3300.00.00 OVERVIEW OF MEDICAID WAIVERS

Indiana's home and community based services waivers, approved under Section 1915(c) of the Social Security Act are designed to provide home care for persons who otherwise would need institutional care. Sections 3305.00 through 3349.00 explain the eligibility requirements that apply to individuals who have been approved for HCBS. Certain provisions are special for HCBS and provide an additional eligibility methodology as an option to regular eligibility in the Aged, Blind, and Disabled categories.

The Healthy Indiana Plan (HIP) is a demonstration waiver under Section 1115(a) of the Social Security Act. The design of the HIP program is set forth under the Special Terms and Conditions approved by the Centers on Medicare and Medicaid Services. Sections 3350.00 through 3398.00 explain the eligibility requirements for HIP.

3305.00.00 GENERAL INFORMATION ABOUT HCBS WAIVERS

There are six home and community-based services (HCBS) waivers:

Aged and Disabled (A&D)
Autism (AU)
Community Integration and Habilitation (DD)
Family Supports (SS)
Traumatic Brain Injury (TBI)
PRTF Waiver

The Medicaid waivers each have a specific number of slots that can be filled in a given time period. When all slots are filled, applicants are placed on waiting lists. The waivers provide special services, in addition to regular Medicaid services, that are designed to allow a person who otherwise would need institutional care, to remain in the community. An individual must meet level of care and cost comparison criteria in order to receive waiver services.

The PRTF waiver is a sustainability waiver that replaces the Community Alternatives to Psychiatric Residential Treatment Facilities Grant (CA-PRTF) which ended 09-30-2012. New participants will not be enrolled, thus the waiver will phase out by attrition. None of the special waiver eligibility rules apply to this waiver.

To qualify for services under one of the approved waivers,

an individual must meet the "waiver" criteria above and also must meet Medicaid eligibility requirements. There may be two different ways in which a person can be eligible for Medicaid under a waiver: regular Medicaid eligibility rules and special waiver rules which are applied in the Aged, Blind, Disabled categories (MA A, MA B, and MA D). The following sections explain the policies and procedures that are used by the Division of Family Resources in determining Medicaid eligibility under each of the waivers. The application for waiver services is handled by other areas of FSSA in the Division on Aging or Division of Disability and Rehabilitative Services. Coordination between waiver case managers and DFR eligibility staff is critical when processing a Medicaid application for an individual who has been allocated a waiver slot and is in processing for waiver eligibility. Medicaid eligibility for a person on a wait list or who will be placed on a wait list is determined using regular Medicaid eligibility provisions, not any of the special provisions that apply to waiver applicants.

3306.00.00 RESERVED

3307.00.00 MONEY FOLLOWS THE PERSON GRANT

The Money Follows the Person Demonstration (MFP Program) is a federally approved special project managed by FSSA's Division on Aging to assist persons in moving from a nursing facility or hospital to a residential setting in the community.

To participate in the MFP Program, the individual must:

- Have lived in a nursing facility or hospital for a certain period of time;
- Be Medicaid eligible for one (1) day;
- Have health needs that can be met through services available in the community;
- Voluntarily consent to participation by signing a consent form; and
- Be eligible for the Aged & Disabled (A/D), Developmental Disabilities (DD), or Traumatic Brain Injury (TBI) waiver.

The MFP Program will provide transitional services for 365 days, after which time, the A/D, DD, or TBI waiver will provide the same services. During this one year period, eligibility for Medicaid is determined using the same rules as for the waivers.

3310.00.00 PERMISSIBLE HCBS WAIVER CATEGORIES

Indiana's approved HCBS waivers specify the eligibility categories under which a person can be approved in order to receive waiver services. The permissible Medicaid categories for the waivers are:

Aged (MA A);
Blind (MA B);
Disabled (MA D);
MED Works (MADW, MADI)
Low-income Families (MA C)
SSI Recipients in low-income families (MA U)
Foster Care Independence (MA14)
Children under Age 1 (MA Y)
Children Age 1-5 (MA Z)
Children Age 1-18 (MA 2, MA 9)
Transitional Medical Assistance (MA F)
IV-E FC Foster Care children (MA 4)
Children receiving Adoption Assistance (MA 8)

If an individual is receiving Medicaid in any other category, the DFR is responsible for processing a category change to determine eligibility in an appropriate waiver category.

