

ARTICLE 2. MEDICAID MEMBERS; ELIGIBILITY

Rule 1. General Requirements; Medicaid Member Eligibility

405 IAC 2-1-1 Definitions

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 1. The following definitions in this section apply throughout this article:

(1) "Applicant" means the person for whom Medicaid is requested.

(2) "Dependent child" means a nonmember child:

(A) under eighteen (18) years of age; or

(B) between eighteen (18) and twenty-one (21) years of age and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him or her for gainful employment.

A dependent child must be the biological or adoptive child of the applicant or member or the biological or adoptive child of the applicant's or member's parent.

(3) "Essential person" means a person who:

(A) is not the applicant's or member's spouse or parent;

(B) lives in the place of residence of the applicant or member; and

(C) is considered by the applicant or member to be essential to his or her well-being because he or she provides services to the applicant or member that would have to be paid for otherwise.

(4) "Institution" means a Title XIX certified hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or public institution. It does not include a facility where federal financial participation is not available under 42 CFR 435.1009.

(5) "Medicaid" means that program described by IC 12-15 and this title, in which the office administers benefits and makes payments to providers for covered services provided to members.

(6) "Member" means an individual who has been determined by the office to be eligible for payment of covered services under IC 12-15 or this title, or both.

(7) "Nonmember" means a person who is not receiving Medicaid.

(8) "Office" means the Indiana family and social services administration, and its offices, divisions, or designees.

(9) "Parent" or "parents" means the biological or adoptive parent or parents living with an unmarried applicant or member who is either:

(A) under eighteen (18) years of age; or

(B) between eighteen (18) and twenty-one (21) years of age and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him or her for gainful employment.

(10) "Spouse" means the legal husband or wife of an applicant or member who is either living with the applicant or member or physically separated from him or her only for medical reasons.

(Office of the Secretary of Family and Social Services; 405 IAC 2-1-1; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1012, eff Apr 1, 1984; filed Jun 19, 1984, 10:25 a.m.: 7 IR 1820, eff Jul 1, 1984 [IC 4-22-2-5 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #84-29 was filed Jun 19, 1984.]; filed Apr 10, 1985, 2:20 p.m.: 8 IR 989; filed Apr 4, 1986, 11:07 a.m.: 9 IR 1854; filed Aug 15, 1986, 3:00 p.m.: 10 IR 6; filed May 11, 1987, 9:30 a.m.: 10 IR 1864; filed Apr 26, 1988, 12:55 p.m.: 11 IR 3028; filed Oct 6, 1989, 4:50 p.m.: 13 IR 282; filed May 2, 1990, 4:55 p.m.: 13 IR 1704; filed Aug 9, 1991, 11:00 a.m.: 14 IR 2224; filed May 14, 1992, 5:00 p.m.: 15 IR 2189; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1780; filed Nov 26, 1996, 4:30 p.m.: 20 IR 955; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-1-1) to the Office of the Secretary of Family and Social Services (405 IAC 2-1-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-1-2 Interview of applicants and members

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 2. (a) In addition to the requirements of 470 IAC 2.1-1-2, each applicant and member, or the individual authorized to act in the individual's behalf must be interviewed by the office at the time of the initial investigation and at each annual reinvestigation of eligibility.

(b) The initial investigation interview required under subsection (a) may be conducted:

- (1) in a division or county office;
- (2) at a home visit;
- (3) by telephone; or
- (4) at a community location designated by the division or designee.

(c) The annual reinvestigation interview required under subsection (a) may be conducted:

- (1) in a division office;
- (2) at a home visit;
- (3) by telephone;
- (4) by mail; or
- (5) at a community location designated by the division or designee.

(d) An application for Medicaid shall be filed on the form prescribed by the division.

(e) The applicant or member may use an authorized representative to apply for Medicaid, to represent the applicant or member in all interviews, and to notify the division of any changes. The authorization must be in writing except as provided in subsections (g) and (h).

(f) Notwithstanding the availability of an authorized representative, the division may require personal contact with the applicant or member in order to obtain information necessary for the determination of eligibility.

(g) The parents of an applicant or member under eighteen (18) years of age may apply for Medicaid on behalf of the applicant or member without the written authorization specified in subsection (e).

(h) The written authorization specified in subsection (e) shall not be required if medical documentation signed by a licensed physician shows that the applicant or member is medically unable to provide such authorization. This subsection shall not apply if the applicant or member is deceased at the time the application is being made.

(i) Unless there is a legally authorized agent, such as an authorized representative, employees of nursing facilities may not be interviewed on behalf of a resident in their facility unless certified medical documentation shows the applicant or member is medically incapable of being interviewed and there is no one else to act on the applicant or member's behalf. This subsection shall not apply if the applicant or member is deceased.

(j) For any applicant or member of long term care services, the application of the individual for such assistance, including any recertification of eligibility for such assistance, shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument as may be specified by the Secretary of Health and Human Services) regardless of whether the annuity is irrevocable or is treated as an asset as follows:

(1) Such application or recertification packet shall include a statement signed by the individual that the state will become a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of Medicaid.

(2) Upon disclosure by an applicant or member under this subsection, the state will notify the issuer of the annuity of its right as a preferred remainder beneficiary for Medicaid furnished to the individual.

(k) The division will accept an application for Medicaid signed with an electronic signature.

(l) An applicant or member who does not meet the requirements of this section shall be ineligible for Medicaid.

(m) The formal initial investigation interview required under subsection (a) is not required for individuals subject to the modified adjusted gross income methodology set forth under 42 CFR 435.603. (*Office of the Secretary of Family and Social Services; 405 IAC 2-1-2; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1013, eff Apr 1, 1984; filed Jun 19, 1984, 10:25 a.m.: 7 IR 1821, eff Jul 1, 1984 [IC 4-22-2-5 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #84-29 was filed with the secretary of state June 19, 1984.]; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1781; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 19, 2009, 10:53 a.m.: 20090318-IR-405080195FRA; filed Aug 18, 2009, 11:33 a.m.: 20090916-IR-405080325FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-1-2) to the Office of the Secretary of Family and Social Services (405 IAC*

2-1-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-1-3 Date of application for assistance

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 3. For the purpose of determining when notice of the decision to approve or deny assistance must be mailed to an applicant for Medicaid under 42 CFR 435.911, the date of application is the date on which the application for assistance, Part I, is received by the county office. (*Office of the Secretary of Family and Social Services; 405 IAC 2-1-3; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1013, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1781; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-1-3) to the Office of the Secretary of Family and Social Services (405 IAC 2-1-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.

Rule 1.1. Methodology for Conducting Eligibility Determinations

405 IAC 2-1.1-1 Definitions

Authority: IC 12-15

Affected: IC 12-15-2; IC 12-15-3

Sec. 1. (a) The definitions in this section apply throughout this rule.

(b) "Applicant" means an individual applying for Medicaid eligibility on the basis of blindness or disability.

(c) "Change in circumstances" means any of the following:

(1) A disabling condition different from, or in addition to, that considered by SSA in making a previous SSA determination.

(2) That more than twelve (12) months after the most recent SSA determination denying disability, an individual's condition has changed or deteriorated resulting in a new period of disability, and such individual has not applied to SSA for a determination with respect to these new allegations.

(3) That less than twelve (12) months after the most recent SSA determination denying disability, an individual's condition has changed or deteriorated, alleging a new period of disability and either the individual:

(A) has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; or

(B) no longer meets the nondisability requirements for SSI but may meet the state's nondisability requirements for Medicaid eligibility.

(d) "FPL" refers to the federal poverty level.

(e) "MAGI" refers to the methodology for how income is counted and how household composition and family size are determined as set forth in 42 CFR 435.603.

(f) "Member" means the individual receiving benefits due to age, disability, or blindness.

(g) "Special income level" refers to an amount equal to three hundred percent (300%) of the maximum benefit payable under the SSI program.

(h) "SSA" refers to the federal Social Security Administration.

(i) "SSA determination" means a final agency action by which SSA has determined an individual's eligibility or ineligibility for SSI.

(j) "SSDI" means Social Security disability insurance benefits provided through SSA.

(k) "SSI" means supplemental security income provided through SSA.

(l) "State" includes the office. (*Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-1; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-1.1-2 Application

Authority: IC 12-13-7-3; IC 12-15

Affected: IC 12-15-2; IC 12-15-3

Sec. 2. This rule applies to individuals seeking or receiving benefits on the basis of age, blindness, or disability. This rule specifically does not include eligibility criteria for individuals receiving benefits on the basis of income as determined using MAGI under 42 CFR 435.603, which is hereby incorporated by reference. (*Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-2; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA*)

405 IAC 2-1.1-3 Applying for benefits

Authority: IC 12-13-7-3; IC 12-15

Affected: IC 12-15-2; IC 12-15-3

Sec. 3. (a) For purposes of this rule, any determination of eligibility on the basis of blindness or disability made by SSA is binding upon the state. A determination of eligibility by SSA for SSI automatically confers Medicaid eligibility upon that individual. This subsection governs when:

- (1) an eligibility determination is to be made by SSA; and
- (2) a determination is to be made by the state.
- (b) SSA determinations.
 - (1) SSA determination of eligibility. When an individual has been determined eligible for SSI by SSA, the state shall:
 - (A) receive notification of such eligibility;
 - (B) adopt SSA's determination; and
 - (C) automatically enroll that individual in Medicaid.
 - (2) SSA determination of ineligibility. SSA's determination of ineligibility for SSI or SSDI on the basis of disability or blindness is binding on the state as it relates to disability or blindness, regardless of any prior determination the state may have made.
 - (3) Changed determination. SSA's determination of eligibility on the basis of disability or blindness is binding on the state until changed by SSA. If such SSA determination is changed, the new SSA determination on the basis of disability or blindness is also binding on the state.
- (c) State determinations.
 - (1) The state must make a determination of eligibility for Medicaid under the following circumstances:
 - (A) Applications for benefits are filed with both SSA and the state;
 - (B) SSA has determined the individual to be blind or disabled, and the individual:
 - (i) is not receiving SSI; and
 - (ii) submitted an application to the state as described in 405 IAC 2-1-2(d); or
 - (C) The individual alleges a change in circumstances as provided in section 1(c) of this rule.
 - (2) Pending application with SSA. Where an individual has applied to both SSA for benefits and the state for Medicaid, the state must make a determination within ninety (90) days of its receipt of the individual's application for Medicaid when no determination has been made by SSA, as set forth in 42 CFR 435.541(c)(2).
 - (3) Where an individual has not applied to SSA for benefits but applies to the state for Medicaid, the state must make a determination of eligibility. In accordance with 42 CFR 435.608, the state shall require such individual to apply for all other benefits he or she may be eligible to receive, including SSI or SSDI benefits, as a condition of Medicaid eligibility.
 - (4) Change in circumstances. The state must make a determination if:
 - (A) SSA has previously determined the individual to be ineligible for SSI on the basis of blindness or disability; and
 - (B) the individual alleges a change in circumstances.

(*Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-3; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA*)

405 IAC 2-1.1-4 Criteria for determining disability

Authority: IC 12-13-7-3; IC 12-15

Affected: IC 12-15-2; IC 12-15-3

Sec. 4. When the state makes disability determinations, it shall do so in accordance with 42 CFR 435.541(d) through 42 CFR 435.541(f). (*Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-4; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA*)

405 IAC 2-1.1-5 Income

Authority: IC 12-13-7-3; IC 12-15

Affected: IC 12-15-2; IC 12-15-3

Sec. 5. (a) Individuals declared eligible for benefits by reason of age, disability, or blindness are subject to the income definition and exclusions set forth in 42 U.S.C. 1382a and 20 CFR Part 416, Subpart K Income.

(b) The income standard to be used is one hundred percent (100%) of FPL.

(c) The following apply in determining the household size of an applicant or member for purposes of determining income:

(1) An unmarried applicant or member will be considered a household of one (1).

(2) A married applicant or member will be considered a household of two (2).

(3) A child applicant or member under eighteen (18) years of age living with only one (1) biological or adopted parent will be considered a household of one (1).

(4) A child applicant or member under eighteen (18) years of age living with:

(A) two (2) biological parents;

(B) two (2) adopted parents; or

(C) one (1) biological and one (1) adopted parent;

will be considered a household of two (2).

(d) A maximum allocation of three hundred ninety-two dollars (\$392) for the year 2020 can be deducted for the below individuals who live with the applicant or member. The allocation amount is adjusted yearly based on federal guidance:

(1) Biological or adopted children of the applicant or member under eighteen (18) years of age not receiving adoption assistance or temporary assistance for needy families.

(2) Biological or adopted children of the applicant or member under twenty-two (22) years of age if attending a college or university as at least a half-time student not receiving adoption assistance or temporary assistance for needy families.

(3) An essential person as defined in 405 IAC 2-1-1(3).

(4) A stepparent.

(5) A biological or adoptive sibling under the care of the child applicant or member's parent or parents.

(e) If the countable income calculated according to subsection (d) for any individual listed in subsection (d)(1) through (d)(5) is greater than three hundred sixty-one dollars (\$361), there will not be a deduction for that individual. If the countable income calculated according to subsection (a) for any individual listed in subsection (d)(1) through (d)(5) is less than three hundred sixty-one dollars (\$361), then the allocated amount to be deducted for such individual shall be the difference between three hundred sixty-one dollars (\$361) and that individual's countable income.

(f) Beginning in calendar year 2014, the allocation amount specified in subsection (d) shall increase annually in the same percentage amount that is applied to SSI benefits under 42 U.S.C. 1382f. The increase in the allocation amount shall be effective on the first day of the same month in which the office processes the Title II costs of living adjustments received by public assistance members under 42 U.S.C. 415(i).

(g) To be considered income eligible while either residing in an institution or while receiving home and community based waiver services, an individual must have countable income that is not more than the special income level as follows:

(1) If residing in an institution, the individual must reside there for a period of not less than thirty (30) continuous days. If a person dies before the thirty (30) continuous days has passed, it is assumed that the thirty (30) continuous days has been met.

(2) The countable income for an individual described in this subsection consists only of income of the individual, which includes the following:

(A) Gross earnings.

- (B) Net rental income.
- (C) Net self-employment income.
- (D) All gross unearned income, excluding SSI.

(3) Any income from another financially responsible relative described under 405 IAC 2-3-4 will not be included when determining whether an individual falls below the special income level.

(4) Income that has been placed or delivered to a trust described in 405 IAC 2-3-22(i)(2) will be disregarded for purposes of determining income eligibility under the special income level.

(Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-5; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-1.1-6 Individuals receiving behavioral and primary health care coordination services

Authority: IC 12-13-7-3; IC 12-15

Affected: IC 12-15-2; IC 12-15-3

Sec. 6. (a) Except as provided under subsection (b), individuals may be eligible for Medicaid services if they meet the following criteria:

(1) They qualify to receive behavioral and primary health care coordination services based on the criteria set forth in 405 IAC 5-21.8-4.

(2) They have met the income threshold set forth in section 5(b) of this rule.

(b) Individuals described in subsection (a)(1) but who do not qualify under subsection (a)(2) may still be eligible for Medicaid services if their countable income is less than one hundred fifty percent (150%) of the FPL. In determining an individual's countable income for purposes of this subsection, the following deductions apply:

(1) For an applicant or individual who is married, income will be calculated in accordance with 405 IAC 2-3-17.

(2) One thousand four hundred thirty-seven dollars (\$1,437) or an amount equal to one hundred fifty percent (150%) FPL, which will increase annually.

