not consider a burial space "held for" an individual under an installment sales agreement or other similar device under which the individual does not currently own nor currently have the right to use the space, nor is the seller currently obligated to provide the space, until the purchase amount is paid in full.

(4) ***Immediate family defined.*** For purposes of this section *immediate family* means an individual's minor and adult children, including adopted children and step-children; an individual's brothers, sisters, parents, adoptive parents, and the spouses of those individuals. Neither dependency nor living-in-the-same-household will be a factor in determining whether a person is an immediate family member.

(b) ***Funds set aside for burial expenses*** —

(1) ***Exclusion.*** In determining the resources of an individual (and spouse, if any) there shall be excluded an amount not in excess of $1,500 each of funds specifically set aside for the burial expenses of the individual or the individual's spouse. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual (or

spouse) and are clearly designated as set aside for the individual's (or spouse's) burial expenses. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds. This exclusion is in addition to the burial space exclusion.

(2) ***Exception for parental deeming situations.*** If an individual is an eligible child, the burial funds (up to $1,500) that are set aside for the burial arrangements of the eligible child's ineligible parent or parent's spouse will not be counted in determining the resources of such eligible child.

(3) ***Burial funds defined.*** For purposes of this section "burial funds" are revocable burial contracts, burial trusts, other burial arrangements (including amounts paid on installment sales contracts for burial spaces), cash, accounts, or other financial instruments with a definite cash value clearly designated for the individual's (or spouse's, if any) burial expenses and kept separate from nonburial-related assets. Property other than listed in this definition will not be considered "burial funds."

(4) ***Recipients currently receiving SSI benefits.*** Recipients currently eligible as of July 11, 1990, who have had burial funds excluded which do not meet all of the requirements of paragraphs (b) (1) and (3) of this section must convert or separate such funds to meet these requirements unless there is an impediment to such conversion or separation; *i.e.*, a circumstance beyond an individual's control which makes conversion/separation impossible or impracticable. For so long as such an impediment or circumstance exists, the burial funds will be excluded if the individual remains otherwise continuously eligible for the exclusion.

(5) ***Reductions.*** Each person's (as described in §§ 416.1231(b)(1) and 416.1231(b)(2)) $1,500 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 any) if the cash surrender value of those policies has been excluded from resources as provided in § 416.1230; and

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

(6) ***Irrevocable trust or other irrevocable arrangement.*** Funds in an irrevocable trust or other irrevocable arrangement which are available for burial are funds which are held in an irrevocable burial contract, an irrevocable burial trust, or an amount in an irrevocable trust which is specifically identified as available for burial expenses.

(7) ***Increase in value of burial funds.*** Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which occur beginning November 1, 1982, or the date of first SSI eligibility, whichever is later, are excluded from resources if left to accumulate and become part of the separate burial fund.

(8) ***Burial funds used for some other purpose.***

(i) Excluded burial funds must be used solely for that purpose.

(ii) If any excluded funds are used for a purpose other than the burial arrangements of the individual or the individual's spouse for whom the funds were set aside, future SSI benefits of the individual (or the individual and eligible spouse) will be reduced by an amount equal to the amount of excluded burial funds used for another purpose. This penalty for use of excluded burial funds for a purpose other than the burial arrangements of the individual (or spouse) will apply only if, as of the first moment of the month of use, the individual would have had resources in excess of the limit specified in § 416.1205 without application of the exclusion.

(9) ***Extension of burial fund exclusion during suspension.*** The exclusion of burial funds and accumulated interest and appreciation will continue to apply throughout a period of suspension as described in § 416.1320, so long as the individual's eligibility has not been terminated as described in §§ 416.1331 through 416.1335.

[48 FR 57127, Dec. 28, 1983, as amended at 55 FR 28377, July 11, 1990; 57 FR 1384, Jan. 14, 1992]

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 416 —Supplemental Security Income for the Aged, Blind, and Disabled
Subpart R —Relationship

Authority: Secs. 702(a)(5), 1612(b), 1614(b), (c), and (d), and 1631(d)(1) and (e) of the Social Security Act (42 U.S.C. 902(a)(5), 1382a(b), 1382c(b), (c), and (d) and 1383(d)(1) and (e)).

Source: 45 FR 71795, Oct. 30, 1980, unless otherwise noted. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981.

Editorial Note: Nomenclature changes to part 416 appear at 68 FR 53509, Sept. 11, 2003.

§ 416.1801 Introduction.

(a) ***What is in this subpart.*** This subpart contains the basic rules for deciding for SSI purposes whether a person is considered married and, if so, to whom; whether a person is considered a child; and whether a person is considered another person's parent. It tells what information and evidence we need to decide these facts.

(b) ***Related subparts.*** Subpart D discusses how to determine the amount of a person's benefits; subpart G discusses what changes in a person's situation he or she must report to us; subpart K discusses how we count income; and subpart L discusses how we count resources (money and property). The questions of whether a person is married, to whom a person is married, whether a person is a child, and who is a person's parent must be answered in order to know which rules in subparts D, G, K, and L apply.

(c) ***Definitions.*** In this subpart—

Eligible spouse means a person—

(1) Who is eligible for SSI,

(2) Whom we consider the spouse of another person who is eligible for SSI, and

(3) Who was living in the same household with that person on—

(i) The first day of the month following the date the application is filed (for the initial month of eligibility for payment based on that application);

(ii) The date a request for reinstatement of eligibility is filed (for the month of such request); or

(iii) The first day of the month, for all other months. An individual is considered to be living with an eligible spouse during temporary absences as defined in § 416.1149 and while receiving continued benefits under section 1611(e)(1) (E) or (G) of the Act.

Spouse means a person's husband or wife under the rules of §§ 416.1806 through 416.1835 of this part.

We and *us* mean the Social Security Administration.

You means a person who has applied for or has been receiving SSI benefits, or a person for whom someone else has applied for or has been receiving SSI benefits.

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, as amended at 60 FR 16376, Mar. 30, 1995; 64 FR 31975, June 15, 1999; 65 FR 16815, Mar. 30, 2000]

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 416 —Supplemental Security Income for the Aged, Blind, and Disabled
Subpart R —Relationship
Who Is Considered Your Spouse

Authority: Secs. 702(a)(5), 1612(b), 1614(b), (c), and (d), and 1631(d)(1) and (e) of the Social Security Act (42 U.S.C. 902(a)(5), 1382a(b), 1382c(b), (c), and (d) and 1383(d)(1) and (e)).

Source: 45 FR 71795, Oct. 30, 1980, unless otherwise noted. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981.

Editorial Note: Nomenclature changes to part 416 appear at 68 FR 53509, Sept. 11, 2003.

§ 416.1802 Effects of marriage on eligibility and amount of benefits.

(a) ***If you have an ineligible spouse*** —

(1) ***Counting income.*** If you apply for or receive SSI benefits, and you are married to someone who is not eligible for SSI benefits and are living in the same household as that person, we may count part of that person's income as yours. Counting part of that person's income as yours may reduce the amount of your benefits or even make you ineligible. Section 416.410 discusses the amount of benefits and § 416.1163 explains how we count income for an individual with an ineligible spouse.

(2) ***Counting resources.*** If you are married to someone who is not eligible for SSI benefits and are living in the same household as that person, we will count the value of that person's resources (money and property), minus certain exclusions, as yours when we determine your eligibility. Section 416.1202(a) gives a more detailed statement of how we count resources and § 416.1205(a) gives the limit of resources allowed for eligibility of a person with an ineligible spouse.

(b) ***If you have an eligible spouse*** —

(1) ***Counting income.*** If you apply for or receive SSI benefits and have an eligible spouse as defined in § 416.1801(c), we will count your combined income and calculated the benefit amount for you as a couple. Section 416.412 gives a detailed statement of the amount of benefits and subpart K of this part explains how we count income for an eligible couple.

(2) ***Counting resources.*** If you have an eligible spouse as defined in § 416.1801(c), we will count the value of your combined resources (money and property), minus certain exclusions, and use the couple's resource limit when we determine your eligibility. Section 416.1205(b) gives a detailed statement of the resource limit for an eligible couple.

(c) ***If you are married, we do not consider you a child.*** The rules for counting income and resources are different for children than for adults. (Section 416.1851 discusses the effects of being considered a child on eligibility and amount of benefits.) Regardless of your age, if you are married we do not consider you to be a child.

(d)

(1) ***General rule:*** Benefits depend on whether you are married or not married at the beginning of each month. If you get married, even on the first day of a month we will treat you as single until the next month. If your marriage ends, even on the first day of a month, we will treat you as married until the next month.

(2) ***Exception: If you both meet eligibility requirements after your date of marriage or after your marriage ends.*** If, in the month that you marry, each of you first meets all eligibility requirements after the date of your marriage, we will treat you as an eligible couple for that month. If, in the month that your marriage ends, each of you first meets all eligibility requirements after the date your marriage ends, we will treat you as eligible individuals. (See subparts D and E regarding how your benefits will be prorated.)

[45 FR 71795, Oct. 30, 1980. Redesignated at 46 FR 29211, May 29, 1981; 46 FR 42063, Aug. 19, 1981, and amended at 51 FR 13495, Apr. 21, 1986; 60 FR 16376, Mar. 30, 1995]

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 416 —Supplemental Security Income for the Aged, Blind, and Disabled
Subpart K —Income

Authority: 42 U.S.C. 902(a)(5), 1381a, 1382, 1382a, 1382b, 1382c(f), 1382j, 1383, and 1383b; sec. 211, Pub. L. 93-66, 87 Stat. 154 (42 U.S.C. 1382 note).
Source: 45 FR 65547, Oct. 3, 1980, unless otherwise noted.

In-Kind Support and Maintenance

Editorial Note: Nomenclature changes to part 416 appear at 68 FR 53509, Sept. 11, 2003.

IN-KIND SUPPORT AND MAINTENANCE

§ 416.1130 Introduction.

(a) ***General.*** Both earned income and unearned income include items received in- kind (see § 416.1102). Generally, we value in-kind items at their current market value, and we apply the various exclusions for both earned and unearned income. However, we have special rules for valuing shelter that is received as in-kind support and maintenance (a type of unearned income). This section and the ones that follow discuss these rules. In these sections (*i.e.,* §§ 416.1130 through 416.1148) we use the in-kind support and maintenance you receive in the month as described in § 416.420 to determine your SSI benefit. We value the in-kind support and maintenance using the Federal benefit rate for the month in which you receive it. *Exception:* For the first 2 months for which a cost-of-living adjustment applies, we value in-kind support and maintenance you receive using the VTR or PMV based on the Federal benefit rate as increased by the cost-of-living adjustment.

Example: Mr. Jones resides in his son's house and receives all of his meals from his son. Mr. Jones receives a monthly SSI Federal benefit rate that is reduced by one-third. This one-third represents the value of the in-kind support and maintenance he receives because he lives, throughout a month, in the household of his son, who provides all of his food and shelter. In January, we increase his SSI

benefit because of a cost-of-living adjustment. For that month, we determine that the VTR rule applies by considering the food and shelter he received from his son two months earlier in November, and we calculate the SSI payment using the Federal benefit rate for January.

(b) ***How we calculate in-kind support and maintenance.***

(1) We calculate in-kind support and maintenance considering any shelter that is given to you or that you receive because someone else pays for it. Shelter includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services. You are not receiving in-kind support and maintenance in the form of room or rent if you are paying the amount charged under a business arrangement. A business arrangement exists when the amount of monthly required rent to be paid equals or exceeds the presumed maximum value described in § 416.1140(a)(1). If the required amount of rent is less than the presumed maximum value, we will impute as in-kind support and maintenance the difference between the required amount of rent and either the presumed maximum value or the current market rental value (see § 416.1101), whichever is less. In addition, cash payments to uniformed service members as allowances for on-base housing or privatized military housing are in-kind support and maintenance.

(2) We have two rules for valuing the in-kind support and maintenance that we count. The one-third reduction rule applies if you are living in another person's household, you receive shelter from others living in the household, and others within the household pay for or provide you with all of your meals (see §§ 416.1131 through 416.1133). The presumed value rule applies in all other situations in which you receive countable in-kind support and maintenance (see §§ 416.1140 through 416.1145). If certain conditions exist, we do not count in-kind support and maintenance. These conditions are discussed in §§ 416.1141 through 416.1145.

[89 FR 21209, Mar. 27, 2024, as amended at 89 FR 25514, Apr. 11, 2024]

§ 416.1131 The one-third reduction rule.

(a) ***What the rule is.*** Instead of determining the actual dollar value of in-kind support and maintenance, we count one-third of the Federal benefit rate as additional income if you (or you and your eligible spouse)—

(1) Live in another person's household (see § 416.1132) for a full calendar month except for temporary absences (see § 416.1149); and

(2) Receive shelter from others living in the household. (If you do not receive shelter from others living in the household, see § 416.1140); and

(3) Others within the household pay for or provide you with all of your meals. If others within the household do not pay for or provide you with all of your meals, any ISM received for shelter will be calculated under the PMV rule (see § 416.1140).

(b) ***How we apply the one-third reduction rule.*** The one-third reduction applies in full or not at all. When you are living in another person's household, and the one-third reduction rule applies, we do not apply any income exclusions to the reduction amount. However, we do apply appropriate exclusions to any other earned or unearned income you receive. If you have an eligible spouse we apply the rules described in § 416.1147.

(c) ***If you receive other support and maintenance.*** If the one-third reduction rule applies to you, we do not count any other in-kind support and maintenance you receive.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48574, Nov. 26, 1985; 89 FR 21210, Mar. 27, 2024]

§ 416.1132 What we mean by "living in another person's household".

(a) ***Household.*** For purposes of this subpart, we consider a household to be a personal place of residence. A commercial establishment such as a hotel or boarding house is not a household but a household can exist within a commercial establishment. If you live in a commercial establishment, we do not automatically consider you to be a member of the household of the proprietor. You may, however, live in the household of a roomer or boarder within the hotel or boarding house. An institution is not a household and a household cannot exist within an institution. (Institution is defined in § 416.1101.)

(b) ***Another person's household.*** You live in another person's household if paragraph (c) of this section does not apply and if the person who supplies the support and maintenance lives in the same household and is not—

(1) Your spouse (as defined in § 416.1806);

(2) A minor child; or

(3) An ineligible person (your spouse, parent, or essential person) whose income may be deemed to you as described in §§ 416.1160 through 416.1169.

(c) ***Your own household—not another person's household.*** You are not living in another person's household (you live in your own household) if—

(1) You (or your spouse who lives with you or any person whose income is deemed to you) have an ownership interest or a life estate interest in the home;

(2) You (or your spouse who lives with you or any person whose income is deemed to you) are liable to the landlord for payment of any part of the rental charges;

(3) You live in a noninstitutional care situation as described in § 416.1143;

(4) You pay at least a pro rata share of household and operating expenses (see § 416.1133); or

(5) All members of the household receive public income—maintenance payments (§ 416.1142).

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48574, Nov. 26, 1985]

§ 416.1133 What is a pro rata share of household operating expenses.

(a) ***General.*** If you pay your pro rata share toward monthly household operating expenses, you are living in your own household and are not receiving in-kind support and maintenance from anyone else in the household. The one-third reduction, therefore, does not apply to you. (If you are receiving shelter from someone outside the household, we value it under the rule in § 416.1140.)

(b) ***How we determine a pro rata share.*** Your pro rata share of household operating expenses is the average monthly household operating expenses (based on a reasonable estimate if exact figures are not available) divided by the number of people in the household, regardless of age.

(c) Household operating expenses are the household's total monthly expenditures for rent, mortgage, property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection service. (The term does not include the cost of these items if someone outside the household pays for them.) Generally, we average household operating expenses over the past 12 months to determine a pro rata share.

[45 FR 65547, Oct. 3, 1980, as amended at 70 FR 6345, Feb. 7, 2005; 89 FR 21210, Mar. 27, 2024]

§ 416.1140 The presumed value rule.

(a) ***How we apply the presumed value rule.***

(1) When you receive in-kind support and maintenance and the one-third reduction rule does not apply, we use the presumed value rule. Instead of determining the actual dollar value of any shelter you receive, we presume that it is worth a maximum value. This maximum value is one-third of your Federal benefit rate plus the amount of the general income exclusion described in § 416.1124(c)(12).

(2) The presumed value rule allows you to show that your in-kind support and maintenance is not equal to the presumed value. We will not use the presumed value if you show us that—

(i) The current market value of any shelter you receive, minus any payment you make for it, is lower than the presumed value; or

(ii) The actual amount someone else pays for your shelter is lower than the presumed value.

(b) ***How we determine the amount of your ISM under the presumed value rule.***

(1) If you choose not to question the use of the presumed value, or if the presumed value is less than the actual value of the shelter you receive, we use the presumed value to figure your ISM.

(2) If you show us, as provided in paragraph (a)(2) of this section, that the presumed value is higher than the actual value of the shelter you receive, we use the actual amount to figure your ISM.

[89 FR 21210, Mar. 27, 2024]

§ 416.1141 When the presumed value rule applies.

The presumed value rule applies whenever we count in-kind support and maintenance as unearned income and the one-third reduction rule does not apply. This means that the presumed value rule applies if you are living—

(a) In another person's household (as described in § 416.1132(b)); you receive shelter from others living in the household; and others within the household do not pay for or provide you with all of your meals;

(b) In your own household (as described in § 416.1132(c)). For exceptions, see § 416.1142 if you are in a public assistance household and § 416.1143 if you are in a noninstitutional case situation; or

(c) In a nonmedical institution including any—

(1) Public nonmedical institution if you are there for less than a full calendar month;

(2) Public or private nonprofit educational or vocational training institution;

(3) Private nonprofit retirement home or similar institution where there is an express obligation to provide your full support and maintenance or where someone else pays for your support and maintenance. For exceptions, see § 416.1144; and

(4) For-profit institution where someone else pays for your support and maintenance. If you or the institution pay for it, see § 416.1145.

[45 FR 65547, Oct. 3, 1980, as amended at 89 FR 21210, Mar. 27, 2024]

§ 416.1142 If you live in a public assistance household.

(a) ***Definition.*** For purposes of our programs, a public assistance household is one that has both an SSI applicant or recipient, and at least one other household member who receives one or more of the listed public income maintenance payments. These are payments made under—

(1) Title IV-A of the Social Security Act (Temporary Assistance for Needy Families);

(2) Title XVI of the Social Security Act (SSI, including federally administered State supplements and State administered mandatory supplements);

(3) The Refugee Act of 1980 (Those payments based on need);

(4) The Disaster Relief and Emergency Assistance Act;

(5) General assistance programs of the Bureau of Indian Affairs;

(6) State or local government assistance programs based on need (tax credits or refunds are not assistance based on need);

(7) U.S. Department of Veterans Affairs programs (those payments based on need); and

(8) The Supplemental Nutrition Assistance Program (SNAP).

(b) ***How the presumed value rule applies.*** If you live in a public assistance household, we consider that you are not receiving in-kind support and maintenance from members of the household. In this situation, we use the presumed value rule only if you receive food or shelter from someone outside the household.

