1000.00.00 INTRODUCTION TO THE INDIANA HEALTH COVERAGE PROGRAM POLICY MANUAL

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1000.00.00 INTRODUCTION TO THE INDIANA HEALTH COVERAGE PROGRAM POLICY MANUAL

The Policy Manual user must have an understanding of the organization and format of the manual. This introduction provides information regarding the following:

Purpose and Scope of the Manual (Section 1005);

Manual Organization and Format (Section 1010);

Manual Numbering Scheme (Section 1015);

Manual Terminology (Section 1020);

Manual Categories (Section 1025);

Accessing the Policy Manual (Section 1030);

Manual Distribution (Section 1035); and

Future Revisions to the Policy Manual (Section 1040).

1005.00.00 PURPOSE AND SCOPE OF THE MANUAL

The manual incorporates policies concerning Medical Assistance, under the traditional Medicaid program, Hoosier Healthwise, & Healthy Indian Plan (HIP). The manual is maintained in an internet version.

Policy and procedures concerning burial assistance are included in this manual; however, the determination of entitlement to burial assistance is not supported by ICES.

Eligibility for Room and Board Assistance (RBA) must be determined manually by workers within the Division of Aging; however, for RBA eligible recipients, ICES will determine eligibility for RBA-related Medicaid.

The provisions of this manual apply to the Division of Family Resources throughout the State of Indiana unless otherwise specifically stated. The manual is intended as a guide for

implementation of all federal and state laws and regulations relating to the eligibility determination of health coverage programs administered by the Division of Family Resources (DFR). For the purposes of this manual, DFR includes division employees and contractors.

1010.00.00 MANUAL ORGANIZATION AND FORMAT

The manual is organized into the following chapters:

Chapter 1000 Introduction
Chapter 1200 General Program Information
Chapter 1400 Administrative Policy
Chapter 1600 Categories of Assistance
Chapter 1800 Application Registration
Chapter 2000 Application Processing
Chapter 2200 Continuing Case Processing
Chapter 2400 Non-financial Eligibility Requirements
Chapter 2600 Resources
Chapter 2800 Income
Chapter 3000 Eligibility Standards
Chapter 3200 Assistance Groups
Chapter 3400 Budgeting and Benefit Calculation
Chapter 3500 Healthy Indiana Plan
Chapter 3600 Benefit Issuance
Chapter 3800 Transitional Medical Assistance
Chapter 4200 Appeals and Hearings
Chapter 4400 Data Exchange
Chapter 4600 Benefit Recovery
Chapter 4800 Burial Provisions
Chapter 5000 Supplemental Assistance for Personal Needs

Within each chapter, the manual material is organized with policy common to all programs presented first, followed by policy specific to a particular program or group of programs. The first section (or passage as referred to on-line) serves as a table of contents for the chapter by listing the main sections contained in the chapter. Footnotes are numbered sequentially within each chapter and the legal references are found within the footnotes.

When a policy applies to all Medical Assistance programs, no program designators are listed after the passage title. When a policy applies to only one program, the program designator is listed in parentheses following the passage title.

When policy in a passage does not pertain to all categories of assistance, the first sentence in the passage will state the specific category or categories for which the passage is applicable. In some instances, the first sentence will state the category or categories for which the passage does not apply.

1015.00.00 MANUAL NUMBERING SCHEME

The numbering scheme used for the Policy Manual provides a method for numbering each chapter and passage of text while providing the flexibility to add or insert passages or chapters without having to renumber or re-index other sections. There may be up to four sets of numbers in each passage number. The first number which represents the chapter and section number is four digits. All other numbers are two digits.

The numbering scheme is illustrated by the following:

- 1600.00.00 Indicates Chapter 1600;

- 1605.00.00 Indicates Chapter 1600, Section 1605;

- 1605.05.00 Indicates Chapter 1600, Section 1605, Subsection 1605.05;

- 1605.05.05 Indicates Chapter 1600, Section 1605, Subsection 1605.05, Second Subsection 1605.05.05;

- 1605.05.10 Indicates Chapter 1600, Section 1605, Subsection 1605.05, Second Subsection 1605.05.10;

- 1605.10.05 Indicates Chapter 1600, Section 1605, Subsection 1605.10, Second Subsection 1605.10.05;

- 1605.10.10.05 Indicates Chapter 1600, Section 1605, Subsection 1605.10, Second Subsection 1605.10.10, and Third Subsection 1605.10.10.05.

1020.00.00 MANUAL TERMINOLOGY

Many of the passage titles in the Policy Manual contain "program designators". These program designations are in parentheses at the end of passage titles.

The program designators and the programs they represent are:

MED Medical programs (The medical, or health coverage, programs are traditional Medicaid, Refugee Medical Assistance, Hoosier Healthwise, and Healthy Indiana Plan.)

The "MED" classification is divided into four sub-groupings reflective of the similarities which exist in the financial and resource eligibility determinations of the categories in each group. If policy and procedure apply to all categories, there will not be any specific designation. If policy and procedure only apply to some of the groupings, one or more specific designators are listed.

The following sections list the specific categories of assistance within each program designation.

1025.00.00 CATEGORIES

The categories within each program designator follow. Further clarification of each category is outlined in Chapter 1600.

1025.10.00 MED 1

Categories in the MED 1 program group are:

- Supplemental Security Income (SSI) Recipients (MASI)
- Aged (MA A)
- Blind (MA B)
- Disabled (MA D)
- Disabled Working(MADW)
- Disabled-Medically Improved (MADI)
- RBA-related (MA R)

1025.15.00 MED 2

The category in the MED 2 Program is:

- Refugee Medical Assistance (MA Q)

1025.20.00 MED 3/MAGI

Categories in the MED 3 Program group are:

- Low-Income Caretakers (MAGF)
- Pregnant Women (MAGP)
- Newborns (MA X)
- Transitional Medical Assistance (MA F)
- Child Under One (MA Y)
- Child Under Six (MA Z)
- Child Six to Nineteen (MA 2)
- Child Age 19 and 20 (MA T)
- Child Age 19, 20, and 21 residing in psychiatric facility (MA O)
- Children One to Nineteen (MA 9)
- Children's Health Plan for Children Birth to Nineteen (MA 10)
- Family Planning Services (MA E)
- Independent Former Foster Children Age 18-20 (MA14)
- Former Foster Care Children Age 18-25 (MA15)
- Adult- Hip Link (MAHL)
- Adult-Hip Plus-Native American Only (MANA)
- Adult-Hip Plus-Co pays (MAPC)
- Adult-Hip Basic (MARB)
- Adult-Hip Basic-State Plan(MASB)
- Adult Hip Plus (MARP)
- Adult Hip Plus-State Plan (MASP)

1025.25.00 MED 4

Categories in the MED 4 program group are:

- Qualified Medicare Beneficiary (MA L)

- Qualified Disabled Worker (MA G)
- Specified Low-Income Medicare Beneficiary (MA J)
- Qualified Individuals (MA I)

1030.00.00 ACCESSING THE ON-LINE MANUAL

The manual is available on-line at the FSSA Home page under the Medical Policy Home tab.

1035.00.00 MANUAL DISTRIBUTION

The manual is available online at http://www.in.gov/fssa/ompp/4904.htm.

1035.10.00 Searching the Manual

The manual may be searched by clicking find in the edit menu of your internet browser or pressing ctrl + f on your pc keyboard.

1040.00.00 FUTURE REVISIONS TO THE POLICY MANUAL

When the manual needs to be revised or updated, flash bulletins will alert workers that a revision has been made. A numbered manual transmittal letter is used to transmit new or revised manual material.

1200.00.00 GENERAL PROGRAM INFORMATION

1215.00.00 MEDICAL ASSISTANCE

1205.05.00 LEGAL BASIS

1215.10.00 PROGRAM OVERVIEW

1215.15.00 ELIGIBILITY CRITERIA

1200.00.00 GENERAL PROGRAM INFORMATION

This chapter presents general information about the Indiana Health Coverage Programs (IHCP).

1215.00.00 MEDICAL ASSISTANCE

Medicaid is a federal and state funded program which pays for the medical care of persons who meet specific categorical non-financial, income, and resource requirements. Individuals can be eligible for full, limited, or emergency Medicaid coverage depending on the category under which they qualify.

1205.05.00 LEGAL BASIS

The Medicaid program is established under Title XIX of the Social Security Act. Federal regulations in Title 42 of the Code of Federal Regulations (CFR) provide further legal authority.

The Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services is the federal agency which has administrative responsibility for the Medicaid Program.

1215.10.00 PROGRAM OVERVIEW

Medicaid became effective in Indiana on January 1, 1970. The Medicaid program covers a wide range of medical care and services for eligible individuals.

1215.15.00 ELIGIBILITY CRITERIA

The determination of eligibility for Medical Assistance is based upon financial and non-financial requirements. The Medicaid program is comprised of numerous categories of assistance. Each category has additional specific criteria which must be met for eligibility to exist. These requirements are discussed in Chapter 1600.

1400.00.00 ADMINISTRATIVE POLICY

1405.00.00 FAMILY AND SOCIAL SERVICES ADMINISTRATION

1405.05.00 DIVISION OF FAMILY RESOURCES

1405.15.00 DIVISION OF MENTAL HEALTH AND ADDICTION

1405.20.00 DIVISION OF AGING

1405.25.00 DIVISION OF DISABILITY AND REHABILITATIVE SERVICES (DDARS)

1405.30.00 OFFICE OF MEDICAID POLICY AND PLANNING (OMPP)

1405.35.00 FSSA OPERATIONS

1410.00.00 PERSONNEL STANDARDS

1410.10.00 MERIT PERSONNEL FOR ELIGIBILITY CASE PROCESSING

1410.15.00 USE OF OTHER STAFF

1410.20.00 SUFFICIENT STAFF

1415.00.00 OUTREACH

1420.00.00 INQUIRIES FOR INFORMATION

1420.05.00 PRINTED MATERIAL

1420.10.00 MANUALS AND PROGRAM DIRECTIVES

1425.00.00 CONFIDENTIALITY

1425.05.00 ACCESS AND USE OF CONFIDENTIAL INFORMATION

1425.10.00 RELEASE OF CONFIDENTIAL INFORMATION

1425.10.05 Release of Confidential Information to the Individual

1425.10.10 Release of Information to Third Parties

1425.10.10.05 Release of Confidential Information without Consent

1425.10.10.20 Issuance of Subpoena

1425.10.15 Release Of Medicaid Numbers To Providers (MED)

1425.10.15.05 Retroactive or Emergency Services

1425.10.15.10 Validation of Correct Medicaid Number (MED)

1430.00.00 PROTECTED CASES

1432.00.00 ADA/REHABILITATION ACT POLICY

1432.05.00 LEGAL BASIS OF THE ADA/REHABILITATION POLICY

1432.05.05 Accommodations for the ADA/Rehabilitation Act
1432.10.00 ADA COORDINATOR
1435.00.00 NON-DISCRIMINATION
1435.05.00 NON-DISCRIMINATION INFORMATION
1440.00.00 COMPLAINTS
1440.10.00 APPLICANT/RECIPIENT COMPLAINTS RECEIVED BY DFR
1440.15.00 COMPLAINTS RECEIVED FROM THIRD PARTIES BY DFR
1440.20.00 COMPLAINTS OF DISCRIMINATION
1440.20.05 The DFR and Discrimination Complaints
1440.20.10 The Family Independence Section and Discrimination Complaints
1445.00.00 MANDATORY REPORTING OF CHILD ABUSE OR NEGLECT
1450.00.00 CASE RECORD MAINTENANCE
1450.10.00 CONTENT OF CASE FILE
1450.15.00 RETENTION OF CASE RECORDS
1450.20.00 RETENTION OF DOCUMENTS WITHIN THE CASE FILE
1450.20.05 Retention of Documents within the Case File
1455.00.00 DESTRUCTION OF CASE MATERIAL
1455.05.00 REMOVAL OF EXTRANEOUS MATERIAL FROM CASE RECORDS

1400.00.00 ADMINISTRATIVE POLICY

This chapter presents administrative policy, including:

Family and Social Services Administration (Section 1405)

Personnel Standards (Section 1410)

Outreach (Section 1415)

Inquiries for Information (Section 1420)

Confidentiality (Section 1425)

Protected Cases (Section 1430)

ADA/Rehabilitation Act Policy (Section 1432)

Non-Discrimination (Section 1435)

Complaints (Section 1440)

Mandatory Reporting of Child Abuse or Neglect (Section 1445)

Case Record Management (Section 1450)

Destruction of Case Material (Section 1455)

1405.00.00 FAMILY AND SOCIAL SERVICES ADMINISTRATION

The Family and Social Services Administration (FSSA) is the agency of the state responsible for social service and financial assistance programs. The administration includes six major service divisions:

The Division of Family Resources (DFR),

The Division of Mental Health and Addiction,

The Division of Aging,

The Division of Disability and Rehabilitative Services,

The Office of Medicaid Policy and Planning (OMPP),

FSSA Operations – includes Medical Review Team (MRT)

The mission of FSSA is to work in partnership with families and the community to develop a system of effective prevention and intervention services. The collaborative effort fosters a climate of openness, empowerment, and mutual respect necessary to meet the needs of our clients. Services are family-based and cut across individual agency lines of responsibility.

The official mission statement of FSSA is: To develop, finance and **compassionately** administer programs to provide healthcare and other social services to Hoosiers in need in order to enable them to achieve **healthy**, **self-sufficient** and **productive** lives.

FSSA's Vision:

To become a high performance, integrated and interdependent agency, leveraging its resources across the continuum of services we provide in order to reliably and consistently serve our customers while acting as astute stewards of the state and federal money provided to us.

1405.05.00 DIVISION OF FAMILY RESOURCES

The Division of Family Resources has the responsibility for administering the Medicaid programs at the regional and county levels.

1405.15.00 DIVISION OF MENTAL HEALTH AND ADDICTION

The Division of Mental Health and Addiction (DMHA) is responsible for mental health needs, addiction services, and operation of the state psychiatric hospitals.

1405.20.00 DIVISION OF AGING

The Division of Aging was created as Indiana's State Unit on Aging in accordance with the Older Americans Act (OAA) and falls directly under the Family and Social Services Administration. By Indiana statute, the division is granted the legal authority to establish and monitor programs that serve the needs of Indiana seniors.

1405.25.00 DIVISION OF DISABILITY AND REHABILITATIVE SERVICES (DDARS)

The Division of Disability and Rehabilitative Services (DDARS) administers social service programs providing continuous lifelong support for citizens in need of disability and rehabilitative supports in the State of Indiana.

1405.30.00 OFFICE OF MEDICAID POLICY AND PLANNING (OMPP)

The Office of Medicaid Policy and Planning (OMPP) is responsible for administering Medicaid programs, supporting the local DFR offices and assisting in compliance with federal regulations and the state plan.

1405.35.00 FSSA OPERATIONS

The Operations Division is responsible for the administrative, logistical, and other duties necessary for the day to day running of the Family and Social Services Administration. The Division includes the Medical Review Team and Estate Recovery.

1410.00.00 PERSONNEL STANDARDS

Certain personnel standards must be followed in the administration of the Medicaid program. The following sections discuss these requirements.

1410.10.00 MERIT PERSONNEL FOR ELIGIBILITY CASE PROCESSING

DFR personnel employed by FSSA used in the determination of eligibility and calculation of benefits are to be state merit staff employed by the Division. Functions of the eligibility staff include but are not limited to interviewing, evaluating, information gathering, and establishing eligibility and benefit levels.

1410.15.00 USE OF OTHER STAFF

The DFR is encouraged to use volunteers in activities such as prescreening, assisting applicants in completing the application, and securing needed verification.

1410.20.00 SUFFICIENT STAFF

The DFR shall employ sufficient staff to perform eligibility and benefit issuance functions accurately and process fair and timely in accordance with the standards set forth in this manual.

1415.00.00 OUTREACH

Outreach promotes education and public awareness of assistance programs as well as increases access to services. Outreach includes:

Providing program information;

Providing referrals to other agencies;

Training community organizations that provide program information to the public to promote assistance programs;

Eliminating the social and geographic barriers to participation; and

Encouraging continued participation by AGs.

1420.00.00 INQUIRIES FOR INFORMATION

An inquiry is a request for information regarding the eligibility requirements for assistance. Individuals inquiring about assistance are to be given information in written form and orally, as appropriate, regarding eligibility requirements, scope of the program, coverage, and the rights and responsibilities of applicants/recipients.[1]

Responses to inquiries regarding eligibility should be general. Information regarding agency procedures, income and resource standards, and program requirements may be provided. In no event should individual requesting information be told that they are eligible or ineligible unless that individual has filed an application and an official determination has been made.

A worker who makes an eligibility statement without receiving an application and/or completing a thorough investigation of an individual's or family's situation puts the agency at risk of providing benefits to ineligible people and denies the client the right to proper notice which is required by federal law. The notice establishes and supports the client's right to appeal. Verbal communication without written notification serves to interfere with the client's rights.

1420.05.00 PRINTED MATERIAL

Written information such as brochures, pamphlets, or other material in paper and electronic form that describes basic

[1] 42 CFR 435.905

financial and non-financial eligibility criteria, the application process, and participant rights and responsibilities, is to be available. This written information shall be distributed at Local Offices and shall be made available to other local agencies upon request.

The written information explaining the rules and procedures governing the appeal and hearing process is to be made available by the DFR to each applicant/recipient and to any other interested person.2

1420.10.00 MANUALS AND PROGRAM DIRECTIVES

The Indiana Health Coverage Program Policy Manual (IHCPPM) and the ICES Program Policy Manual (IPPM) and supplemental instructions used in the determination of eligibility shall be accessible via the internet at DFR for examination by members of the public on regular workdays during regular office hours.[3]

1425.00.00 CONFIDENTIALITY

All information obtained by the DFR and maintained in the case record about an applicant/recipient and his circumstances is confidential.

Information obtained by DFR from participants or individuals, whether or not they are currently participating, is also considered confidential.

1425.05.00 ACCESS AND USE OF CONFIDENTIAL INFORMATION

Access and use of confidential information is to be restricted to those DFR staff members with direct responsibility for establishing eligibility, authorizing benefit levels, and providing services for the individual or family for whom the information was obtained. Confidential information may also be shared with DFR staff who have responsibility for administration and oversight of the programs for which the confidential information was secured.

Under no circumstances may a list of names and addresses of applicants/recipients be released for commercial or political purposes.[4]

1425.10.00 RELEASE OF CONFIDENTIAL INFORMATION

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[2] 42 CFR 435.905
[3] 42 CFR 435.905
[4] IC 12-14-22-8

Sections 1425.10.05 through 1425.10.15 describe circumstances in which confidential information may be released.

1425.10.05 Release of Confidential Information to the Individual

Upon request of an applicant/recipient and/or his authorized representative for the examination of his case record, all case information pertaining to that individual is to be made available excluding recorded telephone conversations (see below). (f5) Individuals who request copies of case material may be charged a fee per page (not to exceed the actual cost of copying) by the Local DFR Office.

Upon request of an applicant/recipient and/or his authorized representative for the examination of a recorded telephone conversation, the recorded telephone conversation shall be made available within a reasonable amount of time. In making this request, the applicant/recipient and/or his authorized representative must provide the date and time of the telephone call and the phone number from which the call was made. Individuals who request a copy of this recording may choose to receive the copy via email or on a disc at the individual's expense, or, request a transcript of the recording. The requesting individual is advised that additional time is required to prepare a transcript. Further, the requesting individual is advised that preparation of a transcript can be costly and the requesting individual is responsible for that cost.

When a hearing has been requested, federal regulations (f6) mandate that "the claimant, or his representative, will have adequate opportunity to examine the contents of his case file and all documents and records to be used by the agency at the hearing at a reasonable time before the date of the hearing as well as during the hearing".

1425.10.10 Release of Information to Third Parties

Unless permitted in one of the following sections, the release of agency information requires a statement signed by the applicant/recipient, authorizing the Local Office to release the information to the requesting agency or individual.[5] This written authorization must specify the scope of information the Local Office is authorized to release, the specific agency or individual to whom the information is to be released, and the

[5] 42 CFR 431.306

period of time for which information is to be released.[6] Authorizations should be preserved in the case file.

1425.10.10.05 Release of Confidential Information without Consent

Confidential information may be released without the applicant's/recipient's permission for purposes directly connected with:

The administration of the SNAP, TANF, Children and Family Services, IMPACT, Child Support, Medicaid, Title XX, and Federal Supplemental Security Income (SSI) programs (such purposes include establishing eligibility, determining the amount of assistance, and providing services);

Any investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of any of the above programs; or

Any audit or similar activity (for example, a review of expenditure reports or a financial review) conducted in connection with any of the above programs by any governmental entity which is authorized by law to conduct such audit or activity.

1425.10.10.20 Issuance of Subpoena

In the event of the issuance of a subpoena for the case record or for a Local Office representative to testify concerning an applicant/recipient, the attorney for the FSSA is to immediately be informed of this fact. The attorney should make a determination of the appropriateness of releasing the information and, where appropriate, bring to the court's attention the statute and regulation regarding confidentiality. When information is to be made available to any person under compulsory legal process, the DFR should make reasonable efforts to furnish prior notice to the client regarding the release.

1425.10.15 Release Of Medicaid Numbers To Providers (MED)

Medicaid providers are encouraged to ask all recipients who request medical services to show a valid Hoosier Health Card (Medicaid Card) at the time the service is rendered. The provision of the Hoosier Health Card facilitates the payment authorization process.

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[6] 470 IAC 2.1-3-1

1425.10.15.05 Retroactive or Emergency Services

Providers, who render services during periods immediately prior to the determination of Medicaid eligibility or to persons in emergency situations, may experience difficulty in billing the Medicaid program as they may never have the opportunity to see a valid Hoosier Health Card. When verification is needed from the DFR, the provider must submit a written request to obtain a valid Medicaid Recipient I.D. number. Medicaid Recipient I.D. numbers are not to be given over the telephone.

The written request from the provider must include the following information:

Recipient's name;

Recipient's Social Security number;

Recipient's address;

Recipient's date of birth; and

Date the service was given.

Once the DFR has verified that the patient is (or was on the date of service) an eligible Medicaid recipient, then a written response is to be given to the provider identifying the recipient's name, Medicaid Recipient I.D. number, and third party liability information, where applicable. The DFR must include the recipient's name exactly as it appears on the Medicaid enrollment/eligibility file. Since the Medicaid contractor must have the above elements for processing provider claims, the DFR must take care in providing accurate information.

The DFR should also provide written information to the provider when the individual for whom a Medicaid Recipient I.D. number is requested is found to be ineligible for Medicaid currently or at the time the service was rendered.

1425.10.15.10 Validation of Correct Medicaid Number (MED)

Occasionally a Medicaid provider may view the card, but miscopy the Medicaid Recipient I.D. number. In these instances, the provider should make every effort to obtain the correct number from the recipient. If such efforts are unsuccessful, the provider may write to the DFR requesting the correct number. The DFR should ask the provider to include in the written request

the name of the recipient and the erroneous Medicaid Recipient I.D. number.

The procedures outlined here and in the preceding subsection must be applied consistently to all Medicaid providers.

1430.00.00 PROTECTED CASES

Protected cases are those cases which have a greater need for security protection as a result of the relationship between the applicant/recipient and one or more of the agency's staff members. Situations requiring a protected case include but are not limited to:

Cases which include an agency staff member;

Cases which include an individual who is related by blood or marriage to an agency staff member; or

Cases which include an individual who is a close friend of an agency staff member.

Once it is determined that a case needs to have protected status it must be assigned to a worker who has no familial or personal relationship to any of the individuals in the case. A relative or close friend may not perform any of the interview or eligibility functions needed to support the protected case or a case that meets the above criteria but has never received protected status.

It may be difficult to discern that a case needs protection until a problem exists. This may be avoided by workers reporting potential conflicts to their supervisors as soon as they are aware of them.

Workers who access the agency's records pertaining to their family and friends are violating the client's right to confidentiality and the agency's security agreement. Violators may be subject to appropriate disciplinary action.

Any hard copy or electronic case file material should also be maintained at a location which is inaccessible to staff who have no responsibility for the case. This is necessary to ensure that confidentiality is maintained.

1432.00.00 ADA/REHABILITATION ACT POLICY

The purpose of Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) is to protect disabled individuals and individuals who have a relationship or association with a disabled person from discrimination based upon the disability in participation of or obtaining benefits and services which they are otherwise qualified to receive. DFR does not discriminate against individuals with disabilities, as defined by Section 504 and/or the ADA.

1432.05.00 LEGAL BASIS OF THE ADA/REHABILITATION POLICY

The legal basis for prohibition against discrimination of disabled individuals is Section 504, and the ADA. As a recipient of federal funds under the Medicaid program, DFR is subject to Section 504 and its implementing regulation promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Part 84. As a state agency providing social services, DFR is subject to the ADA and implementing regulations promulgated by the U.S. Department of Justice, 28 CFR Part 35.

1432.05.05 Accommodations for the ADA/Rehabilitation Act

It is DFR’s policy to provide reasonable accommodations by furnishing individuals with disabilities appropriate auxiliary aids and services where necessary to afford those individuals an equal opportunity to participate in and enjoy the benefits of DFR’s programs and services for which they are otherwise qualified to receive.

DFR provides primary consideration to the accommodation requests of individuals with disabilities; however, requests which fundamentally alter the nature of a service, the programs, or create undue financial or administrative burden upon DFR are addressed by the ADA Coordinator to ensure to the maximum extent possible individuals with disabilities who meet the essential eligibility requirements for the receipt of such DFR services have access to participate in and enjoy the benefit of DFR’s programs and services.

1432.10.00 ADA COORDINATOR

DFR has an ADA Coordinator to ensure compliance with Section 504 and the ADA. The ADA Coordinator will provide training, advice, and guidance regarding Section 504 and the ADA. DFR staff and contractors with any specific questions or issues regarding compliance with the Section 504 or ADA provide inquiries to the REM, who will contact the ADA Coordinator. The ADA Coordinator

works with REM to resolve questions or issues, and evaluate the next steps, if any, needed to comply with Section 504 or the ADA.

1435.00.00 NON-DISCRIMINATION

Individuals will not be discriminated against for reasons of age, race, color, sex, disability, religious creed, national origin, (f10) marital status, or political beliefs in any aspect of program administration including, but not limited to:

The acceptance of and responsiveness to a request for assistance;

The eligibility determination;

The issuance of Medicaid cards or benefits;

Fair hearing procedure; or

Any other service offered by DFR.

1435.05.00 NON-DISCRIMINATION INFORMATION

In accordance with federal law and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. If you believe that you have been discriminated against and wish to file a complaint, you may do so by contacting the Department of Health and Human Services, Regional Manager, Region V, Office for Civil Rights, 233 N. Michigan Ave,, Suite 240, Chicago, Illinois 60601. You may call them at (800) 368-1019 or for TDD calls, (800) 537-7697.

The U.S. Department of Health and Human Services is an equal opportunity provider and employer.

In order to inform all individuals of their protection against discrimination and to ensure agency compliance with civil rights laws and policies:

DFR publicizes the procedures for filing state and federal complaints in order to inform individuals of nondiscrimination compliance;

Information regarding the complaint system and an explanation of the procedure must be provided to all individuals immediately upon request.

1440.00.00 COMPLAINTS

An applicant/recipient, or a person acting in his behalf, may register any dissatisfaction he may have regarding DFR action or inaction relative to his entitlement to benefits as well as any mistreatment by agency staff. Complaints may be made to the DFR in person, by telephone or by letter. Some complaints may be directed to the FSSA or other officials of federal or state government. Complaints directed to other governmental offices are normally referred to the DFR for investigation and reply.

All complaints are to be given prompt, courteous, and thorough attention by DFR staff.

1440.10.00 APPLICANT/RECIPIENT COMPLAINTS RECEIVED BY DFR

Upon receipt of a complaint from an applicant/recipient, the DFR is to take immediate steps addressing the problem, including any or all of the following:

Review the situation to determine whether the action taken was in accord with federal and state law and regulation; (If an error occurred, adjusting action is to be taken immediately.)

Promptly interview, telephone, or write the complainant to interpret appropriate aspects of the program;

Provide the complainant with appropriate program leaflets;

Advise the complainant of other programs and community resources that may be able to meet his needs; and advise complainants of their appeal rights and help them to understand the appeal and hearing process. See IHCPPM 4205.00.00 – 4205.10.00 regarding appeal rights.

1440.15.00 COMPLAINTS RECEIVED FROM THIRD PARTIES BY DFR

When the DFR receives a complaint or inquiry on behalf of the applicant/recipient from an individual other than the applicant/recipient, specific information about the applicant/recipient cannot be released without his signed consent. See IHCPPM 1425.00.00 – 1425.10.10.20 regarding confidentiality.

If such inquiry is received without an authorization for release of information, the DFR is to provide general information relative to the nature of the complaint. The complainant should

be advised of the confidentiality of case records and of the necessity of obtaining the applicant's or the recipient's signed consent should the general information not be sufficient.

1440.20.00 COMPLAINTS OF DISCRIMINATION

Prohibited Discrimination

Discrimination in the Medicaid program is specifically prohibited on the basis of race, color, national origin, sex, age, or disability. Individuals with any of these conditions are referred to as 'protected classes'. In addition, federal civil rights laws make it illegal to discriminate against someone who has filed a complaint or has engaged in other Equal Employment Opportunity (EEO) or civil rights activity.

Examples of Discrimination

Discrimination can occur in many different ways. The actions below are examples of discrimination and non-compliance with civil rights requirements when the action is motivated by or results from a policy that disproportionately has an adverse impact on a person or group of people who belong to one of the protected classes:

Denial of an individual or household of any service or benefits provided under the program for which the individual or household is otherwise eligible (for example not providing a translator or other foreign language assistance to a household with limited English proficiency).

Failure of DFR staff to provide the same quality, quantity or manner of service or benefits to all.

Segregation or separate treatment of individuals in any manner related to the application for or receipt of program benefits (separate facilities or separate procedures based on race or another protected status and having noticeably better office space in one part of town versus another where populations include a greater percentage of those with protected status).

Use of criteria or methods of administration that have the effect of defeating or impairing the objectives of any program (imposing additional eligibility criteria on certain individuals).

Selection of sites for offices that exclude or discourage individuals from accessing the benefits of the program such as offices that are not accessible to persons with disabilities or offices located far away from an eligible minority community and not served by public transportation.

Adverse treatment such as rude, unprofessional and unresponsive behavior directed at any individual with protected status.

Evidence of Discrimination

Evidence of discrimination is established when all of the following conditions are met:

A complainant shows that he has been adversely affected by a program decision;

The adverse action is related to a protected condition; and

The person against whom the action was taken is a member of the protected class.

Timeframes for Client to File a Formal Complaint

The complaint must be filed no later than 180 days from the date of the alleged discrimination or when the complainant became aware of the action. If circumstances warrant, the Civil Rights Director of the Department of Agriculture or the Director of Health and Human Services may extend the filing time.

To Whom to Complain

Program applicants or program recipients who feel that they have been discriminated against can complain to the following:

DFR Office Director or Civil Rights Complaint Coordinator;

Family Independence Section of the Division of Family Resources, 402 W. Washington Street, Room W363, Indianapolis, IN 46204, or call (317) 232-4946;

HHS, Region V - Chicago
Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

You may call them at:

Voice Phone (800) 368-1019
FAX (312) 886-1807
TDD (800) 537-7697

Complaint Format

People who feel they have been discriminated against may file a written or verbal complaint. Anyone contacted about a complaint should make every effort to obtain the following information from the complainant:

Name, address, telephone number or other means of contacting the complainant;

Name and location of office where the alleged discrimination took place;

Nature of the incident that led to the complaint;

Protected status (i.e. race, color, national origin, sex, age, religion, political beliefs or disability) that the complainant believes was violated;

Names and contact information of the individuals who have knowledge of the discriminatory action; and

Date of the alleged discriminatory action.

1440.20.05 The DFR and Discrimination Complaints

The DFR's responsibilities related to handling complaints of discrimination are listed below.

1. **Responsible Person**. Each DFR office must handle or designate a responsible staff person(s) to handle civil rights complaints for all public assistance programs. This person(s) will be responsible for receiving and investigating complaints, recommending and monitoring corrective action, and reporting all related information to the Family Independence Section in a timely manner. The DFR office should inform all eligibility staff of the person(s) designated as the Civil Rights Complaint Coordinator.

2. **Public Notification**. The DFR office will provide information at each office location regarding the client's right to file a discrimination complaint.

3. **Right to File**. Anyone has the right to file a complaint of alleged discriminatory action with any of the entities listed under 'To Whom to Complain' in Section 1440.20.00. The local DFR office will accept any complaint alleging discrimination based on race, color, national origin, age, sex, disability, religion, or political beliefs.

4. **Age Discrimination**. All complaints alleging discrimination based on age must be forwarded to: Regional Director, Civil Rights/EEO, USDA, Food and Nutrition Service, Midwest Regional Office, 77 W. Jackson Blvd., 20th Floor, Chicago, IL 60604-3591, within 5 working days of the date received.

5. **Prohibited Actions**. No DFR personnel shall intimidate, threaten, harass, coerce, or discriminate against any individual in order to interfere with his/her right to file a complaint, testify, assist, or participate in any manner with the investigation, proceedings, or hearing.

6. **Acknowledgement**. The DFR, including all local offices, will accept and acknowledge all discrimination complaints filed, whether written, verbal, or anonymous, and inform the complainant of the process for resolving the complaint.

7. **Verbal Complaints**. If a complainant makes an allegation in person or through a telephone conversation and refuses to put it in writing, the DFR employee who receives the complaint must put it in writing. Every effort should be made to obtain sufficient information to look into a complaint of discrimination. See 'Complaint Format' in Section 1440.20.00 for the information that should be sought from the complainant.

8. **Other Federal Agencies**. Whenever a complaint is received that involves another federal agency, it should be referred to that agency and the complainant should be notified of the referral.

9. **Filing Timeframe**. The DFR will accept and investigate all complaints of discrimination filed within 180 days of the date of the action. Complaints over 180 days old should be referred

In accordance with federal law and United States Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. If you

believe that you have been discriminated against and wish to file a complaint, you may do so by contacting the Department of Health and Human Services, Regional Manager, Region V, Office for Civil Rights, 233 N. Michigan Ave,, Suite 240, Chicago, Illinois 60601. You may call them at (800) 368-1019 or for TDD calls, (800) 537-7697.

This will enable the Secretary of HHS to make a decision as to whether there are special circumstances that justify an extension of the 180 day time limit.

10. **Review of Complaint**. Within 5 days from the date the alleged discrimination is reported, review all complaints, and acknowledge them in writing, plan appropriate action, or request additional information from the complainant.

11. **Additional Information Requests**. Additional information should be requested in the following circumstances:

a. The specific assistance program is not identified or cannot be determined from the content of the letter;

b. A protected status is not mentioned (i.e. the complaint says that there has been discrimination but does not say whether it is because of race, color, national origin, or any of the other protected status categories discussed in 1440.20.00;

c. Discrimination or rude treatment is mentioned but no protected status is referenced (as discussed in 1440.20.00 is given.

All requests or additional information must include a postage paid, self-addressed envelope.

12. **Purpose of Investigation**. An investigation should be conducted to substantiate or refute the allegations on all complaints that establish evidence of discrimination. The purpose of the investigation is to determine if the action was taken because someone belongs to a protected class. It is also to determine if there are office or individual caseworker practices that result in people being treated differently because they are members of a protected class or if any policies or practices that seem neutral on their face impact disproportionately on any protected class.

13. **Conducting an Investigation**. The following actions should be taken when conducting an investigation:

a. Interview the complainant. The interview should clarify the issues, attempt to determine why the complainant feels that the action was based on discrimination, and provide other information such as names of witnesses or observation of other circumstances where the discriminatory behavior has occurred. The interviewer should try to get any other information that would be helpful in determining whether the action that was taken was motivated by the fact that the complainant belongs to a protected class.

b. Have the complainant sign an information release form consenting to having his or her name released to local office staff and others who need to be contacted in connection with the complaint. If the complainant refuses to consent to this, have him or her sign in acknowledgement that this may limit the scope of the investigation.

c. Interview other applicants and/or participants who have knowledge of the alleged incident.

d. Interview other applicants and/or participants who belong to the same protected class as the complainant to determine if they have experienced similar or different treatment.

e. Interview other applicants and/or participants who do not belong to the same protected class as the complainant to determine if they have experienced similar treatment.

f. Interview DFR staff to see if they recall the particular incident and why it occurred.

g. Review case files to determine what occurred in the complainant's case. As appropriate, review other case files to determine if similar actions were taken.

h. Contact local community organizations to determine if they have received similar complaints or if they are aware of any alleged problems at the DFR, including in the local office.

14. **Discontinued Investigation**. An investigation may be discontinued under the following circumstances:

a. The complainant indicates that the discrimination did not occur.

b. The complainant indicates that he understands how and why the case was handled the way it was and no longer thinks it was because of discrimination.

c. The complainant indicates that he no longer wishes to pursue the complaint or withdraws the complaint. In these situations it is important to make sure that the complainant is not being coerced or pressured to drop the complaint.

15. **Continued Investigation**. Even if a complainant does not wish to continue pursuing the complaint, the DFR representative should continue the investigation if he or she believes that further action may be necessary based on the available information.

16. **Draft Decision Letter**. The DFR will review and evaluate the facts gathered during the investigation and draft a decision letter informing the complainant of the findings and of completion of the investigation and any follow up action that will be taken based on the findings. The draft should contain the following information:

a. A description of the allegation;

b. The scope of the investigation;

c. Facts and information obtained that refute or support the allegation;

d. A closing statement summarizing the decision and the basis on which the determination was made; and

e. A statement explaining the complainant's right to appeal the decision by sending an appeal to: **HHS**, **Region V – Chicago,** Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. Voice Phone (800) 368-1019, FAX (312) 886-1807, TDD (800) 537-7697.

The draft decision letter must be sent to Family Independence Section for review. Included with the draft decision letter should be a written report containing a summary of the findings of the investigation and a summary of each interview.

17. **Probable Non-Compliance**. When it is determined that a local DFR employee or office has failed to follow a civil rights requirement or is engaging in practices that adversely impact disproportionately on a protected class, the finding of an investigation should indicate 'probable non-compliance.' In these instances, the following steps should be taken:

a. The DFR should make every effort to come into compliance with civil rights requirements.

b. The decision letter must indicate all steps taken to comply with civil rights requirements.

c. The decision letter should also indicate any corrective actions taken to correct benefits.

d. The effective date of the 'probable non-compliance' is the date of the completed investigation.

e. Within 60 days of the date of 'probable non-compliance', steps must be taken to achieve voluntary compliance with civil rights requirements.

1440.20.10 The Family Independence Section and Discrimination Complaints

The Family Independence Section’s responsibilities in resolving complaints of discrimination are described below:

1. Complaint is received. Attempt to get as much information as possible as described in Section 1440.20.00 under '**Complaint Format**'.

2. If the complaint alleges discrimination by a specific worker, or refers to one incident (and there is no allegation of or reason to believe that there is a policy or practice in the office that may be discriminatory), refer the complainant to the appropriate DFR State Eligibility Manager and Regional Manager within one day after receipt.

3. If the complaint alleges widespread discrimination or discriminatory practices in the local office, arrange to have someone from Family Independence Section go to the local office to investigate the allegation. The investigation would be conducted in a manner similar to the procedures described in Section 1440.20.05, but more emphasis would be put on contacting other applicants and

recipients of the same protected class as the complainant to see if they had experienced similar treatment. These cases would also be handled in the same timeframes described under local office procedures.

4. Acknowledge receipt of the complaint to the complainant in writing within 5 days after receipt.

5. Review the draft of the decision letter prepared by the local DFR office or Family Independence Section staff after the investigation is completed. Determine if the investigation was thorough and whether appropriate action was taken.

6. If all of the information is complete and the decision is in keeping with stated findings, forward the report to the appropriate federal regional office.

7. Instruct the DFR to forward a copy of the final decision letter to the complainant.

8. If an investigation was not conducted, review the DFR's written report to determine if the reason(s) for not conducting an investigation are acceptable.

9. Follow up on all findings of 'probable non-compliance' to insure that corrective actions have been taken and that problems are not recurring.

10. Review discrimination complaint logs to determine if there are any patterns of complaints that may require training or other corrective actions either statewide or in particular project areas.

11. Analyze participation data to determine if there are areas where any protected classes appear to be under represented, and take corrective action (such as outreach) as needed.

12. Insure that state agency staff and the DFR understand and receive annual training on civil rights requirements.

1445.00.00 MANDATORY REPORTING OF CHILD ABUSE OR NEGLECT

Indiana law requires any individual who has reason to believe that a child is a victim of child abuse or neglect to make a report. A person who knowingly fails to make such a report

commits a Class B misdemeanor. Reports are to be made by contacting the local Department of Child Services or law enforcement agency.

Each local DFR office should have an established policy which addresses how staff is to report suspected child abuse and neglect. Each worker should be aware of this policy and be encouraged to make appropriate reports.

1450.00.00 CASE RECORD MAINTENANCE

The worker is responsible for the maintenance of a complete and accurate case record. (f12) Case records serve the following purposes:

Provides historical information to substantiate DFR action;

Provides essential information about the individual and his current situation to reflect his need for assistance;

Helps to ensure continuity of service by the DFR and/or proper referral to other needed resources;

Prevents needless repetition of fact gathering;

Provides material for research and statistical purposes;

Provides material by which agency policies, practices, and standards of performance can be substantiated and evaluated; and

Is the basis for the state's payment to or on behalf of an AG.

1450.10.00 CONTENT OF CASE FILE

The electronic copy eligibility case file must contain all signed application forms necessary to support the eligibility determination, collateral sources of verification, and correspondence.

There is no mandatory requirement as to how material is to be arranged in the eligibility case files. However, it is important that the method adopted by the DFR or worker be understood and consistently used.

Information in the file(s) should be consistent with information entered into the ICES system.

At a minimum, case records must contain the following information:

Current and previous Self-Sufficiency plans

Copies of referral forms to service providers and/or other organizations;

Copies of appointment notices or documentation of appointments if scheduling was done manually; and

Contracted service providers are also to maintain case files in accordance with their contracts.

Case notes should be kept on comment screens to document the specific barriers participants face and their resolution; contacts between participant, DFR, and contracted service provider; and any other pertinent information.

1450.15.00 RETENTION OF CASE RECORDS

Hard or electronic copy case records are not to be taken from the DFR except for official use by employees or for use by proper authority upon court order. Receipts should be made and acknowledged in such cases and proper follow-up should be made to ensure the return of the case records to the file.

1450.20.00 RETENTION OF DOCUMENTS WITHIN THE CASE FILE

Most case records are to be maintained for three years. The three year period starts at different times for different documents. The following is the list of documents that must be retained for the entire life of the case and three years following the date on which the eligibility or claims collection case was discontinued:

Application;

Interview guide;

Combined application form used for application actions;

Medical information;

Absent parent information;

Assignment of rights forms;

Court records;

Legal agreements;

Records establishing overpaid benefits and/or fraud;

Social Security Numbers;

Birth and death records;

Citizenship records

Other case file records must be retained for a three year period beginning with the effective date of the action it supports. Those records include but are not limited to:

Budget forms;

Income and expense records used to support the eligibility determination and benefit calculation;

Notices;

Hearing decisions;

Benefit issuance records not related to overpaid or underpaid benefits.

Inactive case records may also be preserved during the life of the individual so long as they may be needed for repayments on existing claims.

1450.20.05 Retention of Documents within the Case File

Records of a deceased recipient may be retained as long as necessary for filing claims for recovery against the estate.

1455.00.00 DESTRUCTION OF CASE MATERIAL

All case file materials must be maintained for review and audit purposes in accordance with the retention guidelines presented previously.

Before destroying case file records it will be important to ensure that the record has lost relevance for all the programs in which the case members participated.

When case records have been inactive for three years, a request for record destruction is submitted to the Archives Division, Commission on Public Records, with a representative sample of

three cases for the year. Upon approval, the other inactive case records may be destroyed.

1455.05.00 REMOVAL OF EXTRANEOUS MATERIAL FROM CASE RECORDS

The periodic removal of extraneous material from the case record assists in case management. All material which supports the current eligibility determination must be retained. Examples of material to be retained are:

Applications,

Medical information,

Medical expense information,

Child support information,

Assignments,

Agreements, and

Overpayment information.

1600.00.00 CATEGORIES OF ASSISTANCE

1600.05.00 MEDICAID ELIGIBILITY CATEGORIES SUMMARY

1610.00.00 MEDICAL ASSISTANCE FOR THE AGED, BLIND & DISABLED (MED 1, MED 4)

1610.02.00 SSI ELIGIBLE INDIVIDUALS (MED 1)

1610.05.00 AGED INDIVIDUALS (MED 1)

1610.10.00 BLIND INDIVIDUALS (MED 1)

1610.20.00 DISABLED INDIVIDUALS (MED 1)

1610.25.00 RCAP ELIGIBLE INDIVIDUALS (MED 1)

1610.26.00 EMPLOYEES WITH DISABILITIES (MED 1)

1610.30.00 QUALIFIED MEDICARE BENEFICIARY (MED 4)

1610.35.00 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (MED 4)

1610.40.00 QUALIFIED DISABLED WORKER (MED 4)

1610.45.00 QUALIFIED INDIVIDUALS (MED 4)

1610.50.00 PREGNANT WOMEN WHOSE INCOME INCREASES (MED 1, 4)

1620.00.00 HOOSIER HEALTHWISE (MED 3)

1620.05.00 LOW INCOME PARENTS / CARETAKERS

1620.05.15 Transitional Medical Assistance

1620.35.00 CHILDREN AGE 19 or 20 (MED 3)

1620.35.05 Native American/Alaska Native HIP 2.0 (MED 3)

1620.36.00 HIP State Plan Plus (MED 3)

1620.37.00 HIP Basic-State Plan (MED 3)

1620.38.00 HIP State Plan PLUS with Co-pays (MED 3)

1620.39.00 HIP Regular Plan Plus (MED 3)

1620.39.05 HIP Regular Basic (MED 3)

1620.40.00 CHILDREN IN PSYCHIATRIC FACILITIES (MED 3)

1620.45.00 REFUGEE MEDICAL ASSISTANCE (MED 2)

1620.50.00 PREGNANT WOMEN - FULL COVERAGE (MED 3)

1620.60.00 CHILDREN UNDER AGE 1 (MED 3)

1620.65.00 CHILDREN AGE 1 - 5 (MED 3)

1620.70.00 CHILDREN AGE 6 - 18 (MED 3)

1620.71.00 CHILDREN AGE 1 - 19 (MED 3)

1620.72.00 CHILDREN'S HEALTH PLAN (MED 3)

1620.73.00 FOSTER CARE INDEPENDENCE

1610.74.00 FORMER FOSTER CHILDREN

1620.75.00 NEWBORNS

1620.80.00 FAMILY PLANNING SERVICES

1621.00.00 BREAST AND CERVICAL CANCER TREATMENT SERVICES

1600.00.00 CATEGORIES OF ASSISTANCE

This chapter of the manual provides information regarding the Medicaid and Hoosier Healthwise program. It also defines each specific Medicaid category under which a person/family can qualify. Additionally, it explains the scope of coverage offered under each category.

The Medicaid program has categorical eligibility requirements which must be met in order to receive assistance. These requirements are discussed in detail in Chapter 2400 - Non-Financial Eligibility Requirements.

The main sections in this chapter are:

Categories of Assistance (Section 1600);

Medical Assistance for the Aged, Blind, & Disabled (Section 1605);

Hoosier Healthwise (Section 1610).

1600.05.00 MEDICAID ELIGIBILITY CATEGORIES SUMMARY

There are 35 categories under which individuals may be eligible for Medicaid coverage. The method used to determine income eligibility (Modified Adjusted Gross Income-MAGI/non-MAGI), the type of coverage (traditional fee-for-service or managed care), and the scope of the benefits provided all vary based on the category under which individuals are eligible. (See Chapters 3200 and 3400 for an explanation of MAGI methodology).

The following table lists all of the Medicaid coverage categories, eligibility criteria for each category, the type of benefit package provided, and whether MAGI methods are applied to determine income eligibility.

Aid Category	Eligibility Criteria/Description	Benefit Package	MAGI applies
MA SI: SSI Recipients	-Receive SSI benefits	Hoosier Care connect (HCC)or Traditional Medicaid Fee-for-Service (FFS)	N
MA X: Newborns	-Born to mother on Medicaid -Age: 0-1 -No FPL Standard	Hoosier Healthwise (HHW) Package A	N
MA Y: Children	-Age: 0-1 -Up to 208% FPL	HHW Package A	Y
MA Z: Children	-Age: 1-5 -Up to 141% FPL	HHW Package A	Y
MA 2: Children	-Age: 6-18 -Up to 106% FPL	HHW Package A	Y
MA 9: Children—MCHIP	-Age: 1-5 141% to 158% FPL -Age 6-18 106% to 158% FPL	HHW Package A	Y
MA10: Children-SCHIP	-Age: 0-1 208% to 250% FPL -Age: 1-18 158% to 250% FPL	HHW/Package C	Y

	-Children 0-18 who lose Medicaid eligibility due to the elimination of income disregards		
MA 8: Children under 19 with adoption assistance	-Automatically eligible if receiving adoption assistance -No FPL standard	HCC or Traditional Medicaid FFS	N
MA 4: Foster children	-Automatic coverage for foster children All are IV-E MAGI excepted -No FPL standard	HCC or Traditional Medicaid FFS	N
MA 14: Former Foster Children	-Independent Former Foster Care up to age 21 -Ages 18-20 -Up to 210% FPL	HCC or Traditional Medicaid FFS	N
MA 15: Former Foster Children Enrolled in Medicaid as of 18th birthday	-Former foster children enrolled in Medicaid as of 18th birthday. Those not eligible for any other Medicaid coverage. Coverage up to age 26. -Ages 18-25 -No FPL standard.	HCC or Traditional Medicaid FFS	Y
MAGF (Parents/	-Parent or caretaker of	HHW Package	Y

Caretaker Relatives)that have Medicare or receive HCBS Waivers	dependent child(ren) -Up to the MAGI equivalent 1988 AFDC income standards	A	
MAGP(Pregnant Women)	-Pregnant -Up to 208% FPL	HHW Package A	Y
MA E Family Planning	Potential beneficiary cannot be eligible for any other Medicaid category. -No age requirement -Up to 141% FPL	Family Planning Only	Y
MA O: Children 19-21 residing in an inpatient psychiatric facility eligible	-Age: 19-21 -Up to the MAGI equivalent 1988 AFDC income standards	Traditional Medicaid FFS	Y
MA T: Children Age 19 or 20 living with	-Age: 19-20 -Up to the MAGI equivalent 1988 AFDC income standards	HHW Package A	Y

parent or specified relative and has Medicare or receives HCBS Waiver			
MA A: Aged	-Age: over 64 years -Up to 100% FPL (SSI Income Methodology) *effective after 1634 conversion	HCC or Traditional Medicaid FFS	N
MA B: Blind	-No age requirement. -Up to 100% FPL (SSI Income Methodology) *effective after 1634 conversion	Traditional Medicaid FFS	N
MA D: Disabled	-No age requirement -Up to 100% FPL (SSI Income Methodology) *effective after 1634 conversion	HCC or Traditional Medicaid FFS	N
MA 12: Breast and Cervical Cancer	-Diagnosed with breast or cervical cancer through the ISDH BCCP program -Up to 200% FPL	HCC or Traditional Medicaid FFS	N
MADW—MEDWorks MADI—Medically	-Working disabled individual -Countable income up to 350% FPL	HCC or Traditional Medicaid	N

Improved		FFS	
MA R: RCAP Related Coverage	Automatic coverage for RCAP beneficiaries	HCC or Traditional Medicaid FFS	N
MAHL HIP Employer Benefit	Adult – HIP Link -up to 133% FPL	HIP LINK	Y
MANA American Indian/Alaska Native	Adult – HIP PLUS – Native American only (no Co-Pays) -Age: 19-64 -up to 133% FPL	Traditional Medicaid FFS	Y
MAPC HIP PLUS State Plan with co-pays	Adult – HIP PLUS – State Plan with Co-pays -Age: 19 – 64 -Up to 133% FPL	HIP State Plan	Y
MARB HIP Regular Basic	Adult – HIP BASIC (Regular Basic) -Age: 19 – 64 -Up to 100% FPL	HIP Regular Basic	Y
MASB HIP Basic-State Plan	Adult – HIP BASIC – State Plan -Age: 19 – 64	HIP State Plan Basic	Y

	-Up to 100% FPL -Low-income parents and caretaker relatives -TMA eligible individuals -Low-income 19/20 year olds -Individuals who qualify as medically frail		
MARP HIP Regular Plus	Adult – HIP PLUS – (Regular Plus) -Age: 19 – 64 -Up to 133% FPL	HIP Regular Plus	Y
MASP HIP Plus – State Plan	Adult – HIP PLUS – State Plan -Age: 19 – 64 -Up to 133% FPL -Low-income parents and caretaker relatives -TMA eligible individuals -Low-income 19/20 year olds -Individuals who qualify as medically frail	HIP State Plan Plus	Y

MA L: QMB (Qualified Medicare Beneficiary)	-Must be eligible for Medicare -Up to 150% FPL	Medicare Parts A & B, premium, deductible, and co-insurance	N
MA J: SLMB (Special Low-Income Medicare Beneficiary)	-Must be eligible for Medicare -Between 150% - 170% FPL	Medicare Part B Premium	N
MA I: Qualified Individual	-Must be eligible for Medicare -Between 170-185% FPL	Medicare Part B Premium	N
MA G: QDW (Qualified Disabled Worker)	-Must have lost free Medicare Part A coverage due to employment status -Up to 200% FPL	Medicare Part A Premium	N
MA F: Transitional Medical Assistance	-Medicaid-enrolled parents, caretaker relatives, and children who lose eligibility due to increased earnings; available for 2 6-month periods. -Up to 185% FPL	HHW Package A	N
MA Q: Refugees	Refugee Medical Assistance (RMA) -Limited to 8 months of	FFS Traditional Medicaid	N

	assistance		

1610.00.00 MEDICAL ASSISTANCE FOR THE AGED, BLIND & DISABLED (MED 1, MED 4)

Medicaid coverage is available to individuals who are aged, blind, or disabled. The scope of coverage varies depending upon the specific category under which an individual qualifies. The categories and scope of coverage are explained in the following sections.

As of April 2015, individuals eligible in MED 1 categories who are not in an institution or on a waiver and who are not eligible for Medicare will be enrolled in Hoosier Care Connect (HCC), a coordinated health care program. Hoosier Care Connect members will have to select a managed care entity (MCE) that will help coordinate care with the member's providers. Care coordination is individualized based on a member's assessed level of need determined through a health screening.

Individuals in MED 1 who are eligible for Medicare and those who reside in institutions or are on a HCBS Waiver will receive Traditional fee-for-service coverage.

1610.02.00 SSI ELIGIBLE INDIVIDUALS (MED 1)

This category is identified in ICES as MA SI.

To be eligible for MA SI Medicaid an individual must receive SSI benefits.

1610.05.00 AGED INDIVIDUALS (MED 1)

This category is identified in ICES as MA A.

To be eligible in this category an individual must be age 65 or older.[1] A person is categorically eligible for MA A beginning with the month he turns age 65.

The full range of Medicaid covered services is available to recipients in the MA A category except for aliens who are eligible for emergency services only.

Prior to June 1, 2014, individuals whose income exceeds the income standard and who meet all other eligibility requirements could qualify for Medicaid under the spend-down provision.

1610.10.00 BLIND INDIVIDUALS (MED 1)

This category is identified in ICES as MA B.

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[1] 42 CFR 435.121; 405 IAC 2-2-1

To be eligible in this category an individual must meet the definition of blindness set forth in State regulation. The definition is the same as that of the SSI program.[2]

Prior to June 1, 2014, individuals whose income exceeds the income standard and who meet all other eligibility requirements could receive Medicaid under the spend-down provision.

The full range of Medicaid covered services is available to recipients in the MA B category, except for aliens who are eligible for emergency services only.

1610.20.00 DISABLED INDIVIDUALS (MED 1)

This category is identified in ICES as MA D.

To be eligible under this category, individuals must be substantially impaired as set forth in the definition of disability in State law.[3]

Prior to June 1, 2014, individuals whose income exceeds the income standard and who meet all other eligibility requirements could receive Medicaid under the spend-down provision.

The full range of Medicaid covered services is available to receipts in the MA D category except for aliens who are eligible for emergency services only.

1610.25.00 RCAP ELIGIBLE INDIVIDUALS (MED 1)

This category is identified in ICES as MA R.

To be eligible for Residential Care Assistance Program - related Medicaid an individual must[4]:

Be approved for Room and Board Assistance (RBA);

Be aged, blind, or disabled. The aged, blind, and disabled requirements for RCAP-related Medicaid are the same as those for RCAP.

The full range of Medicaid covered services is available to recipients in the MA R category.

1610.26.00 EMPLOYEES WITH DISABILITIES (MED 1)

M.E.D. Works - Medicaid for Employees with Disabilities -

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[2] 42 CFR 435.121; 405 IAC 2-2-2

[3] 405 IAC 2-2-3

[4] 42 CFR 435.234

consists of two categories identified in ICES as MADW and MADI.

A federal law, known as the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIA) added two new optional Medicaid categories designed to remove barriers to employment for persons with disabilities by providing access to health care. Effective July 1, 2002, Indiana's Medicaid Program was expanded to cover these categories with the enactment of P.L. 287-2001.

MADW is the basic MED Works category for individuals who meet the Medicaid definition of disability without regard to the person's employment. MADI is the medically improved category for persons who lose eligibility in the basic category because of an improvement in their medical condition which although is not a medical recovery, is improved to the extent that the Disability definition for the basic category is no longer met.[5]

To be eligible, individuals must be age 16-64. Depending on their income, some MED Works members must pay premiums. All members pay the regular Medicaid co-payments.

1610.30.00 QUALIFIED MEDICARE BENEFICIARY (MED 4)

This category is identified in ICES as MA L.

To be eligible in this category an individual must be entitled to Medicare Part A.[6] There is no other blindness or disability requirement for the QMB category.

Medicaid coverage under QMB is limited to payment of:[7]

The monthly premium for Medicare Part B;

The monthly premium for Premium Hospital Insurance under Medicare Part A for individuals not entitled to free Part A; and

Medicare Parts A and B deductibles and co-insurance.

An individual can be simultaneously eligible for QMB and any other full coverage MA.

1610.35.00 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (MED 4)

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[5] IC 12-15-41; Social Security Act (SSA) 1902(a)(10)(ii)(XV); SSA 1902(a)(10)(ii)(XVI)

[6] SSA 1902(a)(10)(E)

[7] SSA 1905(p)(3)

This category is identified in ICES as MA J.

To be eligible in this category an individual must be entitled to Medicare Part A.[8] There is no other blindness or disability requirement for the Specified Low-Income Medicare Beneficiary (SLMB) category.

Medicaid coverage under SLMB is limited to payment of the Medicare Part B premium.[9]

An individual can be simultaneously eligible for SLMB and any other full coverage MA category.

1610.40.00 QUALIFIED DISABLED WORKER (MED 4)

This category is identified in ICES as MA G.

To be eligible in this category an individual must have lost or will lose premium-free Medicare Part A coverage due to his employment status.[10]

Medicaid coverage under this category is limited to payment of the monthly premium for Medicare Part A.[11]

An individual is not eligible under this category if he is eligible for Medicaid under any other category.

1610.45.00 QUALIFIED INDIVIDUALS (MED 4)

This category is identified in ICES as MA I.

To be eligible in this category, an individual must be entitled to Medicare Part A.[12] There is a capped amount available for QIs each year.

MA I pays the Medicare Part B premium.[13]

An individual eligible under any other Medicaid category cannot be eligible as a QI.

1610.50.00 PREGNANT WOMEN WHOSE INCOME INCREASES (MED 1, 4)

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[8] SSA 1902(a)(10)(E)

[9] SSA 1905(p)(3)(A)(ii)

[10] SSA 1902(a)(10)(E)

[11] SSA 1905(p)(3)(A)(i)

[12] SSA 1902(a)(10)(E)

[13] SSA 1905(p)(3)

When a pregnant woman receives an increase in income, her Medicaid eligibility must continue without change.[14] She remains eligible in the same category regardless of an income increase. If she were to be found eligible under MAGP, she may choose have her eligibility switched to that category.

1620.00.00 HOOSIER HEALTHWISE (MED 3)

Medical coverage is available to certain parents/caretakers, infants and children, former foster children up to age 21, former foster children ages 18 to 26 who were enrolled in Indiana Medicaid on their 18th birthday, and pregnant women under the Hoosier Healthwise Program. Additionally, medical coverage under the Healthy Indiana Plan (HIP 2.0) is available to adults between ages 19 and 64, effective February 1, 2015.

Hoosier Healthwise is funded by Title XIX-Medicaid and by the Children’s Health Insurance Program-Title XXI and is composed of three benefit packages. Coverage under these packages is generally comprehensive, with a few exceptions, which are noted below. The packages are as follows:

Package A (Standard Plan) provides comprehensive healthcare coverage to some eligible parents and other caretaker adults , infants and children, former foster children ages 18 to 26 who were enrolled in Indiana Medicaid on their 18th birthday, and pregnant women. There are no premiums or co-payments for children under age 18. ICES category codes under this package are, MA F, MAGF, MAGP, MA T, MA X, MA Y, MA Z, MA 2, MA 9, and MA 15.

Package C (Children's Health Plan) provides comprehensive healthcare coverage to children under age 19. Although comprehensive, some services are subject to limits and some services covered under Package A are not covered under Package C. This package includes a premium (based on income and family size) and co-payments for certain services. The ICES category code under this package is MA 10.

Package E (Emergency Services Only) provides coverage for serious medical emergencies to some immigrants and certain visitors to the U.S. who meet all other categorical and financial requirements. There is no specific ICES category for this benefit package. ICES designate whichever category is appropriate to the individual's circumstances.

Children who are wards of the State, children receiving adoption assistance, foster children and former foster children (MA 4, MA 8, MA 14, MA 15) may opt out of Package A and voluntarily enroll in Hoosier Care Connect, a

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[14] 1902(e)(6)

coordinated care program (see 1610.00.00 for a description of the Hoosier Care Connect program).