(c) There is no asset test when subsection (b) is applicable. *(Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-6; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)*

405 IAC 2-1.1-7 Posteligibility treatment of income

Authority: IC 12-13-7-3; IC 12-15

Affected: IC 12-15-7-2

Sec. 7. (a) This section applies to individuals who are determined eligible under section 5(g) of this rule who are either residing in an institution or are receiving home and community based waiver services.

(b) Except as provided in 405 IAC 2-3-17, the following procedure shall be used to determine the amount of income to be paid to an institution for an applicant or member who has been determined eligible under section 5(g) of this rule and who is residing in an institution as defined in 405 IAC 2-1-1(4) or receiving home and community based waiver services:

(1) Determine the applicant's or member's total income that is not excluded by federal statute, which includes amounts deducted in the eligibility determination under section 5(g)(3) of this rule.

(2) Subtract the minimum personal needs allowance equal to either of the following amounts:

(A) Specified in IC 12-15-7-2 for an individual residing in an institution.

(B) The special income level for an individual receiving home and community based waiver services.

(3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant or member's legal guardian, not to exceed thirty-five dollars (\$35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney's fees for which the guardian is liable.

(4) Subtract the amount of any health insurance premiums.

(5) Subtract an amount for expenses incurred for necessary or remedial care recognized by state law but not covered under

the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.

(6) Subtract an amount for federal, state, and local taxes owed and paid by the applicant or member. This deduction is limited to one (1) calendar month per year.

The resulting amount is the amount by which the Medicaid payment to the institution where the individual resides, or to other Medicaid approved providers, when the individual is receiving home and community based waiver services, shall be reduced.

(c) A child under eighteen (18) years of age determined eligible for benefits under section 5(g) of this rule will not have any resources or income from his or her parents deemed to such child under this section. *(Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-7; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

405 IAC 2-1.1-8 Resource definitions and exclusions

Authority: IC 12-13-7-3; IC 12-15

Affected: IC 12-15-2; IC 12-15-3

Sec. 8. Individuals declared eligible for benefits by reason of age, disability, or blindness are subject to resource definitions and exclusions set forth in 42 U.S.C. 1382b and 20 CFR Part 416, Subpart L, Resources. *(Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-8; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)*

405 IAC 2-1.1-9 Appeals

Authority: IC 12-13-7-3; IC 12-15

Affected: IC 12-15

Sec. 9. When any appeal of a determination is filed with FSSA, such appeal will be conducted in accordance with the procedures set forth in 405 IAC 1.1. *(Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-9; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)*

405 IAC 2-1.1-10 Individuals receiving end stage renal disease services

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-13-7-3; IC 12-15

Sec. 10. In order to be eligible for end stage renal disease (ESRD) services under this rule, an individual must meet the following conditions:

(1) Has been diagnosed with ESRD.

(2) Is currently enrolled in Medicare.

(3) Has income between one hundred fifty percent (150%) and three hundred percent (300%) of the FPL.

(4) Has resources below one thousand five hundred dollars (\$1,500) for an individual or two thousand two hundred fifty dollars (\$2,250) for a couple.

(5) Is not institutionalized.

(6) Meet all other Medicaid nonfinancial eligibility criteria.

(7) Is not Medicaid eligible on any other basis, or is eligible under ESRD waiver Population 1, effective May 31, 2014.

(Office of the Secretary of Family and Social Services; 405 IAC 2-1.1-10; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

Rule 2. Eligibility Requirements Other than Need

405 IAC 2-2-1 Age requirement; Medicaid for the aged

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 1. In order to be eligible for assistance under the Medicaid for the aged program as an aged person, the applicant must be at least sixty-five (65) years of age. (*Office of the Secretary of Family and Social Services; 405 IAC 2-2-1; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1014, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-2-1) to the Office of the Secretary of Family and Social Services (405 IAC 2-2-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-2-2 Visual eligibility; Medicaid for the blind

Authority: IC 12-15

Affected: IC 12-13-7-3

Sec. 2. (a) To be considered blind for eligibility purposes, a person must meet the criteria set forth in 42 U.S.C. 1382c(a)(2).

(b) There is no minimum age requirement for a person who is blind.

(c) A person must have a medical determination of blindness before the office can determine eligibility. (*Office of the Secretary of Family and Social Services; 405 IAC 2-2-2; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1014, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-2-2) to the Office of the Secretary of Family and Social Services (405 IAC 2-2-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-2-3 Disability definition and determination

Authority: IC 12-15-1-10

Affected: IC 12-13-7-3; IC 12-14-15-1; IC 12-15

Sec. 3. The definition of disability set forth in 42 U.S.C. 1382c(a)(3) will be used in making the disability determination of an individual applying for disability benefits. (*Office of the Secretary of Family and Social Services; 405 IAC 2-2-3; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1015, eff Apr 1, 1984; errata, 7 IR 1254; filed Dec 21, 2000, 2:06 p.m.: 24 IR 1342; errata filed Apr 30, 2001, 3:27 p.m.: 24 IR 2709; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 21, 2005, 3:00 p.m.: 29 IR 9; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-2-3) to the Office of the Secretary of Family and Social Services (405 IAC 2-2-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-2-4 Payment for examinations and tests

Authority: IC 12-15-1-10

Affected: IC 12-13-5-1

Sec. 4. If the office of Medicaid policy and planning (office) makes the individual's disability determination, then the office shall pay for the costs of necessary medical examinations and diagnostic tests required to determine whether the applicable visual or disability requirement is met to qualify for Medicaid to the blind or disabled, subject to the following limitations:

- (1) Payment will be made only to the medical practitioner upon submission of a completed claim form prescribed by the office.
- (2) Payment for the cost of submitting a report of a previously completed medical examination or other record shall not exceed ten dollars (\$10).
- (3) Payment for an eye examination and completion of a report thereon shall not exceed twenty-nine dollars (\$29).
- (4) Payment for a physical examination or evaluation and completion of a report thereon shall not exceed sixty-five dollars (\$65). Examination fees include expenses for basic blood testing and urinalysis. Fees relating to these tests will not be reimbursed separately.
- (5) Payment for a psychiatric evaluation or testing and completion of a report thereon shall not exceed eighty dollars (\$80).

per hour.

(6) Diagnostic procedures, such as laboratory tests, x-rays, and special testing, may be reimbursed only if authorized in advance of the procedure by the Medicaid medical review team (MMRT) physician. Authorization will only be granted if additional testing is necessary in order to:

- (A) confirm the diagnosis or to measure the severity of the impairment; or
- (B) assist in completing the examination.

Payment will not be made for any treatment given to the applicant.

(7) All prior-authorized additional testing, as referenced in subdivision (6), will be reimbursed according to the Medicaid fee-for-service schedule applicable on the date of service.

(Office of the Secretary of Family and Social Services; 405 IAC 2-2-4; filed Nov 1, 1995, 8:30 a.m.: 19 IR 351; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)

Rule 2.5. Eligibility for Medicaid under Modified Adjusted Gross Income Standards

405 IAC 2-2.5-1 Definitions

Authority: IC 12-15-21

Affected: IC 12-15-2; IC 12-15-3

Sec. 1. For purposes of this rule, the following definitions apply:

(1) "Family size" means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman:

- (A) the pregnant woman is counted as herself plus the number of children she is expected to deliver for her own eligibility determination; and
- (B) the pregnant woman is counted as one (1) person in any other assistance group where she is included.

(2) "MAGI" or "modified adjusted gross income" means a methodology for how income is counted and how household composition and family size are determined, as specified at 42 CFR 435.603.

(3) "MAGI-based income" means income calculated using the same financial methodologies used to determine modified adjusted gross income under 26 U.S.C. 36B(d)(2)(B), which is hereby incorporated by reference, with the following exceptions:

- (A) An amount received as a lump sum is counted as income only in the month received.
- (B) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.
- (C) American Indian/Alaska Native exceptions. The following are excluded from income:
 - (i) Distributions from Alaska Native Corporations and Settlement Trusts.
 - (ii) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the United States Secretary of the Interior.
 - (iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from any of the following:
 - (AA) Rights of ownership or possession in any lands described in subdivision (ii).
 - (BB) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources.
 - (iv) Distributions resulting from real property ownership interests related to natural resources and improvements:
 - (AA) located on or near a reservation or within the most recent boundaries of a prior federal reservation; or
 - (BB) resulting from the exercise of federally-protected rights relating to such real property ownership interests.
 - (v) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual,

traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

(vi) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(4) "MAGI group" refers to individuals whose eligibility is being determined in accordance with the income standards set forth in this rule. This includes, but is not limited to, the following categories of Medicaid assistance:

- (A) Child under one (1) year of age.
- (B) Child one (1) to five (5) years of age.
- (C) Child six (6) to nineteen (19) years of age.
- (D) Parent or caretaker relative.
- (E) Pregnancy.
- (F) Adult nineteen (19) to sixty-five (65) years of age.
- (G) Extension of income-ineligible pregnant women.
- (H) Individuals between nineteen (19) and twenty-one (21) years of age residing in an inpatient psychiatric facility who would be eligible.
- (I) Former foster children up to twenty-one (21) years of age.
- (J) Children one (1) year of age to nineteen (19) years of age (MCHIP).
- (K) Children's health plan for children from birth to nineteen (19) years of age.
- (L) Family planning services for women and men.

(5) "Non-MAGI group" includes individuals eligible for or receiving services under the following categories of Medicaid assistance:

- (A) Aged.
- (B) Blind.
- (C) Disabled.
- (D) IV-E foster children.
- (E) Former foster children enrolled as of his or her eighteenth birthday.
- (F) Deemed newborn.
- (G) Children under nineteen (19) years of age with adoptive assistance.
- (H) Women with breast and cervical cancer.
- (I) Medicaid for employees with disabilities (MED Works).
- (J) Medicaid for the medically improved for employees with disabilities.
- (K) Residential Care Assistance Program related coverage.
- (L) Qualified Medicare beneficiary.
- (M) Specified low income Medicare beneficiary.
- (N) Qualified disabled and working individuals.
- (O) Qualified individual.
- (P) Refugee.
- (Q) Ongoing transitional medical assistance.

(6) "Tax dependent" means an individual for whom another individual claims a deduction for a personal exemption under 26 U.S.C. 152, which is hereby incorporated by reference.

(Office of the Secretary of Family and Social Services; 405 IAC 2-2.5-1; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-2.5-2 Eligibility under MAGI

Authority: IC 12-15-21

Affected: IC 12-15-2; IC 12-15-3

Sec. 2. (a) The eligibility requirements in this rule only apply to the MAGI group defined in section 1 of this rule. The office shall continue to apply all other eligibility standards as provided in this title to non-MAGI groups.

(b) Notwithstanding any other provision in this article, the office shall not apply any asset or resource test or income or expense disregards, except for the five percent (5%) income disregard in subsection (d), for any individuals in the MAGI eligibility group

with the highest income standard under which the individual may be determined.

(c) Except as provided in subsection (j), an individual's financial eligibility for Medicaid under this section is based on the individual's household income as defined in subsection (d). An individual whose eligibility is being determined under this section will be eligible for Medicaid if the MAGI-based income of the individual's household meets the financial threshold requirements in accordance with federal poverty levels established by the office under this title.

(d) Except as provided in subdivision (1), household income is the sum of the MAGI-based income, as defined in section 1 of this rule, of the individual and every individual in the individual's household, minus the amount equivalent to five (5) percentage points of the federal poverty level for the applicable family size as follows:

(1) The MAGI-based income for a tax filer will include the income of a claimed child or tax dependent if the child or tax dependent will be required to file a tax return under 26 U.S.C. 6012(a)(1) for the taxable year in which eligibility is being determined.

(2) If the child or tax dependent will not be required to file a tax return under 26 U.S.C. 6012(a)(1), the income of the child or tax dependent will not count in the household income for the taxpayer who claims them for the taxable year in which eligibility is being determined.

(e) The composition of a household for purposes of household income shall be determined as follows:

(1) For an individual who:

(A) expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made; and

(B) does not expect to be claimed as a tax dependent by another taxpayer;
the household consists of the taxpayer and, subject to subsection (f), all persons whom such individual expects to claim as a tax dependent.

(2) In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with subdivision (3) in the case of the following:

(A) Individuals other than a spouse or a biological, adopted, or step child who expect to be claimed as a tax dependent by another taxpayer.

(B) Individuals under nineteen (19) years of age who expect to be claimed by one (1) parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return.

(C) For the purposes of this section, in determining which parent claims an individual under nineteen (19) years of age as a tax dependent, who expect to be claimed as a tax dependent, the following documentation will be used to determine the tax dependent status:

(i) A court order or binding separation, divorce, or custody agreement establishing physical custody controls.

(ii) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(3) In determining the household composition, the household includes an individual who:

(A) does not expect to file a federal tax return and does not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made; or

(B) is described in subdivision (2)(A), (2)(B), or (2)(C); the household consists of the individual and, if living with the individual:

(i) the individual's spouse;

(ii) the individual's natural, adopted, and step children under the age of nineteen (19) years of age; and

(iii) in the case of individuals under nineteen (19) years of age, the individual's natural, adopted and step parents and natural, adoptive, and step siblings under nineteen (19) years of age.

(4) In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under 26 U.S.C. 6013, which is hereby incorporated by reference, or whether one (1) spouse expects to be claimed as a tax dependent by the other spouse.

(f) The office may require the individual under this section to verify the household size for subsection (e)(1). This verification may include a self-attestation from the individual as to household size. If the individual cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the

household of the taxpayer is determined in accordance with subsection (e)(3).

(g) Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(h) Except as provided in subdivision (1), for individuals who have been determined financially eligible for Medicaid using the MAGI-based methods set forth in this section, the office shall base financial eligibility on income based on current household income and family size for the remainder of the current calendar year under subsection (i). Application of the MAGI-based methods will not be applied to Medicaid beneficiaries determined eligible for Medicaid to begin on or before December 31, 2013. Application of the MAGI-based methodologies for individuals under this subsection will not be applied until either:

(1) March 31, 2014; or

(2) the next regularly scheduled renewal of eligibility for such individual;

whichever is later.

(i) The office may accept an individual's attestation of projected annual household income and household size for purposes of establishing financial eligibility for Medicaid under this section. The office may require the individual to submit additional documentation to resolve discrepancies, including documentation sufficient to establish a reasonably predictable increase or decrease in future income or family size. Such documentation may include, but is not limited to:

(1) a signed contract for employment;

(2) a clear history of predictable fluctuations in income or family size; or

(3) other clear indicia of future changes in income or family size.

(j) In determining annual household income and family size under subsection (g) or (h), the office will include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease, or both, in future income.

(k) If the household income of an individual determined in accordance with this section results in financial ineligibility for Medicaid and the household income of such individual determined in accordance with 26 CFR 1.36B-1(e) is below one hundred percent (100%) federal poverty level, Medicaid financial eligibility will be determined in accordance with 26 CFR 1.36B-1(e), which is hereby incorporated by reference. (*Office of the Secretary of Family and Social Services; 405 IAC 2-2.5-2; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-2.5-3 Administrative appeals

Authority: IC 12-15-21

Affected: IC 12-15-2; IC 12-15-3; IC 12-15-28

Sec. 3. An individual may appeal the office's determination of ineligibility under this rule in accordance with the appeal procedures under 405 IAC 1.1. (*Office of the Secretary of Family and Social Services; 405 IAC 2-2.5-3; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

Rule 3. Eligibility Requirements Based on Need; Aged, Blind, and Disabled Program

NOTE: 405 IAC 2-3 was transferred from 470 IAC 9.1-3. Wherever in any promulgated text there appears a reference to 470 IAC 9.1-3, substitute 405 IAC 2-3.