Special eligibility rules apply in the Aged, Blind, and Disabled categories for waiver individuals and are explained in the following sections. Individuals who qualify for any of the other allowable waiver categories will remain eligible in those categories without any special rules being applied. The policies and procedures explained in Sections 2035.30 and 2035.30.15 regarding the Medicaid category determination is applicable.

3315.00.00 USE OF THE SPECIAL INCOME LEVEL TEST

The Special Income Level (SIL) test is a specific financial eligibility determination that applies only to the Aged, Blind, and Disabled categories. The SIL eligibility test applies to all of the waivers, except the PRTF waiver. Refer to Section 3325.05.00 for SIL budgeting procedures.

When the SIL test is applicable, there are other specific eligibility provisions that apply as follows:

For the A&D waiver, TBI waiver, and MFP program for A/D and TBI, if the applicant/recipient passes the SIL test, then the spousal impoverishment protection resource provisions explained in Sections 2635.10.10 through 2635.10.10.15 are used. Spousal impoverishment protection is not used for any of the other waivers.

If the individual passes the SIL test, which is an eligibility step, then post-eligibility is the next step to determine the amount, if any, of the spend-down.

Parental income is exempt in the SIL test and if the child passes the SIL test, parental resources are exempt. If Medicaid coverage is needed prior to the start date of waiver services, retroactive coverage can be approved using regular eligibility rules for those months, including parental deeming as appropriate for the child's category. If the parents request Medicaid coverage to coincide with the waiver start date, the parents are not required to provide any information regarding their income or resources.

3320.00.00 RESOURCE LIMITS AND METHODOLOGIES

All of the resource principles explained in Chapter 2600 regarding resource ownership, availability, and exemptions are applicable to waiver applicants/recipients.

The Resource Limits specified in Chapter 3000 apply to waiver applicants and recipients based on their category.

When the Special Income Level is used in the determination of eligibility for children, parental resources are excluded as explained in the previous section.

3320.05.00 SPOUSAL IMPOVERISHMENT PROTECTION

If the waiver applicant/recipient passes the SIL financial test, the resource eligibility rules for married couples explained in Sections 2635.10.10 through 2635.10.10.15 apply for the following waivers:

Aged and Disabled (A/D);

Traumatic Brain Injury (TBI)

MFP Program for A/D and TBI

If the waiver spouse fails the SIL test, regular resource rules and limits apply. The spousal impoverishment protection rules do not apply to any of the other waivers.

In determining whether spousal impoverishment protection applies in a given circumstance, waiver services are considered in the same manner as institutionalization. For example, a married couple both of whom are institutionalized are not subject to the special spousal rules; similarly, a married couple both of whom receive (or will receive if Medicaid eligible) waiver services are not subject to the special spousal rules. If the spouse of the waiver applicant/recipient is institutionalized, the special spousal rules do not apply regardless of the waiver type.

The resource assessment (RA) date (or snapshot, as it is sometimes called) is determined as explained in Section 2635.10.10 if the waiver spouse has a prior continuous period of institutionalization or receipt of A&D, TBI, or MFP services.

> EXAMPLE:
>
> Married applicant was hospitalized on May 10, and then discharged on May 30 to a nursing home where she remained until December 1 when A&D waiver services were approved for her. Her resource assessment date is May 10.

If the waiver spouse has never had a prior continuous period of institutionalization nor received waiver services, the snapshot date is determined as follows:

1. The date of the Medicaid application is the RA date if it is later than any of the dates below:

   - The date the waiver slot is obligated for the individual;
   - The date on which level of care is approved (not effective date);
   - The date on which the waiver Cost Comparison Budget (CCB) is approved.

2. If the date of the Medicaid application is earlier than all of the dates in #1, the RA date is the earliest of the 3 dates in #1.

The Community Spouse Resource Allowance used in the resource eligibility determination is the same as that used for institutionalized situations and is specified in Chapter 3000.