HIP 2.0 is funded through a Section 1115 demonstration waiver with the CMS, Indiana's existing cigarette tax revenues, and from a Hospital Assessment Fee.[15] HIP 2.0 coverage is available to adults aged between 19 and 64 years, who do not have Medicare, have income equal to or less than 133% of the FPL, and are not eligible for any other Medicaid category excluding:

- Low-Income parents / caretakers;
- Transitional Medical Assistance; &
- Low-Income 19/20 year olds that do not reside in a psychiatric facility.[16]

Under HIP 2.0, a person will qualify for either State Plan Benefits or Regular Plan Benefits. Within each plan exists Plus and Basic. Please, refer to IHCPPM 3500.00 to see the difference in benefits and cost sharing between HIP Plus and HIP Basic. To receive coverage under either HIP State Plan Plus (MASP) or HIP Regular Plan Plus (MARP), a person must make financial contributions towards a Personal Wellness and Responsibility (POWER) account that is equal to 2% of their income but can be no less than $1 per month regardless of a person's income. To receive coverage under either HIP State Plan Basic (MASB) or HIP Regular Plan Basic (MARB), the income standard is 100% of the FPL, unless a person qualifies for transitional medical assistance, and the person fails to make financial contributions toward a POWER account.

HIP State Plan Plus (MASP) benefits, refer to **3520.10.00**
HIP State Plan Basic (MASB) benefits, refer to **3520.15.00**
HIP Regular Plan Plus (MARP) benefits, refer to **3520.25.00**.
HIP Regular Plan Basic (MARB) benefits, refer to **3520.30.00**

A woman who is a member of any HIP 2.0 category who becomes pregnant and reports the pregnancy to the DFR will no longer have to make any required co-pays under HIP Basic or financial contributions to a POWER account under HIP Plus. Additionally, HIP members who become pregnant will be automatically switched to MAGP if they are pregnant at redetermination. If their due date is prior to their redetermination they can opt to remain in their HIP category during the course of the pregnancy.

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[15] http://www.in.gov/fssa/hip/files/HIP_2.0_Financing_Overview.pdf

[16] 405 IAC 10-4-1.

1620.05.00 LOW INCOME PARENTS / CARETAKERS

This category is identified in ICES as MAGF.

The category consists of parents and caretaker relatives of dependents less than 18 years of age. A parent includes biological, adopted, and step-parent. For the definition of a caretaker relative, please, refer to IHCPPM 2420.00.00.

1620.05.15 Transitional Medical Assistance

This category is identified in ICES as MA F. Although MA F is considered Hoosier Healthwise, MA F is not considered a MED 3 category. Nor is it considered MED 2. Please, refer to IHCPPM Chapter 3800 for more specific information on MA F.

Up to 12 months of full medical coverage under the Transitional Medical Assistance (TMA) category is available to parents/caretaker relatives who have been discontinued from or are denied MAGF because of the earnings of a caretaker relative who was eligible for and received MAGF in Indiana in three of the preceding six months. TMA is also available to certain dependents. Please, refer to Chapter 3800. (NOTE: MAGF eligibility in the retro period for new application counts towards the three of six months.) To qualify for TMA, the AG must be ineligible for MAGF for one of the following reasons:[17]

> New or increased earnings of a parent or caretaker relative who is a participating member of the AG;
>
> New or increased earnings of a MA sanctioned parent or caretaker relative who is a non-participant due to a sanction; or

The effective date of TMA corresponds to the date of discontinuance or the date, on which the AG first becomes ineligible, whichever is earlier.[18]

1620.35.00 CHILDREN AGE 19 or 20 (MED 3)

This category is identified in ICES as MA T.

To be eligible in this category a child must be either age 19 or 20, live in the home of a parent or caretaker relative, and meet the MAGF income requirements.[19] A parent includes biological, adopted, and step-parents. For the

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[17] SSA 1925

[18] 1902(e)(1)(A)

[19] 42 CFR 435.222

definition of a caretaker relative, please, refer to IHCPPM 2420.00.00

1620.35.05 Native American/Alaska Native HIP 2.0 (MED 3)

Native Americans and Alaska Natives who qualify for HIP 2.0 will automatically be placed into HIP State Plan. Additionally, Native American and Alaskan Native HIP members will not be required to make any financial contributions to a POWER Account or make any required co-pays.

If a Native American and Alaska Native chooses to be covered by fee-for-service, rather than managed care, the person will then have eligibility under the MANA category.

1620.36.00 HIP State Plan Plus (MED 3)

This category is identified in ICES as MASP.

To be eligible in this category an adult must be at least 19 years of age and less than 65 years of age and have income equal to or less than 133% of the FPL, unless the person qualifies for TMA. The upper age limit is waived for Low-Income Parent/Caretakers. A potential member may not be enrolled in or eligible for enrollment in the federal Medicare program. Participants included are:

- Low Income parents and caretaker relatives;
- TMA eligible individuals;
- low-income 19/20 year olds; or
- individuals that qualify as medically frail.[20]

HIP Plus State Plan requires the participant to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department. MASP members, who become pregnant or are American Indian/Alaska Natives, are not required to make a financial contribution to a POWER Account.

1620.37.00 HIP Basic-State Plan (MED 3)

This category is identified in ICES as MASB.

To be eligible in this category an adult must be at least 19 years of age and less than 65 years of age (upper age limit is waived for Low-Income Parent/Caretakers). They must have income at or below 100% FPL, unless the person

[20] 405 IAC 10-4-1

qualifies for TMA. They will be enrolled in HIP Basic State Plan if they fail to make financial contributions toward a POWER account and fall into one of the following groups:

- low-income parents and caretaker relatives;
- TMA eligible individuals;
- low income 19/20 year olds; or
- individuals that qualify as medically frail.[21]

MASB members who become pregnant will no longer be required to make co-pays for services throughout their pregnancy as well as the 60-day post-partum period.

1620.38.00 HIP State Plan PLUS with Co-pays (MED 3)

This category is identified in ICES as MAPC.

- To be eligible in this category an adult must have been eligible under MASP, while being determined medically frail, having income between 100% FPL and 133% FPL, and fail to make ongoing financial contributions to a POWER account.
- If an MAPC member's income decreases to below 100% FPL, they will be moved into the State Plan Basic category.
- MAPC members who become pregnant will no longer be responsible for any cost-sharing to receive services throughout their pregnancy as well as the 60-day post-partum period.

1620.39.00 HIP Regular Plan Plus (MED 3)

- This category is identified in ICES as MARP.
- To be eligible in this category an adult must at least 19 years of age and less than 65 years of age. A potential member may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible for any other Medicaid category.[22] The income standard is 133% FPL. HIP Regular Plus requires the participant to pay a monthly POWER Account contribution

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[21] 405 IAC 10-4-1

[22] 405 IAC 10-4-1

(PAC) and only has co-payments on non-emergency use of the hospital emergency department.

- MARP members who become pregnant are not required to make a financial contribution to a POWER Account throughout their pregnancy as well as the 60-day post-partum period.

1620.39.05 HIP Regular Basic (MED 3)

This category is identified in ICES as MARB.

To be eligible in this category an adult must be at least 19 years of age and less than 65 years of age with income at or below 100% FPL and will be enrolled in HIP Basic after failing to make financial contributions to a POWER account. A potential member may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible under any other Medicaid category.[23] The HIP Basic benefit package applies co-payments to services. The ''HIP Basic'' Plan maintains essential benefits, but incorporates reduced benefit coverage, has a more limited pharmacy benefit, does not include dental, and does not include vision benefits.

MARB members who become pregnant are no longer required to make co-pays for services throughout the rest of their pregnancy as well as the 60-day post-partum period.

1620.40.00 CHILDREN IN PSYCHIATRIC FACILITIES (MED 3)

This category is identified in ICES as MA O.

To be eligible in this category a child must be under age 21, an inpatient of a Medicaid certified psychiatric facility, and meet MAGF eligibility requirements (except the age 18 limitations) as if he were living at home.[24] A recipient who is approved for MA prior to his 21st birthday remains eligible until age 22 as long as he remains in the psychiatric facility.

1620.45.00 REFUGEE MEDICAL ASSISTANCE (MED 2)

This category is identified in ICES as MA Q.

Individuals receiving or would be eligible for receiving Refugee Cash Assistance (RCA) are eligible for Medicaid under this category. Additionally, if a refugee is ineligible for Medicaid under any other category, he can be eligible for

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[23] 405 IAC 10-4-1

[24] IC 12-15-2-9; 42 CFR 435.222

Refugee Medical Assistance (RMA) under the spend-down provision if his income exceeds the RCA standard.[25]

A MA Q AG which becomes ineligible for assistance due solely to new or increased earnings may receive continued Medicaid until the end of the eight month eligibility period. In case where a member of the AG obtains private medical coverage, it is imperative to code it properly on AEFMC. A refugee may not receive Medicaid under this provision once his initial eight month eligibility period ends

1620.50.00 PREGNANT WOMEN - FULL COVERAGE (MED 3)

This category is identified in ICES as MAGP.

To be eligible in this category a woman must have an attestation of pregnancy and have income less than or equal to 208% of the Federal Poverty Level, calculated with MAGI methodology. There are no resource eligibility requirements for this coverage category.

If a pregnant woman receiving coverage under the MAGP category receives an increase in income which causes her countable income to exceed the standard, she remains eligible for pregnancy-related coverage through the end of the 60 day postpartum period, as explained in Section 1610.50.00.[26]

The 60 day postpartum period is available to a woman who:

> Applies for Medical Assistance while pregnant and is eligible on the date pregnancy ends (by birth or other means); or
>
> Applies for Medical Assistance after the child is born (or the pregnancy is terminated by other means) and is found to have been eligible for Medical Assistance in the application month or one of the three months of the retroactive period.

The 60 day period begins on the last day of pregnancy and extends through the end of the month in which the last day of the 60 day period ends.

During the 60 day period, Medicaid coverage is limited to payment of pregnancy-related and postpartum medical care.

1620.60.00 CHILDREN UNDER AGE 1 (MED 3)

This category is identified in ICES as MA Y.

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[25] 42 CFR 435.406

[26] SSA 1902(e)(5); 42 CFR 435.170

To be eligible in this category a child must be under the age of one.[27]

The income standard for this category is less than or equal to 208% of the Federal Poverty Level and there are no resource requirements.

1620.65.00 CHILDREN AGE 1 - 5 (MED 3)

This category is identified in ICES as MA Z.

To be eligible in this category a child must be at least one year of age, but not six years old. Income standards are based on 141% of the Federal Poverty Level and there are no resource requirements.[28]

1620.70.00 CHILDREN AGE 6 - 18 (MED 3)

This category is identified in ICES as MA 2.

To be eligible in this category a child must be at least age six (6), but under age nineteen (19).[29] The income standard is based on 106% of the Federal Poverty Level and there are no resource requirements.

1620.71.00 CHILDREN AGE 1 - 19 (MED 3)

This category is identified in ICES as MA 9.

This category is an eligibility expansion effective July 1, 1998. It is funded under the federal "Children's Health Insurance Program" (CHIP) enacted in the Balanced Budget Act of 1997. To be eligible in this category:

- A child must be age 1 through age 5 with income between 141% - 158% of the federal poverty level; or

- Age 6 through 18 with income between 106% - 158% of the federal poverty level, and not eligible in any other Medicaid category.

There are no resource requirements.

1620.72.00 CHILDREN'S HEALTH PLAN (MED 3)

This category of Hoosier Healthwise is designated as MA 10 on ICES.

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[27] SSA 1902(a)(10)(A)(i)(IV)

[28] SSA 1902(a)(10)(A)(i)(VI)

[29] SSA 1902(a)(10)(A)(i)(VII)

Effective January 1, 2000, comprehensive medical coverage, under an eligibility expansion funded through the federal Children's Health Insurance Program (CHIP), is available to Indiana children under the age of nineteen.[30] Under this category, also known as Package C, the income limit was 200% of the federal poverty guidelines at implementation and increased to 250% of the federal poverty guidelines, as of October 1, 2008. (Refer to IHCPPM Section 3010.30.00). There are no resource requirements. Coverage is provided only to children who are ineligible for all other categories of Hoosier Healthwise. MA 10 is, therefore, last in the ICES Medical Hierarchy. Please note, however, that a child who fails MA 9, but who would be eligible for MA D or MA B with a spend-down, could receive MA 10, if otherwise eligible. (Refer to IHCPPM Section 2035.30.10).

Unlike the other Hoosier Healthwise categories, MA 10 has cost-sharing requirements. There are premiums that must be paid as a condition of enrollment and ongoing eligibility, and there are co-payments for some services. Retroactive coverage is not available under this category. Coverage begins with the month of application. (Refer to IHCPPM Section 2035.60.00).

1620.73.00 FOSTER CARE INDEPENDENCE

This category is identified in ICES as MA 14.

To be eligible under this category, individuals must be 18, 19, or 20 years of age and have been a ward in foster care on their 18th birthday in a state other than Indiana. Income standards are based on 210% of the Federal Poverty Level and there are no resource requirements.[31]

1610.74.00 FORMER FOSTER CHILDREN UP TO AGE 26

This category is identified in ICES as MA 15.

To be eligible under this category, an individual must have been in foster care and enrolled in Indiana Medicaid on his/her 18th birthday and must be 18 through 26 years old.[32]

There are no income standards or resource requirements for this eligibility group.

1620.75.00 NEWBORNS

This category is identified in ICES as MA X.

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[30] IC 12-17.6-3-2

[31] SSA 1902(a)(10)(ii)(XVII)

[32] SSA 1902(a)(10)(A)(i)(IX)

A child born to a woman who was receiving (and eligible for) traditional Indiana Medicaid or any Hoosier Healthwise benefit package except Package C, at the time of the child's birth, is deemed automatically eligible for Medicaid in the Newborn category. Coverage in this category continues for the 12 months from the month of birth. Refer to Sections 2225.10 and 2428.00.

1620.80.00 FAMILY PLANNING SERVICES

This category is identified in ICES as MA E.

Individuals may be eligible under this category when family planning services are requested. There is no age requirement. Income standards are based on 141% of the Federal Poverty Level and there are no resource requirements.

1621.00.00 BREAST AND CERVICAL CANCER TREATMENT SERVICES

This category is identified in ICES as MA 12. To be eligible a woman must be screened and found to be in need of treatment for breast or cervical cancer by the Breast and Cervical Cancer Treatment program (BCCP) and have income equal to or less than 200% of the FPL. In Indiana, the BCCP is administered by the State Department of Health. Alternatively, a woman can receive coverage for treatment under the BCCP Option 3 program if she was diagnosed with breast or cervical cancer, but not screened through BCPP if:

She is between the ages of 18 and 65.

She has income at or below 200% of the FPL.

She is not eligible for Medicaid under any other category.

She has no health insurance that will cover her treatment.

1800.00.00 APPLICATION REGISTRATION

1805.00.00 REQUEST FOR AN APPLICATION

1810.00.00 REQUEST FOR AN INDEPENDENT RESOURCE ASSESSMENT (MED 1)

1815.00.00 INFORMED CHOICE

1820.00.00 INITIAL CONTACT PERSON

1825.00.00 APPLICATION REGISTRATION PROCESS

1825.05.00 COMPLETION OF THE APPLICATION

1825.05.05 Receipt Of A Application

1825.05.15 Individual Clearance

1825.10.00 PERSON WHO SIGNS THE APPLICATION

1825.10.05 Alias

1825.15.00 DATE OF THE APPLICATION

1835.00.00 SCHEDULING THE INTERVIEW (MED 1, 2, 4)

1835.05.10 Applicant Interview (MED 1, MED 2, MED 4)

1835.15.00 DENYING AN APPLICATION WHEN THERE IS NO INTERVIEW

1800.00.00 APPLICATION REGISTRATION

This chapter contains the application registration processes. It includes:

Request for an Application (Section 1805);

Request for an Independent Resource Assessment (MED 1) (Section 1810);

INFORMED CHOICE (Section 1815.00.00);

Initial Contact Person (Section 1820);

COMPLETION OF THE APPLICATION (Section 1825.05.00);

Receipt of an Application (Section 1825.05.00);

Individual Clearance (Section 1825.05.15);

Individual Clearance (Section 1825.05.15);

PERSON WHO SIGNS THE APPLICATION (Section 1825.10.00);

Alias (Section 1825.10.05);

DATE OF THE APPLICATION (Section 1825.15.00);

SCHEDULING THE INTERVIEW (MED 1, 2, 4) (Section 1835.00.00);

Applicant Interview (MED 1, MED 2, MED 4) (Section 1835.05.10);

1805.00.00 REQUEST FOR AN APPLICATION

The Indiana Application for Health Coverage must be accessible to clients at all times during which the office is open. It will also be provided in an on-line version during open office hours and when the office is closed. All reception staff, eligibility workers and those answering telephone calls must inform clients that an application will be accepted when the name and address is completed and the form is signed. No other requirements or

limitations can be placed on the client's right to file an application for Health Coverage. For the Healthy Indiana Plan (HIP), please, refer to Chapter 3500.

Individuals may request assistance in person, by mail, by telephone, or online. If requested, the individual will be referred to our application portal on the FSSA website or may be given or mailed an Indiana Application for Health Coverage. When an application form is provided, assistance in completing the application is to be offered.[1]

Applications will also be received through electronic account transfer from the Federal Marketplace.[2]

Program information must be provided electronically, in print, and orally to all applicants and other authorized individuals who request it, such as parents of dependent children, authorized representatives, certain power-of-attorneys, and legal guardians. Information that must be provided includes[3]:

(1) The eligibility requirements;

(2) Available Medicaid services

(http://member.indianamedicaid.com/programs--benefits.aspx); and

(3) The rights and responsibilities of applicants and beneficiaries.

Such information must be provided to applicants and beneficiaries in plain language and in a manner that is accessible and timely to:

(1) Individuals who are limited English proficient through the provision of language services at no cost to the individual (the language line is 877-261-6608; and

(2) Individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

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[1] 42 CFR §435.908
[2] 42 CFR §435.907
[3] 42 CFR §435.905

Individuals may also receive help with the health coverage application through a Certified Indiana Navigator including Enrollment Center staff.[4] [5]

The individual requesting assistance should be encouraged to file an application the same day the DFR is contacted. The individual is to be informed that prompt filing is important as the date of entitlement is affected by the date the signed application is received by the DFR or the Federal Marketplace.

An individual has the right to apply and the right to have the determination of eligibility made without discrimination because of race, color, sex, age, disability, religion, national origin, marital status, or political belief. An application must be provided without question or delay to any individual requesting assistance without regard to apparent ineligibility.[6]

1810.00.00 REQUEST FOR AN INDEPENDENT RESOURCE ASSESSMENT (MED 1)

An aged, blind, or disabled individual, who becomes institutionalized on or after September 30, 1989 and whose spouse is living in the community, is entitled to a resource assessment without filing a Medicaid application. The request for an independent assessment can be made by either spouse or his representative.

An Independent Resource Assessment should be requested when a spouse enters a long term care facility and anticipates that he may have to apply for Medicaid at a later date.

The assessment establishes the total value of the couple's nonexempt resources on the exact date of admission to the facility so that the "spousal share" can be calculated. The spousal share, or one-half of a couple's combined resources, is a critical element in the Medicaid eligibility determination as it represents the amount of resources, not to exceed the current limit listed in Section 3005.15.00, which can be protected for the community spouse when the institutionalized spouse applies for Medicaid. Refer to Section 2635.10.10.05 which explains the resource assessment determination and the procedures to follow.

The spousal share is determined off-line by the caseworker using the State Form 45919 (R/11-96)/FI 2060 and entered on ARRA. If a

[4] IC 27-19-2-12
[5] IC 27-19-2-3
[6] 42 CFR §435.906

data entry error or mathematical error is discovered, the supervisor can access ARRA and correct the spousal share. The determination cannot be appealed until a Medicaid application is filed.

An Independent Resource Assessment is never done in conjunction with an application. It is only completed when there is no Indiana Application for Health Coverage. When an Indiana Application for Health Coverage is made for an individual residing in long term care and that individual has a spouse in the community, ARAD should be completed just as it is for any other applicant. The resource assessment will then be done on-line during the application entry process. If an Independent Resource Assessment was completed prior to an Indiana Application for Health Coverage, the spousal share will be displayed on AERRA.

1815.00.00 INFORMED CHOICE

ICES is designed around the outreach concept of "informed choice" which provides clients the option to apply for any or all programs (FS, TANF, MA) of assistance in one interview. The household should be informed that each program has specific eligibility requirements that do not apply to the other programs, and that loss of benefits under one program does not always mean that other program benefits will also be lost. It is the obligation of the DFR to provide the individual with sufficient objective information to allow the individual to make an informed choice. Additional programs may be selected by the client during the subsequent interview with the caseworker or at any time the client desires but will require an application to be completed.

1820.00.00 INITIAL CONTACT PERSON

The agency must accept an application from the applicant, an adult who is in the applicant's household, or family, an authorized representative, or if the applicant is a minor or incapacitated, or someone acting responsibly for the applicant.

The individual who makes the initial request for assistance is referred to as the Initial Contact Person (ICP) for the application. The ICP completes the application registration process and signs the Indiana Application for Health Coverage. The ICP may or may not be seeking assistance for himself and may or may not be the interviewee during the application interview, if applicable. Refer to Section 2005.05.10 which explains who may be interviewed, if required.

The worker must inform the ICP that information about Rights and Responsibilities are included as an attachment to the Application.

If an interview is required, please, refer to IHCPPM 2005.05.10.

1825.00.00 APPLICATION REGISTRATION PROCESS

Application registration begins the application process for individuals requesting assistance. The purpose of application registration is to:

Gather basic demographic information on the individual(s) for application completion;

Perform individual clearance, statewide clearance, prior contact checks and address inquiries through ICES; Initiate tracking of applications through ICES.

1825.05.00 COMPLETION OF THE APPLICATION

The application process is initiated when either the Initial Contact Person (ICP) requests assistance from the DFR to complete the Indiana Application for Health Coverage or actually submits a complete Indiana Application for Health Coverage with the DFR through the FSSA Benefits Portal (https://www.ifcem.com/CitizenPortal/application.do). The ICP must be given an opportunity to review the information that was recorded and must be given a copy of the information. This application is then signed by the ICP. The application can be printed in either English or Spanish.

The ICP may also elect to take a printed application form from the FSSA Benefits Portal to complete outside the office or the form may be mailed to an individual or family identified by the ICP by having the application printed through the FSSA Benefits Portal. The ICP should be advised that the completed application should be mailed to the FSSA Document Center, brought to the DFR, or faxed to 1-800-403-0864.

An Indiana Application for Health Coverage is considered valid when, at minimum, a name, address, and signature are provided. Individuals without a fixed address (homeless) may use the address of the DFR when applying, if the individual has no other reliable address where she can receive mail. Once the application has been signed, the recorded information supplied by the ICP is not to be changed nor is information to be added.

The date of application is the date on which a signed application is received by the DFR.

1825.05.05 Receipt Of A Application

When a valid application is received electronically, through the mail, by fax, over the phone, or is hand delivered, the date of receipt of the application will be recorded. Inquiry into ICES will be performed to determine the active, inactive, pending, or unknown status of the individual. Refer to Section 1825.05.15 for information regarding individual clearance.

When an invalid application (missing name, address and/or signature) is received through the mail, the screener does not record its receipt. The form is returned to sender with instructions for proper completion. Further, if an outdated application form such as the old FI 2400 or HHW application is received by the DFR, such application should be considered acceptable as long as it meets minimum requirements according to IHCPPM 1825.05.00. However, the individual who submitted the application should be contacted about utilizing the FSSA Benefits Portal to obtain the correct application in the future.

1825.05.15 Individual Clearance

It is imperative to check the client’s name and address via the ICES system in order to identify whether the client has any previous history documented in the ICES system. The check must be performed prior to the clearance process for each and every individual residing at the household address using both name and SSN. The screener must resolve any clearance problems before application registration processing continues. Failure to match someone correctly may lead to multiple records and duplicate benefits.

If the worker does not find a name match in the ICES system and no name or SSN match is found, proceed as follows:

- Worker will start Application Registration in ICES. Demographic information on all household members will be entered as it appears on the application.

If the caseworker does find an exact match for any individual on the application, proceed as follows:

- Worker will start Application Registration in ICES. Demographic information on all household members will be entered as it appears on the application. The screener will

need to review the display that is shown to ensure that all information was entered correctly. For an exact match, the screener can place an “X” in the select column and hit <ENTER>. The next individual will display and the same process is repeated until all individuals have been cleared.

If the demographic data as known to ICES is different from that provided by the ICP, proceed as follows:

- Worker will start Application Registration in ICES. Demographic information for each individual in the household should be entered exactly as it appears on the inquiry screen and that information will be displayed as it was found in ICES. At this time, this information should be examined to ensure an exact match. If it is not an exact match, the PF17 key will allow the screener to return to the previous screen. The information that was incorrect will then need to be corrected so it is an exact match to the screen that first showed the individual match. If it is an exact match, the screener can place an “X” in the select column and hit <ENTER>. The system will allow the individual to PASS.
- Once the individual has been allowed to PASS, do not change information for any individuals until reaching the ICES screen reflecting the relationships of all household members or the ICES screen showing the individuals living at the case address. Types of changes that may occur on these screens include:
  - Spelling of individuals name;
  - Date of Birth;
  - Sex Code;
  - Ethnic Code; and
  - Social Security Number.

If it is discovered that someone’s verified SSN has been entered for another individual, the following guidelines should be observed:

NOTE: Do not simply key over the name/DOB/sex/race fields to attach the SSN to the correct individual. This will tangle their data under one RID. Follow this procedure:

1. If the SSN is found for an individual in an open case, check the SSN verification in case file and if necessary, re-verify the SSN.
2. If the SSN is found for an individual in a closed case, you may temporarily enter the individual into the

case being processed, adding his demographic data. Clearance will run for this individual and the information must match.

To correct the SSN in either situation 1 or 2 above, blank out the incorrect SSN and press ENTER. This will free the SSN to be entered for the verified SSN owner. The correct SSN may then be added to the blank field.

In situation 2, the individual may then be deleted. If both workers verify the SSN to be correct, the problem must be resolved with the Social Security Administration.

If an individual appears on ICES with multiple SSN’s, contact the ICES Help Desk so the situation can be corrected.

When ICP cannot provide sufficient information for the screener to make a “match” without doubt that the match is correct, the worker should start Application Registration without entering the questionable individual(s).

For all individuals for whom a definite match cannot be made, proceed as follows:

- A memo should be attached by the screener to the Indiana Application for Health Coverage alerting the caseworker that the individual(s) should be added and pass clearance.
- An entry should also be made in Running Record Comments. The ICP must be encouraged by the screen to obtain the missing demographic information by the scheduled interview.

If any individual is found to be active in an existing ICES case, refer to Section 1825.05.05 for instructions on how to proceed.

If the address given by the ICP matches an address known to ICES as active, refer to Section 1825.05.05 for instructions on how to proceed.

1825.10.00 PERSON WHO SIGNS THE APPLICATION

Anyone can sign the Indiana Application for Health Coverage. The person signing the application is required to swear or affirm that the information he provides on the application is true and correct to the best of his knowledge or belief. Once the application is signed, the recorded information supplied by the ICP is not to be changed, nor is information to be added.

The agency must require that all initial applications are signed under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission must be accepted.[7]

1825.10.05 Alias

The individual's legal name is to be used on the application in most cases. If the individual has an alias or has used other names in the past, it is important to establish which name the individual uses most frequently when doing business. The individual's most commonly used name is the name under which the case is to be established.

1825.15.00 DATE OF THE APPLICATION

The date of application is the date a signed application is received by DFR.[8] In the instance where the application is mailed into the DFR, the Local DFR Office must ensure that the actual date of receipt is stamped on the application. When an application is mailed to the local office, it is considered received when it is date stamped. When an application is completed over the phone, the received date is the date it was completed over the phone. In the instance where the Indiana Application for Health Coverage is completed on-line or is faxed to the DFR, the received date of the application will be the actual date the application was completed on-line or received via fax. A day runs from 12:00 a.m. through 11:59 p.m. If an application is received from the Federal Marketplace, the date of application will be the date it was received by the Federal Marketplace.

If a signed application is received by a local DFR office designee at an outreach or itinerate location, the date of application is the date the application is received by the designee. If the request for an application is received by the DFR over the telephone, a worker within the DFR is expected to assist in the completing the application by going over the on-line application with the ICP. When an application is completed over the telephone, the applicant should be sent a copy of the application upon request.

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[7] 42 CFR §435.907

[8] 405 IAC 2-1-3

1835.00.00 SCHEDULING THE INTERVIEW (MED 1, 2, 4)

After the inquiry and Application Registration processes have been completed, an interactive interview must be scheduled for the applicant whose eligibility is being determined under a non-MAGI category. If the interview is not held on the same day that the application is received, an appointment must be scheduled. The system will generate an appointment notice to the client if an appointment is scheduled at least seven business days in advance for initial applications, five business days for general appointments, six business days for redeterminations, and ten days for IMPACT appointments. If an appointment is scheduled sooner, a manual notice must be prepared and given to applicant. This can be accomplished by screen printing CSAS.

The initial interview may be held on the same day that the application is received or as soon as possible. The initial interview should be scheduled to give sufficient time to determine eligibility and provide benefits within the timeliness standards.

All individuals must be informed of the conditions under which an out of office interview may be conducted.

1835.05.10 Applicant Interview (MED 1, MED 2, MED 4)

To determine initial eligibility there must be an interview with the applicant[9] or with someone acting responsibly for him. Refer to Sections 2005.00.00 and 2005.05.10. The interview may take place in the DFR or on the telephone.

The worker must be assured that it is not a hardship on the applicant to come to the office.

Interviews cannot be required for someone whose eligibility is being determined under MED 3, unless she is also being considered potentially eligible under MED 1, 2, or 4.

1835.15.00 DENYING AN APPLICATION WHEN THERE IS NO INTERVIEW

If an individual whose eligibility is being determined under a non-MAGI category does not keep an appointment for an interview within 30 days of the application date, the worker must then take action to deny the application on the 30th day. The application should not be closed until the 30th day for failure to keep an appointment. If the 30th day falls on a non-business

[9] 405 IAC 2-1-2

day, the denial action must be taken on the next business day in order to be timely. An entry should be made in Running Record Comments to explain the denial situation. An applicant may voluntarily withdraw the application at any time.

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2000.00.00 APPLICATION PROCESSING

At the end of the application registration process, client scheduling takes place in order to schedule an interactive interview.

The policies in this chapter pertain to the processing of new applications after the application registration and interviewing scheduling processes have occurred.

The Federal Health Insurance Marketplace and the State Medicaid Agency will be coordinated in their eligibility determinations of individuals that follow the application process through the Marketplace or the DFR.

The following sections are contained in this chapter:

The Interview (Section 2005);

RESERVED (Section 2010);

Responsibilities of the Applicant/Recipient (Section 2015);

Application Time Standards (Section 2020);

Verification (Section 2025);

Concluding the Interview/Providing Information (Section 2030);

Determination of Initial Eligibility (Section 2035);

Reapplications (Section 2040); and

MSP Applications from SSA LIS Data File (MED 4) (Section 2050).

2005.00.00 THE INTERVIEW (MED 1, MED 2, MED 4)

This section does not apply to any MED 3 category, and an interview cannot be required for any MED 3 category. It may not be known at time the application is received whether or not the applicant will have eligibility determined under a MED 3 category or another applicable category. Once it is known that MED 3 is not applicable, an interview appointment notice must be sent to the applicant and any authorized representative. Refer to IHCPPM 2005.05.10.

An interactive interview is required for all other individuals who submit an application, where a MED 3 category is

inapplicable. The interviewee may select additional programs of assistance during the interview.

Effective June 1, 2014, SSI recipients are exempt from the interview requirement.

2005.05.00 COOPERATION WITH THE ELIGIBILITY INTERVIEW AND RESCHEDULING (MED 1, 2, MED 4)

An application is to be denied if an individual does not cooperate with the interview requirement. Refusal is determined when the AG is able to cooperate, but clearly demonstrates a refusal to be interviewed. Applications are to be denied on the 30th day (or next business day when the 30th day is a non-business day) when the applicant has failed to keep scheduled appointments or to reschedule an appointment by the 30th day.

If there is any question as to whether the household has merely failed to cooperate, as opposed to refused to cooperate, the household should not be denied, and the agency should provide assistance to complete the interview requirement.[1]

If the individual contacts the DFR to reschedule, the interview should be rescheduled as soon as possible in an attempt to stay within processing time frames. A copy of written notices to reschedule should be kept in the case record. Appointments scheduled by phone should be documented in Running Record Comments.

2005.05.10 Who Can Be Interviewed

In addition to who can be interviewed for an applicant/recipient, this section may also be applied towards who DFR can discuss missing and needed verifications in order to determine Medicaid eligibility for an applicant/recipient.

An applicant or authorized representative may be the interviewee and can conduct all business related to the application process. For Authorized Representatives, the Authorized Representative for Health Coverage, State Form 55366 must be used to authorize someone to apply on behalf of an AG and must be filed in the case record.

Any individual other than the parent of an applicant/recipient under age 18 must be authorized in writing by the applicant unless medical documentation is presented showing that the applicant is medically unable to provide such authorization.[2] For a spouse of an applicant/recipient to be interviewed, the spouse must either be an authorized representative for the applicant/recipient or be given verbal permission by the

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[1] 405 IAC 2-1-2

[2] 405 IAC 2-1-2

applicant/recipient to be interviewed on behalf of the applicant/recipient. Verbal permission can occur in person or over the phone. If it is done over the phone, DFR must ensure that the applicant/recipient giving the verbal permission is in fact the applicant/recipient by asking that person to verify a few things about themselves including but not limited to: last four digits of SSN, date-of-birth, address, case number, and RID number. An applicant/recipient may also give verbal authorization to someone other than a spouse. Someone who is merely given verbal permission is not an authorized representative and is not authorized to speak with the DFR about the applicant/recipient's case beyond that occurrence.

In spite of the availability of an authorized representative, the DFR may require personal contact with the applicant if such contact is necessary in order to determine eligibility under any program.

Legal guardians and powers of attorney may apply for assistance on behalf of the applicant and must present the appropriate documents verifying their status to be interviewed. A power of attorney document must be general enough to encompass applying for assistance. If it is specific to only a certain activity, it does not suffice for application purposes and a POA crafted for the sole purpose of applying for Medicaid is not acceptable.

The chief of social services (or his/her designee) of any institution under the control of the Family and Social Services Administration may apply for assistance on behalf of patients in the institution and be interviewed. The social services staff person may apply for assistance for an individual who will remain in the facility or for whom plans are in process to move to an alternative placement and be interviewed.[3] The most common usage of this procedure will occur with state institutions under the supervision of the Division of Mental Health.

The authorized representative must be familiar with the AG situation to represent them properly. The worker will determine if the authorized representative is representing the AG appropriately.

Authorized representatives assume responsibility for the accuracy of the information provided. AGs who utilize an authorized representative are subject to the same disqualification penalties and possible prosecution as AGs representing themselves.

For Medicaid, employees of nursing facilities may not be interviewed on behalf of a resident in their facility unless the client is medically incapable of being interviewed and there is no one else to act on the client's behalf.

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[3] IC 29-3-3-5

When an application is received for a deceased applicant, the application must be processed and an eligibility determination completed. An interested party that has information specific to the applicant's situation can provide required verifications including the death certificate. Each situation must be evaluated to determine if necessary information to complete the eligibility determination can be obtained. Any application processing questions for this scenario should be sent to the Central Office Policy Unit for clarification.

2015.00.00 RESPONSIBILITIES OF THE APPLICANT/RECIPIENT

The DFR must advise each applicant/recipient of his rights and responsibilities as indicated in the following sections.

Each applicant will receive this information as part of the submitted application. When an application is completed over the phone, the Rights and Responsibilities must be read orally (an audio recording of the Rights and Responsibilities is acceptable) to the person completing the phone application.

2015.05.00 PROVIDE PROOF OF INFORMATION

The applicant/recipient must consent to the release of any information necessary to determine his initial and continuing eligibility for assistance.[4] He must supply required documents and records and must assist the DFR in obtaining verifications[5], including proof of incapacity. Failure or refusal by an applicant to provide the DFR with information or verification of information required to determine eligibility will render the AG ineligible for assistance.[6]

If the individual is doing all that he can to cooperate in verifying the information, but is unable to do so, the DFR must assist the AG in verifying the information.

In cases where the individual is a victim of domestic violence, it is important to understand the barriers that can exist in the process of obtaining verifications. This is especially important where the abusing party is in possession of the needed documentation and any attempt to obtain said documentation would pose a threat to the individual applicant/recipient.

When neither the worker nor the individual is able to secure the necessary documentation, the individual's statement is to be accepted as sufficient documentation upon the approval of a supervisor. However, it is important that the worker document the reason for the use of client statement.

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[4] 470 IAC 2.1.-1-2

[5] 470 IAC 2.1.-1-2

[6] 470 IAC 2.1.-1-2

2015.10.00 UNDERGO MEDICAL EXAMINATION (MED 1)

A blind or disabled applicant or incapacitated recipient must undergo a medical examination necessary to establish categorical eligibility for MA.[7] A blind, disabled, or incapacitated recipient must undergo subsequent medical examinations, if required, to establish continuing eligibility.[8]

2015.15.00 COOPERATE IN TREATMENT PLAN (MED 1)

The blind or disabled recipient must cooperate in any treatment plan which has been recommended by the examining physician and approved for payment by the Medicaid program's Prior Authorization Process. The goal of such treatment must be full or partial alleviation of his visual impairment, incapacity, or disability.[9] Failure to cooperate in such plan without good cause will render the recipient ineligible for assistance.[10]

"Good cause" includes, but is not limited to:

> The treatment is contrary to the applicant's religious beliefs;
>
> Previous surgery of the same type recommended was unsuccessful;
>
> The recommended treatment is very risky because of its magnitude or unusual nature; or Amputation of a major limb is involved.[11]

2015.20.00 REPORT CHANGES IN CIRCUMSTANCES

The applicant/recipient must report any changes in circumstances affecting Medicaid eligibility to the DFR within 10 days of the date on which the change occurred or became known to the recipient.[12]

AGs will be advised at the point of application in the Rights and Responsibilities of their responsibility to report changes. This provision is applicable at any time after submission of the application, regardless of whether it has been approved or not.

2020.00.00 APPLICATION TIME STANDARDS

Due to federal requirements, applications must be processed within specific time standards. The time allowed varies depending

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[7] 470 IAC 2.1.-1-2
[8] 470 IAC 2.1.-1-2
[9] 470 IAC 2.1.-1-2
[10] 470 IAC 2.1.-1-2
[11] 470 IAC 2.1.-1-2
[12] 470 IAC 2.1.-1-2

on whether the applicant is alleging a disability. The time standard is counted beginning with the day following the date of application, and ending with the date on which the eligibility notice is mailed.

Time standards for application processing as required by the individual programs are explained in the following sections.

2020.15.00 APPLICATION TIME STANDARDS (MED)

The DFR must determine eligibility within federally prescribed time standards and must so inform each applicant both verbally and in writing at time of application. Notification to applicant may also be electronic. These time standards are:[13]

> 45 days for all MA categories except the Disabled categories (MA D and MADW), which is 90 days.
>
> The time standard covers the period from the date of application to the date the eligibility notice is mailed.[14]

The DFR must not utilize the time standard as a waiting period before granting MA. Additionally, the fact that a case is going to pend beyond the time standard cannot be used as the basis for denying the application.[15]

2020.20.00 APPLICATION PROCESSING DELAY

Delay exists when an application is not processed within the federally prescribed time standards. The worker is to determine the reason for delay and whether the delay was caused by the AG or the DFR by using the information in the following sections.

2020.20.10 EXCEPTIONS TO APPLICATION TIME STANDARDS

Every effort must be made by the DFR to process all applications within the time standards. If an application pends beyond the time standard, the reason must be clearly documented in the Running Record Comments section of the case record and entered on AEFPY.[16] Reasons are as follows:

> Awaiting documentation of life insurance cash value from life insurance company;
>
> Awaiting medical or visual information from the examining physician;

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[13] 42 CFR 435.911
[14] 42 CFR 435.911
[15] 42 CFR 435.911
[16] 42 CFR 435.911

No extenuating circumstances;

Receipt of hearing decision (ICES will require a delay code to be entered on AEFPY if a denial was overturned by the ALJ).

2025.00.00 VERIFICATION

In order to determine eligibility for assistance, the DFR is required to verify information to support the eligibility determination process such as:

Non-financial factors of eligibility;

Resources;

Income; and

Claimed expenses

These factors will vary by program.

The use of client statement should be used only as a last resort.

2025.05.00 VERIFICATION REQUIREMENTS

The DFR must have adequate factual information on which to base case eligibility decisions. Therefore, at least one source of verification must be obtained for each eligibility factor. Verification is the use of third party information or documentation to establish the accuracy of statements on the application as well as statements obtained during the interactive interview. Verifications must be reasonable and limited to those that are necessary to ensure an accurate eligibility determination. For example, financial and demographic information is required only for those individuals living in the home who are members of the AG (as participants or non-participants). Therefore, when dealing with a household made up of AG members and excluded persons, the worker may not require the AG, as a condition of eligibility, to provide information and verify the circumstances of the non-AG members. (See Chapter 3200 for information concerning AG membership as a participant or non-participant and exclusion from AG membership).

Verifications may be secured by one of the following methods:

Electronically (if an interface or data exchange is available)

Telephone contact;

Personal contact (including home visits); or

Written (hard copy) documentary evidence; including verifications received by fax or other electronic devices where the authenticity of the source of the verification along with the verification itself can be validated.

Running Record Comments must contain all telephone or personal contacts and documentary evidence used as verification. At a minimum, the following must be recorded:

The eligibility factors verified;

The name of the contact person;

The date of the contact; and

The information obtained from the contact.

This entry in Running Record Comments (CLRC) should be in sufficient detail to support the determination of eligibility or ineligibility.

2025.05.05 Verification of Questionable Information

All eligibility factors that are questionable must be verified prior to the approval of the AG. To be considered questionable, the information on the application must be inconsistent with:

Statements made by the applicant;

Information on previous applications; or

Information available to the worker

When determining if the information is questionable, the worker will base the decision on the circumstances of the AG. Further verifications may be necessary if the following situations occur:

A report of expenses that exceed income;

The AG reports no income and/or no assets, yet is managing financial affairs; or

Information has been received that individuals not included on the application reside with the applicant/recipient and, therefore, the composition of the AG is questionable.

Questionable information alone does not serve as a basis for a denial or termination of the case.

When unclear information is received from a third party or from the AG, clarification and verification of the AG’s circumstances must be pursued. A written request, which clearly advises the AG of the verification needed and actions needed to clarify the

circumstances must be sent. The notice must advise the AG it has 13 days to respond and clarify its circumstances and that failure to respond will result in denial/closure.

If the AG does not respond to the written notice or does respond but refuses to provide sufficient information to clarify the circumstances, adverse action is taken to terminate the case. A new application is required if the AG wishes to continue to receive benefits.

If the AG responds and provides sufficient information, the reported information must be acted upon.

Benefits for one category cannot be terminated solely because benefits under another category are terminated.

2025.05.10 Collateral Contacts

There are some institutions such as banks, insurance companies, and medical institutions which will not release information without the written consent of the individual. If information from such sources is essential to the determination of eligibility, and the individual does not or cannot provide the necessary information and refuses to sign a release form, eligibility cannot be established and consequently, the application must be denied.

When contacting collateral contacts, disclosure of information should be limited to that which is absolutely necessary to obtain the information being sought. Disclosure that the AG has applied for or is receiving Medicaid should not occur.

2025.10.00 RESPONSIBILITY FOR OBTAINING VERIFICATION

The applicant or authorized representative has the responsibility for providing adequate data to substantiate his request for assistance insofar as it is possible. The applicant or authorized representative is not required to present evidence in person at the DFR. The evidence may be supplied in person, through the mail, by facsimile or other electronic devices as listed in IHCPPM 2025.05.00. Some information may be obtained electronically through interfaces or other databases as specified in the State’s Verification Plan.

Good judgment is required on the part of workers when determining what, if any, verifications can be furnished by the applicant or authorized representative. The worker will accept any reasonable evidence and will be primarily concerned with how adequately the evidence proves the statements on the application.

If it is difficult or impossible for the individual or authorized representative to obtain the evidence in a timely manner or the

AG has presented insufficient documentation, the worker must offer assistance.

In cases where the applicant/recipient is a victim of domestic violence, it is important to understand the barriers that can exist in the process of obtaining verifications where the abusing party may be in possession of the needed documentation and any attempt to obtain said documentation would pose a threat to the applicant/recipient.

When neither the worker nor the applicant/recipient is able to secure the necessary documentation, the applicant/recipient's statement is to be acceptable information.

2025.15.00 REQUESTS FOR INFORMATION

If the worker requires information or verification from the individual, he must provide the individual with:

A written list of specific information required in order to complete the application process;

The date the information is due; and

Information on the consequences of not returning additional information by the due date.[17]

When asked to release information necessary to process an application, the date and the name of the person or organization from which information is being requested must be listed on the release form prior to requesting the client's signature. This policy applies to the Authorization for Release of Information Form, or any of the other forms such as the FI-0014 and FI-0065 used to document the client's authorization for the release of confidential information. All of these forms must show the date signed by the client and may not be honored if more than 90 days old. The client may also revoke this authorization at any time prior to the expiration of the release.

The worker must provide the verification checklist for all AGs within the household.

The individual is responsible for providing as much of the required information as possible and must be informed that time extensions can be requested. However, any delay may affect potential benefits. The worker must assist the individual when the individual is unable to act wholly on his own or when the individual requests assistance obtaining information.

[17] 470 IAC 2.1.-1-2

When additional information or verifications are required, the individual must be informed of the above specifications. ICES will not automatically generate this notice.

If there is electronic data available from the federal data services hub or other electronic the worker must first use the available electronic data before requesting additional information from the individual.

2025.20.00 TIME STANDARDS FOR PROVIDING INFORMATION

If it is determined at the interview or at any time during the application process that additional information or verification is required, the AG must be notified and given 13 calendar days to comply with the request.

For all, the verification due date is 13 calendar days from the date the pending verification checklist is provided. If the verification due date falls on a holiday or weekend, the deadline for the requested information is the next working day.

Effective June 1, 2014, applicants claiming they are disabled will be required to apply for disability benefits through the Social Security Administration (SSA) within 45 days after the date of the application unless the disabled applicant is under 18 years of age or for another acceptable reason. Please, refer to IHCPPM 2404.00.00 and IHCPPM 2432.00.00. MRT will determine disability for children who are disabled unless SSA has already made such a determination.

2030.00.00 PROVIDING INFORMATION TO THE APPLICANT/RECIPIENT OR PARENT OF APPLICANT/RECIPIENT (MED 1, MED 2, MED 4)

The worker must verbally explain the following information to each interviewee:

That the AG will receive written notices stating the actions that must be taken to stay eligible. (If the AG cannot comply, the client should call before the deadline to explain the reason.);

All eligibility factors pertaining to the Medicaid categories which have been chosen;

That there is an Appeals and Hearings process available;

The applicant's rights and responsibilities that are outlined within the Indiana Application for Health Coverage;

The fact that the application will be processed for the category with the most benefits that the individual may be eligible to receive;

The applicant's freedom of choice as to the type and number of categories under which he applies, including the QMB category for applicants entitled to Medicare Part A;

The applicable timeline standards to determine eligibility for the application;

That if the AG disagrees with any action taken by the DFR, it may request a fair hearing;

That the AG's SSNs will be matched against the records of other agencies to detect unreported income and resources;

The next steps to be taken by both the applicant and the DFR; and

The fact that the individual may withdraw his application at any time during the application process or request that his assistance be discontinued.

Applicants determined eligible under a MED 3 category will receive this information within the Rights and Responsibilities portion of the application.

2030.10.00 PROVIDING INFORMATION TO APPLICANTS

The following information must be provided:

If an applicant is approved, a Hoosier Health Card will be sent to each enrollee within two weeks after the approval is authorized. This is a plastic identification card expected to be retained throughout the person's eligibility for Hoosier Healthwise or traditional Medicaid in Indiana. If a person is discontinued and reapplies, the same card can once again be used if the person is re-enrolled. Coverage under traditional Medicaid and all benefit packages of Hoosier Healthwise except Package C, may be retroactive up to three months prior to the month of application, if all requirements are met. Coverage under Package C can begin no earlier than the month of application. Also, coverage under MA L cannot begin any month earlier than the month of application.

Coverage under the premium-free packages will be explored first and if the person wishes coverage under Package C, payment of the premium is required.

Annual redeterminations of eligibility are required for all enrolled persons.

If determined to be eligible for Medicaid, the person will be able to select a Medicaid provider(s) of his choice or[18], if he is in a managed care category, he must select a health plan.

Discuss the medical assignment and explain that the free service of paternity establishment is not available for children who are found eligible under Package C.

Discuss the premium requirements of M.E.D. Works for disabled applicants who are working.

2035.00.00 DETERMINATION OF INITIAL ELIGIBILITY

This section discusses policy for:

Disposition:

- The initial determination of eligibility or ineligibility;

Date of entitlement:

- The initial date of eligibility for assistance.

Refer to Chapter 2200.00.00 for determination of on-going eligibility, redeterminations and certification periods.

2035.10.00 REASONABLE COMPATIBILITY OF INCOME (MED 3)

Reasonable compatibility standard will be used to address situations where an applicant's self-attested information and electronic sources of information are inconsistent.[19]

Self-Attested Income	Income Obtained from the Work Number or other electronic sources	Worker Action
Below the Standard	Below the standard	Use the reported income. No further proof is needed.

[18] 405 IAC 1-1-2; SSA 1902(a)(23); 42 CFR 431.51

[19] 42 CFR §435.603

Self-Attested Income	Income Obtained from the Work Number or other electronic sources	Worker Action
Below the standard	Above the standard	Refer to the Reasonable Compatibility section below.
Above the standard	Below or above the standard	Use the reported income. No further proof is needed.

1. If individual attests on the application to income below the Medicaid or S-CHIP applicable income standard and if electronic data on income is unavailable, further documentation will be required from the applicant.

2. If an individual attests on the application to income above the Medicaid or S-CHIP applicable income standard and the electronic data indicates income below the applicable income threshold, the individual is determined ineligible with no additional information sought. The individual is screened for eligibility for other insurance affordability programs.

3. If an individual attests on the application to income below the Medicaid or S-CHIP applicable income standard and the electronic data indicates income above the applicable standard, documentation will be required from the applicant to resolve.

4. If the difference between what an individual attests on the application and the electronic data results in a different benefit package or cost-sharing amount, documentation will be required from the applicant to resolve.

Refer to Chapter 3000 for the applicable MED 3 income standards for each individual.

2035.15.00 PRE-ADMISSION SCREENING IS PENDING (MED 1)

When pre-admission screening (PAS) is pending on an individual who has entered a nursing facility, ICF/MR or CRF/DD, it is to be assumed that the individual will be approved, absent evidence to the contrary. An "S" for screened should be entered in the Pre-Admission Screening field on AEIII. If any other code is entered, ICES will determine a spend-down instead of a liability. The date is either the date the screening was initiated, if known, or the date the individual entered the facility.

The DFR will not receive a copy of the Form 450B (Physician Certification for Long Term Care Services) when the level of care determination is made. DFR should arrange a procedure with Medicaid facilities so that the facilities will notify the caseworker if a level of care is denied. When a denial is received by the worker, the information on AEIII must be updated accordingly.

2035.20.00 HOME AND COMMUNITY-BASED SERVICE WAIVERS (MED 1)

Parental income and resources are not considered when determining the Medicaid eligibility of individuals less than 18 years of age who are being considered for Home and Community-Based Services (HCBS). Parents should be asked early in the interview if they want retroactive Medicaid coverage for the child. If retroactive coverage prior to the waiver effective date is requested, the parents must provide verification of their income and resources. Generally most parents do not want retroactive coverage for the child prior to the waiver and are resistant about being asked any questions about themselves. If the parents do not want the retroactive coverage, they are not required to provide information about their own finances for those retroactive months.

As each screen is completed, the questions will relate to the situation of the child only, if retroactive coverage is not desired.

2035.30.00 DETERMINATION OF MEDICAL CATEGORY (MED)

In the absence of a stated preference by the applicant[20], ICES will determine the category according to the hierarchy listed below. A brief description of the categories can be found in Chapter 1600. The hierarchy is designed so that the applicant is first considered under the category which provides the most comprehensive scope of coverage in the most expeditious manner. If the client states an intention to apply for the Aged, Blind, or Disabled category, the preferred category can be entered by the worker on AEICP. However, a person who is eligible in a mandatory category cannot choose to be in an optional category. Therefore, individuals who are working and eligible in the Disabled category cannot choose to be in M.E.D. Works. Additionally, applicants do not have the option to choose the MA 10 category when eligible under another category. An individual who is eligible for MADW (not MADI) can choose to be enrolled under MA D. Workers must ensure that the applicant is in fact eligible for MA D. For example, if the applicant’s gross earned income minus impairment-related work expenses is more than the SGA limit, MA D cannot be approved. Refer to Sections 1620.87.00 and 2035.30.10 regarding MA10 determinations, and to Section

[20] 42 CFR 435.404

2035.30.05 which explains the special considerations for MA 9, children age 1 - 19.

MA SI SSI Recipient – full coverage, HCC or FFS

MA X Newborn – HHW Package A, full coverage;

MA Y Children under age one - HHW Package A, full coverage;

MA Z Children age one through five - HHW Package A, full coverage;

MA 2 Children age 6 through 18 - HHW Package A, full coverage;

MAGF Parent/Caretaker - HHW Package A, full coverage;

MA F Transitional Medical Assistance (TMA) - HHW Package A, full coverage;

MAGP Pregnant women - HHW Package A, full coverage;

MA T 19 and 20 year olds - HHW Package A, full coverage;

MA O Children age 19-21 residing in inpatient psychiatric facilities – full coverage, FFS;

MA 15 Former Foster Care ages 18 through 25 – full coverage, HCC or FFS;

MA 14 Independent Former Foster Care age 18, 19, 20 – full coverage, HCC or FFS;

MA 9 Children age one through 18 - HHW Package A, full coverage;

MA R RCAP related - full coverage, HCC or FFS;

MA A Aged - full coverage, HCC or FFS;

MA B Blind - full coverage, FFS;

MA D Disabled – full coverage, HCC or FFS;

MADW MED Works, Basic category – Medicaid for Employees with Disabilities; full coverage, HCC or FFS;

MADI MED Works, Medically improved category – Medicaid for Employees with Disabilities - full coverage, HCC or FFS;

MA Q Refugee Medical Assistance (RMA) - full coverage, FFS;

MA L Qualified Medicare Beneficiary (QMB) - limited coverage;

MA J Specified Low-Income Medicare Beneficiary (SLMB) – limited coverage;

MA I Qualified Individual (QI) – limited coverage;

MA G Qualified Disabled Working (QDW) - limited coverage;

MA10 Children birth through 18; HHW Package C, comprehensive coverage, some services subject to limits;

MA E Family Planning Services for Women and Men – limited coverage, FFS.

2035.30.05 Determination of MA 9 Category (MED 3)

This category, established effective July 1, 1998, includes 141% - 158% of the Federal Poverty Level, and children age 6 through 18 with income between 106% - 158% of the poverty level.[21] The MA 9 income standards are listed in Section 3010.30.15.

MA 9 is positioned in the hierarchy after MA 2 and before MA B and MA D. However, if a blind or disabled child is determined eligible for MA B or MA D, without a spend-down, she/he will be authorized in one of those categories not MA 9. New applicants will be considered first in MA 9 without being required to go through the medical determination process with the MMRT. If they fail MA 9 eligibility, then they will be considered under MA B or MA D. Recipients who are eligible in the MA B or MA D categories without a spend-down, but who meet the MA 9 financial requirements will remain in MA B or MA D. Recipient children in MA B or MA D who are in Medicaid certified facilities and who have liabilities will remain in those categories. A child who meets the MA 9 requirements, but would also be eligible for MA B or MA D with a spend-down, will be approved in MA 9.

2035.30.10 Determination of MA 10 Category (MED 3)

This category, established effective January 1, 2000, includes children aging from birth through the age of 18, who are not eligible in any other medical category. MA 10 is Benefit Package C of Hoosier Healthwise. The income standards were set at 200% of the federal poverty guidelines until October 1, 2008 when they were increased under an MA 10 expansion to 250% of the federal poverty guidelines. The standards are listed in Sections

[21] Title XXI of the Social Security Act

3010.30.20 and 3010.30.25. Information on budgeting under the expansion is found at Section 3460.15.05.

MA 10 is positioned at the bottom of the medical hierarchy due to the requirement that eligibility be pursued under the other categories first. However, the same provision as in MA 9, that is applied to children who would be eligible in the Blind and Disabled categories with a spend-down, is applicable to MA 10. Refer to the previous section, 2035.30.05.

2035.30.15 Determination Of M.E.D. Works Category

A disabled individual will be considered under all applicable categories according to the hierarchy. If the individual's gross earnings, minus Impairment-Related Work Expenses (IRWE) exceed the Substantial Gainful Activity amount specified in Section 3046.00.00, or his total countable income or resources exceed the MA D limits listed in Chapter 3000, he will then be considered for eligibility in M.E.D. Works. MADW is considered first. An applicant for Medicaid cannot be approved initially in MADI. If the Medical Review Team or the Social Security Administration determines that an MADW recipient is no longer disabled due to a medical improvement in his condition, MRT will determine whether the improvement does not constitute a full medical recovery. If there is not a full medical recovery, such individual will be determined for MADI categorical eligibility.

2035.30.20 Determination of MA 14 Category (MED 3)

This category includes 18, 19, and 20-year-olds that were in foster care when they turned age 18. MA 14 is positioned after MA 2 in the medical hierarchy.

Therefore, 18-year-old former foster children will first be considered for eligibility in MA 2. If the child's income exceeds the limit for MA 2 or when the child turns age 19, MA 14 will be considered.

2035.30.25 Determination of MA 15 Category (MED 3)

This category includes individuals who were in Indiana Foster Care and enrolled in Indiana Medicaid upon attaining age 18 and who are less than 26 years of age.

2035.30.30 Determination of MA E (MED 3)

A person must request that he or she wishes to receive family planning services for an eligibility determination under this category. Services under this category are limited to those related to family planning. Pregnant women who deliver or whose pregnancy is terminated will automatically be considered for MA E if not eligible for another category.

2035.31.00 DESIGNATION OF THE PACKAGE C PREMIUM PAYER

When an Indiana Application for Health Coverage is filed, the person signing the application understands that if the child is eligible for Package C, there will be a premium due before the child can be enrolled. The premium payer is assigned according to the following default logic: mother, father, non-parent caretaker. The caseworker may override the system designation of payer in the following circumstances:

The mother is living in the home and the system has designated her, but it is the father (also in the home) who wants to be the payer.

The child is a ward of the DCS and is placed with someone other than the parents. (If the ward is placed with a parent, the parent will be designated premium payer.)

The child has a legal guardian and is placed with the parent. In this situation, it will be necessary to determine which of these individuals is financially and legally responsible for the child and enter that person as premium payer.

2035.32.00 ENROLLMENT PROCESS FOR MA 10

Once eligibility is established, a conditional approval for MA 10 is to be authorized. This means that the children meet all eligibility requirements of MA 10 except for payment of the first premium(s). The first premium month is the month after authorization. The months of application and months through the month of authorization are premium-free. The children will be enrolled when the premium has been paid.

The billing process allows for an overdue billing, which gives the payer a subsequent opportunity to pay the premium before the application will be closed. If a payment is not received by the final due date, the conditional approval will be system denied.

If the individual is discontinued for nonpayment of premiums then that individual may enter a lockout period up to 90 days in which the individual cannot be eligible for CHIP. The individual, however, may pay back all outstanding premiums during the lockout period which will allow for the Client to be eligible again for the MA10 Program and not have to serve the full 90 days. In this case the lockout period ends upon receipt of the outstanding premium payments. Once the Client is eligible again a new application needs to be submitted in order to be reopened.

If the individual does not make payment of the outstanding premium balance before the end of the lockout period then the individual must re-apply for MA10 once the lockout period ends. If the individual re-applies after the lockout period ends the individual is not required to pay the previously owed premiums.

2035.33.00 DESIGNATION OF MED WORKS PREMIUM PAYER ENROLLMENT PROCESS

MADW/I premium payer is set in the following default order:

Applicant/recipient age 18 and older

Mother of applicant/recipient under age 18

Father of applicant/recipient under age 18

Applicant/recipient under age 18, who is not living with a parent/caretaker.

The caseworker can change the payer of a child under age 18 from mother to father, as requested by the parent. In the case of a married couple, when both are applicants/recipients of M.E.D. Works, each spouse will be designated as his or her own premium payer. However, the premium will be a ‘couple premium’, meaning one premium is assigned to both spouses. Both will be enrolled when the one premium is paid and both will be denied if the premium is not paid. One billing statement will be sent to the couple.

Applicants who pass all eligibility requirements and based on income are required to pay a premium in order to be enrolled will be conditionally approved until the premium is paid. The first premium month is the month following the month of authorization. All prior months in which the individual is eligible are premium-free.

2035.35.00 DETERMINATION OF INELIGIBILITY

An AG is to be denied if just one eligibility requirement fails to be met causing the AG to be ineligible. However, if, in the course of the eligibility study the worker verifies that other requirements are not met; <u>all</u> reasons for denial must be entered on AEWAA.

2035.40.00 AUTHORIZATION

An AG must be authorized when all required eligibility information is documented and the determination of eligibility is complete. Please note the exception in section 2035.40.05. In all other instances, AGs are to be authorized whenever the eligibility determination is complete. Authorization of an AG is not to be delayed while awaiting completion of the eligibility determination for other AGs in the case.

Before authorizing an AG, the worker should carefully review all data and the case eligibility summary screen (AECES) eligibility results for accuracy. This involves reviewing every retroactive month as well as the recurring month.