405 IAC 2-3-1 Transfer of property to meet eligibility requirements (*Repealed*)

Sec. 1. (*Repealed by Office of the Secretary of Family and Social Services; filed Mar 13, 2002, 10:09 a.m.: 25 IR 2475*)

405 IAC 2-3-1.1 Transfer of property; penalty

Authority: IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5; IC 12-15-39.6

Sec. 1.1. (a) The following definitions apply throughout this section:

(1) "Assets" includes all income and resources of the applicant or member, and of the applicant's or member's spouse, including any income or resources that the applicant or member or the applicant's or member's spouse is entitled to receive but does not

receive because of action by:

- (A) the applicant or member or the applicant's or member's spouse;
- (B) a person, including, but not limited to, a court or administrative body with legal authority to act in place of or on behalf of the applicant or member or the applicant's or member's spouse; or
- (C) a person, including, but not limited to, a court or administrative body acting at the direction or upon the request of the applicant or member or the applicant's or member's spouse.

The term includes assets that an individual is entitled to receive but does not receive because of failure to take action subject to subsection (j).

(2) "Individual" means an applicant or member of Medicaid.

(3) "Institutionalized individual" means an applicant or member who is:

- (A) an inpatient in a nursing facility;
- (B) an inpatient in a medical institution for whom payment is made based on a level of care provided in a nursing facility; or
- (C) receiving home and community based waiver services.

(4) "Net income" means the income produced by real property after deducting allowable expenses of ownership. Allowable and nonallowable expenses are as follows:

(A) The following are allowable expenses of ownership if the owner is responsible for the expenses:

- (i) Property taxes.
- (ii) Interest payments.
- (iii) Repairs and maintenance.
- (iv) Advertising expenses.
- (v) Lawn care.
- (vi) Property insurance.
- (vii) Trash removal expenses.
- (viii) Snow removal expenses.
- (ix) Utilities.
- (x) Any other expenses of ownership allowed by the Supplemental Security Income program.

(B) The following are not allowable expenses of ownership:

- (i) Depreciation.
- (ii) Payments on mortgage principal.
- (iii) Personal expenses of the owner.
- (iv) Mortgage insurance.
- (v) Capital expenditures.

(5) "Noninstitutionalized individual" means an applicant or member receiving any of the services:

- (A) Home health care services.
- (B) Home and community care services for functionally disabled elderly individuals.
- (C) Personal care services as defined in 42 U.S.C. 1396a(a)(24).

(6) "Qualified long term care insurance policy" has the meaning set forth in 760 IAC 2-20-30.

(7) "Uncompensated value" means the difference between the fair market value of the asset and the value of the consideration received by the applicant or member in return for transferring the asset.

(b) A look back date is sixty (60) months before the first date as of which the individual both:

- (1) is an institutionalized individual; and
- (2) has applied for Medicaid.

(c) If an applicant or member of Medicaid, or the spouse of an applicant or member, disposes of assets for less than fair market value on or after the look back date, the applicant or member is ineligible for Medicaid for services described in subsection (e) for a period of time known as the penalty period. The penalty period is equal to the number of months specified in subsection (g) and shall begin on the later of the first day of the month in which assets have been transferred for less than fair market value, or the date on which the individual would be eligible for services described in subsection (e), based on an approved application for such assistance without regard to any penalty periods, whichever is later, and which does not occur during any other period of ineligibility.

(d) A transfer of assets includes any cash, liquid asset, or property that is transferred, sold, given away, or otherwise disposed

of as follows:

- (1) Transfer includes any total or partial divestiture of control or access, including, but not limited to, any of the following:
 - (A) Converting an asset from individual to joint ownership.
 - (B) Relinquishing or limiting the applicant's or member's right to liquidate or sell the asset.
 - (C) Disposing of a portion or a partial interest in the asset while retaining an interest.
 - (D) Transferring the right to receive income or a stream of income, including, but not limited to, income produced by real property.
 - (E) Renting or leasing real property.
 - (F) Waiving the right to receive a distribution from a decedent's estate, or failing to take action to receive a distribution that the individual is entitled to receive by law subject to subsection (j).
 - (G) For transactions converting funds to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage:
 - (i) has a repayment term that is actuarially sound in accordance with actuarial publications of the Social Security Administration;
 - (ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
 - (iii) prohibits the cancellation of the balance upon the death of the lender.
 - (H) For the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least one (1) year beginning immediately after the date of purchase.
- (2) If an applicant or member relinquishes ownership or control over a portion of an asset, but retains ownership, control, or an interest in the remaining portion, the portion relinquished is considered transferred.
- (3) A transfer of the applicant's or member's assets completed by the applicant's or member's power of attorney or legal guardian is considered a transfer by the applicant or member.
- (4) For purposes of this section, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered transferred by the applicant or member when any action is taken, either by the applicant or member or by any other person, that reduces or eliminates the applicant's or member's ownership or control of the asset.
- (5) This section applies without regard to the exclusion of the home described in 42 U.S.C. 1382b(a)(1).
- (6) This section applies without regard to the exclusion of income-producing real property except for property used in a trade or business. The transfer of income-producing real property other than property used in a trade or business is subject to penalty under subsections (h) and (l). "Trade or business" means a trade or business that is actively managed or operated by the applicant or member.
- (e) During the penalty period, an institutionalized individual is ineligible for Medicaid for the following services:
 - (1) Nursing facility services.
 - (2) A level of care in any institution equivalent to that of nursing facility services.
 - (3) Home or community based waiver services.
- (f) If an individual is ineligible for Medicaid for services under this section, expenses for those services are not allowable medical expenses in calculating an individual's nursing home liability for any month of Medicaid eligibility.
- (g) The number of months of ineligibility shall be equal to the total, cumulative uncompensated value of all assets transferred by the individual, or the individual's spouse, on or after the look back date specified in subsection (b), divided by the average monthly cost to a private patient of nursing facility services in the geographic area that includes the county where the individual resides at the time of application. As used in this subsection, "geographic area" means the region identified in Section 2640.10.35.20 of the Family and Social Services Administration Program Policy Manual for Cash Assistance, Food Stamps, and Health Coverage. If in calculating the period of ineligibility a fractional period of ineligibility is determined, the state shall not round down, or otherwise disregard any fractional period of ineligibility.
- (h) This subsection applies to the transfer of a stream of income, including, but not limited to, the transfer of the income generated by income-producing real property. The uncompensated value of income transferred is determined by calculating the greater of:
 - (1) the fair market value; or
 - (2) the actual amount;

of total net income that the property or other source of income is capable of producing during the lifetime of the transferor, based on life expectancy tables published by the office, and subtracting the income, if any, that the transferor will receive from the property or other source of income after the transfer.

(i) When an individual accepts a rental payment that is less than the fair market rental value for income-producing property, the uncompensated value of the transfer is determined by:

- (1) calculating the difference between the fair market rental value and the amount of rent accepted; and
- (2) multiplying the difference by the person's life expectancy based on life expectancy tables published by the office.

(j) This subsection applies to a transfer of assets that results from failure to take action to receive assets to which one is entitled to receive by law. No penalty will be imposed if any of the following circumstances applies:

(1) The applicant or member, or the individual with legal authority to act on behalf of the applicant or member, is unaware of his or her right to receive assets or becomes aware of the right to receive assets after the deadline for taking action has passed. If the office notifies the applicant or member of his or her right to receive assets prior to the deadline for taking action, the individual will be presumed to be aware of his or her right to receive assets unless subdivision (2) applies.

(2) A physician states that the applicant or member is not capable of taking action to receive the assets, and there is no guardian or other individual with the authority to act on the applicant's or member's behalf.

(3) The expenses of collecting the assets would exceed the value of the assets.

(4) In the case of a surviving spouse who fails to take a statutory share of a deceased spouse's estate, no penalty will be imposed if the deceased spouse has made other equivalent arrangements to provide for a spouse's needs. "Other equivalent arrangements" includes, but is not limited to, a trust established for the benefit of the surviving spouse.

(k) An applicant or member shall not be ineligible for Medicaid under this section if any of the following apply:

(1) The assets transferred were a home, and title to the home was transferred to any of the following persons:

(A) The spouse of the applicant or member.

(B) A child of the applicant or member who is:

- (i) under twenty-one (21) years of age; or
- (ii) blind or disabled as defined in 42 U.S.C. 1382c.

(C) A sibling of the applicant or member who:

- (i) has an equity interest in the home; and
- (ii) was residing in the applicant's or member's home for a period of at least one (1) year immediately before the date the applicant or member becomes an institutionalized individual.

(D) A son or daughter of the applicant or member, other than a child described in clause (B), who:

- (i) was residing in the applicant's or member's home for a period of at least two (2) years immediately before the date the applicant or member becomes an institutionalized individual; and
- (ii) the office determines has provided care to the applicant or member that permitted the applicant or member to reside at home rather than in an institution or facility.

(2) The assets were transferred to:

(A) the applicant's or member's spouse; or

(B) another for the sole benefit of the applicant's or member's spouse.

(3) The assets were transferred from the applicant's or member's spouse to another for the sole benefit of the applicant's or member's spouse.

(4) The assets were transferred to:

(A) the applicant's or member's child who is disabled or blind as defined in 42 U.S.C. 1382c; or

(B) a trust, including a trust described in section 22(i) of this rule, established solely for the benefit of the applicant's or member's child who is disabled or blind as defined in 42 U.S.C. 1382c.

(5) The assets were transferred to a trust, including a trust described in section 22(i) of this rule, established solely for the benefit of an individual under sixty-five (65) years of age who is disabled as defined in 42 U.S.C. 1382c.

(6) The assets transferred are disregarded for eligibility purposes through the use of a qualified long term care insurance policy under IC 12-15-39.6. If an asset is disregarded through the use of a qualified long term care insurance policy, that asset and any income generated by that asset may be transferred without penalty.

(7) A satisfactory showing is made to the office, in accordance with standards specified under 42 U.S.C. 1396p(c)(2)(C) by the Secretary of Health and Human Services, that:

- (A) the applicant or member intended to dispose of the assets at fair market value or for other valuable consideration;
- (B) the assets were transferred exclusively for a purpose other than to qualify for Medicaid; or
- (C) all assets transferred for less than fair market value have been returned to the applicant or member.

In order to establish that a transfer was made exclusively for purposes other than qualifying for Medicaid, the applicant or member must submit sufficient evidence to show that the transfer was made exclusively for reasons not related to Medicaid eligibility, estate recovery, or lien.

(8) The office may waive the application of this section in cases of undue hardship, but only to the extent required by standards specified under 42 U.S.C. 1396p(c)(2)(D) by the Secretary of Health and Human Services and section 24 of this rule.

(l) For transfers of income-producing real property not used in a trade or business on and after July 1, 2003, six thousand dollars (\$6,000) of the equity value can be transferred without penalty if the transferred property produces an annual income of at least three hundred sixty dollars (\$360). If the equity value of the property is less than six thousand dollars (\$6,000), the property can be transferred without penalty if the property produces an annual income of at least six percent (6%) of the equity. This six thousand dollars (\$6,000) exemption is a single, one (1) time exemption that applies to the total value of all income-producing real property transferred by the applicant during the applicant's lifetime. If the property does not produce an annual income of at least six percent (6%) of the lesser of six thousand dollars (\$6,000) or the equity value, the entire equity is the uncompensated value.

(m) In the case of a transfer by the spouse of an applicant or member that results in a period of ineligibility for Medicaid, the office shall apportion the period of ineligibility, or any portion of that period, between the applicant or member and the applicant's or member's spouse, if the spouse otherwise becomes eligible for Medicaid, as specified in regulations promulgated under 42 U.S.C. 1396p(c)(4) by the Secretary of Health and Human Services. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-1.1; filed May 1, 1995, 10:45 a.m.: 18 IR 2223; errata filed Jun 9, 1995, 2:30 p.m.: 18 IR 2796; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 13, 2002, 10:09 a.m.: 25 IR 2472; filed Apr 8, 2004, 3:16 p.m.: 27 IR 2479; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 18, 2009, 11:33 a.m.: 20090916-IR-405080325FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-3-1.2 Annuities

Authority: IC 12-15-1-10

Affected: IC 12-15-4

Sec. 1.2. (a) For purposes of this section, "annuity" means a policy, certificate, contract, or other arrangement between two (2) or more parties whereby one (1) party pays a lump sum of money or other valuable consideration to the other party in return for the right to receive payments in the future and shall include any similar financial instrument, as may be specified by the Secretary of Health and Human Services. An annuity not purchased from an entity described in subsection (b) will be considered a transfer for inadequate consideration.

(b) The purchase of an annuity, any instrument purporting to be an annuity, or any other arrangement that meets the definition of an annuity in subsection (a) shall be considered an uncompensated transfer of assets resulting in a penalty under section 1.1 of this rule unless the annuity is purchased from one (1) of the following:

- (1) An insurance company or another commercial company that sells annuities as part of the normal course of business.
- (2) A nonprofit organization qualified under Section 501(c) of the Internal Revenue Code as amended.
- (c) An annuity described in subsection (a) is not an asset for purposes of section 1.1 of this rule if:

(1) the annuity is:

- (A) an annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986, as amended; or
- (B) purchased with proceeds from an account or trust described in subsection (a), (c), or (p) of Section 408 of such Code, a simplified employee pension within the meaning of Section 408 of the Code, or a Roth IRA described in Section 408(A) of such Code; or

(2) the annuity:

- (A) is irrevocable and nonassignable;
- (B) is actuarially sound; and
- (C) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

- (d) An annuity shall be treated as a transfer of property for less than fair market value under section 1.1 of this rule unless:
 - (1) the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on the behalf of the applicant for Medicaid;
 - (2) the state is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value; or
 - (3) the individual purchased a long term care insurance policy that protects the annuity.

(e) Individual retirement accounts (IRAs), Keogh Plans, 401K Plans, pensions, annuities, and other work related plans are considered retirement accounts and are an available resource to an individual if there is an option of withdrawing an amount for any reason, even though the member may not yet be eligible for periodic payments unless:

- (1) the applicant or member must terminate employment in order to obtain any payment from the retirement account; or
- (2) pursuant to (c)(2) [subsection (c)(2)], when the retirement account has been annuitized and regular, periodic payments are being received, the account is no longer a countable resource and the payments are considered unearned income. If the IRA has sporadic withdraws, then this is a conversion of resources and is not income, but remains a resource.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-1.2; filed May 1, 2002, 10:38 a.m.: 25 IR 2726; errata filed Aug 22, 2002, 3:12 p.m.: 26 IR 35; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 18, 2009, 11:33 a.m.: 20090916-IR-405080325FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-3-2 Life care contracts

Authority: IC 12-15

Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) An applicant who has entered into a life care contract with an institution whereby he or she has transferred his or her available assets to the institution in exchange for full maintenance and medical care during his or her lifetime in that institution is ineligible for Medicaid for the aged, blind, or disabled unless the contracting institution can prove to the division by a complete and accurate accounting of all funds involved that it is unable to fulfill its contract obligations to the applicant.