3320.10.00 MILLER TRUSTS

Qualifying Income Trusts (QIT), commonly referred to as Miller Trusts, are exceptions to the trust provisions outlined in Section 2615.75.20, if the trust is established for the benefit of a waiver applicant/recipient whose eligibility is being determined using the Special Income Level test, and the terms of the trust specify the following:

The trust is to be funded only by the income of the individual including accumulated interest on that income. The trust will not be funded with the individual’s resources, nor the income or resources of other persons;

Upon the death of the individual, the State of Indiana will

receive all remaining funds in the trust up to the amount of Medicaid expenditures paid on the individual's behalf;

Income must be placed into the trust after first being received by the individual. If the right to receive the income is assigned or otherwise transferred to the trust, the QIT exception is nullified.

If a Miller Trust is revocable, funds that accumulate are countable resources. If the Miller trust is irrevocable, accumulated funds are exempt as resources. When income is placed into a Miller Trust, a transfer of property violation does not occur if the trust specifies that income placed into the trust will in turn be paid out of the trust for medical care, including nursing home care and home and community-based services, provided to the individual. Additionally, if funds placed into a Miller trust are then transferred for the sole benefit of the person's spouse, a transfer penalty will not be imposed. However, if the funds are to be used for this purpose, the terms of the trust must state that the particular trust property can be used only for the benefit of the individual's spouse while the trust exists and that the trust cannot be terminated and distributed to any other entities for any other purpose.

Miller Trusts have been developed basically for the sole purpose of allowing an individual with income in excess of the SIL to become Medicaid eligible. It is a statutorily permissible work-around of the inflexible income cap of the SIL. The SIL is used only for home and community-based services, not for institutional situations. The method in which income is treated and budgeted when an individual has a Miller trust is discussed in Sections 3325.05.00 and 3325.10.00.

3320.15.00 TRANSFER OF PROPERTY - HCBS

The transfer of property requirements detailed in Section 2640.10.00 and following subsections are applicable to individuals who are approved for home and community based waiver services. For transfers on and after 11-1-09 the new rules contained on the internet version of the policy manual on the front page table of contents labeled "Medicaid Transfers and Certain Assets – Update January 1, 2012" are applicable. During a transfer penalty, no special waiver budgeting is applicable. The DFR should verify with the waiver case manager whether or not the waiver slot will remain approved for the individual while the penalty period is in force.

3325.00.00 INCOME ELIGIBILITY FOR HCBS

There are two eligibility budgeting methods that may apply to waiver applicants, depending on the type of waiver and

whether the applicant is a child or an adult, single or married. These methods are the Special Income Level (SIL) test and regular budgeting. A post-eligibility calculation is completed to determine the spend-down amount if the applicant/recipient is eligible under the Special Income Level.

Refer to Section 3315.00.00 which explains the circumstances that allow the use of the Special Income Level.

3325.05.00 BUDGETING WITH THE SPECIAL INCOME LEVEL

The SIL test is an eligibility test used in the MA A, MA B and MA D categories. If the individual passes the SIL test, it is followed by a post-eligibility calculation to determine the amount, if any, of the spend-down.

The Special Income Level (SIL) standard is 300% of the maximum benefit payable under the SSI program. The SIL increases annually when SSI increases in January. Refer to Chapter 3000 for the SIL amount. There is no couple SIL for a married applicant/recipient.

The income of the applicant/recipient is included in the SIL test. Income of parents and income of spouses is not included.

Countable income in the SIL test is as follows:

- Gross earnings (no exemptions, and no employment disregard)
- Net rental income (Sections 3420.05, 3420.05.05, 3415.10)
- Net self-employment income (Section 3410.15)
- All gross unearned income except SSI.

The amount of any income placed into an approved Miller trust as defined in Section 3320.10.00, is exempt in the SIL test. The amount of income placed into the trust could be the entire amount or a portion. The terms of the trust must specify the income source and amount in order for it to be exempt in the SIL test. Income placed into the Miller trust counts in the post-eligibility calculation.

If countable income is equal to or less than the SIL, the person passes the SIL test.