2035.40.05 Authorizing When Citizenship or Immigration Status Is Not Verified

If a person would be determined otherwise eligible for Medicaid under any category due to meeting all verification requirements to allow for a determination of Medicaid except for the verification of either Citizenship or Immigration Status having not been fulfilled, then the person must be determined eligible for Medicaid.[22] Please, refer to IHCPPM 2402.15.10 and 2402.20.00 with all applicable subsections for individuals declaring to be immigrants. Persons who do not have citizenship or immigration status verified promptly by the DFR through an electronic match or by other means but can otherwise be determined eligible are given 95 days after being determined eligible to provide proof of Citizenship or Immigration Status. If such person has not verified Citizenship or Immigration Status after 95 days, the person is to be discontinued from eligibility.

2035.60.00 EFFECTIVE DATE (MED 1, 2, 3)

The effective date of health coverage is determined in accordance with the following guidelines:

For traditional Medicaid and all benefit packages of Hoosier Healthwise except Benefit Package C, the effective date can be no earlier than the third month prior to the month of application if all eligibility requirements are met.[23] This provision for retroactive coverage also applies to individuals who were deceased at the time of application.[24] For Hoosier Healthwise Benefit Package C, the effective date can be no earlier than the first day of the month of application.

For spend-down AGs, Medicaid payment of medical care is available each month once the spend-down obligation has been met. This is no longer effective June 1, 2014.

The effective date for an individual who was living in another state just prior to moving to Indiana will be no earlier than the month the individual became an Indiana resident.

SSI recipients are automatically eligible upon receipt of SSI. SSI recipients can obtain three months of retroactive eligibility from date of SSI initial entitlement if they meet financial and non-financial eligibility criteria for those months.

2035.65.00 EFFECTIVE DATE OF QMB MEDICAID (MED 4)

The QMB category of assistance (MA L) has no provision for retroactive coverage. The effective date of QMB coverage begins

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[22] 42 CFR §435.407

[23] SSA 1902a(a)(34); 42 CFR 435.915

[24] SSA 1902a(a)(34); 42 CFR 435.915

with the month after the month in which the QMB eligibility determination is made.

2035.70.00 EFFECTIVE DATE OF QDW MEDICAID (MED 4)

The effective date of QDW coverage (MA G) begins with the effective date of Medicare Premium Part A, but no earlier than three months prior to application.

2035.75.00 EFFECTIVE DATE OF SLMB MEDICAID (MED 4)

The effective date of SLMB can be no earlier than the first of the third month prior to the month of application, but not earlier than the date of entitlement to Medicare Part B. The effective date for a recipient who is already bought in and whose Medicaid coverage is being reduced to SLMB is the first day of the month following the closure of the other MA category. For example, if MA D terminates March 31st, the SLMB effective date is April 1st.

2035.80.00 EFFECTIVE DATE OF QI MEDICAID (MED 4)

The effective date of QI (MA I) can be no earlier than the first of the third month prior to the month of application, but not earlier than the date of entitlement to Medicare Part B. The effective date for a recipient who is already bought in and whose Medicaid coverage is being reduced to QI is the first day of the month following the closure of the other MA category.

2040.00.00 REAPPLICATIONS

A reapplication may be made at any time by an individual whose application for assistance was denied or whose assistance was discontinued.

If a recipient comes into compliance prior to the effective date of discontinuance, it is appropriate to rescind the adverse action rather than to require a reapplication.

If assistance was discontinued at the point of redetermination for failure to provide required information, the person will not be required to submit a new application if the Medicaid mailer and/or the missing information is provided within 90 days from the effective date of discontinuance. Further, eligibility should extend back to the date of discontinuance. Refer to IHCPPM 2238.25.00.

An individual who appeals a denial or discontinuance which had become effective may file a reapplication at any time. He is not to be denied the right to reapply pending the decision of the Administrative Law Judge (ALJ). If the hearing decision is in his favor, the DFR is to take adjusting action as directed in the decision. If the DFR action is sustained, the reapplication is to

be processed in the usual manner. The DFR is not to delay the processing of a reapplication taken under these circumstances until the hearing decision is issued as this is not considered an extenuating circumstance for pending a case beyond the time standard.

2050.00.00 MSP APPLICATIONS FROM SSA LIS DATA FILE (MED 4)

Beginning on January 1, 2010, in accordance with the Medicare Improvements for Patients and Provider Act of 2008 (MIPPA - P.L. 110-275), the SSA will begin using a revised application for the Medicare Part D Low-Income Subsidy (LIS) that tells applicants that their application will be sent to the State Medicaid agency unless the applicant checks a box opting out of the referral. Once SSA makes the LIS eligibility determination, the person's information will be transmitted to the State via the LIS/MSP data file.[25] ICES will process this file daily and generate worker notifications for every application received.

The LIS/MSP data file acts as an application for the Medicare Savings Program (MSP). The applicant will not be asked to sign a separate MSP or Medicaid application. An eligibility interview is not to be scheduled.

2050.05.00 THE MSP APPLICATION DATE (MED 4)

The date of the LIS application is the protected date for establishing MSP eligibility. The date that is used to start the 45-day processing clock is the date that the file is received by ICES.[26]

Example 1

The LIS/MSP data file is received on February 10 for Applicant Joe. The LIS application date recorded on the file is January 4. Based on Joe's income, he is approved for SLMB and authorized on March 15. MA J is effective October 1 which is 3 months retroactive based on the protected date of January 4. This application was processed within the allowable time standard as it was authorized within 45 days of the date that the LIS/MSP data file was received.

[25] SSA 1144(c)(3)

[26] SSA 1925(a)(3)

Example 2

The LIS/MSP data file is received on February 10 for Applicant Lou. The LIS application date recorded on the file is January 4. Based on Lou's income, she is approved for QMB and authorized on March 15. MA L is effective April 1 which is the month after eligibility is determined. The MIPPA legislation did not change this rule for QMB which does not offer retroactive coverage. This application was processed within the allowable time standard as it was authorized within 45 days of the date that the LIS/MSP data file was received.

2050.10.00 INITIAL SYSTEM PROCESSING OF LIS/MSP APPLICATION (MED 4)

There are 3 possible LIS decision types:

Adjudicated LIS denial:

In this situation, SSA collected and verified all income and resource information and denied the LIS application. MSP will be denied and a system-generated notice will be sent to the applicant without further follow up by a worker. The MSP denial notice provides the website address for more information on the MSP and also the telephone number of the Area Agency on Aging (AAA) which has an outreach grant for the MSP. The AAA will send the individual an MSP application upon request.

Non-adjudicated LIS denial:

In this situation, the SSA has accepted self-declaration that the applicant and spouse, if applicable, have resources in excess of the LIS limit. Question 3 on the LIS application asks if the applicant's resources exceed the LIS limit. If the applicant checks ''yes'', a non-adjudicated LIS denial results. If the applicant does not opt out of applying for the MSP, then SSA will send the application to the State. Follow up processing of the application for MSP is required by the worker as explained in Section 2050.20.00.

LIS approval:

In this situation, the SSA has collected and verified information and issued a determination that the applicant is eligible for the LIS. Follow up processing of the application for MSP is required by the worker as explained in Section 2050.20.00.

A system generated acknowledgment letter will be sent to the individuals who received LIS approvals and non-adjudicated denials. For applicants with no previous or current case, the

notice will explain that an MSP application has been received and they may be contacted for verifications. Applicants who have a current application pending will be advised that processing on their case will continue including eligibility for MSP. For individuals already receiving MSP benefits, the notice will state that they are already covered by the MSP and to call the DFR if they have any questions.

2050.20.00 VERIFICATION AND ELIGIBILITY DETERMINATION (MED 4)

Applications received via the LIS/MSP data file are to be processed for MSP eligibility. An individual can file an application for full coverage Medicaid as desired. If a Medicaid application is already pending, the processing will continue including the MSP determination as usual. If a full coverage Medicaid application for the individual is received after the MSP application is set up, the date of the application for full coverage Medicaid would be the date that the full coverage application was received.

For LIS approvals, SSA’s verification of the following income types is acceptable verification unless there is a known discrepancy: Social Security, retirement pension, VA, and Railroad Retirement. A discrepancy would include differing information from SSA than existing information on the individual from a previous case or the DEBN match. All discrepancies must be resolved. If the total of these income types for the applicant and spouse cause MSP to fail and there is no discrepancy, the application can be denied for excess income without follow up. EXCEPTION: If the household size is more than 2 if there is a spouse or more than 1 if there is no spouse, then household composition must be obtained from the applicant to determine if there are dependent children under the age 18 and thus the applicant might be financially eligible. Income of the dependent children must be verified as well.

All other income and resources listed on the LIS/MSP data file must be verified, and for non-adjudications, none of the LIS income or resource information is acceptable verification for MSP.

If the application cannot be denied for excess income as explained above, follow up verification must be obtained. The information from the LIS/MSP data file other than the aforementioned unearned types is considered leads data, but it is not complete in all circumstances to make an accurate eligibility determination for the MSP.

The new form, Medicare Savings Program - Application Information (State Form 54211), must be included with the Form 2032 when requesting verifications. This form includes the program rights and responsibilities.

Citizenship does not have to be verified under existing Medicaid rules. However, it may be possible for an applicant to be a lawful immigrant, and this is not denoted on the LIS/MSP data file. Therefore, the following question must be entered on the 2032: ‘‘Are you a citizen of the U.S.? If you answer no, please attach of copy of your immigration document showing your lawful resident status’’.

The LIS/MSP data file transmits mailing address not residence address. Therefore, Indiana residence must be verified. In addition to checking the ‘‘residence’’ box on the 2032, enter the following: ‘‘Is your households address the same as your mailing address? If no, please provide your household address’’.

The LIS program does not ask for or count the cash value of life insurance so verification of the CSV must be requested of all applicants.

The LIS application does not ask for race/ethnicity, so this must be requested. This would not affect the person’s eligibility, however, if not provided.

If the applicant’s first response to the first request for verification is timely but incomplete or causes the need for additional clarification, a second request must be sent to clarify. An application is not to be denied based on a partial response to the first verification request. If a response is not received at all by the first due date, a reminder must be sent.

Whenever an MSP-only recipient subsequently asks for full coverage Medicaid, another application is not required.

If the LIS/MSP applicant has full coverage Medicaid already open, an MSP decision can be made based on the information already in the Medicaid case, even if MSP was previously denied or discontinued. However, discrepant information must be resolved.

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2200.00.00CONTINUING CASE PROCESSING

This chapter contains policy regarding continuing case processing, including:

Redeterminations (Section 2205);
Changes (Section 2215);
Processing Changes (Section 2220);
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Correction of Spend-down and Liability (Section 2239);
AG Address Change (Section 2240); &
Voluntary Withdrawal from Assistance (Section 2250).

2205.00.00 REDETERMINATIONS

Periodic reviews of eligibility must be made on assistance cases to ensure that benefits are computed correctly. The requirements for redeterminations are discussed in this section.

A redetermination is the process in which the caseworker gathers information on the circumstances of the case members and verifies all changeable elements to establish continuing eligibility.

In general, during a redetermination the following must occur:

A new redetermination summary, which is considered the Eligibility Review Form, containing current information is printed and signed by the individual or authorized representative; and

All changeable eligibility factors for the AG are verified.

Individuals eligible under MASI are not required to complete a redetermination with the DFR.

2205.05.00ESTABLISHING THE REDETERMINATION MONTH

The redetermination month is the month during which eligibility for all assistance groups in a case is reinvestigated. Federal regulations define the maximum time frames for completion of redeterminations for each program. If there are multiple AGs in the case, the redetermination month is established at the earliest required interval based on the following requirements:

For MAGI Medicaid, different individuals within the same AG may have different redetermination periods; AGs under MAGI-based income must be redetermined once every 12 months, and no more frequently than once every 12 months;[1]

For Non-MAGI Medicaid, a redetermination must be completed at least once every 12 months;[2]

The Non-MAGI Medicaid categories redetermination periods cannot exceed 12 months but can be shortened to align with other TANF or FS within the same AG.

2205.10.00 SCHEDULING REDETERMINATION INTERVIEWS

Interviews cannot be required for MAGI or Non-MAGI Medicaid recipients who are having their eligibility redetermined.

2205.15.00 REDETERMINATIONS BY MAIL

A redetermination may be completed by an in-office or telephone interview, or by mail using the system generated Eligibility Review Form. All members will receive the system generated Eligibility Review Form as the preferred method for conducting redeterminations. An in-office or phone interview for recipients of Medicaid/Hoosier Healthwise is not required, but it is an option that is available. If the member asks for a phone interview, one must be granted.

For MAGI-Medicaid only cases, the agency must make a redetermination of eligibility without requiring information from the individual if able based on reliable information contained in the individual’s account or other more current information available to the agency. The earliest this would begin is December 2014 for AG’s determined eligible under MAGI rules from AG’s previous eligibility determination.

If the agency is unable to redetermine the eligibility of the individual with already available information then one Eligibility Review Form is sent per individual. The non-asset version is used when all assistance groups in a case are Hoosier

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[1] 42 CFR 435.916

[2] 42 CFR 435.916

Healthwise AGs that have no asset requirement. It includes a cover page with information about the process and instructions for returning the form. The asset version is used when one or more of the AGs in a case have an asset requirement. For example, if the AGs in a case are MA 2, and MA D, the asset version of the form is used. It includes a cover page with information about the process and special circumstances involving asset disclosure, and instructions for returning the form. The Eligibility Review Form is sent to one of the Authorized Representatives in the case who is designated ‘‘apply’’. If there is no representative so designated, the form is sent to an adult AG payee or parent/caretaker of a child AG. If a child is the only case member and there is no authorized representative, the form is sent to the child. A Notice of Redetermination (NOR) is sent to the other adult AG payees and authorized representatives in the case informing them that the Eligibility Review Form has been sent. The NOR identifies the recipients who are being reviewed and the due date listed on the Eligibility Review Form. A Reminder Notice is sent when the Eligibility Review Form is not returned timely by the AG.

2215.00.00 CHANGES

The individual may report a change in circumstances or the DFR may learn of a change which could affect eligibility or the benefit amount. The worker is responsible for promptly evaluating the change and taking any indicated action to adjust the benefit. A person eligible under MASI reporting changes to DFR should be informed that the reported change (i.e. change of address) should also be reported to the Social Security Administration.

Changes in circumstances include, but are not limited to:

Changes in income;

Changes in composition of the AG;

Changes in living arrangement;

Changes in resources;
Changes in the legal obligation to pay child support;

Changes in household tax relationship or tax filing status;

Changes in health insurance coverage.

2215.10.00 DATE CHANGE REPORTED

The date a change is reported is the date on which an individual reports the change in person, by phone, by fax, or in writing to the Local Office or Document Center. This includes speaking directly to the worker or other staff member and leaving messages

for the worker. All reports of changes are to be accurately documented in Running Record Comments and should be entered in ICES the same day the change is reported. ICES establishes the date that the information is entered in the system as the date it was reported. The "occur date" is the date on which the change actually occurred.

2215.15.00 WORKER RESPONSIBILITIES REGARDING CHANGES

Prompt action must be taken on all changes to determine if they affect eligibility. The case record must include the date the reported change was received, whether the change was reported by mail, telephone, the DFR Benefits portal, fax, or personal visit, the nature of change and any other appropriate information. The worker must take appropriate action on all reports of changed information promptly but no later than 10 days from the date of the receipt of the change.

The individual must be notified of any change in eligibility or benefit. In addition, if the change was reported by the AG, the AG will be notified even if there is no change in eligibility or benefit amount.

If the worker is made aware of discrepant information or information that could affect eligibility or level of benefits, but lacks enough information to determine the effect, he will issue a request for verification. This request should be issued on the date of receipt of the change if at all possible, outlining the needed information or verification, and giving the AG 13 days from the date the notice is issued to provide the information.

If the AG provides the requested information or verification within the designated 13 day period, the worker will take appropriate action. If the AG refuses to provide the requested information or verification within the designated 13 day period, the worker will, on the first day following expiration of the 13 day period, take action to recalculate eligibility and authorize the appropriate action for each AG. The worker must enter the appropriate reason code on AEWAA which reflects the element which the AG did not verify.

If a potential change in medical expenses is identified when the AG presents verification of expenses to meet the spend-down, the AG may be asked to confirm if a change has occurred. If the AG voluntarily provides all verification and information necessary to process the change, including the frequency of any new expenses and possible third party liability, the change must be processed. If the AG is unable or unwilling to provide the necessary information/ verification, the change cannot be processed because the AG is not required to report or provide verification of medical expenses.

All medical expense changes identified from sources other than the household will not be acted upon unless all necessary verifications are obtained and action can be taken without contacting the AG.

2220.00.00 PROCESSING CHANGES

Individuals are given 10 days to report the change, 13 days to verify the change, and if the action is negative, 10 days (plus three days for mail delivery) timely notice of adverse action. If the individual is doing all that he can to cooperate in verifying the information but is unable to do so, an extension may be granted or the DFR may accept the responsibility of verifying the information. Document the reason for any extension in Running Record Comments. In either instance, if the individual and the worker are unable to adequately verify the information within a reasonable time, the worker is to use the best available information to process the change and document in Running Record Comments.

When it becomes necessary to take adverse action (that is, reduce the benefit level) on an AG, there must be time to give advance notice of the adverse action. This is referred to as timely notice. The time period is 13 calendar days for all programs.

The following sections discuss change processing.

2220.05.00 CHANGES REPORTED AND VERIFIED TIMELY

When a change is reported within 10 days of the date the change occurred and is also verified within 13 days of the report date, action is taken as indicated below:

When a change results in a positive action or increases the level of benefit, including the addition of a mandatory AG member, the effective date of the change is the month following the month the change was reported.

EXAMPLE: An individual reports on 7/25 that his last day of work was 7/16 and his last paycheck will be 7/26. He provides a statement from his employer on 7/30 (within 13 day guideline). The earnings are removed from the budget effective 8/1.

If the AG's benefit level decreases or the AG becomes ineligible as a result of the change, the decrease in the benefit level is effective the month following the expiration of the timely notice period.

There is an exception for women who become pregnant and are receiving coverage for Family Planning Services for Women and Men under MA E. If the pregnant woman reports that she is pregnant, eligibility for MAGP will need to be determined and coverage may be granted retroactively without requiring another application being filed. In such situations, the appropriate DFR staff member would need to contact the Help Desk/PAL regarding the situation as a fileaid would need to be done, if appropriate, to end date the MA E coverage so MAGP coverage could be granted.

2220.10.00 CHANGES REPORTED UNTIMELY YET VERIFIED TIMELY

If a change is not reported within 10 days yet is verified within 13 days following the report date, action is taken as indicated below:

When the change results in an increase in benefits or other positive action, the change is effective the month following the date reported.

EXAMPLE 1:
An individual who is required to pay a premium for health coverage is fired from his job on 6/3 and received his last paycheck on 6/23. He calls to report the change on 6/28. On 7/3 he faxes in his last paycheck stub. The caseworker verifies by phone that his last day was 6/3 and his last pay was 6/23. The loss of earnings are reflected 7/1 with a supplemental benefit of either a lower premium or no premium for health coverage beginning 7/1.

When the change results in a decrease in benefits or the AG becomes ineligible, the change is effective the month following the expiration of timely notice.

EXAMPLE 2:
An individual begins a job on 5/26 which he reports on 7/19. His earnings require the payment of a premium for health coverage effective 9/1. Recovery is pursued for July and August. Refer to Chapter 4600.00.00.

2220.15.00 FAILURE OF ASSISTANCE GROUP TO REPORT CHANGES

If the DFR discovers that the AG failed to report a change as required above and as a result received benefits to which it was

not entitled, a referral is made to Benefit Recovery (BV) on screen BVBR to initiate claim determination and benefit recovery.

2220.25.00 PROCEDURES WHEN MEDICAID FACILITY LOSES CERTIFICATION

When a Medicaid-certified long term care facility receives notification from the Department of Health that its Medicaid provider agreement will be terminated a copy of the notification is sent to the Local DFR Office. Generally, the facility is given 30 days advance notice of the loss of certification. However, the facility does have appeal rights. If the facility appeals and the Department of Health rules that the patients are not in immediate and serious danger, the facility's Medicaid certification may be allowed to continue during a specified period of time while the deficiencies cited by the Department of Health are being remedied.

The DFR will need to stay in close communication with the facility concerning the facility's continuing Medicaid certification. Steps to change the recipients' data in ICES (Screen AEIII) should not be undertaken immediately by the worker upon receipt of the initial decertification letter. The facility's appeal status and any subsequent rulings of the Department of Health must be ascertained. If the worker cannot obtain the necessary documentation from the facility, the Central Office, Policy Answer Line, should be contacted.

2225.00.00 ADDING AN INDIVIDUAL TO THE AG (MED 2, MED 3)

When a request to add an individual to the AG is received or a mandatory AG member enters the home, all eligibility factors must be reviewed.

Neither an application nor an interview is necessary, but all of the required information and verification regarding the new member must be obtained in order to make an eligibility determination and add him to the AG.

The new member is entered on AEIID. Pertinent information is then added to the appropriate screens as they appear. The system will generate a notice to inform the AG of the results. If adding a non-participating mandatory member causes the individual to lose Medicaid eligibility, ICES will explore continued Medicaid eligibility under other categories.

To provide the new member with retroactive coverage, it will be necessary to fiat to create an AG (consisting solely of the new person or persons) for the retroactive months. The sequence number to be used for the retroactive AG will depend upon the number already in use for the first AG. If the sequence number for the original AG is 01, the sequence number for the fiated AG

will be 02. Additionally, it is important to remember to end-date the fiated AG appropriately.

2225.10.00 ADDING A NEWBORN CHILD

An infant born alive to a woman enrolled in any MA category except MA10 is deemed eligible for Medicaid without an application for the infant being submitted. The baby is to be immediately added to ICES upon the agency receiving notification of the birth. Refer to Section 2428.00 for more information regarding eligibility in the Newborn category.

Health coverage under the Newborn category is effective the first day of the month in which the child is born and continues for 12 consecutive months. The only allowable reasons to discontinue MA before the end of the 12-month Newborn period are 1) the child no longer lives in Indiana, 2) the child’s parent or caretaker provides a written voluntary withdrawal statement, or 3) the child dies. Newborn coverage continues regardless of whether the infant continues to live with the birth mother or whether the child ever lived with the birth mother in the case of adoption or other custody arrangement. However, if the child is adopted and the names and location of the adoptive parents are unknown, the child can only be covered for the duration of the hospitalization starting with the month of birth. If the infant has not been named, the name assigned to her/him by the hospital for identification purposes, should be used.

Information sufficient to enroll the infant in the Newborn category is the child's name, sex, and date of birth. Birth notification may be made by the parent; however, notification is also to be accepted from the hospital, authorized representative in the case, medical provider or Hoosier Healthwise health plan that can knowingly provide the required information.

When the 12-month Newborn coverage period expires, eligibility under other medical categories must be explored and verified. The child was deemed to have applied at birth, and therefore an application cannot be required in pursuing a category change.

Newborn coverage does not extend to babies born to mothers covered under the MA 10 category (Hoosier Healthwise Package C). However, upon request by the parent/caretaker or other notification of the birth, an application is to be immediately provided or mailed to the family, or information given about obtaining an application from the internet. Hospitals and other Indiana Medical Providers that are Hoosier Healthwise enrollment centers should be encouraged to take the applications for newborns. They will know the eligibility status of the mother by using their Eligibility Verification System, which will indicate the benefit package of the mother.

2232.00.00 TIMELY NOTICE OF ADVERSE ACTION

Recipients must be given timely, advance written notice of any adverse action. In most circumstances, "timely" is 10 days (plus 3 for mailing) before the date the action is effective. The 3-day mailing period starts the day after the notice is mailed. The monthly Adverse Action dates are located on table TBIC. The Medicaid program has provisions which allow for exceptions to the 10 day (plus 3 for mailing) timely notice period. The following sections explain the MED timely notice exceptions.

Workers should carefully choose the reason code to be entered on AEWAA. It must be appropriate to the category and if timely notice is not required, enter a code with a priority of 1 on the TSRC Table. If a negative code in addition to the 650 code is not already displayed, the worker will be required to enter one. It is necessary to select the reason code carefully so that the notice will correctly reflect the reason benefits are terminating.

2232.10.00 EXCEPTIONS TO TIMELY NOTICE (MED)

The following situations do not require timely notice, but do require notice to be sent no later than the effective date of action:[3]

The DFR has factual information confirming the death of a recipient;

The DFR has received a written voluntary withdrawal of assistance; or

The DFR has verified that the recipient has been accepted for assistance in a new jurisdiction (county, state, territory or commonwealth).

2235.00.00 CHANGES IN CATEGORY OF ASSISTANCE (Clevidence Ruling) (MED)

When a Medicaid recipient loses eligibility under his/her current category of assistance, eligibility under all potential categories must be explored. If the case record contains information that a recipient is potentially eligible in another category, a new pending category will be formed by ICES according to recipient’s recorded information reflected in his/her case file and the Medicaid categorical hierarchy (see IHCPPM 2035.30.00). Medicaid MUST NOT BE INTERRUPTED WHILE A DETERMINATION IS BEING MADE CONCERNING THE RECIPIENT’S ELIGIBILITY IN THE NEW CATEGORY.

[3] 42 CFR 431.213

If there is no information indicating possible eligibility under another category, Medicaid is to be discontinued. If the recipient is found to be ineligible in the newly formed category, Medicaid is to be discontinued. When eligibility is to be discontinued, a discontinuance notice is mailed to the recipient, which contains a list of all applicable categorical groups. If the client supplies information indicating potential eligibility under another categorical group prior to the recipient's effective date of discontinuance, Medicaid eligibility must be reinstated while eligibility under the new potential category is being determined.

When a change is reported that results in a new Medicaid category, Medicaid benefits continue without interruption. The worker must ensure that the proper reason code is entered for any adverse action, such as the imposition of a spend-down, liability, or premium. If the person is required to pay a CHIP or MED Works premium, continued eligibility is conditional upon the first day of the first month the premium categorical coverage begins. Whenever there is an adverse action, recipients must be given timely notice before the effect of the adverse action takes place. Please, refer to IHCPPM 2232.00.00.

If the eligibility status for a recipient under a new category is pending because of missing verification(s), the worker must send the Medicaid Category Change Form, FI 0017, to the client. Form FI 0017 must be completed by a worker and sent to the recipient with a 13-day deadline. If the client fails to contact the DFR by the due date specified on Form 0017, Medicaid is to be discontinued. If the client contacts the DFR any time after receipt of the discontinuance notice and provides information which was specified on Form 0017, the client must come into compliance prior to the effective date of discontinuance to have eligibility continued. (Refer to IHCPPM 2040.00.00). If the DFR is contacted after the effective date of discontinuance, the client will have to re-apply.

Once a recipient responds timely providing additional information to continue eligibility and provides sufficient verification to determine eligibility under the new category, Medicaid eligibility continues without interruption. If the recipient provides information indicating possible eligibility under another category but does not provide sufficient verification, FI 2032 must be sent providing a 13-day deadline requesting the new verifications needed for eligibility determination under the new category. If the missing information is not returned by the due date on the 2032, Medicaid eligibility is to be discontinued.

If the missing information is related to blindness or disability not being verified (see IHCPPM 2412.10.00 and 2412.30.00) for the recipient, then DFR must schedule an interview with the client to conduct the Social Summary and collect Medical Evidence (refer to IHCPPM 2412.10.00 and IHCPPM 2412.30.05) for the preparation of the medical packet to be sent to MRT for a determination of

disability or blindness (refer to IHCPPM 2412.15.15 and IHCPPM 2412.50.00).

If a woman self-attests to being pregnant (refer to IHCPPM 2426.00.00), then eligibility may be considered under that category.

Example #1

A parent lives with her only child and receives MAGF. The child is seventeen and turns eighteen. The parent is no longer eligible to receive MAGF because she is no longer the caretaker of a dependent under 18. DFR notices that she previously claimed she was disabled but had never had disability determined by MRT or SSA. A Form FI 0017 is sent to the parent and prior to the deadline on that form, she contacts DFR and re-claims that she is disabled. DFR conducts the interview to complete Form 251B, Determination of Disability Social Summary, and the worker requests medical records in accordance with IHCPPM 2412.30.05. Unless medical records are not timely received due to a failure by the recipient, Medicaid will continue until MRT renders a determination that she does not meet the disability determination. If MRT determines that she is disabled and she meets all other criteria for MA D, her coverage under MAGF will be discontinued but she will then be granted MA D coverage.

Example #2

A 20-year-old recipient lives with her mother and is eligible under MA T. She turns 21, and according to the current information in ICES she would not qualify under any other category. DFR closes her AG, and a discontinuance notice is mailed to the MA T recipient. The MA T recipient contacts the DFR prior to her effective date of discontinuance and states she just learned that she is pregnant. The self-attestation of pregnancy meets verification requirements under IHCPPM 2426.00.00. DFR determines her eligible under MAGP, and there is no interruption in her benefits. Her coverage will change from MA T to MAGP.

2236.00.00 REDUCTION IN SCOPE OF MEDICAID COVERAGE (MED)

The following circumstances will result in the DFR taking action to reduce the scope of benefits. These are adverse actions requiring timely notice.

A recipient formerly eligible for full coverage becomes eligible for QMB-only, SLMB-only, or QI coverage;

A recipient eligible for full benefits loses eligibility for payment of nursing facility services or Home and Community-Based Services due to a violative transfer of property;

A recipient who was eligible for QMB-only coverage becomes eligible for SLMB-only coverage.

A recipient who was eligible for SLMB-only coverage becomes eligible for QI coverage.

A recipient who was receiving full coverage becomes eligible for Family Planning Services for Women and Men.

2237.00.00 SUSPENSION OF MEDICAID BENEFITS (MED 1, 4)

If a change in circumstances causes temporary financial ineligibility for MA, the AG may be suspended for up to two months. This can only be done in situations where it is reasonably certain that the recipient will again be eligible after the suspension. The typical situation in which this provision is applicable is in nursing home cases when the recipient accumulates excess resources. If there is a specified plan to spend the excess to the allowable limit without violating the transfer of property law, a suspension may be appropriate. If the recipient is eligible before the end of the suspension period, eligibility is to be reinstated without a reapplication. If after the suspension period the recipient remains ineligible, Medicaid must be discontinued. (Timely notice is required.)

2237.05.00 SUSPENSION INCARCERATION/PSYCHIATRIC ADMISSION

This provision is effective January 1, 2010.

When a recipient becomes incarcerated or is admitted to a psychiatric facility that results in ineligibility, the individual’s health coverage is to be suspended, not discontinued.[4] The case action for either one of these circumstances is always to be suspension, regardless of the expected length of institutionalization. The suspension continues until the individual is released from the facility, but will not

[4] IC 12-15-1-20.4(a)

exceed 12 months. There is no limit on the number of times a recipient can be suspended. A single 12-month period will not be extended for any reason. The 12-month period begins on the first day of the month after institutionalization (or the following month if required to meet adverse action rules) and ends on the last day of the 12th month, at which time health coverage is discontinued if the individual remains institutionalized.

The suspension policy applies to all MED categories regardless of the age of the recipient.

The suspension policy applies only to recipients. It does not apply to applicants including individuals in MA10 and MADW conditional status.

Incarceration or psychiatric admission which will last for less than 30 days does not require an eligibility review.

Upon receiving notification that a recipient is institutionalized for at least 30 days, a review of the change in circumstances is required to determine whether the recipient remains eligible in the institution (in the case of a psychiatric admission) and what impact there is on other case members and other program eligibility. For children who enter juvenile detention facilities, correctional facilities for children, and secure facilities not licensed as child-care facilities, state law requires the juvenile court that adjudicated the delinquency to notify the DFR of the detention. This notification requirement was effective 7-1-09.[5]

During the period of suspension, case management activity such as redeterminations, processing data exchange updates, etc., will not occur when there are no other eligible recipients in the case. On the last day of the 12-month suspension period, the individual's eligibility status is systematically changed from suspended to closed.

2237.10.00 REINSTATEMENT OF BENEFITS FOR SUSPENDED INDIVIDUALS

Benefits for individuals who are in suspend status in accordance with Section 2237.05.00, are to be reinstated without a reapplication if the individual returns to an eligible living arrangement before the 12 month suspension period has expired, and the requirements of this Section are met.

State law requires that the DFR office be notified by the Department of Correction within 40 days of a suspended child's

[5] IC 31-37-22-9

release from a facility specified in Section 2237.05.00.[6] This requirement is also applicable to all suspended former recipients whose release date from a facility is established. If the release back to the community, including the release date, is timely reported and documented in writing, the change must be processed in time so that the individual's Medicaid coverage is active upon release from the facility. Coverage for these members should start first of the month in the month they reapplied and/or notified the DFR of release. In HIP cases the individual will be opened up in Basic, with a potential plus flag, regardless of whether they are below or above 100% of the FPL. The member will be given 60 days, from the date of authorization, to pay the PAC payment. If the PAC is not paid within the 60 days, members who are below 100% of the FPL will remain in Basic and members who are above 100% of the FPL will be closed. In the case of MA10 or MADW with a premium, the AG must be conditionally approved within the 40

In order for Medicaid to be reinstated timely, the report of release/discharge must include at minimum, the release date, community address, living arrangement, and household members and be provided to the DFR within 40 days of release/discharge. If all documentation is timely reported but the exact discharge date is not specified, benefits are not to be reinstated until the date is documented. This may result in benefits not being available on the date of release/discharge.

If the former recipient returns to an active case, the existing redetermination month will apply to the recipient upon reinstatement. Follow up verification of eligibility factors is required on reported information and discrepant information. MADW cannot be reinstated unless current employment is verified. If a progress report is due, MA D, MADW, or MA B cannot be reinstated until the MRT approves the continuation of disability.

If the individual returns to a case with no active members, the redetermination month will be systematically reset to 3 months in the future.

2238.00.00 DISCONTINUANCE

When an AG fails to meet the eligibility requirements of any category within a program, assistance is discontinued for that program. Discontinuance is effective the first day of the month following the expiration of the required timely notice.

2238.05.00 DISCONTINUANCE DUE TO DEATH

When a recipient dies, the living arrangement code on AEIDC is to be changed to "05" and the correct verified date of death is

[6] IC 12-15-1-20.4(b)

entered as the occur date. This action will invoke ED/BC and the AG can then be closed. This is crucial for Medicaid AGs because the fiscal contractor must have the correct date of death to ensure that claims will not be paid erroneously.

When an institutionalized recipient dies, the end date and delete code for death are entered on AEIII. This will bring up AEIDC where the living arrangement type of "05" and the date of death can then be entered.

It is important to allow ED/BC to run so that the individual is denied in ICES prior to deleting the individual. This ensures that the information is passed correctly to MMIS.

2238.06.00 DISCONTINUANCE DUE TO WHEREABOUTS UNKNOWN

When mail is returned as undeliverable with no forwarding address, efforts must be made to confirm the correct address, including checking documents in the case records, calling the individual at the phone number(s) on record, checking all available electronic resources and sending a 2032 address verification request to the last known address in the case record or to an authorized representative. Sending the pending request form may of course result in another returned mail, but it is an important step to ensure that the client is not discontinued inappropriately. If it becomes necessary to discontinue assistance because the client cannot be located and mail has been returned as undeliverable with no forwarding address, timely notice is required. If the client contacts the DFR before the effective date of the discontinuance and provides the new address, the discontinuance must be rescinded.[7]

2238.10.00 CLOSED CASE FILES

When all the AGs in a case are closed, the system will automatically transfer the case to closed files 90 days after the effective date of the discontinuance.

2238.15.00 CERTIFICATES OF MEDICAID COVERAGE

On August 21, 1996, The Health Insurance Portability and Accountability Act (HIPAA) were enacted. This law is designed to improve the availability of health insurance to working families and their children, including eligible individuals who have previous coverage under Medicaid. The provision of the law that directly affects the Division of Family and Children is the requirement concerning the issuance of certificates of creditable coverage. An individual, who enrolls in a health care plan that imposes an exclusionary period for a pre-existing medical condition, may be able to have that period reduced by prior

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[7] 42 CFR 431.231

coverage under another plan, including Medicaid. The DFR must issue the Certificate of Medicaid Coverage (FI Form 0021) to the individual so that he can present it as documentation to the new health insurance plan. Periods of Medicaid eligibility beginning July 1, 1996 for all full coverage categories and the pregnancy-related category, except as explained below, are included as creditable coverage:

Exclude QMB-Only, SLMB-Only, and QI coverage. Unlike the pregnancy-related categories, these categories do not provide coverage of regular Medicaid services.

Exclude months of ineligibility for which a recovery claim has been established and is currently in dispute through the administrative hearing process.

Exclude months the person did not meet spend-down.

The following procedures are to be used when issuing the certificate:

1. The ICES discontinuance notices for reasons other than death of the recipient contain the following paragraph which notifies the assistance groups that Certificates of Creditable Coverage are available upon request:

   Important information about health insurance coverage. If you enroll in a health insurance plan that does not give you coverage for a preexisting medical condition, you may need to furnish proof of your Medicaid benefits. Ask the Plan Administrator of your health insurance about this. If you need proof of Medicaid eligibility, contact the caseworker whose name is on the first page of this notice and ask for a Certificate of Medicaid Coverage.
   When it is necessary to issue a manual discontinuance notice (619M), workers must include the above paragraph in the additional information section of the notice. If the recipient's Medicaid coverage since 7-1-96 consisted solely of QMB only or SLMB only, it is not necessary to include the paragraph. However, if since that time, the person had full coverage or pregnancy-related coverage the paragraph must be entered on the notice.

2. Upon request by a former recipient, the FI Form 0021, Certificate of Medicaid Coverage, must be completed and mailed first class to the individual within 10 working days of the request. The DFR is encouraged to try to accommodate requests made in person by giving the certificate to the individual at the time of the request. However, if this is not possible, the aforementioned time frame should be met. When mailing the Certificate, the current address should be

obtained from the individual rather than relying on the last address in ICES.

As an alternative to mailing a Certificate, it can be faxed directly to the health care plan administrator or the information can be provided by phone to the administrator only if the following conditions are met:

The individual requests it; and

The alternative method being requested by the individual is acceptable to the plan administrator.

If the two conditions are not met, the Certificate must be mailed to the individual.

3. As a general rule, one Certificate is completed per family. However, separate certificates are to be provided if requested. This could be needed if, for example, children are being enrolled in different insurance plans held by non-custodial parents.

4. Enter the name and address of the DFR and indicate the name and telephone number of a contact person in case the health insurance plan has any questions. This person can be the recipient's worker or anyone designated in the DFR to serve as coordinator for matters concerning the certificates.

5. Enter the name of each recipient in the family requesting the Certificate. Note that the Certificates do not necessarily have to correspond to the former assistance groups. For example, one AG may have been a child living with grandmother and the other AG in another case was the child's sibling and mother. When the certificate is requested, the mother and her 2 children are now living together. Unless there is a reason to issue separate certificates as requested by the family, or because there are too many eligibility periods, one certificate using all 3 recipients and their Medicaid coverage periods should be issued.

6. Enter the recipient's Medicaid number, i.e., the RID, not the case number.

7. List all creditable coverage periods after July 1, 1996 up to the present time without regard to category changes. For example, if a child was on MA 2 from 1/1/97 to 6/30/97 and MA D from 7/1/97 to 9/30/97, the entry on the certificate would be

BEGIN 1/1/97 END 9/30/97

Coverage prior to July 1, 1996 should not be listed. If an individual had coverage prior to July 1, 1996 enter the begin date on the certificate as July 1996. If the person is currently on Medicaid, enter "currently covered" in the end date box.

The statement on the Certificate which states that prior breaks in coverage may be included is information for health insurance companies only. The law specifies that certain coverage that has been interrupted cannot count as creditable coverage. The insurance company determines how creditable coverage is applied to an exclusionary period and the statement on the Certificate is simply to alert them to the fact that all coverage periods, regardless of breaks, are being reported on the form. The following are examples of how to enter eligibility periods on a Certificate:

EXAMPLE 1
Recipient was eligible from 10/96 through 11/97 with a spend-down. He met his spend-down in the months of 10/96, 12/96, 3/97, and 10/97. Entries on the Certificate should be listed as follows: BEGIN END 10/02/96 10/31/96 12/05/96 12/31/96 03/10/97 03/31/97 10/01/97 10/31/97 (Months that the spend-down is not met are not listed, and the DFR should inquire of HP what months spend-down was/was not met.)

2238.20.00 CONTINUOUS ELIGIBILITY FOR CHILDREN UNDER AGE 3

Children under the age of 3 who are determined or redetermined eligible for any category of Medicaid will remain continuously eligible until their annual redetermination.[1] Medicaid coverage is to be retained for a full 12 months regardless of income or other factors that would otherwise cause the child to be discontinued. The CE period ends on the last day of the month in which redetermination is due.

There can be up to three consecutive CE periods. Category changes from full (Package A, Medicaid or HHW) to limited (Package C, MA 10) benefits are not allowed, and closure should only happen for these reasons:

Death;
Moved out of State;
Written voluntary withdrawal;
Failure to pay Package C premium.

[1] IC 12-15-2-15.8

When redetermining eligibility for a new 12 month period, CE protection is lifted and normal eligibility rules apply. If the child is no longer eligible, benefits can be denied at redetermination. If the child is still under 3 and is redetermined to be eligible, a new protected CE period begins. If the child turns 3 or the CE period ends prior to the scheduled redetermination, the case review occurs at redetermination.

EXAMPLE 1

In January an application is submitted for a baby who is 18 months old, and MA Z is authorized with three months of retroactive coverage. The CE period is set as January through December.

In June, income increases and MA 10 forms for the child. Because MA 10 is not equivalent coverage, a FIAT must be done to maintain the MA Z coverage until redetermination.

At the redetermination in December, MA 10 continues to form and can be authorized for the second CE period, which will start in January of the new year and continue until that December.

The child will have her 3rd birthday in the middle of her second CE period, but her coverage can continue until the scheduled redetermination in December.

Change reporting (other than a change of address) is not required for a child in a CE period. If a redetermination is done for other family members during the child's CE period, the family is not required to verify any income or assets belonging to the child as they pertain to the child's eligibility. If the family chooses to verify anyway, the following changes can be made:

- The child can move from Package C to another medical assistance category;
- MA 10 premiums and Medicaid spend-downs can be decreased or increased.

While other category changes may occur during the CE period, a child covered under traditional Medicaid or Hoosier Healthwise Package A is not to be moved to Package C (MA 10) as this would entail the closure of Medicaid. Approval of Package C can only be permitted during the child's Medicaid redetermination.

EXAMPLE 2
A child is initially approved for MA 10 coverage. In month 4 of the CE period, his mother is due for a redetermination. Her Medicaid is closed for failing to provide updated income. Medicaid for the MA 10 child must be left open (as long as premiums are being paid), which may require a FIAT.

In month 6 of the child's CE period, the needed information to rescind the redetermination denial is provided and the income causes the child's premium to increase. Because he was already receiving MA 10 and this is not a category change, it can be authorized.

In month 8, the child's mother reports that she is getting fewer hours at work. The newly verified income causes his MA 10 to switch to MA 9. Because this is a beneficial category change, it can be authorized.

It should be noted that children are deemed eligible for coverage in MA X due to their mother's Medicaid status. Redeterminations are not set for this category; instead, eligibility under a new category of medical assistance must be determined when the child turns 1. Except for citizenship, the usual eligibility factors (including social security number) are to be verified. If found eligible, the child's first CE period would begin the month the new category is authorized.

2238.25.00 REDETERMINATION 90-DAY EXTENSION FOR FAILURE TO VERIFY

If an AG is discontinued for failing to verify required information during the re-determination process, the DFR must timely consider eligibility without requiring the AG to submit a new application when the missing verification(s), which were the reason(s) for discontinuance, are received by DFR within 90 days after the AG had eligibility effectively discontinued.[8]

If an AG is denied eligibility, this sub-section is inapplicable. If an AG is discontinued for failing to verify required information after a report of change has been received by DFR, this sub-section is inapplicable. If an AG is discontinued at point of redetermination for any reason(s) other than failing to verify required information, such as being over income, this subsection is inapplicable.

[8] 42 CFR 435.916(a)(3)(C)(iii)

2239.00.00 CORRECTION OF SPENDDOWN AND LIABILITY (MED 1)

If an authorized spend-down or liability amount is lower than it should be (for example, client or agency error, or hearing decision), recovery of any Medicaid overpayments must be pursued in accordance with the provisions in Chapter 4600.

However, in specific circumstances, authorized spend-down and liability amounts which are higher than they should be can be corrected to a lower amount by using screen CUMED. Acceptable reasons to use CUMED are as follows:

Timely appeal filed after cut-off;

Beneficial change timely reported and verified after cut-off;

Agency error in calculation of spend-down or liability amount;

Hearing decision decreased spend-down or liability amount;
Court ordered decreased spend-down or liability amount.

No other reasons are acceptable in using CUMED. If a worker encounters a circumstance not listed above and feels the spend-down or liability correction should be made, the Policy Answer Line must be contacted.

When a change is made on CUMED for a given month, the "BNFT/S-L" field on IQAE for the eligibility segment containing that month, will be highlighted. This serves as an alert that at least one of the months in that eligibility segment has been changed via CUMED. AEBMB can be accessed to view the correct spend-down and/or liability amounts.

2240.00.00 AG CHANGES ADDRESS

Moving to a new address in Indiana, in and of itself, does not cause ineligibility. A new living situation may trigger new elements to be verified; however eligibility must not lapse while the systematic process of changing cases is completed.

2250.00.00 VOLUNTARY WITHDRAWAL FROM ASSISTANCE

A recipient may voluntarily withdraw from assistance at any time.

The withdrawal may be made in writing or verbally; however, if made verbally, a notice should be sent requesting confirmation. There should be a copy of the corroborating collateral request in the case file. Eligibility should not be discontinued if the written confirmation is not received.

For situations where the recipient wishes to waive timely adverse notice, reference sections 2232.05.00 thru 2232.15.00.

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2404.25.10 Penalties for SSN Non-Compliance

2404.30.00 VERIFICATION OF SOCIAL SECURITY NUMBER

2404.30.05 Social Security Numbers Not Verified Through Data Exchange

2406.00.00 RESIDENCY

2406.05.00 RESIDENCY OF HOMELESS INDIVIDUALS

2406.20.00 RESIDENCY REQUIREMENTS

2406.20.05 Residency of Non-Institutionalized Individuals

2406.20.10 Residency of Institutionalized Individuals

2406.20.10.05 Out-Of-State Placement In An Institution

2406.25.00 TEMPORARY ABSENCE FROM INDIANA

2406.30.00 PERMANENT ABSENCE FROM INDIANA

2406.35.00 RESIDENCY VERIFICATION

2410.00.00 AGE

2410.05.00 DEFINITION OF A CHILD (MED 2, MED 3)

2410.05.05 Age Requirements (MED 3)

2410.05.20 Child Attains Age Limit (MED 3)

2410.05.25 Verification of Age (MED 3)

2410.15.00 AGE REQUIREMENT (MED 1)

2412.00.00 BLINDNESS OR DISABILITY (MED 1)

2412.05.00 DEFINITION OF BLINDNESS (MED 1)

2412.10.00 VERIFICATION OF THE VISUAL REQUIREMENT (MED 1)

2412.15.00 PAYMENT FOR EYE EXAMINATION (MED 1)

2412.15.05 Eye Examination Requirement for Reapplications (MED 1)

2412.15.10 INABILITY TO OBTAIN EYE REPORT (MED 1)

2412.15.15 Decision Of Medical Review TEAM (MED 1)
2412.15.20 Required Re-Examination of Eyesight (MED 1)
2412.20.00 TREATMENT FOR RESTORATION OF EYESIGHT (MED 1)
2412.25.00 DEFINITION OF DISABILITY (MED 1)
2412.30.00 VERIFICATION OF THE DISABILITY REQUIREMENT (MED 1)
2412.30.05 Exceptions when MRT will determine disability
2412.30.10 Preparation of Medical Packet for MMRT (MED 1)
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2414.00.00 SSI STATUS
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2414.10.10 Disabled Adult Children
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2415.00.00 CATEGORICAL ELIGIBILITY FOR MEDICAID WAIVERS
2416.00.00 MEDICARE STATUS (MED 4)
2416.05.00 QUALIFIED MEDICARE BENEFICIARY (MED 4)
2416.10.00 QUALIFIED DISABLED AND WORKING INDIVIDUALS (MED 4)
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2416.20.00 QUALIFIED INDIVIDUALS (MED 4)
2418.00.00 Household Tax Relationships (MED 3)
2420.00.00 RESIDENCE IN THE HOME OF A SPECIFIED RELATIVE (MED 3)
2420.05.05 Verification of Relationship (MED 3)
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2432.05.00 REQUIREMENTS FOR REFUGEES (MED 2)

2433.00.00 HEALTH INSURANCE COVERAGE CONSIDERATIONS (MA 10)

2434.00.00 ASSIGNMENT OF MEDICAL RIGHTS

2434.05.00 MEDICAL SUPPORT COOPERATION REQUIREMENTS

2434.10.00 IV-D SANCTION REQUEST

2434.15.00 IDENTIFICATION OF MEDICAL RESOURCES

2434.20.00 THE RIGHT TO CLAIM GOOD CAUSE - MEDICAL SUPPORT

2434.20.05 Medical Support Good Cause Determination

2434.20.10 DFR Review Of Good Cause Determination

2434.25.00 PENALTIES FOR MEDICAL SUPPORT NON-COMPLIANCE

2434.30.00 CIRCUMSTANCES WHEN PENALTIES ARE NOT APPLIED

2435.00.00 HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

2400.00.00 NON-FINANCIAL REQUIREMENTS

This chapter contains the various non-financial eligibility requirements which must be considered depending upon the types of assistance for which an individual is applying. The major sections in this chapter are:

Citizenship/Immigration Status (Section 2402)
Requirement to Provide a Social Security Number (Section 2404)
Residency (Section 2406)
Age (Section 2410)
Blindness or Disability (Section 2412)
SSI Status (Section 2414)
Medicare Status (Section 2416)
Household Tax Relationships(Section 2418)
Residence in the Home of a Specified Relative (Section 2420)
Institutional Status (Section 2422)
Level of Care/Preadmission Screening (Section 2424)
Pregnancy (Section 2426)
Newborn Status (Section 2428)
Requirement to File for Other Benefits (Section 2432)
Health Insurance Coverage Considerations (Section 2433)
Assignment of Medical Rights (Section 2434)
Health Insurance Premium Payment Program (Section 2435).

The requirements for each of these non-financial factors and their verification requirements are described in this chapter.

2402.00.00 CITIZENSHIP/IMMIGRATION STATUS

In order to be eligible for assistance, an individual must be:

- A citizen of the United States;
- a U.S. non-citizen national (a person born in an outlying possession of the United States, American Samoa or Swain's Island);
- an immigrant who is in a qualified immigration status as defined in Section 2402.20, and who meets the specific requirements of each program; or
- an individual who meets other specific requirements for a specific program as defined in the following sections.

2402.05.00 DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

The policy stated in this section does not apply to MA X.

On the application, each applicant declares whether he is a citizen of the United States or not.

A Systematic Alien Verification Entitlements request and response of inaccurate documentation does not serve this purpose. An applicant's statement or any other third party information does not constitute a determination of unlawful status. A worker should not seek to obtain an immigrant's status unless the immigrant requests help in obtaining this verification.

A refusal to declare citizenship or immigration status will result in the ineligibility for that individual.[1]

2402.10.00 DEFINITION OF U.S. CITIZENSHIP

To be considered a U.S. citizen, an individual must meet one of the following conditions:

- be born in the U.S. or a U.S. territory (2402.10.05);
- be a naturalized citizen (2402.10.10); or
- be born abroad to a U.S. citizen and meet specified criteria (2402.10.15).

2402.10.05 Born in the U.S. or a U.S. Territory

An individual is considered born in the U.S. or a U.S. territory if either of the following conditions are met:

- the individual is born in one of the United States or the District of Columbia (D.C.); or
- the individual is born in one of the following current territories:
    - Puerto Rico;
    - Northern Marianas;
    - American Samoa;
    - Harcon Tract;
    - Swain's Island;
    - Guam; or
    - The Virgin Islands.

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[1] Social Security Act, Section 1137(d)

2402.10.10 Naturalized Citizens

An individual is considered a naturalized citizen when U.S. citizenship is gained after his birth either:

- Through individual naturalization; or
- Derived from a naturalized parent

Women who could have been lawfully naturalized and, prior to September 22, 1922, were married to citizens, or were married to aliens who became citizens before that date, automatically become citizens. An alien married to a U.S. citizen on and after September 22, 1922, must apply for naturalization to become a U.S. citizen.

2402.10.15 Children Born Abroad to U.S. Citizens

In most instances, citizenship is acquired at birth if at least one of the natural parents is a U.S. citizen. It should not be presumed, however, that the child was a citizen at birth unless at least one citizen parent was a previous U.S. resident or lived in a U.S. territory. (Refer to Section 2402.10.05)

For children born before May 24, 1934, U.S. citizenship may only be established in this way for legitimate children through their citizen father who would have had to meet the above-mentioned residency requirement. For children born after May 24, 1934, both parent’s U.S. citizenship and residency may serve as the basis for the foreign-born child's own U.S. citizenship.

2402.10.20 Citizenship After Birth

Children become U.S. citizens after birth when <u>all</u> of the following requirements are met:

- At least one parent is a U.S. citizen either by birth or naturalization;
- The child is under 18 years of age; and
- The child is residing in the United States in the legal and physical custody of the United States citizen parent, pursuant to a lawful admission for permanent resident. (If adopted, the child must meet all of the requirement above, as well as satisfy the requirements applicable to adopted children under Section 101(b)(1) of the Social Security Act.)[2]

[2] 8 CFR 320.2

2402.15.00 VERIFICATION REQUIREMENTS FOR U.S. CITIZENS

Verification of citizenship is required for Medicaid eligibility when applicants declare themselves to be U.S. citizens.

2402.15.10 Verification of U.S. Citizenship

In compliance with federal law (Section 1903(x) of the Social Security Act as added by the Deficit Reduction Act of 2005) documentation of citizenship is required as a condition of eligibility for Medicaid, Hoosier Healthwise, and HIP. The requirement applies to applications filed on and after August 15, 2006 and redetermination interviews occurring on or after August 15, 2006.

Proof of citizenship must be provided to the DFR for persons declaring on the application to be citizens with either documentary evidence or electronic verification through the VLP, except in the following circumstances:

The individual is eligible in the Newborn (MA X) category. Further, citizenship documentation is not required for these children at the time of any future eligibility determinations that occur after the child ages out of the Newborn category.

The individual is an SSI (Supplemental Security Income) recipient. Citizenship would have been documented by SSA, so further proof would not be needed for Medicaid. Verification can be found on DESX or IQSSA in the “Alien Indicator” field;

The individual is a Medicare beneficiary;

The individual receives Social Security benefits based on their own disability;

The individual is a ward of the DCS (Department of Child Services). Federal citizenship requirements for Medicaid are met for wards without verification by the DFR because federal rules allow an exception for them as children receiving assistance with IV-B funds;

The individual is a recipient of foster care or adoption assistance under Title IV-E.

Case record requirements are as follows:

If electronic verification is not available through the VLP, original documents or certified copies of original documents must be viewed and copied for the case file. The copy must be annotated: “Copy of original document” or “Copy of certified copy” as appropriate. Also, a CLRC entry as to the way in which citizenship was documented must be made;

Once completely and acceptably verified, citizenship is not to be re-verified at subsequent reapplications and redeterminations;

While medical coverage is pending for verification of citizenship, the VR field for citizenship on AEIIA should be coded “?”;

The ***citizenship*** verification should be entered on AEIIA, not the ***identity*** verification. For example, if a birth certificate and a driver’s license are presented, “BC” is to be entered as verification on AEIIA, not “DL”;

A CLRC entry must be made for every contact made with the client and every action taken by the caseworker regarding citizenship verification. It is important that the comments are specific. Simply indicating that “the client could not get a birth certificate” is not sufficient.

Case processing procedures include:

Providing the “Notification of Requirement to Provide Documentation of Citizenship” (FI 2326 or FI 2326 S, the Spanish version) if citizenship has not been electronically verified through the VLP. When an application interview is not required (refer to IHCPPM 2005.00.00), the form should be sent when a worker is processing the application. When an application interview is required (refer to IHCPPM 2005.00.00), the form should be sent no later than the day following the required interview. The names of all persons for whom documentation is required should be listed. Each applicant whose name is on the form will have 95 days to provide proof of citizenship beginning the date after the form is sent. Please note, the “Pending Verifications for Applicants/Recipients” (FI 2032) is not to be used in lieu of this form;

Giving the applicant a 90 day deadline (on the FI 2326) to provide the documents.

Assisting the family in locating verification sources when necessary. This would include such things as helping to find websites, telephone numbers or mailing addresses so that out-of-state birth certificates can be ordered;

Entering a detailed CLRC comment for each contact made with the client regarding citizenship verification;

If an applicant has provided all required criteria to allow for an eligibility determination, except for fulfilling his citizenship verification requirement, the applicant should be determined eligible without undue delay. If documentation of citizenship was not provided to the DFR by the applicant and electronic verification of citizenship through VLP is not received after 95 days after the applicant received "Notification of Requirement to Provide Documentation of Citizenship", eligibility is to be discontinued.

Referring the case to the supervisor so that an inquiry can be sent to the Policy Answer Line (PAL) if there is uncertainty as to whether benefits should be denied or discontinued for failing to meet the citizenship requirement.

The applicant may request a birth certificate by telephone, mail, or online at https://www.vitalchek.com/birth-certificates.

There are two general sources of citizenship documentation: primary, for which one source document is acceptable and secondary, which requires a source document for citizenship and proof of identity.

Primary sources of citizenship documentation are:

A U.S. passport, issued without limitations, even if it is expired. Please note, however, that passports issued to persons born in Puerto Rico must be current. Refer to IHCPPM, Section 2402.15.15;

A Certificate of Naturalization – N-550 or N-570;

A Certificate of Citizenship – N-560 or N-561;

Documentation from a federally recognized tribe. The document must identify the federally recognized Indian Tribe which issued it, identify the individual by name, and confirm the individual's membership, enrollment in, or affiliation with that

Tribe. Some examples include Tribal enrollment/membership cards, a certificate of degree of Indian blood issued by the Bureau of Indian Affairs, a Tribal census document, or a document issued by a Tribe indicating an individual's affiliation with the Tribe. These documents are examples of documents that may be used, but do not constitute an all-inclusive list of such documents.

When any of the above documents are submitted as citizenship verification, no further proof of identity is required.

Secondary sources of citizenship documentation are:

A U.S. public birth certificate showing birth in one of the 50 States, District of Columbia, Puerto Rico (if born on or after January 1, 1941), Guam (if born on or after 1899), the U.S. Virgin Islands (if born on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (if born after November 4, 1986;

A Certification of Report of Birth (DS-1350);

A Consular Report of Birth Abroad of a Citizen of the United States (FS-240);

A Certification of Birth Abroad (FS-454);

A United States Citizen Identification Card (I-197);

An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code "KIC";

A Northern Mariana Card (I-873);

A Final Adoption Decree showing the child's name and place of birth in the U.S.;

Evidence of civil service employment by the U.S. government before June 1, 1976;

An official military record of service that shows a U.S. place of birth.

The above sources are preferred secondary sources. The following two sources can be used *only* when the individual has provided a plausible reason as to why the preferred sources are not available:

An extract of a hospital record, on hospital letterhead, established at the time of birth, if created five years before the initial Medicaid application date;

A life, health or other insurance record showing a U.S. place of birth if created at least five years before the initial Medicaid application date;

The following **“last resort”** documents are to be used rarely and only when the more reliable sources listed previously are not available or cannot reasonably be obtained. Please note that this would not include situations where the individual is unwilling to pay the cost of ordering a birth certificate.

A Seneca Indian tribal census record showing a U.S. place of birth, which was created at least 5 years before the application for Medicaid;

A Bureau of Indian Affairs tribal census record of the Navajo Indians, showing a U.S. place of birth, which was created at least five years before the application for Medicaid;

A U.S. State Vital Statistics official notification of birth registration showing a U.S. place of birth, which was created at least five years before the application for Medicaid;

A statement signed by the physician or midwife who was in attendance at the birth, showing a U.S. place of birth, which was created at least 5 years before the application for Medicaid;

Institutional admission papers from a nursing facility or other institution showing a U.S. place of birth;

Clinic, doctor, or hospital records, created at least five years before the application for Medicaid that indicate a U.S. place of birth. For children under sixteen, the document must have been created near the time of birth, or five years before the application for Medicaid;

A religious record (recorded by a religious organization)in the U.S. created within three months of the individual’s birth. Please note that entries in a family’s personal religious text are not considered to be religious records for the purpose of citizenship verification;

Early school records showing a U.S. place of birth;

A special affidavit signed, State Form 53691, under penalty of perjury, by two individuals (other than the applicant/recipient) who have personal knowledge of the event establishing the person's citizenship status. At least one of the individuals must be unrelated to the applicant/recipient and both must prove their own citizenship.

As stated previously, when secondary documentation is used, the individual's identity must also be verified. Sources of identity documentation include:

A driver's license with picture or other identifying information;

A school picture ID;

Nursery or day care records for a child not yet in school;

A U.S. military card or draft record;

State, federal, or local government ID containing information identical to that on a driver's license;

A military dependent's ID card;

A U.S. Coast Guard Merchant Mariner card;

A Certificate of Degree of Indian Blood or other U.S. American Indian/Alaska Native tribal document, if it contains a photograph or other identifying information;

Three or more corroborating documents verifying the individual's identity. Examples would be high school and college diplomas from accredited institutions, marriage certificates, property deeds and titles, and employee ID cards;

For children under 16, clinic, doctor and hospital records;

For children under 16 if none of the above records are available, a special affidavit signed under penalty of perjury by the parent, guardian, or caretaker relative is acceptable;

Identity affidavits may also be used for disabled individuals in residential care facilities. They are

acceptable only if there is no other means of verifying the individual's identity and should be signed by the residential care facility director or administrator.

Please note that an affidavit cannot be used to verify identity if affidavits were used to verify citizenship.

2402.15.15 Verification of Citizenship for Persons Born in Puerto Rico

The purpose of this section is to explain the effect of legislation enacted in 2009 by the Commonwealth of Puerto Rico on Medicaid and Hoosier Healthwise eligibility. The legislation was enacted by the Commonwealth to reissue certified birth certificates for its residents. This is relevant to the citizenship verification process because, due to its commonwealth status, persons born in Puerto Rico are U.S. citizens at birth.