[45 FR 65547, Oct. 3, 1980, as amended at 57 FR 53850, Nov. 13, 1992; 70 FR 6345, Feb. 7, 2005; 70 FR 41137, July 18, 2005; 89 FR 28622, Apr. 19, 2024]

§ 416.1143 If you live in a noninstitutional care situation.

(a) ***Definitions.*** For purposes of this subpart you live in a noninstitutional care situation if all the following conditions exist:

(1) You are placed by a public or private agency under a specific program such as foster or family care;

(2) The placing agency is responsible for your care;

(3) You are in a private household (not an institution) which is licensed or approved by the placing agency to provide care; and

(4) You, a public agency, or someone else pays for your care.

(b) ***How the presumed value rule applies.*** You are not receiving in-kind support and maintenance and the presumed value rule does not apply if you pay the rate the placing agency establishes. We consider this established rate to be the current market value for the in-kind support and maintenance you are receiving. The presumed value rule applies if you pay less than the established rate and the difference is paid by someone else other than a public or private agency providing social services described in § 416.1103(b) or assistance based on need described in § 416.1124(c)(2).

§ 416.1144 If you live in a nonprofit retirement home or similar institution.

(a) ***Definitions.*** For purposes of this section the following definitions apply:

(1) ***Nonprofit retirement home or similar institution*** means a nongovernmental institution as defined under § 416.1101, which is, or is controlled by, a private nonprofit organization and which does not provide you with—

(i) Services which are (or could be) covered under Medicaid, or

(ii) Education or vocational training.

(2) ***Nonprofit organization*** means a private organization which is tax exempt under section 501(a) of the Internal Revenue Code of 1954 and is of the kind described in section 501 (c) or (d) of that code.

(3) An *express obligation to provide your full support and maintenance* means there is either a legally enforceable written contract or set of membership rules providing that the home, institution, or organization—

(i) Will provide at least all of your food and shelter needs; and

(ii) Does not require any current or future payment for that food and shelter. (For purposes of this paragraph, a lump sum prepayment for lifetime care is not a current payment.)

(b) ***How the presumed value rule applies.*** The presumed value rule applies if you are living in a nonprofit retirement home or similar institution where there is an express obligation to provide your full support and maintenance or where someone else pays for your support and maintenance. The rule does not apply to the extent that—

(1) The home, institution, or nonprofit organization does not have an express obligation to provide your full support and maintenance; and

(2) The home, institution, or nonprofit organization receives no payment for your food or shelter, or receives payment from another nonprofit organization.

[45 FR 65547, Oct. 3, 1980, as amended at 51 FR 34464, Sept. 29, 1986; 70 FR 6345, Feb. 7, 2005]

§ 416.1145 How the presumed value rule applies in a nonmedical for-profit institution.

If you live in a nonmedical for-profit institution, we consider the amount accepted by that institution as payment in full to be the current market value of whatever food or shelter the institution provides. If you are paying or are legally indebted for that amount, you are not receiving in-kind support and maintenance. We do not use the presumed value rule unless someone else pays for you.

[45 FR 65547, Oct. 3, 1980, as amended at 70 FR 6345, Feb. 7, 2005]

Title 26 —Internal Revenue
Chapter I —Internal Revenue Service, Department of the Treasury
Subchapter A —Income Tax
Part 1 —Income Taxes

Authority: 26 U.S.C. 7805, unless otherwise noted. Section 1.401-12 also issued under 26 U.S.C. 401(d)(1). Section 1.410(b)-2 also issued under 26 U.S.C. 410(b)(6). *See Part 1 for more*

Source: T.D. 6500, 25 FR 11402, Nov. 26, 1960; 25 FR 14021, Dec. 21, 1960; T.D. 9989, 89 FR 17606, Mar. 11, 2024, unless otherwise noted. T.D. 6500, 25 FR 11402, Nov. 26, 1960; 25 FR 14021, Dec. 21, 1960, unless otherwise noted. T.D. 6500, 25 FR 11402, Nov. 26, 1960; 25 FR 14021, Dec. 31, 1960, T.D. 9381, 73 FR 8604, Feb. 15, 2008, unless otherwise noted. *See Part 1 for more*

Qualified ABLE Programs

QUALIFIED ABLE PROGRAMS

Source: T.D. 9923, 85 FR 74034, Nov. 19, 2020, unless otherwise noted.

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(a) Electronic furnishing of statements.

(1) In general.

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§ 1.529A-8 *Applicability dates and transition relief.*

(a) Applicability dates.

(b)Transition relief.

(1) In general.

(2) Transition period.

(3) Compliance after transition period.

§ 1.529A-1 Exempt status of qualified ABLE program and definitions.

(a) ***In general.*** A qualified ABLE program described in section 529A is exempt from Federal income tax, except for the tax imposed under section 511 on any unrelated business taxable income of that program. See § 1.511-2(e).

(b) ***Definitions.*** For purposes of section 529A, this section and §§ 1.529A-2 through 1.529A-8—

(1) ***ABLE account*** means an account established under a qualified ABLE program and owned by the designated beneficiary of that account.

(2) ***Contribution*** means any payment directly allocated to an ABLE account for the benefit of a designated beneficiary, including amounts transferred to an ABLE account between December 22, 2017, and January 1, 2026, from a qualified tuition program described in section 529.

(3) ***Designated beneficiary*** means the individual for whom the account was established at a time when he or she was an eligible individual or who has succeeded the former designated beneficiary in that capacity (successor designated beneficiary). The designated beneficiary is the owner of the ABLE account. If the designated beneficiary is not able to exercise signature authority over his or her ABLE account or chooses to have an ABLE account established but not to exercise signature authority, references to the designated beneficiary with respect to his or her actions include actions by the person with signature authority over the account. See § 1.529A-2(c)(1) and (2).

(4) ***Disability certification*** means a certification to establish a certain level of an individual's physical or mental impairment that meets the requirements described in § 1.529A-2(e).

(5) ***Distribution*** means any payment from an ABLE account. However, a program-to-program transfer, a Medicaid reimbursement under § 1.529A-2(o), or a payment of administrative or investment fees charged by a qualified ABLE program is not a distribution.

(6) ***Earnings*** attributable to an ABLE account are the excess of the total account balance on a particular date over the investment in the account as of that date.

(7) ***Earnings ratio*** as applied to a particular distribution means the amount of earnings attributable to the ABLE account as of the date of the distribution, divided by the total account balance on that same date.

(8) ***Eligible individual*** for a taxable year means an individual who either:

(i) Is receiving benefits under title II or XVI of the Social Security Act based on blindness or disability or whose entitlement to such benefits under title XVI has been suspended solely due to excess income or resources, provided that such blindness or disability occurred before the date on which the individual attained age 26 (and, for this purpose, an individual is deemed to attain age 26 on his or her 26th birthday); or

(ii) Is the subject of a disability certification filed with the Secretary of the Treasury or his delegate (Secretary) for that taxable year.

(9) ***Excess contribution*** means the amount by which the amount contributed during the taxable year of the designated beneficiary to an ABLE account exceeds the limit in effect under section 2503(b) for the calendar year in which the taxable year of the designated beneficiary begins.

(10) ***Excess aggregate contribution*** means—

(i) The amount contributed during the taxable year of the designated beneficiary that causes the total of amounts contributed since the establishment of the ABLE account (or of an ABLE account for the same designated beneficiary that was rolled into the current ABLE account) to exceed the limit in effect under section 529(b)(6); or

(ii) In the context of the safe harbor in § 1.529A-2(g)(3), the amount contributed that causes the account balance to exceed the limit in effect under section 529(b)(6).

(11) ***Investment in the account*** means—

(i) The sum of all contributions made to the ABLE account, reduced by the aggregate amount of contributions included in distributions, if any, made from the account; or

(ii) In the case of a rollover contribution into an ABLE account, the amount of the rollover contribution that constituted the amount described in paragraph (b)(11)(i) of this section with respect to the ABLE account from which the rollover contribution was made.

(12) ***Member of the family*** means a sibling, whether by blood or by adoption, and includes a brother, sister, stepbrother, stepsister, half-brother, and half-sister.

(13) ***Program-to-program transfer*** means—

(i) The direct transfer of the entire balance of an ABLE account into an ABLE account of the same designated beneficiary after which the transferor ABLE account is closed upon completion of the transfer; or

(ii) The direct transfer of part or all of the balance to an ABLE account of another eligible individual who is a member of the family of the former designated beneficiary.

(14) ***Qualified ABLE program*** means a program established and maintained by a State, or agency or instrumentality of a State, under which an ABLE account may be established by and for the benefit of the account's designated beneficiary who is an eligible individual, and that meets the requirements described in § 1.529A-2.

(15) ***Qualified disability expenses*** means any expenses incurred at a time when the designated beneficiary is an eligible individual that relate to the blindness or disability of the designated beneficiary of an ABLE account, including expenses that are for the benefit of the designated beneficiary in maintaining or improving his or her health, independence, or quality of life. See § 1.529A-2(h). However, any expenses incurred at a time when a designated beneficiary is neither disabled nor blind within the meaning of § 1.529A-1(b)(8)(i) or § 1.529A-2(e)(1)(i), even if the designated beneficiary is an eligible individual for that entire taxable year, do not relate to blindness or disability and therefore are not qualified disability expenses.

(16) ***Rollover*** means a contribution to an ABLE account of a designated beneficiary (or of an eligible individual who is a member of the family of the designated beneficiary) of all or a portion of an amount distributed from the designated beneficiary's ABLE account, provided the contribution is made within 60 days of the date of the withdrawal and, in the case of a rollover to the designated beneficiary's ABLE account, no rollover has been made to an ABLE account of the designated beneficiary within the 12 month period immediately preceding the rollover to the ABLE account.

(c) ***Applicability date.*** This section applies to calendar years beginning on or after January 1, 2021. See § 1.529A-8 for the provision of transition relief.

§ 1.529A-2 Qualified ABLE program.

(a) ***In general.*** A qualified ABLE program is a program established and maintained by a State, or an agency or instrumentality of a State, that satisfies all of the requirements of this section and under which—

(1) An ABLE account may be established for the purpose of meeting the qualified disability expenses of the designated beneficiary of the account;

(2) A designated beneficiary is limited to only one ABLE account at a time except as otherwise provided in paragraph (c)(3) of this section;

(3) Any person may make contributions to such an ABLE account, subject to the limitations described in paragraph (g) of this section; and

(4) Distributions (other than returns of contributions as described in paragraph (g)(4) of this section) may be made only to or for the benefit of the designated beneficiary of the ABLE account.

(b) ***Established and maintained by a State or agency or instrumentality of a State*** —

(1) ***Established.*** A program is established by a State or its agency or instrumentality if the program is initiated by State statute or regulation or by an act of a State official or agency with the authority to act on behalf of the State.

(2) ***Maintained*** —

(i) ***In general.*** A program is maintained by a State or an agency or instrumentality of a State if—

(A) The State or its agency or instrumentality sets all of the terms and conditions of the program, including but not limited to who may contribute to the program, who may be a designated beneficiary of the program, and what benefits the program may provide; and

(B) The State or its agency or instrumentality is actively involved on an ongoing basis in the administration of the program, including supervising the implementation of decisions relating to the investment of assets contributed under the program. Factors that are relevant in determining whether a State or its agency or instrumentality is actively involved in the administration of the program include, but are not limited to: Whether the State or its agency or instrumentality provides services to designated beneficiaries that are not provided to persons who are not designated beneficiaries; whether the State or its agency or instrumentality establishes detailed operating rules for administering the program; whether officials of the State or its agency or instrumentality play a substantial role in the operation of the program, including selecting, supervising, monitoring, auditing, and terminating the relationship with any private contractors that provide services under the program; whether the State or its agency or instrumentality holds the private contractors that provide services under the program to the same standards and requirements that apply when private contractors handle funds that belong to the State or its agency or instrumentality or provide services to the State or its agency or instrumentality; whether the State or its agency or instrumentality provides funding for the program; and whether the State or its agency or instrumentality acts as trustee or holds program assets directly or for the benefit of the designated beneficiaries. For example, if the State or its agency or instrumentality exercises the same authority over the funds invested in the program as it does over the investments in or pool of funds of a State employees' defined benefit pension plan, then the State or its agency or instrumentality will be considered actively involved on an ongoing basis in the administration of the program.

(ii) ***Multiple States, agencies, or instrumentalities.*** A program may be maintained by two or more States or the agencies or instrumentalities of two or more States if the program meets the requirements of paragraph (b)(2)(i) of this section for each of the States represented. If a State or an agency or instrumentality of a State participates in such a consortium of States or agencies or instrumentalities of States, the consortium's program is considered to be the program of each State represented.

(3) ***Community Development Financial Institutions (CDFIs).*** In addition to having the ability to contract with private contractors as provided in paragraph (b)(2)(i)(B) of this section, a State or its agency or instrumentality or qualified ABLE program may contract with one or more Community Development Financial Institutions (CDFIs) (as defined in 12 U.S.C. 4702(5) and 12 CFR 1805.104) to perform some or all of the services described in paragraphs (b)(2)(i)(A) and (B) of this section.

(c) ***Establishment of an ABLE account and signature authority*** —

(1) ***Establishment of the ABLE account*** —

(i) ***In general.*** A qualified ABLE program must provide that an ABLE account may be established only for an eligible individual.

(A) The ABLE account may be established by the eligible individual;

(B) The ABLE account may be established by a person selected by the eligible individual; or

(C) If an eligible individual (whether a minor or adult) is unable to establish his or her own ABLE account, an ABLE account may be established on behalf of the eligible individual by the eligible individual's agent under a power of attorney or, if none, by a conservator or legal guardian, spouse, parent, sibling, grandparent of the eligible individual, or a representative payee appointed for the eligible individual by the Social Security Administration (SSA), in that order.

(ii) ***Authority.*** A qualified ABLE program may accept a certification, made under penalties of perjury, from the person seeking to establish an ABLE account as to the basis for the person's authority to establish the ABLE account, and that there is no other person with a higher priority, under paragraphs (c)(1)(i)(A), (B), and (C) of this section, to establish the ABLE account.

(2) ***Signature authority*** —

(i) ***Signatory.*** In general, the designated beneficiary will have signature authority over his or her ABLE account. However, if an individual other than the designated beneficiary establishes the account in accordance with paragraph (c)(1)(i)(B) or (C) of this section, such individual will have signature authority.

(A) At any time, the designated beneficiary may remove and replace any person with signature authority over the designated beneficiary's ABLE account. The replacement may be the designated beneficiary or any other person selected by the designated beneficiary.

(B) The designated beneficiary may designate a successor to the person with signature authority. In the absence of any designation of a successor by the designated beneficiary, a person with signature authority over the designated beneficiary's ABLE account may designate a successor, consistent with the ordering rules in paragraph (c)(1)(i)(C) of this section.

(ii) ***Co-signatories.*** A qualified ABLE program may permit an ABLE account to have co-signatories, consistent with paragraph (c)(1)(i)(C) of this section. If co-signatories are permitted, all of the other provisions of this paragraph (c)(2) continue to apply, and references to the *signatory* refer to the co-signatories acting separately or jointly, as determined by that qualified ABLE program.

(iii) ***Authority over sub-accounts.*** The person with signature authority over the ABLE account may appoint and from time to time may remove, replace, or name a successor for any person with signature authority over a sub-account described in paragraph (c)(3)(iii) of this section.

(3) ***Only one ABLE account*** —

(i) ***In general.*** Except as provided in paragraph (c)(3)(ii) of this section, a designated beneficiary is limited to one ABLE account at a time, regardless of where located. To ensure that this requirement is met, a qualified ABLE program must obtain a verification, signed under penalties of perjury by the person establishing the ABLE account, that the individual establishing the ABLE account neither knows nor has reason to know that the eligible individual already has an existing ABLE account (other than an ABLE account that will terminate with the rollover or program-to-program transfer of its assets into the new ABLE account) before that program can permit the establishment of an ABLE account for that eligible individual. In the case of a rollover, the ABLE account from which amounts were distributed must be closed as of the 60th day after the date of the distribution in order to allow the account receiving the rollover to be treated as an ABLE account.

(ii) ***Treatment of additional accounts.*** If an individual is the designated beneficiary of an ABLE account established in accordance with paragraph (c)(1) of this section, no other account subsequently established for that individual under a qualified ABLE program (additional account) will be an ABLE account. The preceding sentence does not apply to an additional account, and that additional account is an ABLE account, if—

(A) The additional account is established for the purpose of receiving a rollover or program-to-program transfer;

(B) All of the contributions to the additional account are returned in accordance with the rules that apply to the return of excess contributions and excess aggregate contributions under paragraph (g)(4) of this section; or

(C) All amounts in the additional account are transferred to the designated beneficiary's preexisting ABLE account and any excess contributions and excess aggregate contributions are returned in accordance with the rules that apply to the return of excess contributions and excess aggregate contributions under paragraph (g)(4) of this section.

(iii) ***Sub-accounts.*** A qualified ABLE program may establish an ABLE account (primary account) that may include multiple sub-accounts. The person with signature authority over the ABLE account, at any time and from time to time, may create one or more sub-accounts, may transfer funds in the ABLE account to one or more of the sub-accounts, and may close one or more of the sub-accounts, to facilitate the acquisition of certain goods or services for the designated beneficiary. Each sub-account may have a different person with signature authority over that sub-account, appointed in accordance with the rules of paragraph (c)(2)(iii) of this section, and that person's authority is limited to making distributions from that sub-account. The primary account and the sub-accounts collectively constitute a single ABLE account and therefore must be aggregated for all purposes, including without limitation the limit on the number of

permissible changes in investment direction under paragraph (l) of this section, the contribution limits under paragraphs (g)(2) and (3) of this section, the computation of gross income and other tax provisions, and the reporting requirements.

(iv) ***Investment options.*** A qualified ABLE program may offer different investment options within each ABLE account without violating the only-one-ABLE-account rule in this paragraph (c)(3). For example, an ABLE account may include a cash fund as well as one or more stock or bond funds.

(4) ***Beneficial interest.*** A person other than the designated beneficiary with signature authority over the ABLE account of the designated beneficiary may neither have nor acquire any beneficial interest in the ABLE account during the lifetime of the designated beneficiary and must administer the ABLE account for the benefit of the designated beneficiary of the account.

(d) ***Eligible individual*** —

(1) ***Documentation*** —

(i) ***In general.*** Whether an individual is an eligible individual is determined for each taxable year of that individual, and that determination applies for the entire year. A qualified ABLE program must specify the documentation that an individual must provide, both at the time an ABLE account is established and thereafter, in order to ensure that the designated beneficiary of the ABLE account is, and continues to be, determined an eligible individual. For purposes of determining whether an individual is an eligible individual, a disability certification as described in paragraph (e)(1) of this section will be deemed to be filed with the Secretary once the qualified ABLE program has received the disability certification or a disability certification has been deemed to have been received under the rules of the qualified ABLE program, which information the qualified ABLE program will file in accordance with the filing requirements under § 1.529A-5(c)(2)(iv).