(b) For purposes of determining an individual's eligibility for, or an amount of, benefits under this article, when an applicant or member residing in a continuing care retirement community or similar life care community collects an entrance fee on admission from such individual the fee shall be considered an available resource to the extent that:

- (1) an individual who has the ability to use the entrance fee, or should the contract provide that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;
- (2) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and
- (3) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-2; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1018, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 18, 2009, 11:33 a.m.: 20090916-IR-405080325FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-4) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-3 Income of applicant or recipient (calculation) (Repealed)

Sec. 3. *(Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA)*

405 IAC 2-3-4 Income of legally responsible relatives; inclusion

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 4. The countable income of an applicant or member includes income of certain legally responsible relatives in the following situations:

- (1) Except as provided in subdivision (3), if the applicant or member is under eighteen (18) years of age and is living with his or her parent, his or her income includes the income of his or her parent.
- (2) If the applicant or member is living with his or her spouse, his or her income includes the income of his or her spouse.
- (3) Income of the parent is not included if the applicant or member is under eighteen (18) years of age and has been approved from home and community based services under an approved waiver, in accordance with 42 U.S.C.A. 1396n, which specifies the exclusion of parental income.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-4; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1019, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1784; filed May 10, 2001, 9:20 a.m.: 24 IR 3022; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-6) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-4) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-5 Income of parents; calculation (Repealed)

Sec. 5. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-6 Income levels for immediate family of institutionalized applicant or recipient (Repealed)

Sec. 6. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-7 Available income of immediate family of institutionalized applicant or recipient (Repealed)

Sec. 7. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-8 Income eligibility of noninstitutionalized applicant or recipient (Repealed)

Sec. 8. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-9 Income eligibility of institutionalized applicant or recipient (Repealed)

Sec. 9. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-10 Spend-down eligibility (Repealed)

Sec. 10. *(Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA)*

405 IAC 2-3-11 Loans; inclusion as income (Repealed)

Sec. 11. *(Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA)*

405 IAC 2-3-12 Contract sale of real property; calculation as income

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 12. (a) A property agreement is a pledge of security of a property for the payment of a debt or the performance of some

other obligation within a specified period of time. A land contract is a property agreement whereby there is a contract for the sale of real estate in which the seller of the real estate retains legal title to the real estate until the total contract price is paid by the buyer. Pursuant to the Deficit Reduction Act of 2005, land contracts or property agreements must meet the following criteria:

- (1) The repayment term must be actuarially sound in that it cannot be set up in terms that exceed the applicant's/member's life expectancy.
- (2) Payment must be made in equal amounts during the term with no deferral of payment and no balloon payment.
- (3) The land contract or property agreement must prohibit the cancellation of the balance upon the death of the lender. If a balance remains upon the death of the lender, it must be designated to the estate of the deceased in order to be considered valid.
- (b) For all land contracts and property agreements meeting the criteria listed in subsection (a):
 - (1) any down payment shall be counted as a resource;
 - (2) the interest portion of the payment shall be counted as income pursuant to 20 CFR 416.1103(f);
 - (3) the principal portion of the payment shall not be considered income;
 - (4) amounts paid towards the principal shall be considered a countable resource as of the first of the month after the payment is received;
 - (5) principal amounts may not be deducted from bank balances or reports of cash on hand, or put into a Miller Trust;
 - (6) the property itself is a *[sic]* not a countable resource because the seller cannot legally convert it to cash while it is encumbered by the non-negotiable agreement; and
 - (7) the property agreement or promissory note has an assumed resource value based on the outstanding principal balance unless the individual furnishes evidence that it has a lower cash value.

(c) If the criteria in subsection (a) are not met, a non-negotiable land contract or property agreement must be treated as a prohibited transfer of resources in accordance with the following requirements:

- (1) Ineligibility periods shall be determined and applied towards the applicant or member.
- (2) The value of the contract to be considered an improper transfer will be the outstanding balance due as of the date of the individual's application for Medicaid or date of admission for long term care, whichever is later.
- (3) In the case of home and community based waiver services, the balance to be used is the amount as of the date of the cost comparison budget approval.

(d) For land contracts that do not meet the criteria in subsection (a), the outstanding principal on the negotiable agreement is considered a countable resource pursuant to 42 U.S.C. 1396p. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-12; filed Mar 1, 1984, 2:33 p.m.: 7 IR 1043, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-14) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-12) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-13 In-kind support and maintenance; inclusion as income (*Repealed*)

Sec. 13. (*Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA*)

405 IAC 2-3-14 Resources, limitations, and exclusions

Authority: IC 12-15

Affected: IC 12-13-7-3

Sec. 14. (a) Individuals eligible under 405 IAC 2-1, 405 IAC 2-2, and this rule, respectively, are subject to resource definitions and exclusions as provided in 42 U.S.C. 1382b and at 20 CFR Part 416, Subpart L Resources.

- (b) Resources identified in 20 CFR 416.1210 are excluded, and other resources that are excluded include the following:
 - (1) The equity value of personal property used to produce food for home consumption or used in the production of income.
 - (2) Income-producing real property if the gross income produced from the real property is greater than the expenses of ownership.
 - (3) For an applicant or member of Medicaid under the blind category, an amount of his or her resources, as specified in an

approved plan for achieving self-support, is disregarded for a period of time not to exceed twelve (12) months. Such a plan will be approved by the office if the plan is in writing and fully documents that the resources to be disregarded will be used by the applicant or member in pursuing a bona fide activity aimed at achieving self-support.

(4) The home including the shelter where at least one (1) of the following individuals resides:

- (A) The applicant or member.
- (B) The spouse of the applicant or member.
- (C) The parent or parents of the applicant or member.
- (D) The applicant's or member's biological or adoptive child or children under eighteen (18) years of age.
- (E) The applicant's or member's blind or disabled biological or adoptive child or children eighteen (18) years of age or older.

The home also includes the land on which the shelter is located and related outbuildings. The home is exempt until such time as it is verified that none of the persons listed in clauses (A) through (E) intends to reside there.

(c) An applicant or member is ineligible for Medicaid for any month in which the total equity value of all nonexempt property exceeds the applicable limitation, set forth as follows, on the first moment of the first day of the month:

(1) Two thousand dollars (\$2,000) for the applicant or member, in addition to the amount determined in subdivision (3), if applicable.

(2) Three thousand dollars (\$3,000) for the applicant or member and his or her spouse if the couple is living together, or if the most recent continuous period of institutionalization of one (1) member of the couple began prior to September 30, 1989.

(3) Twenty-three thousand four hundred forty-eight dollars (\$23,448), subject to adjustment under Section 1924(g) of the Social Security Act, as the spousal resource standard provided for in Section 1924(f)(2)(A)(i) of the Social Security Act, or a higher amount as determined under:

- (A) Section 1924(f)(2)(A)(ii);
- (B) Section 1924(f)(2)(A)(iii); or
- (C) Section 1924(f)(2)(A)(iv);

of the Social Security Act for a community spouse as defined in Section 1924(h) of the Social Security Act.

(d) In determining eligibility of an individual applying for Medicaid with respect to nursing facility services or other long term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds five hundred forty-three thousand dollars (\$543,000). The dollar amount specified in this subsection shall be increased from year to year in accordance with federal law. The limitation in this subsection shall not apply if:

- (1) the individual's spouse or dependent child under twenty-one (21) years of age or blind or disabled child lawfully resides in the home;
- (2) a reverse mortgage or home equity loan has reduced the individual's equity interest in the home below the equity interest restriction;
- (3) the individual purchased a long term care insurance policy that will protect the excess home equity;
- (4) the individual can prove through the process in section 24 of this rule that the application of this subsection will create a hardship for the individual under the standards stated in that rule.

(e) As a condition of eligibility for Medicaid for the aged, blind, and disabled, each applicant and member and his or her legally responsible relatives must sign an agreement to offer for sale or for rent all nonexempt real property that he or she or his or her legally responsible relatives own, except in those situations involving a community spouse and an institutionalized spouse, as defined in Section 1924(h) of the Social Security Act, wherein the total equity value of all resources of the couple does not exceed the sum of the institutionalized spouse's resource limitation specified in subsection (c)(3) and the community spouse resource standard, as determined under Section 1924(f)(2)(A) of the Social Security Act.

(f) If nonexempt real property is not offered for sale or for rent at current market value within thirty (30) days of written notification of Medicaid or within thirty (30) days after the agreement referenced in subsection (e) is signed, whichever is later, the member shall be ineligible for Medicaid. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-14; filed Dec 16, 1986, 11:00 a.m.: 10 IR 1079, eff Feb 1, 1987; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-16) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-14) by P.L.9-1991, SECTION 131, effective January 1,

1992.

405 IAC 2-3-15 Resources; limitations and exclusions (*Repealed*)

Sec. 15. (*Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA*)

405 IAC 2-3-16 Funeral trusts; consideration

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15; IC 30-2-10

Sec. 16. A funeral trust established under IC 30-2-10 et seq. which contains a technical defect in the documents required by IC 30-2-10-5 shall be deemed for the purposes of Medicaid eligibility to be valid as of the original date of establishment of the trust if the defect is corrected within twenty (20) days after receipt of notice from the county department of the defect. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-16; filed Dec 16, 1986, 11:00 am: 10 IR 1081; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-18) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-16) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-17 Income eligibility of institutionalized applicant or member with community spouse; posteligibility

Authority: IC 12-15-1-10

Affected: IC 12-15

Sec. 17. (a) As used in this section, "institutionalized spouse" and "community spouse" have the meanings set forth in 42 U.S.C.A. 1396r-5(h)(1).

(b) The income eligibility of an institutionalized applicant or member with a community spouse shall be determined in accordance with 405 IAC 2-1.1-5(g).

(c) If an applicant or member is determined eligible for Medicaid under subsection (b), posteligibility treatment of income to calculate the amount of income to be paid to the institution is determined as follows:

(1) Subtract from the applicant's or member's gross income determined according to ownership provisions set forth in 42 U.S.C.A. 1396r-5(b) those exclusions required by federal law.

(2) Subtract a spousal allocation equal to the community spouse's total income, in accordance with ownership provisions set forth in 42 U.S.C.A. 1396r-5(b), subtracted from the sum of nine hundred eighty-four dollars (\$984), plus an excess shelter allowance determined under 42 U.S.C.A. 1396r-5(d)(4), subject to all provisions of 42 U.S.C.A. 1396r-5(d), 42 U.S.C.A. 1396r-5(e), and 42 U.S.C.A. 1396r-5(g).

(3) Subtract an allocation for each dependent family member, as defined in subsection (e), equal to one-third (1/3) of the amount by which nine hundred eighty-four dollars (\$984) exceeds the family member's total income, subject to the provisions of 42 U.S.C.A. 1396r-5(d), 42 U.S.C.A. 1396r-5(e), and 42 U.S.C.A. 1396r-5(g).

(d) The spousal allocation calculated in subsection (c)(2) is deducted from the institutionalized applicant's or member's income only to the extent that it is actually made available to, or for the benefit of, the community spouse.

(e) "Dependent family member", for the purpose of determining the allocation in subsection (c)(3), is a person listed, as follows, who resides with the community spouse:

(1) Biological or adoptive children of either spouse under twenty-one (21) years of age.

(2) Biological or adoptive children of the community or institutionalized spouse who are:

(A) twenty-one (21) years of age or over; and

(B) claimed for tax purposes by either spouse under the Internal Revenue Service Code.

(3) The parent or parents of the community or institutionalized spouse who are claimed as dependents by either spouse for tax purposes under the Internal Revenue Service Code.

(4) Biological and adoptive siblings of the community or institutionalized spouse who are claimed by either spouse for tax

purposes under the Internal Revenue Service Code.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-17; filed Dec 1, 1989, 5:00 p.m.: 13 IR 628; filed May 2, 1990, 4:55 p.m.: 13 IR 1707; filed Aug 9, 1991, 11:00 a.m.: 14 IR 2227; filed May 14, 1992, 5:00 p.m.: 15 IR 2191; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1785; filed Feb 23, 1998, 11:30 a.m.: 21 IR 2383; filed Feb 7, 2000, 3:26 p.m.: 23 IR 1377; errata filed Mar 20, 2000, 3:19 p.m.: 23 IR 2003; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:55 a.m.: 26 IR 2867; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-19) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-17) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-18 Income standards (Repealed)

Sec. 18. (Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA)

405 IAC 2-3-19 Income deemed from parents (Repealed)

Sec. 19. (Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA)

405 IAC 2-3-20 Income eligibility of applicant or recipient (Repealed)

Sec. 20. (Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA)

405 IAC 2-3-21 Posteligibility income calculation (Repealed)

Sec. 21. (Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA)

405 IAC 2-3-22 Trusts

Authority: IC 12-13-5-3; IC 12-15-1-10

Affected: IC 12-15-2-17; IC 12-15-3

Sec. 22. (a) This section:

- (1) governs the treatment of trusts when determining eligibility of an applicant or member of Medicaid; and
- (2) applies to trusts established by an applicant or member of Medicaid as defined in subsection (e).

As used in this section, "individual" means an applicant or member of Medicaid.

(b) A revocable trust established by an applicant or member shall be considered as follows:

- (1) The corpus of the trust shall be considered resources available to the individual.
- (2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.
- (3) Any other payments from the trust shall be considered assets disposed of by the individual for purposes of section 1.1 of this rule.

(c) An irrevocable trust established by an applicant or member shall be considered as follows:

- (1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus or income from which payment to the individual could be made shall be considered resources available to the individual. Payments from that portion of the corpus or income shall be counted as follows:

(A) Payments to or for the benefit of the individual shall be considered income of the individual.

(B) Payments for any other purpose shall be considered assets disposed of by the individual subject to section 1.1 of

this rule.

(2) If there are no circumstances under which payment from a portion of the trust could be made to or for the benefit of the individual, the portion of the corpus or income from which no payment to the individual could be made shall be considered to be assets disposed of by the individual for purposes of section 1.1 of this rule. For purposes of section 1.1 of this rule, the following shall apply:

(A) The assets shall be considered disposed of as of the date:

- (i) of establishment of the trust; or
- (ii) on which payment to the individual was foreclosed;

whichever is later.

(B) The value of the trust shall be determined by including the amount of any payments made from that portion of the trust after the date in clause (A).

(d) As used in this section, "trust" includes, but is not limited to, any legal instrument or device that is similar to a trust. The term includes an annuity only to such extent and in such manner as allowed by regulations of the Secretary of Health and Human Services.

(e) For purposes of this section, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust, and if any of the following individuals established the trust other than by will:

- (1) The individual.
- (2) The individual's spouse.
- (3) A person with legal authority to act in place of or on behalf of the individual or the individual's spouse, including, but not limited to, a court or administrative body.
- (4) A person acting at the direction or upon the request of the individual or the individual's spouse, including, but not limited to, a court or administrative body.

(f) As used in this section, "assets" includes all income and resources of the individual and of the individual's spouse, including any income or resources that the individual or the individual's spouse is entitled to but does not receive because of action by:

- (1) the individual or the individual's spouse;
- (2) a person with legal authority to act in place of or on behalf of the individual or the individual's spouse, including, but not limited to, a court or administrative body; or
- (3) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(g) In the case of a trust, the corpus of which includes assets of an individual and assets of any other person or persons, this subsection shall apply to that portion of the trust attributable to the assets of the individual.

(h) Subject to subsection (i), this subsection shall apply without regard to any of the following:

- (1) The purposes for which a trust is established.
- (2) Whether the trustees have or exercise any discretion under the trust.
- (3) Any restrictions on when or whether distributions may be made from the trust.
- (4) Any restrictions on the use of distributions from the trust.

(i) This section shall not apply to any of the following trusts:

(1) A trust containing the assets of an individual under sixty-five (65) years of age who is disabled as defined in 42 U.S.C. 1382c(a)(3), and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court, if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total Medicaid paid on behalf of the individual.