Individuals born in Puerto Rico and applying for Medicaid for the first time on or after November 1, 2010 are affected by the reissue of Puerto Rican birth certificates. For those individuals, a birth certificate issued prior to July 1, 2010 cannot be accepted. If using a birth certificate to document citizenship, these applicants will have to obtain a new certified birth certificate. The applicant may request a birth certificate by telephone, mail, or online at https://www.vitalchek.com/birth-certificates. Instructions in Spanish, for obtaining a new Puerto Rican birth certificate can be found at www.prfaa.com/certificadosdenacimiento/. The instructions should be printed out for applicants without computer access. It should be noted that the case processing procedures found in IHCPPM, Section 2402.15.10 also apply to persons born in Puerto Rico.

As with other individuals declaring U.S. citizenship, a passport issued to a person born in Puerto Rico is a primary source of citizenship documentation. However, the policy regarding passports of persons of Puerto Rican birth differs in that the passport cannot have expired. If the applicant's passport has expired, an alternate document, as listed in IHCPPM, Section 2402.15.10, will need to be obtained.

As with citizenship issues involving American born applicants, questions can be submitted to the Policy Answer Line (PAL). Similarly, you are encouraged to contact PAL before denying or discontinuing benefits because the individual has not obtained a new birth certificate from Puerto Rico.

Please note that persons of Puerto Rican birth who are reapplying for medical assistance or whose eligibility is being redetermined are not to be required to obtain new birth certificates if their citizenship has been documented previously.

2402.20.00 IMMIGRANTS

Individuals who are not citizens of the United States may qualify for assistance based on their status granted by the U.S. Citizenship and Immigration Service (USCIS). Listed below are "qualified" immigrants as defined in federal law. However, the eligibility of these immigrants varies among the programs and is based on certain factors as explained in the following sections. Do not authorize or deny assistance based solely on this list. Read the following sections to understand the distinctions in program eligibility and benefits. Immigrants in any other USCIS classification are not eligible for full coverage Medicaid, but can be eligible for emergency Medicaid coverage.

1. Lawful Permanent Resident under the Immigration and Naturalization Act (INA).
2. Asylees under Section 208 of the INA.
3. Refugees under Section 207 of the INA.
4. Parolees under Section 212(d)(2) of the INA if paroled for at least one year.
5. Persons whose deportation is withheld under Section 243(h) of the INA.
6. Conditional entrants under Section 203(a)(7) of the INA in effect prior to April 1, 1980.
7. Cuban and Haitian entrants.
8. Amerasians admitted pursuant to Section 584 of P.L. 100-202 and amended by P.L. 100-461.

The eligibility provisions are mandated by federal law: Title IV of the Personal Responsibility and Work Opportunities Reconciliation Act (P.L. 103-193) as amended by the Balanced Budget Act of 1997 (P.L. 105-33), the Agricultural Research, Extension and Education Reform Act of 1998 (P.L. 105-185), and the Farm Security and Rural Investment Act of 2002 (P.L. 107-171).

2402.20.05 Lawfully Admitted For Permanent Residence

Under the Immigration and Nationality Act (INA), a Lawfully Admitted Permanent Resident (LPR) is one who has been lawfully accorded the privilege of permanently residing in the U.S. as an

immigrant in accordance with Section 101(a)15 and 101 (a)20 of the INA, with such status not having changed since admission.

Lawful Permanent Residents should present USCIS Form I-551 as documentation of their immigration status. Caseworkers should check the coding on the I-551 for code, RE-6, RE-7, RE-8, or RE-9. This denotes entry as a refugee with subsequent adjustment to LPR status. Refer to Section 2402.20.15 concerning eligibility of refugees.

Lawful Permanent Residents who were residing in the U.S. prior to 8/22/96 are eligible for full Medicaid coverage. However, LPRs who enter the U.S. on and after 8/22/96 are eligible for emergency coverage only for 5 years unless they are honorably discharged U.S. veterans or in active duty in the U.S. military. Further, spouses or dependent children of veterans or military personnel who die during active military duty can be eligible for full coverage (Refer to Section 2402.20.45). At the end of the 5 year period, LPRs can be eligible for full coverage.

2402.20.05.05 American Indians Born In Canada

A North American Indian born in Canada may freely enter and reside in the U.S. and is considered to be lawfully admitted for permanent residence if he is of at least 50% American Indian blood. This does not include the spouse or child of such an Indian nor a non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50% American Indian blood.

Sources of verification are:

- Birth or baptismal record issued on a reservation;
- Tribal records;
- Letter from the Canadian Department of Indian Affairs; or
- School records.

2402.20.10 Conditional Entrant Refugee

Section 203(a)(7) of the Immigration and Nationality Act (INA) in effect before April 1, 1980 provides conditional entrant refugee status for persons who, because of persecution or fear of persecution on account of race, religion, or political opinion, have fled from a Communist or Communist-dominated country or from the area of the Middle East or who are refugees from natural catastrophes. (Section 203(a)(7) of the INA was replaced by Section 207 effective April 1, 1980.)

Individuals with this status can be eligible for full Medicaid coverage. (Note a person entering the U.S. on and after 8/22/96 will not be given this USCIS status, since it is no longer in effect.)

Verification is established by viewing USCIS Form I-94, Arrival-Departure Record, bearing the stamped legend "Refugee - CONDITIONAL ENTRY" and citing the section of the INA under which they were admitted, or USCIS Form I688B annotated "274a.12(a)(3)" or I-766 annotated “A1”, “A3”.

2402.20.15 Refugees Under Section 207

Individuals admitted as refugees under Section 207 of the INA are eligible for full coverage Medicaid once they obtain this status. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the U.S.

Refugees will have USCIS Form I-94 annotated with a stamp showing entry as refugee under Section 207 and date of entry, USCIS Form I-688B annotated "274a.12(a)(3)", or I-766 annotated "A3". USCIS Form I-571 also indicates status as a refugee, but does not reflect the date of admission. If Form I-94 is not available, verification must be obtained from the USCIS.

2402.20.20 Parolees Under Section 212(d)(5)

Individuals who were granted parole under Section 212(d)(5) for at least one year, and who entered the U.S. prior to 8/22/96 can be eligible for full Medicaid coverage. Those who enter the U.S. on and after 8/22/96 can be eligible for emergency Medicaid only, unless they are veterans of the U.S. military or in active duty in the U.S. military. Veterans and military personnel can be eligible for full Medicaid coverage. (Refer to Section 2402.20.45 concerning veterans and active duty military.)

Verification is established by viewing USCIS Form I-94 annotated with a stamp showing granting of parole under Section 212(d)(5) of the INA and a date showing granting of parole for at least 1 year- or Form I-688B annotated “274a.12(a)(4), 274a.12(c)(11) or Form I-766 annotated “C11” or “A4”.

2402.20.25 Asylees Under Section 208

Asylees can be eligible for full-coverage Medicaid. Verification of the asylee status includes USCIS Form I-94 annotated with a stamp showing granting of asylum under Section 208 of the INA or a grant letter from the Asylum Office of the

USCIS. Forms I-688B annotated "274 a.12 (a)(5)" or I-766 annotated "A5" indicate status as an asylee. The date of the form does not reflect when the status was granted. Request Form I-94, the grant letter, or the person's copy of a court order. Verify with USCIS if none of these are available.

2402.20.30 Deportation Withheld Under Section 243(h)

Individuals with a deportation withheld order are eligible for full-coverage Medicaid.

An immigrant who has had deportation withheld under this status will have an Order of an Immigration Judge showing deportation withheld under Section 243(h) of the INA and date of the grant. USCIS Forms I-688B annotated "274a.12(a)(10)" or I-766 annotated "A10" indicate deportation was withheld under Section 243(h) or removal withheld under Section 241(b)(3), but normally do not reflect the date of withholding. Request the person's copy of the court order. If not available, verification must be obtained from the USCIS.

2402.20.35 Amerasian Immigrants

Certain Amerasians from Vietnam, with their close family members, have been allowed entry into the U.S. in immigrant status through the Orderly Departure Program beginning March 20, 1988.

They can be eligible for full coverage Medicaid. Acceptable documentation of this status is:

- I-94 indicating codes AM1, AM2, or AM3;
- I-551 indicating codes AM6, AM7, AM8;
- Vietnamese Exit Visa, Vietnamese Passport, or U.S. passport if stamped by the USCIS with the codes AM1, AM2, or AM3;
- Temporary I-551 stamp in foreign passport; or
- I-571 Refugee Travel Document

2402.20.40 Cuban and Haitian Entrants

Cuban and Haitian entrants, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, can be eligible for full coverage Medicaid.

2402.20.45 Veteran or Active Duty Member of the Armed Forces

As explained in the previous sections, immigrants with certain USCIS classifications who would otherwise be subject to assistance limitations can be eligible if they are veterans, are on active duty in the military, have served minimum active duty service requirements, or are spouses or dependent children of veterans or military personnel who die during active military duty. The exemption for veterans also applies to individuals who served in the Philippine Commonwealth Army during World War II or as Philippine Scouts following the war.

An eligible veteran is a person who served in the active U.S. military, naval, or air service, and was released with a discharge characterized as honorable and not on account of alienage. Veterans should have received a full copy of DD Form 214 (Certificate of Release of Discharge from Active Duty) that contains the necessary information. An honorable discharge is denoted by the entry of "Honorable" in the "Character of Service" block of DD Form 214. If the evidence characterizes the discharge as anything other than "Honorable", such as "Under Honorable Conditions", the individual and family members cannot be determined eligible based on the veteran exception. Eligibility based on veteran status cannot be established if the reason for discharge was based on alien status, lack of U.S. citizenship or other "alienage" reasons, or if the "Separation Code" block contains an entry JCP, KCP, SCP, or YCP. Those codes establish discharge based on alienage. If the individual states that he or she meets the veteran requirements but is unable to present the appropriate discharge papers as documentation, the worker should contact the Veterans Affairs Regional Office.

The eligibility exception for veterans also applies to the Hmong and other Highland Lao tribal people who fought on behalf of the U.S. Armed Forces during the Vietnam conflict.

Persons who fulfill the minimum active duty service requirements or their un-remarried surviving spouse and dependent children are also exempt from other alien requirements. Minimum active duty served by a person who initially enters service after 9/7/80 is 24 months of continuous active duty or the full period for which the person was called or ordered to active duty.

A person who is on active duty in the U.S. Armed Forces (other than active duty for training) is also not subject to the assistance limitations placed on immigrants in his particular classification. Documentation of active duty status is the individual's Armed Forces of the United State Geneva Conventions

Identification Common Access Card (CAC). The CAC, a “smart” card about the size of a credit card, is the standard identification for active duty uniformed service personnel. Other types of verification of active duty status include, but are not limited to: a copy of the soldier’s orders indicating active duty status, an enlistment contract, or a letter from the soldier’s commanding officer. A blue (retiree) or beige (dependent) card is not evidence of active duty.

2402.20.49 Iraqi And Afghani Special Immigrants

Certain Iraqi and Afghan nationals have special immigrant status under section 101(a)(27) of the Immigration and Nationality Act (INA) and may be eligible for Medicaid and Hoosier Healthwise. Iraqi and Afghani Special immigrants are eligible for all benefits available to the same extent and for the same period of time as refugees pursuant to Section 207 of the Immigrations and Nationality Act.

Both Iraqi and Afghani special immigrants will either enter the U.S. as Lawful Permanent Residents (LPRs) with the special immigrant visa or will adjust to special immigrant status after entering the U.S. under another immigration status (such as an asylee or parolee). Therefore, unless the immigrant is a qualified alien and is eligible under current program rules, the date of eligibility may or may not coincide with the special immigrant’s date of entry.

This policy is based on the Department of Defense Appropriations Act of 2010 (Section 8120, P.L. 111-118) enacted on December 19, 2009.

2402.20.50 Other Immigrants, Visitors, and Non-Immigrants

Any other immigrants, including those who lack immigration documentation or whose immigration status cannot be verified, who are not specified in the previous sections can be eligible for emergency Medicaid coverage only if they meet all other requirements of the category in which they qualify. However, eligibility for emergency services only may not be approved under the MA 10 category. A child who is undocumented or a visitor or non-immigrant as described in paragraph four below, is not eligible for Hoosier Healthwise Benefit Package C, regardless of family income. It is important to remember that the eligibility restrictions and prohibitions apply only to the applicant's immigration status, not other family members. For example, a child who is a U.S. citizen may have parents who lack immigration documentation or whose immigration status cannot be

verified. The child in this circumstance can be eligible for health coverage, if all other requirements are met, without regard to parents' status.

If an immigrant alleges to be in a qualified immigrant status as defined in the previous sections, but is unable to present documentation, the Local Office is to advise him in writing of his obligation to contact the USCIS to obtain the documentation if not obtainable through using SAVE. If the verification cannot be obtained through SAVE and the applicant does not provide documentation from the INS, he is eligible only for emergency Medicaid coverage. If such an applicant has provided all required criteria to allow for an eligibility determination, except for fulfilling his immigration verification requirement, the applicant should be determined eligible without undue delay. If he does not verify immigration status within the 90-day timeframe from notice to provide immigration status was sent and his immigration status is not electronically verified within 95-days from when the form was sent, then his eligibility must be discontinued.[3]

Certain visitors and non-immigrants, as described below, may be eligible for emergency Medicaid coverage.[4] They must meet all eligibility requirements except the factor of citizenship/immigration status and Social Security numbers.

These non-citizens would have the following types of documentation:

- I-94, Arrival - Departure Record;
- I-185, Canadian Border Crossing Card;
- SW-434, Mexican Border Visitor's Permit;
- I-186, Non-Resident Alien Mexican Border Crossing Card;
- I-95A, Crewman's Landing Permit; or
- I-184, Crewman's Landing Permit and Identification Card.

Note, that these individuals may not meet the State residency requirement and would not be eligible for health coverage:

> Visitors, tourists, foreign students, temporary workers, crewmen on shore leave, diplomats, members of foreign information media, exchange visitors, and so forth, who are lawfully admitted for specific periods of time and with no intention of establishing a permanent residence in the U.S.

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[3] 42 CF 435.911

[4] Social Security Act, Section 1903(v)

Under no circumstances, are immigrants who lack immigration documentation or whose immigration status cannot be verified, who are applying for or receiving traditional Medicaid or Hoosier Healthwise, to be reported by the Division of Family and Children to the U.S. Citizenship and Immigration Service (USCIS). This also applies to family members of such applicants.

2402.20.50.05 Definition of Emergency Services

This section applies to all categories except MA 10 and MAHN. The classifications of immigrants who qualify for emergency services only (see Section 2402.20.50) are not eligible for MA 10 or MAHN.

Emergency services are defined as services required for a medical condition (including labor and delivery) manifesting itself by acute symptoms (including severe pain) serious enough that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

A non-citizen eligible only for emergency services will receive a Hoosier Health Card. When providers use their Eligibility Verification System, the enrollee's limited coverage will be reported. Providers are alerted to this coverage limitation, and have information on the definition of an emergency and claims payment restrictions. The DFR is not expected to address claims payment difficulties or disputes concerning the emergency nature of an illness. Providers are to be referred to Provider Assistance at the Fiscal Contractor.

2402.20.55 Systematic Alien Verification For Entitlements (SAVE)

In addition to obtaining documentation from the AG or through an electronic interface or batch process(as discussed in Section 2402.20.05), the DFR is required to verify each alien's immigration status with Systematic Alien Verification for Entitlements (SAVE)if the verification is not obtained electronically or through a batch process from the appropriate citizenship or immigration source. SAVE was established by the Immigration and USCIS to implement a provision of the Immigration Reform and Control Act of 1986 which mandated direct verification of alien immigration status with USCIS.

NOTE: SAVE procedures are not to be initiated for individuals who declare that they are U.S. citizens by birth or

naturalization. (Verification requirements for citizens are discussed in Sections 2402.15.00 and 2402.15.05.)

All alien applicants must present original documentation of alien registration or another form of documentation which is reasonable evidence of their status if the immigration status is not able to be verified through an electronic interface or batch process. Aliens without documentation should be referred to the local CIS office prior to using SAVE procedures. Most alien applicants will present documentation that contains an Alien Registration Number (A-number). The seven or nine digit number preceded by the letter "A" is unique for each individual.

The DFR requests SAVE verification by utilizing the Policy Answer Line (PAL). A SAVE request must include the case name and number and each alien case member's:

name;
alien registration number; and
program choices.
The name of the person making the request should also be included.

Upon receipt of a SAVE request, Central Office staff accesses the SAVE database for the following information:

Verification number (this number must be documented in the case record;
Last name;
First name;
Date of birth (mm/dd/yy);
Employment eligibility statement;
Immigration status;
Country of birth;
SSN if known;
Alternate ID number, if known; and
Date of entry (mm/dd/yy).

The data is then transmitted to the Local Office from the Policy Answer Line (PAL).

Through access of the SAVE database by Central Office staff, we may receive a response from SAVE indicating “Additional Verification Required”. If this occurs, Central Office staff will respond to the Local Office with a request for further information that will include:

I-94 Number

Eligibility system Case Number

Document Type (Examples of which could include):

- I-327 - Re-entry Permit
- I-551 - Permanent Resident Card
- I-571 - Refugee Travel Document
- I-688 - Temporary Resident Card
- I-688A - Employment Authorization Card
- I-688B - Employment Authorization Document
- I-766 - Employment Authorization Card
- I-94 - Arrival/Departure Record Card
- Other - use document description

Unexpired Foreign Passport

Document Date

Document Expiration Date

Date of Birth

Upon receipt of this additional information, Central Office staff will submit the information to SAVE. This secondary request to SAVE takes approximately 3-7 business days for CIS to research. The response from SAVE will either note the requested alien status or will request the need for a Documentation Verification Request (Form G-845) to be sent.

The G-845 is to be sent to CIS with a copy of the original documentation provided by the AG. This material is sent to the following address:

U.S. Citizenship and Immigration Services
10 Fountain Plaza, 3rd Floor
Buffalo, NY 14202
Attn: Immigration Status Verification Unit
NOTE: If the original alien documentation presented by the AG does not contain an alien registration number, the Local Office must contact CIS as indicated above. Central Office staff cannot access the SAVE database without the alien registration number.

When the Form G-845 has been returned to the Local Office, any necessary changes to the Alien/Refugee Information screen AEICZ should be made.

NOTE: Normal case processing is to continue once the AG has provided the initial verification of alien status. Benefits are not to be delayed, denied, or reduced on the basis of pending SAVE verifications. If an applicant has provided all required criteria to allow for an eligibility determination, except for fulfilling his immigration verification requirement, the applicant should be determined eligible without undue delay. If he does not verify immigration status within the 90-day timeframe from when notice to provide immigration status was sent and the immigration status cannot be verified electronically, then his eligibility must be discontinued.[5]

2403.00.00 NATIVE AMERICANS/ALASKAN INDIANS (MA 10)

Children who are Native Americans or Alaskan Indians (NA/AI) are exempt from the cost-sharing requirements of the Children's Health Plan, Package C of Hoosier Healthwise. (f4a) A child must be a member of a federally recognized tribe or have received a service from the Indian Health Services, a tribal health program, or urban Indian health program, or through a referral from one these programs in order to receive the exemption. Any individual claiming Native American racial-ethnic heritage for a child applicant or recipient should be asked whether the child is a member of a federally recognized tribe or the child received a service as mentioned above. If it is alleged that the individual is a member of a recognized tribe, membership must be verified in order for the exemption to apply. Verification is accomplished by viewing the I.D. card or tribal letter issued to each enrolled member. The I.D. card or letter should specifically state that the child is an enrolled member and that the tribe is recognized by the federal government. If the documentation has been lost, the parent/caretaker may provide the telephone number of the tribal administrative office so that the child's membership can be verified. If the parent declares potential membership but the child has never been formally enrolled, he/she is not eligible for the cost sharing exemption.

The only tribe currently recognized in Indiana is the Pokagon Band of the Potawatomi Indians. The tribe's I.D. card features a red tribal emblem (an eagle on a branch) and an enrollment number, and shows the child as a member of the Pokagon Band of the Potawatomi Tribe as certified by the tribal chairman. If the parent indicates that the child is an enrolled member, but written documentation has been lost or stolen, enrollment may be verified by calling the Pokagon Band Administrative Offices at 1-888-782-1001. Although the Pokagon Band is the only certified

[5] 42 CFR 435.911

tribe in Indiana, it is important to remember that members of federally recognized tribes may be living anywhere. A child who is an enrolled member of any federally recognized tribe is entitled to the exemption, if otherwise eligible for MA 10.

Since these individuals are not to be required to pay a premium or co-payments, it will be necessary to fiat MA 9 eligibility once it has been established that the child qualifies in all other respects for MA 10. The situation must be fully documented on CLRC (Running Record Comments).

2404.00.00 REQUIREMENT TO PROVIDE SOCIAL SECURITY NUMBER

The policy stated in this section does not apply to MA Q or MA X or to individuals who are eligible for emergency services only under Medicaid.

Each applicant must, as a condition of eligibility, furnish his Social Security Number (SSN).[6] A verbal statement from the individual or his authorized representative is sufficient to meet this requirement. If the SSN is unknown or has never been obtained, the individual must apply for a SSN through the local Social Security Administration (SSA) office. The procedure to apply for a number is outlined in Section 2404.10.00.

Household members who are not applying for Medicaid do not have to provide their SSN as a condition of eligibility. The determination of eligibility is not to be delayed, denied, or discontinued due to the waiting on an SSN to be issued.

Certain applicants, because of well established religious objections, may refuse to obtain an SSN and would not be required to obtain one as a condition of eligibility for Medicaid. The term *well established objections* mean that the applicant:

i) Is a member of a recognized religious sect or division of the sect; and
ii) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.[7]

The caseworker must request that AG members whose income or resources are included in the budget, but who are not

[6] 42 CFR 435.910
[7] 42 CFR 435.910

participating members of the AG, provide their SSN for purposes of data exchange. These individuals are not required to comply with this request. Refer to Section 3205.00.[8]

If any applicant/recipient shows multiple cards for himself to the Local Office, it is to be reported to the local SSA District Office for investigation. The same procedure applies if it is suspected that multiple SSNs exist.

2404.10.00 COMPLETION OF SOCIAL SECURITY NUMBER REFERRAL

The policy stated in this section does not apply to MA Q, MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

An applicant/recipient who does not have an SSN or who cannot remember the SSN, must contact the SSA and apply for a number. An eligibility system generated Social Security Number Referral must be given to the individual at the time of the initial interview. The caseworker enters a "?" in the verification field on AEIID. The caseworker then enters the print request on the AEWPR screen. The caseworker and applicant/recipient are to sign the form. The original and one copy are given to the applicant/recipient, and the third copy is retained in the case file. When the SSN application has been submitted, the SSA will complete the bottom portion of the Social Security Number Referral and send the original to the Local Office and the copy to the applicant/recipient. The form must be retained in the case file as documentation that the individual has complied with the eligibility requirements, and the appropriate verification code is to be entered on AEIID.

2404.10.05 Social Security Number Referral Follow-Up

The policy stated in this section does not apply to MA Q, MA X, or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

If the Social Security Number Referral form is not received by the Local Office within 10 days of the date it was given to the individual, the caseworker must send a follow-up letter to the applicant/recipient, advising him of the responsibility to apply for a SSN. The caseworker must track the initial 10 day period. The letter must advise the individual to immediately contact the caseworker if he is having difficulty complying with the SSA's request for documentation, or if the individual has received his

[8] 42 CFR 435.910

copy of the Social Security Number Referral form. If the individual does not respond, a final follow-up letter must be sent, allowing him adequate time to comply before the application is denied.

If an individual has fully complied with the SSA's requirements for an SSN application and is otherwise eligible, the Local Office is not to deny assistance, delay granting assistance, or discontinue assistance pending issuance of the SSN.[9]

2404.15.00 HOSPITAL ENUMERATION

The policy stated in this section does not apply to MA Q, MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

The notice provided by hospitals indicating that an individual applied for a SSN is sufficient verification of compliance with eligibility requirements **only** if the notice (SSA-2853) contains the applicant's name and is signed and dated by a hospital representative and includes the title of the representative.

2404.25.00 REFUSAL TO COMPLY WITH SOCIAL SECURITY NUMBER REQUIREMENT

The policy stated in this section does not apply to MA Q or MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

Penalties may be assessed when an individual does not apply for, or provide, a SSN. These penalties are discussed in the following sections.

2404.25.10 Penalties for SSN Non-Compliance

The policy stated in this section does not apply to MA Q or MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

The refusal of an applicant to provide or apply for an SSN results in his ineligibility.[10] This ineligibility will continue until the applicant who has failed to comply comes into compliance with the SSN requirement.

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[9] 42 CFR 435.910

[10] 42 CFR 435.910

When the ineligible individual is a parent or sibling required to be included in the AG, his income and resources must be considered when determining the financial eligibility of the remaining AG members.[11]

2404.30.00 VERIFICATION OF SOCIAL SECURITY NUMBER

The policy stated in this section does not apply to MA Q, MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting aliens.

Eligibility system complete a data exchange with the SSA for the purpose of verifying SSNs. When a SSN is verified, the eligibility system will be automatically updated with "DE" to reflect the verification on screen AEIID.

2404.30.05 Social Security Numbers Not Verified Through Data Exchange

The policy stated in this section does not apply to MA Q, MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting aliens.

If verification does not occur through data exchange, eligibility system will generate alert number 708, SSA Numident Match DISCRP-DENB. The caseworker must obtain verification of the individual's SSN to ensure the correct number is being submitted for verification. The following documentation is acceptable:

- Social Security card;
- correspondence from SSA containing the individual's name and account number (if the number has an A, J, M, or T suffix, this is the SSN);
- a Social Security check issued on the individual's own account number;
- a Medicare card issued on the individual's own account number (if the number has an A, J, M, or T suffix, this is the SSN); or
- a SSA certificate of award which will contain a claim number (if the number has an A, J, M, or T suffix, this is the SSN).

[11] 42 CFR 435.910

The caseworker must establish that Social Security coverage is provided under the individual's own account number and not someone else's with the individual as a beneficiary.

Once verification is obtained, the caseworker enters a verification code on the DENB screen.

2406.00.00 RESIDENCY

In order to receive assistance, an applicant must be a resident of Indiana.

2406.05.00 RESIDENCY OF HOMELESS INDIVIDUALS

Homeless individuals and residents of public or private nonprofit shelters for the homeless and/or Domestic Violence victims located in Indiana meet Indiana residency requirements. An otherwise eligible individual must not be required to reside in a permanent dwelling or have a fixed mailing address.

2406.20.00 RESIDENCY REQUIREMENTS

Federal regulations regarding residency specifically prohibit states from denying MA to any individual on the grounds that he has not resided in the state for a specific period of time, or did not establish residence in the state prior to entering an institution. However, workers must make sure those individuals who were not approved are not Indiana residents according to the eligibility rules.[12]

In determining whether or not an individual meets the residency requirement, "capability of indicating intent" is a factor. An individual is considered incapable of indicating intent if he:

Has an I.Q. of 49 or less, or a mental age of seven or less;

is judged legally incompetent; or

is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of mental retardation.

2406.20.05 Residency of Non-Institutionalized Individuals

[12] 42 CFR 435.403

Individuals under age 21:

The state of residence is the state where the individual is currently living.

If the individual is emancipated from his parents or married, and is capable of indicating intent, the state of residence is the state where he is living with the intention to live there permanently or indefinitely.[13]

Individuals age 21 and over, the state of residence is the state where the individual is:

Living with the intention to remain there permanently or indefinitely;

Living and where he entered with a job commitment or seeking employment (whether or not currently employed); or

Living, if incapable of indicating intent.[14]

2406.20.10 Residency of Institutionalized Individuals

Individuals under age 21:

For any institutionalized individual who is neither married nor emancipated, the state of residence is:

The parents' state of residence at the time of the individual's placement in the institution (if a legal guardian has been appointed and parental rights are terminated, the guardian's state of residence is used instead of the parents');

The current state of residence of the parent who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

The state of residence of the person who filed the application if the individual has been abandoned by

[13] 42 CFR 435.403

[14] 42 CFR 435.403

his parents, does not have a legal guardian, and is institutionalized in that state.[15]

If the individual is emancipated from his parents or married, and is capable of indicating intent, the state of residence is the state where he is living with the intention to live there permanently or indefinitely.

Individuals age 21 and over:

For an institutionalized individual who is capable of indicating intent, the state of residence is the state where he is living with the intention to remain there permanently or indefinitely.

For an institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except when another state makes a placement. (Refer to Section 2406.20.10.05 regarding out-of-state placement.)[16]

For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is:

That of the parent applying for Medicaid on the individual's behalf, if the parent lives in a separate state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the legal guardian is used instead of the parent);

The parent's state of residence at the time of the individual's placement in the institution (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);

The current state of residence of the parent who files the application, if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

The state of residence of the person who files the application, if the individual has been abandoned by his

[15] 42 CFR 435.403

[16] 42 CFR 435.403

parents, does not have a legal guardian, and is institutionalized in that state.[17]

The applicant's intent to remain in Indiana must always be determined. If the applicant is capable of indicating intent according to the criteria in Section 2406.20.00, the worker must ask the applicant if he plans to remain in Indiana permanently or indefinitely. An applicant who intends to return to the state of origin whenever a bed becomes available, or one who will return to the other state after a temporary institutionalization, is not to be considered an Indiana resident.

Be alert to situations in which the family searched for a bed in the other state before resorting to placement in Indiana and when the applicant is on a waiting list for a facility in the other state.

When a person resided in another state prior to placement in an Indiana facility, the worker will need to ask the reason(s) the applicant was placed in Indiana instead of in a facility in the state where the person had resided prior to the placement. In many cases the family member's clear intent may be to move the applicant back to the other state as soon as a bed becomes available. However, it is the applicant's intent that must be determined. If the applicant is incapable of indicating intent, he is considered an Indiana resident unless the other state arranged the placement. Section 2406.20.10.05 explains what constitutes placement by a state.

2406.20.10.05 Out-Of-State Placement In An Institution

The state arranging or actually making a placement is considered as the individual's state of residence. This includes any agency of the state or entity recognized under state law as being under contract with the state for such purposes.[18]

Any action beyond providing information to the individual and his family would constitute arranging or making a state placement. The following actions do not constitute state placement:

- Providing basic information to individuals about another state's Medicaid program, and information about the

[17] 42 CFR 435.403

[18] 42 CFR 435.403

availability of health care services and facilities in another state; or

- Assisting an individual in locating an institution in another state, provided the individual is capable of indicating intent and independently decides to move.

When a state has made a placement of a competent individual and such individual leaves that facility, the individual's state of residence is where he is physically located. When a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence.

2406.25.00 TEMPORARY ABSENCE FROM INDIANA

Residence is retained until abandoned. Temporary absence from Indiana, with subsequent returns to the state or intent to return when the purpose of the absence has been accomplished, does not interrupt continuity of residence. Assistance cannot be discontinued when an individual leaves the state temporarily and no other state recognizes him as a resident for assistance purposes during the absence.[19]

2406.30.00 PERMANENT ABSENCE FROM INDIANA

If the recipient leaves Indiana with the intent of establishing residence in another state, assistance is to be discontinued.

2406.35.00 RESIDENCY VERIFICATION

Unless questionable, client statement can accepted for residency. It is appropriate to request verification when residency is in question due to, for example, returned mail or a date exchange record that shows an out-of-state residence for the member/s. Documentation that provides a name and address, such as the following, may be used to verify residency:

driver's license;
school records;
other forms of I.D;
employment records;
church records;
rent/mortgage receipts and/or utility bills;
local postal record; or

[19] 42 CFR 435.403

written statement from a third party

In the event no written documentation is available, a collateral contact such as the following may be used:

landlord;
neighbor;
utility company;
school;
shelter manager; or
employer.

2410.00.00 AGE

Some Medicaid categories have age related requirements. Age may be either a requirement for eligibility, or a requirement for special budget considerations.

2410.05.00 DEFINITION OF A CHILD (MED 2, MED 3)

To be considered a child for program eligibility purposes, an individual must be under the age of 18 and unmarried, divorced or separated.

For the MA T and MA O, there are special age requirements associated with those categories. Please, refer to 1620.30.00, 1620.35.00, and 2410.05.05.

2410.05.05 Age Requirements (MED 3)

The age requirements for the categories of assistance under MED 3 vary. The age requirements for each category are listed below.

There are no age requirements for the following categories:

MAGF – MA for parents or caretakers

MAGP - Full Range MA for Pregnant Women; and

MA Q (MED 2) - MA for Refugees who are ineligible for Cash Assistance

Medical Assistance is available to children under age 18 in the following categories:

MA F - Transitional MA (a parent/caretaker would not be subject to an age requirement);

Medical Assistance is available to children under age 21 in the following category:

MA O - MA for Children in Psychiatric Hospitals.
Medical Assistance is available for dependent children age 19- 21

MA T - MA for 19 and 20 Year Olds.

The age requirements for the other categories under MED 3 vary, and are listed below:

MA E - There is no age requirement

MA X and MA Y - birth through one year old.

MA Z - a child is at least age one, but not yet age six.

MA 2 - a child at least six years of age but not yet age nineteen.

MA 9 – a child at least age one, but not yet nineteen.

MA 10 – a child aged from birth through age eighteen.

MA 14 – an individual 18, 19, or 20 years of age.

MA 15 – an individual at least age 18 and through age 25.

2410.05.20 Child Attains Age Limit (MED 3)

When a child attains the age limit on the first day of the month, he is ineligible for that month.

When a child attains the age limit on a date other than the first of the month, the child is eligible for the entire month. Ineligibility will begin the first day of the following month.

2410.05.25 Verification of Age (MED 3)

Acceptable sources of verification of age include, but are not limited to, the following:

- Birth certificate or health department records; or other credible sources, including:
- hospital records;
- physician's records;
- Bureau of Vital Statistics;
- baptismal, confirmation, or other church records;

- passport;
- naturalization papers;
- immigration papers;
- alien registration card;
- court records, including adoption records, in which the child's age has been noted;
- records of social agencies (including the Local Office);
- insurance company records; and
- school records

2410.15.00 AGE REQUIREMENT (MED 1)

There is no age requirement for MA B and MA D.

To be eligible for Medicaid under the MA A category, an applicant must be 65 years of age or older.[20] An otherwise eligible individual who turns age 65 during a month is eligible for Medicaid under the aged category for that entire month. An applicant must meet the disability or blind requirements in the month preceding the month in which he becomes age 65 in order to be considered under the blind or disabled category. Refer to Section 2412.25.00.

To be eligible for M.E.D. Works (MADW and MADI) an individual must be at least 16 years of age but less than 65 years of age.[21]

2412.00.00 BLINDNESS OR DISABILITY (MED 1)

The policy stated in this section only applies to the MA B, MA D, MADW, MADI, and MA R categories of assistance.

During the interview, it is important to ask whether each applicant for health coverage is blind and/or disabled, and ensure that the response is correctly reflected in the eligibility system. This will enable the blind and or disabled category to be correctly evaluated even if initially the applicant qualifies under another category.

In order to qualify for assistance as blind or disabled individual, specific medical criteria must be met. These requirements are discussed in the following sections.

2412.05.00 DEFINITION OF BLINDNESS (MED 1)

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[20] 405 IAC 2-2-1

[21] 1902(a)(10)(A)(ii)(XV) and 1902(a)(10)(A)(ii)(XVI) of the Social Security Act

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The visual requirement, which must be met to receive MA under the Blind category, is as follows:

An individual is considered blind if he has central visual acuity of 20/200 or less in the better eye with correction or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance of no greater than 20 degrees.[22]

2412.10.00 VERIFICATION OF THE VISUAL REQUIREMENT (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The visual requirement is verified as follows[23]:

> The applicant is receiving Supplemental Security Income (SSI) benefits as a "blind individual", "blind child", or "blind spouse".[24] This is verifiable by the State Data Exchange (SDX); or
>
> If the applicant alleges to be receiving SSI on the basis of blindness, but it is not verifiable through the SDX, the applicant can obtain proof of SSI Blind status from the Social Security Administration. This verification must be directly issued by the SSA and must be current within 30 days; or
>
> The Medicaid Medical Review Team reviews visual information submitted by the eligibility worker and determines that the person meets the definition of blindness.

When blindness cannot be verified by the SDX or statement from the SSA, the MMRT will make a determination of blindness. The policy and procedures outlined below are to be followed by eligibility workers.

If both of the applicant’s eyes are missing, a statement from a medical practitioner is required. This is merely corroborating evidence, not a full examination, and can be a certification from any medical professional treating the applicant including the ocularist who fitted the individual’s prosthetic eyes. This

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[22] 405 IAC 2-2-2

[23] 42 CFR 435.531

[24] 42 CFR 435.531; 405 IAC 2-2-2

certification can be a current statement or copy of existing medical records in which the fact that the individual's eyes are missing is noted. In all other situations, the applicant will be required to have an eye examination by an ophthalmologist or optometrist[25] licensed in the State of Indiana.[26] The requirement to have an eye examination is applicable even for the applicant who objects to such on religious grounds.[27] The report must be based on an examination given not more than six months prior to the date of the eye examiner's report.[28]

The findings of the eye doctor must be submitted on Form 45, Physician's/ Optometrist's Report on Eye Examination. The caseworker is to send the eye report to the doctor, or the applicant, if able to do so, may take the forms to the doctor on the date of the appointment. The caseworker should follow up to be sure that the doctor received the forms. If the doctor prefers, he may submit a letter containing the same information as the Form 45. The eligibility worker is responsible for carefully reviewing the eye report to ensure that all items are completed and the form is legible, signed and dated by the doctor. The complete packet of visual information is submitted to the MMRT.

2412.15.00 PAYMENT FOR EYE EXAMINATION (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The maximum payment for an eye examination necessary to establish initial or continuing eligibility for MA is $29.[29] The maximum payment for completion of an eye report based on a previous examination for which the doctor has already been paid is $10.[30]

Providers should be referred to www.indianamedicaid.com for procedures to submit claims for payment on Medicaid Blind exams or submission of medical records.

2412.15.05 Eye Examination Requirement for Reapplications (MED 1)

[25] SSA 1902(a)(12); 42 CFR 435.531
[26] 405 IAC 2-2-2
[27] 42 CFR 440.270
[28] 405 IAC 2-2-2
[29] 405 IAC 2-2-4
[30] 405 IAC 2-2-4

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The guidelines enumerated below are to be followed for reapplications:

> If receipt of SSI on the basis of blindness is verified as explained in Section 2412.10, the blindness requirement is met.
>
> If the date previously established by the MMRT for a re-examination of eyesight is in the future, or the MMRT waived further eye examinations in its previous determination, the visual requirement is met. Any future eye examination must be completed for continuing eligibility.[31] If the eligibility worker is aware that the applicant had vision restorative eye surgery since the last eye examination in the case, a current eye report is to be submitted to the MMRT.

2412.15.10 INABILITY TO OBTAIN EYE REPORT (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

In no instance is an application to be denied solely because the eye doctor did not return Form 45 to the Local Office, if the applicant is still interested in pursuing his application. As it is the joint responsibility of the applicant and the caseworker to make every effort to obtain visual information, caseworkers must monitor a pending application closely for receipt of the visual information in accordance with the following guidelines:

> If the visual information is not received within 20 days from the date of application, the caseworker should check the notice history (CNHS) to make sure the "Initial Letter to Blind Applicant" has been sent to the applicant to remind him that determination of eligibility cannot be made without the necessary visual information. CM08 is the code on CNHS for the 20 day initial letter.
>
> If the applicant contacts the local office after receiving the initial letter, the caseworker should advise him to personally contact the doctor. The caseworker should also immediately contact the doctor by letter or telephone.

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[31] 405 IAC 2-2-2

If the visual information has not been received within 30 days from the date of application, the caseworker should check CNHS to ensure that the "Follow-up Letter to Blind Applicant" has been sent to the applicant. CM09 is the code on CNHS for the 30 day follow-up letter.

If the applicant responds within the time period specified in the follow-up letter, the caseworker must:

Personally contact the doctor or, as a last resort,

refer the applicant to another eye doctor.

If the applicant does not respond to the follow-up letter by the specified date, the application is to be denied.

2412.15.15 Decision Of Medical Review TEAM (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The MRT will make one of the following decisions regarding the applicant's blindness and enter the decision on AEOMD:

The applicant meets the definition of blindness and further re-examinations of eyesight are waived;

The applicant meets the definition of blindness and a re-examination of eyesight is needed at a future specified date;

The applicant does not meet the definition of blindness; or

Additional visual information is required in order to make a decision as to whether the applicant meets the definition of blindness. If additional medical information is needed from the eye doctor due to omissions or inconsistencies on the eye report, the MRT will secure the requested information directly from the doctor. If a consultative examination is needed to clarify diagnosis, the MRT will contact the applicant to arrange the examination and obtain the eye report.

As of June 1, 2014, a positive determination of blindness made by MRT is no longer considered effective <u>when the SSA has determined blindness for an individual</u>. If MRT determines a person to be blind and a later determination is made by SSA that agrees with the MRT decision, there is no change regarding the

determination of blindness for that individual. The decision made by the SSA nonetheless still controls once the SSA renders the decision. If MRT determines a person to be blind and the SSA later determines the person is not blind, the person will no longer be considered blind once the SSA determines the individual is not blind.

2412.15.20 Required Re-Examination of Eyesight (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

The applicant whose vision might be expected to improve will be required to have a re-examination of eyesight as a condition of continuing MA eligibility.

For recipients who initially met the visual requirement because of receiving SSI on the basis of blindness, the caseworker must verify at each redetermination that the recipient continues to receive such benefits. If, for any reason, the recipient's SSI eligibility has been terminated, he must have an eye examination and an eye report must be submitted to the MRT.

If the worker questions the continued eligibility of a recipient with regard to the visual requirement, arrangements are to be made for the recipient to have an eye examination. A letter of explanation is to be attached to the eye report and submitted to the MRT.

2412.20.00 TREATMENT FOR RESTORATION OF EYESIGHT (MED 1)

The policy stated in this section only applies to the MA B and MA R categories of assistance.

A blind recipient is required to cooperate in any treatment plan recommended by the examining ophthalmologist and approved for payment by Medicaid which may fully or partially restore his eyesight.[32]

A recipient cannot be required to undergo any treatment if good cause for refusing exists. "Good cause" includes, but is not necessarily limited to:

The treatment is contrary to his religious beliefs;

[32] 470 IAC 2.1-1-2

Previous surgery of the same type recommended was unsuccessful; or

The recommended treatment is very risky because of its magnitude or unusual nature.[33]

If the blind person refuses the recommended treatment without good cause, the worker is to report this fact and the reason(s) for his refusal to the MRT.

The decision to discontinue MA due to the refusal of recommended treatment will be made by the MRT. This determination cannot be made by the eligibility worker.

2412.25.00 DEFINITION OF DISABILITY (MED 1)

In order to qualify as Disabled under MA D, MADW, or MA R, an individual must be determined disabled according to SSI criteria.[34]

Disability for adults is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which as lasted or can be expected to last for a continuous period of not less than twelve (12) months.[35]

If the individual is a child under the age of 18, the individual will be considered to be disabled if the child has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months. No child who engages in substantial gainful activity may be considered disabled.[36]

An individual can qualify for the basic category of M.E.D. Works, MADW, if that person meets the above disability definition except for the fact that he is working.

The above definition also applies to MA R.

A recipient of M.E.D. Works in the basic category, MADW, who becomes ineligible in that category due to medical improvement, can qualify in the medically improved category of M.E.D. Works,

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[33] 470 IAC 2.1-1-2

[34] 405 IAC 2-2-3; 42 CFR 435.540

[35] 20 CFR 416.905

[36] 20 CFR 416.906

MADI, as long as the medical condition has not been resolved, or the person is not completely recovered.[37]

2412.30.00 VERIFICATION OF THE DISABILITY REQUIREMENT (MED 1)

The policy stated in this section only applies to the MA D, MADW and MA R categories of assistance.

The Disability requirement is verified as follows:

> The applicant is receiving Supplemental Security Income (SSI) benefits as a "disabled individual", "disabled child", or "disabled spouse." This is verifiable by the State Data Exchange (SDX); or
>
> The applicant is receiving Social Security Disability (SSDI) as verified by the SSA BENDEX data exchange and the “onset of disability” date is documented; or
>
> If the applicant alleges to be receiving Social Security benefits on the basis of disability, but it is not verifiable through the SDX or BENDEX, the applicant can obtain proof of Disability status from the Social Security Administration. This verification must be directly issued by the SSA, must be current within 30 days of receipt by the DFR , and must specify receipt of benefits on the basis of the individual’s disability; or
>
> The Medicaid Medical Review Team reviews medical evidence and social history information submitted by the eligibility worker and determines that the person meets the definition of disability. Additionally, in the above circumstance of proof of disability status from the SSA, the MMRT will record the disability approval in the system upon receipt of documentation from the eligibility worker.

When disability cannot be verified by the SSA data exchanges or statement from the SSA, the MMRT will make a determination of disability. The policy and procedures outlined below are to be followed by eligibility workers. In no situation can the individual be considered as “not cooperating” due to failure to obtain documentation from the SSA regarding disability status. This is an available option for the individual and if this verification is not obtained, the eligibility worker must pursue

[37] 405 IAC 2-9-7

medical information collection as explained in the following sections.

An individual who has been determined by the SSA to not be disabled, will not meet the Medicaid definition of disability unless the condition has worsened since the SSA denial or the individual has had onset of a new condition not considered by the SSA. In this situation, medical information must be submitted to the MMRT for decision.[38]

2412.30.05 Exceptions when MRT will determine disability

SSA will determine disability for Medicaid except in the following circumstances where MRT will determine disability:

a) An individual has never applied to the SSA for disability benefits.

b) An individual has applied to the SSA for disability benefits, but SSA has not yet rendered a decision.

c) An individual had applied to the SSA and the SSA determination denied disability is more than 12 months old and the individual is currently claiming a change in condition since the SSA denial.

d) An individual had applied to the SSA and the SSA determination denied disability less than 12 months ago, the individual is currently claiming a change in condition since the SSA denial, and the individual has applied to SSA for reconsideration of its disability decision but the SSA refused to reconsider.

If any condition described in either a), b), or c) the individual will be required to provide proof that the individual also applied for disability to the SSA by the 45th day following the date of the individual's submitted application for Medicaid or from the 13th day after the mailing date of the pending verification checklist that indicates that the individual must apply for disability benefits, whichever is longer. If there is an SDX match showing a pending application, this requirement would be met.

If a person is required to apply for benefits with the SSA, the person must receive notice of the requirement by being given a 2032 after the interview is held. Refer to IPPM 2005.00.00.

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[38] 42 CFR 435.541

Further, workers must not delay requesting medical information needed to determine disability due to this requirement.

For purposes of c) and d), when the individual has appealed the SSA determination, the date considered to be the SSA determination is the date the SSA made its original determination, not the date of the SSA hearing decision.

If the condition described in d) is met, that individual will not be required to apply for disability benefits to the SSA. MRT will make the disability determination.

2412.30.10 Preparation of Medical Packet for MMRT (MED 1)

The policy stated in this section only applies to the MA D, MADW, and MA R categories of assistance.

The medical packet submitted to the MMRT consists of the social history summary obtained from the applicant or representative during the interview and medical evidence obtained from the individual’s medical providers.

SOCIAL SUMMARY

The eligibility worker must thoroughly complete the social summary leaving no sections blank. Information includes work history, education, living arrangements, economic status, medical treatment history, SSI/SSDI status and other pertinent information that indicates the extent to which the disability interferes with the applicant's ability to function in his social, family, and economic situation.

If the applicant is a child, the social summary should reflect the developmental and educational achievements (or lack of same) of the child. If the child is not attending school, the eligibility worker should obtain as much information as possible from the parent or representative about the child's development relative to the normal development of a child of his chronological age. If the child is in special education or learning disabled classes, the social summary must contain information about the reason he is in these classes, the degree of learning delay and what classes/subjects are involved.

Treatment history for the previous 12 months must be thoroughly discussed during the interview and recorded on the social summary. If the applicant does not have any medical services to list in the “Treatment History Section”, eligibility workers are

to enter “none” in this section. Leaving it blank or entering “N/A” is not sufficient for an MMRT decision.

MEDICAL EVIDENCE

A complete 12-month medical history on the individual is needed unless the documented impairment began less than 12 months prior to application. The eligibility worker is to request copies of all medical records from physicians, clinics, and/or hospitals indicated by the applicant as having treated/examined the applicant for his/her documented impairment(s) since the onset of the condition(s) or 12 months prior to the date of application, whichever is longer. Evidence must include medical history, clinical findings, laboratory findings, diagnosis, treatment, and medical assessment.

The applicant, who is not under the care of a physician, is to be examined by a physician licensed to practice medicine in Indiana or another state.[39] The requirement to have a medical examination is applicable even for the applicant or, in the case of a child, the guardian or parent, who objects on religious grounds.[40] For an applicant who has no physical impairment at all, but whose disability is based solely on mental status, an examination is required by a psychiatrist, psychologist, or mental health professional holding HSPP certification.

If a current physical examination is needed, the Local Office is to forward the following forms to the examining physician:

> Form 251, Authorization for Physical Examination to Determine Disability for Medical Assistance;
>
> Form 251A, Determination of Disability - Medical Information;

The applicant, if able to do so, and agrees to do so, may take the forms to the doctor. Caseworkers should follow up to be sure the doctor received the forms.

All applicable portions of Form 251A are to be completed by the physician. Copies of other pertinent medical data, such as x-ray and laboratory results, hospitalization records, and so forth, should also be included. The Form 251A must be signed and dated by the examining physician and returned to the Local Office. If the physician prefers not to complete Form 251A, he may submit

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[39] 470 IAC 2.1-1-2

[40] 470 IAC 2.1-1-2

the medical evidence in letter format, or copies of existing medical records on the individual.

The 251A Medical Form is not to be sent to mental health providers. Information obtained from these sources should be supplied in the practitioner's usual and customary format.

Failure to receive medical evidence is not an acceptable reason for denial of an application if the disabled person is still interested in obtaining Medicaid coverage. As it is the joint responsibility of the applicant and the caseworker to make every effort to obtain the medical information, caseworkers must monitor a pending application closely for receipt of the medical information in accordance with the following guidelines:

Give the applicant a 30-day deadline to arrange for an examination and inform the eligibility worker of the appointment date, with a follow-up 10-day deadline if the applicant does not respond.

When requesting medical records from a provider, give a 20-day deadline; with another follow-up 20-day deadline if the records are not received after the first letter. Telephone contact should be made to the provider with a 3rd 20-day deadline given if the provider indicates intention to submit the records.

When a provider does not respond to any of the requests for medical records, the eligibility worker is to notify the applicant or authorized representative to contact the provider. A 10-day deadline is to be given for the applicant/representative to contact the worker. This step in the process is not a condition of eligibility being imposed on the applicant to obtain the medical records. It is an attempt to engage the applicant's help in obtaining the records, with the only requirement being to contact the eligibility worker.

Partial records may be submitted by the local office to the MRT if all attempts to obtain the medical history documentation have not been successful. The providers who did not respond must be listed in the medical packet.

MRT will request Additional Information from providers and the applicant when additional testing or consultative exam is needed to make the determination of disability.

2412.30.10 Payment for Disability Examinations (MED 1)

The policy stated in this section only applies to the MA D, MADW, MADI, and MA R categories of assistance.

The maximum payment for a disability examination, including completion of the report, is $65. The maximum payment for completion of a report based on a previous examination for which the doctor has already been paid is $10.[41] Psychological exams/testing are reimbursed at the rate of $80 per hour.[42] Additional payments may be allowed for x-rays, tests, and so forth, which are necessary to confirm the primary diagnosis if approved by the MMRT.

Providers should be referred to www.indianamedicaid.com for procedures to submit claims for payment on Medicaid disability exams or submission of medical records.

2412.40.00 DISABILITY INFORMATION ON REAPPLICATIONS/CATEGORY CHANGES (MED 1)

The policy stated in this section only applies to the MA D, MADW, and MA R categories of assistance.

The guidelines to follow concerning the submission of medical/social information to the MRT for individuals who are reapplying for Medicaid and those whose Medicaid category is changing back to a disability category are outlined below. These guidelines apply when a decision is required by the MRT because the individual's disability is not verifiable through the SSA data exchanges

A. Medicaid Reapplications

- If the most recent SSA or MRT decision for an applicant is disapproval, new medical and social information must be submitted to the MRT, and the conditions in Section 2412.30.05 are applicable. (Note that the applicant may or may not have last received Medicaid under the MA D category.)

- If an applicant was previously discontinued under MA D, MADW, or MA R, 48 months or more before the date of the reapplication, new medical and social information is required, unless the applicant is still considered disabled

[41] 405 IAC 2-2-4

[42] 405 IAC 2-2-4

according to the SSA. If new medical and social information is required to be sent to MRT, the conditions in Section 2412.30.05 are applicable.

- If an applicant last received Medicaid under MA D, MADW, or MA R and was closed for a non disability-related reason 48 months or less prior to the date of the reapplication, new medical information is not required unless a Progress Report as required by the MRT is due. The Progress Report is required by the due date previously established by the MRT, but not sooner. Additionally, if an improvement in the applicant’s condition is noted, a Progress Report should be submitted immediately; however, if the MRT had not previously required a Progress Report, Medicaid is to be approved if all other requirements are met pending the MRT's decision on the Progress Report. A Progress Report will be considered inapplicable if the person is still considered disabled according to the SSA. If new medical and social information is required to be sent to MRT, the conditions in Section 2412.30.05 are applicable.

If the disability approval was made by an Administrative Law Judge, Agency Review or court decision in reversing an MRT decision, the above requirements with regard to the time frames are applicable to that decision.

B. Category Change to MA D, MADW, or MA R

- If 48 months or less have elapsed since the date that the recipient last received Medicaid under MA D, MADW, or MA R, new medical information is not required unless a Progress Report as required by the MMRT is due. The Progress Report is required by the due date previously established by MMRT, but not sooner. The Progress Report will not be required if the person is considered disabled according to the SSA. If the Progress Report is required, Section 2412.30.05 is applicable. If the person is required to (re-)apply to the SSA for benefits, the 45-day time frame for this scenario begins the day after the 2032 is sent.

- If more than 48 months have elapsed since the date that the recipient last received Medicaid under MA D, MADW, or MA R, new medical and social information is required unless the individual is considered disabled according to the SSA. If new medical and social information is required, Section 2412.30.05 is applicable. If the person is required to (re-)apply to the SSA for benefits, the 45-day time frame for this scenario begins the day after the 2032 is sent.

The above requirements include changes back and forth between QMB/SLMB-also coverage and QMB/SLMB-only coverage. For example:

John receives full coverage Medicaid as a QMB-also (MA D and MA L). Effective 6/1, MA D is closed due to excess resources and MA L remains open, so his coverage is reduced to QMB-only. In December, John notifies the DFR that his resources have been depleted and he wants reconsideration for full coverage Medicaid. Because his MA D was closed for a non-disability reason less than 48 months ago, new medical information is not required unless the SSA no longer considers John to be disabled and he is not claiming a change in condition since that SSA determination.

2412.45.00 DECISION OF MEDICAL REVIEW TEAM (MED 1)

The policy stated in this section applies to the MA D, MADW, and MA R categories of assistance.

The Medicaid Medical Review Team, which is comprised of physicians, nurses and consultants,[43] will review the medical evidence and the social information and make one of the following decisions:

The applicant meets the disability requirement; a progress report is not required.

The applicant meets the disability requirement; a progress report is required by a date specified by the MMRT.

The applicant does not meet the disability requirement.

Whenever necessary, the MRT will request Additional Information from medical providers and the applicant in order to make a decision as to whether the applicant meets the disability requirement.

The MMRT decision and reason for a denial when applicable, is transmitted to the eligibility system. The MMRT will issue a detailed explanation for a denial to the applicant and a copy will transmit to the applicant's electronic eligibility file. This letter along with the eligibility decision notice that contains appeal rights should be used in the appeals process.

As of June 1, 2014, a positive determination of disability made by MRT is no longer considered effective <u>when the SSA has</u>

[43] 42 CFR 435.541

determined disability for an individual. If MRT determines a person to be disabled and a later determination is made by SSA that agrees with the MRT decision, there is no change regarding the determination of disability for that individual. The decision made by the SSA nonetheless still controls once the SSA renders the decision. If MRT determines a person to be disabled and the SSA later determines the person is not disabled. Refer to the next section, 2412.50.00.

2412.50.00 PROGRESS REPORTS AND ONGOING ELIGIBILITY (MED 1)

The policy stated in this section only applies to the MA D, MADW, MADI, and MA R categories of assistance.

When a Progress Report is required by the MRT or an ALJ, or when it is learned that the individual's disabling condition has improved, the caseworker must conduct an interview with the recipient, complete a new social summary, and obtain medical information following the same guidelines listed in Section 2412.30.05.

When a Progress Report is required, Section 2412.30.05 applies. The forty-five (45) day timeframe begins the day after the 2032 is sent requesting proof of application for benefits with the SSA. Attempts by DFR to obtain medical documentation should not be delayed due to this requirement.

Upon receipt of the Progress Report medical packet, the MMRT will review the information and make a decision on the recipient's continuing disability status. For the recipient who is currently open in MADW, the MRT will determine if he remains eligible in that category, is eligible under the medically improved category MADI, or if he has medically recovered to the point at which the disability definition is no longer met. If the recipient remains eligible, another Progress Report may be required.

When the DFR is notified that SSA benefits have terminated due to loss of disability status, either by the SSA data exchanges or direct documentation from SSA, the recipient must be contacted to learn whether or not a timely appeal with SSA has been filed. The pending verification form can be used for this purpose with the usual 13-day deadline for responding. Continued benefits must be verified by the SSA data exchange or by direct documentation issued to the beneficiary by the SSA. If SSA benefits on the basis of disability continue due to a timely appeal, the Medicaid disability requirement continues to be met until the SSA rules on the appeal that the person is no longer

disabled. Medicaid under a disability category is to be discontinued with timely notice when a final termination decision is made by the SSA. Prior to any such discontinuance, consideration of eligibility in one of the other Medicaid categories must be pursued.

When an individual is determined disabled by MRT, receives benefits under MA D, and is subsequently denied disability benefits by the SSA because the SSA determined the person to not be disabled, the person shall remain eligible in MA D for a minimum of 60 days from the date the SSA denied the individual benefits on the basis that the SSA determined the individual to not be disabled. If the individual appeals the determination with the SSA within the 60 day period from when the SSA denied the individual disability benefits, the person shall remain eligible for MA D while the SSA appeal is being processed. Once a final determination regarding disability is made by the SSA, the decision is considered binding whether the appeal upholds the original SSA determination or is fully favorable to the SSA appellant. If the SSA appeal decision finds that the individual is not disabled, the individual cannot be considered disabled for Medicaid purposes. When an individual does not appeal the SSA determination within 60 days from the date the SSA denial of disability benefits was made, the determination of disability made by the SSA is binding, and the individual will not be considered disabled for purposes of Medicaid eligibility.

If a recipient of MADW is determined to no longer be disabled according to the SSA, a Progress Report is required to determine whether the recipient would remain eligible under MADI and medical records should be sent to MRT. While this Progress Report is being processed, the recipient is to remain eligible for Medicaid under MADW.

2412.55.00 TREATMENT FOR RESTORATION OF PHYSICAL/MENTAL HEALTH (MED 1)

The policy stated in this section applies to the MA D, MADW, MADI, and MA R categories of assistance.

A disabled recipient is required to cooperate in any treatment plan recommended by the examining physician and approved for payment by Medicaid, which may fully or partially restore his physical or mental health.[44]

[44] 470 IAC 2.1-1-2

A recipient cannot be required to undergo any treatment if good cause for refusing exists. "Good cause" includes, but is not necessary limited to:

The treatment is contrary to his religious beliefs;

Previous surgery of the same type recommended was unsuccessful;

The recommended treatment is very risky because of its magnitude or unusual nature; or

Amputation of a major limb is involved.[45]

If the recipient refuses the recommended treatment without good cause, the caseworker is to report this fact and the reason(s) for his refusal to the Medical Review Team, Office of Medicaid Policy and Planning.

The decision to discontinue MA due to the refusal of recommended treatment will be made by the MRT.

2414.00.00 SSI STATUS

In some situations, an individual's benefit status with the Supplemental Security Income (SSI) program has an effect on his non-financial eligibility. The following sections discuss these situations.

Effective June 1, 2014, SSI recipients are deemed eligible for Medicaid coverage in Indiana. SSI recipients will be eligible under the MASI category.

The following sections cover special groups of former SSI recipients that are considered eligible for Medicaid.

2414.10.00 SSI 1619 STATUS

Section 1619 of the Social Security Act provides an incentive to the blind or disabled SSI recipient to continue work when his earned income reaches levels that would otherwise jeopardize eligibility. Individuals in 1619(a) status receive reduced SSI benefits, while individuals in 1619(b) status receive no SSI benefits.

A recipient's 1619-SSI status is verified through data exchange. The eligibility system automatically updates an individual's SSI

[45] 470 IAC 2.1-1-2

status on the AEIDC screen and notifies the worker of the update through an alert.

Blind or disabled SSI recipients who are in SSI 1619(a) or 1619(b) status are eligible for continued Medicaid coverage if they were on Medicaid in the month immediately preceding the month in which an individual's 1619 status last began. The only non-financial requirement that must be met is state residency.

If 1619 status is subsequently lost because the individual is no longer considered disabled, a progress report must be submitted immediately to the MRT to see if the individual qualifies for MEDworks. If a re-examination of eyesight is required for a blind recipient in 1619 status, notification to the MRT is unnecessary. However, an eye report is required immediately upon termination of 1619 status.

Refer to Section 3475.00.00 for additional information about Medicaid eligibility for persons in 1619 status.

2414.10.10 Disabled Adult Children

When child has attained the age of 18 and their disability started before turning 22 and loses SSI benefits due to receipt of or an increase in Retirement, Survivors, and Disability Insurance (RSDI) disabled children’s benefits, and the person still meets current SSI criteria, excluding the RSDI benefit, is considered eligible for Medicaid purposes.