3325.10.00 POST-ELIGIBILITY BUDGETING

The post-eligibility calculation is completed for individuals who pass the SIL test. When the individual has an approved Miller trust, the amount of income that is placed into the trust and which is exempt in the SIL test, is added back in for post-eligibility.

The Personal Needs Allowance is deducted from total income. For all of the waivers, the Personal Needs Allowance is the same as the SIL.

Additional deductions are allowed as follows:

The amount of a health insurance premium for coverage of the applicant/recipient. Premiums for indemnity policies that provide income replacement rather than coverage for incurred medical costs are not allowed;

When spousal impoverishment protection is applicable, a community spouse allocation (3455.15.10.10) and a family member allocation (3455.15.10.15);

When spousal impoverishment protection is not applicable an allowance for children under age 18 living with the applicant/recipient. The amount is the MA C standard for the number of children involved, per the table labeled AG with Children Only in Section 3010.25.00.

Any amount remaining is the spend-down amount subject to all regular spend-down processing. From a practical standpoint, the above deductions for post-eligibility only have an effect when the individual has a Miller Trust. Otherwise there is no spend-down anyway because the Personal Needs Allowance is the same as the SIL.

3325.15.00 REGULAR BUDGETING

Regular budgeting applies to all waivers. For the Aged, Blind and Disabled categories, it is the second choice budget used when the applicant/recipient fails the SIL test. It is also used for the individual who is serving a transfer of property penalty.

3325.20.00 REGULAR DISABILITY VS MED WORKS

An employed individual whose gross earnings minus IRWEs(Section 3455.07) exceed the SGA level, is not eligible for Medicaid under the Disability category (MA D), with the only exception being a person who is entitled to special 1619 Medicaid (Section 2414.10.10). This is true regardless of whether or not the individual is on a waiver. The proper category is MADW. Use of the SIL test is not an option when earned income of the applicant/recipient exceeds the SGA level.

3350.00.00 OVERVIEW OF THE HEALTHY INDIANA PLAN (HIP)

The Healthy Indiana Plan is a demonstration waiver approved under Section 1115(a) of the Social Security Act effective January 1, 2008. The authority for this program is the Special Terms and Conditions approved by the Centers on

Medicare and Medicaid Services, along with State law IC 12-15-44.2, and state regulations at 405 IAC Article 9.

HIP provides a comprehensive benefit plan for eligible uninsured adults. It is a high deductible health plan that utilizes an account similar to a health savings account called the POWER account - Personal Wellness and Responsibility account - which provides incentives for members to obtain necessary preventive care. Members contribute based on their income and the State funds the balance. Unlike the regular Medicaid categories, HIP are subject to enrollment and expenditure limits. For individuals who are approved, a 12-month benefit period is established, and in the event that the enrollment limitations are reached, eligible members will not lose eligibility for that reason alone. When the limitations are reached, the program will close to new applications. Women on HIP who become pregnant remain eligible for health coverage; however, their eligibility must be changed to a Hoosier Healthwise category.

The following sections of this Chapter explain the eligibility requirements and methodologies used by the Division of Family Resources to determine HIP eligibility and to calculate the members' annual POWER account contribution. Additional information about HIP and how to apply can be found on the website www.in.gov/fssa.

3355.00.00 AGE AND HEALTH INSURANCE STATUS

To qualify for HIP an individual must be at least age 19 but not yet age 65.

There are 3 separate requirements relative to health insurance status that an individual must meet in order to be eligible for HIP. 1) Must be uninsured; 2) must not be eligible for his or her employer's insurance plan; and 3) must not have been insured for 6 months. The following Sections explain these requirements in more detail and specify the exceptions to the 6-month waiting period.

3355.05.00 INSURANCE DEFINITION FOR HIP ELIGIBILITY

An individual who has health insurance is not eligible for HIP. Health insurance for this purpose includes limited benefit policies. Unlike Hoosier Healthwise Package C, insurance for HIP eligibility does not have to be comprehensive hospital and medical/major medical coverage in order to disqualify an applicant.

Medicare beneficiaries are not eligible for HIP, nor are persons receiving Medicaid in another category. An eligible Medicaid recipient cannot choose to voluntarily withdraw from Medicaid for the purpose of enrolling in HIP.