(2) A trust established under subdivision (1) on or after December 13, 2016, may be established by an individual with a disability under sixty-five (65) years of age for his or her own benefit.

(3) A qualified income trust composed only of:

- (A) pension;
- (B) Social Security;
- (C) other income of the individual; and
- (D) accumulated income in the trust;

where income of clauses (A) through (C) is delivered to the trustee of the trust, and the trust instrument provides that the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total Medicaid

paid on behalf of the individual. The trust cannot be allowed to terminate in any manner at any time before the death of the individual.

(4) A trust containing the assets of an individual who is disabled as defined in 42 U.S.C. 1382c(a)(3) that meets the following conditions:

- (A) The trust is established and managed by a nonprofit association.
- (B) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- (C) Accounts in the trust are established solely for the benefit of individuals who are disabled by:
 - (i) the parent, grandparent, or legal guardian of the individuals;
 - (ii) the individuals; or
 - (iii) a court.
- (D) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of Medicaid paid on behalf of the beneficiary.

(j) The office may waive the application of this section in cases of undue hardship, but only to the extent required by standards specified under 42 U.S.C. 1396p(d)(5) by the Secretary of Health and Human Services and section 24 of this rule.

(k) This section applies to trusts established on or after August 11, 1993. Trusts established before August 11, 1993, are governed by 42 U.S.C. 1396a(k). (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-22; filed May 1, 1995, 10:45 a.m.: 18 IR 2225; errata filed Jun 9, 1995, 2:30 p.m.: 18 IR 2796; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 18, 2009, 11:33 a.m.: 20090916-IR-405080325FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-3-23 Savings bonds

Authority: IC 12-15-1-10

Affected: IC 12-15-3

Sec. 23. (a) United States Savings Bonds are considered an available resource for Medicaid eligibility purposes beginning the first day following the mandatory retention period.

(b) The value of the bonds shall be determined as follows:

- (1) Bonds issued at face value shall be valued at face value.
- (2) Bonds issued for less than face value shall be valued at the purchase price.

(c) If the ownership of the bond is shared, each owner shall own equal shares of the redemption value of the bond. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-23; filed Oct 10, 2002, 10:50 a.m.: 26 IR 730; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-3-24 Undue hardship exception for Medicaid eligibility purposes

Authority: IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-2-10

Sec. 24. (a) At the time an applicant is notified that they are being denied Medicaid benefits due to:

- (1) section 1.1 of this rule;
- (2) section 22 of this rule; or
- (3) both sections 1.1 and 22 of this rule;

the state shall notify the applicant that a hardship exception to the rules exists.

(b) An applicant may file for a hardship exception only if the applicant chooses not to file for an administrative appeal on the merits of their determination. By filing a request for a hardship exception, an applicant:

- (1) admits that a transfer for less than adequate consideration was made and the agency's determination of any penalty was

correct;

(2) waives the right to file a request for an administrative appeal; and

(3) revokes any previously filed administrative appeal.

If an applicant simultaneously files an administrative appeal and a hardship exception, the request for the hardship exception will be denied and forwarded to the administrative law judge (ALJ) for consideration.

(c) The following persons can apply for the hardship exception and will have standing to pursue an appeal of denial of such exception:

(1) The applicant for benefits.

(2) The applicant's personal representative.

(3) The nursing facility in which the applicant currently resides, so long as the applicant or the applicant's personal representative consent.

(d) A request for a hardship exception must be received by the office of Medicaid policy and planning by close of business as defined in 405 IAC 1.1-1-3(c) not later than thirty-three (33) calendar days from the mailing date of the notification to the applicant of the denial of Medicaid benefits under subsection (a).

(e) In order to qualify for a hardship exception, the member shall supply written documentation proving that the application of transfer of asset rules will deprive the applicant of:

(1) medical care such that the applicant's health would be endangered; or

(2) food, clothing, shelter, or other necessities of life.

(f) An undue hardship shall not exist when:

(1) the imposition of the transfer of assets provisions:

(A) merely cause the applicant inconvenience; or

(B) such imposition might restrict the applicant's lifestyle but not put the applicant at risk of serious deprivation;

(2) an individual is required to sell an asset in an arms length transaction, which would result in a sale of the asset that is less than the current fair market value;

(3) the undoing of a transfer causes:

(A) adverse tax consequences; or

(B) penalties, interest, or other contract damages;

however where such penalties, interest, and contract damages are incurred in a contract between members of the same family (including step- and half- family members) the penalties, interest, and damages shall be considered transfers for inadequate consideration;

(4) the applicant claims that:

(A) imposition of the transfer penalty will result in the dissolution of a marriage; or

(B) the only way to avoid the transfer penalty is to dissolve the marriage;

(5) the undoing of a transfer will cause hardship to an individual who is not the applicant.

This list shall not be exclusive, and the decision to deny an undue hardship exception shall not be limited to situations described in this subsection.

(g) The decision to grant or deny an undue hardship exception shall be made by the office within forty-five (45) days of receiving a request for an exception. Denial of an undue hardship exception under this section may be appealed by following the rules under 405 IAC 1.1. An ALJ may only issue a hardship waiver when the denial of the hardship waiver by the office is being appealed. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-24; filed Aug 18, 2009, 11:33 a.m.: 20090916-IR-405080325FRA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

405 IAC 2-3-25 College savings accounts

Authority: IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-3-8; IC 21-9-2-2; IC 21-9-2-11

Sec. 25. (a) Subject to subsection (b) and any applicable federal law, any money deposited in an account (as defined in IC 21-9-2-2) of an education savings program (as defined in IC 21-9-2-11) may not be considered as a resource or asset in determining an

applicant's or recipient's eligibility for Medicaid.

(b) Any money withdrawn from an account described in subsection (a) shall be used for eligible educational expenses, as determined by 26 U.S.C. 529, for the designated beneficiary.

(c) Any money withdrawn from an account described in subsection (a) that is not used in accordance with subsection (b) may be considered one (1) of the following:

(1) An invalid transfer subject to a penalty as described in section 1.1 of this rule.

(2) A converted resource countable in the month of the withdrawal unless the converted resource is otherwise exempt.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-25; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

Rule 3.1. Eligibility Requirements Based on Need; Pregnancy-Related Coverage; Coverage for Children 18 Years of Age and Under (Voided)

NOTE: Voided by P.L.119-1997, SECTION 6, effective April 9, 1997.

Rule 3.2. Presumptive Eligibility Services for Pregnant Women

405 IAC 2-3.2-1 Definitions

Authority: IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 1. The following definitions apply throughout this rule:

(1) "Ambulatory prenatal care services" means outpatient services related to pregnancy, including prenatal services and services related to other conditions that may complicate the pregnancy.

(2) "Division" means:

(A) the office of the Indiana family and social services administration;

or

(B) an office that is operated by a contractor of the office to accept Medicaid applications.

(3) "Qualified provider" means a provider who:

(A) is enrolled in the Indiana Medicaid program;

(B) maintains a valid agreement, as prescribed by the office, to make determinations regarding presumptive eligibility; and

(C) meets all other requirements set forth in 42 U.S.C. 1396r-1(b)(2).

(4) "Verifiable pregnancy" means a pregnancy that has been verified by a medical provider, such as a positive pregnancy test performed by a licensed practitioner or a staff person employed by a qualified provider. Results of self-administered, over-the-counter testing devices, such as home pregnancy tests, cannot be used to verify a pregnancy for purposes of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3.2-1; filed Mar 19, 2010, 11:15 a.m.: 20100414-IR-405090262FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-3.2-2 Qualified providers provided with application tools and information

Authority: IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 2. The office shall provide each qualified provider with the following:

(1) Access to application forms for presumptive eligibility and Medicaid.

(2) Information on how to assist a woman in applying for presumptive eligibility and Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3.2-2; filed Mar 19, 2010, 11:15 a.m.: 20100414-IR-405090262FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)

405 IAC 2-3.2-3 Application; qualified providers to establish presumptive eligibility; presumptive eligibility criteria

Authority: IC 12-15-1-10

Affected: IC 12-15-2-13

Sec. 3. (a) An application for presumptive eligibility must be made to a qualified provider.

(b) A qualified provider shall establish presumptive eligibility if the:

(1) woman is pregnant, as evidenced by a verifiable pregnancy;

(2) qualified provider determines, on the basis of preliminary information provided by the woman, that the:

(A) gross family income of the woman does not exceed the amount set forth in IC 12-15-2-13;

(B) woman is an Indiana resident;

(C) woman is a United States citizen or a qualified alien, as defined in 8 U.S.C. 1641, who has resided in the United States for at least five (5) years; and

(D) woman is not an inmate of a public institution;

(3) woman is not currently enrolled in Medicaid; and

(4) woman has not previously been granted presumptive eligibility for her current pregnancy.

(c) If a qualified provider establishes presumptive eligibility for a woman, the qualified provider must:

(1) notify the office of the determination within five (5) business days after the date the determination is made; and

(2) inform the woman at the time the determination is made that she is required to apply for Medicaid not later than the last day of the month following the month during which the presumptive eligibility determination is made.

(d) If a qualified provider determines that presumptive eligibility cannot be established, the qualified provider shall inform the woman in writing:

(1) of the reason for the determination; and

(2) that she may file an application for Medicaid if she wishes to have a formal determination made.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3.2-3; filed Mar 19, 2010, 11:15 a.m.: 20100414-IR-405090262FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)

405 IAC 2-3.2-4 Period of presumptive eligibility

Authority: IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 4. (a) The period of presumptive eligibility begins on the date the qualified provider establishes presumptive eligibility.

(b) The period of presumptive eligibility ends on the earlier of the:

(1) date the division makes a Medicaid eligibility determination with respect to the woman;

(2) date the woman's pregnancy ends or terminates; or

(3) last day of the month following the month during which the qualified provider established presumptive eligibility, if the woman has not filed an application for Medicaid by that day.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3.2-4; filed Mar 19, 2010, 11:15 a.m.: 20100414-IR-405090262FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)

405 IAC 2-3.2-5 Covered and noncovered services

Authority: IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 5. (a) Ambulatory prenatal care services are covered by presumptive eligibility.

(b) The following services are not covered by presumptive eligibility:

(1) Inpatient hospital services.

(2) Labor and delivery services.

(3) Postpartum care services.

- (4) Contraception.
- (5) Sterilization.
- (6) Ectopic pregnancy services.
- (7) Abortion.
- (8) Abnormal products of conception.
- (9) Hospice.
- (10) Long-term care.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3.2-5; filed Mar 19, 2010, 11:15 a.m.: 20100414-IR-405090262FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)

405 IAC 2-3.2-6 Appeal rights

Authority: IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 6. (a) A qualified provider's decision regarding presumptive eligibility is not a Medicaid eligibility determination. The notice and appeals rights of Medicaid applicants and members set forth in 405 IAC 1.1 do not apply. A woman cannot appeal a qualified provider's decision regarding presumptive eligibility.

(b) The notice and appeal rights of Medicaid applicants and members will apply when the division makes a Medicaid eligibility determination with respect to the woman. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3.2-6; filed Mar 19, 2010, 11:15 a.m.: 20100414-IR-405090262FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

Rule 3.3. Presumptive Eligibility Determinations by Qualified Hospitals

405 IAC 2-3.3-1 Definitions

Authority: IC 12-15-2.3-12; IC 12-15-21

Affected: IC 12-15-2; IC 12-15-2.3

Sec. 1. The following definitions apply throughout this rule:

- (1) "Applicant" means an individual who has been determined presumptively eligible for Medicaid and has submitted an application.
- (2) "Application" means an Indiana application for health coverage.
- (3) "Presumptive eligibility period" means the period that begins on the day on which a qualified hospital makes a presumptive eligibility determination and ends on the earlier of the following:
 - (A) In the case of an applicant, the day that a decision is made on the application.
 - (B) In the case of a presumptively eligible individual, the last day of the month following the month in which a qualified hospital determined the individual to be presumptively eligible.
 - (C) In the case of an individual eligible under 405 IAC 10-4-1(a), the periods, as applicable, in accordance with 405 IAC 10-4-11(c) through 405 IAC 10-4-11(e).
- (4) "Presumptively eligible individual" refers to a person who has been determined presumptively eligible by a qualified hospital but has not yet attained full Medicaid eligibility.
- (5) "Qualified hospital" means a hospital that meets all of the following criteria:
 - (A) Participates as a Medicaid or waiver provider.
 - (B) Notifies the office of its intention to make presumptive eligibility determinations under this rule.
 - (C) Agrees to make presumptive eligibility determinations in accordance with applicable laws and policies.
 - (D) Agrees to assist an applicant or individual in completing and submitting an application during the presumptive eligibility period.
 - (E) Is not disqualified in accordance with section 3 of this rule.
- (6) "Sufficiently complete" means an application that includes, at a minimum, an applicant's:

- (A) name;
- (B) date of birth;
- (C) Social Security number;
- (D) marital status;
- (E) citizenship status;
- (F) pregnancy status;
- (G) presumptive eligibility member identification number;
- (H) income;
- (I) home address;
- (J) mailing address;
- (K) phone number;
- (L) number of members in family; and
- (M) signature.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3.3-1; filed Sep 14, 2015, 2:07 p.m.: 20151014-IR-405130497FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-3.3-2 Presumptive eligibility determinations

Authority: IC 12-15-2.3-12; IC 12-15-21

Affected: IC 12-15-2; IC 12-15-2.3

Sec. 2. The office shall provide reimbursement for covered services during the presumptive eligibility period to an individual who is determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3.3-2; filed Sep 14, 2015, 2:07 p.m.: 20151014-IR-405130497FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)*

405 IAC 2-3.3-3 Presumptive eligibility performance standards and sanctions

Authority: IC 12-15-2.3-12; IC 12-15-21

Affected: IC 12-15-2.3

Sec. 3. (a) A qualified hospital shall meet the following performance standards with regard to an applicant's application during the following time periods in order to make presumptive eligibility determinations:

- (1) Between the effective date of this rule and December 31, 2015, as follows:

- (A) Eighty percent (80%) of presumptively eligible individuals from a qualified hospital shall complete and submit an application before the end of the presumptive eligibility period.
- (B) Seventy-five percent (75%) of applications submitted for applicants will be sufficiently complete.
- (C) Ninety percent (90%) of the applicants who complete and submit an application shall be determined eligible for a Medicaid program.

- (2) Beginning January 1, 2016, as follows:

- (A) Ninety-five percent (95%) of presumptively eligible individuals from a qualified hospital shall complete and submit an application before the end of the presumptive eligibility period.
- (B) Ninety percent (90%) of applications submitted for applicants will be sufficiently complete.
- (C) Ninety-five percent (95%) of the applicants who complete and submit an application shall be determined eligible for a Medicaid program.

(b) The office shall periodically review a qualified hospital's application submissions and assess its performance. The office shall initiate the following actions if its review of a qualified hospital's performance indicates it fails to meet the performance standards in subsection (a) during any given calendar quarter:

- (1) The office shall issue a written warning to the qualified hospital and require the qualified hospital to submit a ninety (90) day corrective action plan within thirty (30) days of its receipt of the written warning if:
 - (A) it is the qualified hospital's first offense; or

(B) eighteen (18) months or more have passed since the occurrence of a first or subsequent offense.

(2) If a second offense occurs within eighteen (18) months of the date of a first or subsequent offense, the office will revoke the qualified hospital's presumptive eligibility status for a period of one (1) year.

(3) If a third or subsequent offense occurs within eighteen (18) months of the date of the second or subsequent offense, the office will revoke the qualified hospital's presumptive eligibility status for a period of three (3) years.