2414.10.15 Pickle

Individuals who would continue to receive SSI but for an increase in their in other benefits from the SSA due to the annual cost-of-living-adjustment (COLA) increases are considered eligible for Medicaid.

2414.10.20 Disabled Widows or Widowers

When an SSI recipient who is at least 60 through 64 years of age, is a widow or widower, and loses SSI benefits solely due to receipt of other new or increased benefits from Social Security, and the individual is not entitled to Medicare Part A, the person is automatically eligible for Medicaid.[46] The person’s countable income from Social Security should be reduced to the applicable SSI benefit amount.

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[46] 42 CFR 435.138

When an SSI recipient who is at least 50 through 59 years of age, is a widow or widower, and loses SSI benefits solely due to receipt of other new or increased benefits from Social Security, and the individual is not entitled to Medicare Part A, the person's countable income from Social Security should be reduced to the applicable SSI benefit amount.

Individuals who have been receiving the special income disregard under Darling v. Bowen in IHCPPM 3455.05.05.25 are entitled to Medicaid eligibility as long as they have been continuously entitled and maintained entitlement to widow's or widower's disability benefits from Social Security.[47]

2415.00.00 CATEGORICAL ELIGIBILITY FOR MEDICAID WAIVERS

In order to be eligible under a Medicaid Home and Community-Based Services waiver, an individual must qualify under one of the specific aid categories that are approved for the waiver. Workers must ensure that waiver applicant/recipients are considered for Medicaid in the proper category. Verification of the specific waiver for which an individual is either applying or already approved, must be obtained from the waiver case manager. Please, refer to IHCPPM 3310.00.00 for permissible categories to receive HCBS waivers.

There are various special eligibility provisions that are applicable in certain categories and under certain waivers as explained in Chapters 3300 and 3400.

2416.00.00 MEDICARE STATUS (MED 4)

Individuals whose status with the federal Medicare program meets certain requirements, and who also meet other eligibility requirements, can qualify for limited Medicaid coverage. The following four sections specify the categories under which this is possible.

2416.05.00 QUALIFIED MEDICARE BENEFICIARY (MED 4)

The policy in this section applies to the MA L category of assistance.

In order to be eligible as a Qualified Medicare Beneficiary (QMB) an individual must be entitled to Medicare Part A. An individual meets this requirement if he is enrolled in Medicare Part A, or is eligible for enrollment if a monthly Part A

[47] 42 CFR 435.137

premium is paid. Medicare Part A enrollment can be verified by viewing the Medicare card, a TPQY, or by correspondence from the SSA. If there is no Medicare Part A enrollment, those who are eligible for Medicare Part A with a monthly premium can be identified as follows:

1. Usually have only SSI income;
2. Are age 65 or over; and
3. Have a HIB number ending in M, J3, J4, K3, or K4, and sometimes T.

Also refer to Page VII-2 of the Medicaid Enrollment Manual Buy-In Section.

No other verification of age is required, nor does the disability requirement applicable to the Medical Assistance for the Disabled category apply to individuals eligible as QMB only.

A QMB must also satisfy the citizenship, residency, SSN, and medical assignment requirements explained in the respective sections of this chapter.

Refer to Section 3010.35.05 for QMB income standards and Section 3005.25.00 for QMB resource standards.

QMB coverage is limited to payment of:[48]

1. The monthly premium for Medicare Part B;
2. The monthly premium for Premium Hospital Insurance under Medicare Part A, for individuals not entitled to free Part A; (These premiums are required of certain persons entitled to hospital insurance benefits only by voluntary enrollment in the premium paying Part A program.); and
3. Medicare Part A and B deductibles and co-insurance. An individual can be simultaneously eligible under another full coverage category and QMB.
4. Co-payments for Medicare Part C (Medicare Advantage plans)[49] (Refer to Section 3465.05.00)

2416.10.00 QUALIFIED DISABLED AND WORKING INDIVIDUALS (MED 4)

[48] SSA 1902(a)(10)(E)

[49] SSA 1905(p)(1)

The policy in this section applies to the MA G category of assistance.

Disabled and working individuals who lost or will lose Medicare coverage because of their working status, are entitled to enroll in Medicare Part A under the provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89). If they also meet certain other eligibility requirements, they are eligible for the category of assistance entitled Qualified Disabled and Working Individuals (QDW).[50]

QDW coverage is limited to payment of the monthly premium for Medicare Part A only. These individuals may also enroll in Medicare Part B (if they are enrolled in Part A), but they will always be responsible for paying the Part B premium themselves.

The individuals who contact the DFR and wish to apply for the QDW category of assistance should be asked to provide a notice from SSA informing them that they will lose their Medicare because of their working status. The affected Medicare beneficiary will receive such a notice in each of the three months prior to discontinuance of Medicare. An individual whose Medicare was previously terminated should provide a notice he has received from SSA, or some other evidence from SSA, that his Medicare was terminated because he was working.

A QDW must also satisfy the citizenship, residency, SSN, and medical assignment requirements explained in the respective sections of this chapter.

Refer to Section 3010.35.15 for QDW income standards and Section 3005.25.00 for QDW resource standards.

An applicant/recipient is not eligible for QDW if he is otherwise eligible for Medicaid.[51]

2416.15.00 SPECIFIED LOW INCOME MEDICARE BENEFICIARY (MED 4)

The policy in this section applies to the MA J category of assistance.

Persons who are entitled to Medicare Part A may qualify under the Specified Low Income Medicare Beneficiary (SLMB) category. The eligibility requirements are the same as those for QMB (refer to Section 2416.05.00) except the income standards are

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[50] SSA 1902(a)(10)(E)

[51] SSA 1905(s)(4) as added by P.L. 101-239

higher. (Refer to Section 3010.35.10 for SLMB income standards.) Coverage is limited to payment of the Medicare Part B premium.[52]

An individual can be simultaneously eligible for SLMB and a full coverage category or can be eligible as "SLMB-only". A recipient entitled as "SLMB-only" will not receive a Medicaid ID card. If the individual's countable income exceeds the QMB standard, eligibility for SLMB will be determined. (Refer to Section 3005.25.00 for SLMB resource standards.)

2416.20.00 QUALIFIED INDIVIDUALS (MED 4)

The policy in this section applies to the MA I category of assistance.

Persons who are entitled to Medicare Part A may qualify under the Qualified Individuals category of assistance, QI. An individual eligible under any other Medicaid category cannot be eligible as a QI.

The QI category is designated as MA I in the eligibility system. The non-financial, income, and resource eligibility criteria are the same as for QMB except that the individual's income for the appropriate family size must be between 120% and 135% of the Federal Poverty Level. (Refer to Section 3010.35.20 for QI income standards and 3005.25.00 for QI resource standards.) QI coverage is limited to payment of the Part B Medicare premium.[53]

Qualified Individuals will not receive a Medicaid ID card.

2418.00.00 Household Tax Relationships (MED 3)

Applicants or recipients whose eligibility is reviewed must attest whether they have filed or expect to file taxes or whether they have been claimed or expect to be claimed as a tax dependent in the year eligibility is being determined or re-determined. A person’s tax filing status will determine the AG formation for that individual. Please, refer to IHCPPM 3200 for specific policy for MAGI categories.[54]

When MAGI does not apply, an applicant or recipient’s eligibility should not depend upon the tax filing status of that individual.

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[52] SSA 1902(a)(10)(E)(iii)
[53] SSA 1902(a)(10)(E)
[54] 42 CFR 435.603

2420.00.00 RESIDENCE IN THE HOME OF A SPECIFIED RELATIVE (MED 3)

The following policy is limited to MAGF and MA T. For MA F, please, refer to IHCPPM 3800.

For MAGF and MA T MAGI relationships generally control. Refer to IHCPPM 3205.05.00 through 3205.20.00. When the non-filing rules apply (refer to IHCPPM 3205.20.00) for that applicant/recipient whose eligibility is being determined under these categories, the applicant/recipient must be living with a person having a specified degree of relationship, in a place of residence. The MAGF applicant/recipient must be considered the caretaker relative for another person under the age of 18. The MA T applicant/recipient must be living with the caretaker relative.[55]

The individual with whom the person resides must be related to the applicant/recipient as specified in the following groups:

1. Any blood relative within the fifth degree of relationship, including, but not limited to, those of half blood, including first cousins, first cousins once removed, nephews, nieces, uncles, aunts, and individuals of preceding generations as denoted by prefixes of grand, great, great-great, or great-great-great; or
2. Legal spouses of any individuals named above, even though the marriage was terminated by death or divorce.[56]

A guardian may receive assistance only when such person is a relative listed above and the child lives with that person.

2420.05.05 Verification of Relationship (MED 3)

The following policy is limited to MAGF and MA T.

It is the responsibility of the applicant/recipient to assist the worker to verify the degree of relationship between an applicant/recipient and a specified relative.

The relationship of a child to a relative listed in the previous section, except for an alleged father, is verified when the caseworker either:

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[55] Social Security Act, Section 406(a)(c)
[56] 45 CFR 233.90

- Sees the child's birth certificate; or

- Obtains verification from two of the sources listed below, when the birth certificate is not seen:

  - Hospital records established at the time of birth (including a hospital issued birth certificate);
  - Physician's records;
  - Marriage records;
  - Court records, including adoption records;
  - Social Security Administration records;
  - Church documents, such as baptismal certificates;
  - Passport;
  - Immigration records;
  - Naturalization records;
  - School records;
  - Records of social agencies (including the Local Office); or
  - Signed statement from an unrelated reliable person having specific knowledge about the relationship of the child to the specified relative

2420.10.05 Verification of Living With (MED 3)

The following policy is limited to MAGF and MA T.

The "living with" requirement may be satisfied by the applicant's/recipient's statement, unless discrepant information exists.

If there is a question whether the child is living with his relative, verification may be obtained from other sources based on the individual situation. Such sources include, but are not limited to:

Seeing the child in the home;
School records;
Child care provider's records;
Landlord's statement;
Hospital, clinic, or physician's records;
Social Security or other benefit records;
Church records;
Court support order;
Child welfare records; and
Signed statement from a reliable individual having personal knowledge of the child living with the specified relative.

2420.15.00 TEMPORARY ABSENCE FROM THE HOME (MED 3)

When MAGI rules apply for all MED 3 categories, absence of the recipient child or parent/caretaker relative from the home for limited periods of time does not affect eligibility, provided that the absent member intends to return to the home.[57]

2422.00.00 INSTITUTIONAL STATUS

An institution, as defined by federal regulation, is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.[58]

2422.10.00 RESIDENTS OF INSTITUTIONS

The Medicaid eligibility of an individual who resides in an institution is governed by the type of institution, in addition to the other eligibility factors. A public institution is an institution that is the responsibility of a municipal, county, state, or federal governmental unit, or over which such a governmental unit exercises administrative control.

Individuals who are serving time for a criminal offense and incarcerated in public correctional institutions such as jails, prisons, and detention facilities including those for juveniles, are not eligible for Medicaid/Hoosier Healthwise.[59] These individuals are defined as “inmates of public institutions”. An individual on parole, or sentenced to home detention except during those times when reporting to a prison for an overnight stay, individuals on parole, individuals living voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and other living arrangements are being made for them (such as a transfer to a community residence, and infants who are permitted to stay in a correctional facility with their inmate mothers are examples of persons who can be eligible for Medicaid if they meet all of the other program requirements.

The following individuals are not eligible for Medicaid: individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial, inmates involuntarily residing at a wilderness camp under governmental control, inmate involuntarily residing in half-way houses under

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[57] 45 CFR 233.90
[58] 42 CFR 435.1009
[59] 42 CFR 435.1009

governmental control, inmates receiving care as an outpatient, and inmates receiving care on premises of a prison, jail, detention center, or other penal setting.

Individuals may be eligible for Medicaid while residing in the types of institutions listed below, public and private, if they are not inmates as described in the above paragraphs. (Special eligibility considerations for persons in psychiatric facilities are explained in Section 2422.10.05.)

- Nursing facilities providing skilled and/or intermediate levels of care;
- Acute care hospitals;
- Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled (ICF/MR, or CRF/DD);
- Public institutions designed to serve no more than 16 persons and which provide services beyond food and shelter, such as social services, help with personal living activities, or training in socialization and life skills [60];
- Public educational or vocational training institutions such as Indiana Schools for the Blind and Deaf and Silvercrest Developmental Center;
- Medicaid certified state institutions, or portions thereof, under the direction of the Indiana Family and Social Services Administration, Division of Mental Health;(;; (note Section 2422.10.05)
- Public residential care institutions such as county homes;
- Any other type of privately owned group living arrangement such as a foster home or group home.

2422.10.05 Residents of Psychiatric Facilities

Residents of psychiatric facilities (public or private) may be eligible for Medicaid under the conditions specified below.

A psychiatric facility, or institution for mental diseases (IMD) as referred to in federal regulations, is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care to persons with mental diseases, including medical care, nursing care, and related services.[61]

Individuals residing in an IMD, as defined above, can be eligible for MA, if they are:

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[60] 42 CFR 435.1009

[61] Social Security Act, Section 1905(i)

- Age 65 or older; or
- Under age 21, reside in a Medicaid certified facility, and have an approved Certification of Need, Form 1261A. Refer to Section 2422.10.10.

Additionally, if a recipient is receiving approved inpatient services prior to age 21, coverage continues until services are no longer required or the recipient reaches age 22, whichever comes first.[62]

2422.10.10 Certification of Need/Inpatient Psychiatric Care

In order for individuals under the age of 21 to be eligible for Medicaid in a Medicaid certified psychiatric facility, an approved certification of need, the Form 1261A, Certification-Plan of Care for Inpatient Psychiatric Hospital Services, is required. If the Plan of Care is disapproved for an applicant/recipient, the individual is ineligible for Medicaid while residing in the facility. In order for individuals age 65 and older to be eligible for Medicaid reimbursement of inpatient psychiatric services, an approved Form 1261A is required; however, such an individual is eligible for all other Medicaid services while residing in the psychiatric facility.

The facility is responsible for the completion and submission of the Form 1261A to the appropriate reviewing authority. State facilities submit the Form 1261A to the Medical Review Team, Office of Medicaid Policy and Planning; privately owned facilities submit the Form 1261A to the prior authorization unit of the Medicaid fiscal contractor.

Following approval or disapproval of the plan of care, the original of the Form 1261A will be returned to the facility and a copy will be forwarded to the Local Office for retention in the case file. Copies of the signed Form 1261A are not to be forwarded to the Medical Review Team by the Local Office.

For individuals under age 21, facilities are instructed to submit the Form 1261A prior to the admission of a Medicaid recipient. Caseworkers are not to initiate case action until a copy of the approved or disapproved Form 1261A is received. If the Form 1261A is approved, an institution budget is to be completed. If the Form 1261A is disapproved, action to suspend Medicaid should be proposed if the recipient remains in the facility; if the recipient leaves the facility, eligibility is

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[62] 42 CFR 441.151

to be determined as appropriate, based on the new living arrangement.

For Medicaid applicants, facilities are instructed to submit the Form 1261A within 10 days after the applicant has been determined eligible for Medicaid. Therefore, caseworkers are to complete the application process in the usual manner, using post-eligibility budgeting procedures. If the Form 1261A is approved, no further case action is required. If the Form 1261A is disapproved, action to suspend should be proposed if the recipient remains in the facility. This is done by entering SUSP on AEWAA and authorizing. If the recipient leaves the facility, eligibility is to be determined as appropriate based on the new living arrangement.

2422.10.15 Persons Age 65 and Older/Inpatient Psychiatric Care

For applicants/recipients age 65 and older who are admitted to Medicaid certified psychiatric facilities, the procedures explained above are applicable except that a disapproved Form 1261A does not render the person ineligible for Medicaid. Disapproval indicated on screen AEIII means that Medicaid will not provide reimbursement to the facility for inpatient psychiatric services. If the recipient remains in the facility, community budgeting is to be used. Refer to Section 2422.10.10.

2424.00.00 LEVEL OF CARE/PREADMISSION SCREENING

A Medicaid applicant/recipient who enters a nursing facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), or Community Residential/Developmentally Disabled (CRF/DD) must first undergo preadmission screening to determine whether the individual requires the level of care provided by a nursing facility or is entitled to reimbursement on his behalf in an ICF/MR or CRF/DD. When completing AEIII, the caseworker will assume preadmission screening/level of care is approved unless there is information to the contrary. The preadmission screening field should be completed by entering "S" - screened, followed by the date that the individual entered the nursing facility. (The date that the preadmission screening was actually completed may be used, if it is known.) The caseworker may then proceed with the eligibility determination, including authorization if the individual passes eligibility.

In the event that preadmission screening and/or level of care is denied for the individual, the DFR will receive a Form 450B, Physician's Certification for Long Term Care Services, which

indicates a denial. The worker should monitor the Forms 450B that are received by the DFR. When a denial is received, the worker should change the preadmission screening field on screen AEIII from "S" to "D" - denied. The individual's eligibility will then be redetermined by eligibility system without the post-eligibility budget.

2426.00.00 PREGNANCY (MED 3)

Within the MED 3 category, the policy stated in this section applies only to MAGP (For definition, see Sections 1620.55.00, 1620.60.00 and 1620.70.00).

To qualify for assistance under these categories, the pregnant woman must self-attest that she is pregnant.[63]

Pregnant women may receive assistance under other categories of assistance, if otherwise eligible, without the need for self-attestation.

Once determined eligible, a pregnant woman’s coverage is maintained throughout the pregnancy (without regard to changes in income) and until the end of the 60-day postpartum period.

2428.00.00 NEWBORN STATUS (MED)

The policy stated in this section only applies to MA X child born to a woman, who is eligible for traditional Indiana Medicaid or Hoosier Healthwise under any benefit package except Package C (MA 10), on the date the child is born, is eligible for 12 continuous months as long as the child continues to live in Indiana. This also includes infants born to mothers who are eligible for emergency Medicaid services only.[64] An application is not required and the only eligibility factor at the time of the birth is that the infant's birth mother was eligible for Medicaid when the infant was born. The 12-month eligibility period will end before the 12th month only due to loss of Indiana residency, a written voluntary withdrawal from the caretaker/parent, or death of the child.

Refer to Section 2225.10.00 for case processing information and Information about adding a newborn to the case. The newborn must be enrolled in Medicaid without delay.

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[63] Social Security Act, Section 1905(n)(1)
[64] Social Security Act, Section 1902(e)(4)

As long as the mother is determined eligible for Medicaid/Hoosier Healthwise for the month of the child's birth, the child is eligible in the Newborn category even when the mother applies for Medicaid after the child is born. If the child is born during a month of the mother's retroactive coverage and she is eligible for that month, the baby eligible for the Newborn category.

Coverage in the Newborn category continues for the 12 month period if the child goes to live with someone other than the birth mother, including adoption when the child leaves the hospital and goes directly to live with the adoptive parent(s). However, if the identity and location of the adoptive parent(s) are not known, or the child is adopted by parents living out of state, benefits under the Newborn category are provided for the birth month through discharge and removed the subsequent month. If the infant has not been named, the name assigned to the child by the hospital for identification purposes may be used. If the child is adopted by parents living out of state, newborn coverage in Indiana is approved for the birth month only.

2432.00.00 REQUIREMENT TO FILE FOR OTHER BENEFITS (MED 1, MED 4)

Individuals must apply for all other benefits for which they may be eligible, as a condition of eligibility unless good cause can be shown for not doing so.[65] Benefits that must be applied for include, but are not limited to:

- Annuities
- Pensions from local, state, or federal government;
- Retirement benefits;
- Disability;
- Social Security benefits;
- Veterans' benefits;
- Unemployment compensation benefits;
- Military benefits;
- Railroad retirement benefits;
- Workmen's Compensation benefits; and
- Health and accident insurance payments.

In some cases, individuals who are already receiving benefits may be eligible for increased benefits due to a change in their circumstances (for example, veterans' benefits). Individuals are required to apply for all increased benefits for which they may

[65] 42 CFR 435.608

potentially qualify. However, they are not required to apply for Social Security benefits at age 62. Individuals may wait until age 65 to apply.

2432.05.00 REQUIREMENTS FOR REFUGEES (MED 2)

A refugee's eligibility for MA is first considered for all categories of assistance other than Refugee Medical Assistance.[66] The eligibility system automatically determines a refugee's eligibility in this manner to comply with federal regulations. (Refer to Section 1605.20.00)

In addition, the worker must refer refugees who are 65 years of age or older, or who are blind or disabled, to the SSA to apply for assistance under the SSI program. Cash Assistance is to be furnished to eligible refugees until eligibility under the SSI program is determined.

2433.00.00 HEALTH INSURANCE COVERAGE CONSIDERATIONS (MA 10)

There are certain limitations to eligibility under Hoosier Healthwise Package C relative to the coverage or possible coverage of the children under other insurance [67] as follows:

Access to the State of Indiana Health Insurance Plan:

- Children whose parents, caretakers or spouses can cover them under the State of Indiana's health coverage plans offered to State employees are not eligible for MA 10. This prohibition applies even if the State employee has chosen not to cover the child, and regardless of whether or not an open enrollment period is available to the employee at the time of the application. The prohibition does not apply if it is a non-custodial parent who is the State employee.

If the requirements for coverage under the State benefit package appear to be met but the State employee maintains that the child in his or her care cannot be covered, the employee must present or obtain verification from the agency's health plan administrator. The application should pend awaiting this verification.

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[66] 45 CFR 400.94

[67] Section 2110(b)(2) of the Social Security Act

Coverage by other health insurance:

- Children who are covered by comprehensive health insurance (hospital and medical or major medical) are not eligible for MA 10, This differs from the limitation above as the issue is verified coverage, not merely access. If a child has health insurance, the MA 10 eligibility determination must pend for verification of the insurance benefit types.

Dropping health insurance coverage:

- Children whose health insurance coverage has been dropped voluntarily may not receive MA 10 for no more than 90 days following the month of termination. The application asks for information concerning the reason for the termination of coverage. If "could not afford" is indicated as the reason, the insurance is considered to have been terminated voluntarily and the child is subject to the 90-day waiting period. Termination of insurance due to loss of employment (even if the loss was due to a voluntary quit) does not affect the child's eligibility for MA 10. If the family lists a reason that is not on the application or the eligibility system table, and the worker is uncertain as to whether the termination should be considered voluntary, the Policy Answer Line should be contacted.

The following reasons for health insurance being dropped will not cause CHIP coverage to be subject to a 90 day waiting period:

-loss of employment

-coverage limit reached

-non-custodial parent dropped insurance coverage

-divorce/death of parent

-employer ended insurance coverage

-insurance premium is more than 5 percent of the family income for the child’s coverage

-cost of family insurance coverage is more than 9.5 percent of family income

-child has special health care needs

2434.00.00 ASSIGNMENT OF MEDICAL RIGHTS

As of July 1, 2011, in support of P.L.153-2011, the assignment of medical rights became operational by State law. This means that no separately executed assignment of rights is required for Medicaid eligibility.

Cooperation in identifying and providing information about responsible third parties, including absent parents, as well as cooperation in obtaining third party payments and medical support, is required unless the applicant/recipient establishes good cause.[68]

2434.05.00 MEDICAL SUPPORT COOPERATION REQUIREMENTS

This section does not apply to pregnant women (MAGP), Transitional Medical Assistance (MA F), or applicant/recipient children under 18 whose eligibility is being determined under a category other than MAGF.

The applicant/recipient is required to cooperate, unless good cause is established, in obtaining medical support and payments for medical care as follows:[69]

- Provide the DFR with all information regarding existing and future medical insurance coverage;
- Advise the DFR of any existing or future court orders which provide support for medical care;
- Advise the DFR of any legal action taken or intended to be taken against a third party for injuries he has sustained in an accident; (this also applies to any other applicant/recipient for whom he is legally responsible);
- Assist in obtaining any support for medical care available to him under any order of a court or administrative agency;
- Assist in obtaining any third party payments which may be available; and
- Pay to the Central Office or DFR any money from any third party who is paid directly to him for medical services which were or will be paid by Medicaid.

2434.10.00 IV-D SANCTION REQUEST

When an IV-D sanction request is received, it must state that the custodial parent or legal guardian failed to cooperate in obtaining medical support. Information regarding policy

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[68] Social Security Act, Section 1912(a);
[69] 42 CFR 433.147

subsequent to the receipt of an IV-D sanction request is found in Section 2434.20.00.

2434.15.00 IDENTIFICATION OF MEDICAL RESOURCES

The DFR must secure information from the applicant and any other knowledgeable source such as a parent, authorized representative or legal guardian on medical resources that are available or were available during the retroactive period to pay for the applicant's medical expenses. Medical resources include, but are not limited to:

- Health insurance policies, including health insurance policies from the Federal Marketplace, carried by the applicant or carried for the applicant by an employer or relative;
- Government financed health programs, such as:
    - Medicare - Parts A and/or B;
    - CHAMPUS (Civilian Health and Medical Program of the Uniformed Services);
    - CHAMPVA (Civilian Health and Medical Program of the Veterans Administration); and
    - Veterans' benefits;
    - Tricare;
    - Workman's compensation (for employment related accidents); and
- Automobile insurance (for automobile accidents).

It is crucial that all medical resources be identified so that, if the applicant is determined to be eligible for MA, the Medicaid Fiscal Contractor, when processing provider claims, can seek payment from these resources **before** payment is made by Medicaid.

2434.20.00 THE RIGHT TO CLAIM GOOD CAUSE - MEDICAL SUPPORT

Upon receipt of a medical sanction request from IV-D, a Medical Assignment Good Cause Notice (FI 2009) must be sent to the client prior to any enforcement of a sanction. The Good Cause notice gives the client 20 days to come into compliance with the medical support obligations by:

Claiming good cause by returning the form, along with evidence supporting their claim, to the DFR. If the form is not returned

within the 20 days, the sanction is enforceable. If the form is returned within 20 days, the sanction is not enforceable, pending the good cause decision. A copy of the notice must be retained in the case record.

Please note that a good cause notice must also be given to an applicant/recipient who is deciding whether or not to claim good cause.

Good cause is defined as any circumstances in which cooperation would result in serious physical or emotional harm to the individual for whom medical support is sought. The evidence needed to substantiate a good cause claim is specified on the good cause notice.

If the client returns the Good Cause Notice to the local office, the form and any other related documentation should be sent to Central Office for review. While Central Office is making a determination, benefits cannot be delayed, denied, or discontinued, as long as all other financial and non-financial eligibility requirements have been met.

If Central Office determines that Good Cause has been established, the sanction is not enforceable.

If Central Office determines that Good Cause was not met, the sanction is enforceable.

A sanctioned person who reapplies for medical assistance must be given another opportunity to comply with the medical support requirements. Consequently, there should be no automatic denial of assistance. If the applicant is otherwise eligible, the benefit is to be provided and the individual should be referred to the IV-D office again.

2434.20.05 Medical Support Good Cause Determination

The Central Office will notify the DFR in writing of the decision on the recipient's good cause claim. If the decision is that good cause does not exist, the DFR must notify the recipient and give him the opportunity to cooperate. Continued refusal to cooperate will result in the discontinuance of Medicaid except in the case of minor applicants/recipients, who are not penalized for their caretaker's refusal to cooperate.

2434.20.10 DFR Review Of Good Cause Determination

At the time of each redetermination, the DFR must review the good cause claim. If the determination of the existence of good cause was based on a circumstance which has changed so that good cause may no longer exist, the DFR must notify the Central Office of such change and recommend that the good cause finding be rescinded.[70]

2434.25.00 PENALTIES FOR MEDICAL SUPPORT NON-COMPLIANCE

This section does not apply to pregnant women (MAGP), Transitional Medical Assistance (MA F), or applicant/recipient children under 18 whose eligibility is being determined under a category other than MAGF.

Medicaid must be denied or terminated for any competent adult applicant/recipient who refuses, without good cause, (Section 2434.20.00), to cooperate in obtaining medical support.

IV-D sanctioned TANF recipients do not automatically lose Medicaid eligibility due to the TANF sanction. The reason for the sanction must be reviewed to determine if the sanctioned individual is out of compliance with his/her medical support requirements before discontinuing Medicaid eligibility.

2434.30.00 CIRCUMSTANCES WHEN PENALTIES ARE NOT APPLIED

An individual can prevent a sanction by coming into compliance with the medical support obligations within the 20 days given by the Medical Assignment Good Cause Notice (FI 2009).In addition to successfully claiming good cause a person can demonstrate compliance within the 20 days by providing proof of a scheduled appointment with the IV-D office.

Also, please note that Medicaid eligibility must be approved/continued for the minor applicant/recipient whose custodial parent or legal guardian refuses, without good cause, to cooperate in obtaining medical support.

EXAMPLE: A recipient father refuses to cooperate in obtaining medical support for his recipient child; the father is not eligible for Medicaid, but the child is.

2435.00.00 HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

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[70] 470 IAC 2.1-4-6

Indiana Medicaid through the Health Insurance Premium Payment (HIPP) Program is required to purchase (wherever available and cost effective) employer-based group health insurance on behalf of covered Medicaid recipients. The enrollment in such insurance plans is a condition of the covered recipients' Medicaid eligibility.

Please refer to the Administrative Letter regarding the Health Insurance Premium Payment Program, dated February 10, 1995, and the Caseworker Training Guide for HIPP on the procedures to follow for this program.

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2600.00.00 RESOURCES

This chapter presents requirements for determining eligibility based on resources. The chapter contains the following main sections:

Principles of Resources (Section 2605)

Resource Limits (Section 2610)

Types and Value of Personal Property Resources (Section 2615)

Types and Value of Real Property Resources (Section 2620)

Plan For Achieving Self-Support (Section 2625)

Resources Exempted Under Federal Law (Section 2630)

Resource Eligibility Determination (Section 2635), and

Transfer of Property (Section 2640)

2605.00.00 PRINCIPLES OF RESOURCES

This entire chapter is inapplicable to MED 3 and TMA (MA F).

The resources owned by specific individuals must be identified and evaluated according to the requirements of each program. A distinction between resources and income must always be made so that proper consideration is given to each. Section 2605 outlines principles which apply to the consideration of resources in the determination of eligibility for assistance.

All property not specifically exempted in the following sections is countable as a resource. When there is an agreement to offer to dispose of excess resources, as in the case of real property or non-liquid personal property, the agreement should be considered to be effective for the purposes of the application (see 2615.95.10 and 2620.20.10).

2605.05.00 DEFINITION OF RESOURCES

Resources are real or personal property that is owned solely or jointly by an individual.

Real property is land, including buildings or immovable objects attached permanently to the land. Real property also includes

life estates, remainder interests, and mineral rights. (Refer to Sections 2605.25.10 and 2620)

Personal property includes all property that is not real property. The ICES resource screens identify the following types of personal property as liquid resources:

- Cash on hand
- Checking accounts
- Savings accounts, including Christmas Club
- Savings certificates
- Trust funds
- Individual retirement accounts
- Keogh plans
- Credit union accounts
- Burial accounts
- Prepaid funeral agreements
- Stocks
- Bonds
- Nursing home accounts

2605.10.00 OWNERSHIP OF RESOURCES

The owner of a resource is any individual who has the ability to liquidate or dispose of the resource. A resource can be solely or jointly owned.

2605.10.05 Joint Ownership of Resources

Joint ownership of resources, consisting of real or personal property, exists when the right to liquidate or dispose of the property is shared by more than one individual. Joint ownership is indicated by entering "Y" on the resource data collection screens (AERLA, AERVH, AERRP, and AERLI). The full amount is entered for each individual in the case who owns part of the resource. Then the joint ownership screen AERJO comes up for each joint owner. If the resource is jointly owned by a married couple, one-half of the resource is to be entered for each spouse on AERJO. Otherwise, the entry on AERJO depends on the type of resource, as explained below.

When any type of account held in a financial institution is jointly owned, the worker is to presume that all of the funds belong to each owner. The individuals are to be advised of this presumption and given the opportunity to rebut it. If an applicant/recipient rebuts, he is responsible for providing proof of ownership of the funds, which includes a record of deposits and withdrawals from the account. Following a successful rebuttal, the funds must be separated and placed in separate accounts. Only the funds actually belonging to the

applicant/recipient will then be counted as a resource to him and entered on screen AERLA.[1] This procedure applies whether or not the joint owners are all applying for or receiving assistance. If the funds are not separated, the balance is counted in its entirety by each joint owner.

In addition to bank accounts, other real and personal property may be jointly owned. If an applicant/recipient owns real property or non-liquid personal property with another applicant/recipient of any assistance program, AERRP is to be completed for each owner. Then proportionate shares of the property are to be assigned to the joint owners on screen AERJO. The percentage amount of the share owned by each individual is entered on screen AERJO. Refer to Section 2605.10.10 regarding the availability determination for jointly-owned vehicles.

When a non-recipient is one of the joint owners of real or personal property, the availability of the applicant's/recipient's proportionate share must be determined. If the individual has the unrestricted right, authority or legal ability to liquidate or dispose of the property or his share of it, his proportionate share is available to him. If the joint owners do not have unrestricted rights to sell their interest in real property according to the title or other legal document, statements must be obtained from all joint owners to determine if they are all willing to sell the property. If all joint owners are willing to sell, then the property will be considered available. The AV (available) question on screen AERRP is answered "Y" and screen AERJO will come up. The percentage amount of his share is to be entered on screen AERJO.

2605.10.10 Joint Ownership of Vehicles

This section addresses the determination of "availability" of jointly owned vehicles. If a vehicle is found to be available, refer to Section 2605.10.05 to determine how to complete AERJO.

A jointly owned vehicle is considered an available resource to the Assistance Group (AG) when:

- It is jointly owned with another, (one or more) applicant/recipient who may or may not be in the same AG, or living at the same address;
- It is jointly owned with a non-recipient who lives with the AG and either owner has physical possession and/or use of the vehicle and the non-recipient owner agrees to sell the vehicle;

[1] 7 CFR 273.8(d)

It is jointly owned with a non-recipient who does not reside with the AG but the AG has physical possession or use of the vehicle and the non-recipient owner agrees to sell the vehicle;

It is jointly owned with a non-recipient who does not live with the AG and the AG does not have physical possession or use of the vehicle but, the joint-owner is willing to sell the vehicle, thus enabling the client to obtain his share of the vehicle's value.

If the client cannot legally sell the vehicle or take action to remove his name from the title (for example a pending lawsuit prohibits this action) the vehicle will not be considered to be available even in the situations listed above. The client must provide proof that the vehicle is not legally available by presenting court or BMV documents.

Therefore, when a vehicle is found to be jointly owned with a non-recipient, the AG must be asked if the non-recipient is willing to sell the vehicle. If the non-recipient is not willing to sell, verification of the non-recipient's statement must be obtained. The recipient must cooperate in locating and obtaining verification from the non-recipient.

2605.15.00 AVAILABILITY OF RESOURCES

Resources are available if the owner has the unrestricted right, authority, or legal ability to liquidate or dispose of the property or his share of the property. Resources must be available in order to be counted in the eligibility determination.[2] Refer to Section 2605.10.10 regarding the availability determination of jointly-owned vehicles. Refer to Section 2615.45 regarding the availability determination of savings bonds for MED 1.

2605.20.00 RESOURCE ELIGIBILITY DATE

The resource eligibility determination is based on resources owned as of the first day of a month. Ownership of excess resources on the first day of the month renders an applicant or recipient ineligible for medical assistance for the entire month.[3] The first day of the month means the first moment of the first day. Therefore, a financial transaction occurring on the first day does not affect the first of the month resource amount.

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[2] 405 IAC 2-3-14

[3] 405 IAC 2-3-15

For applicants, resources must be verified as of the first day of each retroactive month and the month of application. For a redetermination or a resource review, verification of the most current value of resources must be obtained. The value is then used to project resource eligibility for the following month.

For liquid resources, the worker must enter on screen AERLA the resource information for each retroactive month and the month of application, including a "begin date" and an "end date" if the amount differs on the first day of each of the months. Subsequent changes in the amounts during the application processing period must be entered accordingly.

2605.25.00 DETERMINING RESOURCE VALUE

The value of a resource must be determined in order to establish the amount that must be counted toward the resource limit. With a few exceptions, the amount of any resource to be counted is the equity value. Equity value is the current fair market value minus the total amount of liens against the property.[4] The exceptions to this procedure are vehicles (Section 2605.25.05) and, in certain instances, real property (Section 2605.25.10).

2605.25.05 Vehicle Valuations

The fair market value of a vehicle is the lowest "wholesale" value as listed in publications written for the purpose of providing guidance to automobile dealers and loan companies. The National Automobile Dealers Association's (NADA) used car guide book or the Red Book published by National Market Reports, Inc. may be used. If these publications are not available, any publication which provides guidance to automobile dealers and loan companies may be used provided they have been updated within the last six months. If the applicant/recipient disputes the "book value" a written statement must be obtained from a licensed automobile dealer.

The AG should be asked to acquire verification of the value of antique, custom made, or classic vehicles, if the worker is unable to make an accurate appraisal.

If a vehicle is especially equipped with apparatus for the handicapped, the book value is to be assigned as if the vehicle were not so equipped.

If a vehicle is no longer listed in a book due to the age of the vehicle, the AG's estimate of the value of vehicle is to be accepted, unless there is reason to believe that the estimate is

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[4] 7 CFR 273.8(c)(2) - F; 45 CFR 233.20- C; 405 IAC 2-3-14 - MED 1, 4

incorrect. A written statement must be obtained from a licensed automobile dealer.

Vehicle verification must include verification of the following:

- Ownership
- License status
- Fair market value, and
- Amount owed

Workers must keep in mind that equity value will increase with each monthly loan payment. Also, the fair market value may decrease whenever the publication used to establish the value is published. For those recipients who are very close to the resource limit, the value of nonexempt vehicles may have to be verified monthly to ensure that the recipient does not have excess resources as of the first day of a month.

2605.25.10 Real Property Value

Fair market value is the reasonable price that real property can be expected to sell for on the open market in the particular geographic area involved. (Refer to 2605.05.00 for definition of real property and to 2620.)

The fair market (FMV) value of real property can be obtained through tax records or from an estimate by a knowledgeable source. When tax records are used, the most recent property tax assessment must be obtained. The fair market value is the assessed value divided by the assessment ratio. The tax assessment cannot be used if:

- It is more than one year old,
- It is under appeal,
- It is based on a fixed rate per acre method, or
- The taxing authority does not provide an assessment ratio, or only provides a range, for example, between 50% and 75%.

If the worker questions an estimate from a knowledgeable source, one or more additional estimates are to be obtained and averaged in order to establish the fair market value.

If the lesser value is accepted, it must be entered on screen AERRP in the EQUITY field. Since the eligibility system calculates the equity based on the worker entered FMV of property, the equity override (EO) field must be answered "Y" to

enable the lesser equity to be entered and used by the system in the eligibility determination.

2605.25.10.05 Life Estate/Remainder Value

Life Estate: A life estate conveys to an individual certain rights in property for his lifetime. The owner of a life estate generally has the right of possession and use of the property, as well as the right to obtain profits from the property and to sell his life estate interest.

Remainder Interest: When an individual conveys property to one person for life (life estate holder) and to a second person (the remainderman) upon the death of the life estate holder, both a life estate interest and a remainder interest are created in the property. A remainderman cannot sell his interest in the property while the life estate holder is alive unless otherwise specified in the deed. At the death of the life estate holder, the remainderman will hold full title.

The fair market value of a life estate or remainder interest is determined as follows:

Determine the fair market value of the property (Section 2605.25.10) in the usual manner,

Refer to the Life Estate and Remainder Interest Tables in Section 2605.25.10.10, and

Using the individual's age as of his last birthday, multiply the figure in the Life Estate or Remainder Interest column for that age by the fair market value of the property to obtain the value of the life estate or remainder interest.

Advise the individual or person acting on his behalf of the presumed value of the life estate obtained from the table and provide him the opportunity to submit documentation of a lesser value. Such documentation will be acceptable only if it is provided by a knowledgeable source based on an evaluation of the specific life estate in question.

If the lesser value is accepted, it must be entered on screen AERRP in the EQUITY field. Since the eligibility system calculates the equity based on the worker entered FMV of property, the equity override (EO) field must be answered "Y" to enable the lesser equity to be entered and used by the system in the eligibility determination.

2605.25.10.10 Life Estate/Remainder Tables

AGE	LIFE ESTATE	REMAINDER
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.0l019
5	.98938	.0l062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934

15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457

31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137

47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998

63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951

79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272

95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

2605.25.10.15 Mineral Rights Value

A mineral right is an ownership interest in certain natural resources such as coal, Sulphur, petroleum, sand, natural gas, and others which are usually obtained from the ground. If the individual owns the land to which the mineral rights pertain, the fair market value of the land can be assumed to include the value of the mineral rights. If the individual does not own the land to which the mineral rights pertain, a fair market value must be obtained from a knowledgeable source such as:

The Bureau of Land Management,

The U. S. Geological Survey, or

Any mining company that holds leases.

2605.30.00 CONVERSION OF RESOURCES

Whenever a resource is sold or converted from one form to another, the proceeds remain a resource rather than income. Verification concerning the new resource must be obtained.

2605.35.00 VERIFICATION OF RESOURCES

All verification of resources must be obtained from the source (for example, by the bank where the account is held) or through a source document. Verification of resources is required in all programs; however, the individual's signed statement as to the amount of cash on hand is sufficient (Refer to Section 2615.05.00). When resources are jointly owned, the portion belonging to the individual must be identified and verified.

2605.40.00 MONITORING OF RESOURCES

Each applicant/recipient must be advised of the resource limits of the assistance programs and his responsibility to report any changes in his resource amounts which may affect his eligibility for assistance.

Resources are verified at each redetermination and must be monitored more frequently if changes are anticipated or resources are close to the limit. When payments are being made on real property or vehicles, the equity value may require monitoring as each payment will increase the property's equity.

Special emphasis must be placed on the need for the recipient to keep his resources within the program's limits in order for assistance to continue. Additionally, workers are responsible for monitoring resources between redeterminations.

In cases where resources are close to the resource limits, the cases must be flagged to alert the worker to check resources frequently or on a monthly basis when necessary. Screen AEFEC - expected changes - should be used for this purpose. Monthly monitoring of the value of resources would not be required.

2610.00.00 RESOURCE LIMITS

The resource limit is the maximum value of nonexempt resources that the AG may retain without affecting eligibility. It is dependent on the composition and living arrangement of the AG and the specific rules that govern each program. An AG with countable resources in excess of the applicable resource limit is ineligible for benefits. Refer to Section 3005.00 for the specific resource limits.

2615.00.00 TYPES AND VALUE OF PERSONAL PROPERTY RESOURCES

This section describes the policy for determining the value of personal property resources. The different types of such resources and their consideration are discussed.

2615.05.00 CASH

Cash that is not part of a current month's income is counted as a resource. Cash includes money the individual owns, no matter where it is located. Cash on hand includes:

Amounts carried by the individual,

Amounts the individual has at home, and

Amounts being held for the individual elsewhere.

A signed statement from the individual owning the cash is sufficient verification.

2615.10.00 BANK AND OTHER ACCOUNTS

Bank accounts refer to funds in a bank, credit union, savings and loan association, or any other financial institution that are usually payable on demand. Bank accounts may be solely or jointly owned. Joint ownership exists when the right to liquidate the account is shared by more than one individual.

This section provides information on:

Checking and savings accounts,

Time deposits, including IRAs and Keogh Plans, and

Guardianship accounts.

2615.10.05 Savings And Checking Accounts

It is assumed that all of the funds in a savings or checking account are owned by and available to the individual designated as owner in the account title.

If the account is jointly owned, it is to be presumed that all of the funds belong to each owner. The individuals are to be advised of this presumption and given the opportunity to rebut it. If an applicant/recipient rebuts, he is responsible for providing proof of ownership of the funds, which includes a record of deposits and withdrawals from the account. Following a successful rebuttal, the funds must be separated and placed in separate accounts. Only the funds actually belonging to the applicant/recipient will then be counted as a resource to him.

The resource value of savings and checking accounts is the balance in the account as of the first moment of the first day in which eligibility is being determined. (Refer to Section 2605.20) However, when determining the balance of a checking account for resource eligibility purposes, any checks that have not cleared the bank as of the date on which eligibility is determined, are to be subtracted from the balance. The worker should also subtract any current month's income which has been deposited in the account before entering the amount on screen AERLA. This includes the "direct deposit" benefit check which is sometimes recorded by the bank at the end of one month instead of early in the next month, when it would normally be received. For example, a "direct deposit" RSDI (Social Security) check shown as a deposit on May 31, but which is truly the June check, will be considered as income for the month of June and will not become a resource until July.

The total value of all bank accounts must be verified at the time of application and at each redetermination. Bank accounts must be verified by documentation obtained directly from the financial institution. In addition to using a bank collateral form, monthly account statements can be utilized to verify bank account balances.

2615.10.05.05 Business Accounts (MED 1, 4)

When funds are in a bank account that has been properly identified as a business account, it is assumed that the funds are being used for the operation of the business and are not counted as a resource. If a business account is not clearly distinguishable from personal resources, such funds must be considered personal resources when determining resource eligibility.

2615.10.05.10 Dedicated Accounts for Individuals Under 18 (MED 1, 4)

When past-due SSI benefit payments are paid into a separate dedicated account established solely for the payment of past-due SSI benefits for an individual under 18, these benefits are to be excluded as a resource until all funds in the dedicated account are depleted or until the individual no longer receives benefits from the Social Security Administration (SSA), whichever occurs first.[5] This exclusion continues:

- when the child turns 18 years of age and continues to receive benefit payments from the SSA,
- the individual receives a new representative payee for the dedicated account, or
- during periods when benefits from the SSA have been temporarily suspended

A dedicated account may be a checking, savings or money market account.

A dedicated account cannot be in the form of certificates of deposit, mutual funds, stocks, bonds or trusts. However, if the lump sum(s) of past due benefits are deposited into either a Special Needs Trust or a Pooled Trust described in section 2615.75.15, the resources in that trust would be exempt.

2615.10.10 Time Deposits

Time deposits held by financial institutions may be solely or jointly owned. If a time deposit is solely owned, the availability of funds is the deciding factor in determining if the time deposit is a resource. A time deposit such as a savings certificate or certificate of deposit usually is available to the individual and is counted as a resource.

Verification is to be obtained from the financial institution involved.

When a time deposit is jointly owned and available, the worker is to presume that all of the funds belong to each owner. The individuals are to be advised of this presumption and given the opportunity to rebut it. If an applicant/recipient rebuts, he is responsible for providing proof of ownership of the funds, which includes a record of deposits and withdrawals from the time deposit account. Immediately following a successful rebuttal, the funds must be separated and placed in separate accounts. Only the funds actually belonging to the applicant/recipient

[5] 20 C.F.R. § 416.546

will then be counted as a resource to him. If funds are not separated, the balance is counted in its entirety by each joint owner.

Any interest penalties imposed for withdrawing the time deposit funds prior to maturity are deducted from the total amount when determining the value of the time deposit resource. Interest penalties may involve a reduction in the interest rate and/or loss of interest for a short period of time.

In rare instances time deposits cannot be withdrawn prior to maturity under any circumstances. Funds in this type of account are not included as an asset until they reach maturity and become available.

Verification of a time deposit certificate from the financial institution must include information on when the funds can be withdrawn and any penalties for early withdrawal.

2615.10.15 Safety Deposit Box

The applicant/recipient must present to the worker a signed statement listing all of the contents of a safety deposit box. The contents must then be evaluated in terms of their count ability as a resource.

2615.15.00 RETIREMENT ACCOUNTS

Retirement accounts are financial plans for providing income when employment ends. They may be in the form of Individual Retirement Accounts (IRAs), Keogh Plans, 401K Plans, pensions, annuities and work related plans. Also, some profit sharing plans may qualify as retirement accounts. Savings accounts, checking accounts and certificates of deposits held at banks or credit unions are not retirement accounts.

Except in the two situations listed below, a retirement account is an available resource to an individual if he has the option of withdrawing an amount for any reason, even though he is not yet eligible for periodic payments. However, a retirement account is NOT considered an available resource if an individual must terminate employment in order to obtain any payment.

Exceptions:

- Funds held in an Individual Retirement Account or work-related pension plan, including Keogh Plans, by a non-recipient spouse are not counted as resources. [6]

- For M.E.D. Works (MADW and MADI), all retirement accounts are exempt including those owned by the M.E.D. Works applicant/recipient. This exemption applies to such funds held by the applicant/recipient and also by the spouse.

The value of a retirement account is the amount that the individual can currently withdraw less any penalty for early withdrawal. Taxes due are not deducted from the retirement account's value. Verification is to be obtained from the administrator of the retirement plan. If there is a delay in payment due to reasons beyond the individual’s control because of the financial organization processing timeframe, it would affect the availability of the resource.

The retirement account is presumed available unless there is evidence showing the processing timeframe for a request to withdraw funds. If the timeframe is equal to or less than twenty working days, the account is considered available in all months. If the timeframe is more than twenty working days the account is considered available after the individual agrees to withdraw the funds from the account (refer to IHCPPM 2615.95) and documented timeframe has passed. If the individual refuses to withdraw the funds, the account is considered available upon the refusal.

Effective June 1, 2014, retirement accounts of an ineligible spouse or ineligible parent are not considered countable for MED 1. They have never been counted for MED 4.

Another type of retirement account is intended for self-employed individuals and is often referred to as a Keogh Plan. Funds on deposit in Keogh Plans are counted as resources if the plan does not involve a contractual obligation with anyone who is not an AG member. If the plan includes a contractual obligation with a non-AG member, the money may not be accessible to the AG member and, therefore, is an unavailable resource. The value is the total amount of the Keogh less any withdrawal penalty.

2615.20.00 BURIAL RELATED RESOURCES

Burial related resources include various methods for reserving funds for burial such as prepaid funeral agreements, funeral

[6] 20 CFR 416.1202

trusts, life insurance, and burial accounts on deposit in financial institutions. Each assistance program has specific requirements in regard to burial related resources.

2615.20.05 Burial Accounts (MED 1, 4)

A burial account refers to a revocable account in which funds are identified to be used for burial purposes. In order for funds or assets to be considered set aside for burial, the account titling must indicate such, or there must be a signed statement by the owner or guardian of the purpose for the funds and the date on which they were set aside. This type of account is available to the owner. If a burial arrangement is irrevocable, it is not to be identified as a burial account. Refer to the following sections on funeral trusts and prepaid funeral agreements which are irrevocable.

The policies contained in this paragraph apply to the MA A, MA B, and MA D categories of assistance, in the circumstance of an institutionalized spouse/community spouse. For each spouse, up to $1500 of any separately identifiable funds set aside and earmarked for burial in a revocable account are exempt, regardless of beneficiary designation. The $1500 maximum must be reduced by the amount in an irrevocable burial trust or by the face value of any life insurance policies whose cash surrender value (CSV) has been exempted because the face value is $10,000 or less and the beneficiary is the estate or funeral home.

EXAMPLE: Mr. Jones is in a nursing facility. Mr. and Mrs. Jones each have a burial account valued at $1500. Mrs. Jones also has a life insurance policy with a face value of $1000. Only $500 of Mrs. Jones' burial account can be exempted.

For other situations, not involving institutionalized/ community spouses, revocable burial accounts are countable resources.

For QMB (MA L), QDW (MA G), SLMB (MA J), and QI (MA I) up to $1500 of any separately identifiable funds in a burial account are exempt. The exemption applies to the applicant/recipient and to his spouse. The $1500 maximum must be reduced by the amount in an irrevocable burial trust or any irrevocable prepaid funeral agreement. It must also be reduced by the face value of any life insurance policies whose cash surrender value has been exempted because the face value does not exceed $1500 <u>regardless of the beneficiary designation</u>.

2615.20.10 Funeral Planning Programs (MED 1, 4)

There are various methods by which an individual may reserve funds for burial, such as burial accounts, prepaid funeral agreements, funeral trusts, and life insurance. In evaluating any of these entities as resources, workers must carefully apply resource eligibility principles applicable to each program. In most situations, the determination of availability of funds reserved by any type of prepaid funeral arrangement will be based on whether the contract is revocable or irrevocable. However, a prepaid funeral agreement does not become irrevocable until 30 days after the contract is signed by the purchaser and seller, unless the 30-day period is waived as described below. [7]During the 30 day waiting period the contract can be revoked, and a revocable contract is a countable resource except in the circumstances explained in the previous section. If the funeral agreement was established on or after July 1, 1997 and includes a waiver of the 30-day waiting period or similar language making the trust immediately irrevocable, the funds in the trust are unavailable and exempt beginning on the date the agreement is signed. When necessary, an FSSA attorney should be consulted.

EXAMPLE: Client signs a prepaid funeral agreement on 7/12. The contract is revocable for 30 days, so the value of the agreement is a countable resource for 8/1. The contract becomes irrevocable 30 days after signing, so the value is unavailable and, therefore, not a countable resource for 9/1.

When an irrevocable assignment of life insurance (an action which eliminates the owner's right to obtain the cash surrender value) is involved as a means of funding an irrevocable funeral trust, the worker must verify two dates:

- The date of the assignment, and
- The date the insurance company accepted the assignment

The date of a legally executed irrevocable assignment of a life insurance policy which will fund a funeral trust is the date that the cash surrender value is considered to be unavailable, provided that the home office of the insurance company subsequently accepts the assignment.

2615.20.10.05 Prepaid Funeral Agreements (MED 2)

[7] IC 30-2-13-12;

The cash value of a prepaid funeral agreement with a funeral home is exempt as a resource, up to a maximum of $1500. One such exemption is allowable for each member of the AG. The amount of cash value exceeding $1500 must be counted as a resource. [8]

However, any prepaid funeral agreement must be reviewed to verify not only its value, but its terms. A determination must be made as to whether the agreement is revocable or irrevocable. Per Indiana statute, a prepaid funeral agreement does not become irrevocable until 30 days after the contract is signed by the purchaser and seller.[9] During the 30 day waiting period the contract can be revoked. An FSSA attorney may be consulted in the determination of whether an agreement is revocable or irrevocable. The value of any type of prepaid funeral agreement is considered available to the individual if the contract is revocable, however, the $1500 exemption explained above is applicable. Refer to Section 2615.20.15 for information regarding funeral trusts.

Funds set aside in a financial institution and designated for burial are counted as a resource to the individual.

2615.20.15 Funeral Trusts

A valid irrevocable Indiana funeral trust is an exempt resource regardless of the value of the trust.[10]

Indiana's funeral trust statute is found at I.C. 30-2-10 et seq. and applies to funeral trusts established on or after July 1, 1982. I.C. 30-2-9 et seq. is applicable to funeral trusts established after June 30, 1978, but before July 1, 1982. The DFR must determine that an Indiana funeral trust is valid and irrevocable in accordance with the criteria specified in the applicable statute. The value of the trust must also be verified.

Interest earned on an irrevocable trust is also exempt if the interest accrues to the principal of the trust. Irrevocable funeral trusts may be reviewed by FSSA Legal if necessary.

A funeral trust established in a state other than Indiana must be evaluated in terms of that state's laws. Such a trust may or may not be irrevocable.

2615.20.21 Death Benefits (MED 1, 4)

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[8] 470 IAC 10.13-1
[9] IC 30-2-13-12
[10] 405 IAC 2-3-16

Death benefits, including gifts and inheritances, received by an individual, to the extent that they are not income because they are to be spent on costs resulting from the last illness and burial of the deceased, are not resources for the calendar month following the month of receipt. However, such death benefits retained until the first moment of the second calendar month following their receipt are resources at that time.[11]

2615.20.20.05 Burial Plots (MED 2)

A burial plot for each participating member of the AG is exempt. This includes a conventional gravesite, crypt, mausoleum, or any other type of repository. [12]

2615.20.20.10 Burial Plots (MED 1, 4)

A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an exempt resource, regardless of value. [13]This includes a conventional gravesite, crypt, mausoleum, urn or any other type of repository.

2615.25.00 INSURANCE

Insurance policies owned by an individual may affect his eligibility and must be identified and evaluated. Some types of insurance that may be taken into consideration are:

- Life insurance,
- Casualty insurance, and
- Indiana Long Term Care Insurance

Sections 2615.25.05.05 through 2615.25.15 discuss how these types of insurance are treated in the eligibility determinations for the different assistance programs.

2615.25.05 Life Insurance

The following definitions are pertinent in the consideration of life insurance as a resource:

The insured is the individual whose life is covered by the policy.

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[11] 20 CFR 416.1201 (4)
[12] 45 CFR 233.20
[13] 405 IAC 2-3-15

The beneficiary is the individual or entity named in the contract to receive the proceeds of the policy upon the death of the insured.

The owner is the individual who has all rights and privileges of the contract and has the absolute right to liquidate the policy, exercise policy loans, change beneficiary, elect settlement options, determine the manner in which dividends will be treated, or any other rights and privileges granted in the policy.

The face value is the amount stated as such on the face of the policy.

The cash surrender value (CSV) is the amount which the insurer will pay upon cancellation of the policy before death or maturity. This value usually increases as more premiums are paid toward the policy.

There are various types of life insurance. However, not all types of life insurance have cash value (for example, term insurance). Policies which have no cash value prior to payment of the death benefit are not counted in the resource determination.

The CSV of insurance is available to the owner unless assigned or in some other manner actually transferred on the records of the insurance company to the insured or another person. Therefore, insurance is to be considered a resource to the owner and not to the insured, if the specific assistance program takes the CSV into consideration.

2615.25.05.10 Life Insurance Value

The CSV of a life insurance policy is counted as a resource if the owner is the applicant/recipient or a person whose resources are deemed to the AG. An exception occurs when life insurance is exempt in accordance with the provision to exempt life insurance with a face value of $10,000 or less for the MA A, MA B, MA D, MADW, and MADI categories, when the beneficiary is the estate or a funeral home, as explained in Section 2615.25.05.15.

The owner of a life insurance policy may be indicated on the policy; however, verification of the CSV must be obtained from the insurance company. As this will usually take several weeks, workers must be sure to follow up and, whenever possible, should enlist the assistance of the applicant/recipient and the local insurance office or agent. Awaiting verification of the cash surrender value is a valid extenuating circumstance for pending a case beyond the time standard. If there is no possibility that the CSV will cause excess resources (for example, the policy has

been in force a short time and the person's other resources are minimal), the application can be approved prior to receipt of verification of the CSV. Efforts to obtain the CSV, however, must be continued.

The CSV must be verified at each redetermination. In cases where resources are close to the resource limits, the cases must be flagged to alert the worker to check resources frequently; at a minimum, on a monthly basis. Screen AEFEC - expected changes - should be used for this purpose. It is recommended that, at the time of application, workers request that the insurance company verify future cash surrender values as well as the current CSV.

2615.25.05.15 Life Insurance Exemption (MED 1)

Effective 7-1-99, when an applicant/recipient is insured by a life insurance policy with a face value of $10,000 or less and the beneficiary of the policy is the applicant's/recipient's estate or the funeral director who will be providing services, the cash surrender value is exempt.[14] This also applies if there is more than one policy and the total face value of all policies is $10,000 or less. If the face value of one or more policies (excepting term policies) exceeds $10,000, the cash surrender value must be considered, regardless of who is designated as the beneficiary.

Effective June 1, 2014, if the total value of an AG's irrevocable funeral trust, irrevocable prepaid funeral agreement, and the face value of one or more policies (excepting term policies) exceeds $10,000, the cash surrender value of the life insurance policy or policies that exceeds the $10,000 exception is countable, regardless of who is designated as the beneficiary of that policy.[15]

Each applicant/recipient is entitled to the $10,000 insurance exemption.

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[14] 405 IAC 2-3-15; IC 12-15-2-17

[15] IC 12-15-2-17(e)

EXAMPLE 1:

Mr. and Mrs. Smith apply for assistance. He has a life insurance policy with a face value of $8,000, and she has one with a face value of $4,000. The beneficiary of both policies is Miller's Funeral Home. The cash surrender value of both policies is exempt because each policy has a face value of $10,000 or less.
The $10,000 limitation is reduced by any amount in an irrevocable burial trust or an irrevocable prepaid funeral agreement.

EXAMPLE 2:

The applicant has a $1000 irrevocable burial trust. Therefore, he is allowed a life insurance face value exemption of $9,000. ($10,000 - $1,000 = $9,000) He has a life insurance policy with a face value of $8,000, and the beneficiary is his estate. The cash surrender value is exempt.

EXAMPLE 3:

The applicant has a $10,500 irrevocable burial trust. Because this is in excess of $10,000, he is not entitled to a life insurance exemption. He has a life insurance policy with a face value of $1000, and the beneficiary is his estate. The cash surrender value is $800 and must be counted.

Before the CSV can be exempt, the worker must verify the face value, the owner, the beneficiary, and the insured.

Policies which insure the non-recipient spouse or parent of the applicant/recipient cannot be exempt under this provision.

2615.25.05.20 Life Insurance Exemption (MED 4)

The CSV of life insurance is exempt when the total face value (FV) of all policies (except term policies) does not exceed $1500, regardless of the beneficiary designation. If the total face value exceeds $1500, the CSV is a countable resource. Both spouses are entitled to have the CSV of life insurance exempted under this provision, whether or not they are both applicants/recipients.

2615.25.10 Indemnity Health Insurance, VA Aid and Attendance Payments, and Casualty Insurance

Payments made to covered persons under an indemnity health insurance plan intended to cover costs associated with health care costs incurred by the applicant/recipient are exempt as resources the month the payments are received and the following month. Any payments from the insurance policy that are not spent on health services during the exempted timeframe are deemed countable once this timeframe has passed.[16] This resource exclusion applies to income received for VA Aid and Attendance payments made to the applicant/recipient.

The proceeds (including interest earned) of casualty insurance received as a result of damage, destruction, loss, or theft of exempt real or personal property are not to be counted as a resource if the applicant/recipient demonstrates that the proceeds are being used to repair or replace the property.[17] For MED 1 and 4 only, the resource is exempt for a period not to exceed nine months from the date of receipt. If the proceeds from casualty insurance are retained by the applicant/recipient or his spouse or parent after the nine month period, they must be counted as a resource.

2615.25.15 Long Term Care Program-Resource Disregard (MED 1, 4)

This section applies to all of MED 1. Within MED 4, it applies only to QMB (MA L).