(ii) ***Safe harbor.*** A qualified ABLE program may establish that an individual is an eligible individual if the person establishing the ABLE account certifies under penalties of perjury—

(A) The basis for the individual's status as an eligible individual (entitlement to benefits based on blindness or disability under title II or XVI of the Social Security Act, or a disability certification described in paragraph (e)(1) of this section);

(B) That the individual is blind or has a medically determinable physical or mental impairment as described in paragraph (e)(1)(i) of this section;

(C) That such blindness or disability occurred before the date on which the individual attained age 26 (and, for this purpose, an individual is deemed to attain age 26 on his or her 26th birthday);

(D) If the basis of the individual's eligibility is a disability certification, that the individual has received and agrees to retain a written diagnosis as described in paragraph (e)(1)(iii) of this section, accompanied by the name and address of the diagnosing physician and the date of the written diagnosis;

(E) The applicable diagnostic code from those listed on Form 5498-QA (or in the instructions to such form) identifying the type of the individual's impairment;

(F) That the person establishing the account is the individual who will be the designated beneficiary of the account or is the person authorized under paragraph (c)(1)(i) of this section to establish the account; and

(G) If required by the qualified ABLE program, the information provided by the diagnosing physician as to the categorization of the disability that may be used to determine, under the particular State's program, the appropriate frequency of required recertifications.

(2) ***Frequency of recertification*** —

(i) ***In general.*** A determination of eligibility must be made annually unless the qualified ABLE program adopts a different method of ensuring a designated beneficiary's continuing status as an eligible individual. Alternative methods may include, without limitation, the use of certifications by the designated beneficiary under penalties of perjury, and the imposition of different recertification frequencies for different types of impairments.

(ii) ***Considerations.*** In developing its rules on recertification, a qualified ABLE program may take into consideration whether an impairment is incurable and, if so, the likelihood that a cure may be found in the future. For example, a qualified ABLE program may provide that the initial certification will be deemed to be valid for a stated number of years, which may vary with the type of impairment. Even if the qualified ABLE program imposes an enforceable obligation on the designated beneficiary or other person with signature authority over the ABLE account to promptly report changes in the designated beneficiary's condition that would result in the designated beneficiary's failing to satisfy the definition of an eligible individual, the designated beneficiary will be considered an eligible individual until the end of the taxable year in which the change in the designated beneficiary's condition occurred. A qualified ABLE program that is compliant with the rules regarding recertification will not be considered to be noncompliant solely because a designated beneficiary fails to comply with this enforceable obligation.

(3) ***Loss of qualification as an eligible individual.*** If the designated beneficiary of an ABLE account ceases to be an eligible individual, then for each taxable year in which the designated beneficiary is not an eligible individual, the account will continue to be an ABLE account, the designated beneficiary will continue to be the designated beneficiary of the ABLE account (and will be referred to as such), and the ABLE account will not be deemed to have been distributed. However, beginning on the first day of the designated beneficiary's first taxable year for which the designated beneficiary does not satisfy the definition of an eligible individual, additional contributions to the designated beneficiary's ABLE account must not be accepted by the qualified ABLE program. In addition, no expense incurred at a time when a designated beneficiary is neither disabled nor blind within the meaning of § 1.529A-1(b)(8)(i) or § 1.529A-2(e)(1)(i), whichever had applied, is a qualified disability expense even if the individual is an eligible individual for the rest of the year under paragraph (d)(1)(i) of this section. If the designated beneficiary subsequently again satisfies the definition of an eligible individual, contributions to the designated beneficiary's ABLE account again may be accepted, subject to the contribution limits under section 529A, and expenses that are incurred thereafter may meet the definition of a qualified disability expense in § 1.529A-1(b)(15) and paragraph (h) of this section.

(e) ***Disability certification*** —

(1) ***In general.*** Except as provided in paragraph (e)(3) of this section or in additional guidance described in paragraph (e)(4) of this section, a disability certification with respect to an individual, that will be deemed filed with the Secretary as provided in paragraph (d)(1)(i) of this section, and is deemed satisfactory to the Secretary, is a certification signed under penalties of perjury by the individual, or by another individual establishing the ABLE account for the individual, that—

(i) Certifies that the individual—

(A) Has a medically determinable physical or mental impairment that results in marked and severe functional limitations (as defined in paragraph (e)(2) of this section), and that—

(*1*) Can be expected to result in death; or

(*2*) Has lasted or can be expected to last for a continuous period of not less than 12 months; or

(B) Is blind (within the meaning of section 1614(a)(2) of the Social Security Act);

(ii) Certifies that such blindness or disability occurred before the date on which the individual attained age 26 (and, for this purpose, an individual is deemed to attain age 26 on his or her 26th birthday); and

(iii) Includes a certification that the individual has obtained and will continue to retain a copy of the individual's diagnosis relating to the individual's relevant impairment or impairments, signed by a physician meeting the criteria of section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)) and including the name and address of the diagnosing physician and the date of the diagnosis.

(2) ***Marked and severe functional limitations.*** For purposes of paragraph (e)(1) of this section, the phrase *marked and severe functional limitations* means the standard of disability in the Social Security Act for children claiming Supplemental Security Income for the Aged, Blind, and Disabled (SSI) benefits based on disability (see 20 CFR 416.906), but without regard to age or to whether the individual engages in substantial gainful activity. Specifically, this is a level of severity that meets, medically equals, or functionally equals the severity of any listing in appendix 1 of subpart P of 20 CFR part 404. See 20 CFR 416.906, 416.924 and 416.926a. Such phrase also includes any impairment or standard of disability identified in future guidance published in the Internal Revenue Bulletin (see § 601.601(d)(2) of this chapter). Consistent with the regulations promulgated by the SSA, the level of severity is determined by taking into account the effect of the individual's prescribed treatment. See 20 CFR 416.930.

(3) ***Compassionate allowance list.*** Conditions listed in the “List of Compassionate Allowances Conditions” maintained by the SSA are deemed to meet the requirements of section 529A(e)(1)(B) regarding the filing of a disability certification, if the condition was present and produced marked and severe functional limitations before the date on which the individual attained age 26. To establish that an individual with such a condition satisfies the definition of an eligible individual, the individual must identify the condition and certify to the qualified ABLE program both the presence of the condition and its resulting marked and severe functional limitations prior to age 26, in a manner specified by the qualified ABLE program.

(4) ***Additional guidance.*** Additional guidance on conditions deemed to meet the requirements of section 529A(e)(1)(B) may be identified in future guidance published in the Internal Revenue Bulletin. See § 601.601(d)(2) of this chapter.

(5) ***Restriction on use of certification.*** No inference may be drawn from a disability certification described in this paragraph (e) for purposes of establishing eligibility for benefits under title II, XVI, or XIX of the Social Security Act.

(f) ***Change of designated beneficiary*** —

(1) ***In general.*** A qualified ABLE program must permit a change in the designated beneficiary of an ABLE account made during the life of the designated beneficiary. At the time when the change becomes effective, the successor designated beneficiary must be an eligible individual. However, a qualified ABLE program may limit the change in designated beneficiary to a member of the family as defined in § 1.529A-1(b)(12) of the current designated beneficiary.

(2) ***Change effective upon death.*** A qualified ABLE program may permit a change in the designated beneficiary of an ABLE account, made during the life of the designated beneficiary, to take effect upon the death of the designated beneficiary. The amount to be transferred pursuant to such a beneficiary designation is first subject to the payment of any qualified disability expenses incurred before the designated beneficiary's death but not yet paid and those described in paragraph (o) of this section, and is subject to the provisions of § 1.529A-4.

(g) ***Contributions*** —

(1) ***Permissible property.*** Except in the case of a program-to-program transfer or a change in designated beneficiary to a new designated beneficiary who is an eligible individual and a member of the family of the former designated beneficiary, contributions to an ABLE account may be made only in cash. A qualified ABLE program may allow cash contributions to be made in the form of a check, money order, credit card, electronic transfer, after-tax payroll deduction, or similar method.

(2) ***Annual contributions limit*** —

(i) ***In general.*** Except as provided in paragraph (g)(2)(ii) of this section, a qualified ABLE program must provide that no contribution to an ABLE account will be accepted to the extent such contribution, when added to all other contributions (whether from the designated beneficiary or one or more other persons) to that ABLE account made during the designated beneficiary's taxable year causes the total of such contributions during that year to exceed the amount in effect under section 2503(b) for the calendar year in which the designated beneficiary's taxable year begins. See paragraph (k)(2) of this section for purposes of applying the rules in this paragraph (g)(2) to rollovers, program-to-program transfers, and designated beneficiary changes.

(ii) ***Additional contributions by an employed designated beneficiary*** —

(A) ***In general.*** An employed designated beneficiary defined in paragraph (g)(2)(iii)(A) of this section may contribute amounts up to the limit specified in paragraph (g)(2)(ii)(B) of this section in addition to the amount specified in paragraph (g)(2)(i) of this section. Although a designated beneficiary's contributions subject to this compensation income limit do not have to be made from that compensation income, any contribution of the designated beneficiary's compensation income made directly by the designated beneficiary's employer is a contribution made by the designated beneficiary. Once the designated beneficiary has made contributions equal to the limit described in paragraph (g)(2)(ii)(B) of this section, additional contributions by the designated beneficiary may be made if permissible under paragraph (g)(2)(i) of this section.

(B) ***Amount of additional permissible contribution.*** Any additional contribution made by the designated beneficiary pursuant to paragraph (g)(2)(ii)(A) of this section is limited to the lesser of—

(*1*) The designated beneficiary's compensation as defined by section 219(f)(1) for the taxable year; or

(*2*) An amount equal to the applicable poverty line, as defined in paragraph (g)(2)(iii)(B) of this section, for a one-person household for the calendar year preceding the calendar year in which the designated beneficiary's taxable year begins.

(iii) ***Additional definitions.*** In addition to the definitions in § 1.529A-1(b), the following definitions also apply for the purposes of this section—

(A) ***Employed designated beneficiary*** means a designated beneficiary who is an employee (including an employee within the meaning of section 401(c)), with respect to whom no contribution is made for the taxable year to—

(*1*) A defined contribution plan (within the meaning of section 414(i)) with respect to which the requirements of sections 401(a) or 403(a) are met;

(*2*) An annuity contract described in section 403(b); and

(*3*) An eligible deferred compensation plan described in section 457(b).

(B) ***Applicable poverty line*** means the amount provided in the poverty guidelines updated periodically in the FEDERAL REGISTER by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2) for the State of residence of the employed designated beneficiary. If the designated beneficiary lives in more than one State during the taxable year, the applicable poverty line is the poverty line for the State in which the designated beneficiary resided longer than in any other State during that year.

(C) ***Excess compensation contribution*** means the amount by which the amount contributed during the taxable year of an employed designated beneficiary to the designated beneficiary's ABLE account exceeds the limit in effect under section 529A(b)(2)(B)(ii) and paragraph (g)(2)(ii)(B) of this section for the calendar year in which the taxable year of the employed designated beneficiary begins.

(iv) ***Example.*** The provisions of paragraph (g)(2)(ii) of this section may be illustrated by the following example: In 2020, A, an employed designated beneficiary as defined in paragraph (g)(2)(iii)(A) of this section, lives in Hawaii. A's compensation, as defined by section 219(f)(1), for 2020 is $20,000. The poverty line for a one-person household in Hawaii was $14,380 in 2019. Because A's compensation exceeded the applicable poverty line amount, A's additional permissible contribution in 2019 is limited to $14,380, the amount of the 2019 applicable poverty line.

(v) ***Ensuring contribution limit is met*** —

(A) ***Responsibility.*** The employed designated beneficiary, or the person acting on his or her behalf, is solely responsible for ensuring that the requirements in section 529A(b)(2)(B)(ii) and paragraph (g)(2)(ii) of this section are met and for maintaining adequate records for that purpose.

(B) ***Certification.*** A qualified ABLE program may allow a designated beneficiary (or the person acting on his or her behalf) to certify, under penalties of perjury, and in the manner specified by the qualified ABLE program that—

(*1*) The designated beneficiary is an employed designated beneficiary; and

(*2*) The designated beneficiary's contributions of compensation are not excess compensation contributions.

(3) ***Cumulative limit*** —

(i) ***In general.*** A qualified ABLE program must provide adequate safeguards to prevent aggregate contributions on behalf of a designated beneficiary in excess of the limit established by that State under section 529(b)(6). For purposes of the preceding sentence, aggregate contributions on behalf of a designated beneficiary include contributions to any prior ABLE account maintained by any State or its agency or instrumentality for the same designated beneficiary, or any former designated beneficiary to the extent his or her ABLE account funds were transferred to the designated beneficiary's ABLE account. The transfer of a designated beneficiary's ABLE account from one qualified ABLE program to another with a lower cumulative limit will not violate this rule, but qualified ABLE programs must prohibit subsequent contributions under this general rule. For purposes of this paragraph (g)(3), contributions do not include rollovers, program-to-program transfers or a designated beneficiary change to a new designated beneficiary who is an eligible individual and member of the family of the former designated beneficiary as defined in § 1.529A-1(b)(12).

(ii) ***Safe harbor.*** A qualified ABLE program maintained by a State or its agency or instrumentality satisfies the requirement under section 529A(b)(6) if it refuses to accept any additional contribution to an ABLE account (except as provided to the contrary in paragraph (g)(3)(i) of this section) while the balance in that account equals or exceeds the limit established by that State under section 529(b)(6). Nevertheless, without regard to the categories of transfers that caused the account balance to exceed the State limit, once the account balance falls below that limit, additional contributions, subject to the annual contributions limit under paragraph (g)(2) of this section and the limit established by such State under section 529(b)(6), again may be accepted.

(4) ***Return of excess contributions, excess compensation contributions, and excess aggregate contributions.*** If an excess contribution as defined in § 1.529A-1(b)(9), an excess compensation contribution as defined in paragraph (g)(2)(iii)(C) of this section, or an excess aggregate contribution as defined in § 1.529A-1(b)(10) is deposited into or allocated to the ABLE account of a designated beneficiary, a qualified ABLE program must return that excess contribution, excess compensation contribution, or excess aggregate contribution, including all net income attributable to that contribution, as determined under the rules set forth in § 1.408-11 (treating references to an IRA as references to an ABLE account and references to returned contributions under section 408(d)(4) as references to excess contributions or excess aggregate contributions), to the person or persons who made that contribution. Each excess contribution, excess compensation contribution, and excess aggregate contribution must be returned to its contributor(s) on a last-in-first-out basis until the entire excess, along with all net income attributable to such excess, has been returned. In the case of an excess compensation contribution, the employed designated beneficiary, or the person acting on the employed designated beneficiary's behalf, is responsible for identifying any excess compensation contribution and for requesting the return of the excess compensation contribution. Returned contributions must be received by the contributor(s) on or before the due date (including

extensions) of the Federal income tax return of the designated beneficiary for the taxable year in which the excess contribution or excess aggregate contribution was made. See § 1.529A-3(a) for Federal income tax considerations for the contributor(s). If an excess contribution or excess aggregate contribution and the net income attributable to the excess contribution or excess aggregate contribution are returned to a contributor other than the designated beneficiary, the qualified ABLE program must notify the designated beneficiary of such return at the time of the return. No notification is required if amounts are rejected by the qualified ABLE program before they are deposited into or allocated to the designated beneficiary's ABLE account.

(5) ***Restriction of contributors.*** A qualified ABLE program may allow the designated beneficiary, from time to time, to restrict who may make contributions to the designated beneficiary's ABLE account.

(h) ***Qualified disability expenses*** —

(1) ***In general.*** Qualified disability expenses are expenses incurred that relate to the blindness or disability of the designated beneficiary of the ABLE account and are for the benefit of that designated beneficiary in maintaining or improving his or her health, independence, or quality of life. See § 1.529A-1(b)(15). Such expenses include, but are not limited to, expenses related to the designated beneficiary's education, housing, transportation, employment training and support, assistive technology and related services, personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, and funeral and burial expenses, as well as other expenses that may be identified from time to time in future guidance published in the Internal Revenue Bulletin. See § 601.601(d)(2) of this chapter. Qualified disability expenses include basic living expenses and are not limited to items for which there is a medical necessity or which solely benefit an individual with a disability.

(2) ***Example.*** The following example illustrates this paragraph (h): B, an individual, has a medically determined mental impairment that causes marked and severe limitations on B's ability to navigate and communicate. A smart phone would enable B to navigate and communicate more safely and effectively, thereby helping B to maintain B's independence and to improve B's quality of life. Therefore, the expense of buying, using, and maintaining a smart phone that is used by B would be a qualified disability expense.

(i) ***Separate accounting.*** A program will not be treated as a qualified ABLE program unless it provides separate accounting for each ABLE account. Separate accounting requires that contributions for the benefit of a designated beneficiary and any earnings attributable thereto must be allocated to that designated beneficiary's ABLE account. Whether or not a program provides each designated beneficiary an annual account statement showing the total account balance, the investment in the account, the accrued earnings, and the distributions from the account, the program must give this information to the designated beneficiary upon request.

(j) ***Program-to-program transfers.*** A qualified ABLE program may permit a change of qualified ABLE program or a change of designated beneficiary by means of a program-to-program transfer as defined in § 1.529A-1(b)(13). In that event, subject to any contrary provisions or limitations adopted by the qualified ABLE program, rules similar to the rules of § 1.401(a)(31)-1, Q&A-3 and 4 (which apply for purposes of a direct rollover from a qualified plan to an eligible retirement plan) apply for purposes of determining whether an amount is paid in the form of a program-to-program transfer.

(k) ***Carryover of attributes*** —

(1) ***In general.*** Upon a rollover, program-to-program transfer, or change of designated beneficiary, all of the attributes of the former ABLE account relevant for purposes of calculating the investment in the account are applicable to the recipient ABLE account. The portion of the rollover or transfer amount that constituted investment in the account from which the distribution or transfer was made is added to investment in the recipient ABLE account. In addition, the portion of the rollover or transfer amount that constituted earnings of the account from which the distribution or transfer was made is added to the earnings of the recipient ABLE account.

(2) ***Annual contribution limit.*** Upon a rollover or program-to-program transfer, for purposes of applying the annual contribution limit under paragraph (g)(2) of this section to the transferee account, annual contributions to the designated beneficiary's transferor ABLE account during the taxable year in which the rollover or program-to-program transfer occurs are included. However, upon a change of designated beneficiary, or upon a rollover or program-to-program transfer to the ABLE account of a different designated beneficiary who is both a member of the family as defined in § 1.529A-1(b)(12) and an eligible individual, no amounts contributed to the prior designated beneficiary's ABLE account are included when applying the annual contribution limit under paragraph (g)(2) of this section.