(c) The office shall revoke a qualified hospital's status for two (2) years if it fails to comply with one (1) or more of the terms of a corrective action plan during the period of the corrective action plan.

(d) Subject to subsection (e), a hospital whose presumptive eligibility status has been revoked under this section may reapply for reinstatement of its presumptive eligibility status only after the sanction period has passed.

(e) The office may consider a hospital's written request for reinstatement of its presumptive eligibility status prior to the passing of the sanction period. The office may consider lifting the sanction if the hospital demonstrates one (1) or more of the following circumstances:

(1) The hospital has experienced a change of ownership.

(2) The hospital has provided adequate assurances that it is sufficiently capable of preventing the issues that resulted in the office's decision to revoke its presumptive eligibility status.

(3) A sufficient amount of time passed between the cited offense and a prior offense.

(4) The office determines that lifting the sanction is in the best interests of the Medicaid program.

(f) A qualified hospital may be referred to the office's program integrity division or the Indiana Medicaid fraud control unit for appropriate action if the office's review suggests potential fraud, waste, or abuse. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3.3-3; filed Sep 14, 2015, 2:07 p.m.: 20151014-IR-405130497FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA*)

405 IAC 2-3.3-4 Administrative appeals

Authority: IC 12-15-2.3-12; IC 12-15-21

Affected: IC 4-21.5-3

Sec. 4. (a) A qualified hospital may appeal the office's revocation of its presumptive eligibility status under the provisions of 405 IAC 1-1.4.

(b) The following actions are not sanctions and are not appealable:

(1) The office's decision to issue a warning to a qualified hospital and to require a corrective action plan.

(2) The office's decision not to exercise its discretion to lift a hospital's request for reinstatement under section 3(e) of this rule. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3.3-4; filed Sep 14, 2015, 2:07 p.m.: 20151014-IR-405130497FRA; filed Dec 21, 2018, 3:17 p.m.: 20190116-IR-405180251FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA*)

Rule 3.4. Presumptive Eligibility Determinations by Other Qualified Providers

405 IAC 2-3.4-1 Definitions

Authority: IC 12-15-2.3-12; IC 12-15-21

Affected: IC 12-15-2; IC 12-15-2.3

Sec. 1. The following definitions apply throughout this rule:

(1) "Applicant" means an individual who has been determined presumptively eligible for Medicaid and has submitted an application.

(2) "Application" means an Indiana application for health coverage.

(3) "Presumptive eligibility period" means the period that begins on the day on which a qualified provider makes a presumptive eligibility determination and ends on the earlier of the following:

(A) In the case of an applicant, the day that a decision is made on the application.

(B) In the case of a presumptively eligible individual, the last day of the month following the month in which a qualified provider determined the individual to be presumptively eligible.

(C) In the case of an individual eligible under 405 IAC 10-4-1(a), the periods, as applicable, in accordance with 405 IAC 10-4-11(c) through 405 IAC 10-4-11(e).

(4) "Presumptively eligible individual" refers to a person who has been determined presumptively eligible by a qualified provider but has not yet attained full Medicaid eligibility.

(5) "Qualified provider" means a community mental health center, federally qualified health center, rural health clinic, or local county health department that meets all of the following criteria:

(A) Participates as a Medicaid or waiver provider, except for local county health departments.

(B) Notifies the office of its intention to make presumptive eligibility determinations under this rule.

(C) Agrees to make presumptive eligibility determinations in accordance with applicable laws and policies.

(D) Agrees to assist an applicant or individual in completing and submitting an application during the presumptive eligibility period.

(E) Is not disqualified in accordance with section 3 of this rule.

(6) "Sufficiently complete" means an application that includes, at a minimum, an applicant's:

(A) name;

(B) date of birth;

(C) Social Security number;

(D) marital status;

(E) citizenship status;

(F) pregnancy status;

(G) presumptive eligibility member identification number;

(H) income;

(I) home address;

(J) mailing address;

(K) phone number;

(L) number of members in family; and

(M) signature.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3.4-1; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-3.4-2 Presumptive eligibility determinations

Authority: IC 12-15-2.3-12; IC 12-15-21

Affected: IC 12-15-2; IC 12-15-2.3

Sec. 2. The office shall provide reimbursement for covered services during the presumptive eligibility period to an individual who is determined by a qualified provider, on the basis of preliminary information, to be presumptively eligible. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3.4-2; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

405 IAC 2-3.4-3 Presumptive eligibility performance standards and sanctions

Authority: IC 12-15-2.3-12; IC 12-15-21

Affected: IC 12-15-2.3

Sec. 3. (a) A qualified provider shall meet the following performance standards with regard to an applicant's application during the following time periods in order to make presumptive eligibility determinations:

(1) Between the effective date of this rule and December 31, 2016, the following:

(A) Eighty percent (80%) of presumptively eligible individuals from a qualified provider shall complete and submit an application before the end of the presumptive eligibility period.

(B) Seventy-five percent (75%) of applications submitted for an applicant will be sufficiently complete.

(C) Ninety percent (90%) of the applicants who complete and submit an application shall be determined eligible for a Medicaid program.

(2) Beginning January 1, 2017, the following:

(A) Ninety-five percent (95%) of presumptively eligible individuals from a qualified provider shall complete and submit an application before the end of the presumptive eligibility period.

(B) Ninety percent (90%) of applications submitted for an applicant will be sufficiently complete.

(C) Ninety-five percent (95%) of the applicants who complete and submit an application shall be determined eligible for a Medicaid program.

(b) The office shall periodically review a qualified provider's application submissions and assess its performance. The office shall initiate the following actions if its review of a qualified provider's performance indicates it fails to meet the performance standards in subsection (a):

(1) The office shall issue a written warning to the qualified provider and require the qualified provider to submit a ninety (90) day corrective action plan within thirty (30) days of its receipt of the written warning if:

(A) it is the qualified provider's first offense; or

(B) eighteen (18) months or more have passed since the occurrence of a first or subsequent offense.

(2) If a second offense occurs within eighteen (18) months of the date of a first or subsequent offense, the office will revoke the qualified provider's presumptive eligibility status for a period of one (1) year.

(3) If a third or subsequent offense occurs within eighteen (18) months of the date of the second or subsequent offense, the office will revoke the qualified provider's presumptive eligibility status for a period of three (3) years.

(c) The office shall revoke a qualified provider's status for two (2) years if it fails to comply with one (1) or more of the terms of a corrective action plan during the period of the corrective action plan.

(d) Subject to subdivision (1), a provider whose presumptive eligibility status has been revoked under this section may reapply for reinstatement of its presumptive eligibility status only after the sanction period has passed. The office may consider a provider's written request for reinstatement of its presumptive eligibility status prior to the passing of the sanction period if the provider demonstrates one (1) or more of the following circumstances:

(1) The provider has experienced a change of ownership.

(2) The provider has provided adequate assurances that it is sufficiently capable of preventing the issues that resulted in the office's decision to revoke its presumptive eligibility status.

(3) A sufficient amount of time passed between the cited offense and a prior offense.

(4) The office determines that lifting the sanction is in the best interests of the Medicaid program.

(e) A qualified provider may be referred to the office's program integrity division or the Indiana Medicaid Fraud Control Unit for appropriate action if the office's review suggests potential fraud, waste, or abuse. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3.4-3; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-3.4-4 Administrative appeals

Authority: IC 12-15-2.3-12; IC 12-15-21

Affected: IC 4-21.5-3

Sec. 4. (a) A qualified provider may appeal the office's revocation of its presumptive eligibility status under the provisions of 405 IAC 1-1.4.

(b) The following actions are not sanctions and are not appealable by qualified providers:

(1) The issuance of a warning or requirement of a corrective action plan to be created.

(2) The office's decision not to exercise its discretion to lift a provider's request for reinstatement under 405 IAC 2-3.3-3(e)(1). (*Office of the Secretary of Family and Social Services; 405 IAC 2-3.4-4; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

Rule 4. Burial Expenses

405 IAC 2-4-1 Payment of burial expenses

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-14; IC 12-15

Sec. 1. (a) For the purpose of implementing the provisions of IC 12-14, a member of Medicaid for the aged, blind, and disabled

is that person who is receiving Medicaid as of the date of his or her death, or who applied for Medicaid prior to the date of his or her death and was subsequently determined eligible.

(b) The state department shall pay for the cost of the deceased member's burial expenses subject to the following limitations:

(1) Payment will be made only to the funeral director or cemetery representative upon submission of a completed claim form prescribed by the state department.

(2) Payment shall not be made to a funeral director who submits a claim for cemetery expenses unless he or she attaches proof to the claim that he or she is the cemetery representative or has been designated the cemetery representative.

(3) In determining the amount to be paid by the state department to the funeral director, contributions paid and payments made or available from the estate of the deceased member in excess of the exclusion provided by IC 12-14 shall be subtracted from the statutory maximum. The balance of the unpaid expenses, up to the statutory maximum, shall be paid by the state department.

(4) In determining the amount to be paid by the state department to the cemetery representative, contributions paid and payments made or available from the estate of the deceased member in excess of the statutory exclusion shall be subtracted from the statutory maximum. The balance of the unpaid expenses, up to the statutory maximum, shall be paid by the state department.

(Office of the Secretary of Family and Social Services; 405 IAC 2-4-1; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1021, eff Apr 1, 1984; errata, 7 IR 1254; filed Aug 2, 1985, 2:39 p.m.: 8 IR 2023, eff Sep 1, 1985; filed Jul 16, 1987, 2:00 p.m.: 10 IR 2671; errata, 11 IR 799; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-4-1) to the Office of the Secretary of Family and Social Services (405 IAC 2-4-1) by P.L. 9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-4-2 Purchase of burial spaces

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) The following definitions apply throughout this section:

(1) "Burial expenses" means the following additional expenses associated with purchasing an applicable burial space:

(A) The transfer of the deceased.

(B) The use of a hearse during a ceremony.

(C) The purchase of death certificates.

(2) "Burial spaces" means burial plots, gravesites, crypts, mausoleums, urns, niches, caskets 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) "Immediate family" means an individual's minor and adult children, including adopted children and step-children, and 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) Pursuant to 20 CFR 416.1231, the purchase of a burial space and burial expenses for the member, the member's spouse, or the member's immediate family members shall be deemed an exempt resource. *(Office of the Secretary of Family and Social Services; 405 IAC 2-4-2; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

405 IAC 2-4-3 Funeral expenses; exclusion of resources in determining eligibility for Medicaid

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15; IC 30-2-13

Sec. 3. (a) Pursuant to IC 12-15-2-17 and IC 30-2-13 and subject to subsection (c), if an applicant for or a recipient of Medicaid:

(1) establishes one (1) irrevocable trust that has a value of not more than ten thousand dollars (\$10,000), exclusive of interest, and is established for the sole purpose of providing money for the burial of the applicant or recipient;

(2) enters into one (1) irrevocable prepaid funeral agreement having a value of not more than ten thousand dollars (\$10,000); or

(3) owns one (1) or more life insurance policies with a combined face value of not more than ten thousand dollars (\$10,000) and with respect to which provision is made to pay not more than ten thousand dollars (\$10,000) toward the applicant's or recipient's funeral expenses;

the value of the trust, prepaid funeral agreement, or life insurance policy may not be considered as a resource in determining the applicant's or recipient's eligibility for Medicaid.

(b) Subject to subsection (c) and (d) and IC 12-15-3-7, if an applicant for or a member of Medicaid owns resources described in subsection (a) and the total value of those resources is more than ten thousand dollars (\$10,000), the value of those resources in excess of the ten thousand dollars (\$10,000) shall be considered as a resource in determining the applicant's or recipient's eligibility for Medicaid.

(c) Subject to subsection (d), if an applicant for or a member of Medicaid establishes an irrevocable trust or escrow under IC 30-2-13, the entire value of the trust or escrow may not be considered as a resource in determining the applicant's or individual's eligibility for Medicaid.

(d) In order for a trust, an escrow, a life insurance policy, or a prepaid funeral agreement to be exempt as a resource in determining an applicant's or a recipient's eligibility for Medicaid under this rule, the applicant or recipient must designate the office or the applicant's or recipient's estate to receive any remaining amounts after delivery of all services and merchandise under the contract as reimbursement for Medicaid assistance provided to the applicant or recipient after fifty-five (55) years of age. The office may receive funds under this subsection only to the extent permitted by 42 U.S.C. 1396p. The computation of remaining amounts shall be made as of the date of delivery of services and merchandise under the contract and must be the excess, if any, derived from:

(1) growth in principal;

(2) accumulation and reinvestment of dividends;

(3) accumulation and reinvestment of interest; and

(4) accumulation and reinvestment of distributions;

on the applicant's or recipient's trust, escrow, life insurance policy, or prepaid funeral agreement over and above the seller's current retail price of all services, merchandise, and cash advance items set forth in the applicant's or recipient's contract. (*Office of the Secretary of Family and Social Services; 405 IAC 2-4-3; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

Rule 5. Determination of Monthly Income

405 IAC 2-5-1 Conversion of income

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-14-2-4

Affected: IC 12-14; IC 12-15

Sec. 1. (a) When determining eligibility and the amount of assistance payment for the months beginning with the month of application, the following computations shall be made to establish income for the payment month:

(1) Income received on a less than monthly basis shall be converted to a monthly amount as follows:

(A) Income received weekly shall be multiplied by four and three-tenths (4.3) to determine the monthly income.

(B) Income received every two (2) weeks shall be multiplied by two and fifteen-hundredths (2.15) to determine the monthly income.

(C) Income received twice per month shall be multiplied by two (2) to determine the monthly income.

(2) Income which is not expected to continue throughout the payment month shall be considered in the actual amount anticipated to be received in that month.

(3) Income received on a contractual basis shall be prorated over the number of months covered under the contract, and the resultant amount shall be considered available monthly income.

(4) Income received on a quarterly, semiannual, or annual basis shall be divided by the appropriate number of months to establish a monthly amount.

(5) Income received to defray the cost of education shall be prorated over the period intended to be covered by the income.

(6) Fluctuating income may be averaged to determine a monthly amount.

(b) In determining eligibility for months prior to the month of application, the actual amount of income received shall be considered income. (*Office of the Secretary of Family and Social Services; 405 IAC 2-5-1; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1778; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA*)

Rule 6. Medical Assistance for Individuals 18, 19, and 20 Years of Age

405 IAC 2-6-1 Medical assistance for individuals 18, 19, and 20 years of age (*Repealed*)

Sec. 1. (*Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA*)

405 IAC 2-6-2 Medicaid eligibility for individuals leaving foster care

Authority: IC 12-15-1-10

Affected: IC 12-14; IC 12-15

Sec. 2. (a) An individual who:

(1) is:

(A) at least eighteen (18) years of age; and

(B) less than twenty-one (21) years of age; and

(2) was receiving foster care when the individual became eighteen (18) years of age; and

(3) meets the eligibility requirements in this section;

is eligible for Medicaid.

(b) An individual described in subsection (a) is eligible for Medicaid if his or her income does not exceed two hundred percent (200%) of the federal poverty guidelines for the individual's family size. Family size is determined by including the individual, his or her spouse, and children under eighteen (18) years of age living with the individual. Income includes the income of the individual's spouse, if the couple is living together.