The Indiana Long Term Care Program (ILTCP) is jointly administered by the Family and Social Services Administration and the Department of Insurance. An individual, who purchases a long term care policy that is a qualifying policy under the ILTCP, as determined by the Department of Insurance, is allowed a special resource disregard in his Medicaid eligibility determination once policy benefits have been utilized.

The amount of the disregard for the individual depends on the type of “asset protection” earned by the qualifying policy. There are two types of disregards depending on the policy: 1) total asset protection; and 2) dollar-for-dollar asset protection.

1) Total Asset Protection is available to the individual who purchased a policy or certificate that includes a maximum benefit equal to or greater than the State-Set dollar amount

[16] 20 C.F.R. § 416.1201(a)(3)

[17] 405 IAC 2-3-15; 470 IAC 10.1-3-1

in force on the original effective date of the policy (i.e. when there was a policy agreement).

a. To view the State Set dollar amounts for certain years, please, see the Total Asset Chart, http://www.in.gov/iltcp/2358.htm.

2) Dollar-for-Dollar Protection is available when the individual does not have Total Asset Protection. The amount of the resource disregard is applicable up to the limit on the policy.

This disregard is in effect for the lifetime of the individual.[18] This disregard only applies to the resources owned by the insured individual, not to any other person whose resources are included in the eligibility determination.

Policy benefits are payable for long term care services provided in a long term care facility or in the home.

Not all long term care insurance policies qualify for this "asset protection". Workers must verify that a policy is qualified under the ILTCP. Insurance companies who sell qualified ILTCP policies are responsible for documenting the amount of benefits paid on behalf of their clients. The first page of the policy will have boxed language stating the policy qualifies for Medicaid asset protection. The insurer must provide a quarterly report to the insured individual summarizing the amount of benefits paid during the quarter and cumulatively since benefits were first paid under the policy, as well as the amount of asset protection earned.[19] When an insured individual applies for Medicaid, the insurance company is required to provide the client with a service summary report.[20] This service summary is the required documentation that workers will need in order to verify that a policy is qualified under the ILTCP and the amount of the resource disregard to be applied in the Medicaid eligibility determination of an applicant/recipient.

[18] IC 12-10-9-8
[19] 760 IAC 2-20-39
[20] 760 IAC 2-20-40

Example 1 - Dollar for Dollar Policy

An individual purchases a dollar for dollar ILTCP policy which provides initial policy benefits of 100,000. She enters a nursing facility and the policy pays out a total of $109,000 (benefits increase due to inflation provision). She then applies to Medicaid and her resources are as follows:

Irrevocable funeral trust	$4,000 (exempt)
Certificate of deposit	$50,000
Life insurance cash value	$15,000
Stocks	$25,500
Mutual Funds	$20,000
Total Resources	$110,500
ILTCP disregard	$109,000
Countable resources	$1,500
Resource Limit	$2,000

Applicant is resource eligible.

Example 2 - Dollar for Dollar Policy

An individual purchases a dollar for dollar ILTCP policy which provides initial policy benefits of $100,000. She enters a nursing facility and the policy pays out a total of $109,000 (benefits increase due to Inflation provision). She then applies to Medicaid and her resources are as follows:

Irrevocable funeral trust	$ 4,000 (exempt)
Certificate of deposit	$50,000
Life insurance cash value	$18,000
Stocks	$25,500
Mutual Funds	$20,000
Total Resources	$113,500
ILTCP disregard	$109,000
Countable resources	$4,500
Resource Limit	$2,000

Applicant has excess resources so application is denied.

Example 3 - Total Asset Policy

An individual purchased a total asset ILTCP policy which provides an initial policy benefit of $200,000 in 2005. Thereafter, she enters nursing facility and the insurance pays out the maximum benefits, which will be more than the initial benefits depending on when she entered the facility. She then applies to Medicaid and her resources are as follows:

2615.30.00 HOUSEHOLD GOODS AND PERSONAL EFFECTS

Household goods and personal effects are exempt as resources.[21] Household goods are items of personal property customarily found in the home and used in connection with the maintenance and occupancy of the home. They include (but are not limited to) furniture, appliances, kitchen utensils, linens, and television sets.

Personal effects are those items of personal property which are worn or carried by an individual. Some examples are clothing, jewelry, and hobby items.

2615.35.00 INCOME-PRODUCING PERSONAL PROPERTY

Income-producing personal property consists of items such as farm machinery, livestock, tools, equipment, a vehicle used in a business, business inventory, and furnishings and appliances included with a rental unit.

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[21] 405 IAC 2-3-15

Such personal property may be solely or jointly owned. If an applicant/recipient jointly owns personal property with another applicant/recipient of any assistance group (AG), for any program, proportionate shares of the property are to be assigned to the joint owners and considered as a resource in accordance with the program requirements. (Refer to Section 2605.10.05)

When a non-recipient is one of the joint owners of real or personal property, the availability of the applicant's/recipient's proportionate share must be determined. If the applicant's/recipient's proportionate share is available to him, it is to be considered a resource as required by the specific assistance category, as discussed in the following sections.

2615.35.10 Income-Producing Personal Property (MED 2)

The equity value of farm or business equipment is a countable resource.

2615.35.15 Income-Producing Personal Property (MED 1, 4)

Items of personal property utilized in the production of income are exempt resources.[22] Examples of such are farm machinery, livestock, tools, equipment, a vehicle used in a business inventory, furnishings, and appliances included with a rental unit. This exemption does not, however, include income-producing financial assets such as certificates of deposit, other interest bearing bank accounts, stocks, bonds, and so forth.

2615.40.00 PERSONAL PROPERTY USED TO PRODUCE FOOD

Personal property necessary for the production of food for home consumption is also exempt as a resource.[23] This would include such things as garden equipment, farm implements, chickens, and livestock.

2615.45.00 STOCKS, BONDS, AND MUTUAL FUND SHARES

Stocks, mutual fund shares, and bonds may be solely or jointly owned. If jointly owned, refer to Section 2605.10.05 for instructions regarding personal property. Stocks, mutual fund shares, and bonds are considered in the eligibility determination as follows:

> Stocks and Mutual Fund Shares: The current market value of shares of stock and mutual fund shares can be verified by reviewing the closing or "bid" price listed in the financial section of the

[22] 405 IAC 2-3-15
[23] 470 IAC 10.1-3-1 - C; 405 IAC 2-3-15 - MED 1, 4

newspaper, or by contacting a brokerage firm. The value to be considered as a resource is the current market value less the legitimate expenses related to the sale of the shares.

Municipal, Corporate, and Government Bonds: A bond is a written obligation to pay a sum of money at a future specified date. It is a negotiable instrument and is transferable.

The worker must verify the current market value of bonds by contacting a securities dealer. As with stocks and mutual fund shares, expenses related to the sale of a bond must be deducted from the current market value in order to determine the cash value to be counted as a resource.

United States Savings Bonds: A United States Savings Bond is an obligation of the federal government but, unlike other government bonds, it is not transferable in that it can only be sold back to the government.

Although many bonds have a table of values on the reverse side of the bond, it is often inaccurate because the interest rate may have changed since the bond was issued. Therefore, the worker should contact a bank to verify the current value. Also the Department of Treasury's web site can be used to calculate the value of bonds. www.publicdebt.treas.gov/

For determining eligibility under a MED 1 category for a month prior to June 1, 2014, savings bonds are considered immediately available if purchased on or after November 9, 2002.[24] This includes but is not limited to Series I and Series EE bonds. During the 6-month period following the date of issuance, bonds issued for face value are counted as a resource in the amount of the face value. Bonds issued at face value include Series I and Series HH bonds. Bonds such as Series EE which are issued at less than face value count as a resource in the amount of the purchase price. Bonds which were purchased prior to November 9, 2002 and are in the 6-month post-issuance period, become a countable resource in the sixth month after purchase. For example, a bond with an issue date in August becomes a countable resource in February; if the value of the bond causes excess resources for the recipient, the worker would discontinue Medicaid effective February 1.

Effective June 1, 2014, Series EE U.S. Savings Bonds purchased after February 1, 2003 are not deemed to be available until the 13th month after the date of purchase.

2615.50.00 MORTGAGES, LOANS, AND PROMISSORY NOTES

[24] 405 IAC 2-3-23

A negotiable mortgage, loan, or promissory note held by an individual is a countable resource. Such items are negotiable when they can be sold (there is no legal barrier to the transfer of ownership). The value counted as a resource is the amount of the outstanding principal balance. Also, any payment received on the principal is a resource. The interest portion of any such payment is unearned income.

Prior to June 1, 2014, if the mortgage, loan, or note is non-negotiable, it is not a resource. In that case total payments received, whether principal or interest, are unearned income.

Effective June 1, 2014, if the mortgage loan or note is non-negotiable, it is not a resource. In that case, only the interest payments received are counted as unearned income.

A mortgage, loan, or promissory note should be reviewed by FSSA Legal to resolve questions of negotiability.

2615.55.00 LAND SALES CONTRACT

A land contract must be evaluated according to the requirements of each assistance category. Property which is being sold on contract is to be entered on screen AERRP.

2615.55.10 Land Sales Contract (MED 2)

When an applicant/recipient is the owner of a contract for the sale of real property, the equity value of the contract is counted toward the resource limit of the AG.

The equity value is equal to the principal balance remaining to be paid on the contract, which is referred to as a land contract or installment contract.

> **EXAMPLE:** A Refugee applicant contracted to sell a piece of real estate for $15,000. To date, $8700 has been paid on the principal. The remainder, $6300, is considered a resource to the applicant.

The equity value of a contract is to be considered a resource

Except when the contract contains a clause that prohibits the owner from selling or transferring the contract. In such an instance, the equity value is exempt. However, the portion of the periodic payment that represents payment toward the principal is counted as a resource.

2615.55.15 Land Sales Contract (MED 1, 4)

When property is being sold on land contract, the down payment is counted as a resource, and the ongoing payments are counted as income.

Effective June 1, 2014: Only the interest payments on loans are counted as income.[25] The value of the contract is exempt as a resource. The person selling property on contract, the promissory note or property agreement is a resource, unless the note or agreement is non-negotiable. The property itself is not a resource because the seller cannot legally convert it to cash while it is encumbered by the agreement. The outstanding principal on a negotiable agreement is considered a countable resource.

2615.60.00 VEHICLES

MED 1 & 4 have different requirements for considering vehicles than MED 2. Requirements may differ between the Medicaid categories. The following sections describe how to determine the resource value of vehicles.

2615.60.05 Definition Of Vehicle

A vehicle is any conveyance that provides transportation of persons or goods from place to place. Automobiles, trucks, vans, motorcycles, mopeds, boats, snowmobiles, and so forth are classified as vehicles.

2615.60.15 Treatment of Vehicles (MED 2)

Each AG is allowed an exclusion of $5000 of the equity in one vehicle. Equity is the vehicle's fair market value less any liens.

If more than one vehicle is owned, the equity in each vehicle is to be determined. Since the $5000 disregard can be applied to only one vehicle, it is to be applied to the vehicle with the highest equity value. No amount is excluded from the equity value of the remaining vehicle even if the value of the first vehicle is less than the $5000 disregard.

2615.60.20 Treatment of Vehicles Prior to June 1, 2014 (MED 1, 4)

This section explains the treatment of vehicles before June 1, 2014.

[25] 20 CFR 416.1103(f)

One vehicle of any value is exempt as a resource if, for the applicant/recipient or a member of his household:

- It is necessary for employment,
- It is necessary for regular medical treatment, or
- It is modified for operation by or transportation of a handicapped person

An applicant/recipient of QMB, QDW, SLMB, or QI is also entitled to have a vehicle exempted if:

- It is necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If more than one vehicle can be exempt, the one with the highest equity should always be the one that is exempt.

When the eligibility determination is made for an institutionalized individual with a community spouse, one vehicle is exempt without having to meet any conditions.

If no vehicle is exempt, $4500 of the fair market value of one vehicle is exempt. The excess market value over $4500 is counted as a resource. Equity is not a consideration in applying this exemption.

The equity value of other vehicles is counted as a resource. The equity value is the fair market value minus total liens. If the other vehicle is used in the production of income, however, it is exempt for that reason.

2615.60.20.05 Treatment of Vehicles On and After June 1, 2014 (MED 1, 4)

This section explains the treatment of vehicles on and after June 1, 2014.

One vehicle of any value is exempt as a resource for the applicant/recipient or a member of his household. If there is more than one vehicle, the one with the highest equity should always be the one that is exempt. The equity value of other vehicles is counted as a resource.

The equity value is the fair market value minus total liens. If the other vehicle is used in the production of income, however, it is exempt for that reason.

2615.60.25 Recreational Vehicles And Equipment

Recreational vehicles such as campers, trailers, and boats must be counted according to their current equity value. If the

recreational or other vehicle serves as the AG's home, it should be evaluated according to the guidelines in Sections 2620.15.05 and 2620.15.10.

2615.65.00 NON-RECURRING LUMP SUM PAYMENTS

A lump sum payment may include retroactive benefits such as SSI, Social Security, and VA benefits. A lump sum may also be a refund of Medicare Part B premiums, an insurance settlement, an inheritance, or other such nonrecurring payment.

Retroactive lump sum payments from Social Security (i.e. SSI, RSDI, or SSDI) are exempt as resources for nine (9) months.[26]

Screen AERLS is scheduled when "yes" is answered to the lump sum payments question on screen AERRQ.

2615.70.00 LIFE CARE CONTRACT (MED 1, 4)

An individual may have entered into an agreement with an institution under which he transferred his available assets to the institution in exchange for full maintenance and medical care in the institution for life. Such individual would normally be ineligible for assistance, as the institution has a legal responsibility to provide care even if the individual's resources are exhausted.

However, in the event the facility claims that the conditions of the contract are no longer applicable because the facility is financially unable to fulfill its legal responsibilities under the contract, the facility must prove this allegation.

The DFR must require an accounting from the facility as to:

- The amount of income and resources the individual assigned to the facility upon admission,
- The cost of the individual's care as paid by the facility,
- Amount of assets refunded to the individual, and
- Amount of assets retained by the individual

If such documentation proves the facility's allegation that the individual's funds have been expended on his care, then the individual can be eligible for Medicaid.[27]

2615.75.00 TRUST FUNDS

[26] 20 CFR 416.1233
[27] 405 IAC 2-3-2

All trusts which involve a member of the AG must be carefully evaluated to determine whether or not the trust principal will be counted as a resource.

2615.75.05 Trust Funds Established Prior to August 11, 1993

The date on which a trust fund was established is a determining factor as to how the trust will be treated for Medicaid eligibility purposes. A change in federal law (OBRA-93) governs the treatment of trusts established on and after August 11, 1993 and is explained in next Section 2615.75.20.

A trust which was established prior to 8-11-93 by the applicant/recipient or his/her spouse as grantor with the applicant/recipient or spouse as the beneficiary is referred to as a "Medicaid qualifying trust". Unless such a trust was created in a will (i.e. a testamentary trust) or was created prior to 4-7-86 solely for the benefit of a mentally retarded individual residing in an ICF/MR, the principal of the trust is a countable resource. The amount to be counted as a resource is the maximum amount available to the beneficiary if the trustee were to exercise full discretion for distribution of the funds according to the terms of the trust. The trust is counted as a resource regardless of whether it is revocable or irrevocable, and whether or not the trustee actually exercises his/her full discretionary authority as allowed by the trust. A trust established by the individual's guardian or legal representative, who is acting on behalf of the individual, falls under the definition of a Medicaid qualifying trust.

In reviewing trust funds established prior to August 11, 1993 which do not meet the definition of a Medicaid qualifying trust, including testamentary trusts and those created prior to 4-7-86 for a mentally retarded individual residing in an ICF/MR, the DFR must determine the "availability" of the trust. Refer to Section 2605.15 for the definition of availability.

2615.75.10 Trust Funds Established On and After August 11, 1993

The policies in this section are applicable to trust funds established, other than by a will, on and after August 11, 1993, and are effective October 1, 1993. [28]

[28] Section 1917(d) of the Social Security Act as added by P.L. 103-66, OBRA-93; 405 IAC 2-322

A trust fund is subject to the provision in this section if the trust is funded with assets of the applicant/recipient or spouse and is established by:

The applicant/recipient,

The spouse of the applicant/recipient,

Anyone, including a court or administrative body, with legal authority to act on behalf of the applicant/recipient or spouse, or

Anyone, including a court or administrative body, who is acting at the direction or request of the applicant/recipient or spouse

Refer to Section 2615.75.15 which explains the types of trust funds which are exempt from these provisions.

These provisions apply if assets of the applicant/recipient were used to fund all or part of the trust. If other person(s)' assets are included, the portion of the trust representing the individual's assets will be evaluated for resource eligibility purposes.

A revocable trust is considered as follows:

- The entire trust principal is an available countable resource.
- Any payments made from the trust to or for the benefit of the individual are counted as income.
- Any payments from the trust which are not made to or for the benefit of the individual must be evaluated as a transfer of property. The look-back period for a transfer in this circumstance is 60 months.

An irrevocable trust is considered in the following manner:

- If the terms of the trust allow for payments to or for the benefit of the individual, under any circumstances, the following rules apply to that portion of the trust:
    - Payments from trust income or principal are treated as income
    - Trust income which could be paid (but isn't being paid) is treated as an available resource
    - The portion of the trust principal which could be paid (but isn't being paid) is treated as an available resource

- Payments made from the trust income or principal to another individual (and not for the benefit of the applicant/recipient or spouse) must be evaluated as a transfer of property. The look-back period for a transfer in this circumstance is 60 months

- If the terms of the trust do not allow part or all of the trust income or principal to be paid to or for the benefit of the individual under any circumstance, the value of that portion of the trust must be evaluated as a transfer of property. The look-back period in this situation is 60 months

Payments made from revocable or irrevocable trusts are considered as being paid to the individual if such payments are paid directly to the individual or to someone acting on his behalf such as a guardian.

A payment for the benefit of the individual is one from which the individual derives a distinguishable benefit. Some examples include the purchase of clothing and items for personal use such as a radio or television, and payment of the individual's utilities or rent. These payments are counted as income to the extent that they would ordinarily be counted as income for eligibility purposes. For example, if a trust pays the individual's medical expenses, the payment made directly to the medical provider is not countable income. Similarly, a payment to a utility company is income-in-kind, but only countable income-in-kind in accordance with Section 2815.15.

2615.75.15 Certain Trusts Receiving Special Consideration

The trust provisions explained in the preceding Section 2615.75.10 do not apply to certain special needs trusts and pooled trusts as well as Miller trusts defined below. The following trusts should not be considered countable resources.

Special Needs Trust

This is a trust containing the assets of a disabled applicant/recipient under age 65, which is set up by the applicant's/recipient's parent, grandparent, legal guardian or by a court, and is established for the sole benefit of the applicant/recipient. The individual must be disabled according to SSI criteria. Such a trust must contain a provision specifying that, upon the death of the individual, the State will receive all amounts remaining in the trust up to the total amount of Medicaid benefits paid on the individual's behalf.

Pooled Trusts

A pooled trust is a trust containing the assets of a disabled applicant/recipient (disabled according to SSI criteria) which meets the following conditions:

- The trust is established and maintained by a non-profit association,
- A separate account is maintained for each of the beneficiaries, but for investment and management purposes the funds are commingled,
- The trust account is established by the applicant/recipient or his parent, grandparent, legal guardian or by a court for the sole benefit of the applicant/recipient,
- There is a provision which specifies that upon the death of the beneficiary, any funds not retained by the trust will be paid to the State up to the total amount of Medicaid benefits paid on the individual's behalf

Miller (Qualified Income Trusts)

A Miller Trust (or Qualified Income Trust (QIT)) is a unique trust that allows persons residing in long-term care facilities or receiving home-and-community-based-services through a 1915(c) waiver (see IHCPPM sections 3305.00.00 and 3320.10.00) who have personal income above the Special Income Level (SIL) (see IHCPPM sections 3455.14.00 and 3010.20.15) to be considered Medicaid eligible. A Miller Trust may be established for a Medicaid applicant/recipient who is a beneficiary of the trust by the applicant/recipient’s Authorized Representative for Medicaid eligibility purposes, legal guardian, power-of-attorney (POA), or family member if the applicant/recipient is incapacitated as shown with documentation from a licensed physician.

A Miller Trust is one that:

- Is funded only by the income of the beneficiary including accumulated interest on that income. The trust will not be funded with the beneficiary’s resources, nor income or resources of other persons, and

- Upon the death of the beneficiary, 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

2615.75.20 Other Trusts Not Governed by OBRA-93

Trusts established on or after August 11, 1993 that are not governed by OBRA-93 must be reviewed for the purpose of determining the "availability" of the trust. Some examples are trusts created by a will (testamentary trust) or by a third party other than a spouse or someone acting on behalf of the applicant/recipient, and funded with the assets of another person(s).

615.80.00 LEGAL GUARDIANSHIP/REPRESENTATIVE PAYEE (MED)

An individual who serves as legal guardian/representative payee for another person is responsible for administering that person's funds and will be listed in bank records as having access to his bank accounts.

Resources that are managed by an individual's legal guardian, representative payee, or other person acting as an agent on behalf of the applicant/recipient are counted as resources to the individual. The resources are not counted as being available to the guardian/payee for his own use. However, the resources must be held in a form that clearly shows they belong to another individual. For example, a bank account that is held by the guardian/payee must be clearly designated as being administered by the guardian/payee on another person's behalf.

2615.90.00 PRORATED INCOME

Income that is prorated (educational income, self-employment income) cannot be counted as a resource for any month during the prorated period.[29]

2615.95.00 DISPOSITION OF NON-EXEMPT NON-LIQUID PERSONAL PROPERTY (MED 1)

An applicant/recipient who meets all eligibility requirements but fails to meet the resources requirement due solely to excess resources, may be determined eligible for Medicaid benefits, if the individual were otherwise eligible if his non-liquid resources were excluded and he agrees to offer (or dispose) his non-liquid resources at fair market value.

2615.95.05 Presumption of Liquidity (MED 1)

Property is generally broken down into two types: liquid and non-liquid.

Liquid resources are cash or other assets, which can be converted to cash within 20 workdays.

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[29] 7 CFR 273.8(e)(9)

Non-liquid resources consist of real and personal property, as well as financial instruments that cannot be converted to cash within 20 workdays. For treatment of non-exempt real property, refer to Section 2620.20.00.

For purposes of this section, it is assumed that the following types of personal property are non-liquid: automobiles, machinery, livestock, noncash business property, life insurance, and certain bonds (see IHCPPM 2615.45.00). It is presumed that all other types of personal property not contained in the list can be converted to cash within 20 workdays and are countable as resources.

A person may overcome this presumption with documentary evidence. For example, if a retirement account cannot be converted to cash within 20 working days from the date the person requests the funds from the account, there would need to be documentary evidence from the financial institution holding the retirement funds showing at what point such funds would be available after the request is made. Once the funds are withdrawn from that date, if retained, they would be considered countable upon the first moment of the first day of the following month.

2615.95.10 Agreement to Dispose / Offer For Sale of Non-Liquid Personal Property at Fair Market Value

In order for Medicaid Eligibility to be established on the disposition of non-liquid resources to be made, the applicant/recipient must sign an agreement to offer property for sale or rent, or dispose of property at current market value. When the agreement is signed, it is effective “for the purposes of the application”, that is, inclusive of retroactive months for that application date.

Once the agreement is signed, the property is no longer excluded after the property has been sold or disposed, but in no condition must the exclusionary period last longer than three months unless Good Cause is established as described in Section 2615.95.15.

Any transfer of assets below fair market value should be noted in the case record for transfer of property purposes. The individual will be penalized only if the transfer occurs during the applicable look-back period. Refer to IHCPPM 2640.10.10.

2615.95.15 Good Cause Failure to Dispose, Rent, or Sell Non-Liquid Personal Property at Fair Market Value

If the property is not sold, rented, or disposed after an initial three-month exclusionary period has passed, a second three-month extension is possible if good cause can be established by a recipient.

Good Cause is established if the failure to dispose of a resource occurred despite reasonable and diligent efforts on the applicant/recipient’s part due to circumstances beyond his control from disposing of the resource. The recipient must produce documentary evidence showing efforts taken to sell, rent, and/or dispose of the resource and proof of the circumstances with an explanation as to why the failure was beyond his control.

If the recipient has not reported the sale, rent, or disposal of a resource after two months from signing the agreement, the DFR must send a notice to the client informing him of his right to claim “Good Cause”. If the form is not received within 20 days with the accompanying documentation showing reasonable and diligent efforts with an explanation as to the failure due to circumstances beyond his control, the non-exempt, non-liquid personal property is countable the fourth month after signing the agreement.

If Good Cause is claimed by a recipient, it will not be awarded if the individual failed to take diligent and reasonable efforts to dispose of the resource. Diligent and reasonable efforts may differ as to the type of non-liquid personal property under consideration. For example, if a person showed that a retirement account was non-liquid due to an inability to convert the retirement account within 20 working days from the date the request to withdraw funds was made, it will not be considered good cause if the individual failed to request the withdrawal of funds from the retirement account within thirty days of signing the agreement.

2620.00.00 TYPES AND VALUE OF REAL PROPERTY RESOURCES

Real property consisting of land, which includes buildings or immovable objects attached permanently to the land, is to be evaluated as a resource according to the requirements of each assistance category.

2620.05.00 REAL PROPERTY OWNERSHIP

Real property is to be considered as a resource according to the requirements of each assistance category and the type of ownership of the property. (Refer to Sections 2605.05.00 and 2605.25.10.) Ownership of real property can consist of an interest in the title as follows:

Sole Ownership:

When property is solely owned by one individual, only he or his legal guardian may sell the ownership interest without conditions imposed by others. He is legally entitled to all income which may be generated from the property.

Joint Ownership:

Joint ownership is the holding of property by two or more persons who have an equal interest in the whole property. At the death of one of two joint owners, the survivor usually becomes the sole owner. At the death of one of three or more joint owners, the survivors become joint owners.

If an applicant/recipient jointly owns real property with another applicant/recipient of any assistance program, proportionate shares of the property are to be assigned to the joint owners and considered as a resource in accordance with the program requirements.

When a non-recipient is one of the joint owners of real property, the availability of the applicant's/recipient's proportionate share must be determined. (Refer to Section 2605.15.00.) If the applicant's/recipient's proportionate share is available to him, it is to be considered a resource as required by the specific assistance program. If the applicant's/recipient's proportionate share is not available to him, the resource is exempt.

Ownership in Common:

An ownership in common is the holding by two or more persons of separate titles in the same real estate. Each owner has a divided interest in the whole property. There is no right of survivorship to an ownership in common. It is not a joint ownership.

Ownership by the Entirety:

Ownership by the entirety refers to property owned by a husband and wife whereby each member has ownership interest in the whole property which is indivisible. Upon the death of one, the survivor becomes sole owner. When a marriage has been legally dissolved, the former spouses become owners in common of the property.

Ownership of real property can also consist of a legal right to the use of property without having title to it, as follows:

Life Estate:

A life estate conveys to an individual certain rights in property for his lifetime. The owner of a life estate generally has the right of possession and use of the property, as well as the right to obtain profits from the property, and to sell his life estate interest. However, the deed establishing the life estate may restrict one or more rights of the individual. Ownership of a life estate interest may affect eligibility for certain assistance programs. (Refer to Section 2605.25.10.05.)

Remainder Interest:

When an individual conveys property to one person for life (life estate holder) and to a second person (the remainderman) upon the death of the life estate holder, both a life estate interest and a remainder interest are created in the property. A remainderman cannot sell his interest in the property while the life estate holder is alive, unless otherwise specified in the deed. At the death of the life estate holder, the remainderman will hold full title. (Refer to Section 2605.25.10.05.)

Reversion Interest:

When an individual owner conveys property to another person for life (life estate holder) and to himself (the reversioner) upon the death of the life estate holder, both a life estate interest and a reversion interest are created in the property. A reversioner cannot sell the property while the life estate holder is alive. At the death of the life estate holder, the reversioner would hold full title. (Refer to Section 2605.25.10.05.)

2620.10.00 VERIFICATION OF REAL PROPERTY OWNERSHIP

Ownership of real property can be verified from one or more of the following sources:

- Deed
- Mortgage
- Property tax receipts (current only)
- County treasurer's records, or
- Title search

2620.15.00 EXEMPT REAL PROPERTY RESOURCES

Certain real property is exempt from being considered as a resource. This determination is program specific so that the exemption or non-exemption of real property must be in accordance with program requirements as explained in the following passages.

2620.15.10 The Home (MED 1, 4)

A home is exempt when it is the principal residence of:

- The applicant/recipient,
- The spouse of the applicant/recipient,
- The parent of an applicant/recipient under age 18,
- The biological or adoptive child under age 18 of the applicant/recipient, or
- The biological or adoptive disabled or blind child age 18 or older of the applicant/recipient.[30]

The home is defined as the shelter in which the individual resides, the land on which the shelter is located, and related outbuildings. In order to be considered part of the home, the surrounding land must adjoin the plot on which the home is located and not be separated from it by intervening real property owned by others. (A road does not separate land.)

Such property remains exempt until it is verified that none of the persons listed above intends to reside there or is physically able to reside there.[31] Whenever there is a conflict between an individual's stated intent to return home and his apparent physical capability to do so, the worker is to obtain documentation from the individual's physician.

2620.15.10.05 Home Replacement (MED 1, 4)

The proceeds from the sale of an exempt home can also be exempt from consideration under certain conditions. If, within a specified time period, the proceeds are used (or obligated to be used) to purchase a replacement home and cover the costs incurred in occupying it, the proceeds can be disregarded. The individual must be committed to the transactions within the "home replacement period", the time period beginning with the date of the receipt of the proceeds and ending on the last day of the third full month following receipt of the funds.

2620.15.20 Income-Producing Real Property (MED 1, 4)

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[30] 405 IAC 2-3-15
[31] 405 IAC 2-3-15

Income-producing property is exempt if the income from it is greater than the expenses of ownership. This exemption also applies to property being sold on land contract. The ownership of income-producing property must be verified to determine who is legally entitled to the income from the property.

2620.15.25 Food-Producing Real Property (MED 1, 4)

Real property used for producing food for home consumption is exempt.[32] An example of such property would be a garden plot.

2620.15.30 Real Property Owned By A Community Spouse (MED 1)

For purposes of Medicaid eligibility, when the resources of an institutionalized spouse and a community spouse are assessed to establish the amount of combined resources for spousal share determination, the equity value of real property owned solely by the community spouse (or jointly with someone other than the institutionalized spouse) is not included. Additionally, such property is not considered in the resource eligibility determination of the institutionalized spouse.

2620.20.00 TREATMENT OF NON-EXEMPT REAL PROPERTY

Real property that is not classified as exempt is taken into consideration in the resource eligibility determination. Nonexempt real property must be considered under the requirements of each assistance program as explained in the following passages.

2620.20.10 Offering Property For Sale Or Rent (MED 1)

Non-exempt real property which is available must be offered for sale or rent at fair market value (FMV) as a condition of eligibility regardless of the value of the property unless the applicant/recipient is in a long term care facility and has a community spouse. In this situation, the provision requiring nonexempt real property to be offered for sale or rent can be invoked only if the equity value causes excess resources. This requirement is also applied to ownership of a life or remainder interest in the property. It also applies to a life or remainder interest in mineral rights.

When it is determined that the applicant/recipient or his financially responsible relatives own property which is not exempt and is available, the owner of the property must sign the form, FI 0118, Agreement to Offer Property For Sale or Rent and

[32] 405 IAC 2-3-15

Repayment Agreement. If the owner of the property refuses to sign the form, the applicant/recipient is ineligible for Medicaid.

If the property owner complies and signs the form, FI 0118, he has 30 days from the date he signed the form or from the date the notice of eligibility is mailed, whichever is later, to offer the property for sale or rent at CMV. When the form is signed, it is effective “for the purposes of the application”, that is, inclusive of retroactive months for that application date. To be considered offered for sale or rent, a sign must be placed at a conspicuous location on the property, stating clearly that the property is for sale (or for rent) and giving the individual's name and address (or telephone number), or listing the property with a realtor.

When the AG owns property that is not exempt and is available, enter a "?" on screen AERRP in the "agree to sell" and "agree to rent" fields, unless the nonexempt property is currently for sale or rent. If the eligibility system determines that it must be offered for sale or rent, the case will be pended and indicated on screen AERED.

When the property owner is contacted and signs the Form 118, Agreement to Offer Property for Sale or Rent and Repayment Agreement, access screen AERRP, change the "?" to "Y" and enter the date it was signed. (If he refuses to sign it, enter "N" in the appropriate fields.) If "Y" was entered, screen AERED will then indicate the client has passed resource eligibility.

The eligibility system will monitor the 30 day period that is allowed to offer the property for sale or rent and the system will generate an alert. When the property owner signs the Form 118A, Report on Property for Sale or Rent, access screen AERRP and enter "Y" in the appropriate field. If the owner does not offer the property for sale or rent, enter "N" in the appropriate field and assistance will be discontinued.[33]

2620.20.10.05 Offering Property For Sale Or Rent (MED 4)

The provision requiring nonexempt real property to be offered for sale or rent as is explained in the preceding passage, 2620.20.10, can be invoked only if the equity value of the real property causes excess resources. If the applicant/recipient is within the applicable resource limitation when the equity value of nonexempt real property is counted, the property owner is not required to agree to offer it for sale or rent. If the equity

[33] 405 IAC 2-3-15

value does cause excess resources, the agreement to offer the real property for sale or rent must be signed.

When the AG owns nonexempt real property, enter a "?" on screen AERRP in the "agree to sell" and "agree to rent" fields, unless the nonexempt property is currently for sale or rent. If the eligibility system determines that it must be offered for sale or rent, screen AERED will display the amount of excess resources in the "sale/rent" field and the case will be pended. Follow instructions in Section 2620.20.10 regarding compliance with the requirement to offer the property for sale or rent.

2625.00.00 PLAN FOR ACHIEVING SELF-SUPPORT

There are two kinds of Plans for Achieving Self-Support (PASS). One is an SSI PASS which is approved by the Social Security Administration for SSI eligibility purposes. The other is a Medicaid PASS which is approved by the Division of Family and Children, Central Office, for Medicaid eligibility purposes. MED 1 and MED 4 have provisions to exempt resources specified in a PASS under certain circumstances as explained in the following two sections. Med 2 has no provisions to exempt a PASS.

2625.10.00 PLAN FOR ACHIEVING SELF-SUPPORT (MED 1, 4)

The policies explained in this section apply only to the MA B, MA G, MA L, SLMB (MA J), and QI (MA I) categories of assistance.

A PASS can be developed for an individual who needs to set aside a part of his resources for a specified period of time necessary to achieve an occupational objective. The resources could be used for current expenditures or saved for a later planned expenditure to achieve a work-related goal such as education, vocational training, starting a business, or purchasing work-related equipment.

For individuals in the MA B category (SSI recipients and non-SSI recipients) as well as non-SSI recipients in the MA L, MA G, MA J, and MA I categories, a PASS must be approved by the Office of Medicaid Policy and Planning (OMPP).[34] In order for a PASS to be approved, the DFR must submit a letter to the OMPP containing:

- The description and objectives of the plan as discussed with the applicant/recipient,
- The source and amount of all income and/or resources and the amounts of each that are to be used in the plan,
- The length of time the plan is to operate, and

[34] 405 IAC 2-3-3

Any other pertinent information including documentation from the Social Security Administration of an SSI recipient's approved PASS.

This letter is to be recorded in the case record with one copy being given to the applicant/recipient, one copy being sent to the OMPP Eligibility Unit at 402 W. Washington Street, MS 07, W374, Indianapolis, IN, 46204, and one copy being retained in the case record. The OMPP will forward a copy to the Blind and Visually Impaired Section of the DMHA for their recommendation. OMPP will then review the self-support plan and recommendation from the Blind and Visually Impaired Section of the Division of DMHA, and notify the DFR by letter of approval or disapproval. The DFR will then notify the applicant/recipient. If the plan is approved, the amount of income and resources disregarded and time period for the disregard, must be documented in the case record. A Medicaid approved PASS is coded in the eligibility system as PM.

In the QMB, QDW, SLMB, and QI eligibility determinations of SSI recipients who have a PASS approved by the Social Security Administration, a separate approval from the Central Office is not required. A copy of SSA's documentation should be obtained and filed in the case record. An SSI PASS is coded in the eligibility system as PS.

A PASS under the MA B category can be approved for a period not to exceed 12 months. For MA L, MA G, MA J, and MA I the PASS exemption will be for at least 18 months and may be extended up to 36 months.

2626.00.00 INDEPENDENCE AND SELF-SUFFICIENCY ACCOUNTS (MED 1)

This section applies to MADW and MADI.

Funds that have been set aside by the applicant/recipient for “independence and self-sufficiency” are disregarded as resources in an amount up to $20,000 as approved by the Central Office of the Family and Social Services Administration.[35] The purpose of an Independence and Self-Sufficiency Account (ISSA) is to allow the M.E.D. Works member to save money in order to purchase goods or services that will increase or maintain his employability or independence. An ISSA will not be approved for any item or service that the person is entitled to receive under Medicaid or

[35] 405 IAC 2-9-4

any other public program. Accounts for general savings or personal recreation will not be approved.

State Form 50929, “MED Works Request for Independence and Self-sufficiency Account”, is to be provided to any Medicaid applicant or recipient in MADW/I who answers “Y” to the question on AEDWI. A 30 day due date is to be specified; however a denial of an application or discontinuance of benefits for failure to turn in the ISSA form i.e., “failure to cooperate” is not appropriate. If the form is not submitted by the individual within 30 days, the response to the question must be changed from “Yes” to “No”. The applicant can submit the form at any time while the application remains pending. Workers should provide the State Form 50929 to any applicant/recipient who asks for it or who indicates the possibility of saving for an ISSA. However, a “yes” response should be entered on AEDWI only when the applicant/recipient answers the question definitively, or at some time after the interview submits a completed form.

EXAMPLE 1 Applicant #1 states in his application interview that he is saving money on a down payment for a car and he does want consideration for this as an ISSA. The worker completes the top portion of the form, enters the 30 day due date, signs and dates it, and gives it to him. A determination of excess resources cannot be made on #1’s application during the 30-day time frame or while the Central Office is reviewing the ISSA request.

EXAMPLE 2 During Recipient #2’s redetermination interview, she says she is thinking about how she might use an ISSA to help her get a better job. She doesn’t have definitive plans and does not have excess resources at the time. The worker completes the top portion of the form but does not give a due date, and enters “No” on AEDWI. Recipient #2 is determined to remain eligible and MADW is authorized. Several weeks later, the worker receives the completed Form 50929. She signs it, a enters “yes” on AEDWI, and forwards the form to Central Office.

An ISSA does not have to be a separate account in order to be disregarded. The disregard will be applied to the person’s total liquid assets. It is applied only to resources owned by the applicant/recipient or owned jointly with the applicant’s/recipient’s spouse. The disregard cannot be applied to resources owned solely by the spouse.

- An approved ISSA must be reviewed by the worker at each redetermination. If the estimated date that the items/services were to be purchased has passed and the item/service has not been purchased, the recipient must submit an updated request Form

50929. If the recipient does not do so within 30 days, the worker is to send an e-mail to the PAL Mailbox on Outlook. It is not necessary for these e-mails to PAL to go through the Policy Contact Person at the local DFR office. The worker can send them directly by entering in the subject field "ISSA UPDATE". Do not include the recipient's name or case number in the subject field. The Central Office will then end date the ISSA, and it will no longer be an allowable resource disregard.

M.E.D. Works members have an obligation to report any changes in their ISSA. If their plans or goals change, they must report this to the DFR. If a request for an ISSA is disapproved or the amount is reduced, the individual has the right to appeal this determination. The letter of decision, that Central Office issues, will explain these obligations and appeal rights.

2627.00.00 HEALTH SAVINGS ACCOUNTS

Health Savings Accounts are exempt as a resource if the account is restricted to use for qualified medical expenses only. The terms of the Health Savings Account are required to be verified to determine if the account can be used for purposes other than qualified medical expenses.

2630.00.00 RESOURCES EXEMPTED UNDER FEDERAL LAW

Each program has specific resources which are exempt by federal law. These exemptions are discussed in the following sections.

2630.05.00 BENEFITS UNDER FEDERAL NUTRITION PROGRAM

Certain benefits which are intended to meet the nutritional needs of low-income individuals are exempt.[36]

2630.05.05 WIC Benefits

Benefits received through the Women's, Infant's, and Children's (WIC) Program is exempt.[37] These payments are usually made through vouchers and can be used to purchase specific items for pregnant or nursing women and young children.

2630.05.10 Older Americans Act

[36] 7 CFR 273.8(e)(11); 45 CFR 233.20; 20 CFR 416.1236
[37] 7 CFR 273.8(e)(11)(iii); 45 CFR 233.20; 20 CFR 416.1236

Benefits received under Title VII, Nutrition Program for the Elderly of the Older Americans Act of 1965, as amended, are exempt.[38]

2630.05.15 Child Nutrition Act

The value of supplemental food assistance received under the Child Nutrition Act of 1966, as amended, is exempt.[39]

2630.05.20 National School Lunch Act

The special food service program for children under the National School Lunch Act, as amended, is exempt.[40]

2630.05.25 Food Stamps/Commodities

The value of food stamps and the value of United States Department of Agriculture donated foods (surplus commodities), are exempt.[41]

2630.10.00 HUD ASSISTANCE

Housing assistance paid directly or indirectly by HUD under the following is exempt:

the Housing Authorization Act of 1976 with respect to a dwelling unit under the United States Housing Act of 1937, as amended (Sections 8, 10, and 23 and the Experimental Housing Allowance Program),

The National Housing Act (loans for housing renovation, mortgage insurance, and investment insurance),

Title V of the Housing Act of 1949 (loans to elderly individuals, farmers, and developers for the construction, improvement, or replacement of farm homes and other buildings), and

Section 101 of the Housing and Urban Development Act of 1965 (payments to certain mortgagors on behalf of tenants with low income who are displaced by government action, age 62 or over, physically handicapped, living in substandard housing, present or past tenants of dwellings damaged or destroyed by disaster, or whose head of the household is on active duty) with the armed forces).[42]

2630.15.00 RELOCATION ASSISTANCE ACT PAYMENTS

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[38] 45 CFR 233.20; 20 CFR 416.1236
[39] 45 CFR 233.20; 20 CFR 416.1236
[40] 45 CFR 233.20; 20 CFR 416.1236
[41] 45 CFR 233.20; 20 CFR 416.1236
[42] 45 CFR 233.20; 20 CFR 416.1238

Relocation assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 is exempt.[43]

2630.20.00 HOME ENERGY ASSISTANCE PAYMENTS

Payments received through the Home Energy Assistance Program (EAP) are exempt.[44]

2630.25.00 ASSISTANCE FOR CERTAIN INDIAN TRIBES/ALASKAN NATIVES

The following Section discusses federal law pertaining to Indian tribes and Alaska natives.

P.L. 92-203, section 29, dated 1/2/76, the Alaska Native Claims Settlement Act, and Section 15 of P.L. 100-241, 2/3/88, the Alaska Native Claims Settlement Act Amendments of 1987 - All compensation (including cash, stock, partnership interest, land, interest in land, and other benefits) received under this Act are excluded from income and resources.

P.L. 93-134, the Judgment Award Authorization Act, as amended by P.L. 97-458, Section 1407, 11/12/83 and P.L. 98-64, 8/2/83, the Per Capita Distribution Act. P.L. 97-458 required the exclusion of per capita payments under the Indian Judgment Fund Act (judgment awards) of $2000 or less from income and resources. The exclusion applies to each payment made to each individual. Initial purchases made with exempt payments distributed between 1/1/82 and 1/12/83 are excluded from resources to the extent that excluded funds were used. P.L. 98-64 extended the exclusion to cover per capita payments from funds which are held in trust by the Secretary of Interior (trust fund distributions).

P.L. 93-531, Section 22 - Relocation assistance payments to members of the Navajo and Hopi Tribes are excluded from income and resources.

P.L. 94-114, Section 6 - Income derived from certain submarginal land held in trust for certain Indian tribes is excluded from income and resources. The tribes that may benefit are:

- Bad River Band of the Lake Superior Tribe of Chippewa Indians of Wisconsin

- Blackfeet Tribe

[43] 45 CFR 233.20; 20 CFR 416.1237
[44] 460 IAC 10.1-3-4; 405 IAC 2-3-3

- Cherokee Nation of Oklahoma

- Cheyenne River Sioux Tribe

- Crow Creek Sioux Tribe

- Lower Brule Sioux Tribe

- Devils Lake Sioux Tribe

- Fort Belknap Indian Community

- Assiniboine and Sioux Tribes

- Lac Courte Oreilles Band of Lake Superior Chippewa Indians

- Keweenaw Bay Indian Community

- Minnesota Chippewa Tribe

- Navajo Tribe

P.L. 94-189, Section 6, 12/31/75 - Funds distributed per capita to the Sac and Fox Indians or held in trust are excluded from income and resources. The funds are divided between members of the Sac and Fox Tribe of the Mississippi in Iowa. The judgments were awarded in Indian Claims Commission dockets numbered 219, 153, 135, 158, 231, 83, and 95.

P.L. 94-540 - Payments from the disposition of funds to the Grand River Band of Ottawa Indians are excluded from income and resources.

P.L. 95-433, Section 2 - Indian Claims Commission payments made pursuant to this Public Law to the Confederated Tribes and Bands of the Yakima Indian Nation and the Apache Tribe of the Mescalero Reservation are excluded from income and resources.

P.L. 96-420, Section 9(c), 10/10/80, Maine Indian Claims Settlement Act of 1980 - Payments made to the Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet are excluded from income and resources.

P.L. 97-403 - Payments to the Turtle Mountain Band of Chippewas, Arizona are excluded from income and resources.

P.L. 97-408 - Payments to the Blackfeet, Grosventre, and Assiniboine tribes, Montana, and the Papago, Arizona, are excluded from income and resources.

P.L. 98-123, Section 3, 10/13/83 - Funds distributed under this Act to members of the Red Lake Band of Chippewa Indians are excluded from income and resources. Funds were awarded in docket number 15-72 of the United States Court of Claims.

P.L. 98-124, Section 5 - Per capita and interest payments made to members of the Assiniboine Tribe of the Fort Belknap Indian Community, Montana, and the Assiniboine Tribe of the Fort Peck Indian Reservation, Montana, under this Act are excluded from income and resources. Funds were awarded in docket 10-81L.

P.L. 98-500, Section 8, 10/17/84, Old Age Assistance Claims Settlement Act, provides that funds made to heirs of deceased Indians under this Act shall not be considered as income or resources.

P.L. 99-146, Section 6(b), 11/11/85 - Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior are excluded from income and resources. Judgments were awarded in Dockets numbered 18-S, 18-U, 18-C and 18-T. Dockets 18-S and 18-U are divided among the following reservations:

Wisconsin

- Bad River Reservation
- Lac du Flambeau Reservation
- Lac Courte Oreilles Reservation
- Sokaogon Chippewa Community
- Red Cliff Reservation
- St. Croix Reservation

Michigan

- Keweenaw Bay Indian Community (L'Anse, Lac Vieux Desert, and Ontonagon Bands)

Minnesota

- Fond du Lac Reservation

- Grand Portage Reservation

- Nett Lake Reservation (including Vermillion Lake and Deer Creek)

- White Earth Reservation

Under Dockets 18-C and 18-T funds are given to the Lac Courte Oreilles Band of the Lake Superior Bands of Chippewa Indians of the Lac Courte Oreilles Reservation of Wisconsin, the Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, the Sokaogon Chippewa Community of the Mole Lake Band of Chippewa Indians, and the St. Croix Chippewa Indians of Wisconsin.

P.L. 99-264, White Earth Reservation Land Settlement Act of 1985, 3/24/86, Section 16 excludes moneys paid under this Act from income and resources. This Act involves members of the White Earth Band of Chippewa Indians in Minnesota.

P.L. 99-346, Section 6(b) (2) - Payments to the Saginaw Chippewa Indian Tribe of Michigan are excluded from income and resources.

P.L. 99-377, Section 4(b), 8/8/86 - Funds distributed per capita to the Chippewas of the Mississippi or held in trust under this Act are excluded from income and resources. The judgments were awarded in Docket Number 18-S. The funds are divided by reservation affiliation for the Mille Lac Reservation, Minnesota; White Earth Reservation, Minnesota; and Leech Lake Reservation, Minnesota.

P.L. 101-41, 6/21/89, the Puyallup Tribe of Indians Settlement Act of 1989, Section 10(b) provides that nothing in this Act shall affect the eligibility of the Tribe or any of its members for any Federal program. Section 10(c) provides that none of the funds, assets or income from the trust fund established in Section 6(b) shall at any time be used as a basis for denying or reducing funds to the Tribe or its members under any Federal, State or local program. (The Puyallup Tribe is located in the State of Washington.)

P.L. 101-277, 4/30/90, funds appropriated in satisfaction of judgments awarded to the Seminole Indians in Dockets 73, 151 and 73-A of the Indian Claims Commission are excluded from income and resources except for per capita payments in

excess of $2000. Payments were allocated to the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida and the independent Seminole Indians of Florida.

P.L. 101-503, Section 8(b), Seneca Nation Settlement Act of 1990, dated 11/3/90, provides that none of the payments, funds or distributions authorized, established, or directed by this Act, and none of the income derived therefrom, shall affect the eligibility of the Seneca Nation or its members for, or be used as a basis for denying or reducing funds under, any Federal program.

P.L. 93-134, Section 8, 10/19/73, the Indian Tribal Judgment Fund Use or Distribution Act, as amended by P.L. 103-66, Section 13736, 10/7/93, provides that interest of individual Indians in trust or restricted lands shall not be considered a resource and up to $2000 per year of income received by individual Indians that is derived from such interests shall not be considered income in determining eligibility for assistance under the Social Security Act or any other Federal or federally assisted program.

If other types, not on this list, are encountered, contact the Policy Answer Line for guidance.

2630.30.05 Compensation To Japanese/Aleuts (MED 1, 4)

Restitution payments by the U.S. Government to individual Japanese-Americans (or, if deceased, to their survivors) and Aleuts who were interned or relocated during World War II are exempt from income and resources. Also, restitution payments from the Canadian government to individual Japanese-Canadians who were interned or relocated during World War II are exempt resources.[45]

2630.35.00 GERMAN REPARATION PAYMENTS (MED 1, 4)

German reparation payments are payments made by the Republic of Germany to certain survivors of the Holocaust and may be received periodically or in a lump sum. They are exempt resources by federal law. [46]

2630.35.05 Crime Victim Payments (MED 1, 4)

Any amount of assistance received from federal funds administered from any state or local government program

[45] 20 CFR 416.1236
[46] Section 1902(r)(1) of the Social Security Act as amended by OBRA-90; P.L. 101-508

established to aid victims of crime is excluded from resources for a period of 9 months beginning with the month following the month of receipt. To be excluded from resources under this section, the individual (or spouse) must demonstrate that any amount received was compensation for expenses incurred or losses suffered as the result of a crime.[47]

2630.40.00 DOMESTIC VOLUNTEER SERVICE ACT COMPENSATION

The following is exempt as a resource by federal law:

> Compensation of any kind (including stipends, supportive services, remuneration for out-of-pocket expenses, and so forth) provided to individuals who are volunteers in programs administered directly or through sponsoring agencies by the United States action Agency under Titles I, II, and III of the Domestic Volunteer Service Act of 1973, is exempt. These programs include the Foster Grandparents Program, Retired Senior Volunteer Program (RSVP), Service Corps of Retired Executives (SCORE), Active Corps of Executives (ACE), Action Cooperative Volunteer Program
>
> (ACV), Senior Companion Program, Volunteers in Service to America (VISTA), and University Year for Action (UYA).[48]

2630.45.00 PAYMENTS TO STUDENTS

Education grants and loans received under Title IV of the Higher Education Act or the Bureau of Indian Affairs (BIA) programs are exempt for undergraduate students Medicaid.[49] These exclusions are allowed for students in high school and GED programs as well as post-secondary education. Examples include:

> Basic Educational Opportunity Grants (BEOG),
>
> Supplemental Educational Opportunity Grants (SEOG),
>
> College Work Study,
>
> National Direct Student Loans (NDSL),
>
> Guaranteed Student Loans,
>
> Pell Grants, and
>
> Federal Perkins Loans

Refer to Section 2860.05 for a comprehensive listing.

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[47] 20 CFR 416.1229 (a) (b)
[48] P.L. 93-113, Sections 404(g) and 418; 20 CFR 416.1124(b)
[49] 45 CFR 233.20; 20 CFR 416.1236

2630.55.00 DISASTER ASSISTANCE PAYMENTS

Assistance received under the Disaster and Emergency Assistance Act of 1974[50] or another federal statute because of a presidentially declared major disaster is permanently exempted as a resource.

2630.60.00 RADIATION EXPOSURE ACT BENEFITS

Payments made from the Radiation Exposure Compensation Trust Fund established under the Radiation Exposure Compensation Act are exempt resources.[51]

2630.65.00 AGENT ORANGE SETTLEMENT ACT PAYMENTS

Payments made from the Agent Orange settlement fund or any fund established as a result of the Agent Orange product liability litigation, are exempt from resource consideration.[52]

2630.95.00 INDIVIDUAL DEVELOPMENT ACCOUNT

Individual Development Accounts (IDA) operated under the Assets for Independence Act (AFIA), Public Law 106-554, are established by or on behalf of eligible TANF recipients for the purpose of purchasing a home, attending postsecondary education or purchasing a business. Eligible individuals may receive matching funds for their IDA through a community development corporation (CDC). Any funds deposited in an IDA are exempt from being counted as a resource. (See also IPPM 2850.05.00)

2635.00.00 RESOURCE ELIGIBILITY DETERMINATION

Resource eligibility requirements for MED 1, 2, or 4 categories must be met for eligibility to be established. The worker is responsible for obtaining and verifying all pertinent information regarding the resources of the appropriate AG members. The consideration of resources will vary according to the age, marital status, and living arrangement of the AG members. The following sections explain the methods used in determining resource eligibility.

2635.10.00 RESOURCE ELIGIBILITY DETERMINATION (MED 1)

In addition to eligibility requirements discussed in the preceding passages of this chapter, the following principles apply to the consideration of resources in the resource

[50] P.L. 93-288; 20 CFR 416.1150
[51] P.L. 101-426 as amended by P.L. 101-510; 20 CFR 416.1236
[52] 20 CFR 416.1124(b); 20 CFR 416.1236(a)(15)

eligibility determination of all persons except institutionalized individuals who entered long term care facilities on or after September 30, 1989, and who have a community spouse.

All available resources owned by the applicant/recipient and his responsible relatives must be considered in regard to the resource limitations listed in Section 3005.15.00. Persons who qualify as "responsible relatives" are as follows:

- The spouse of the applicant/recipient if the couple is living together, or separated only for medical reasons such as nursing home placement. If the spouse of an applicant/recipient is absent from the home due to desertion or separation for reasons other than medical, the spouse's resources are not to be considered.

- The biological or adoptive parent(s) and stepparents living with an applicant/recipient under age 18[53], unless the child is receiving Home and Community-Based Services under any of Indiana's waivers. If the applicant/recipient child is institutionalized (including hospitalization) the parent(s)' resources are not considered in the month following the month of admission. If the non-recipient parent of the child applicant/recipient owns resources in excess of the resource limit, the excess is to be counted as a resource of the child.[54] However, excess resources of the child applicant/recipient cannot be counted as a resource to the parent. Also, excess resources of the recipient parent cannot be counted as a resource to the child.

Parents' resources are considered through the month in which the child applicant/recipient reaches age 18 unless the child turns 18 on the first of the month.

When the applicant/recipient is a student between the ages of 18 and 21, the parent's resources are not counted.

Resources owned solely by the following individuals are exempt:

- Non-recipient children or siblings of the applicant/recipient,

- The stepparent of an applicant/recipient,

- parents of an institutionalized applicant/recipient beginning in the month following the month of admission, or beginning in the month of birth if the child remains institutionalized/hospitalized in the following month,[55]

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[53] 20 CFR 416.1202(b)
[54] 405 IAC 2-3-15
[55] IC 12-15-3-4 as added by P.L. 2-1992, Sec. 9

- Parents of a child who has been determined eligible for Home and Community-Based Services (HCBS) Waiver.[56] See Chapter 3300.

2635.10.05 QMB, QDW, SLMB, and QI Resource Determinations (MED 4)

In addition to the eligibility requirements discussed in the preceding sections of this chapter, the following principles apply to the consideration of resources in the Qualified Medicare Beneficiary (QMB), Qualified Disabled Worker (QDW), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI) eligibility determination:

Resources owned by the following individuals must be considered:

- The applicant/recipient, and
- The spouse of the applicant/recipient if the couple is living together.

Resources owned solely by the spouse of the applicant/recipient who does not live with him are not considered.

Resource limitations listed in Section 3005.25 must be met before resource eligibility can be established.

2635.10.10 Resources/Institutionalized/Community Spouse (MED 1)

The policies stated in this section apply only to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

Special resource provisions apply to an institutionalized individual who has a community spouse or to a waiver applicant/recipient who has a community spouse, and are explained further in Sections 2635.10.10.05, 2635.10.10.10, and 2635.10.10.15.

- To qualify for consideration under these special provisions, an institutionalized spouse must be in a hospital, nursing facility, ICF/MR, or psychiatric facility for 30 consecutive days, or be likely to remain in such a facility for that period or longer. If an individual dies before the 30th consecutive day, the individual should be treated as though she would have resided in the institution for 30 consecutive days. The "community" spouse must be living in a setting other than one of the aforementioned facilities.

[56] IC 12-15-3-4 as added by P.L. 2-1992, Sec. 9; 405 IAC 2-3-15

The special resource provisions apply only to individuals who are legally married to community spouses and who begin continuous periods of institutionalization on or after September 30, 1989.

An individual is in a "continuous period of institutionalization" until such continuity is broken by the absence from a hospital, nursing facility, ICF/MR, or psychiatric facility for at least 30 consecutive days.

These special resource provisions no longer apply beginning the month following the month in which circumstances change so that the couple no longer meets the criteria.

An individual living in a residential facility, such as one participating in the Room and Board Assistance (RBA) program, is not entitled to have eligibility determined under the special provisions. A resident of an RBA facility qualifies as a community spouse when the other spouse is institutionalized in a hospital, nursing facility, ICF/MR, or psychiatric facility.

2635.10.10.05 Resource Assessment And Spousal Share (MED 1)

The policies stated in this section apply only to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

Institutionalized individuals who are married to community spouses and who meet the specific criteria in Section 2635.10.10 must have a resource assessment completed. The resource assessment is a very important process whereby the combined countable resources of the couple are determined as of the beginning (date of admission) of the institutionalized spouse's first continuous period of institutionalization which began on or after September 30, 1989.[57] From this information, a "spousal share" for the community spouse, equaling one-half of the couple's combined countable resources, is then established for use in determining the institutionalized spouse's resource eligibility.

Countable resources for assessment purposes are determined in the same manner as in regular situations with the following exceptions:

> Up to $2000 of any separately identifiable funds or assets which have been set aside for burial can be excluded. This exemption can be given to both spouses if applicable; however, the $2000 maximum must be reduced by the face value of any life insurance policies whose cash surrender value has been exempted, or by the amount in any irrevocable burial trust. [Please, note the

[57] Social Security Act, Section 1924(c)(1)

exempted value prior to June 1, 2014, was $1,500]. In order for funds or assets to be considered set aside for burial, the account titling must indicate such, or there must be a signed statement by the owner or guardian of the purpose for the funds and the date on which they were set aside.

One motor vehicle of any value is exempt.

The equity value of nonexempt real property owned solely or jointly by the institutionalized spouse is a countable resource. (The "agree to sell" rule is applied only to eligibility determinations, not for purposes of calculating the spousal share.) The equity value of real property owned solely by the community spouse (or jointly with someone other than the institutionalized spouse) is not included when determining the amount of combined assets for spousal share purposes.

The resource assessment can be requested independently of an application for assistance by either spouse or their authorized representative. In that situation, the assessment request should occur promptly upon admission to the facility. DFR Offices are to provide Form 2060, Resource Assessment Notice and Request, to interested persons upon request and should provide a supply to facilities in the county. A completed Form 2060 can be mailed to FSSA Document Center or the local DFR office.

When a request for an independent resource assessment is received, the screener is to access ARRA, complete the screens, and schedule an appointment for the assessment interview. The interview can be conducted in person or by telephone. During the interview the worker is to complete Form 2061, Resource Assessment for Medical Assistance to the Aged, Blind and Disabled. The responsibility for providing the required documentation and verification rests entirely with the couple and any representative. The Form 2060 explains this fact and also lists the type of documentation which must be provided to the DFR. Workers are to give advice and guidance to the individual as to the most effective means of obtaining verification but are not required to obtain verifications directly, although it is not prohibited when a properly signed consent has been obtained.

If the necessary documentation is not received by the DFR within 20 days of the date of the assessment request, the worker will receive an alert and is to send a reminder letter to both spouses and their representative listing the necessary documentation and asking for an update on the status of their verification process. At the end of 30 days, a second letter

should be sent stating that the assessment cannot be completed until the verification is submitted.

- When the necessary documentation is received, the DFR is to proceed in an expedient manner to complete the assessment and determine the spousal share. Once completed, copies of the Form 2061 and the verifications must be provided to both spouses. If a representative has acted on behalf of either spouse, the DFR must provide him with a copy also. The worker is to access ARRA and enter the amount of the spousal share.

A copy of all complete or incomplete assessments, as well as the documentation and any correspondence, must be retained by the DFR as the spousal share, or the inability to establish one, is crucial information in the determination of the institutionalized spouse's eligibility when an application is filed. Copies of the independent resource assessments are to be retained indefinitely.

The spousal share cannot be appealed until an application for Medicaid is filed and the eligibility determination is completed. If a mathematical or keying error is made by the worker, ARRA can be accessed by the supervisor who can enter the correct spousal share.

If an individual not entitled to an independent resource assessment under the special resource provisions requests an assessment via the Form 2060, the DFR must advise the individual in writing of the reason the assessment will not be completed.