(3) ***Investment direction limit.*** Upon a rollover or program-to-program transfer, the number of investment directions by the designated beneficiary include the number of investment directions made prior to the rollover or program-to-program transfer during the same taxable year for purposes of paragraph (l) of this section. However, upon a change of designated beneficiary, or upon a rollover or program-to-program transfer to the ABLE account of a different designated beneficiary who is both a member of the family as defined in § 1.529A-1(b)(12) and an eligible individual, the number of investment directions made for the prior designated beneficiary's ABLE account are not included in determining the number of investment directions made for the new designated beneficiary's ABLE account in that same year.

(l) ***Investment direction.*** A program will not be treated as a qualified ABLE program unless it provides that the designated beneficiary of an ABLE account established under such program may direct, whether directly or indirectly, the investment of any contributions to the program (or any earnings thereon) no more than two times in any calendar year. Such an investment direction does not include a request to transfer any part of the account balance from an investment option to a cash equivalent option to effectuate a distribution, or the automatic rebalancing of the assets of an ABLE account to maintain the asset allocation level chosen when the account was established or by a subsequent investment direction.

(m) ***No pledging of interest as security for a loan.*** A program will not be treated as a qualified ABLE program unless the terms of the program, or a State statute or regulation that governs the program, prohibit any interest in the program or any portion thereof from being used as security for a loan. For this purpose, the program administrator's advance of funds to satisfy a withdrawal request during the period between the sale of an asset in the ABLE account (whose value is sufficient to satisfy the withdrawal request) and the clearing or settlement of that sale, does not constitute a loan, pledge, or grant of security for a loan. Similarly, the use of checking accounts or debit cards to facilitate a qualified ABLE program's ability to make distributions will not be treated as a pledge or grant of security for a loan during the period between the use of the check or debit card and the clearing or settlement of that transaction, provided that the ABLE program does not advance funds to a designated beneficiary in excess of the amount in the designated beneficiary's ABLE account.

(n) ***No sale or exchange.*** A qualified ABLE program must ensure that no interest in an ABLE account may be sold or exchanged.

(o) ***Post-death payments.*** A qualified ABLE program must provide that a portion or all of the balance remaining in the ABLE account of a deceased designated beneficiary must be distributed to a State that files a claim against the designated beneficiary or the ABLE account itself with respect to benefits provided to the designated beneficiary under that State's Medicaid plan established under title XIX of the Social Security Act. The payment of such claim (if any) will be made only after providing for the payment from the designated beneficiary's ABLE account of the designated beneficiary's funeral and burial expenses (including the unpaid balance of a pre-death contract for those services) and all outstanding payments due for his or her other qualified disability expenses, and will be limited to the amount of the total medical assistance paid for the designated beneficiary after the establishment of the ABLE account over the amount of any premiums paid, whether from the ABLE account or otherwise by or on behalf of the designated beneficiary, to a Medicaid Buy-In program under any such State Medicaid plan. The establishment of the ABLE account is the date on which the ABLE account was established or, if earlier, the date on which was established any ABLE account for the same designated beneficiary from which amounts were rolled over or transferred to the ABLE account, but in no event earlier than the date on which the designated beneficiary became the designated beneficiary of the account from which amounts were transferred. After the expiration of the applicable statute of limitations for filing Medicaid claims against the designated beneficiary's estate, a qualified ABLE program may distribute the balance of the ABLE account to the successor designated beneficiary or, if none, to the deceased designated beneficiary's estate. A State law prohibiting the filing of such a claim against either the ABLE account or the designated beneficiary's estate will not prevent that State's program from being a qualified ABLE program.

(p) ***Reporting requirements.*** A qualified ABLE program must comply with all applicable reporting requirements, including without limitation those described in §§ 1.529A-5 through 1.529A-7.

(q) ***Applicability date.*** This section applies to calendar years beginning on or after January 1, 2021. See § 1.529A-8 for the provision of transition relief.

§ 1.529A-3 Tax treatment.

(a) ***Taxation of distributions*** —

(1) ***In general.*** Each distribution from an ABLE account consists of an earnings portion of the account (computed in accordance with paragraph (c) of this section) and investment in the account. If the total amount distributed from an ABLE account to or for the benefit of the designated beneficiary of that ABLE account during his or her taxable year does not exceed the qualified disability expenses of the designated beneficiary paid during that year, no amount distributed is includible in the gross income of the designated beneficiary for that year. If the total amount distributed from an ABLE account to or for the benefit of the designated beneficiary of that ABLE account during his or her taxable year exceeds the qualified disability expenses of the designated beneficiary paid during that year (regardless of when incurred), the distributions from the ABLE account, except to the extent excluded from gross income under this section or any other provision of chapter 1 of the Internal Revenue Code, must be included in the gross income of the designated beneficiary in the manner provided under this section and section 72. The amount to be included in gross income is based on the earnings portion of each distribution, computed in accordance with paragraph (c) of this section. The earnings portion that is includible in gross income is the sum of the earnings portion of all distributions made in that year, reduced by an amount that bears the same ratio to the total earnings portion as the amount of qualified disability expenses paid during the year bears to such total distributions during the year. If an excess contribution or excess aggregate contribution is returned

within the time period required in § 1.529A-2(g)(4), any net income distributed is includible in the gross income of the contributor(s) in the taxable year in which the excess contribution or excess aggregate contribution was made.

(2) ***Additional period.*** The designated beneficiary may treat as having been paid during the preceding taxable year qualified disability expenses paid on or before the 60th day immediately following the end of the designated beneficiary's preceding taxable year. Qualified disability expenses treated, pursuant to the rule in the preceding sentence, as having been paid during the designated beneficiary's taxable year immediately prior to the year of their actual payment may not be included in the total qualified disability expenses for the year in which they were paid.

(b) ***Additional exclusions from gross income*** —

(1) ***Rollover.*** A rollover as defined in § 1.529A-1(b)(16) is not included in gross income under paragraph (a) of this section.

(2) ***Program-to-program transfers.*** A program-to-program transfer as defined in § 1.529A-1(b)(13) is not a distribution and is not included in gross income under paragraph (a) of this section.

(3) ***Change of designated beneficiary*** —

(i) ***In general.*** A change of designated beneficiary of an ABLE account is not treated as a distribution for purposes of section 529A, and is not included in gross income under paragraph (a) of this section, if the successor designated beneficiary is—

(A) An eligible individual for the taxable year in which the change is made; and

(B) A member of the family (as defined in § 1.529A-1(b)(12)) of the former designated beneficiary.

(ii) ***Other designated beneficiary changes.*** In the case of any change of designated beneficiary not described in paragraph (b)(3)(i) of this section, the former designated beneficiary of that ABLE account will be treated as having received a distribution of the fair market value of the assets in that ABLE account on the date on which the change is made to the new designated beneficiary.

(4) ***Payments to creditors post-death.*** Distributions made after the death of the designated beneficiary in payment of outstanding obligations due for qualified disability expenses, as well as the funeral and burial expenses of the designated beneficiary, are not included in gross income of the designated beneficiary or his or her estate. Included among these obligations is the post-death payment of any part of a claim filed against the deceased designated beneficiary or his or her estate or ABLE account by a State with respect to benefits provided to the designated beneficiary under that State's Medicaid plan.

(c) ***Computation of earnings.*** The earnings portion of a distribution is equal to the product of the amount of the distribution and the earnings ratio, as defined in § 1.529A-1(b)(7). The balance of the distribution (the amount of the distribution minus the earnings portion of that distribution) is the portion of that distribution that constitutes the return of investment in the account.

(d) ***Additional tax on amounts includible in gross income*** —

(1) ***In general.*** If any amount of a distribution from an ABLE account is includible in the gross income of a person for any taxable year under paragraph (a) of this section (includible amount), the income tax imposed on that person by chapter 1 of the Internal Revenue Code will be increased by an amount equal to 10 percent of the includible amount.

(2) ***Exceptions*** —

(i) ***Distributions on or after the death of the designated beneficiary.*** Paragraph (d)(1) of this section does not apply to any distribution made from the ABLE account on or after the death of the designated beneficiary to the estate of the designated beneficiary, to an heir or legatee of the designated beneficiary, or to a creditor described in paragraph (b)(4) of this section.

(ii) ***Returned excess contributions and additional accounts.*** Paragraph (d)(1) of this section does not apply to any return made in accordance with § 1.529A-2(g)(4) of an excess contribution as defined in § 1.529A-1(b)(9), an excess compensation contribution as defined in § 1.529A-2(g)(2)(iii)(C), excess aggregate contribution as defined in § 1.529A-1(b)(10), or an additional account as referenced in § 1.529A-2(c)(3)(ii)(A), (B), or (C).

(e) ***Tax on excess contributions.*** Under section 4973(h), a contribution to an ABLE account in excess of the annual contributions limit described in § 1.529A-2(g)(2) is subject to an excise tax in an amount equal to 6 percent of the excess contribution. However, any the excess contribution or excess compensation contribution as defined in § 1.529A-2(g)(2)(iii)(C) returned in accordance with the provisions of § 1.529A-2(g)(4) is not treated as a contribution.

(f) ***Filing requirements.*** A qualified ABLE program is not required to file Form 990, "Return of Organization Exempt From Income Tax," Form 1041, "U.S. Income Tax Return for Estates and Trusts," or Form 1120, "U.S. Corporation Income Tax Return." However, a qualified ABLE program is required to file Form 990-T, "Exempt Organization Business Income Tax Return," if such filing would be required under the rules of §§ 1.6012-2(e) and 1.6012-3(a)(5) if the ABLE program were an organization described in those sections.

(g) ***No inference outside section 529A.*** The rules provided in this section concerning the Federal tax treatment of contributions apply only for purposes of the application of section 529A. No inference is intended with respect to the application of any other Code provisions or Federal tax doctrines. For example, a contribution made by an employer to the ABLE account of an employee or an employee's family member is subject to the rules governing the Federal taxation of compensation.

(h) ***Applicability date.*** This section applies to calendar years beginning on or after January 1, 2021. See § 1.529A-8 for the provision of transition relief.

§ 1.529A-4 Gift, estate, and generation-skipping transfer taxes.

(a) ***Contributions*** —

(1) ***In general.*** Each contribution by a person to an ABLE account other than by the designated beneficiary of that account is treated as a completed gift to the designated beneficiary of the account for gift tax purposes. Under the applicable Federal gift tax rules, a contribution from a corporation, partnership, trust, estate, or other entity is treated as a gift by the shareholders, partners, or other beneficial owners in proportion to their respective ownership interests in the entity. See § 25.2511-1(c) and (h) of this chapter. A gift to an ABLE account is not treated as either a gift of a future interest in property, or a qualified transfer under section 2503(e). To the extent a contributor's gifts to the designated beneficiary, including gifts paid into the designated beneficiary's ABLE account, do not exceed the annual limit in section 2503(b), the contribution is not a taxable gift. This provision, however, does not change any other provision applicable to the transfer. For example, a contribution by the employer of the designated beneficiary's parent continues to constitute earned income to the parent and then a gift by the parent to the designated beneficiary. The timely return of an excess contribution or an excess aggregate contribution in accordance with § 1.529A-2(g)(4) is not a taxable gift.

(2) ***Generation-skipping transfer (GST) tax.*** To the extent the contribution into an ABLE account is a nontaxable gift for Federal gift tax purposes, the inclusion ratio for purposes of the GST tax will be zero pursuant to section 2642(c)(1).

(3) ***Designated beneficiary as contributor.*** A designated beneficiary may make a contribution to fund his or her own ABLE account. That contribution is not a gift.

(b) ***Distributions.*** No distribution from an ABLE account to or for the benefit of the designated beneficiary is treated as a taxable gift to that designated beneficiary.

(c) ***Transfer to another designated beneficiary.*** Neither gift tax nor generation-skipping transfer tax applies to the transfer (by rollover, program-to-program transfer, or change of beneficiary) of part or all of an ABLE account to the ABLE account of a different designated beneficiary if the successor designated beneficiary is both an eligible individual and a member of the family (as described in § 1.529A-1(b)(12)) of the designated beneficiary. Any other transfer will constitute a gift by the designated beneficiary to the successor designated beneficiary, and the usual gift and GST tax rules will apply.

(d) ***Transfer tax on death of designated beneficiary.*** Upon the death of the designated beneficiary, the designated beneficiary's ABLE account is includible in his or her gross estate for estate tax purposes under section 2031. The payment of outstanding qualified disability expenses and the payment of certain claims made by a State under its Medicaid plan may be deductible for estate tax purposes if the requirements of section 2053 are satisfied.

(e) ***Applicability date.*** This section applies to calendar years beginning on or after January 1, 2021. See § 1.529A-8 for the provision of transition relief.

§ 1.529A-5 Reporting of the establishment of and contributions to an ABLE account.

(a) ***In general.*** A filer defined in paragraph (b)(1) of this section must, with respect to each ABLE account—

(1) File an annual information return, as described in paragraph (c) of this section, with the Internal Revenue Service; and

(2) Furnish an annual statement, as described in paragraph (d) of this section, to the designated beneficiary of the ABLE account.

(b) ***Additional definitions.*** In addition to the definitions in § 1.529A-1(b), the following definitions also apply for purposes of this section—

(1) ***Filer*** means the State or its agency or instrumentality that establishes and maintains the qualified ABLE program under which an ABLE account is established. The filing may be done by either an officer or employee of the State or its agency or instrumentality having control of the qualified ABLE program, or the officer's or employee's designee.

(2) ***TIN*** means taxpayer identification number as defined in section 7701(a)(41).

(c) ***Requirement to file return*** —

(1) ***Form of return.*** For purposes of reporting the information described in paragraph (c)(2) of this section, the filer must file Form 5498-QA, "ABLE Account Contribution Information," or any successor form, together with Form 1096, "Annual Summary and Transmittal of U.S. Information Returns."

(2) ***Information included on return.*** With respect to each ABLE account, the filer must include on the return—

(i) The name, address, and TIN of the designated beneficiary of the ABLE account;

(ii) The name, address, and TIN of the filer;

(iii) Information regarding the establishment of the ABLE account, as required by the form and its instructions;

(iv) Information regarding the disability certification or other basis for eligibility of the designated beneficiary, as required by the form and its instructions. For further information regarding eligibility and disability certification, see § 1.529A-2(d) and (e), respectively;

(v) The total amount of any contributions made with respect to the ABLE account during the calendar year; such contributions do not include any contribution rejected and returned to the contributor before being deposited into or allocated to the ABLE account or any excess contributions, excess compensation contributions, or excess aggregate contributions returned as described in § 1.529A-2(g)(4);

(vi) The fair market value of the ABLE account as of the last day of the calendar year; and

(vii) Any other information required by the form, its instructions, or published guidance. See §§ 601.601(d) and 601.602 of this chapter.

(3) ***Time and manner of filing return*** —

(i) ***In general.*** Except as provided in paragraph (c)(3)(ii) of this section, the information returns required under this paragraph must be filed on or before May 31 of the year following the calendar year with respect to which the return is being filed, in accordance with the forms and their instructions.

(ii) ***Extensions of time.*** See §§ 1.6081-1 and 1.6081-8 for rules relating to extensions of time to file information returns required in this section.

(iii) ***Electronic filing.*** See § 301.6011-2 of this chapter for rules relating to electronic filing. See also Instructions for Forms 1099-QA and 5498-QA, Distributions From ABLE Accounts and ABLE Account Contribution Information.

(iv) ***Substitute forms.*** The filer may file the returns required under this paragraph (c) on an acceptable substitute form. See Publication 1179, "General Rules and Specifications for Substitute Forms 1096, 1098, 1099, 5498, and Certain Other Information Returns."

(d) ***Requirement to furnish statement*** —

(1) ***In general.*** The filer must furnish a statement to the designated beneficiary of the ABLE account for which it is required to file a Form 5498-QA (or any successor form). The statement must include—

(i) The information required under paragraph (c)(2) of this section;

(ii) A legend that identifies the statement as important tax information that is being furnished to the Internal Revenue Service; and

(iii) The name and address of the office or department of the filer that is the information contact for questions regarding the ABLE account to which the Form 5498-QA relates.

(2) ***Time and manner of furnishing statement*** —

(i) ***In general.*** Except as provided in paragraph (d)(2)(ii) of this section, the filer must furnish the statement described in paragraph (d)(1) of this section to the designated beneficiary on or before March 15 of the year following the calendar year with respect to which the statement is being furnished. If mailed, the statement must be sent to the designated beneficiary's last known address. The statement may be furnished electronically, as provided in § 1.529A-7.

(ii) ***Extensions of time.*** The Internal Revenue Service may, at its discretion, grant an extension of time to furnish statements required in this section.

(3) ***Copy of Form 5498-QA.*** The filer may satisfy the requirement of this paragraph (d) by furnishing either a copy of Form 5498-QA (or successor form) or an acceptable substitute form. See Publication 1179, "General Rules and Specifications for Substitute Forms 1096, 1098, 1099, 5498, and Certain Other Information Returns."

(e) ***Request for TIN of designated beneficiary.*** The filer must request the TIN of the designated beneficiary at the time the ABLE account is established if the filer does not already have a record of the designated beneficiary's correct TIN. The filer must clearly notify the designated beneficiary that the law requires the designated beneficiary to furnish a TIN so that it may be included on an information return to be filed by the filer. The designated beneficiary may provide his or her TIN in any manner including orally, in writing, or electronically. If the TIN is furnished in writing, no particular form is required. Form W-9, "Request for Taxpayer Identification Number and Certification," may be used, or the request may be incorporated into the forms related to the establishment of the ABLE account.

(f) ***Penalties*** —

(1) ***Failure to file return.*** The section 6693 penalty may apply to the filer that fails to file information returns at the time and in the manner required by this section, unless it is shown that such failure is due to reasonable cause. See section 6693 and § 301.6693-1 of this chapter.

(2) ***Failure to furnish TIN.*** The section 6723 penalty may apply to any designated beneficiary who fails to furnish his or her TIN to the filer. See section 6723, and § 301.6723-1 of this chapter, for rules relating to the penalty for failure to furnish a TIN.

(g) ***Applicability date.*** The rules of this section apply to information returns required to be filed, and payee statements required to be furnished, after December 31, 2020. See § 1.529A-8 for the provision of transition relief.

§ 1.529A-6 Reporting of distributions from and termination of an ABLE account.

(a) ***In general.*** The filer as defined in § 1.529A-5(b)(1) must, with respect to each ABLE account from which any distribution is made or which is terminated during the calendar year—

(1) File an annual information return, as described paragraph (b) of this section, with the Internal Revenue Service; and

(2) Furnish an annual statement, as described in paragraph (c) of this section, to the designated beneficiary of the ABLE account and to each contributor who received a returned contribution in accordance with § 1.529A-2(g)(4) attributable to the calendar year.

(b) ***Requirement to file return*** —

(1) ***Form of return.*** For purposes of reporting the information in paragraph (b)(2) of this section, the filer must file Form 1099-QA, "Distributions From ABLE Accounts," or any successor form, together with Form 1096, "Annual Summary and Transmittal of U.S. Information Returns."