(c) Assets owned by the individual and family members are exempt. (*Office of the Secretary of Family and Social Services; 405 IAC 2-6-2; filed May 30, 2007, 8:26 a.m.: 20070627-IR-405060014FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA*)

405 IAC 2-6-3 Medicaid eligibility for former foster care children under age 26

Authority: IC 12-15-1-10

Affected: IC 12-14; IC 12-15

Sec. 3. (a) Beginning January 1, 2014, an individual who:

(1) is:

(A) under twenty-six (26) years of age; and

(B) not eligible for and enrolled in other mandatory Medicaid coverage;

(2) was in foster care under the responsibility of the state of Indiana or a federally recognized tribe's responsibility, whether or not under Title IV-E; and

(3) enrolled in Medicaid or any Section 1115 waiver demonstration pursuant to 42 U.S.C. 1315 upon attaining eighteen (18) years of age;

is eligible for Medicaid.

(b) The office shall not consider the income or resources of an individual described in subsection (a) when determining eligibility. (*Office of the Secretary of Family and Social Services; 405 IAC 2-6-3; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

Rule 7. Medical Assistance for Individuals Receiving Supplemental Security Income Benefits

405 IAC 2-7-1 Definitions (*Repealed*)

Sec. 1. (*Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA*)

405 IAC 2-7-2 Medical assistance for supplemental security income recipients (*Repealed*)

Sec. 2. (*Repealed by Office of the Secretary of Family and Social Services; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA*)

Rule 8. Claims Against Estate of Medicaid Members

405 IAC 2-8-1 Claims against estate for benefits paid

Authority: IC 12-13-5-3; IC 12-15-1-10

Affected: IC 12-15-9; IC 12-15-39.6-10

Sec. 1. (a) Upon the death of a Medicaid member fifty-five (55) years of age or older, the office of Medicaid policy and planning (office) shall seek recovery from the member's estate for Medicaid paid on behalf of the member after the member became fifty-five (55) years of age or older. Recovery shall be made for benefits provided prior to October 1, 1993, only if the member was sixty-five (65) years of age or older at the time the benefits were provided.

(b) As used in this section, "estate", with respect to a deceased member, shall include all of the following:

(1) All real and personal property and other assets included within the member's estate as defined for purposes of state probate law.

(2) Any interest in real property owned by the individual at the time of death that was conveyed to the individual's survivor through joint tenancy with right of survivorship, if the joint tenancy was created after June 30, 2002.

(3) Any real or personal property conveyed through a nonprobate transfer. As used in this section, "nonprobate transfer" means a valid transfer, effective at death, by a transferor who immediately before death had the power, acting alone, to prevent transfer of the property by revocation or withdrawal and:

(A) use the property for the benefit of the transferor; or

(B) apply the property to discharge claims against the transferor's probate estate.

The term does not include a transfer of a survivorship interest in a tenancy by the entireties real estate or payment of the death proceeds of a life insurance policy.

(c) If the member is survived by a spouse, recovery shall be made after the death of the surviving spouse. Only those assets that are included in the member's estate as defined in subsection (b) are subject to recovery.

(d) If the member is survived by a child, no recovery shall be made while the child is either:

(1) under twenty-one (21) years of age; or

(2) blind or disabled as defined in 42 U.S.C. 1382c.

(e) A claim may not be enforced against the following assets:

(1) Personal effects, ornaments, or keepsakes of the deceased.

(2) Assets of an individual who purchases a long term care insurance policy that are disregarded pursuant to IC 12-15-39.6-10.

(3) Nonprobate assets that were determined exempt or unavailable for purposes of the decedent's Medicaid eligibility prior to May 1, 2002.

(4) Assets that the decedent transferred through a nonprobate transfer prior to May 1, 2002.

(f) The office may waive the application of this section in cases of undue hardship pursuant to section 2 of this rule. (*Office of the Secretary of Family and Social Services; 405 IAC 2-8-1; filed May 1, 1995, 10:45 a.m.: 18 IR 2226; filed Feb 15, 1996, 11:20 a.m.: 19 IR 1563; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:55 a.m.: 26 IR 731; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3984; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021,*

2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-8-1.1 Claims against estate; exemption

Authority: IC 12-13-5-3; IC 12-15-1-10

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 1.1. (a) This section applies only to real property owned by the individual at the time of death that was conveyed to the individual's survivor through joint tenancy with right of survivorship.

(b) The office may enforce its claim against property described in subsection (a) only to the extent that the value of the member's combined total interest in all real property described in subsection (a) subject to the claim exceeds seventy-five thousand dollars (\$75,000). (*Office of the Secretary of Family and Social Services; 405 IAC 2-8-1.1; filed Oct 10, 2002, 10:55 a.m.: 26 IR 732; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3984; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-8-2 Undue hardship due to Medicaid estate recovery

Authority: IC 12-13-5-3; IC 12-15-1-10; IC 12-15-9-6

Affected: IC 12-15-9; IC 29-1-14-9

Sec. 2. (a) The office may waive the enforcement of the state's claim, in whole or in part, if enforcement of the state's claim will result in substantial and undue hardship for the surviving beneficiaries of the decedent's estate. The state's claim is suspended as long as the undue hardship condition continues to exist. This rule is not applicable to undue hardships encountered by Medicaid applicants due to:

(1) the imposition of transfer of property penalties; or

(2) rules related to the availability of trusts.

(b) For purposes of this section, undue hardship exists only if enforcement of the state's claim would result in one (1) or more of the following conditions:

(1) Causing a beneficiary of the decedent's estate to become eligible for public assistance. As used in this section, "public assistance" means:

(A) Aid to Families with Dependent Children;

(B) Medicaid;

(C) food stamps; or

(D) Supplemental Security Income.

(2) Causing a beneficiary of the decedent's estate who is currently eligible for public assistance to remain dependent on that public assistance.

(3) The complete loss of an income-producing asset or assets when the:

(A) beneficiary of the decedent's estate has no other source of income; and

(B) beneficiary's income does not exceed one hundred percent (100%) of the poverty level as determined annually by the U.S. Department of Health and Human Services.

(4) Other compelling circumstances as determined on a case-by-case basis by the office.

Undue hardship does not exist in circumstances where the state's recovery simply results in a loss of a preexisting standard of living.

(c) To be eligible for consideration for an undue hardship waiver, the beneficiary of the decedent's estate must, with the exception noted in this subsection, be a member of the immediate family of either the deceased member or the deceased member's spouse. For purposes of this section, "immediate family" means a:

(1) spouse;

(2) child;

(3) grandchild;

(4) great-grandchild;

(5) parent;

(6) grandparent;

- (7) brother; or
- (8) sister.

In exceptional circumstances, if good cause is shown, a person other than an immediate family member may be eligible for consideration for an undue hardship waiver.

(d) The office shall notify the executor or personal representative of the deceased Medicaid member's estate of the state's claim against the estate and the affected beneficiary's right to apply for an undue hardship waiver. Application for an undue hardship waiver shall:

- (1) be submitted to the office on such forms as may be designated by the secretary;
- (2) include:
 - (A) the name of the deceased member;
 - (B) the name of the person filing the application;
 - (C) the relationship of the applicant to the deceased;
 - (D) an explanation of the basis for requesting an undue hardship waiver;
 - (E) documentation of the existence of one (1) or more of the conditions described in subsection (b);
 - (F) other information as may be deemed necessary by the secretary; and
 - (G) a statement attesting to the accuracy of the information contained in the application;

(3) be signed by the applicant; and

(4) be filed with the office within ninety (90) calendar days of the date that the executor or personal representative of the deceased's estate receives notification of the state's claim.

(e) The office shall review and rule on an application for a waiver of the state's claim within forty-five (45) calendar days of the receipt of a properly completed waiver application.

(f) If the office determines that an undue hardship does not exist, the office shall:

(1) notify the applicant of its decision in writing; and

(2) inform the applicant of his or her right to request an administrative hearing and the procedures for filing an appeal.

An appeal and request for hearing must be filed within thirty (30) days of receipt of the office's decision that an undue hardship waiver has been denied.

(g) The office may not grant an undue hardship waiver if the granting of the waiver will result in the payment of claims to other creditors with a lower priority standing in accordance with IC 29-1-14-9.

(h) The office may deny an undue hardship waiver if the granting of the waiver will not result in the abatement of the undue hardship. (*Office of the Secretary of Family and Social Services; 405 IAC 2-8-2; filed Feb 15, 1996, 11:20 a.m.: 19 IR 1564; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-40507031RFA; filed Aug 18, 2009, 11:33 a.m.: 20090916-IR-405080325FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

Rule 9. Medicaid for Employees with Disabilities

405 IAC 2-9-1 Purpose and general eligibility requirements

Authority: IC 12-15

Affected: IC 12-15-41

Sec. 1. (a) This rule establishes the eligibility requirements for the two (2) optional Medicaid categories for employees with disabilities identified in 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI), and in accordance with the provisions of IC 12-15-41.

(b) As used in this rule, "applicant or member" means an individual whose Medicaid eligibility is being determined under one (1) of the Medicaid categories referenced in subsection (a) and in accordance with the requirements of this rule.

(c) A person who is:

(1) less than sixteen (16) years of age; or

(2) sixty-five (65) years of age or older;

is not eligible for Medicaid for employees with disabilities.

(d) A member must report any change in income, resources, employment status, or marital status within ten (10) days of the date of the change. An additional ten (10) days is allowed to provide any necessary verification.

(e) A disabled individual will be considered for eligibility under this rule if the individual is ineligible for Medicaid under the disability category for any of the following reasons:

(1) The individual's income exceeds the applicable standard specified in 405 IAC 2-1.1-5.

(2) The individual's resources exceed the limit in 20 CFR 416.1205.

(3) The individual's gross earnings exceed the substantial gainful activity amount established by the Social Security Administration in 20 CFR 416.974.

(f) In addition to the requirements in this rule, the requirements in the following apply to applicants and members of Medicaid for employees with disabilities:

(1) 405 IAC 2-1-2.

(2) 405 IAC 2-1-3.

(3) 405 IAC 2-2-4.

(4) 405 IAC 2-3-1.1.

(5) 405 IAC 2-3-2.

(6) 405 IAC 2-3-12.

(7) 405 IAC 2-3-14.

(8) 405 IAC 2-3-22.

(9) 405 IAC 2-4-1.

(10) 405 IAC 2-5-1.

(11) 405 IAC 2-8-1.

(12) 405 IAC 2-8-2.

(Office of the Secretary of Family and Social Services; 405 IAC 2-9-1; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3115; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-9-2 Income of applicant or member

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15

Affected: IC 12-15-2-6.5; IC 12-15-41

Sec. 2. (a) Individuals eligible under 405 IAC 2-1, 405 IAC 2-2, and 405 IAC 2-3, respectively, are subject to income definitions and exclusions as provided in 42 U.S.C. 1382a and at 20 CFR Part 416, Subpart K Income.

(b) Countable income from the following individuals shall be excluded:

(1) The spouse of the applicant or member.

(2) The parent or parents of the applicant or member.

(c) Funds from a grant, scholarship, or fellowship that are designated for tuition and mandatory books and fees at an educational institution or for vocational rehabilitation or technical training purposes shall be deducted from the total of such funds except as prohibited by federal regulations.

(d) A general income disregard of twenty dollars (\$20) is deducted per month.

(e) Payments made to foster parents or licensed child caring institutions from county funds or reimbursed under Title IV-B of the Social Security Act on behalf of an applicant or member who is a ward of the county department are excluded.

(f) Income of the spouse of the applicant or member is excluded.

(g) Income of the parents of the applicant or member is excluded. *(Office of the Secretary of Family and Social Services; 405 IAC 2-9-2; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3116; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

405 IAC 2-9-3 Income eligibility and posteligibility determinations of applicant or member

Authority: IC 12-15

Affected: IC 12-15-7-2

Sec. 3. (a) An applicant's or member's income eligibility shall be determined by the following procedures:

- (1) Determine the applicant's or member's income in accordance with section 2 of this rule.
- (2) Subtract the monthly income standard that is equal to three hundred fifty percent (350%) of the federal poverty guideline for a family size of one (1), divided by twelve (12) and rounded up to the next whole dollar.
- (3) If the resulting amount in subdivision (2) is zero dollars (\$0) or less than zero dollars (\$0), the applicant or member is eligible for Medicaid for employees with disabilities. If the resulting amount is greater than zero dollars (\$0), the applicant or member is not eligible.

(b) The income standard referenced in subsection (a)(2) shall be increased annually beginning the second month following the month in which the federal poverty guidelines are published in the Federal Register.

(c) The following procedures are used to determine the amount of income to be paid to an institution for an applicant or member who has been determined eligible under subsection (a) and who is residing in a Title XIX certified health care facility:

- (1) Determine the applicant's or member's total income that is not excluded by federal statute. Total income includes amounts deducted in the eligibility determination under subsection (a).
- (2) Subtract the minimum personal needs allowance specified in IC 12-15-7-2.
- (3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant's or member's legal guardian, not to exceed thirty-five dollars (\$35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney's fees for which the guardian is liable.
- (4) Subtract the amount of health insurance premiums.
- (5) Subtract an amount for expenses incurred for necessary medical or remedial care recognized by state law but not covered under the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.
- (6) The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced.

(Office of the Secretary of Family and Social Services; 405 IAC 2-9-3; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3117; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-9-4 Resource eligibility of applicant or member

Authority: IC 12-15

Affected: IC 12-15-2-6.5; IC 12-15-41-2

Sec. 4. (a) An applicant or member is subject to resource definitions and exclusions as provided in 405 IAC 2-3-14.

(b) The resources of the applicant's or member's parents are excluded.

(c) In addition to that property required to be excluded under subsections (a) and (b), the following property is exempt from consideration:

- (1) Up to twenty thousand dollars (\$20,000), as approved by the central office of the family and social services administration, for an independence and self-sufficiency account defined in IC 12-15-41-2(3). A resource disregard for this purpose will be approved if the applicant or member submits a plan in writing to the office that describes specifically the goods or services, or both, that he or she intends to purchase that will increase, maintain, or retain his or her employability or independence. The items must be reasonable in terms of the applicant's or member's ability to achieve a stated goal that is focused on the individual's employability by removing barriers. Items for personal recreational use will not be approved. A request to save money without specifying goods or services to be purchased within an achievable period of time will not be approved. An approved account will be reviewed by the local office of family and children caseworker at each annual redetermination. If the terms of the original approved account have not been met, the member will be required to submit an updated request to the caseworker within thirty (30) days of receiving written notification from the caseworker that such an update is required.

If the member fails to submit the update, the disregard will be disapproved and resource eligibility will be redetermined without it. The caseworker will forward updates to the central office for approval. At any time during the period of eligibility under the Medicaid for employees with disabilities program, the member may submit an update requesting an adjustment in the approved amount. Approval will not be given for any services that are available to the member under Medicaid or any other publicly funded program.

(2) Retirement accounts held by the applicant or member or his or her spouse are exempt. This includes Individual Retirement Accounts, Keogh Plans, and 401(k), 403(b), and 457 plans, and any employer-related retirement account.

(Office of the Secretary of Family and Social Services; 405 IAC 2-9-4; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3118; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-9-5 Employment requirements; continuing eligibility when employment ends

Authority: IC 12-15-1-10; IC 12-15-41-15

Affected: IC 12-15-2-6.5; IC 12-15-41

Sec. 5. (a) In order for an individual to be eligible for Medicaid for employees with disabilities, the individual must be engaged in a substantial and reasonable work effort. This means that the person must be either employed or self-employed, with the intent of such work activity being ongoing. The individual's monthly earned income must exceed the sixty-five dollar (\$65) earned income disregard described in section 2 of this rule. Employment must be verifiable by pay stubs or other verification from an employer documenting that the income is subject to income tax and FICA withholding. Self-employment must be verified by the individual's income tax return or, in the case of a new business for which a tax return has not yet been filed, the personal business records of the individual.