If the institutionalized spouse is applying for Medicaid, the resource assessment will be an integral part of the eligibility study. Do not complete ARRA. When a person is applying for Medicaid and needs a resource assessment as part of his eligibility determination, that individual will be entered into the system just like any other application. When the application is processed in AE, screens AERRA and AERRC are to be completed with the resource data necessary to determine the spousal share. When resources are jointly owned by the spouses, they are to be entered once on screen AERRA and AERRC in the institutionalized spouse's name. Then the spousal share can be correctly calculated. Resource values for assessment purposes must be verified as of the first date of continuous institutionalization, whether it is in a hospital or a nursing facility.

When an assessment is being completed in conjunction with an application for assistance, the securing of necessary resource verification is a joint applicant/worker effort conducted in the usual manner.

2635.10.10.10 Resource Eligibility/Institutionalized Spouse (MED 1)

The policies stated in this section apply only to the MA A, MA B, MA D, MADW, and MADI categories of assistance and are applicable to institutionalized individuals who meet the specific criteria in Section 2635.10.10.

The community spouse resource limit is the greatest of the following:[58] (Refer to Section 3005.15.00 for current amounts)

The minimum current state standard,

The spousal share not exceeding the current maximum,

Any amount of resources ordered to be transferred by a court against the institutionalized spouse for the support of the community spouse, or

The amount established by an Administrative Law Judge as the result of an appeal.

The first of the month resource eligibility rule (refer to Section 2605.20.10) is applicable to resource eligibility determinations made under the special resource provisions for an institutionalized spouse with a community spouse. The special provisions are applicable beginning with the first month of institutionalization included in the possible Medicaid covered period (that is the three month retro period). The institutionalized spouse's resource eligibility for any month in which the special resource provision does not apply, (for example, the month before institutionalization), is to be determined using all of the regular resource methodologies and the resource limitation for a couple.

- Beginning with the first month in which the special resource provisions apply, the procedure outlined below is required. This procedure establishes the initial month of eligibility, which is the point at which the community spouse's resources are no longer considered.

The couple's combined countable resources are determined by applying all of the regular resource methodologies, except as follows:

- Up to $1500 of separately identifiable burial funds is disregarded.[59] This exemption can be given to both spouses if applicable. However, the $1500 maximum must be reduced by the

[58] SSA 1924(f)(2)

[59] Social Security Act, Section 1924(c)(5)(A) as amended by OBRA-90

amount in an irrevocable burial trust or by the face value of any life insurance policies whose cash surrender value has been exempted because the face value is $1500 or less and the beneficiary is the estate or funeral home,

- One motor vehicle is exempt regardless of value or purpose,

- The equity value of real property owned solely by the community spouse (or jointly with someone other than the institutionalized spouse) is exempt,

- Nonexempt real property owned solely or jointly by the institutionalized spouse is not subject to the requirement to offer it for sale or rent, unless the total value of the couple's countable resources, including the real property, exceeds their combined resource standards.

The total value of the couple's non-exempt resources, including real property owned by the institutionalized spouse, is compared to their combined resource limit (the community spouse limit plus the standard for a single individual). If countable resources are equal to or less than the current standard, the institutionalized spouse is eligible for assistance for that month, which is the initial month of special resource eligibility for the institutionalized spouse. For subsequent months during the continuous period of institutionalization, resources owned solely by the community spouse are exempt.

If the countable resources exceed the current standard, and ownership of real property is not involved, the institutionalized spouse is ineligible for that month.

The process is repeated for subsequent months. If a month of eligibility does not occur, the application is to be denied.

If the countable resources, including non-exempt real property, are greater than the current standard, the next step is to subtract the equity value of the real property. If there still are excess resources in personal property, the applicant is ineligible. If not, the applicant must agree to offer the real property for sale or rent as a condition of eligibility.

If, for the initial month of eligibility under this provision, resources in the name of the institutionalized spouse exceed the single individual standard, a post-eligibility transfer of resources will be required within a specified time limit as explained in Section 2635.10.10.15.

If the institutionalized spouse assigns to the State of Indiana his rights for support from the community spouse, the

institutionalized spouse cannot be determined ineligible due to resources under this section.

2635.10.10.15 Post Eligibility Protected Period (MED 1)

The policies stated in this section apply only to the MA A, MA B, MA D, MADW, and MADI categories of assistance and are applicable only to individuals who meet the specific criteria in Section 2635.10.10.

Once initial resource eligibility has been established, any amount of the community spouse resource standard spousal share which is not already solely in the community spouse's name, can be transferred to him by the institutionalized spouse and not be counted in determining the institutionalized spouse's continuing resource eligibility.[60] The institutionalized spouse must indicate a willingness to transfer resources into the community spouse's name sufficient to reduce his resources to the allowable single individual standard.

He will have a period of 90 days in which to complete this transfer. This protected period begins with the date of the notice of eligibility which approves assistance. The worker must enter on screen AEFEC the expected date of the end of the 90 day period. During this protected period, the amount subject to transfer (the difference between the community spouse resource standard and the actual amount of resources solely owned by the community spouse) will not be counted as a resource of the institutionalized spouse.

Once the DFR determines that an institutionalized spouse/applicant is resource eligible for an initial month, but that the community spouse does not actually own resources equal to the community spouse resource standard, the institutionalized spouse, community spouse, and any representative must be advised in writing of the amount to be transferred to the community spouse and the deadline for doing so. This letter will be a part of the eligibility system-generated approval notice.

The DFR must monitor the couple's resources monthly through the end of the protected period to ensure that the transfer actually takes place. When it does, this is to be documented in the case record. Should the transferor need more time than the 90 day protected period to complete the transfer, he should contact the DFR and report this. More time must be granted by the DFR if the transfer is being pursued but has been delayed in whole or part by circumstances beyond the institutionalized spouse's control,

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[60] Social Security Act, Section 1924(f)(1) as amended by OBRA-90 (P.L. 101-508)

such as a court order requirement, uncooperative insurance company, and so forth. If the protected period is extended by the DFR, access screen AEFEC and change the expected date of the end of the 90 day protected period. Monthly resource monitoring must continue until the transfer is completed.

If there is no extension and the 90 day period ends without the transfer having occurred, the DFR must contact the institutionalized spouse or his representative relative to the status of transfer activity. If the transfer is not being pursued or there is no good cause for an extension, the protected assets immediately become countable again as resources of the institutionalized spouse and assistance will be discontinued.

2635.10.20 Applicant/Recipient With Excess Resources (MED 1)

This section and its following subsections named below apply to MA A, MA B, and MA D for months when eligibility is determined prior to June 2014.

Whenever an applicant/recipient has resources in excess of the applicable limitation in Section 3005.15.00, the worker must complete an off-line evaluation of the person's entitlement to "resource spend-down". This provision is required in accordance with the Indiana Supreme Court ruling in the case of Indiana Department of Public Welfare v. Hazen Payne. The policy and procedures to be applied in determining eligibility are explained in the following sections.

2635.10.20.05 Entitlement to Resource Spend-Down/SSI Determination

2635.10.20.10 Resource Spend-Down Determination

2635.10.20.15 Eligibility System Procedures When Resource Spend-Down Is Involved

2635.10.20.20 Processing Appeal Cases Remanded Under IDPW v. Payne

2635.10.20.05 Entitlement To Resource Spend-Down/SSI Determination

This section applies to MA A, MA B, and MA D.

The first step in determining an applicant's/recipient's resource eligibility when his resources exceed the applicable limitation (and no other reason for ineligibility exists), is to determine whether or not the person meets SSI requirements for

each month under consideration. An applicant/recipient who does not meet SSI requirements is not entitled to the resource spend-down provision. If the applicant/recipient received SSI benefits, he is entitled to resource spend-down consideration. For those not receiving SSI benefits, the worker must determine if the applicant/recipient meets SSI requirements.

The SSI resource policies which differ from Medicaid are explained below.

1. The SSI resource limits effective 1/1/89 are:

   $2000 for an individual

   $3000 for a married couple

2. The cash surrender value (CSV) of life insurance is exempt if the total face value of policies owned by the individual (excluding term insurance and burial insurance) does not exceed $1500, regardless of beneficiary designation. This exemption applies to the applicant/recipient and his spouse. The maximum face value exemption is reduced by the amount in an irrevocable pre-paid funeral contract/trust.

3. Up to $1500 of funds in a revocable account earmarked for burial is exempt. This exemption is available to the applicant/recipient and his spouse, or parent/stepparent. The $1500 maximum burial fund exclusion is reduced by the amount of exempt life insurance in #2 above, and/or the amount of an irrevocable funeral contract/trust.

4. Resources of the stepparent of a child applicant/recipient under age 18 are deemed to the child, unless the child's natural/adoptive parent is deceased or the couple is divorced.

5. Pension or retirement funds, including Keogh plans and IRAs owned by an ineligible spouse or ineligible parent are exempt.

6. Resources owned by the community spouse of an institutionalized applicant/recipient are exempt beginning the month after the month of admission.

7. The unspent portion of a retroactive RSDI or SSI payment is exempt for six months if it is identifiable from other resources.

8. Any unspent portion of a Federal tax refund or advanced Earned Income Tax Credit payment is exempt for one month following the month of receipt.

9. Funds remaining from assistance paid by the Violent Crime Compensation program are exempt for nine months after the month of receipt of the payment.

10. Proceeds from the sale of an excluded home are exempt for three months after the month of receipt if the individual plans to purchase another exempt home.

11. If an allocation is budgeted for an essential person, the resources of the essential person are included. If doing so causes ineligibility, the essential person allocation is removed from the budget.

12. Resources set aside under a Plan for Achieving Self-Support (PASS) by an applicant/recipient in the Blind or Disabled category are exempt. The PASS must be approved by the Central Office in the same manner as a Medicaid PASS as explained in Section 2625.10.00.

13. Non-business real property, such as rental property, is subject to the "6000/6% rule". Up to $6000 in equity is excluded if the net annual income generated from the property is at least 6% of the excluded equity. If the income is less than 6% the entire equity is a countable resource. If the individual owns more than one piece of non-business income-producing property, each property must meet the 6% test in order to be exempt, and the $6000 equity limit applies to the total equity value of all properties.

14. The principal balance of a land contract is a countable resource. The interest portion of the installment payment is income. (Note: This policy is the same as TANF policy concerning land contracts. Refer to Section 2875.10.10.)

15. Resources owned by the sponsor of an alien applicant/recipient are deemed for three years after entry into the United States. If this situation is present in a particular case, the DFR should contact the Policy Answer Line for guidance on the deeming methodology.

16. Resources which have been disregarded under the asset protection provision of the Indiana Long Term Care Program (ILTCP) are counted in the resource spend-down/SSI determination. Refer to Section 2615.25.15 for a discussion of the ILTCP.

The SSI income policies which differ from MA are explained below.

1. The income standards are the same as those for Medicaid listed in Manual Section 3010.20.05. However, they are effective in January of the year in which the Medicaid standards are effective.
2. The general income disregard is $20.
3. Income of the stepparent of a child applicant/recipient under age 18 is deemed to the child unless the child's natural/adoptive parent is deceased or the couple is divorced.
4. VA pension payments are counted in full without deducting the $20 general income disregard.
5. Up to $400 of earned income a month, not to exceed $1620 in a calendar year, is disregarded for the applicant/recipient under age 18 who is a student.
6. Parental income is not deemed to the applicant/recipient who is age 18 or older.
7. One-third of the amount of child support payments made on behalf of an applicant/recipient under age 18 is disregarded.
8. Court-ordered child support payments or support enforced under Title IV-D are allowed as a deduction from the income of an ineligible spouse or ineligible parent.
9. Income set aside under a Plan for Achieving Self-Support (PASS) by an applicant/recipient in the Blind or Disabled category is exempt. The PASS must be approved by the Central Office in the same manner as a Medicaid PASS as explained in Section 2625.10.00.
10. A deduction is allowed from the earned income of an applicant/recipient under the Blind category for work-related expenses. Allowable expenses are those that are reasonably attributable to the earning of the income and that are not subject to reimbursement. Examples are:

    - Medical services, equipment, and supplies which are not covered by Medicaid or a third party,

    - Income and FICA taxes withheld from paychecks,

    - Expenses associated with care and maintenance of a guide dog,

    - Professional association dues,

    - Union dues,

- Mandatory payroll deductions such as pension and disability contributions,

- Meals consumed during work hours

- Work-related equipment specially designed to accommodate the person's visual impairment.

Non-allowable expenses are:

- Those deducted under another provision such as PASS,

- Life maintenance expenses such as meals consumed outside of work hours, self-care items which are cosmetic rather than work-related, general educational development,

- Savings plans including voluntary contributions to a pension plan,

- Life and health insurance premiums,

- Expenses claimed on a self-employment tax return

11. Income of the sponsor of an alien applicant/recipient is deemed for three years after entry into the United States. If this situation is present in a particular case, the DFR should contact the Policy Answer Line for guidance on the deeming methodology.

The worker should complete State Form 45885, Budgeting Worksheet, to determine SSI income eligibility. The methodology and order of deductions are the same. If there are blind work expenses, these are to be deducted from the "Countable Earned Income" figure on Line 18 and the result is added to the "Countable Unearned Income" amount on Line 10 to arrive at "Total Countable Income". If total countable income (after deducting a P.A.S.S., if appropriate) is less than the income standard, the applicant/recipient meets SSI requirements.

The results of the off-line SSI determination must be documented in the hard copy case file and also in Running Records Comments. If the applicant/recipient meets SSI income and resource eligibility requirements, the worker is to complete the resource spend-down determination as explained in the next section, 2635.10.20.10.

2635.10.20.10 Resource Spend-Down Determination

This section applies to MA A, MA B, and MA D.

For each month in which the applicant/recipient is either receiving SSI or is determined to meet SSI eligibility requirements, the Medicaid determination is to be made by taking resource spend-down into consideration. The surplus income amount (on AEBMB) and the excess resource amount (from AERED) are added together. His spend-down amount is the sum of the surplus income and the excess resources, rounded down to the next whole dollar.

If the applicant/recipient is in a long term care facility, the eligibility determination, as explained above, is to be completed. If the individual is eligible, the amount of the resource spend-down (excess resources rounded down to next whole dollar) is added to the liability calculated in the post-eligibility step to arrive at the actual liability for the month. If the final liability amount exceeds the facility's private rate, the liability is treated as a spend-down. (Note: this is the same procedure which is always applied whenever the liability exceeds the private rate.)

The following examples illustrate how eligibility is determined when taking resource spend-down into consideration. Calculations are based on the income standard, general disregard and resource limit in effect 01-01-08. Current standards can be found in Chapter 3000.

EXAMPLE 1: $656 income $1902.45 resources -15.50 general disregard -1500.00 resource limit = 640.50 = 402.45 excess resources -637.00 income standard + 3.50 surplus income = $3.50 surplus income $ 405.95 total Applicant is eligible enrolled for this month with a spend-down of $405. If the applicant is in LTC, the liability would be $1009. ($656 - $52 personal needs = $604 + $405 resource spend-down)

EXAMPLE 2: $653.00 income $ 1625 resources - 15.50 general disregard - 1500 limit = 637.50 =$ 125 excess resources - 637.00 income standard = $.50 The spend-down is $125 for this month and the applicant/recipient is enrolled with the resource spend-down, even though there is no income spend-down.

If the excess resources have not been reduced by the time the application is ready to be authorized, establish the income/resource spend-down for the recurring month.

2635.10.20.15 Eligibility System Procedures When Resource Spend-Down Is Involved (MED 1)

The procedures in this section apply to MA A, MA B, and MA D.

When an applicant/recipient fails eligibility due to excess resources, the internal reason code of 480 or 483 will be set by the system on AEWAA. If there is no other reason for ineligibility, the AG cannot be authorized until the off-line determination is made concerning the applicant's/recipient's entitlement to the resource spend-down provision explained in the previous sections. If the AG is ineligible for any other reason in addition to excess resources, the AG should be denied/closed as usual. If the worker attempts to deny or close an AG who fails with reason code 480 or 483, the error message "determine resource spend-down and enter RC" will appear. If the applicant/recipient is not entitled to resource spend-down because he does not meet SSI requirements as explained in Section 2635.10.20.05, enter reason code 476.

When the worker determines that an applicant/recipient is eligible with a resource spend-down, fiat is required to establish the correct spend-down or liability amount.

2640.00.00 TRANSFERS OF PROPERTY

The transfers of certain real or personal property to another individual must be considered in relation to the law and/or regulations in effect on the date that the transfer occurred. The specific policy for transfers of property varies by program and is explained in Sections 2640.05.00 through 2640.10.35.05.

Screen AERRQ contains the transfer of property question. When the answer is "yes", screen AERRT must be completed with the transfer information.

2640.10.00 TRANSFER OF PROPERTY LAW

The Medicaid eligibility of an individual who transfers property on or after August 11, 1993, is governed by federal law. Section 1917(c) of the Social Security Act (42 U.S.C. 1396 p-C), as amended by OBRA-93 requires a penalty period of reduced Medicaid coverage for persons found to have made a property transfer for less than fair market value and for the purpose of becoming eligible for Medicaid.

The following sections explain the procedures for consideration of transfers of property occurring on or after August 11, 1993. State regulations, as amended, at 405 IAC 2-3-1.1 and 405 IAC 2-3-1.2 are applicable to certain transfers effective June 1, 2002 regarding annuities, income transfers, and failure to take action to receive assets. Additional provisions are effective July 1, 2003 regarding the start of a transfer penalty, penalty periods for successive transfers, and transfers of income producing real property.

2640.10.05 General Applicability of Transfer of Property Law

The transfer of property provision is applicable to applicants/recipients who are:

- Inpatients of nursing facilities or other medical institutions in which they are receiving equivalent nursing facility services, or
- Receiving Home and Community-Based Services (HCBS)

If an applicant/recipient does not meet one of the above conditions a transfer penalty is not invoked. If such an individual has transferred property, the worker is to record the occurrence but will not require verifications nor attempt to determine whether the transfer was violative. However, if the individual later enters a nursing facility or begins receiving HCBS, the worker would then be required to determine whether the transfer was violative.

Transfers are potentially violative made by the:[61]

- Applicant/recipient,
- The spouse of the applicant/recipient,
- Anyone with legal authority to act on behalf of the applicant/recipient or spouse, such as a parent or legal guardian (including a court or administrative body),
- Anyone acting at the direction or request of the applicant/recipient or spouse (including a court or administrative body).

Federal law defines assets as both income and resources (real and personal property) owned by the applicant/recipient and spouse. Refer to Section 2640.10.15.05 regarding transfers of homes and income-producing real property.

Also included as an asset are income and resources, which the applicant/recipient is entitled to receive but doesn't because of his actions or those of his spouse, a person with legal

[61] 405 IAC 2-3-1.1(a)

authority to act on his or his spouse's behalf, including a court or administrative body, or any other person, court or administrative body acting at the direction or request of the individual.

Examples of actions which would cause income or resources not to be received are:

Irrevocably waiving pension income,

Waiving the right to receive, or failing to take the necessary action to receive an inheritance,

Not accepting injury settlements.

Each individual circumstance of an individual failing to take an action to obtain assets must be carefully examined, as this may not always be considered a violative transfer. A transfer of property penalty will not be imposed in the following circumstances:[62]

(a) The applicant/recipient, or the person with the legal authority to act on behalf of the applicant/recipient is unaware of the right to receive assets, or becomes aware after the deadline for taking action has passed. If the DFR or other division of FSSA informs the individual of his right to receive assets prior to the deadline for taking action, the individual will be presumed to be aware of his rights.

(b) A physician who is knowledgeable of the medical condition of the applicant/recipient provides a written statement that the applicant/recipient is not capable of taking the necessary action to receive the asset. A physician’s statement can only be used for this purpose if the applicant or recipient has no legal guardian or other person who has the authority to act on the individual’s behalf in whatever action is needed to receive the assets.

(c) The expense of collecting the assets would exceed the value of the assets.

(d) In the case of a surviving spouse who fails to take a statutory share of a deceased spouse’s estate, a penalty is not imposed if the deceased spouse made other equivalent arrangements to provide for the surviving spouse’s needs, including but not limited to setting up a trust.

2640.10.10 Determining The Transfer Review Period

[62] 405 IAC 2-3-1.1(i)

As stated in the preceding section, the transfer of property law is made an active consideration only by the applicant/recipient being or becoming institutionalized in a nursing facility (or receiving Home and Community-Based Services). When this factor is present in a case situation, the worker must then determine the time period that must be reviewed, during which transfers made could be violative. This time period is the "review period", or “look-back” period.

The review period for looking at a transfer involving non-trust property prior to November 1, 2009, is 36 months prior to the first date when the individual was institutionalized and had applied for Medicaid, and continues indefinitely thereafter.

Upon November 1, 2014, the review period for looking at a transfer involving non-trust property is 60 months prior to the first date when the individual was institutionalized and had applied for Medicaid, and continues indefinitely thereafter. (This date is referred to as the baseline date.)

The review period for looking at a transfer involving non-trust property between November 1, 2009, and November 1, 2014, extends back to November 1, 2009, when the individual was institutionalized and had applied for Medicaid, and continue indefinitely thereafter.

The review period for transfers involving trust funds in the circumstances explained in Section 2615.75.15 is 60 months prior to the baseline date defined above and continues indefinitely thereafter.

When a Medicaid recipient becomes institutionalized or begins receiving Home and Community-Based (HCBS) waiver services, the baseline date is the date when both conditions, i.e., an application and institutionalization, or HCBS, are met. This would be the date of institutionalization or effective date of waiver services.

EXAMPLE: Individual living at home transfers property on January 10, 1995. She applies for Medicaid on April 7, 1995 and enters a nursing facility on September 11, 1995. The baseline date is September 11. Therefore, the transfer took place within the review period.

2640.10.15 Allowable Transfers of Property

If it is determined that a transfer occurred within the review period, the next step is to determine whether the transfer automatically qualifies as allowable. No transfer of property penalty can be invoked when an individual makes a transfer to:

His spouse (or to another for the sole benefit of the spouse), or

The applicant's/recipient's child who is blind or disabled, according to SSI criteria, or to a trust fund for such a child.

Additionally, the transfer of a home to certain individuals as explained in Section 2640.10.15.05 is allowable.

Transfers on and after 8-11-93, to certain types of trust funds, as defined in section 2615.75.15, for disabled individuals are allowable.

2640.10.15.05 Transfers Of Homes And Income-Producing Real Property (MED)

There is no transfer of property penalty if a home, as defined in section 2620.15.10, is transferred to:

A spouse,

Children under age 21 of the applicant/recipient,

Blind or disabled (according to SSI criteria) children of the applicant/recipient,

a sibling of the applicant/recipient who has equity interest in the home and who was residing in the home for at least one year prior to the individual's nursing facility admission, or

A child of the applicant/recipient who was living in the home at least two years prior to the individual's admission to the nursing facility and who provided care that was necessary to permit the individual to remain at home rather than be institutionalized. In these situations, documentation of the individual's condition and the extent of care provided by the child is required in the case record.

An individual who transfers his home to a person not specified above remains subject to a transfer of property penalty.

For transfers of income-producing real property on and after 7-1-03, the following rules apply:

(1) $6,000 of the equity value can be transferred without penalty if the property produces at least $360 a year in income. [63]The uncompensated value is the equity over $6,000. If the property does not produce at least $360 per year in income, the entire equity is the uncompensated value. The transfer of the income must be evaluated based on the fair market value of the income in accordance with Section 2640.10.25.20.

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[63] Section 1917 (c)(5)

If the real property has equity of less than $6,000, the property can be transferred without penalty if it produces income that is at least 6% of the equity value. If it produces income that is less than 6% of the equity, the entire equity is the uncompensated value. Refer to Section 2640.10.25.20 regarding transfer of the income.

The $6,000 transfer exemption is a single, one-time exemption that applies to the total value of all income-producing real property transferred by the individual during the individual's lifetime.

(2) Income producing real property that is used in a trade or business can be transferred without application of the $6,000/6% limitation. In order to qualify as a trade or business, the property must be actively managed or operated by the applicant/recipient.

(3) Income-producing real property for which the individual owns a government permit or license, or other governmental authority to engage in income-producing activity is not subject to the $6,000/6% limitation. Examples of this are commercial fishing permits and tobacco crop allotments issued by the USDA. (This does not include crop subsidies and soil banks.) Both of these circumstances are very uncommon in Indiana, therefore, if DFR is processing a case in which the individual claims to own such property, the Policy Answer Line must be contacted. When contacting PAL, be sure to explain what type of license or permit the individual submitted as verification.

EXAMPLE 1

Medicaid applicant in nursing facility owned rental property with an equity value of $50,000. She received $2,400 per year in rent. The month before applying for Medicaid, she gave it away to a relative with no consideration received and did not show

EXAMPLE 2

Medicaid applicant in nursing home owned farmland with an equity value of $100,000 which she cash rented to her son who paid all of the expenses and gave her $100 a year income. The uncompensated value is $100,000 (plus the amount of income that was also transferred) because the property did not produce at least $360 annual income for her.

EXAMPLE 3

Medicaid recipient in a nursing facility owns a 25% share as tenancy in common, in rental property valued at $200,000. Her share is $50,000 and she receives FMV rent of $2,100 per year. She gave her share of the property away to her son and received no consideration. The uncompensated value is $44,000 plus the amount of the income that was transferred.

2640.10.15.06 Home Equity Restriction

A penalty consisting of ineligibility for LTC services is invoked due to the *ownership* of the home if the applicant's equity interest or his share of equity interest, in his or her home is greater than the home equity limit:

11-01-09 $500,000
01-01-11 $506,000
01-01-12 $525,000
01-01-13 $536,000
01-01-14 $543,000

The penalty starts on the date that the applicant is otherwise eligible for Medicaid and would be receiving LTC services under Medicaid were it not for the equity restriction provision, but not before 11-01-09. The penalty continues as long as the equity value remains over the home equity limit.

The home is the applicant's principal place of residence prior to requiring LTC services. A hospitalization, visit with friends or family, or other absence from the home does not change the home designation for the purpose of this provision. Income-producing home property is subject to the equity restriction.

This restriction does not apply if the individual's spouse, dependent child under the age of twenty-one (21), or blind or disabled (per SSI standards) child of any age, is lawfully residing in the home. Additionally, the amount of equity that would fall under the asset protection of a long term care partnership policy reduces the amount of the equity in excess of the limitation.

The equity value of a home is the current fair market value (FMV) minus any encumbrance against the property. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan, or other debt secured by the home. The current property tax assessment must be obtained as verification of the FMV. Any such assessment other than the most

current one is unacceptable. If the individual disputes the property tax assessment, a current arm's length, independent professional appraisal can be submitted and will be used in lieu of the assessment. Arm's length means that there can be no special relationship, directly or indirectly, between the appraiser and the applicant/recipient so that the interests of both are independent of each other.

If there is an encumbrance against the property such as a mortgage, home equity loan, reverses mortgage, etc., the date that the encumbrance was established must be verified for the purposes of eligibility and whether or not an improper transfer occurred. If, for example, a home equity loan was taken out within the review period, the loan transaction in and of itself may not be a violative transfer. However any subsequent transaction involving the proceeds from the loan must be evaluated for determination of whether an improper transfer occurred.

The equity restriction works in conjunction with the existing eligibility provisions regarding the treatment of real property, not in lieu of them. Even if all other eligibility provisions are met, the home equity restriction may still be a factor in whether or not LTC services will be paid for on the individual's behalf.

Example:
Single individual entered a nursing facility on 10-15-13 and listed her home for sale with a realtor. She applies for Medicaid on 11-11-13. Her home is valued at $800,000. For resource eligibility purposes, the value of the home which is up for sale at fair market value is exempt. However she is subject to the home equity restriction penalty beginning the first of the month in which she is otherwise eligible for LTC services under Medicaid. Her first retro month is 07-13. She meets all other eligibility requirements and her application is approved with Medicaid effective 07-01-13. Her LTC penalty starts 10-01-13, the month in which she was otherwise eligible for LTC.

This provision applies to individuals who apply for Medicaid on and after November 1, 2009, and for these individuals, any subsequent redeterminations that occur as the result of seeking LTC services as well as the annual scheduled redeterminations.

Example:
Single individual entered a nursing facility on 10-15-13 and listed her home for sale with a realtor. She applies for Medicaid on 11-11-13. Her home is valued at $800,000. For resource eligibility purposes, the value of the home which is

up for sale at fair market value is exempt. However she is subject to the home equity restriction penalty beginning the first of the month in which she is otherwise eligible for LTC services under Medicaid. Her first retro month is 07-13. She meets all other eligibility requirements and her application is approved with Medicaid effective 07-01-13. Her LTC penalty starts 10-01-13, the month in which she was otherwise eligible for LTC.

This provision applies to individuals who apply for Medicaid on and after November 1, 2009, and for these individuals, any subsequent redeterminations that occur as the result of seeking LTC services as well as the annual scheduled redeterminations.

2640.10.15.10 DE MINIMIS TRANSFER Of PROPERTY ALLOWANCE

Beginning with applications filed on 10-1-09, an annual transfer amount is allowed that will not invoke a transfer penalty and will be excluded from the total uncompensated value of an improper transfer under the circumstances explained below. This is referred to as the de minimis transfer allowance and the amount is $1200 per year.[64]

The de minimis transfer allowance is applicable if the gift is made by the applicant, during the review period directly to:

A family member who is related to the applicant by blood, adoption, or existing marriage, or

A nonprofit organization qualified under Section 501(c) of the Internal Revenue Code as amended, which gives the organization tax-exempt status, and

The application for Medicaid long term care services (Medicaid facility or HCBS waiver services) is filed on or after 10-01-09.

The de minimis allowance is subtracted after any and all transfers have been evaluated in terms of being permissible or improper. Up to $1200 per year is deducted from the uncompensated value of transfers that are otherwise improper.

Example 1
Applicant in nursing facility applies for Medicaid on 10-15-09 and reports the following transfers: $10,000 to an irrevocable funeral trust, $1200 to his son. The purchase of the funeral

[64] IC 12-15-2-23 as added by P.L.14-2009

trust was permissible without penalty and the gift to the son was determined to be for the purpose of becoming eligible for Medicaid without adequate consideration. The gift to the son does not invoke a transfer penalty because it did not exceed the de minimis allowance and was made to a family member. No penalty is imposed.

The de minimis allowance is an annual total for all otherwise improper transfers, regardless of how many individuals received gifts from the applicant.

Example 2
$800 is given to applicant's grandson, and $900 is given to a non-profit charity during one year. The 2 gifts are combined for a total of $1700. The $1200 is subtracted from the total gifted amount, resulting in an improper transfer amount of $500.

The de minimis transfer allowance does not apply to transfers made by the applicant's spouse.

Example 3
Applicant gives $400 to his son. His spouse gives $600 to her sister. The de minimis transfer allowance is $400, because the de minimis allowance does not apply to the transfer made by the applicant's spouse.

The year of calculation for de minimis gifting is based upon the established baseline date and each calendar year of the review period. Any excess over $1200 in a calendar year does not carry over to a subsequent year. The de minimis allowance can be applied to more than one qualifying individual or non-profit organization in a given year. However, not more than $1200 in any one calendar year is allowed.

To allow a de minimis transfer allowance, the applicant is required to establish the relationship of the individual being claimed as a family member and the tax exempt status of any organization to which a gift was made. Required Documentation in the Case File:

- The name, date of birth, and relationship lineage of a family member must be provided by the applicant. Signed statements from the applicant and family member(s) will suffice unless contradicting information is known to the worker, in which case clarifying information must be

provided. For example, documentation of a gift to a grandson would include a statement that the grandson is the son of the applicant's daughter, giving his birth date, and his and his mother's names.

- Collateral documentation of the 501(c) tax exempt status of an organization must be provided by the applicant. It is customary practice for these organizations to give receipts for gifts so that donors will have documentation for their own tax purposes. This type of receipt is sufficient documentation. Information about the organization should reveal its status as well, if the receipt is not available, such as brochures, websites, etc. In addition, proof of payment to the organization whose status is being documented must be provided. For example, if a gift is reported to Charity #1 and a cancelled check to Organization #2 is provided, the de minimis allowance cannot be applied until the discrepancy is reconciled.

Documentation of the proof necessary to apply a de minimis transfer allowance is the responsibility of the applicant/recipient. It is the agency's responsibility to explain what type of documentation is required and follow existing procedures for obtaining documentation.

2640.10.16 Transfers Of Personal Effects And Household Goods

The following items can be transferred without receipt of adequate consideration and without imposition of a transfer penalty:

One wedding ring of the applicant/recipient and spouse,

One engagement ring of the applicant/recipient and spouse,

Medical equipment required due to the applicant's/recipient/s physical condition, which are not used extensively or primarily by others,

$2000 of equity in other personal effects and household goods.

If personal effects and household goods not exempted above are given away without receipt of adequate consideration, a violative transfer has occurred.[65]

Wedding rings and engagement rings are those purchased by one spouse for the other spouse (or intended spouse in the case of engagement ring). If a ring is purchased by someone after marriage and labeled an engagement or wedding ring upon giving

[65] Social Security Act, Section 1917(e)(5)

it away, a violative transfer has occurred. The uncompensated value is the equity value in excess of $2000.

2640.10.20 Determining Adequacy Of Consideration

If a transfer cannot be determined automatically non-violative in accordance with the preceding sections, the DFR must proceed to determine whether or not adequate consideration was received.

Consideration is whatever compensation the individual received in return for the transferred property. In order to determine a transfer as non-violative, the individual must have received adequate consideration. Consideration is adequate when the fair market value minus loans, mortgages or other encumbrances, of the transferred property is equal to the consideration received. Fair market value is the current market value of the property at the time of the transfer.

The applicant/recipient is required to supply any necessary records, documentation and information which verify the fair market value and consideration received.

The value of the consideration received is based on the agreement and expectation of the parties <u>at the time of the transfer</u>. The value of consideration is the gross amount paid by the purchaser, and it may be paid in one or more forms such as those discussed in the following sections. (Other forms of consideration may also be possible.) The compensation received for an asset must be in a tangible form with intrinsic value. For example, love and affection does not constitute adequate consideration because there is no dollar value attributable to love and affection.

2640.10.20.05 Compensation In Cash

Compensation in the form of cash is the total amount of cash paid or agreed to be paid in exchange for the property.

2640.10.20.10 Compensation In Real or Personal Property

Compensation in the form of real or personal property is valued according to the fair market value of that property at the time of the property transfer.

2640.10.20.15 Compensation By Support/Maintenance

The value of compensation in the form of support and/or maintenance provided, or agreed to be provided, is based on the fair market value and duration of the support and/or maintenance.

EXAMPLE: Mrs. Pierce has transferred a sum of money to a retirement community with the expectation that they will provide her with support and maintenance for a period of time.

2640.10.20.20 Compensation By Services

The value of services provided, or agreed to be provided, in exchange for the property is based on the market value of such services and the frequency and duration of the services. In order for services to have adequate consideration, there must have been agreement at the time the services were provided that compensation was to be paid in return for the services.

2640.10.25 Determining Uncompensated Value

If inadequate consideration was received, the DFR must determine the uncompensated value. The uncompensated value is the difference between the fair market value, minus loans, mortgages, or other encumbrances, and the consideration received by the individual. When the transferred property was jointly owned, the uncompensated value is the difference between the individual's share of the fair market value and the consideration received by the individual.

2640.10.25.05 Transfers Involving Life Estates

When an individual who owns real property transfers ownership of the property to another person and retains a life estate, the uncompensated value must be determined. The uncompensated value is the fair market value of the property, less the amount of loans, mortgages, or other encumbrance, minus the value of the life estate and minus any other consideration received. The value of the life estate is determined in accordance with Section 2605.25.10.05.

EXAMPLE The applicant, age 66, owned a home valued at $235,000. She transferred the title to her daughter for $20,000 and retained a life estate. Using the Table in Section 2605.25.10.10, the life estate value is $156,394.85 ($235,000 x .66551). The total compensation received is $176,394.85 ($156,394.85 + $20,000). The uncompensated value is $58,605.15.

When an individual purchases a life estate interest in real property in the home of another person, a transfer penalty is imposed, using the full amount of the purchase price, when an

individual purchases a life estate interest in another individual’s home and does not reside in that home for at least one full year after the date of the purchase. The year of residence in the home begins with the month after the documented purchase and continues for 12 consecutive months. This 12-month period is not a waiting period. The individual must establish and provide documentation of residence in the property and live there for the one year period. Otherwise, a transfer penalty will be imposed. The penalty cannot be prorated or shortened in any fashion based on fewer months of residence. The start date of the penalty and length of the penalty period is determined the same as described previously for post-11/1/09 transfers.

In addition under resource eligibility policy, if the purchased life estate is not producing income and is no longer the person’s home, then the life estate interest will have to be offered for sale or rent at FMV as a condition of Medicaid eligibility. Any transfer or otherwise disposal of the life estate must be evaluated as a transfer of property. This provision applies to individuals who purchase a life estate in another individual’s home on and after November 1, 2009.

2640.10.25.10 Transfers Involving Annuities

An annuity is an investment product, policy, certificate, contract, or other arrangement between two or more parties. One party pays a sum of money or other valuable consideration to the other party in return for the right to receive future payments. The term “annuity” includes any financial instrument that claims to be an annuity, as well as any instrument that meets the definition of an annuity. Annuities are generally purchased by individuals from financial institutions, insurance companies, or non-profit organizations. However, “private annuities" exist that are arrangements between non-commercial, non-organizational entities such as family members, friends, or other individuals.

Different companies may use slightly varied terminology for their products. However, there are basic and common definitions that apply to annuities in general:

A. A deferred annuity allows interest to accumulate until the purchaser elects monthly payments to begin. Income payments often start many years after purchase.

B. With an immediate annuity, payments start no later than one year after the premium is paid.

C. The annuitant is the person on whose life expectancy the annuity payments will be calculated.

D. Annuitize is when the accumulated value of the annuity is converted into a guaranteed stream of income. At this point, the annuitant decides how the payments will be received. He could choose monthly fixed or variable payments, or a balloon payment at the end of the term, for example.

The purchase of an annuity is a transfer of property and, therefore, it is necessary to determine whether or not adequate consideration was (will be) received.

For annuities purchased on or after June 1, 2002; or annuitized on or after June 1, 2002, regardless of the purchase date, adequate consideration (will be) received if all of the following criteria are met:

A. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business, or from a tax-exempt non-profit organization,

B. The annuity provides monthly payments of interest and principal so that, for a specific year, the total payments for the year do not differ by more than five percent from the total paid in the previous year, and

C. The annuity must return the full purchase price to the purchaser or the purchaser’s spouse within the annuitant’s life expectancy using the Life Expectancy Tables that appear later in this section. If the individual does not (will not) receive compensation in the amount of the full purchase price within his lifetime (or within the contract’s specified time period if shorter than the life expectancy), the uncompensated amount is the difference between the purchase price and the amount that the annuity will pay out to the individual within the individual’s life expectancy, or term of the contract if shorter than life expectancy.

If an annuity is not purchased from a company that regularly sells such financial products or not purchased from a non-profit organization, the uncompensated amount is the entire purchase price. An example is the purchase of a private annuity from a family member. The purchase of a private annuity is a violative transfer of property.

If the annuity pays (will pay) a lump sum balloon payment or if the total annual payments vary by more than five percent, then

the uncompensated amount is the entire amount of the purchase price.

If an annuity does not meet any of the criteria that render it automatically a violative transfer of property, then a determination of whether adequate consideration will be received must be made by the DFR. The value of the expected income is determined by multiplying the monthly income by the individual's life expectancy (or term of the annuity, if shorter). Convert years to months using the figure for the person's age at the time of purchase. The uncompensated value is the difference between the purchase price of the annuity and the amount of income expected to be received by the purchaser or his spouse, during the lifetime of the annuitant, or term of the annuity if shorter.

EXAMPLE 1 Female applicant, age 85, purchases a $50,000 immediate annuity from a life insurance company. She elects to receive income payments of $375 per month. Per the Life Expectancy Table for females, her life expectancy is 6.63 years or 79.56 months. $375 x 79.56 = $29,835. The applicant is not expected to receive in payments what she transferred in principal. The uncompensated value is $20,165. ($50,000 - $29,835).

EXAMPLE 2 Male applicant, age 60, purchases a $100,000 annuity on June 1, 2002 from an insurance company and will receive equal income payments of $500 per month. Per the Life Expectancy Table for males, his life expectancy is 18.42 years or 221.04 months. $500 x 221.04 = $110,520. The applicant is expected to receive income greater than the purchase price. Adequate consideration will be received.
EXAMPLE 3 Male applicant, age 90, purchases a $20,000 annuity from an insurance company on July 1, 2002 and will receive 45 payments of $250 per month. Since the annuity was purchased after June 1, 2002 and the individual will receive a balloon payment, the uncompensated amount is $20,000 – the full purchase price of the annuity.

For annuities that have been annuitized prior to June 1, 2002, adequate consideration was (will be) received if the annuity will return to the individual the full purchase price within the individual’s life expectancy (or within the contract’s specified time period if shorter than the life expectancy). These annuities do not have to be purchased from a commercial company or a non-profit organization. The total annual payments do not

have to be equal and lump sum or deferred payments toward the end of the individual's life expectancy may be made. The uncompensated amount is the difference between the purchase price and the amount that the annuity will return within the annuitant's life expectancy.

For annuities purchased, annuitized, or where certain specified changes were made on or after November 1, 2009, the following provisions apply:

The new provisions require disclosure of annuities, specify the circumstances in which a purchase or transaction involving an annuity will be treated as an improper transfer, and require the State to be beneficiary. The new provisions apply to purchases and certain transactions as described below occurring on and after November 1, 2009.

Transactions that are subject to the new provisions include any action taken by the individual that changes the course of payment to be made by the annuity, or the treatment of the income or principal of the annuity, including such actions taken on annuities purchased before November 1, 2009. These actions include:

- additions of principal
- elective withdrawals
- requests to change the distribution of the annuity
- elections to annuitize the contract
- a change in ownership, or
- any other non-routine action not listed below.

The following types of changes and events would not subject an annuity purchased prior to November 1, 2009 to treatment under the new rules:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances,
- Changes that occur based on terms of the annuity which existed prior to November 1, 2009 and which do not require a decision, election or action to take effect, or
- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic condition.

Any interest in an annuity must be reported. The requirement to disclose all resources when applying for Medicaid has always been

in effect for LTC applicants/recipients. These new provisions specifically require disclosure of any interest that the LTC applicant/recipient and or spouse have in annuities. The failure to disclose and provide all necessary documentation will result in denial or closure due to failure to cooperate. At minimum, the applicant/recipient must provide a copy of the complete annuity contract and documentation of transactions that occur after the purchase. The application and redetermination forms have been revised to allow for annuity disclosure as required by federal law.

The State must be beneficiary. Annuities purchased and transactions made on annuities owned by the applicant/recipient and spouse must name the State as a remainder beneficiary in accordance with the rules that follow below. If these rules regarding the beneficiary assignment in the correct position are not met, the full purchase price of the annuity is considered an improper transfer and a penalty must be imposed.

1. An annuity must name the State as the remainder beneficiary in the first position unless there is a community spouse and/or a minor or disabled child. A disabled child is one who meets the SSI or SSDI disability criteria.

2. If there is a community spouse and/or minor or disabled child, the State must be named as the remainder beneficiary in the second position after the community spouse or minor or disabled child.

3. If the State has been named as a remainder beneficiary after a community spouse and/or a minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the State must then be named beneficiary in the first position.

4. The requirement is waived if the individual has purchased a long-term care insurance policy that protects the annuity as approved by the Indiana Long-Term Care Partnership (ILTCP).

As remainder beneficiary, the State is entitled to receive the total amount of medical assistance paid on behalf of the applicant for medical assistance.

Additional Criteria Applicable ONLY to the person in LTC The rules explained below do not apply to annuities owned by or transactions made by community spouses. There are 2 separate sets of criteria that, if met by the terms of the annuity, will not result in a transfer penalty. The first set will be referred to as “soundness” criteria. The second set will be referred to as

“class exceptions”. The annuity does not have to meet both sets of criteria – it has to meet the criteria from either set.

The purchase of an annuity or transactions completed will not result in a transfer of property penalty if the following conditions, referred to as soundness criteria, are met:

1. The annuity is irrevocable and non-assignable in that it cannot be cashed in nor ownership transferred to another individual or entity, *and*

2. The annuity is actuarially sound in that it is expected to return full principal and interest within the institutionalized individual’s life expectancy, *and*

3. The annuity provides payments in approximately equal amounts with no deferred or balloon payments. To determine actuarial soundness for promissory notes, loans and annuities use the Life Expectancy Table at the end of this document.

If the individual does not (will not) receive compensation in the amount of the full purchase price within his lifetime (or within the contract’s specified time period if shorter than the life expectancy), the uncompensated amount is the difference between the purchase price and the amount that the annuity will pay out to the individual within the individual’s life expectancy, or term of the contract if shorter than life expectancy.

Ownership of an annuity in one of the following classes of retirement annuities will not result in a transfer of property penalty:

1. An individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or

2. A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408(q) of the IRC), or

3. The annuity is purchased with proceeds from a traditional IRA (IRC Sec. 408a), or

4. The annuity is purchased with proceeds from certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c)), or

5. The annuity is purchased with proceeds from a simplified retirement account (IRC Sec. 408 §(p)),

6. The annuity is purchased with proceeds from simplified employee pension (IRC Sec 408 §(k))

7. The annuity is purchased with proceeds from a Roth IRA (IRC Sec. 408A).

To determine that an annuity is established under any of the various provisions of the Internal Revenue Code that are referenced above, rely on verification from the financial institution, the employer or the employer association that issued the annuity. The burden of proof is on the applicant or recipient (or his/her authorized representative) to produce this documentation.

The life expectancy tables for males and females are listed below and are effective January 1, 2016. The life expectancy is provided in years.

LIFE EXPECTANCY TABLES

TABLE 1 - MALE		TABLE 2 - FEMALE
Average Number of Years		Average Number of Years
Age of Life Remaining		Age of Life Remaining
55	25.41	28.74
56	24.61	27.88
57	23.82	27.01
58	23.03	26.16
59	22.25	25.31
60	21.48	24.46
61	20.72	23.62
62	19.97	22.78
63	19.22	21.95
64	18.48	21.13
65	17.75	20.32
66	17.03	19.52
67	16.32	18.73
68	15.61	17.95
69	14.92	17.18
70	14.24	16.43
71	13.57	15.68
72	12.92	14.95
73	12.27	14.23
74	11.65	13.53
75	11.03	12.83

76	10.43	12.16
77	9.85	11.50
78	9.28	10.86
79	8.73	10.24
80	8.20	9.64
81	7.68	9.05
82	7.19	8.48
83	6.72	7.94
84	6.27	7.42
85	5.84	6.92
86	5.43	6.44
87	5.04	5.99
88	4.68	5.57
89	4.34	5.17
90	4.03	4.80
91	3.74	4.45
92	3.47	4.13
93	3.23	3.84
94	3.01	3.57
95	2.82	3.34
96	2.64	3.12
97	2.49	2.93
98	2.36	2.76
99	2.24	2.60
100	2.12	2.45
101	2.01	2.30
102	1.90	2.17
103	1.80	2.03
104	1.70	1.91
105	1.60	1.78
106	1.51	1.67
107	1.42	1.56
108	1.34	1.45
109	1.26	1.35
110	1.18	1.26
111	1.11	1.17
112	1.04	1.08

113	0.97	1.00
114	0.90	0.92
115	0.84	0.85
116	0.78	0.78
117	0.72	0.72
118	0.67	0.67
119	0.61	0.61

2640.10.25.20 Establishing Joint Ownership (MED)

When property is converted from individual ownership to joint ownership on or after July 1, 1996, a transfer of property has occurred. The amount considered to be transferred is the proportionate value of the new owner(s) share of the property.

When evaluating this kind of a transfer workers should keep in mind that the joint interests might not all be equal. The deed or contract should specify the proportionate interests of each owner, but if it is not clear or the worker has questions, an FSSA attorney should be consulted for assistance.

EXAMPLE 1
Property value = $60,000. One equal joint owner is added. $30,000 was transferred.

EXAMPLE 2
Property value = $80,000. Two joint owners are added and all 3 have equal interests. $53,333.34 was transferred. (The 2 new owners' value of the property.)

If property is jointly owned and additional new owners are added, the amount transferred is the difference between individual's interest before the transfer and after the transfer.

EXAMPLE 3
Property valued at $90,000 is jointly owned by the applicant and his son. His interest is $45,000. He adds his daughter as another joint owner, and all 3 have equal shares. His interest is now $30,000, so the amount transferred is $15,000. ($45,000 - $30,000).

If the property which has been converted to joint ownership has a lien or mortgage, the amount transferred is the proportionate equity value.

EXAMPLE 4
Applicant owns real property valued at $150,000 and has a $70,000 mortgage. She adds her son as an equal joint owner. The amount transferred is $40,000. ($150,000 - $70,000 = $80,000 equity value. $80,000 - $40,000, new owner's share of the equity, = $40,000).

2640.10.25.25 Transfers Of Income

This section applies to transfers of income that occur on and after June 1, 2002.[66]

When an individual transfers a stream of income or the right to receive income, the uncompensated value is the difference between the actual amount of income received, and the fair market value (FMV) of income that should be received. The FMV of the income that should be received is determined by multiplying the FMV by the life expectancy of the individual based on the Tables in Section 2640.10.25.10. Any income that the property was producing, or was capable of producing, is included in the definition of assets for purposes of the transfer law. The resource that was transferred may have been exempt or non-exempt.

In the situation of a transfer of income-producing, non-home real property, the value of the property in excess of $6,000 is considered an uncompensated transfer. See Section 2640.10.15.05 for instructions on calculating the uncompensated value of income-producing real property. In addition, the value of the income that the property was producing or was capable of producing is a transfer. The uncompensated value is the fair market value of the income that the property could reasonably be expected to produce multiplied by the person’s life expectancy at the time of the transfer.

If an individual rents real property for less than FMV, the uncompensated amount is the difference between the FMV of the rent and the amount of rent being received, based on the person’s life expectancy.

[66] 405 IAC 2-3-1.1

EXAMPLE 1
A 75 year old recipient in a nursing home owns rental property with an equity value of $50,000, and is receiving $500 a month in rent. This rental amount is consistent with other similar properties in the neighborhood, and is therefore considered the fair market value. After subtracting allowable rental expenses, he has $400 rental income in his Medicaid budget. His legal guardian transfers full title to the property to himself. The uncompensated value of the transfer of the income is $400 x 110.88 months (9.24 years obtained from the life expectancy tables, $44,352. This is added to the uncompensated value of the property in excess of $6,000 for a total uncompensated value of $88,352. ($44,000 real property plus $44,352 income.)

EXAMPLE 2
A 70 year old Medicaid recipient moves into a nursing home and signs the agreement to put her home up for sale or rent at fair market value. She hires a realtor who assesses the value at $95,000 with a rental value of $800 per month. Two months later, she rents the property to her son for $10 dollars a month. He will pay the allowable expenses which amount to $150 per month. The uncompensated value is $640 ($800 - $150 - $10) x 184.20 months (15.35 years), $117,888.

2640.10.25.30 Loans, Promissory Notes As Transfers of Assets

This provision applies to loans established on and after November 1, 2009. It applies to individuals who loan money directly to another as well as those who may purchase a loan or promissory note that was originally entered into between 2 other persons. The likelihood of the latter may be small, however given the concern that many private loans are merely gifts appearing to be loans, it is important to understand the possible transactions that may occur by someone trying to shelter assets to become eligible for Medicaid.

Whenever an individual has a promissory note, loan agreement, or mortgage as presumed evidence that a transfer of money was not a gift but was made with the expectation of full repayment, the arrangement will be considered an improper transfer unless all of the following criteria are met:

a) The repayment term is actuarially sound in accordance with the Life Expectancy Table included at the end section 2640.10.25.10,

b) The agreement provides for payments to be made in equal amounts during the term of the loan, with no deferral of payments and no balloon payments, and

c) The promissory note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan or mortgage, that does not satisfy the requirements above and is established on or after 11-1-09, the value of such contract considered as an improper transfer will be the outstanding balance due as of the date of the individual's application for Medicaid or date of LTC admission, whichever is later. In the case of HCBS, the balance to be used is the amount as of the date of the Cost Comparison Budget approval.

When determining if the loan is actuarially sound, refer to the person's age on the Life Expectancy Table as of the date the loan is established. If the loan cannot be repaid within the person's life expectancy, it is not actuarially sound, and is therefore an improper transfer.

The interest amount of the loan payments are countable income.

2640.10.25.35 Treatment of Continuing Care Retirement Community Entrance Fees

A Continuing Care Retirement Community (CCRC) or similar life care community typically provides a variety of living arrangements, from independent living through skilled nursing care. In many cases, potential residents must provide extensive information about their finances, including their assets and income, before being accepted for admission. In addition, they frequently must pay substantial entrance fees and sign detailed contracts before moving to the community.

Effective with contracts entered into on and after November 1, 2009, entrance fees paid by an individual to a CCRC or similar life care community are counted as an available non-exempt resource of the individual for Medicaid eligibility determinations when all of the following 3 conditions apply:

1. The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, even in part, to pay for care if the person's other resources or income are insufficient to pay for their care. It is not necessary for the CCRC to provide a full, lump sum refund of the entrance fee to the resident. If even a portion of the fee can be refunded or applied to pay for care as required, this condition would be met.

2. The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the contract and leaves the community.

In order to meet this second condition, it is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This second condition is met as long as the resident could receive a refund were the contract to be terminated or if the resident dies.

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

Ownership interest generally means the right to possess and convey property. Therefore, the resident will be required to verify whether or not they have an ownership interest in a CCRC or life care community by presenting documentation from the facility to that effect. If the CCRC or life care community confirms that the entrance fee does not confer an ownership interest to the resident, then the third condition described above is met.

For Medicaid eligibility determinations, all spousal impoverishment protection rules regarding income and asset allocations for a community spouse are applicable when one spouse resides in the skilled nursing care section of the facility, and the other spouse (the community spouse) resides in an independent living setting. CCRC and similar life care community contracts are required by federal law to account for spousal impoverishment income and asset allocations to a community spouse before determining the amount of resources that a resident must spend on his or her own care.

2640.10.25.40 Transfers Involving Funeral Trusts for Immediate Family Members

Pursuant to FSSA v. Culley, irrevocable funeral trusts purchased with assets owned by applicants or recipients that name an immediate family member as the beneficiary of the funeral trust are not considered improper transfers that invoke a penalty period. Immediate family members of applicants and recipients include spouses, children, stepchildren, and spouses of children or stepchildren.

2640.10.30 Presumption of Intent In Transferring Property

Once the uncompensated value for a transfer of property has been established, this figure will be used to determine a penalty period unless a satisfactory showing is made to the DFR that the property was transferred exclusively for a purpose other than to

qualify for Medicaid, or that the individual intended to transfer the property at fair market value. DFR will presume Medicaid eligibility to be the motive and must give the individual the opportunity to rebut this presumption.

If the individual wishes to rebut this presumption, he is responsible for presenting convincing evidence to the DFR in support of his contention that the property was transferred exclusively for some other purpose or that he intended to transfer the property at fair market value.

If the individual chooses to rebut the presumption, he must provide a statement concerning the circumstances of the transfer. The statement should cover, but need not be limited to the:

- Purpose for transferring the property,
- Attempts to dispose of the property at fair market value,
- Reason for accepting less than fair market value for the property,
- Means of or plans for supporting himself after the transfer, and
- Relationship (for example: familial or business) to the person to whom the property was transferred.

In addition, the individual must submit any and all pertinent documentary evidence such as legal documents, realtor listing agreements, relevant correspondence, and so forth, to the DFR. An allegation by the individual that the property transfer was done to avoid Medicaid estate recovery will not be accepted as a satisfactory showing that the property was transferred exclusively for a purpose other than to become eligible for Medicaid. Clearly, an individual who makes this claim has the intention of becoming eligible for Medicaid, or estate recovery would not even be an issue. Furthermore, a simple statement made by or on behalf of a recipient who has transferred property, that the transfer did not affect eligibility and is therefore allowable, does not constitute a satisfactory showing. The individual may be trying to protect all future eligibility. Again the avoidance of estate recovery may be the intent and will not suffice.

If the DFR finds the individual has made a satisfactory showing that the resource was not transferred to attain Medicaid eligibility, or that he intended to transfer it for fair market value, a penalty period will not be established.

2640.10.35 Determining the Transfer Penalty Period Begin Date

An unsuccessful rebuttal of the presumption of intent combined with a determination of inadequate consideration will result in the DFR invoking a penalty period. During a transfer of property penalty period, the recipient is ineligible for nursing facility services and home and community-based services.

For transfers on and after 8-11-93 but prior to July 1, 2003, the penalty period will begin with the month of the transfer (if that month is not a part of another penalty period) and continues for the full number of penalty months determined by dividing the uncompensated value by the nursing facility private pay rate in effect as of the application month. (Refer to Section 3006.00.00 for the private pay rate). The process of rounding down the number of penalty months is no longer valid policy and the procedure is now prohibited.

The penalty start date for transfers of property occurring on and after 11/01/2009, the penalty period will begin on the **later** of:

- The date on which the individual would be otherwise eligible for Long Term Care Services under Medicaid based on an approved application were it not for the imposition of the penalty period, OR
- The first day of a month during which assets have been transferred for less than fair market value (FMV), AND
- The penalty does not occur during any other transfer of property penalty.

Please, note that advance notice of an adverse action is applicable for individuals who have been determined eligible for Medicaid. IHCPPM 2232.00.00. Therefore, if the calculation of the penalty period based on the criteria previous stated in this section would have any portion of the penalty period cover month(s) where the individual was previously determined eligible for and received Medicaid long-term care services, a claim for benefit recovery must be initiated to recover the portion of the nursing home per diem paid for by Medicaid during the calculated penalty period the individual incorrectly received. Please, refer to IHCPPM Chapter 4600 for Benefit Recovery. The notice of the benefit recovery action serves as the notice for advanced notice of adverse action in this instance.

If the individual residing in a long-term care facility is a new applicant whose eligibility requires a transfer penalty period, the begin date will most often be the first month the person is otherwise eligible.

Example:
Individual entered LTC facility on 10/15/2009.

12/05/2009 Gifted Money
05/10/2010 Apply for Medicaid

The months covered by the application are February, March April and continuing. During the eligibility process it is determined that the gifting was an improper transfer, and that the applicant had excess resources for the months of February and March.

Therefore, Medicaid is effective 04/01/2010 and a transfer penalty is imposed starting the same date, 04/01/2010. Assume the penalty period is 5 full months. The penalty begins on 04/01/2010 and ends on 08/31/2010.

Under the old rules, the transfer penalty would have begun on 01/01/2010, the month after the month of transfer and ended on 05/31/2010.

2640.10.35.05 Calculation of the Penalty Period

All improper transfers occurring on and after 11-01-09 are accumulated into one total amount to determine the penalty period. The facility rate as of the date of application, not the date of transfer, is used in the calculation. Refer to IPPM 3006.00. The uncompensated value determination must take into consideration the de minimis transfer allowance as explained in IPPM 2640.10.15.10. Transfer penalties using the specific method explained below may end on any date in a month not just the last day of a month.

Two standard values are used in the penalty period calculation:

- Monthly Standard of days in a month - 30.42 days. (365 days divided by 12).
- Average Monthly Facility Private Rate - Refer to IPPM 3006.00 for the applicable rate to use based on the date of an application.

Once the final uncompensated value (UV) of all improper transfers made on and after 11-01-09 has been determined, the steps below are to be followed to determine the length of the penalty period:

1) Divide the UV by the current Facility Private Rate. Round up at 2 decimal places. (For example, 2.26216807 are 2.27 months.) This result is the length of the penalty period.

2) If the above division happens to result in whole months, the calculation of the penalty is complete.

3) If the length of the penalty period as calculated above includes a fractional month, the next step is to convert the fractional month into days. Multiply the partial month by 30.42 and round up to determine the number of days in last month of the penalty period.

Example:
UV = 10,129.24 Private Rate = $4,611

$10,129.24 divided by $4611 = 2.1967555 2.20 months

Partial month .20 x 30.42 Standard of days = 6.084 7 days
Penalty period is 2 months, 7 days.

2640.10.35.10 Multiple Transfers of Property

For transfers occurring on or after November 1, 2009: If multiple transfers occurred during a person's look-back review period that require a transfer of property penalty period, there is to be one overall penalty period that is a cumulative total of all the improper transfers.

Example:
Individual admitted to Long Term Care facility on 10/08/09 with application filed 11/20/2010.

Facility Private Rate is $4,826. Refer to IHCPPM 3006.00.00.

First month of eligibility is 10/2010. (Applicant ineligible for August and September due to excess resources)
Transfers:

11/03/2009: $10,000 cash gift to sister
11/09/2010: $800 cash gift to son
11/14/2010: $20,000 cash to best friend

Evaluation:
All transfers are determined to be improper and subject to penalty. Because the application was filed after 10/01/2009, the $1200 de minimis transfer allowance rule applies to each year of transfers. The $10,000 transfer is reduced to $8,800 because the gift was to a family member. $8,800 divided by $4826 = 1.823 = 1.83 months. Convert. The partial .23 months to days: 30.42 x .83 = 24.2486 days = 25 days. The penalty begins 11/01/2010 and ends 12/25/2010.

The uncompensated value of the transfer in 2010 = $20,800. Only the $800 gift to a family member is subject to the de minimis; the gift to the friend is not reduced. The uncompensated value subject to penalty is $20,000.

$20,000 divided by $4,826 = 4.1442 months = 4.15 months. Convert the .15 partial months to days: 30.42 x .15 = 4.563 days = 5 days. Penalty period is 4 months 5 days. Combined with the other penalty period, this penalty extends from 12/26/2010 and ends on 4/30/2011.

For transfers involving trusts occurring before November 1, 2009, but within the client's look-back review period, multiple transfers are handled differently. For multiple transfers involving trusts before November 1, 2009, that occur in the same month or in consecutive months, the total cumulative value of the transfers will be considered one transfer for purposes of calculating the penalty. The penalty period begins with the month following the first transfer.

Multiple transfers involving trusts before November 1, 2009, that are not made in consecutive months will result in separate penalty periods. Each penalty period will begin in the month following the month of transfer or, if that month is already part of a penalty period, in the month after the prior period ends. Penalty periods do not overlap.