(2) ***Information included on return.*** The filer must include on the return—

(i) The name, address, and TIN of the recipient of the payment, whether the designated beneficiary of the ABLE account or any contributor who received a returned contribution in accordance with § 1.529A-2(g)(4) attributable to the calendar year;

(ii) The name, address, and TIN of the filer;

(iii) Whether the return is being filed with respect to the designated beneficiary or to a contributor;

(iv) The aggregate amount of distributions or returned contributions (including net income attributable to the returned contributions) from the ABLE account to the recipient during the calendar year;

(v) Information as to basis and earnings with respect to such distributions or returns of contributions;

(vi) Information regarding termination (if any) of the ABLE account if the recipient is the designated beneficiary;

(vii) Information regarding each program-to-program transfer from the ABLE account during the designated beneficiary's taxable year; and

(viii) Any other information required by the form, its instructions, or published guidance. See §§ 601.601(d) and 601.602 of this chapter.

(3) ***Information excluded.*** A State filing a claim against the estate or ABLE account of a deceased designated beneficiary with respect to benefits provided to the designated beneficiary under that State's Medicaid plan is a creditor, and not a beneficiary, so the payment of the claim is not a distribution from the ABLE account and should not be reported as such on the Form 1099-QA for that year.

(4) ***Time and manner of filing return*** —

(i) ***In general.*** Except as provided in paragraph (b)(4)(ii) of this section, the Forms 1099-QA and 1096 must be filed on or before February 28 (March 31 if filing electronically) of the year following the calendar year with respect to which the return is being filed, in accordance with the forms and their instructions.

(ii) ***Extensions of time.*** See §§ 1.6081-1 and 1.6081-8 for rules relating to extensions of time to file information returns required in this section.

(iii) ***Electronic filing.*** See § 301.6011-2 of this chapter for rules relating to electronic filing. See also Instructions for Forms 1099-QA and 5498-QA, Distributions From ABLE Accounts and ABLE Account Contribution Information.

(iv) ***Substitute forms.*** The filer may file the return required under this paragraph (b) on an acceptable substitute form. See Publication 1179, "General Rules and Specifications for Substitute Forms 1096, 1098, 1099, 5498, and Certain Other Information Returns."

(c) ***Requirement to furnish statement*** —

(1) ***In general.*** The filer must furnish a statement to the designated beneficiary and each contributor (if any) of the ABLE account for which it is required to file a Form 1099-QA (or any successor form). The statement must include—

(i) The information required under paragraph (b)(2) of this section.

(ii) A legend that identifies the statement as important tax information that is being furnished to the Internal Revenue Service; and

(iii) The name and address of the office or department of the filer that is the information contact for questions regarding the ABLE account to which the Form 1099-QA relates.

(2) ***Time and manner of furnishing statement*** —

(i) ***In general.*** Except as provided in paragraph (c)(2)(ii) of this section, a filer must furnish the statement described in paragraph (c)(1) of this section to the designated beneficiary or contributor on or before January 31 of the year following the calendar year with respect to which the statement is being furnished. If mailed, the statement must be sent to the recipient's last known address. The statement may be furnished electronically, as provided in § 1.529A-7.

(ii) ***Extensions of time.*** The Internal Revenue Service may, at its discretion, grant an extension of time to furnish statements required in this section.

(3) ***Copy of Form 1099-QA.*** A filer may satisfy the requirement of this paragraph (c) by furnishing either a copy of Form 1099-QA (or successor form) or an acceptable substitute form. See Publication 1179, “General Rules and Specifications for Substitute Forms 1096, 1098, 1099, 5498, and Certain Other Information Returns.”

(d) ***Request for TIN of contributor(s)*** —

(1) ***In general.*** Except as provided in paragraph (d)(2) of this section, a filer must request the TIN of each contributor to the ABLE account at the time a contribution is made, if the filer does not already have a record of that person's correct TIN.

(2) ***Exception.*** If the filer has a system in place to identify and reject amounts that either would constitute an excess contribution or excess aggregate contribution (as defined in § 1.529A-1(b)(9) or (10), respectively) or were contributed to an additional ABLE account as described in § 1.529A-2(c)(3)(ii)(C) (excess amounts) before those excess amounts are deposited into or allocated to an ABLE account, the filer need not request the TIN of each contributor at the time of contribution. A filer with such a system must request a contributor's TIN only if and when an excess contribution or excess aggregate contribution nevertheless is deposited into or allocated to an account and the filer must return the excess amounts including net income to the contributor. The filer must clearly notify each such contributor to the account that the law requires that person to furnish a TIN so that it may be included on an information return to be filed by the filer. The contributor may provide his or her TIN in any manner including orally, in writing, or electronically. If the TIN is furnished in writing, no particular form is required. Form W-9, “Request for Taxpayer Identification Number and Certification,” may be used, or the request may be incorporated into the forms related to the establishment of the ABLE account.

(e) ***Penalties*** —

(1) ***Failure to file return.*** The section 6693 penalty may apply to a filer that fails to file information returns at the time and in the manner required by this section, unless it is shown that such failure is due to reasonable cause. See section 6693 and § 301.6693-1 of this chapter.

(2) ***Failure to furnish TIN.*** The section 6723 penalty may apply to any contributor who fails to furnish his or her TIN to the filer in accordance with paragraph (d) of this section. See section 6723, and § 301.6723-1 of this chapter, for rules relating to the penalty for failure to furnish a TIN.

(f) ***Applicability date.*** The rules of this section apply to information returns required to be filed, and payee statements required to be furnished, after December 31, 2020. See § 1.529A-8 for the provision of transition relief.

§ 1.529A-7 Electronic furnishing of statements to designated beneficiaries and contributors.

(a) ***Electronic furnishing of statements*** —

(1) ***In general.*** A filer required under § 1.529A-5 or § 1.529A-6 to furnish a written statement to a designated beneficiary of or contributor to an ABLE account may furnish the statement in an electronic format in lieu of a paper format. A filer who meets the requirements of paragraphs (a)(2) through (6) of this section is treated as furnishing the required statement.

(2) ***Consent*** —

(i) ***In general.*** The recipient of the statement must have affirmatively consented to receive the statement in an electronic format. The consent may be made electronically in any manner that reasonably demonstrates that the recipient can access the statement in the electronic format in which it will be furnished to the recipient. Alternatively, the consent may be made in a paper document if it is confirmed electronically.

(ii) ***Withdrawal of consent.*** The consent requirement of this paragraph (a)(2) is not satisfied if the recipient withdraws the consent and the withdrawal takes effect before the statement is furnished. The filer may provide that a withdrawal of consent takes effect either on the date it is received by the filer or on another date no more than 60 days later. The filer also may provide that a request for a paper statement will be treated as a withdrawal of consent.

(iii) ***Change in hardware or software requirements.*** If a change in the hardware or software required to access the statement creates a material risk that the recipient will not be able to access the statement, the filer must, prior to changing the hardware or software, provide the recipient with a notice. The notice must describe the revised hardware and software required to access the statement and inform the recipient that a new consent to receive the statement in the revised electronic format must be provided to the filer if the recipient does not want to withdraw the consent. After implementing the revised hardware and software, the filer must obtain from the recipient, in the manner described in paragraph (a)(2)(i) of this section, a new consent or confirmation of consent to receive the statement electronically.

(iv) ***Examples.*** For purposes of the following examples that illustrate the rules of this paragraph (a)(2), assume that the requirements of § 1.529A-7(a)(3) have been met:

(A) ***Example 1.*** Filer F sends Recipient R a letter stating that R may consent to receive statements required under § 1.529A-5 or § 1.529A-6 electronically on a website instead of in a paper format. The letter contains instructions explaining how to consent to receive the statements electronically by accessing the website, downloading the consent document, completing the consent document, and emailing the completed consent back to F. The consent document posted on the website uses the same electronic format that F

will use for the electronically furnished statements. R reads the instructions and submits the consent in the manner provided in the instructions. R has consented to receive the statements electronically in the manner described in paragraph (a)(2)(i) of this section.

(B) ***Example 2.*** Filer F sends Recipient R an email stating that R may consent to receive statements required under § 1.529A-5 or § 1.529A-6 electronically instead of in a paper format. The email contains an attachment instructing R how to consent to receive the statements electronically. The email attachment uses the same electronic format that F will use for the electronically furnished statements. R opens the attachment, reads the instructions, and submits the consent in the manner provided in the instructions. R has consented to receive the statements electronically in the manner described in paragraph (a)(2)(i) of this section.

(C) ***Example 3.*** Filer F posts a notice on its website stating that Recipient R may receive statements required under § 1.529A-5 or § 1.529A-6 electronically instead of in a paper format. The website contains instructions on how R may access a secure web page and consent to receive the statements electronically. By accessing the secure web page and giving consent, R has consented to receive the statements electronically in the manner described in paragraph (a)(2)(i) of this section.

(3) ***Required disclosures*** —

(i) ***In general.*** Prior to, or at the time of, a recipient's consent, the filer must provide to the recipient a clear and conspicuous disclosure statement containing each of the disclosures described in paragraphs (a)(3)(ii) through (viii) of this section.

(ii) ***Paper statement.*** The recipient must be informed that the statement will be furnished on paper if the recipient does not consent to receive it electronically.

(iii) ***Scope and duration of consent.*** The recipient must be informed of the scope and duration of the consent. For example, the recipient must be informed whether the consent applies to statements furnished every year after the consent is given until it is withdrawn in the manner described in paragraph (a)(3)(v)(A) of this section, or only to the statement required to be furnished on or before the due date immediately following the date on which the consent is given.

(iv) ***Post-consent request for a paper statement.*** The recipient must be informed of any procedure for obtaining a paper copy of the recipient's statement after giving the consent and whether a request for a paper statement will be treated as a withdrawal of consent.

(v) ***Withdrawal of consent.*** The recipient must be informed that—

(A) The recipient may withdraw a consent by writing (electronically or on paper) to the person or department whose name, mailing address, and email address is provided in the disclosure statement;

(B) The filer will confirm, in writing (electronically or on paper), the withdrawal and the date on which it takes effect; and

(C) A withdrawal of consent does not apply to a statement that was furnished electronically in the manner described in this paragraph (a) before the date on which the withdrawal of consent takes effect.

(vi) ***Notice of termination.*** The recipient must be informed of the conditions under which a filer will cease furnishing statements electronically to the recipient.

(vii) ***Updating information.*** The recipient must be informed of the procedures for updating the information needed by the filer to contact the recipient. The filer must inform the recipient of any change in the filer's contact information.

(viii) ***Hardware and software requirements.*** The recipient must be provided with a description of the hardware and software required to access, print, and retain the statement, and the date when the statement will no longer be available on the website.

(4) ***Format.*** The electronic version of the statement must contain all required information. See Publication 1179, "General Rules and Specifications for Substitute Forms 1096, 1098, 1099, 5498, and Certain Other Information Returns."

(5) ***Notice*** —

(i) ***In general.*** If the statement is furnished on a website, the filer must notify the recipient that the statement is posted on a website. The notice may be delivered by mail, electronic mail, or in person. The notice must provide instructions on how to access and print the statement. The notice must include the following statement in capital letters, "IMPORTANT TAX RETURN DOCUMENT AVAILABLE." If the notice is provided by electronic mail, the foregoing statement must be in the subject line of the electronic mail.

(ii) ***Undeliverable electronic address.*** If an electronic notice described in paragraph (a)(5)(i) of this section is returned as undeliverable, and the correct electronic address cannot be obtained from the filer's records or from the recipient, then the filer must furnish the notice by mail or in person within 30 days after the electronic notice is returned.

(iii) ***Corrected statements.*** If the filer has corrected a recipient's statement that was furnished electronically, the filer must furnish the corrected statement to the recipient electronically. If the recipient's statement was furnished through a website posting and the filer has corrected the statement, the filer must notify the recipient that it has posted the corrected statement on the website within 30 days of such posting in the manner described in paragraph (a)(5)(i) of this section. The corrected statement or the notice must be furnished by mail or in person if—

(A) An electronic notice of the website posting of an original statement or the corrected statement was returned as undeliverable; and

(B) The recipient has not provided a new email address.

(6) ***Access period.*** Statements furnished on a website must be retained on the website through October 15 of the year following the calendar year to which the statements relate (or the first business day after such October 15 if October 15 falls on a Saturday, Sunday, or legal holiday). The filer must maintain access to corrected statements that are posted on the website through October 15 of the year following the calendar year to which the statements relate (or the first business day after such October 15 if October 15 falls on a Saturday, Sunday, or legal holiday) or the date 90 days after the corrected statements are posted, whichever is later. The rules in this paragraph (a)(6) do not replace the filer's obligation to keep records under section 6001 and § 1.6001-1(a).

(b) ***Applicability date.*** This section applies to statements required to be furnished after December 31, 2020. See § 1.529A-8 for the provision of transition relief.

§ 1.529A-8 Applicability dates and transition relief.

(a) ***Applicability dates.*** Except as otherwise provided in paragraph (b) of this section, §§ 1.529A-1 through 1.529A-4 apply for calendar years beginning on or after January 1, 2021, §§ 1.529A-5 and 1.529A-6 apply to information returns required to be filed, and payee statements required to be furnished, after December 31, 2020, and § 1.529A-7 applies to statements required to be furnished after December 31, 2020.

(b) ***Transition relief*** —

(1) ***In general.*** Any program purporting to be a qualified ABLE program will not be disqualified during the transition period set forth in paragraph (b)(2) of this section (transition period) solely because of noncompliance with one or more provisions of §§ 1.529A-1 through 1.529A-7, provided that the program is established and operated in accordance with a reasonable, good faith interpretation of section 529A. Similarly, no ABLE account established and maintained under a program that meets the requirements of this paragraph will fail to qualify as an ABLE account during the transition period. However, to be a qualified ABLE program and an ABLE account under such a program after the transition period, the program and each account established and maintained under the program must be in compliance with §§ 1.529A-1 through 1.529A-7 by the end of the transition period. In no event, however, will a complete failure to file and furnish reports, information returns and payee statements required under section 529A(d)(1) for any accounts established and maintained under the program (including for calendar years beginning prior to January 1, 2021), be deemed to be due to reasonable cause for purposes of avoiding penalties imposed under section 6693.

(2) ***Transition period.*** For purposes of paragraph (b)(1) of this section, the transition period begins with the establishment of the program purporting to be a qualified ABLE program and continues through the later of—

(i) November 21, 2022; or

(ii) The day immediately preceding the first day of the qualified ABLE program's first taxable year beginning after the close of the first regular session of the State legislature that begins after November 19, 2020. If a State has a two-year legislative session, each calendar year of such session will be deemed to be a separate regular session of the State legislature for purposes of this paragraph.

(3) ***Compliance after transition period.*** After the transition period, a program and an account established and maintained under that program must be in compliance with §§ 1.529A-1 through 1.529A-7.

Title 42 —Public Health
Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter C —Medical Assistance Programs
Part 433 —State Fiscal Administration
Subpart A —Federal Matching and General Administration Provisions

Authority: 42 U.S.C. 1302.
Source: 43 FR 45201, Sept. 29, 1978, unless otherwise noted.

§ 433.36 Liens and recoveries.

(a) ***Basis and purpose.*** This section implements sections 1902(a)(18) and 1917(a) and (b) of the Act, which describe the conditions under which an agency may impose a lien against a beneficiary's property, and when an agency may make an adjustment or recover funds in satisfaction of the claim against the individual's estate or real property.

(b) ***Definition of property.*** For purposes of this section, "property" includes the homestead and all other personal and real property in which the beneficiary has a legal interest.

(c) ***State plan requirement.*** If a State chooses to impose a lien against an individual's real property (or as provided in paragraph (g)(1) of this section, personal property), the State plan must provide that the provisions of paragraphs (d) through (i) of this section are met.

(d) ***Procedures.*** The State plan must specify the process by which the State will determine that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home as provided in paragraph (g)(2)(ii) of this section. The description of the process must include the type of notice to be given the individual, the process by which the individual will be given the opportunity for a hearing, the hearing procedures, and by whom and on what basis the determination that the individual cannot reasonably be expected to be discharged from the institution will be made. The notice to the individual must explain what is meant by the term lien, and that imposing a lien does not mean that the individual will lose ownership of the home.

(e) ***Definitions.*** The State plan must define the following terms used in this section:

(1) Individual's home.

(2) Equity interest in home.

(3) Residing in the home for at least 1 (or 2) year(s).

(4) On a continuing basis.

(5) Discharge from the medical institution and return home.

(6) Lawfully residing.

(f) ***Exception.*** The State plan must specify the criteria by which a son or daughter can establish to the agency's satisfaction that he or she has been providing care which permitted the individual to reside at home rather than in an institution, as provided in paragraph (h)(2)(iii)(B) of this section.

(g) ***Lien provisions*** —

(1) ***Incorrect payments.*** The agency may place a lien against an individual's property, both personal and real, before his or her death because of Medicaid claims paid or to be paid on behalf of that individual following a court judgement which determined that benefits were incorrectly paid for that individual.

(2) ***Correct payments.*** Except as provided in paragraph (g)(3) of this section, the agency may place a lien against the real property of an individual at any age before his or her death because of Medicaid claims paid or to be paid for that individual when—

(i) An individual is an inpatient of a medical institution and must, as a condition of receiving services in the institution under the State plan, apply his or her income to the cost of care as provided in §§ 435.725, 435.832 and 436.832; and

(ii) The agency determines that he or she cannot reasonably be expected to be discharged and return home. The agency must notify the individual of its intention to make that determination and provide an opportunity for a hearing in accordance with State established procedures before the determination is made. The notice to an individual must include an explanation of liens and the effect on an individual's ownership of property.

(3) ***Restrictions on placing liens.*** The agency may not place a lien on an individual's home under paragraph (g)(2) of this section if any of the following individuals is lawfully residing in the home:

(i) The spouse;

(ii) The individual's child who is under age 21 or blind or disabled as defined in the State plan; or

(iii) The individual's sibling (who has an equity interest in the home, and who was residing in the individual's home for at least one year immediately before the date the individual was admitted to the medical institution).

(4) ***Termination of lien.*** Any lien imposed on an individual's real property under paragraph (g)(2) of this section will dissolve when that individual is discharged from the medical institution and returns home.

(h) ***Adjustments and recoveries.***

(1) The agency may make an adjustment or recover funds for Medicaid claims correctly paid for an individual as follows:

(i) From the estate of any individual who was 65 years of age or older when he or she received Medicaid; and

(ii) From the estate or upon sale of the property subject to a lien when the individual is institutionalized as described in paragraph (g)(2) of this section.

(2) The agency may make an adjustment or recovery under paragraph (h)(1) of this section only:

(i) After the death of the individual's surviving spouse; and

(ii) When the individual has no surviving child under age 21 or blind or disabled as defined in the State plan; and

(iii) In the case of liens placed on an individual's home under paragraph (g)(2) of this section, when there is no—

(A) Sibling of the individual residing in the home, who has resided there for at least one year immediately before the date of the individual's admission to the institution, and has resided there on a continuous basis since that time; or

(B) Son or daughter of the individual residing in the home, who has resided there for at least two years immediately before the date of the individual's admission to the institution, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he or she has been providing care which permitted the individual to reside at home rather than in an institution.