(b) In order for a member of Medicaid for employees with disabilities to remain eligible when the definition of medically improved disability in section 7 of this rule is met, the member must be employed as defined in subsection (a) and must have monthly earnings as calculated under 405 IAC 2-5-1 that are equal to or greater than the federal minimum wage times forty (40), unless the provisions in subsection (c) are met.

(c) A member who is involuntarily not working can remain eligible for the Medicaid for employees with disabilities program for up to twelve (12) months if he or she meets all other program requirements and either:

- (1) is on temporary medical leave from his or her employment as defined in subsection (d); or
- (2) maintains a connection to the workforce by participating in at least one (1) of the following activities:
 - (A) Enrollment in a vocational rehabilitation program.
 - (B) Enrollment or registration with the department of workforce development.
 - (C) Participation in a transition from school to work program.
 - (D) Participation with an approved provider of employment services.

(d) As used in this section, "temporary medical leave" means a leave from the place of employment due to health reasons when the employer is keeping a position open for the individual to return. If the employer is no longer holding a position open, the member must maintain a connection to the workforce as defined in subsection (c)(2) in order for coverage to continue under Medicaid for employees with disabilities.

(e) In order to remain eligible upon becoming unemployed, the member or his or her authorized representative must submit a written request for continued coverage to the local office of family and children no later than sixty (60) days after termination of employment. Attached to this written request must be verification that the member meets the requirements in subsection (c). On a quarterly basis thereafter, as long as the member continues to be unemployed and wishes coverage to continue, verification of his or her medical leave or workforce connection status must be provided to the local office of family and children. The quarterly verification must consist of a statement from the agency or service provider that documents the member's continued participation in an activity that constitutes connection to the workforce, or from the member's employer stating he or she remains on a temporary involuntary medical leave.

(f) A member who voluntarily terminates his or her employment for any reason is not eligible for Medicaid for employees with disabilities. Eligibility for the other Medicaid categories will be pursued.

(g) A member who fails to submit the initial request for coverage continuation within the required sixty (60) day period or who

fails to submit the quarterly verification report is no longer eligible for Medicaid for employees with disabilities. Eligibility for other Medicaid categories will be pursued. (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-5; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3119; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35; filed Jun 21, 2005, 3:00 p.m.: 29 IR 10; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-9-6 Medical disability determination

Authority: IC 12-15

Affected: IC 12-15-2-6.5; IC 12-15-41

Sec. 6. In order to qualify for Medicaid for employees with disabilities, an applicant must meet the definition of disability in 405 IAC 2-2-3. If not for earned income, the applicant or member would medically qualify for Medicaid under the traditional disability category according to statute. (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-6; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3120; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-9-7 Medically improved disability

Authority: IC 12-15

Affected: IC 12-14-15-1; IC 12-15-2-6.5; IC 12-15-41

Sec. 7. (a) In order to qualify for the Medicaid for employees with disabilities program after improvement of a medical condition, a member must meet the requirements in this section.

(b) The person must be a member of Medicaid under the Medicaid for employees with disabilities group described in section 6 of this rule who no longer qualifies for coverage under that category due to a medical improvement in his or her condition. The improvement of the condition must be verifiable by acceptable clinical standards; however, the disease, illness, or process must be of a type that, due to the nature and course of the illness, will continue to be a disabling impairment. A condition that has been resolved or a person who is completely recovered does not medically qualify for this program.

(c) The determination of whether a member meets the medical eligibility requirements for this category will be made either:

(1) when the Social Security Administration determines the member is no longer disabled according to 20 CFR 416.905 or 20 CFR 416.906; or

(2) at the time of the member's next medical review as determined by the Medicaid medical review team (MMRT).

Determination of medical eligibility under this section is made by the MMRT. (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-7; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3120; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Apr 8, 2014, 12:37 p.m.: 20140507-IR-405130533FRA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-9-8 Premiums

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15

Affected: IC 12-14-15-1; IC 12-15-2-6.5; IC 12-15-41

Sec. 8. (a) To be eligible for Medicaid for employees with disabilities, an individual must pay monthly premiums in accordance with the requirements specified in this section, unless the gross income of the individual and the individual's spouse is less than one hundred fifty percent (150%) of the federal poverty level. The amount of the premium is based on the gross income of the member and the member's spouse as a percentage of the federal poverty level for the applicable family size as determined in subsection (b) or (c). The amount of the premium will be adjusted by the premium amount of other creditable private health insurance as defined in 42 U.S.C. §300gg-91 that covers the applicant or member and is paid by the applicant or member or his or her spouse or parent. The amount of the premium is calculated as described in the following Table:

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Income as a Percent of the Federal Poverty Level	Amount of Premium	
	Individual	Married Couple
Less than 150%	No premium required	No premium required
150% to 175%	\$48	\$65
More than 175% to 200%	\$69	\$93
More than 200% to 250%	\$107	\$145
More than 250% to 300%	\$134	\$182
More than 300% to 350%	\$161	\$218
More than 350%	\$187	\$254

(b) The individual premium amount is used when the individual, regardless of age, is not married or not living with his or her spouse. When the individual premium amount is used, only the individual's income is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of one (1).

(c) The married couple premium amount is used when the individual is legally married and living with his or her spouse. When the couple premium amount is used, the income of both spouses is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of two (2).

(d) When an applicant is determined eligible, the applicant will be conditionally approved pending payment of the premium. The first month for which a premium is required is the month following the month in which an applicant is approved as conditional. After the premium is received, coverage will be retroactive to the first day of the third month prior to the month of application if all eligibility requirements were met in the prior months.

(e) The individual must pay the first premium in order to receive coverage. If payment is not received by the due date specified in the second premium notice, the Medicaid application will be denied. A payment of less than the full amount due will be considered nonpayment.

(f) If any premium after the first premium is not paid by the due date, coverage will continue for a maximum of sixty (60) days before being discontinued. When an individual or couple have been discontinued from the program due to nonpayment of premiums, an application must be filed in order to be considered for eligibility. To be reenrolled based on an application filed after such a discontinuance, the individual must pay all past due premiums in addition to premiums owed for the current application. Past due premiums remain the obligation of the individual as a condition of eligibility for two (2) years after the date of discontinuance.

(g) When both spouses are members of Medicaid for employees with disabilities, the enrollment and continued eligibility of the couple is based on the payment of the married couple premium amount. Failure to pay the required premium amount in accordance with this section will result in the discontinuance of Medicaid coverage for both spouses.

(h) When a member reports a change in income or marital status as required by section 1(d) of this rule, and the change results in a lower premium, the new premium amount will be effective the first month following the date in which verification of the change is received.

(i) When a member who is eligible for Medicaid in the blind or disabled categories obtains employment, the change must be reported within ten (10) days as required by 470 IAC 2.1-1-2. An additional ten (10) days is allowed to provide verification of the employment. If the member is eligible for Medicaid for employees with disabilities, eligibility begins the first month following the date on which verification is received, subject to the timely notice requirements in 42 CFR 431.211. (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-8; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3120; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

Rule 10. Lien Attachment and Enforcement

405 IAC 2-10-1 Definitions

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 1. The following definitions apply throughout this rule:

- (1) "Disabled" is defined according to the criteria established under 42 U.S.C. 1382c.
- (2) "Interest" means any equitable right, title, or interest in real property.
- (3) "Lawfully residing in the home" means residing in the member's place of residence with the permission of the owners or, if under guardianship, the owner's legal guardian.
- (4) "Medical institution" means a long term care facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or other residential medical facility.
- (5) "Member's home" means the member's place of residence prior to institutionalization.
- (6) "Permanently institutionalized" means an individual of any age who:
 - (A) is an inpatient in a nursing facility, ICF/IID facility, or other medical institution;
 - (B) is required, as a condition of receiving services in such institution under the state plan, to spend for costs of medical care all but a minimum amount of his or her income required for personal needs; and
 - (C) after notice and opportunity for a hearing, has been determined to have a medical condition of such severity that he or she cannot reasonably be expected to be discharged from the medical institution and returned to the noninstitutional home environment prior to death.
- (7) "Real property" means land, including houses or immovable structures or objects attached permanently to the land in which a member has ownership rights and interests, including, but not limited to, the member's home.
- (8) "Residing in member's home on a continuous basis" means using the home as the principal place of residence.
- (9) "TEFRA" means Tax Equity Fiscal Responsibility Act.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-1; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1547; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-10-2 Recovery

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 2. The office shall seek reimbursement for Medicaid benefits paid on behalf of a member by either or both of the following methods:

- (1) Filing and enforcing a lien in accordance with this rule.
- (2) Filing and enforcing a claim against the estate of a deceased member in accordance with 405 IAC 2-8.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-2; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1547; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-10-3 Criteria for instituting a TEFRA lien

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 3. (a) When the office in accordance with 42 U.S.C. 1396p determines that a Medicaid member who resides in a medical institution cannot reasonably be expected to be discharged and return home, the office may attach a lien on the Medicaid member's real property subject to the provisions of this rule and IC 12-15-8.5.

(b) The office may not obtain a lien on the member's home if any of the following people lawfully reside in the home of the institutionalized member:

- (1) The member's spouse.
- (2) The member's child who is less than twenty-one (21) years of age, blind, or disabled as defined in 42 U.S.C. 1382c.
- (3) The member's sibling who:
 - (A) was residing in the member's home for a period of at least one (1) year immediately before the member's

institutionalization; and

(B) has an ownership interest in the home.

(4) The member's parent.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-3; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1547; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3984; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-10-4 Notice and opportunity for hearing

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 4. (a) The office shall notify the member and the member's authorized representative, if applicable, of its determination that the member is permanently institutionalized and not reasonably expected to return home and its intent to file a lien on member's real property. Notice must include an explanation of liens and their effect on an individual's ownership of real property.

(b) The office may file a lien not less than thirty-one (31) days following notice to member and after any hearing process has been completed, if a hearing is requested. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-4; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

405 IAC 2-10-5 Appeal

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 5. (a) A member or his or her designee may, within thirty-three (33) days after receipt of notice described in this rule, request an administrative hearing under this rule.

(b) Administrative hearings and appeals by Medicaid members are governed by the procedures and time limits set out in 405 IAC 1.1. Only one (1) appeal shall be afforded to a member, for each notice received in accordance with section 4 of this rule, notwithstanding the number of parcels owned by the member and identified in the notice. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-5; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

405 IAC 2-10-6 Lien attachment

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 6. (a) The office or its designee shall file a notice of lien with the recorder of the county in which the real property subject to the lien is located. The notice shall be filed prior to the member's death and shall include the following:

(1) Name and place of residence of the member against whom the lien is asserted.

(2) Legal description of the real property subject to the lien.

(b) The office shall file one (1) copy of the notice of lien with the county office of family and children in the county in which the real property is located. The county office shall retain a copy of the notice with the county office's records.

(c) The office shall provide one (1) copy of the notice of lien to the member or the member's authorized representative, if applicable, whose real property is affected. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-6; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

405 IAC 2-10-7 Effect of filing; duration

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 7. (a) From the date on which the notice of lien is recorded in the office of the county recorder, the notice of lien:

(1) constitutes due notice of a lien against the member or member's estate for any amount then recoverable and any amounts that become recoverable under this article; and

(2) gives a specific lien in favor of the office on the Medicaid member's interest in the real property.

(b) The lien continues from the date of filing until the lien:

(1) is satisfied;

(2) is released; or

(3) expires.

The lien automatically expires unless the office commences a foreclosure action not later than two (2) years after the Medicaid member's death. (*Office of the Secretary of Family and Social Services; 405 IAC 2-10-7; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3985; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-10-7.1 Notice to office to file an action to foreclose the lien

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 7.1. (a) This section applies after the death of the Medicaid member whose property is subject to a lien under this rule or after the sale or other transfer of property that is subject to the lien.

(b) A lien under this rule is void if both of the following occur:

(1) The owner of property subject to a lien under this rule or any person or corporation having an interest in the property, including a mortgagee or a lienholder, provides written notice to the office to file an action to foreclose the lien.

(2) The office fails to file an action to foreclose the lien in the county where the property is located not later than thirty (30) days after receiving the notice. However, this section does not prevent the claim from being collected as other claims are collected by law.

(c) A person who gives notice under subsection (b)(1) by registered or certified mail to the office at the address given in the recorded statement and notice of intention to hold a lien may file an affidavit of service of the notice to file an action to foreclose the lien with the recorder of the county in which the property is located. The affidavit must state the following:

(1) The facts of the notice.

(2) That more than thirty (30) days have passed since the notice was received by the office.

(3) That no action for foreclosure of the lien is pending.

(4) That no unsatisfied judgment has been rendered on the lien.

(d) The recorder shall:

(1) record the affidavit of service in the miscellaneous record book of the recorder's office; and

(2) certify on the face of the record any lien that is fully released.

When the recorder records the affidavit and certifies the record under this subsection, the real estate described in the lien is released from the lien. (*Office of the Secretary of Family and Social Services; 405 IAC 2-10-7.1; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3985; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA*)

405 IAC 2-10-8 Enforcement; foreclosure

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 8. (a) The office may not enforce a lien on the member's home under this rule if the following individuals are lawfully residing in the member's home and have resided there on a continuous basis since the member's date of admission to the medical institution:

(1) The member's child of any age who:

(A) resided in the member's home for at least twenty-four (24) months before the member was institutionalized; and

(B) establishes to the satisfaction of the office that he or she provided care to the member that enabled the member to reside in his or her home delaying institutionalization.

(2) The member's sibling who has resided in the member's home for a period of at least one (1) year immediately before the date of the member's admission to the medical institution.

(b) The office may not enforce a lien on the real property of the member under this rule as long as the member is survived by any of the following:

(1) The member's spouse.

(2) The member's child who is less than twenty-one (21) years of age, blind, or disabled as defined in this rule.

(c) If there is no condition present in subsection (a) or (b), the office, or its designee, may bring a proceeding in foreclosure on the lien or to make arbitration of the amount due on the lien as follows:

(1) If the real property or member's interest is sold or otherwise transferred during the lifetime of the member.

(2) Upon the death of the member.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-8; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3985; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)

405 IAC 2-10-9 Release; subordination

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 9. (a) The office shall release a lien obtained under this rule within ten (10) business days after the county office of family and children receives notice that the member is no longer institutionalized and is living in his or her home.

(b) A lien obtained under this rule is subordinate to the security interest of a financial institution as defined in IC 12-15-8.5 that loans money to the member provided that the member is able to establish to the satisfaction of the office that the funds were used for operating capital for the operation of the member's farm, the member's business, or the member's real property that is income-producing.

(c) If the real property subject to the lien is sold, the office shall release its lien at the closing, and the lien shall attach to the net proceeds of the sale. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-9; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1549; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3986; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov 13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA; filed Jun 11, 2021, 2:35 p.m.: 20210707-IR-405190602FRA)*

405 IAC 2-10-10 Exemption (Repealed)

Sec. 10. *(Repealed by Office of the Secretary of Family and Social Services; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3986)*

405 IAC 2-10-11 Exemption

Authority: IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-39.6-10

Sec. 11. Real property that is disregarded for eligibility purposes in connection with the purchase and use of a qualified long term care insurance policy pursuant to IC 12-15-39.6-10 is exempt from lien placement and enforcement. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-11; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3986; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; readopted filed Nov*

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13, 2019, 11:54 a.m.: 20191211-IR-405190487RFA)

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