The following types of coverage do not prohibit HIP eligibility:

Access to care at a VA facility;

Wishard Hospital Advantage Program (county operated hospital in Indianapolis);

Accident only, credit, dental, vision, long term care or disability income insurance;

Coverage issued as a Supplement to liability insurance;

Workers' Compensation;

Automobile medical payment insurance;

A specified disease policy;

A short term insurance plan that may not be renewed and has duration of not more than 6 months;

A student health plan;

A policy that provides indemnity benefits not based on any expense incurred requirement including a plan that provides coverage for hospitalization, critical illness, intensive care, or gaps for deductibles or co-payments; these policies are more like income replacement/supplement policies not health insurance paid for incurred medical costs.

3355.10.00 UNINSURED WAITING PERIOD

To be eligible for HIP, an individual must be uninsured for at least 6 months. This waiting period does not apply in the following circumstances:

Loss of any of the types of insurance listed in Section 3355.05.00 which are defined as not prohibiting eligibility;

Expiration of COBRA coverage or "COBRA-like" coverage. COBRA-like coverage is defined as health insurance that an individual can retain from his or her former employer at the time of employment termination and which is time limited. For example, non-profit organizations may not have the ability to offer COBRA coverage but will have another arrangement that functions in the same manner as COBRA, but perhaps for a shorter period of time than COBRA's 18 months and is not subject to Department of Labor oversight. Voluntarily dropping COBRA and COBRA-like insurance is not to be confused with expiration of such health coverage. Voluntarily dropping this coverage prior to the expiration date will result in the 6-month waiting period.

Becoming ineligible for Medicaid;

Becoming ineligible for Medicare; this is expected to be quite rare but does happen. A person who chooses to opt out of Medicare cannot become eligible for HIP.

3355.15.00 ELIGIBLE FOR EMPLOYER OFFERED INSURANCE

An individual who is eligible for health insurance coverage through his or her employer is not eligible for HIP. This requirement is specific to the individual's own employer. Therefore, an individual who could be covered by the employer-sponsored insurance of a spouse or parent can be eligible for HIP.

Individuals who declined their employer's insurance during an open enrollment period are not eligible for HIP. Ineligibility results whether the open enrollment is an annual event or a one time event.

3360.00.00 CATEGORICAL ELIGIBILITY FOR HIP

There are 2 categories under HIP: caretaker relatives (MAHC), and non-caretaker relatives (MAHN). Although both categories are subject to expenditure limitations and will close to new applicants when limitations are reached, the non-caretaker category also has a hard cap on the number of enrollees. The categorical requirement of both categories is explained in the following two sections.

3360.05.00 CARETAKER RELATIVE CATEGORY OF HIP

To meet the categorical requirement of the caretaker category of HIP, an individual must have responsibility for the care and control of a child under age 18 who is living in the home of the caretaker relative. The relational requirement for caretaker relative for HIP eligibility is the same as that for specified relative in IPPM Section 2420.05.00.

3360.10.00 NON-CARETAKER CATEGORY OF HIP

There is no categorical requirement, per se, for the non-caretaker category of HIP. An individual must meet all program requirements, and care and control of a dependent child is not a determining factor.

3365.00.00 OTHER HIP NON-FINANCIAL REQUIREMENTS

The Medicaid requirements outlined in Chapter 2400 regarding the following are applicable to HIP:

Requirement to provide a Social Security Number;

State residency;

Assignment of medical rights and medical support cooperation;

Citizenship status including the documentation requirements.

Immigration status requirements for HIP have some distinctions from regular Medicaid, based on the HIP category for which the immigrant is eligible. There is no emergency services only health coverage available under the non-caretaker category. Therefore, undocumented immigrants in the non-caretaker category and qualified immigrants who are in the 5-year period barring full coverage are not eligible. For the caretaker category, the immigration status requirements are the same as outlined in Chapter 2400 for regular Medicaid. Individuals who meet the HIP program requirements are eligible for Medicaid emergency services only. The usual 3 months of retroactive coverage is available if the person is eligible.

Use of SAVE is required for HIP.

The remainder of the HIP eligibility requirements will be in a future transmittal.