(i) ***Prohibition of reduction of money payments.*** No money payment under another program may be reduced as a means of recovering Medicaid claims incorrectly paid.

[43 FR 45201, Sept. 29, 1978, as amended at 47 FR 43647, Oct. 1, 1982; 47 FR 49847, Nov. 3, 1982]

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 404 —Federal Old-Age, Survivors and Disability Insurance (1950-)
Subpart D —Old-Age, Disability, Dependents' and Survivors' Insurance Benefits; Period of Disability

Authority: Secs. 202, 203(a) and (b), 205(a), 216, 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 403(a) and (b), 405(a), 416, 423, 425, and 902(a)(5)).

Source: 44 FR 34481, June 15, 1979, unless otherwise noted.

Child's Benefits

CHILD'S BENEFITS

§ 404.350 Who is entitled to child's benefits?

(a) ***General.*** You are entitled to child's benefits on the earnings record of an insured person who is entitled to old-age or disability benefits or who has died if—

(1) You are the insured person's child, based upon a relationship described in §§ 404.355 through 404.359;

(2) You are dependent on the insured, as defined in §§ 404.360 through 404.365;

(3) You apply;

(4) You are unmarried; and

(5) You are under age 18; you are 18 years old or older and have a disability that began before you became 22 years old; or you are 18 years or older and qualify for benefits as a full-time student as described in § 404.367.

(b) ***Entitlement preclusion for certain disabled children.*** If you are a disabled child as referred to in paragraph (a)(5) of this section, and your disability was based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535) and your benefits ended after your receipt of 36 months of benefits, you will not be entitled to benefits based on disability for any month following such 36 months regardless of the number of entitlement periods you have had if, in such following months, drug addiction or alcoholism is a contributing factor material to the later determination of disability (as described in § 404.1535).

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 60 FR 8146, Feb. 10, 1995; 61 FR 38363, July 24, 1996]

§ 404.351 Who may be reentitled to child's benefits?

If your entitlement to child's benefits has ended, you may be reentitled on the same earnings record if you have not married and if you apply for reentitlement. Your reentitlement may begin with—

(a) The first month in which you qualify as a full-time student. (See § 404.367.)

(b) The first month in which you are disabled, if your disability began before you became 22 years old.

(c) The first month you are under a disability that began before the end of the 84th month following the month in which your benefits had ended because an earlier disability had ended; or

(d) With respect to benefits payable for months beginning October 2004, you can be reentitled to childhood disability benefits at anytime if your prior entitlement terminated because you ceased to be under a disability due to the performance of substantial gainful activity and you meet the other requirements for reentitlement. The 84-month time limit in paragraph (c) in this section continues to apply if your previous entitlement to childhood disability benefits terminated because of medical improvement.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 61 FR 38363, July 24, 1996; 71 FR 66865, Nov. 17, 2006]

§ 404.352 When does my entitlement to child's benefits begin and end?

(a) We will find your entitlement to child's benefits begins at the following times:

(1) If the insured is deceased, with the first month covered by your application in which you meet all other requirements for entitlement.

(2) If the insured is living and your first month of entitlement is September 1981 or later, with the first month covered by your application throughout which you meet all other requirements for entitlement.

(3) If the insured is living and your first month of entitlement is before September 1981, with the first month covered by your application in which you meet all other requirements for entitlement.

(b) We will find your entitlement to child's benefits ends at the earliest of the following times:

(1) With the month before the month in which you become 18 years old, if you are not disabled or a full-time student.

(2) With the second month following the month in which your disability ends, if you become 18 years old and you are disabled. If your disability ends on or after December 1, 1980, your entitlement to child's benefits continues, subject to the provisions of paragraphs (c) and (d) of this section, until the month before your termination month (§ 404.325).

(3) With the last month you are a full-time student or, if earlier, with the month before the month you become age 19, if you become 18 years old and you qualify as a full-time student who is not disabled. If you become age 19 in a month in which you have not completed the requirements for, or received, a diploma or equivalent certificate from an elementary or secondary school and you are required to enroll for each quarter or semester, we will find your entitlement ended with the month in which the quarter or semester in which you are enrolled ends. If the school you are attending does not have a quarter or semester system which requires reenrollment, we will find your entitlement to benefits ended with the month you complete the course or, if earlier, the first day of the third month following the month in which you become 19 years old.

(4) With the month before the month you marry. We will not find your benefits ended, however, if you are age 18 or older, disabled, and you marry a person entitled to child's benefits based on disability or person entitled to old-age, divorced wife's, divorced husband's, widow's, widower's, mother's, father's, parent's, or disability benefits.

(5) With the month before the month the insured's entitlement to old-age or disability benefits ends for a reason other than death or the attainment of full retirement age (as defined in § 404.409). Exception: We will continue your benefits if the insured person was entitled to disability benefits based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of his or her disability (as described in § 404.1535), the insured person's benefits ended after 36 months of payment (see § 404.316(e)) or 12 consecutive months of suspension for noncompliance with treatment (see § 404.316(f)), and the insured person remains disabled.

(6) With the month before the month you die.

(7) With the month in which the divorce between your parent (including an adoptive parent) and the insured stepparent becomes final if you are entitled to benefits as a stepchild and the marriage between your parent (including an adoptive parent) and the insured stepparent ends in divorce.

(c) If you are entitled to benefits as a disabled child age 18 or over and your disability is based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535), we will find your entitlement to benefits ended under the following conditions:

(1) If your benefits have been suspended for a period of 12 consecutive months for failure to comply with treatment, with the month following the 12 months unless you are otherwise disabled without regard to drug addiction or alcoholism (see § 404.470(c)).

(2) If you have received 36 months of benefits on that basis when treatment is available, regardless of the number of entitlement periods you may have had, with the month following such 36-month payment period unless you are otherwise disabled without regard to drug addiction or alcoholism.

(d)

(1) Your benefits may be continued after your impairment is no longer disabling if—

(i) You are participating in an appropriate program of vocational rehabilitation services, employment services, or other support services, as described in § 404.327(a) and (b);

(ii) You began participating in the program before the date your disability ended; and

(iii) We have determined under § 404.328 that your completion of the program, or your continuation in the program for a specified period of time, will increase the likelihood that you will not have to return to the disability benefit rolls.

(2) We generally will stop your benefits with the earliest of these months—

(i) The month in which you complete the program; or

(ii) The month in which you stop participating in the program for any reason (see § 404.327(b) for what we mean by "participating" in the program); or

(iii) The month in which we determine under § 404.328 that your continuing participation in the program will no longer increase the likelihood that you will not have to return to the disability benefit rolls.

Exception to paragraph (d) : In no case will we stop your benefits with a month earlier than the second month after the month your disability ends, provided that you meet all other requirements for entitlement to and payment of benefits through such month.

(e) If, after November 1980, you have a disabling impairment (§ 404.1511), we will pay you benefits for all months in which you do not do substantial gainful activity during the reentitlement period (§ 404.1592a) following the end of your trial work period (§ 404.1592). If you are unable to do substantial gainful activity in the first month following the reentitlement period, we will pay you benefits until you are able to do substantial gainful activity. (Earnings during your trial work period do not affect the payment of your benefits during that period.) We will also pay you benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity during those succeeding months. After those three months, we cannot pay you benefits for any months in which you do substantial gainful activity.

[68 FR 4707, Jan. 30, 2003, as amended at 70 FR 36506, June 24, 2005; 75 FR 52621, Aug. 27, 2010]

§ 404.353 Child's benefit amounts.

(a) ***General.*** Your child's monthly benefit is equal to one-half of the insured person's primary insurance amount if he or she is alive and three-fourths of the primary insurance amount if he or she has died. The amount of your monthly benefit may change as explained in § 404.304.

(b) ***Entitlement to more than one benefit.*** If you are entitled to a child's benefit on more than one person's earnings record, you will ordinarily receive only the benefit payable on the record with the highest primary insurance amount. If your benefit before any reduction would be larger on an earnings record with a lower primary insurance amount and no other person entitled to benefits on any earnings record would receive a smaller benefit as a result of your receiving benefits on the record with the lower primary insurance

amount, you will receive benefits on that record. See § 404.407(d) for a further explanation. If you are entitled to a child's benefit and to other dependent's or survivor's benefits, you can receive only the highest of the benefits.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 48 FR 21928, May 16, 1983; 51 FR 12606, Apr. 14, 1986; 61 FR 38363, July 24, 1996]

§ 404.354 Your relationship to the insured.

You may be related to the insured person in one of several ways and be entitled to benefits as his or her child, *i.e.*, as a natural child, legally adopted child, stepchild, grandchild, stepgrandchild, or equitably adopted child. For details on how we determine your relationship to the insured person, see §§ 404.355 through 404.359.

[63 FR 57593, Oct. 28, 1998]

§ 404.355 Who is the insured's natural child?

(a) ***Eligibility as a natural child.*** You may be eligible for benefits as the insured's natural child if any of the following conditions is met:

(1) You could inherit the insured's personal property as his or her natural child under State inheritance laws, as described in paragraph (b) of this section.

(2) You are the insured's natural child and the insured and your mother or father went through a ceremony which would have resulted in a valid marriage between them except for a "legal impediment" as described in § 404.346(a).

(3) You are the insured's natural child and your mother or father has not married the insured, but the insured has either acknowledged in writing that you are his or her child, been decreed by a court to be your father or mother, or been ordered by a court to contribute to your support because you are his or her child. If the insured is deceased, the acknowledgment, court decree, or court order must have been made or issued before his or her death. To determine whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a), the written acknowledgment, court decree, or court order will be considered to have occurred on the first day of the month in which it actually occurred.

(4) Your mother or father has not married the insured but you have evidence other than the evidence described in paragraph (a)(3) of this section to show that the insured is your natural father or mother. Additionally, you must have evidence to show that the insured was either living with you or contributing to your support at the time you applied for benefits. If the insured is not alive at the time of your application, you must have evidence to show that the insured was either living with you or contributing to your support when he or she died. See § 404.366 for an explanation of the terms "living with" and "contributions for support."

(b) ***Use of State Laws*** —

(1) ***General.*** To decide whether you have inheritance rights as the natural child of the insured, we use the law on inheritance rights that the State courts would use to decide whether you could inherit a child's share of the insured's personal property if the insured were to die without leaving a will. If the insured is living, we look to the laws of the State where the insured has his or her permanent home when you apply for benefits. If the insured is deceased, we look to the laws of the State where the insured had

his or her permanent home when he or she died. If the insured's permanent home is not or was not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, we will look to the laws of the District of Columbia. For a definition of permanent home, see § 404.303. For a further discussion of the State laws we use to determine whether you qualify as the insured's natural child, see paragraphs (b)(3) and (b)(4) of this section. If these laws would permit you to inherit the insured's personal property as his or her child, we will consider you the child of the insured.

(2) ***Standards.*** We will not apply any State inheritance law requirement that an action to establish paternity must be taken within a specified period of time measured from the worker's death or the child's birth, or that an action to establish paternity must have been started or completed before the worker's death. If applicable State inheritance law requires a court determination of paternity, we will not require that you obtain such a determination but will decide your paternity by using the standard of proof that the State court would use as the basis for a determination of paternity.

(3) ***Insured is living.*** If the insured is living, we apply the law of the State where the insured has his or her permanent home when you file your application for benefits. We apply the version of State law in effect when we make our final decision on your application for benefits. If you do not qualify as a child of the insured under that version of State law, we look at all versions of State law that were in effect from the first month for which you could be entitled to benefits up until the time of our final decision and apply the version of State law that is most beneficial to you.

(4) ***Insured is deceased.*** If the insured is deceased, we apply the law of the State where the insured had his or her permanent home when he or she died. We apply the version of State law in effect when we make our final decision on your application for benefits. If you do not qualify as a child of the insured under that version of State law, we will apply the version of State law that was in effect at the time the insured died, or any version of State law in effect from the first month for which you could be entitled to benefits up until our final decision on your application. We will apply whichever version is most beneficial to you. We use the following rules to determine the law in effect as of the date of death:

(i) If a State inheritance law enacted after the insured's death indicates that the law would be retroactive to the time of death, we will apply that law; or

(ii) If the inheritance law in effect at the time of the insured's death was later declared unconstitutional, we will apply the State law which superseded the unconstitutional law.

[63 FR 57593, Oct. 28, 1998]

§ 404.356 Who is the insured's legally adopted child?

You may be eligible for benefits as the insured's child if you were legally adopted by the insured. If you were legally adopted after the insured's death by his or her surviving spouse you may also be considered the insured's legally adopted child. We apply the adoption laws of the State or foreign country where the adoption took place, not the State inheritance laws described in § 404.355, to determine whether you are the insured's legally adopted child.

[44 FR 34481, June 15, 1979, as amended at 63 FR 57594, Oct. 28, 1998]

§ 404.357 Who is the insured's stepchild?

You may be eligible for benefits as the insured's stepchild if, after your birth, your natural or adopting parent married the insured. You also may be eligible as a stepchild if you were conceived prior to the marriage of your natural parent to the insured but were born after the marriage and the insured is not your natural parent. The marriage between the insured and your parent must be a valid marriage under State law or a marriage which would be valid except for a *legal impediment* described in § 404.346(a). If the insured is alive when you apply, you must have been his or her stepchild for at least 1 year immediately preceding the day you apply. For purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), you will be considered to meet the one year duration requirement throughout the month in which the anniversary of the marriage occurs. If the insured is not alive when you apply, you must have been his or her stepchild for at least 9 months immediately preceding the day the insured died. This 9-month requirement will not have to be met if the marriage between the insured and your parent lasted less than 9 months under one of the conditions described in § 404.335(a)(2)(i)-(iii).

[48 FR 21928, May 16, 1983, as amended at 64 FR 14608, Mar. 26, 1999; 70 FR 61365, Oct. 24, 2005]

§ 404.358 Who is the insured's grandchild or stepgrandchild?

(a) ***Grandchild and stepgrandchild defined.*** You may be eligible for benefits as the insured's grandchild or stepgrandchild if you are the natural child, adopted child, or stepchild of a person who is the insured's child as defined in §§ 404.355 through 404.357, or § 404.359. Additionally, for you to be eligible as a grandchild or stepgrandchild, your natural or adoptive parents must have been either deceased or under a disability, as defined in § 404.1501(a), at the time your grandparent or stepgrandparent became entitled to old-age or disability benefits or died; or if your grandparent or stepgrandparent had a period of disability that continued until he or she became entitled to benefits or died, at the time the period of disability began. If your parent is deceased, for purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), your parent will be considered to be deceased as of the first day of the month of death.

(b) ***Legally adopted grandchild or stepgrandchild.*** If you are the insured's grandchild or stepgrandchild and you are legally adopted by the insured or by the insured's surviving spouse after his or her death, you are considered an adopted child and the dependency requirements of § 404.362 must be met.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21928, May 16, 1983]

§ 404.359 Who is the insured's equitably adopted child?

You may be eligible for benefits as an equitably adopted child if the insured had agreed to adopt you as his or her child but the adoption did not occur. The agreement to adopt you must be one that would be recognized under State law so that you would be able to inherit a child's share of the insured's personal property if he or she were to die without leaving a will. The agreement must be in whatever form, and you must meet whatever requirements for performance under the agreement, that State law directs. If you apply for child's benefits after the insured's death, the law of the State where the insured had his or her permanent home at the time of his or her death will be followed. If you apply for child's benefits during the insured's life, the law of the State where the insured has his or her permanent home at the time or your application will be followed.

§ 404.360 When a child is dependent upon the insured person.

One of the requirements for entitlement to child's benefits is that you be dependent upon the insured. The evidence you need to prove your dependency is determined by how you are related to the insured. To prove your dependency you may be asked to show that at a specific time you lived with the insured, that you received contributions for your support from the insured, or that the insured provided at least one-half of your support. These dependency requirements, and the time at which they must be met, are explained in §§ 404.361 through 404.365. The terms *living with, contributions for support,* and *one-half support* are defined in § 404.366.

§ 404.361 When a natural child is dependent.

(a) ***Dependency of natural child.*** If you are the insured's natural child, as defined in § 404.355, you are considered dependent upon him or her, except as stated in paragraph (b) of this section.

(b) ***Dependency of natural child legally adopted by someone other than the insured.***

(1) Except as indicated in paragraph (b)(2) of this section, if you are legally adopted by someone other than the insured (your natural parent) during the insured's lifetime, you are considered dependent upon the insured only if the insured was either living with you or contributing to your support at one of the following times:

(i) When you applied;

(ii) When the insured died; or

(iii) If the insured had a period of disability that lasted until he or she became entitled to disability or old-age benefits or died, at the beginning of the period of disability or at the time he or she became entitled to disability or old-age benefits.

(2) You are considered dependent upon the insured (your natural parent) if:

(i) You were adopted by someone other than the insured after you applied for child's benefits; or

(ii) The insured had a period of disability that lasted until he or she became entitled to old-age or disability benefits or died, and you are adopted by someone other than the insured after the beginning of that period of disability.

[64 FR 14608, Mar. 26, 1999]

§ 404.362 When a legally adopted child is dependent.

(a) ***General.*** If you were legally adopted by the insured before he or she became entitled to old-age or disability benefits, you are considered dependent upon him or her. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits during the life of the insured, you must meet the dependency requirements stated in paragraph (b) of this section. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits after the death of the insured, you are considered dependent upon him or her. If you were adopted after the insured's death by his or her surviving spouse, you may be considered dependent upon the insured only under the conditions described in paragraph (c) of this section.

(b) ***Adoption by the insured after he or she became entitled to benefits*** —

(1) ***General.*** If you are legally adopted by the insured after he or she became entitled to benefits and you are not the insured's natural child or stepchild, you are considered dependent on the insured during his or her lifetime only if—

(i) You had not attained age 18 when adoption proceedings were started, and your adoption was issued by a court of competent jurisdiction within the United States; or

(ii) You had attained age 18 before adoption proceedings were started; your adoption was issued by a court of competent jurisdiction within the United States; and you were living with or receiving at least one-half of your support from the insured for the year immediately preceding the month in which your adoption was issued.

(2) ***Natural child and stepchild.*** If you were legally adopted by the insured after he or she became entitled to benefits and you are the insured's natural child or stepchild, you are considered dependent upon the insured.

(c) ***Adoption by the insured's surviving spouse*** —

(1) ***General.*** If you are legally adopted by the insured's surviving spouse after the insured's death, you are considered dependent upon the insured as of the date of his or her death if—

(i) You were either living with or receiving at least one-half of your support from the insured at the time of his or her death; and,

(ii) The insured had started adoption proceedings before he or she died; or if the insured had not started the adoption proceedings before he or she died, his or her surviving spouse began and completed the adoption within 2 years of the insured's death.

(2) ***Grandchild or stepgrandchild adopted by the insured's surviving spouse.*** If you are the grandchild or stepgrandchild of the insured and any time after the death of the insured you are legally adopted by the insured's surviving spouse, you are considered the dependent child of the insured as of the date of his or her death if—

(i) Your adoption took place in the United States;

(ii) At the time of the insured's death, your natural, adopting or stepparent was not living in the insured's household and making regular contributions toward your support; and

(iii) You meet the dependency requirements stated in § 404.364.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 56 FR 24000, May 28, 1991; 57 FR 3938, Feb. 3, 1992]

§ 404.363 When is a stepchild dependent?

If you are the insured's stepchild, as defined in § 404.357, we consider you dependent on him or her if you were receiving at least one-half of your support from him or her at one of these times—

(a) When you applied;

(b) When the insured died; or

(c) If the insured had a period of disability that lasted until his or her death or entitlement to disability or old-age benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

[44 FR 34481, June 15, 1979, as amended at 75 FR 52621, Aug. 27, 2010]

§ 404.364 When is a grandchild or stepgrandchild dependent?

If you are the insured's grandchild or stepgrandchild, as defined in § 404.358(a), you are considered dependent upon the insured if—

(a) You began living with the insured before you became 18 years old; and

(b) You were living with the insured in the United States and receiving at least one-half of your support from him or her for the year before he or she became entitled to old-age or disability benefits or died; or if the insured had a period of disability that lasted until he or she became entitled to benefits or died, for the year immediately before the month in which the period of disability began. If you were born during the 1-year period, the insured must have lived with you and provided at least one-half of your support for *substantially all* of the period that begins on the date of your birth. Paragraph (c) of this section explains when the *substantially all* requirement is met.

(c) The "substantially all" requirement will be met if, at one of the times described in paragraph (b) of this section, the insured was living with you and providing at least one-half of your support, and any period during which he or she was not living with you and providing one-half of your support did not exceed the lesser of 3 months or one-half of the period beginning with the month of your birth.

[44 FR 34481, June 15, 1979, as amended at 73 FR 40967, July 17, 2008]

§ 404.365 When an equitably adopted child is dependent.

If you are the insured's equitably adopted child, as defined in § 404.359, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at the time of his or her death. If your equitable adoption is found to have occurred after the insured became entitled to old-age or disability benefits, your dependency cannot be established during the insured's life. If your equitable adoption is found to have occurred before the insured became entitled to old-age or disability benefits, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at one of these times—

(a) When you applied; or

(b) If the insured had a period of disability that lasted until he or she became entitled to old-age or disability benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

§ 404.366 "Contributions for support," "one-half support," and "living with" the insured defined—determining first month of entitlement.

To be eligible for child's or parent's benefits, and in certain Government pension offset cases, you must be dependent upon the insured person at a particular time or be assumed dependent upon him or her. What it means to be a dependent child is explained in §§ 404.360 through 404.365; what it means to be a dependent parent is explained in § 404.370(f); and the Government pension offset is explained in § 404.408a. Your dependency upon the insured person may be based upon whether at a specified time you were receiving *contributions for your support* or *one-half of your support* from the insured person, or whether you were *living with* him or her. These terms are defined in paragraphs (a) through (c) of this section.

(a) ***Contributions for support.*** The insured makes a contribution for your support if the following conditions are met:

(1) The insured gives some of his or her own cash or goods to help support you. Support includes food, shelter, routine medical care, and other ordinary and customary items needed for your maintenance. The value of any goods the insured contributes is the same as the cost of the goods when he or she gave them for your support. If the insured provides services for you that would otherwise have to be paid for, the cash value of his or her services may be considered a contribution for your support. An example of this would be work the insured does to repair your home. The insured person is making a contribution for your support if you receive an allotment, allowance, or benefit based upon his or her military pay, veterans' pension or compensation, or social security earnings.

(2) Contributions must be made regularly and must be large enough to meet an important part of your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. If the insured person only provides gifts or donations once in a while for special purposes, they will not be considered contributions for your support. Although the insured's contributions must be made on a regular basis, temporary interruptions caused by circumstances beyond the insured person's control, such as illness or unemployment, will be disregarded unless during this interruption someone else takes over responsibility for supporting you on a permanent basis.

(b) ***One-half support.*** The insured person provides one-half of your support if he or she makes regular contributions for your ordinary living costs; the amount of these contributions equals or exceeds one-half of your ordinary living costs; and any income (from sources other than the insured person) you have available for support purposes is one-half or less of your ordinary living costs. We will consider any income which is available to you for your support whether or not that income is actually used for your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. A contribution may be in cash, goods, or services. The insured is not providing at least one-half of your support unless he or she has done so for a reasonable period of time. Ordinarily we consider a reasonable period to be the 12-month period immediately preceding the time when the one-half support requirement must be met under the rules in §§ 404.362(c)(1) and 404.363 (for child's benefits), in § 404.370(f) (for parent's benefits) and in § 404.408a(c) (for benefits where the Government pension offset may be applied). A shorter period will be considered reasonable under the following circumstances:

(1) At some point within the 12-month period, the insured either begins or stops providing at least one-half of your support on a permanent basis and this is a change in the way you had been supported up to then. In these circumstances, the time from the change up to the end of the 12-month period will be considered a reasonable period, unless paragraph (b)(2) of this section applies. The change in your source of support must be permanent and not temporary. Changes caused by seasonal employment or customary visits to the insured's home are considered temporary.

(2) The insured provided one-half or more of your support for at least 3 months of the 12-month period, but was forced to stop or reduce contributions because of circumstances beyond his or her control, such as illness or unemployment, and no one else took over the responsibility for providing at least one-half of your support on a permanent basis. Any support you received from a public assistance program is not considered as a taking over of responsibility for your support by someone else. Under these circumstances, a reasonable period is that part of the 12-month period before the insured was forced to reduce or stop providing at least one-half of your support.

(c) ***"Living with" the insured.*** You are living with the insured if you ordinarily live in the same home with the insured and he or she is exercising, or has the right to exercise, parental control and authority over your activities. You are living with the insured during temporary separations if you and the insured expect to live together in the same place after the separation. Temporary separations may include the insured's absence because of active military service or imprisonment if he or she still exercises parental control and authority. However, you are not considered to be living with the insured if you are in active military service or in prison. If *living with* is used to establish dependency for your eligibility to child's benefits and the date your application is filed is used for establishing the point for determining dependency, you must have been living with the insured throughout the month your application is filed in order to be entitled to benefits for that month.

(d) ***Determining first month of entitlement.*** In evaluating whether dependency is established under paragraph (a), (b), or (c) of this section, for purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), we will not use the temporary separation or temporary interruption rules.

[44 FR 34481, June 15, 1979, as amended at 45 FR 65540, Oct. 3, 1980; 48 FR 21928, May 16, 1983; 52 FR 26955, July 17, 1987; 64 FR 14608, Mar. 26, 1999]

§ 404.367 When you are a "full-time elementary or secondary school student".

You may be eligible for child's benefits if you are a full-time elementary or secondary school student. For the purposes of determining whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a)(2)(i), if you are entitled as a student on the basis of attendance at an elementary or secondary school, you will be considered to be in full-time attendance for a month during any part of which you are in full-time attendance. You are a full-time elementary or secondary school student if you meet all the following conditions:

(a) You attend a school which provides elementary or secondary education as determined under the law of the State or other jurisdiction in which it is located. Participation in the following programs also meets the requirements of this paragraph:

(1) You are instructed in elementary or secondary education at home in accordance with a home school law of the State or other jurisdiction in which you reside; or

(2) You are in an independent study elementary or secondary education program in accordance with the law of the State or other jurisdiction in which you reside which is administered by the local school or school district/jurisdiction.

(b) You are in full-time attendance in a day or evening noncorrespondence course of at least 13 weeks duration and you are carrying a subject load which is considered full-time for day students under the institution's standards and practices. If you are in a home schooling program as described in paragraph (a)(1) of this section, you must be carrying a subject load which is considered full-time for day students under standards and practices set by the State or other jurisdiction in which you reside;

(c) To be considered in full-time attendance, your scheduled attendance must be at the rate of at least 20 hours per week unless one of the exceptions in paragraphs (c) (1) and (2) of this section applies. If you are in an independent study program as described in paragraph (a)(2) of this section, your number of

hours spent in school attendance are determined by combining the number of hours of attendance at a school facility with the agreed upon number of hours spent in independent study. You may still be considered in full-time attendance if your scheduled rate of attendance is below 20 hours per week if we find that:

(1) The school attended does not schedule at least 20 hours per week and going to that particular school is your only reasonable alternative; or

(2) Your medical condition prevents you from having scheduled attendance of at least 20 hours per week. To prove that your medical condition prevents you from scheduling 20 hours per week, we may request that you provide appropriate medical evidence or a statement from the school.

(d) You are not being paid while attending the school by an employer who has requested or required that you attend the school;

(e) You are in grade 12 or below; and

(f) You are not subject to the provisions in § 404.468 for nonpayment of benefits to certain prisoners and certain other inmates of publicly funded institutions.

[48 FR 21928, May 16, 1983, as amended at 48 FR 55452, Dec. 13, 1983; 56 FR 35999, July 30, 1991; 61 FR 38363, July 24, 1996]

§ 404.368 When you are considered a full-time student during a period of nonattendance.

If you are a full-time student, your eligibility may continue during a period of nonattendance (including part-time attendance) if all the following conditions are met:

(a) The period of nonattendance is 4 consecutive months or less;

(b) You show us that you intend to resume your studies as a full-time student at the end of the period or at the end of the period you are a full-time student; and

(c) The period of nonattendance is not due to your expulsion or suspension from the school.

[48 FR 21929, May 16, 1983]

Comparing the eCFR in effect on **9/30/2024** to what was previously in effect on **9/29/2024**.
Changes are highlighted in the text below.

Title 20 —Employees' Benefits
Chapter III —Social Security Administration
Part 416 —Supplemental Security Income for the Aged, Blind, and Disabled
Subpart K —Income

ENHANCED CONTENT - TABLE OF CONTENTS

EDITORIAL NOTE ON PART 416

Editorial Note: Nomenclature changes to part 416 appear at 68 FR 53509, Sept. 11, 2003.

In-Kind Support and Maintenance

§ 416.1130 Introduction.

~~CROSS REFERENCE~~

~~Link to an amendment published at 89 FR 21209, Mar. 27, 2024.~~

~~CROSS REFERENCE~~

~~Link to an amendment published at 89 FR 25514, Apr. 11, 2024.~~

(a) ***General.*** Both earned income and unearned income include items received in- kind (*see* § 416.1102). Generally, we value in-kind items at their current market value, and we apply the various exclusions for both earned and unearned income. However, we have special rules for valuing ~~food or~~ shelter that is received as ~~unearned income~~ (in-kind support and maintenance *(a type of unearned income*). This section and the ones that follow discuss these rules. In these sections (*i.e.,* §§ 416.1130 through 416.1148) we use the in-kind support and maintenance you receive in the month as described in § 416.420 to determine your SSI benefit. We value the in-kind support and maintenance using the Federal benefit rate for the month in which you receive it. *Exception:* For the first 2 months for which a cost-of-living adjustment applies, we value in-kind support and maintenance you receive using the VTR or PMV based on the Federal benefit rate as increased by the cost-of-living adjustment.

Example: Mr. Jones ~~receives an SSI benefit which is computed by subtracting one-third from the Federal benefit rate~~*resides in his son's house and receives all of his meals from his son. Mr. Jones receives a monthly SSI Federal benefit rate that is reduced by one-third*. This one-third represents the value of the ~~income~~ *in-kind support and maintenance* he receives because he lives*, throughout a month,* in the household of ~~a~~ *his* son*,* who provides ~~both~~ *all of his* food and shelter ~~(in-kind support and maintenance)~~. In January, we increase his SSI benefit because of a cost-of-living adjustment. ~~We base his SSI payment for~~ *For* that month ~~on the~~ *, we determine that the VTR rule applies by considering the* food and shelter he received from his son two months earlier in November. ~~In determining the value of that food and shelter he received in November, we use the~~ *, and we calculate the SSI payment using the* Federal benefit rate for January.

(b) ***How we ~~define~~ calculate in-kind support and maintenance.*** ~~In~~

*(1) We calculate in-*kind support and maintenance

~~means~~

considering any

~~food or~~

shelter that is given to you or that you receive because someone else pays for it. Shelter includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services. You are not receiving in-kind support and maintenance in the form of room or rent if you are paying the amount charged under a business arrangement. A business arrangement exists when the amount of monthly

~~rent~~

required

~~to be paid equals the current market rental value (see § 416.1101). *Exception:* In the States in the Seventh Circuit (Illinois, Indiana, and Wisconsin), a business arrangement exists when the amount of monthly~~

rent

~~required~~

to be paid equals or exceeds the presumed maximum value described in § 416.1140(a)(1).

~~In those States, if~~

If the required amount of rent is less than the presumed maximum value, we will impute as in-kind support and maintenance

~~;~~

the difference between the required amount of rent and either the presumed maximum value or the current market *rental* value *(see § 416.1101)*, whichever is less. In addition, cash payments to uniformed service members as allowances for on-base housing or privatized military housing are in-kind support and maintenance.

(

~~c) *How we value in-kind support and maintenance.* Essentially, we~~

2) *We* have two rules for valuing the in-kind support and maintenance

~~which~~

that we

~~must~~

count. The one-third reduction rule applies if you are living in

~~the household of a person who provides you with both food and shelter (~~

another person's household, you receive shelter from others living in the household, and others within the household pay for or provide you with all of your meals (see §§ 416.1131 through 416.1133). The presumed value rule applies in all other situations

~~where~~

in which you

~~are receiving~~

receive countable in-kind support and maintenance (*see* §§ 416.1140 through 416.1145). If certain conditions exist, we do not count in-kind support and maintenance. These *conditions* are discussed in §§ 416.1141 through 416.1145.

*[~~45 89 FR 6554~~7*21209*, ~~Oct~~Mar. ~~32~~7, ~~1980~~2024, as amended at ~~50 89 FR 48574, Nov. 26, 1985; 51 FR 13488,~~ 25514, Apr. ~~21, 1986; 60 FR 16375, Mar. 30, 1995; 63 FR 33546, June 19, 1998; 70 FR 6345, Feb. 7, 2005; 75 FR 54287, Sept. 7, 2010~~11, 2024]*

§ 416.1131 The one-third reduction rule.

~~CROSS REFERENCE~~

~~Link to an amendment published at 89 FR 21210, Mar. 27, 2024.~~

(a) ***What the rule is.*** Instead of determining the actual dollar value of in-kind support and maintenance, we count one-third of the Federal benefit rate as additional income if you (or you and your eligible spouse)—

(1) Live in another person's household (see § 416.1132) for a full calendar month except for temporary absences (see § 416.1149)~~,~~*;* and

(2) Receive ~~both food and~~ shelter from *others living in* the ~~person in whose~~ household ~~you are living~~. (If you do not receive ~~both food and~~ shelter from ~~this person~~*others living in the household*, see § 416.1140)*; and*

(3) Others within the household pay for or provide you with all of your meals. If others within the household do not pay for or provide you with all of your meals, any ISM received for shelter will be calculated under the PMV rule (see § 416.1140).

(b) ***How we apply the one-third reduction rule.*** The one-third reduction applies in full or not at all. When you are living in another person's household, and the one-third reduction rule applies, we do not apply any income exclusions to the reduction amount. However, we do apply appropriate exclusions to any other earned or unearned income you receive. If you have an eligible spouse we apply the rules described in § 416.1147.

(c) ***If you receive other support and maintenance.*** If the one-third reduction rule applies to you, we do not count any other in-kind support and maintenance you receive.

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48574, Nov. 26, 1985; 89 FR 21210, Mar. 27, 2024]

§ 416.1132 What we mean by "living in another person's household".

(a) ***Household.*** For purposes of this subpart, we consider a household to be a personal place of residence. A commercial establishment such as a hotel or boarding house is not a household but a household can exist within a commercial establishment. If you live in a commercial establishment, we do not automatically consider you to be a member of the household of the proprietor. You may, however, live in the household of a roomer or boarder within the hotel or boarding house. An institution is not a household and a household cannot exist within an institution. (Institution is defined in § 416.1101.)

(b) ***Another person's household.*** You live in another person's household if paragraph (c) of this section does not apply and if the person who supplies the support and maintenance lives in the same household and is not—

(1) Your spouse (as defined in § 416.1806);

(2) A minor child; or

(3) An ineligible person (your spouse, parent, or essential person) whose income may be deemed to you as described in §§ 416.1160 through 416.1169.

(c) ***Your own household—not another person's household.*** You are not living in another person's household (you live in your own household) if —

(1) You (or your spouse who lives with you or any person whose income is deemed to you) have an ownership interest or a life estate interest in the home;

(2) You (or your spouse who lives with you or any person whose income is deemed to you) are liable to the landlord for payment of any part of the rental charges;

(3) You live in a noninstitutional care situation as described in § 416.1143;

(4) You pay at least a pro rata share of household and operating expenses (see § 416.1133); or

(5) All members of the household receive public income—maintenance payments (§ 416.1142).

[45 FR 65547, Oct. 3, 1980, as amended at 50 FR 48574, Nov. 26, 1985]

§ 416.1133 What is a pro rata share of household operating expenses.

~~CROSS REFERENCE~~

~~Link to an amendment published at 89 FR 21210, Mar. 27, 2024.~~

(a) ***General.*** If you pay your pro rata share toward monthly household operating expenses, you are living in your own household and are not receiving in-kind support and maintenance from anyone else in the household. The one-third reduction, therefore, does not apply to you. (If you are receiving ~~food or~~ shelter from someone outside the household, we value it under the rule in § 416.1140.)

(b) ***How we determine a pro rata share.*** Your pro rata share of household operating expenses is the average monthly household operating expenses (based on a reasonable estimate if exact figures are not available) divided by the number of people in the household, regardless of age.

(c) ~~***Average household operating expenses.***~~ Household operating expenses are the household's total monthly expenditures for ~~food,~~ rent, mortgage, property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection service. (The term does not include the cost of these items if someone outside the household pays for them.) Generally, we average household operating expenses over the past 12 months to determine a pro rata share.

[45 FR 65547, Oct. 3, 1980, as amended at 70 FR 6345, Feb. 7, 2005; 89 FR 21210, Mar. 27, 2024]

§ 416.1140 The presumed value rule.

~~CROSS REFERENCE~~

~~Link to an amendment published at 89 FR 21210, Mar. 27, 2024.~~

(a) ***How we apply the presumed value rule.***

(1) When you receive in-kind support and maintenance and the one-third reduction rule does not apply, we use the presumed value rule. Instead of determining the actual dollar value of any ~~food or~~ shelter you receive, we presume that it is worth a maximum value. This maximum value is one-third of your Federal benefit rate plus the amount of the general income exclusion described in § 416.1124(c)(12).

(2) The presumed value rule allows you to show that your in-kind support and maintenance is not equal to the presumed value. We will not use the presumed value if you show us that—

(i) The current market value of any ~~food or~~ shelter you receive, minus any payment you make for ~~them~~*it*, is lower than the presumed value; or

(ii) The actual amount someone else pays for your ~~food or~~ shelter is lower than the presumed value.

(b) ***How we determine the amount of your ~~unearned income~~ ISM under the presumed value rule.***

(1) If you choose not to question the use of the presumed value, or if the presumed value is less than the actual value of the ~~food or~~ shelter you receive, we use the presumed value to figure your ~~unearned income~~*ISM*.

(2) If you show us, as provided in paragraph (a)(2) of this section, that the presumed value is higher than the actual value of the ~~food or~~ shelter you receive, we use the actual amount to figure your ~~unearned income~~*ISM*.

[~~45~~ 89 FR ~~6554~~721210, ~~Oct~~Mar. ~~3, 1980, as amended at 50 FR 48575, Nov. 26, 1985; 58 FR 63888, Dec. 3, 1993; 70 FR 6345, Feb. 7, 2005~~27, 2024]

§ 416.1141 When the presumed value rule applies.

~~CROSS REFERENCE~~

~~Link to an amendment published at 89 FR 21210, Mar. 27, 2024.~~

The presumed value rule applies whenever we ~~must~~ count in-kind support and maintenance as unearned income and the one-third reduction rule does not apply. This means that the presumed value rule applies if you are living—

(a) In another person's household (as described in § 416.1132(b)) ~~but not receiving both food and shelter from that person;~~*; you receive shelter from others living in the household; and others within the household do not pay for or provide you with all of your meals;*

(b) In your own household (as described in § 416.1132(c)). For exceptions, see § 416.1142 if you are in a public assistance household and § 416.1143 if you are in a noninstitutional ~~care~~ *case* situation; *or*

(c) In a nonmedical institution including any—

(1) Public nonmedical institution if you are there for less than a full calendar month;

(2) Public or private nonprofit educational or vocational training institution;

(3) Private nonprofit retirement home or similar institution where there is an express obligation to provide your full support and maintenance or where someone else pays for your support and maintenance. For exceptions, see § 416.1144; and

(4) For-profit institution where someone else pays for your support and maintenance. If you or the institution pay for it, see § 416.1145.

[45 FR 65547, Oct. 3, 1980, as amended at 89 FR 21210, Mar. 27, 2024]

§ 416.1142 If you live in a public assistance household.

~~CROSS REFERENCE~~

~~Link to an amendment published at 89 FR 28622, Apr. 19, 2024.~~

(a) ***Definition.*** ~~A~~ *For purposes of our programs, a* public assistance household is one ~~in which every member receives some kind of public income~~ *that has both an SSI applicant or recipient, and at least one other household member who receives one or more of the listed public income* maintenance payments. These are payments made under—

(1) Title IV-A of the Social Security Act (Temporary Assistance for Needy Families);

(2) Title XVI of the Social Security Act (SSI, including federally administered State supplements and State administered mandatory supplements);

(3) The Refugee Act of 1980 (Those payments based on need);

(4) The Disaster Relief and Emergency Assistance Act;

(5) General assistance programs of the Bureau of Indian Affairs;

(6) State or local government assistance programs based on need (tax credits or refunds are not assistance based on need); and

(7) U.S. Department of Veterans Affairs programs (those payments based on need); *and*

(8) The Supplemental Nutrition Assistance Program (SNAP).

(b) ***How the presumed value rule applies.*** If you live in a public assistance household, we consider that you are not receiving in-kind support and maintenance from members of the household. In this situation, we use the presumed value rule only if you receive food or shelter from someone outside the household.

[45 FR 65547, Oct. 3, 1980, as amended at 57 FR 53850, Nov. 13, 1992; 70 FR 6345, Feb. 7, 2005; 70 FR 41137, July 18, 2005; 89 FR 28622, Apr. 19, 2024]

§ 416.1143 If you live in a noninstitutional care situation.

(a) ***Definitions.*** For purposes of this subpart you live in a noninstitutional care situation if all the following conditions exist:

(1) You are placed by a public or private agency under a specific program such as foster or family care;

(2) The placing agency is responsible for your care;

(3) You are in a private household (not an institution) which is licensed or approved by the placing agency to provide care; and

(4) You, a public agency, or someone else pays for your care.

(b) ***How the presumed value rule applies.*** You are not receiving in-kind support and maintenance and the presumed value rule does not apply if you pay the rate the placing agency establishes. We consider this established rate to be the current market value for the in-kind support and maintenance you are receiving. The presumed value rule applies if you pay less than the established rate and the difference is paid by someone else other than a public or private agency providing social services described in § 416.1103(b) or assistance based on need described in § 416.1124(c)(2).

§ 416.1144 If you live in a nonprofit retirement home or similar institution.

(a) ***Definitions.*** For purposes of this section the following definitions apply:

(1) ***Nonprofit retirement home or similar institution*** means a nongovernmental institution as defined under § 416.1101, which is, or is controlled by, a private nonprofit organization and which does not provide you with—

(i) Services which are (or could be) covered under Medicaid, or

(ii) Education or vocational training.

(2) ***Nonprofit organization*** means a private organization which is tax exempt under section 501(a) of the Internal Revenue Code of 1954 and is of the kind described in section 501 (c) or (d) of that code.

(3) An *express obligation to provide your full support and maintenance* means there is either a legally enforceable written contract or set of membership rules providing that the home, institution, or organization—

(i) Will provide at least all of your food and shelter needs; and

(ii) Does not require any current or future payment for that food and shelter. (For purposes of this paragraph, a lump sum prepayment for lifetime care is not a current payment.)

(b) ***How the presumed value rule applies.*** The presumed value rule applies if you are living in a nonprofit retirement home or similar institution where there is an express obligation to provide your full support and maintenance or where someone else pays for your support and maintenance. The rule does not apply to the extent that—

(1) The home, institution, or nonprofit organization does not have an express obligation to provide your full support and maintenance; and

(2) The home, institution, or nonprofit organization receives no payment for your food or shelter, or receives payment from another nonprofit organization.

[45 FR 65547, Oct. 3, 1980, as amended at 51 FR 34464, Sept. 29, 1986; 70 FR 6345, Feb. 7, 2005]

§ 416.1145 How the presumed value rule applies in a nonmedical for-profit institution.

If you live in a nonmedical for-profit institution, we consider the amount accepted by that institution as payment in full to be the current market value of whatever food or shelter the institution provides. If you are paying or are legally indebted for that amount, you are not receiving in-kind support and maintenance. We do not use the presumed value rule unless someone else pays for you.

[45 FR 65547, Oct. 3, 1980, as amended at 70 FR 6345, Feb. 7, 2005]

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Ten-ish Medicaid Regulations You'll Want to Know

1

Meet the Snyder Family

Tom and Barbara Snyder, both high school teachers, meet with you to discuss special needs planning for their daughter, Katie. Katie is 16 years old, vibrant and social, but she has moderate developmental disabilities that will likely prevent her from living entirely independently as an adult. The Snyders also have a younger son, Peter, age 14, who is healthy and active. Like many parents in their situation, Tom and Barbara are focused on providing for both children fairly while ensuring Katie has lifelong care, support and services. Right now, the family is financially stable. Tom and Barbara's combined income is comfortable, and they've always managed to meet their household needs. But as they look to the future, they want to make sure Katie is protected.

2

Tom and Barbara were advised by friends and Katie's school that they should apply for Supplemental Security Income (SSI) for Katie, and they are looking to you for guidance. Katie is not working, has no income, and has no assets in her name.

3

20 C.F.R. § 416.1856 – Who is considered a child

The SSA considers Katie a child if:

(a) (1) She is under 18 years old; or (2) she is under 22 years old and a student regularly attending school or college or training that is designed to prepare her for a paying job;

(b) She is not married; and

(c) She is not the head of a household.

4

20 C.F.R. § 416.202 – Who may get SSI benefits

Katie is eligible for SSI benefits if she meets ALL of the following requirements under this regulation which, *in part*, include:

- Katie are aged 65 or older, blind or disabled.
  - Katie – under 18: SSA will consider her disabled if she has have a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. (§416.906)
  - Katie – over 18: inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (§416.905)

5

20 C.F.R. § 416.202 – Who May Get SSI Benefits

- Katie does not have more income than is permitted.
  - Income is anything that Katie receives in cash or in-kind that she can use to meet her needs for food or shelter. (§416.1102)
- Katie does not have more resources than are permitted.
  - Resources means cash or other liquid assets or any real or personal property that an individual owns and could convert to cash to be used for Katie's support and maintenance. (§416.1201)

Based upon the foregoing, Katie is eligible for SSI – right? But wait, not so fast …

6

20 C.F.R. § 416.1160 – Deeming of income - child

The SSA uses the term deeming to identify the process of considering another person's income to be your own. When the deeming rules apply, it does not matter whether the income of the other person is actually available to you.

The SSA will look at Katie's parents' income to decide whether it must deem some of it to be Katies. This is done because the SSA expects Katie's parents to use their income to take care of her needs.

See also: § 416.1165

7

20 C.F.R. § 416.1202 (b) – Deeming of resources - child

In the case of Katie who is under age 18, the SSA will deem to her child any resources, not otherwise excluded, of her ineligible parents who are living in the same household with her. The SSA will deem to Katie her parents' resources whether or not those resources are actually available to her.

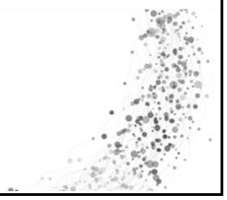
Resource limit: $2,000

Katie's parents have more than $2,000 in non-excluded resources.

Katie is not eligible for SSI while she is under 18. She must wait until she turns 18 to apply for SSI.

8

Katie is now 18 years old, lives at home and is expected to remain in school until she ages out at 21. Tom and Barbara now apply for SSI for Katie. They would like to maximize Katie's SSI benefit enabling her to qualify for the highest amount possible. For 2025, the monthly maximum is $967.



9

20 C.F.R. § 416.1130 – Introduction to ISM

Both earned income and unearned income include items received in- kind. Generally, the SSA values in-kind items at their current market value, and it applies the various exclusions for both earned and unearned income. However, the SSA has special rules for valuing shelter that is received as in-kind support and maintenance (ISM), which is a type of unearned income.

See generally: §§ 416.1130 through 416.1141

Katie lives with her parents in a home they own.

The SSA ISM Katie receives in the month to determine her SSI benefit.

10

20 C.F.R. § 416.1130 – Introduction to ISM

- The SSA calculates ISM by considering any shelter that is given to Katie or that she receives because someone else pays for it. Shelter includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services.
- The SSA has two rules for valuing ISM:
  - The one-third reduction rule applies if you are living in another person's household, you receive shelter from others living in the household, and others within the household pay for or provide you with all of your meals.

    See §§ 416.1131 through 416.1133.
  - The presumed value rule applies in all other situations in which you receive countable in-kind support and maintenance

    See §§ 416.1140 and 416.1141.
- Effective 9/30/2024, food is no longer included in ISM calculations.

11

ISM Calculation for Katie living with parents rent-free

1. The SSI Federal Benefit Rate is $967.00.

2. One-third of the SSI Federal Benefit Rate of $967.00 is $322.33.

3. $322.33 (1/3 of the Federal Benefit Rate)
   +$20.00 (from the PMV rule)

   =$342.33 (the PMV of in-kind support and maintenance)

4. $342.33 (the PMV of in-kind support and maintenance)
   -20.00 (general income exclusion)

   = $322.33 (the amount of the reduction due to in-kind support and maintenance)

5. $967.00 (Federal Benefit Rate)
   -$322.33 (reduction due to in-kind support and maintenance)

   = $644.67 (Katie's SSI benefit amount)

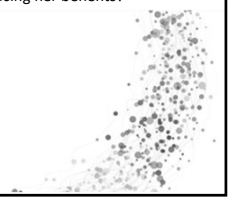
12

20 C.F.R. § 416.1130 (b)(1) – Paying rent

- Katie is not receiving ISM in the form of room or rent if she is paying the amount charged under a business arrangement. A business arrangement exists when the amount of monthly required rent to be paid equals or exceeds the presumed maximum value described in § 416.1140(a)(1) ($342.33 for 2025).
- Katie enters into a room and board contact with her parents for $500 enabling her to receive the full SSI benefit of $967/month.

13

Katie is now 28 years old. She and her brother Peter are moving into a rental apartment. The rent is $1,500 per month, with each sibling responsible for one-half. Tom and Barbara would like to help with Katie's share of the rent, but they want to ensure that their assistance does not trigger an ISM reduction in Katie's SSI payment. How can they provide support without reducing her benefits?



14

Options

A. Pay Katie's landlord directly for her $750 share.
B. Give Katie $750 in cash each month, which she then pays to the landlord.
C. Pay part of the household utilities instead of rent.
D. Contribute $750 into Katie's ABLE account, which she can then use to pay her rent.

15

Analysis

A. Pay Katie's landlord directly for her $750 share.
   - Trigger ISM since they are paying her housing directly.

B. Give Katie $750 in cash each month, which she then pays to the landlord.
   - Cash given directly to SSI recipient is treated as unearned income. If Tom and Barbara did this, Katie's SSI benefit would be reduced dollar-for-dollar after a $20 disregard

C. Pay part of the household utilities instead of rent.
   - Trigger ISM since they are paying her housing directly

D. Contribute $750 into Katie's ABLE account, which she uses to pay her rent.

16

26 C.F.R. §§ 1.529A-0 - 1.529A-8 Qualified ABLE Programs

- Tax-advantaged savings for people with disabilities
- Disability must have begun before age 26 (expanding to 46 in 2026)
- Contributions: annual IRS limit (currently $19,000)
- SSI disregards balances up to $100,000
- Non-qualified withdrawals: taxable + 10% penalty
- Distributions can be made for Qualified Disability Expenses (QDEs) including **housing**, education, transportation, therapy, assistive technology.

17

26 C.F.R. §§ 1.529A-0 - 1.529A-8 Qualified ABLE Programs

- One major benefit: distributions used for housing are **not treated as ISM** if they flow through the ABLE account.
- Katie's parents can fund an ABLE Account and $750 can be withdrawn each month to pay for Katie's share of the rent resulting in no ISM calculation and no impact on Katie's SSI benefit.
- ABLE Account can provide Katie with some additional independence as well.

18

In fostering Katie's independence, Tom and Barbara would like to understand which resources Katie may own that will not be counted for SSI eligibility purposes.

19

SSI does not count the following resources (if owned by Katie)

- The home Katie lives in and the land it is on (§416.1212)
- Household goods and personal effects (§416.1216)
- Life insurance policies with a combined face value of $1,500 or less (§416.1230)
- One vehicle, regardless of value (§416.1218)
- Burial space (§416.1201)
- Burial funds valued at $1,500 or less (§416.1201)
- Up to $100,000 of funds in an ABLE account (POMS SI 01130.740, D.1)

20

Katie has found a partner, Charlie, with whom she wants to spend the rest of her life. The Snyders are delighted, they love Charlie and are grateful for the respect and companionship he shows Katie. Now, Katie and Charlie want to get married. Tom and Barbara return to you for guidance: What effect would marriage have on Katie's SSI benefits?

21

Options

A. Nothing changes, SSI is an individual benefit and marriage has no effect.
B. Katie's SSI is automatically terminated when she marries.
C. If Charlie has income and/or assets they will be counted toward Katie, which may reduce or eliminate her SSI.
D. Katie's SSI will increase because she is now part of a married couple.

22

20 C.F.R. § 416.1801 (c) – Eligible Spouse

Charlie is an eligible spouse if:

- He Is eligible for SSI
- SSA considers his spouse Katie as eligible for SSI, and
- They live together in the same household

23

20 C.F.R. § 416.1802 (a) – Effects of marriage on eligibility

- If Charlie is an ineligible spouse and Katie receives SSI benefits and they are living in the same household:
  - Counting Income: SSA may count part of Charlie's income as Katie's income. Counting part of Charlie's income may reduce the amount of Katie's benefits or even make her ineligible. See § 416.1163 explains how SSA counts income for an individual with an ineligible spouse.
  - Counting Resources: SSA counts the value of Charlie's resources (money and property), minus certain exclusions, as Katies when they determine Katie's eligibility. See § 416.1202(a) regarding deeming of resources for a married individual.

24

20 C.F.R. § 416.1802 (b) – Effects of marriage on eligibility

- If Charlie is an eligible spouse and Katie receives SSI:
  - Counting income. SSA will count their combined income and calculated the benefit amount for them as a couple.
  - Counting resources. SSA will count the value of their combined resources (money and property), minus allowable exclusions, and use their resource limit when they determine your eligibility. $3,000 – see §416.1205.

25

Options - Analysis

A. Nothing changes, SSI is an individual benefit and marriage has no effect.
   - Not correct

B. Katie's SSI is automatically terminated when she marries.
   - SSI isn't automatically cut off, it depends on Charlie's income and resources

C. If Charlie has income and/or assets they will be counted toward Katie, which may reduce or eliminate her SSI.
   - When Katie marries, Charlie's income and resources are "deemed" to Katie. If Charlie has little or no income/resources, Katie may still qualify. But if Charlie works or has assets, Katie's SSI will likely be eliminated

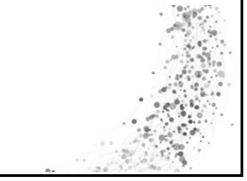
D. Katie's SSI will increase because she is now part of a married couple.
   - If Charlie is an eligible spouse the maximum combined amount is $1,450 (2025)

26

Tom and Barbara, both 68, are now retired and collect Social Security retirement benefits.

How does this change Katie's SSI benefit?

Is the analysis different if Katie marries Charlie and she now receives a Social Security Disability Insurance (SSDI) Disabled Adult Child (DAC) benefit?



27

20 C.F.R. § 404.350 – Who is entitled to child's benefits?

- Katie is entitled to child's benefits on the earnings record of an insured person who is entitled to old-age or disability benefits or who has died if Katie:
  - (1) is the insured person's child;
  - (2) is a dependent on the insured (natural child);
  - (3) applies;
  - (4) **is unmarried**; and
  - (5) under age 18; or **is 18 years old or older and has a disability that began before she became 22 years old**; or 18 years or older and qualify for benefits as a full-time student as described in § 404.367.

28

Social Security Disability Insurance – Disabled Adult Child

- SSA will pay SSDI benefits to Katie because her disability began before the of 22 provided she is not married. It is considered a "child's" benefit because it is paid on a parent's Social Security earnings record. Katie's DAC benefits will continue for as long as she has a disability and she remains unmarried. Katie does not need to have worked to get these benefits.

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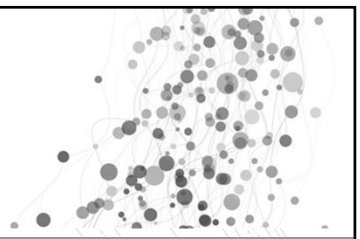

Thank you!

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