2640.10.35.15 Transferred Property is Returned to the Original Owner

If the transferred property is returned in its entirety, no penalty can be established. If a penalty has already been established, and then the property is returned to the individual, this transaction nullifies the penalty. It has the effect of restoring ownership of the property to the individual back to the month of the transfer. It does not necessarily restore full Medicaid coverage to the individual. The worker must redetermine Medicaid for the months in question by considering the value of the property. When only a portion of the property or its equivalent value is returned, the penalty period is to be reduced proportionately.

2640.10.35.20 Budgeting Procedures During A Transfer Penalty Period

During the penalty period, "eligibility step" budgeting is to be used. Before June 1, 2014, refer to IHCPPM 3455.05.25. For

months, including June 2014 and thereafter, the “eligibility step” is the comparison of individual income to the Special Income Level (SIL). Refer to IHCPPM 3455.14.00. The post-eligibility step is never completed.

Once the penalty period has been served, the post-eligibility calculation to determine the liability amount is to be effective the month after the last month of the penalty period. Caseload controls must be in place to ensure that desk reviews are completed for appropriate action immediately after the penalty period expires.

2640.10.40 Transfer Penalty Hardship Exception

The hardship procedures explained in this section are used when a transfer penalty has been imposed on an individual for a transfer of property occurring on and after November 1, 2009, except when the penalty is due to an annuity purchase. There is no hardship exception for an annuity purchase.

POLICY

When a penalty is imposed, the eligibility system generated notice will explain that an appeal based on the merits of the penalty determination can be filed, *or* a hardship exception can be requested if the individual alleges and can document that such a hardship exists. Procedures for filing the Request for Hardship Exception-Transfer of Property directly to the FSSA Office of Medicaid Policy & Planning (OMPP) are explained in the notice. (The text of the hardship language on the eligibility notice is at the end of this section.) The request for an undue hardship exception will serve as admission by the individual that a transfer of assets for less than adequate consideration was made and that the agency’s penalty determination was correct.

The penalty will be removed or modified under a hardship exception if documentation substantiates that the recipient’s health is endangered as result of the penalty or that the recipient will be deprived of food, clothing, shelter, or other necessities of life.

PROCEDURE

A hardship exception request must be filed within 30 days of the notice imposing the transfer penalty. The following persons can apply for a hardship exception:

The recipient,
The recipient’s authorized representative, or
The nursing facility in which the recipient currently resides, if written consent from the recipient or the

recipient’s personal representative is given for the nursing facility to file the request.

The OMPP will make the decision to waive all or a portion of the transfer penalty based solely on the evidence submitted with the request. The Notice of Decision on Transfer of Property Hardship Exception Request will be issued by OMPP to the requestor within 45 days of receiving a request for an exception. A denial of a hardship exception is subject to administrative appeal. A copy of the Notice of Decision on Transfer of Property Hardship Exception Request will be sent to the Division of Family Resources.

An approval of a hardship exception must be acted upon by the Division within 10 days (normal change processing requirements) to remove or shorten the penalty as approved.

2800.00.00 INCOME

2800.05.00 Income

2800.10.00 Household Income (MED 3)

2805.00.00 EARNED AND UNEARNED INCOME

2805.10.00 AVAILABILITY OF INCOME

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2870.05.00 CONTRIBUTIONS (MED 1, 2, 4)

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2800.00.00 INCOME

This chapter discusses types of income for modified adjusted gross income ("MAGI") categories (MED 3) and non-MAGI categories (MED 1, 2, 4). Refer to Chapter 3200 to determine which assistance group (AG) members must have their income considered.

The specific income situations discussed in this chapter are:

Definition of Income (Section 2805);
Earned Income (Section 2810);
In-kind Income (Section 2815);
Vendor Payments (Section 2820);
Infrequent or Irregular Income (Section 2825);
Support, Child, Spousal (Section 2830);
Assistance from Government Programs (Section 2835);
Benefit Programs (Section 2840);
Benefits Due to Federal Law (Section 2845);
Dividends and Interest (Section 2850);
Reimbursements (Section 2855);
Student Loans, Grants, and Scholarships (Section 2860);
Loans (Section 2865);
Contributions (Section 2870);
Residential Living Allowances (Section 2835.50);
Real Estate Income (Section 2875);
Lump Sum Payments (Section 2880);
Deemed Income (Section 2885);
Verification of Income (Section 2890).

2800.05.00 Income

Income is the gain or benefit, earned or unearned, which is received or is available to the AG.

All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or allocated to dependents as allowed by state or federal regulation, is to be evaluated in determining initial and continuing eligibility.

2800.10.00 Household Income (MED 3)

For Modified Adjusted Gross Income ("MAGI") (MED 3) AGs, eligibility is based upon household income, which is the sum of

every individual included in the individual's household (refer to Chapter 3200 for the complete definition of "household").[1] Household income does not include:

- Income of a child living with his or her natural, adopted, or step parent and is not required to file a tax return for the taxable year in which Medicaid eligibility is determined whether or not a tax return is filed; or

- Income of a tax dependent living with a taxpayer and is not required to file a tax return for the taxable year in which Medicaid eligibility is being determined whether or not a tax return is filed. Cash support provided by the person claiming a tax dependent who is not a spouse or biological, adopted or step-child is not counted as income.[2]

To determine if a child or tax dependent is required to file taxes, please, refer to tables in IHCPPM 2810.25.00.

Income is calculated using the same financial methodologies used to determine MAGI as defined in section 36B(d)(2)(B) of the Internal Revenue Code ("IRC").[3] The IRC defines MAGI as adjusted gross income plus any foreign income, tax exempt interest, and non-taxable Social Security benefits. Supplemental Security Income ("SSI") is excluded under MAGI.[4] The following are three exceptions from MAGI for Medicaid eligibility purposes:

(1) A lump sum amount is counted as income only in the month received.

(2) Scholarships, awards, or fellowship grants for educational purposes and not for living expenses are excluded from income.

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[1] 42 CFR 435.603(d)

[2] 42 CFR 435.603(d)

[3] 42 CFR 435.603(e)

[4] 26 USC 36B(d)(2)(B)

(3) Certain American Indian and Alaska Native settlement trusts, distributions, and student financial assistance.[5]

Eligibility based upon MAGI-based income does not include an asset (resources) test and does not include any income or expense disregards except for—an amount equivalent to 5 percentage points of the applicable income standard for the family size as set forth in IHCPPM 2800.15.00.[6] Any items that are tax deductible should be deducted from a person's MAGI-based income.

Income under MAGI-based methodologies includes, but is not limited to, the following:

1) Wages and salaries;

2) Rents;

3) Royalties;

4) Gains from dealings in property;

5) Taxable interest;

6) Tax exempt interest;

7) Dividends;

8) State income tax refunds;

9) Alimony received;

10) Business income;

11) Capital gains;

12) Income from life insurance and endowment contracts;

13) Other gains;

14) Taxable IRA distributions;

15) Taxable pensions and annuities;

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[5] 42 USC 1396a(e)(14); 42 CFR 435.603(e)

[6] 42 USC 1396a(e)(14)(B)-(C); 42 CFR 435.603(g)

16) Distributive share of partnership gross income;

17) Estate and trust income;

18) Farm income;

19) Unemployment compensation;

20) Taxable Social Security benefits;

21) Non-taxable Social Security benefits (SSI, however, is excluded);

22) Net operating loss;

23) Gambling earnings;

24) Cancellation of debt;

25) Foreign earned income exclusion; and

26) Foreign earned income. [7]

Under MAGI-based methodologies, the following deductions apply:

1) Educator expenses;

2) Certain business expenses of reservists, performing artists, and
fee-basis government officials (vehicle and transportation costs).

3) Health savings account deduction.

4) Moving expenses.

5) Deductible part of self-employment tax.

6) Self-employed SEP, SIMPLE, and qualified plans

7) Self-employed health insurance deduction

8) Penalty on early withdrawal of savings

9) Alimony paid b Recipient’s SSN

[7] 42 CFR 435.603; and IRS Form 1040

10) IRA deduction

11) Student loan interest deduction

12) Tuition and fees.

13) Domestic production activities deduction.[8]

2805.00.00 EARNED AND UNEARNED INCOME

Income is broken down into two categories: earned income and unearned income.

Earned income is payment received in the form of wages, salaries and commissions from an employer or from self-employment. In-kind earnings such as goods or services received in lieu of wages are also considered earned income. It can also be profits from the sale of farm crops, livestock, or poultry.[9]

Unearned income is income for which there is no current performance of work or services. Unearned income may include:

Retirement income, disability payments, unemployment/worker's compensation;

annuities, pensions, and other regular payments;

alimony and support payments;

dividends, interest, and royalties;

proceeds of life insurance policies (when paid in installments);

winnings, prizes and awards;

gifts and inheritances;

child support; and

benefits administered through the Social Security Administration.

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[8] 42 CFR 435.603; IRS Form 1040

[9] 26 USC 32(c)(2)

2805.10.00 AVAILABILITY OF INCOME

Income is considered available when it is actually received and/or when the individual has the ability to make the income available. Refer to IHCPPM 3405.00.00 regarding the income budgeting principals.

2805.15.00 OWNERSHIP OF INCOME

The individual who has title to the proceeds of a payment or property is the individual who "owns" the income.

If the income is received by an individual's legal representative or guardian, the individual still owns the income.

When a legal representative receives the income, ownership through one of the following documents must be verified:

- the designation on the payment, check, award letter, or other document; or
- the title to the property.

2805.15.05 Establishing Income Ownership

The ownership of all sources of income must be determined according to the criteria listed below. This process establishes the income attributable to each individual.

For non-MAGI (MED 1, 2, 4) AGs, income received and used for the care and maintenance of an individual who is not an AG member is not counted as income. When a single payment is received for AG and non-AG members, the portion intended and used for the care and maintenance of the non-AG member will not be counted as income to the AG.

For MAGI (MED 3) AGs, payment for the care and maintenance of an AG member or non-AG member is only counted as income if it is taxable income. However, available cash support is not counted as income if provided by the person claiming a tax dependent if the tax dependent is someone other than a spouse or biological, adopted, or step-child.

When a legal representative receives the income, ownership may be verified by the following if electronic verification is not possible:

- By specific designation on the payment, check, award letter, or other document; or

- By contacting the payment source to ascertain for whom payment is intended and for what purpose is payment being made.

After ownership has been established, each income source must be attributed to the appropriate owner(s).

2805.15.05.05 Income from Non-Trust Property

Consider income paid in the name of one individual to be the income of that individual.

For income paid in the name of one individual and another person or persons, consider available to each person the amount representing the individual's proportionate interest.

For non-MAGI (MED 1, 2, 4) AGs, consider child support income to be the income of the child. For MAGI (MED 3) AGs, child support income is excluded from income.

For non-MAGI (MED 1, 2, 4) AGs, consider income paid in the name of one spouse to be the income of that spouse.

For income paid in the names of both spouses, consider one-half of the income to be available to each spouse.

For income paid in the name of one or both spouses **and** to another person or persons, consider available to each spouse the amount representing the spouse's proportionate interest. When no interest is specified, consider available to each spouse one-half of the couple's joint interest.

2805.15.05.10 Income from Trust Property

The income from a trust source should be considered as available to each individual or to each spouse in accordance with the specific terms of the trust. In the absence of specific provisions, the preceding rules for ownership of income from a non-trust source will apply.

2805.20.00 INCOME THAT IS GARNISHED

Income earned by an AG member that is garnished by an employer and paid to a third party, such as IRS garnishments, is included as income.

2805.25.00 INVOLUNTARY WITHHOLDING OF TAXES (MED 1, 2 and 4)

The amount of tax that is involuntarily withheld from an individual's unearned income is an allowable deduction from income. In order for the tax to be considered involuntarily withheld, the payee must have no choice as to whether the tax is withheld or not. If the payee can choose the amount of a mandatory withholding, the deduction must be allowed in the smallest permissible amount.

The amount of tax that is being voluntarily withheld from an individual's unearned income is not an allowable deduction from income.

2810.00.00 EARNED INCOME

Earned income is earnings received through wages, salaries, commissions, or profit from activities in which a person is engaged through either employment or self-employment. Income, in order to be considered as "earned", must entail personal involvement and effort on the part of the recipient, including managerial responsibilities.

Examples of earned income include, but are not limited to

Wages, salaries, commissions, bonuses, or profit received as a result of holding a job or being self-employed; this would include earnings from a graduate assistantship, if subject to taxation and available to the student for meeting non-educational living expenses;

Wages received from sheltered workshop employment;

Compensation for jury duty;

Tips;

Goods and services received in lieu of wages for work performed;

The dollar value, as established by the employer, of income received in-kind for work performed when in-kind earnings are received in lieu of wages. Refer to IHCPPM 2815.

2810.05.00 SALE OF BLOOD OR PLASMA

For MED 2 and 3 AGs, income from the sale of blood or plasma is included as earned income.

For MED 1 and 4 AGs, income from the sale of blood or plasma is considered as unearned income.

2810.10.00 TIPS

The amount of tips reported by the employee is included as earned income. Many times an employer will include on the pay stub of the employee an amount the employer must report to the IRS for tax purposes. This is an allocated amount which may or may not be considered as the amount actually earned or received by the employee. The tip amount reported by the employee can be accepted unless questioned.

In some instances, the employee reports actual tips to the employer. In this instance, the employer can verify actual tips earned. The individual should keep records on a daily basis if the tips are not reported to the employer, so this information can be used for verification. NOTE: Worker should be aware that when the hourly wage is less than the minimum wage, the possibility of tips may exist.

2810.15.00 SHELTERED WORKSHOP EARNINGS

Any payments from a sheltered workshop are included as earned income. A sheltered workshop is a special workshop offering limited employment experience for the mentally or physically handicapped. Refer to IHCPPM 3455.15.10.05.

2810.20.00 Earnings of Children

All of the earned income of a child under age 14 is disregarded.[10]

2810.25.00 Earnings (EARNED AND UNEARNED) of Children or Tax Dependents (MED 3)

Household income does not include the MAGI-based income (earned or unearned) of a child who is included in the household of his or her natural, adopted or step parent or a tax dependent who is included in the household of a taxpayer and is not required to file a tax return for the taxable year in which Medicaid eligibility is being determined whether or not a tax return is filed. However, if such child or tax dependent is required to file a tax return pursuant to the IRC for the taxable year, the child’s or tax dependent’s MAGI-based income will be included in

[10] 405 IAC 2-3-3

the calculation of household income for eligibility purposes.[11]

The following table provides minimum amounts for when a child or tax dependent must file a tax return based upon earned income per IRS rules (please note that the DFR must accept self-attestation for tax filing and tax dependency status, unless there is conflicting information in the case record that cannot be resolved without other means of verification. If an individual is uncertain how to answer the tax questions, the DFR can refer the individual to the following charts and information):

Marital Status - Single	**Amount**
Under 65 and not blind	$6,100
Either 65 or older or blind	$7,600
65 or older and blind	$9,100
Marital Status – Married	**Amount**
Under 65 and not blind	$6,100
Either 65 or older or blind	$7,300
65 or older and blind	$8,500

[12]

The following table provides when a child or tax dependent must file a tax return based upon unearned income:

Marital Status - Single	**Amount**
Under 65 and not blind	$1,000
Either 65 or older or blind	$2,500
65 or older and blind	$4,000

[11] 42 CFR 435.603(d)(2)(i)-(ii)

[12] IRS Publication 929, *Tax Rules for Children and Dependents* (2013)

Marital Status – Married	Amount
Under 65 and not blind	$1,000
Either 65 or older or blind	$2,200
65 or older and blind	$3,400

[13]

If a child or tax dependent has both earned and unearned income, the following IRS Filing Requirement Worksheet for most dependents can be completed to determine if a tax return must be filed. Generally, a child or tax dependent must file a return if his or her gross income (both earned and unearned) is more than line 5 of the worksheet.

Filing Requirement Worksheet for Most Dependents			
1.	Enter dependent's earned income plus $350		
2.	Minimum amount		$1,000
3.	Compare lines 1 and 2. Enter the **larger** amount		
4.	Maximum amount		6,100
5.	Compare lines 3 and 4. Enter the **smaller** amount		
6.	Enter the dependent's gross income (from earned and unearned). If line 6 is more than line 5, the dependent **must file** an income tax return. If the dependent is married and his or her spouse itemizes deductions on a separate return, the dependent must file an income tax return if line 6 is $5 or more.		

Even if he or she does not meet the aforementioned requirements for filing, a child or tax dependent may also be required to file a tax return in the following circumstances:

1) He or she owes Social Security and Medicare taxes on tips not reported to his or her employer or on employer wages where the employer did not withhold these taxes;

2) He or she owes uncollected Social Security and Medicare or railroad retirement taxes on tips reported to his or her employer or on group-term life insurance;

[13] IRS Publication 929, *Tax Rules for Children and Dependents* (2013)

3) He or she owes an alternative minimum tax;

4) He or she owes additional tax on a health savings account;

5) He or she owes recapture taxes (*e.g.* recapture of an education credit);

6) He or she owes additional tax on a qualified plan (IRA);

7) He or she had $102.28 or more of wages from a church or qualified church-controlled organization that is exempt from employer social security and Medicare taxes; or

   He or she had net self-employment earnings of $400.00 or more.[14]

2810.26.00 EARNINGS OF STUDENTS UNDER AGE 22 (MED 1)

Effective June 1, 2014, earned income of a student regularly attending school at least half-time is excluded up to certain maximum amounts. The exclusion applies to an applicant/recipient as well as non-participating members of a MED 1 AG whose eligibility is being determined under the 100% FPL income standard.

For 2017, the first $1,790 of monthly earned income is to be excluded. This exclusion cannot exceed $7,200 for the calendar year. For 2016 the monthly amount was $1,780 and the annual amount was $7,180.

2810.30.00 SELF-EMPLOYMENT

An individual is self-employed when the individual owns a business or otherwise engages in a private enterprise. Income derived from self-employment is considered earned income. Refer to IHCPPM 3410.05.00 for specific definitions.

This includes, but is not limited to:

operating a small business;

sales from a franchise company;

picking up and selling cans;

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[14] IRS Publication 929, *Tax Rules for Children and Dependents* (2013)

farm self-employment;

selling newspapers;

Income from roomers and boarders is treated like self-employment for MED 2 and MED 3; and income from rental property involving an average of 20 hours per week management is treated as self-employment income for F. Refer to IHCPPM sections 2875.05.05 and 2875.05.10.

Refer to IHCPPM 3410.00.00 to determine how self-employment income is budgeted. Refer to IHCPPM 2890.05.05 for proper verification of self-employment income.

2810.30.05 SELF-EMPLOYMENT DEDUCTIONS

An individual who is self-employed may be eligible for certain business deductions from his or her taxable income when calculating household income. All IRS deductions are allowable for MAGI categories and MED 1. This section, however, does not apply to MA F or RMA. Deductible business expenses must be both ordinary and necessary. An ordinary expense means an expense that is common and accepted for a certain business. A necessary expense is an expense that is helpful and appropriate for a certain business. The full amount of the business expense is deducted if the business makes a profit and the business expense is both ordinary and necessary.

The following are types of business expenses that may be deducted:

1) Employees’ pay;

2) Retirement and savings plans;

3) Rent expenses;

4) Business interest expense or amount charge for borrowing money for business;

5) Depreciation (for MED 1, 3, and 4 only)

6) Taxes – certain federal, state, local, and foreign taxes directly attributable to business;

7) Legal and professional fees;

8) Travel, meals, and entertainment;

9) Business use of home; and

10) Insurance.

2810.35.00 INCOME RECEIVED FROM TRAINING PROGRAMS

When an individual participates in a work or on-the-job training program that involves work for payment, the payment is included as earned income for non-MAGI (MED 1, MED 2 and MED 4) AGs. The income is included in the household income for MAGI (MED 3) AGs if the individual participating in the on-the-job training program is required to file taxes. (Refer to IHCPPM 2810.25.15). Training allowances from vocational and rehabilitative programs recognized by a government agency are also included income, unless excludable as a reimbursement. For example, IMPACT and Job Training Partnership Act (JTPA) program payments or allowances are included income unless provided as a reimbursement or otherwise identified as excluded income in the following sections. Refer to IHCPPM 2855.00 for additional information on reimbursements.

2810.35.05 JTPA Income (MED 1, 4)

Income received through a JTPA program for on-the-job training is counted as earned income. Reimbursements for supportive services are exempt.

2810.40.00 Seasonal Income

Seasonal employees are hired to work fewer than 12 months of the year. This may be a permanent job with recurring periods of work and non-work, or temporary work for a busy season of a few months.

Permanent seasonal workers have a position where they can reasonably predict the months they will work each year (ex: construction workers, farmers), or where they are contracted to work established dates (ex: bus drivers, teachers). Some of these workers are paid only for the months in which they work, while others have the option to have their pay spread out over the entire 12 months of the year. For MAGI Medicaid, we are required to use the monthly income for the month of application to determine initial eligibility, but for ongoing MAGI and all other Medicaid budgeting, the income of permanent seasonal workers should always be annualized to establish a monthly amount.

Temporary seasonal workers are hired on a short-term basis (ex: retailers hire extra workers for the holiday season, ski resorts hire during winter ski season, and amusement parks hire summer help). The employee is not automatically hired back each year and would have to reapply in order to return. This type of income can be counted as monthly while it is being received, and removed from the budget if the employee is released from employment at the end of the season.

It is possible for a person to return every year to work in a position which appears to be temporary seasonal work (ex: employee is hired by the same employer every year to assist in tax preparation from January through May). If a pattern of ongoing employment can be seen, this income may be annualized as well.

2815.00.00 IN-KIND INCOME, BARTERING, GIFTS, AND GAMBLING

Non-cash or in-kind benefits, bartering, gifts, and gambling are discussed in the following sections.

2815.05.00 IN-KIND EARNINGS (MED 1, 2, 4)

In-kind earnings are goods and services received in exchange for working i.e., in lieu of cash. The dollar value of the work performed as established by the employer is counted as earned income only in situations where the employee has the option of receiving cash for the performed work. If the employee does not have the option of receiving cash for the performed work, the goods and services received are exempt as income.

> EXAMPLE
>
> If an AG member works off his rent and the landlord states he would pay the client $200 a month, but he prefers to receive free rent in lieu of the money. Count $200 income and allow $200 as a shelter cost.
>
> If the landlord states he would not pay the client to do the work, do not count any income or allow any shelter deduction.

2815.10.00 IN-KIND SUPPORT AND MAINTENANCE (MED 1, 4)

Within MED 1, the policy stated in this section applies to MA A, MA B, and MA D.

In-kind support and maintenance, or income-in-kind, is food, clothing, or shelter received by the applicant/recipient (and his spouse or parent) because someone else pays for it. Shelter expenses are room, rent or mortgage payments, property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services.

The amount to be budgeted as income is the actual value of the in-kind support and maintenance received, not to exceed one-third of the applicable federal benefit rate of SSI. (Refer to IHCPPM 3455.25.00. The actual value is determined and verified by a signed statement from the person providing the in-kind support and maintenance. The one-third value is determined by dividing the income standard by three. Situations which require consideration of income-in-kind are enumerated below. The term "individual" used in this section means the applicant/recipient and his spouse or parent.

If the individual lives in his own household (owns or rents), income-in-kind is received if someone else pays for **all** of the food expenses or **all** of the shelter expenses.

If another person in the household regularly pays a designated amount to the individual for shelter and/or food, that amount is to be considered as rental income from a roomer/boarder.

If the members of a household state that they "share" food and shelter expenses, income-in-kind is not received by the individual. A signed statement by the adult household members must be obtained as verification that the applicant/recipient pays his share.

If the individual lives in another person's household and pays nothing toward the food and shelter expenses, income-in-kind is received.

If the individual pays a designated amount for food and/or shelter, he is not receiving income-in-kind.

In situations where the individual has no ownership interest or rental liability in his residence and he does not pay for **any** of the shelter expenses, income-in-kind is received. A statement from the property owner or leaseholder as to the value of the shelter being provided is to be obtained as verification. If the individual pays any part of the shelter expense, for example, utilities, income-in-kind **is not** received.

If someone provides all of the individual's clothing, income-in-kind is received.

Effective June 1, 2014, gifts from a non-profit organization as described under section 501(c)(3) of the Internal Revenue Code to or for the benefit of a child under 18 years of age and has a life-threatening condition are exempt so long as the gift does not exceed $2,000 in any calendar year. Any gift not converted to cash is considered an in-kind gift.[15]

Refer to IHCPPM 3455.25.00 regarding budgeting in-kind income.

2815.10.05 Cash Support for Certain Dependents (MED 3)

Cash support is excluded for MAGI purposes for a child under 19 years old who:

- is claimed by as tax dependent by someone other than a spouse or a biological, adopted, or step-parent; and

- receives financial support from the person claiming the child as the dependent.

2815.15.00 BARTERING (MED 3)

Bartering is an exchange of property or services. The fair market value of the services or property being bartered is taxable income to the individual receiving the services or property. Therefore, such income is counted in the calculation of MAGI for purposes of Medicaid eligibility.

2815.20.00 GIFTS AND INHERITANCES (MED 3)

Property received as a gift, bequest, or inheritance is not considered taxable income and is not included in the calculation of MAGI for determination of eligibility. If such gifts,

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[15] 20 CFR 416.1124(c)(21)

bequests, or inheritances produce income (*e.g.*, interest, dividends, rent) at a later date, that income will be considered taxable income. In addition, if such gift, bequest, or inheritance is placed in a trust for the individual and the income is paid or distributed to the individual, such income is taxable and included in the calculation of household income for eligibility determinations.

2815.25.00 GAMBLING WINNINGS (MED 3)

Cash winnings and the fair market value of non-cash prizes (*e.g.*, bonds, cars, houses, etc.) as a result of gambling, lotteries, and raffles are considered taxable income and must be included in the calculation of MAGI for eligibility determinations. Gambling losses can be deducted from income but only up to the amount of the individual's winnings.

2820.00.00 CANCELED DEBT (MED 3)

A debt is any amount of money for which an individual is liable or which attaches to property owned by an individual. If a debt owed by an individual is canceled or forgiven, the canceled amount is taxable income and must be included in the calculation of household income for purposes of eligibility determinations. However, if the canceled debt is intended as a gift to the individual, it is not taxable income and is not included in the calculation of MAGI for purposes of eligibility determinations. Some examples of canceled debt that are gifts include:

A relative who is not an AG member pays the rent directly to the landlord; or

medical payments made by a third party to a medical provider.

2825.00.00 INFREQUENT OR IRREGULAR INCOME (MED 1, 4)

Within MED 1, the policy stated in this section applies to MA A, MA B, and MA D.

The following disregard is applicable to all individuals whose income is included in the eligibility determination.

Up to $20 of unearned income and $10 of earned income if the income is "infrequent" or "irregular" as defined below, **and** does not exceed the applicable $20 or $10 maximum **in a given month**.

Infrequent - received quarterly or less often than quarterly from a single source;

Irregular - cannot reasonably be expected.

Once it is determined that a source of income cannot be excluded under this provision, it must be considered in the eligibility determination.

EXAMPLE 1 Interest income on a certificate of deposit paid semi-annually in the amount of $25 must be budgeted. Reason: It is "infrequent" (semi-annually is less often than quarterly), but it exceeds the $20 maximum. Applicable budgeting rule is to divide by the appropriate number of months. Therefore, $4.17 is budgeted monthly.
EXAMPLE 2 Interest income on a certificate of deposit paid semi-annually in the amount of $20 is disregarded. Reason: It is "infrequent" and does not exceed the $20 maximum.
EXAMPLE 3 Interest income on a passbook savings account paid monthly averaging $4 must be budgeted. It is not "infrequent" (monthly is more often than quarterly), although it is less than $20 in a given month.
EXAMPLE 4 Two sources of interest income are received: $2 paid quarterly on a savings account and $15 from a certificate of deposit paid semi-annually. Each source is evaluated separately for the "I or I" determination, then combined to determine if the total exceeds $20. Therefore, both the $2 and the $15 are disregarded. (They are infrequent and the total of $17 does not exceed $20.) Refer to IHCPPM 2850.00.00.

2830.00.00 CHILD AND SPOUSAL SUPPORT

Child support payments are those funds paid by a legal, adjudicated, or alleged parent intended for the support or maintenance of a child. Child support can be voluntarily paid by the non-custodial parent, or court-ordered. However, in order for voluntary payments to be considered child support for eligibility purposes, both parents must be in agreement that the payments are for the support or maintenance of a child. Without

this agreement, the payments are considered to be contributions rather than child support.

Child support is unearned income and is considered the child's income.

Spousal support or alimony is an amount of money allocated from one spouse to another by a court in a divorce or separation agreement. A spousal support or alimony payment is unearned income for MED 1, 2, and 4 AGs.

For MAGI (MED 3) AGs, spousal support or alimony is taxable income for the individual receiving the support. Spousal support or alimony paid to an ex-spouse is deducted for the individuals who paid spousal support or alimony to an ex-spouse for purposes of calculating MAGI.

2830.05.00 CHILD SUPPORT (MAGI, MED 3)

The amount of child support received or anticipated to be received for any member of the AG is excluded from the calculation of MAGI for household income.

2830.10.00 CHILD SUPPORT AND ALIMONY (MED 1, MED 4)

Child support payments, as defined in IHCPPM 2830.00 are counted as unearned income in the full amount paid on behalf of the child. Payments received for a child no longer in the home and not used for the child's benefit are considered a contribution.

Effective June 1, 2014, for child applicants or recipients who receive child support payments, the child support income will be deducted by one-third (1/3) of the total amount received.

Effective June 1, 2014, child support payments and alimony payments made by a non-recipient spouse, parent, or stepparent through a court order or Title-IV are not included as income for the non-recipient member.

2835.00.00 ASSISTANCE FROM GOVERNMENT PROGRAMS

The treatment of assistance from government agencies will vary depending on the nature of the program and the payment.

2835.05.00 ENERGY ASSISTANCE PAYMENTS

Home energy assistance payments made to or on behalf of the AG by the Indiana Department on Aging and Community Services under the Energy Assistance to Low Income Families Program are

excluded from income for all Medicaid categories.[16] This includes the Energy Assistance Program (EAP), Project SAFE, and Project HEAT.

2835.10.00 TOWNSHIP TRUSTEE ASSISTANCE

All payments made by Township Trustees are exempt as income for all Medicaid categories.

2835.15.00 HUD PAYMENTS

HUD payments are payments made by the Department of Housing and Urban Development.

Housing assistance paid directly or indirectly by the United States Department of Housing and Urban Development under the following Acts are exempt:

The Housing Authorization Act of 1976 with respect to a dwelling unit under the United States Housing Act of 1937, as amended (Sections 8, 10, and 23 and the Experimental Housing Allowance Program);

The National Housing Act (loans for housing renovation, mortgage insurance, and investment insurance);

Title V of the Housing Act of 1949 (loans to elderly individuals, farmers, and developers for the construction, improvement, or replacement of farm homes and other buildings); and

Section 101 of the Housing and Urban Development Act of 1965 (payments to certain mortgagors in behalf of tenants with low income who are displaced by government action, age 62 or over, physically handicapped, living in substandard housing, present or past tenants of dwellings damaged or destroyed by disaster, or the head of the household is on active duty with the armed forces.[17]

2835.20.00 RELOCATION ASSISTANCE ACT PAYMENTS

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[16] 405 IAC 2-3-3; 20 CFR 416.1157

[17] P.L. 94-375, Section 2 (h); P.L. 92-213, Section 9; 20 CFR 416.1124 and 1238

Relocation assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970[18] is exempt for all Medicaid categories.

2835.25.00 DISASTER ASSISTANCE PAYMENTS

Payments made under the Disaster Relief and Emergency Assistance Act of 1988[19] are excluded for all AG Medicaid categories. There must be a Presidentially declared disaster for these payments to be excluded.

2835.30.00 FOSTER CARE AND ADOPTION ASSISTANCE PAYMENTS

The following sections describe program specific policy on foster care and adoption assistance payments for children and adults received from any agency

2835.30.05 Foster Care Payments

For non-MAGI (MED 1, 2, 4) AGs, foster care payments received by a foster care parent from any federal, state or local foster care maintenance payments intended to provide for adults or children are exempt income.

For MAGI (MED 3) AGs, foster care payments received from any federal, state or local foster care agency for the care of qualified foster individuals in the home are exempt from taxable income unless foster care is being provided for five individuals age 19 or older. A qualified foster individual is a person who is living in a foster family home and was placed in the home by an agency of the state or one of its political subdivisions or a qualified foster care agency.[20]

Difficulty of care payments, compensation for providing additional care for physically, mentally, or emotionally handicapped foster individuals, for more than 10 qualified foster individuals under age 19 or 5 qualified foster individuals age 19 or older are also included in taxable income for purposes of determining household income. In addition, if an individual receives compensation for maintaining space in

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[18] P.L. 91-646, Section 216; 20 CFR 416.1124

[19] P.L. 100-707; 20 CFR 416.1124

[20] 45 CFR 233.20(a)(1)(II), (MED 2, 3); 405 IAC 2-3-3, (MED 1)

their home for emergency foster care, such compensation is also included as taxable income.

2835.30.10 Adoption Assistance (MAGI, MED 3)

Federal, state or local adoption assistance payments for special needs children, children whom the state's child welfare agency considers difficult to place for adoption, are exempt as income to the individual.[21]

2835.30.15 Adoption Assistance (MED 1, 4)

Adoption assistance cash payments are considered income to the adopted child even though made to the adoptive parent.

2835.35.00 SUPPLEMENTAL SECURITY INCOME

The following sections discuss program-specific policy on the inclusion or exclusion of income received from the Supplemental Security Income (SSI) program.

SSI benefits are available through the Social Security Administration under Title XVI of the Social Security Act to individuals age 65 or older, blind, or disabled, and who meet specific income and resource requirements. Individuals who have never paid into the Social Security program may be eligible for SSI as well as individuals who are receiving RSDI in an amount less than the current SSI maximum benefit. Refer to IHCPPM 2890.10.10 for appropriate verification sources.

2835.35.05 Supplemental Security Income (MAGI, MED 3)

SSI income is excluded from the calculation of household income when determining an AG's eligibility.[22]

2835.35.15 Supplemental Security Income (MED 1, 4)

Within MED 1, the policy stated in this section applies to MA A, MA B, and MA D.

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[21] 45 CFR 233.20; www.irs.gov/taxtopics/tc607.html

[22] 45 CFR 233.20

SSI benefits of a non-institutionalized Medicaid applicant/recipient are exempt.[23] SSI benefits of a non-participating member of an AG are counted.

Note: In post-eligibility budgeting, SSI is counted for applicants/recipients in Medicaid-certified facilities with the following exceptions:

> The maximum SSI payment for a recipient in a Medicaid-certified facility is $30. However, the full benefit amount may be erroneously paid for a few months to an individual just entering a facility. These erroneous payments can be disregarded only if the check is returned to the Social Security Administration uncashed.
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> SSI payments made to recipients who are in 1619 status and who enter public institutions and Medicaid certified facilities (hospital, nursing facility, ICF/MR, or CRF) are not reduced to the $30 cap for the first two full months of institutionalization. For Medicaid purposes, the SSI payments made during these two months are to be disregarded as income.[24]
>
> The SSI payments made for 90 days to recipients who are temporarily institutionalized are exempt. The SSA issues a special notice to these recipients indicating they are receiving benefits under P.L. 100-203. The DFR must retain a copy of this notice in the recipient's case file unless the temporary benefits are documented on DESX.

2835.40.00 TANF/RCA PAYMENTS

For non-MAGI (MED 1, 2, 4) AGs, cash assistance (TANF and RCA) must be included as unearned income. This includes a payment for an AG which has a protective payee or a sanctioned member.

2835.40.05 Retroactive/Corrective TANF/RCA Payments (NON-MAGI, MED, 1, 4)

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[23] SSA 1902(f)

[24] SSA 1619

Retroactive/corrective TANF/RCA payments are exempt as income or as a resource in the month of receipt.[25] Thereafter, amounts retained are treated as a resource.

2835.45.00 FOOD STAMPS/NUTRITION PROGRAMS

Benefits received under the following federal or federally-assisted programs seeking to improve the nutrition of low and moderate income families and individuals are exempt:

Food Stamp Act of 1977, as amended;[26]

Child Nutrition Act of 1966 (WIC), as amended;[27]

National School Lunch Act, as amended;[28]

Title VII Nutrition Program for the Elderly of the Older Americans Act of 1965 (Meals on Wheels), as amended;[29]

2835.50.00 RESIDENTIAL LIVING ALLOWANCES

Residential Living Allowances provided by the Semi-Independent Living Program or the Alternative Family Program are exempt.

For MED 1 and 4, this disregard does not apply to essential persons. However, the nature of the Semi-Independent Living Program and the Alternative Family Program is such that the applicant/recipient would not have an essential person.

2840.00.00 BENEFIT PROGRAMS

The following sections discuss types of benefits payable to individuals and their treatment as unearned income.

2840.05.00 SOCIAL SECURITY INCOME (MED 1, 2, 4)

Benefits that are paid by the Social Security Administration (SSA) are unearned income for MED 1, 2, 4 AGs. These types of

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[25] SSA 402(a)(22); 45 CFR 233.20

[26] P.L. 88-525, Section 7(c); 20 CFR 416.1124(b)

[27] P.L. 89-642, Section 11(b); 20 CFR 416.1124(b)

[28] P.L. 90-302, Section 13(h); 20 CFR 416.1124(b)

[29] P.L. 92-258, Section 709; 20 CFR 416.1124(b)

benefits include Retirement, Survivors, and Disability Insurance (RSDI), special age 72 payments (PROUTY), and black lung benefits. These benefits may be available through the SSA under Title II of the Social Security Act to the covered former wage earner and his dependents or survivors.

Black Lung benefits may be available through the United States Department of Labor under Title IV of the Federal Coal Mine Health and Safety Act of 1969 to the former miner and his dependents or survivors. Application for benefits is to be made through the nearest Social Security Administration District Office.

Social Security benefits recouped by SSA that are not received by the household are not counted as income. Refer to IHCPPM 2890.10.15 for verification requirements.

All Social Security payments to individuals whose disability is based on Drug Addiction and/or Alcoholism (DAA) are required to be paid to a representative payee. Some organizations act as the representative payee but charge a fee for providing payee services.

2840.05.05 SOCIAL SECURITY BENEFITS (MED 3)

Social security benefits include monthly retirement, survivor, and disability benefits. Social security benefits do not include supplemental security income (SSI). Social security benefits can be taxable or tax exempt. However, all social security benefits, whether taxable or tax exempt, received by an individual are included in the calculation of MAGI for determining household income.[30]

Black Lung benefits made available through the United States Department of Labor under Title IV of the Federal Coal Mine Health and Safety Act of 1969 to the former miner and his dependents or survivors are considered countable income.

2840.10.00 VETERANS' BENEFITS

Veterans' benefits are unearned income in the form of compensation or pension benefits available through the Department of Veterans' Affairs to veterans and their dependents or survivors.

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[30] 26 USC 36B(d)(2)(B)

Compensation is paid to veterans with service-connected disabilities and is based on the degree of the disability. Pensions are available to certain wartime veterans who are permanently and totally disabled. Additionally, a veteran who is in a nursing home or who needs regular assistance from another person for daily activities may qualify for an Aid and Attendance Allowance or a Housebound Allowance. A single veteran or a widow of a veteran who is in a Medicaid certified nursing home may be receiving a reduced pension of $90 per month.[31]

Any portion of the VA benefit which is allowed for a dependent is considered unearned income of the dependent. Refer to IHCPPM 2890.10.20 concerning verification requirements.

For MAGI AGs,(MED 3) VA benefits are not taxable income. Therefore, VA benefits are not counted in the calculation of household income.

For MED 1, 4, MA F and RMA, VA benefits are counted for eligibility purposes.

2840.10.05 Spina Bifida Allowance for Veterans' Children

For non-MAGI (MED 1, 2, 4) AGs, allowances paid to children who are born with Spina Bifida and are children of Vietnam veterans will have this allowance excluded from the income and resource determination.[32]

The monthly payment is to be considered as exempt income.

Left over amounts (previous month's payment that isn't spent in that previous month) of this allowance from previous months payments and/or lump sum payments of this allowance are to be considered as an exempt resource. If the client has this in an account with other countable resources, the client must supply the worker with the amount of money that is the Spina Bifida amount so this amount may be exempt from the resource determination. It does not have to be in a separate account, but the client or a family member must keep track of the amount.

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[31] Section 3203 of Title 38 U.S.C. as amended by OBRA-90

[32] P.L. 104-204

EXAMPLE:

A client is receiving a monthly payment of $700 for Spina Bifida for his child and the client is a Vietnam veteran. The $700 is exempt income.

The next month the client receives another payment of $700 which is directly deposited into his bank account. The client also has $500 in this account of which $400 is money left over from the Spina Bifida allowance received in the previous month. For the resource determination, only $100 would be counted and the remaining $400 would be a left over Spina Bifida allowance from the previous month's payment and this $400 would be an exempt resource.

For MAGI (MED 3) AGs, allowances paid to children who are born with Spina Bifida and are children of Vietnam veterans are not taxable income. Therefore, such allowances are not counted in the calculation of MAGI for household income.

2840.10.10 VA AID & ATTENDANCE ALLOWANCE AND HOUSEBOUND ALLOWANCE

Aid and Attendance Allowance and Housebound Allowances are not considered income.

2840.15.00 RAILROAD RETIREMENT BENEFITS (MED 1, 2, 4)

Railroad retirement benefits are unearned income and may be available to former railroad workers and their dependents or survivors. Included are retirement and disability benefits. The Railroad Retirement benefit and Social Security benefit are usually combined in one payment if the individual is entitled to both benefits. Verification of benefits is essential. Refer to IHCPPM 2890.10.25.

28440.15.05 RAILROAD RETIREMENT BENEFITS (MED 3)

For MAGI, railroad retirement benefits can be taxable or tax exempt. However, all railroad retirement benefits, whether taxable or tax exempt, received by an individual are included in the calculation of MAGI for determining household income.[33]

2840.20.00 PENSIONS

[33] 26 USC 36B(d)(2)(B)

Payments may be available from private industry, local or state governments, or the federal government to former employees and their dependents or survivors. These payments are the result of purchase of an annuity, retirement from employment, survivor benefits for a former employee's dependents, or injury or disability, and may be made by an employer, an insurance company, or public or private funds.

2840.20.05. PENSIONS (MED 1, 2, 4)

For non-MAGI (MED 1, 2, 4) AGs, pensions are counted as unearned income. Refer to IHCPPM 2890.10.35 for verification requirements. The amount of funds being recouped from a pension is an allowable deduction.

Effective June 1, 2014, for MED 1 and 4, any pension paid by a state to person who was an honorably discharged veteran of the armed forces based on a disability determination made by the state making the pension payments is not considered as income.[34]

2840.20.10 PENSIONS (MED 3)

For MAGI AGs, pension payments from a qualified employer retirement plan may be fully or partially taxable income. Pension payments are fully taxable if the individual did not contribute to the pension, the employer did not withhold contributions from the individual’s salary, or the individual received tax-free contributions in previous years. Such pension payments are counted in the calculation of MAGI for household income. Pension payments are partially taxable if the individual contributed after tax dollars to the pension. The part of the pension payment that represents the amount paid with after tax dollars by the individual is not taxable. The part of the pension payment that represents the amounts that the individual did not contribute to the pension or the amounts contributed by the individual but were tax free is taxable income and will be included in calculating MAGI for the household income.

If an individual has a traditional Individual Retirement Account (IRA), a full deduction is allowed for the amount contributed to the IRA as long as the individual and the spouse, if applicable, do not have a traditional IRA plan at a place of employment.

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[34] 20 CFR 416.1124(c)(24)

If an individual has a traditional IRA plan at his or her place of employment, his or her contributions are deductible in full or partially based upon income limitations.

Roth IRA contributions are not deductible from taxable income.

2840.25.00 UNEMPLOYMENT COMPENSATION BENEFITS

Unemployment compensation benefits (UCB) may be available through Indiana Workforce Development to unemployed individuals who have a recent history of "covered" work and who are currently available for work.

For non-MAGI (MED 1, 2, 4) AGs, UCB is counted as unearned income. Refer to IHCPPM 2890.10.40 for verification requirements.

For MAGI (MED 3) AGs, UCB is taxable income and counted in the calculation of MAGI for household income. However, any amount an individual voluntarily contributes to a private fund is not taxable income and not counted in the calculation of MAGI for household income. The only amounts taxable from private funds are amounts received by the individual greater than the individual’s contribution.

For purposes of calculating MAGI, if an individual is required to repay a portion of UCB, the amount repaid is deducted from the amount he or she receives.

2840.30.00 WORKER'S COMPENSATION

Worker's Compensation may be awarded to an injured employee or his survivors under federal and state worker's compensation statutes. Payment may be made in a lump sum payment or in monthly payments.

2840.30.05 WORKER’S COMPENSATION (MED 1, 2, 4)

Worker’s Compensation is treated as unearned income and is counted when determining a client’s eligibility. Refer to IHCPPM 2890.10.45 for verification requirements.

3840.30.10 WORKER’S COMPENSATION (MED 3)

For MAGI, Worker’s Compensation is not taxable income if it is paid pursuant to a worker’s compensation act or statute. Therefore, Worker’s Compensation is not counted in the calculation of MAGI for household income.

2840.35.00 STRIKE BENEFITS

Strike Benefits may be awarded to employees who are striking against their employer and are considered countable unearned income.

2840.40.00 MILITARY ALLOTMENTS

An individual may be receiving or be eligible to receive a Military Allotment if the spouse, adult child, or parent, is in the United States Armed Forces.

2840.40.05 MILITARY ALLOTMENTS (MED 1, 2, 4)

These payments are counted as unearned income.

If the individual in the military makes money available to the applicant or participating AG, the money is a contribution to the AG. Usually, this is done by direct deposit into a joint checking account.

2840.40.10 MILITARY ALLOTMENTS (MED 3)

For MAGI AGs, Military Allotments may or may not be taxable income depending on the purpose of the allotment. For example, if the Military Allotment is for child support, it is not considered taxable income for the individual receiving the allotment. Therefore, the purpose of the Military Allotment must be determined. If such purpose results in taxable income to the individual receiving the Military Allotment, then the income is counted in the calculation of MAGI for household income.

2840.45.00 DISABILITY PAYMENTS

An individual may have insurance coverage that pays a specified amount for a specific period of time during which he is unable to work because of a disabling condition.

2840.45.05 DISABILITY PAYMENTS (MED 1, 2, 4)

Disability Payments are counted as unearned income.

2840.45.10 DISABILITY PAYMENTS (MED 3)

For MAGI, Disability Payments may or may not be taxable income depending on who paid for the disability insurance. Disability Payments are fully taxable if the individual did not contribute to the disability insurance premium payments or the employer did not withhold premium payments from the individual’s salary.

Such Disability Payments are counted in the calculation of MAGI for household income. Disability Payments are not taxable if the individual paid for the premium payments with after tax dollars, and such payments will not be counted in the calculation of MAGI for household income. Disability Payments may also be partially taxable depending on who paid for the premium payments and whether such payments were with pre-tax or after tax dollars. Generally, any payments made by the individual with after tax dollars toward the disability insurance premium will not be considered taxable income and will not be considered in the calculation of MAGI for household income.

2840.45.05 Indemnity Health Insurance Payments

Indemnity health insurance plans pay a specified benefit to a person based on the number of days the individual is hospitalized. There are other variations to this type of insurance, including accident and cancer policies. For eligibility purposes, an indemnity policy means one in which the terms of the plan do not in any way limit the manner in which the applicant/recipient can use the benefits.

2840.45.05.05 Indemnity Health Insurance Payments (MED 1, 2, 4)

Payments made by an indemnity health insurance plan are counted as unearned income unless the applicant/recipient uses the payments to pay his medical expenses. A payment or any portion thereof used to pay the applicant's/recipient's medical expenses is not counted as income.

Once the DFR verifies the applicant's/recipient's receipt and usage of indemnity benefits, income will be budgeted accordingly. **Note:** Some payments may fall under the definition of lump sum, others may be regular, or fluctuating. In many of these situations the income will be considered through recovery.

The amount of the premium of an indemnity policy is not an income deduction in the post-eligibility income determination of an institutionalized applicant/recipient, nor a medical expense in spend-down determinations.

2840.45.05.10 Indemnity Health Insurance Payments (MED 3)

For MAGI, payments made by an indemnity health insurance plan may or may not be taxable income depending on who paid the premiums for the insurance. Payments are fully taxable if the individual did not contribute to the insurance premium payments

or the employer did not withhold premium payments from the individual's salary. Such payments from an indemnity health insurance plan are counted in the calculation of MAGI for household income. Payments from an indemnity health insurance plan are not taxable if the individual paid for the premium payments with after tax dollars, and such payments will not be counted in the calculation of MAGI for household income. Payments made by an indemnity health insurance plan may also be partially taxable depending on who paid for the premium payments and whether such payments were with pre-tax or after tax dollars. Amounts paid to reimburse for medical expenses incurred after the insurance plan was established are not counted as income.

2840.50.00 Long-Term Care Insurance Payments (MED 1, 4)

Payments from insurance, including a qualified Indiana Long Term Care Program (ILTCP) or other long-term care insurance policy, are not counted as unearned income as long as the applicant/recipient uses them to pay medical expenses. They are considered reimbursement of an expense even if payments are made directly to the individual to make the payment. Workers must verify the applicant's/recipient's receipt and usage of the LTC insurance payments.

2845.00.00BENEFITS RECEIVED DUE TO FEDERAL LAW

The benefits that are listed in the following sections are those that are received due to federal statute.

2845.05.00 Domestic Volunteer Service Act Compensation

The following are exempt income:

Assistance to volunteers who participate in ACTION programs funded under Public Law 93-113, including VISTA and other programs under Title I of that law; and

Payments for supportive services or reimbursement for expenses made to volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving on the Service Corps of Retired Executives, Active Corps of Executives, and other programs under Title II and III of the Act.[35]

2845.10.00 OLDER AMERICANS ACT

The organizations involved in the Senior Community Service Employment Program (Title V Public Law 89-73) are Experience Works, National Council on Aging, National Council on Senior Citizens, American Association of Retired Persons, U.S. Forestry Services, National Association of Spanish Speaking Elderly, National Urban League, and the National Council on Black Aging.

2845.10.05 OLDER AMERICANS ACT (MED 1, 2, 4)

Payments other than wages/salaries made under the Older Americans' Act are exempt unearned income. Wages/salaries are earned income.

2845.10.10 OLDER AMERICANS ACT (MED 3)

For MAGI, payments received under the Older Americans’ Act are taxable income, and such payments are included in the calculation of MAGI for household income.

2845.15.00 ASSISTANCE FOR CERTAIN INDIAN TRIBES/ALASKAN NATIVES

The following Section discusses federal law pertaining to Indian tribes and Alaska natives.

> P.L. 92-203, section 29, dated 1/2/76, the Alaska Native Claims Settlement Act, and Section 15 of P.L. 100-241, 2/3/88, the Alaska Native Claims Settlement Act Amendments of 1987 - All compensation (including cash, stock, partnership interest, land, interest in land, and other benefits) received under this Act are excluded from income and resources.

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[35] 42 USC 5044(f)

P.L. 93-134, the Judgment Award Authorization Act, as amended by P.L. 97-458, Section 1407, 11/12/83 and P.L. 98-64, 8/2/83, the Per Capita Distribution Act. P.L. 97-458 required the exclusion of per capita payments under the Indian Judgment Fund Act (judgment awards) of $2000 or less from income and resources. The exclusion applies to each payment made to each individual. Initial purchases made with exempt payments distributed between 1/1/82 and 1/12/83 are excluded from resources to the extent that excluded funds were used. P.L. 98-64 extended the exclusion to cover per capita payments from funds which are held in trust by the Secretary of Interior (trust fund distributions).

P.L. 93-531, Section 22 - Relocation assistance payments to members of the Navajo and Hopi Tribes are excluded from income and resources.

P.L. 94-114, Section 6 - Income derived from certain sub marginal land held in trust for certain Indian tribes is excluded from income and resources. The tribes that may benefit are:

- Bad River Band of the Lake Superior Tribe of Chippewa Indians of Wisconsin
- Blackfeet Tribe
- Cherokee Nation of Oklahoma
- Cheyenne River Sioux Tribe
- Crow Creek Sioux Tribe
- Lower Brule Sioux Tribe
- Devils Lake Sioux Tribe
- Fort Belknap Indian Community
- Assiniboine and Sioux Tribes
- Lac Courte Oreilles Band of Lake Superior Chippewa Indians
- Keweenaw Bay Indian Community
- Minnesota Chippewa Tribe
- Navajo Tribe

P.L. 94-189, Section 6, 12/31/75 - Funds distributed per capita to the Sac and Fox Indians or held in trust are excluded from income and resources. The funds are divided between members of the Sac and Fox Tribe of the Mississippi in Iowa. The judgments were awarded in Indian Claims Commission dockets numbered 219, 153, 135, 158, 231, 83, and 95.

P.L. 94-540 - Payments from the disposition of funds to the Grand River Band of Ottawa Indians are excluded from income and resources.

P.L. 95-433, Section 2 - Indian Claims Commission payments made pursuant to this Public Law to the Confederated Tribes and Bands of the Yakima Indian Nation and the Apache Tribe of the Mescalero Reservation are excluded from income and resources.

P.L. 96-420, Section 9(c), 10/10/80, Maine Indian Claims Settlement Act of 1980 - Payments made to the Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet are excluded from income and resources.

P.L. 97-403 - Payments to the Turtle Mountain Band of Chippewas, Arizona are excluded from income and resources.

P.L. 97-408 - Payments to the Blackfeet, Grosventre, and Assiniboine tribes, Montana, and the Papago, Arizona, are excluded from income and resources.

P.L. 98-123, Section 3, 10/13/83 - Funds distributed under this Act to members of the Red Lake Band of Chippewa Indians are excluded from income and resources. Funds were awarded in docket number 15-72 of the United States Court of Claims.

P.L. 98-124, Section 5 - Per capita and interest payments made to members of the Assiniboine Tribe of the Fort Belknap Indian Community, Montana, and the Assiniboine Tribe of the Fort Peck Indian Reservation, Montana, under this Act are excluded from income and resources. Funds were awarded in docket 10-81L.

P.L. 98-500, Section 8, 10/17/84, Old Age Assistance Claims Settlement Act, provides that funds made to heirs of deceased Indians under this Act shall not be considered as income or resources nor otherwise used to reduce or deny food stamp benefits except for per capita shares in excess of $2000.

P.L. 99-146, Section 6(b), 11/11/85 - Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior are excluded from income and resources. Judgments were awarded in Dockets numbered 18-S, 18-U, 18-C and 18-T. Dockets 18-S and 18-U are divided among the following reservations:

Wisconsin

- Bad River Reservation
- Lac du Flambeau Reservation
- Lac Courte Oreilles Reservation
- Sokaogon Chippewa Community
- Red Cliff Reservation
- St. Croix Reservation

Michigan

- Keweenaw Bay Indian Community (L'Anse, Lac Vieux Desert, and Ontonagon Bands)

Minnesota

- Fond du Lac Reservation
- Grand Portage Reservation
- Nett Lake Reservation (including Vermillion Lake and Deer Creek)
- White Earth Reservation

Under Dockets 18-C and 18-T funds are given to the Lac Courte Oreilles Band of the Lake Superior Bands of Chippewa Indians of the Lac Courte Oreilles Reservation of Wisconsin, the Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, the Sokaogon Chippewa Community of the Mole Lake Band of Chippewa Indians, and the St. Croix Chippewa Indians of Wisconsin.

P.L. 99-264, White Earth Reservation Land Settlement Act of 1985, 3/24/86, Section 16 excludes moneys paid under this Act from income and resources. This Act involves members of the White Earth Band of Chippewa Indians in Minnesota.

P.L. 99-346, Section 6(b)(2) - Payments to the Saginaw Chippewa Indian Tribe of Michigan are excluded from income and resources.

P.L. 99-377, Section 4(b), 8/8/86 - Funds distributed per capita to the Chippewas of the Mississippi or held in trust under this Act are excluded from income and resources. The judgments were awarded in Docket Number 18-S. The funds are divided by reservation affiliation for the Mille Lac Reservation, Minnesota; White Earth Reservation, Minnesota; and Leech Lake Reservation, Minnesota.

P.L. 101-41, 6/21/89, the Puyallup Tribe of Indians Settlement Act of 1989, Section 10(b) provides that nothing in this Act shall affect the eligibility of the Tribe or any of its members for any federal program. Section 10(c) provides that none of the funds, assets or income from the trust fund established in Section 6(b) shall at any time be used as a basis for denying or reducing funds to the Tribe or its members under any federal, state or local program. (The Puyallup Tribe is located in the State of Washington.)

P.L. 101-277, 4/30/90, funds appropriated in satisfaction of judgments awarded to the Seminole Indians in Dockets 73, 151 and 73-A of the Indian Claims Commission are excluded from income and resources except for per capita payments in excess of $2000. Payments were allocated to the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida and the independent Seminole Indians of Florida.

P.L. 101-503, Section 8(b), Seneca Nation Settlement Act of 1990, dated 11/3/90, provides that none of the payments, funds or distributions authorized, established, or directed by this Act, and none of the income derived therefrom, shall affect the eligibility of the Seneca Nation or its members for, or be used as a basis for denying or reducing funds under, any federal program.

P.L. 93-134, Section 8, 10/19/73, the Indian Tribal Judgment Fund Use or Distribution Act, as amended by P.L. 103-66, Section 13736, 10/7/93, provides that interest of individual Indians in trust or restricted lands shall not be considered a resource and up to $2000 per year of income received by individual Indians that is derived from such interests shall not be considered income in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

If other types, not on this list, are encountered, contact the PAL for guidance.

In determining MAGI for household income, the following are excluded:

(1) Distributions from Alaska Native Corporations and Settlement Trusts;
(2) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or under the supervision of the Secretary of the Interior;
(3) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from—
   a. Rights of ownership or possession in any lands described in paragraph (2) of this section; or
   b. Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;
(4) Distributions resulting from real property ownership interests related to natural resources and improvements—
   a. Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or
   b. Resulting from the exercise of federally-protected rights relating to such real property ownership interests;
(5) 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; and
(6) Student financial assistance provided under the Bureau of Indian Affairs education programs.[36]

2845.20.00 COMPENSATION TO GERMANS, JAPANESE, AND ALEUTS

German reparation and Japanese and Aleutian restitution payments are discussed in the following sections.

2845.20.05 Payments to Japanese And Aleuts

Restitution payments by the U.S. government under P.L. 100-383 to individual Japanese-Americans (or, if deceased, to their survivors) and Aleuts who were interned or relocated during World War II are excluded from income and resources. Also, restitution payments from the Canadian government to individual

[36] 42 CFR 435.603(e)

Japanese-Canadians who were interned or relocated during World War II are excluded from income.[37]

2845.20.10 German Reparation Payments

Payments made by the Republic of Germany to certain survivors of the Holocaust that may be received periodically or in a lump sum are exempt as income and resources.

2845.25.00 AGENT ORANGE BENEFITS

Payments made from the Agent Orange Settlement Program[38] are excluded as income to the veteran receiving the benefit as well as the veteran's survivors. The veteran receives a payment once per year while he is disabled for the life of the program. Survivors of the deceased veteran receive a one-time lump sum payment.

2845.30.00 FEDERAL TAX REFUND PAYMENTS

For non-MAGI (MED 1, 2, 4) AGs, federal tax refunds received after December 31, 2009 are disregarded as income in the month received and as a resource for a period of 12 months for all federal means-tested programs including Medicaid. The resource exclusion lasts for 12 months.

The federal tax refund is to be excluded as a resource by subtracting any tax refund received by the AG in the last 12 months form the AG’s resources. If the difference between the resources and the amount of the federal tax refund is less than the resource limit, the AG meets the resource limit.

> **Example**: AG applies today and has total resources of $4000. AG verified receipt of a federal refund in the amount of $3287 received in January of this year. This federal refund amount would need to be deducted from the total resources and the difference of $713 would be countable as a resource.

For MAGI (MED 3) AGs, federal tax refund payments are not considered income, so will not be counted in the calculation of MAGI for household income.

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[37] 20 CFR 416.1124(b); 20 CFR 416.1236

[38] P.L. 101-201; 20 CFR 416.1124(b); 20 CFR 1236

2845.35.00 CHILD CARE PAYMENTS

Child care payments from Step Ahead voucher agents and other government agencies made on behalf of TANF recipients, former TANF recipients transitioning from TANF and families at risk of becoming eligible for TANF are exempt as income. Additionally, no deduction is allowed for dependent care covered by these payments. These payments are income for the child care provider who receives them.

2845.40.00 RADIATION EXPOSURE ACT BENEFITS

Payments made from the Radiation Exposure Compensation Trust Fund established under the Radiation Exposure Compensation Act are exempt as income.[39]

2845.45.05 Crime Victim Payments

If a crime victim applies for assistance from any federal, state or local government program that uses federal funds, the program may not include victim compensation benefits paid through the Crime Act of 1984 when determining income eligibility.[40] Victim compensation payments are made to crime victims or their dependents for expenses such as medical expenses, funeral expenses, lost wages and psychological counseling. In Indiana, victim compensation payments are made through the Indiana Criminal Justice Institute's Violent Crime Compensation Division.

2845.50.00 UTILITY EXPENSE PAYMENTS

Payments made as a result of any federal law, such as HUD or FmHA, for the purpose of paying an AG's utility expenses, are exempt as income regardless of how they are paid.

2845.55.00 SETTLEMENT PAYMENTS UNDER WALKER V. BAYER CORPORATION, ET. AL.

Payments made to individuals from the settlement fund in the class action lawsuit, Susan Walker v. Bayer Corporation, et. al. are exempt as income and resources in the Medicaid eligibility

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[39] P.L. 101-426

[40] P.L. 203-322

determination for non-MAGI (MED 1, 2, 4) AGs and are exempt as income for MAGI (MED 3) AGs.[41]

2845.60.00 MILITARY SUBSISTENCE ALLOWANCES

Enlisted members of the Armed Forces may receive a cash benefit up to $500 per month. The benefits are issued by the Department of Defense and are shown on the member's Leave and Earnings Statement as Family Subsistence Supplemental Allowance. This form is the standard wage information form used by the military.

These benefits are to be considered as earned income for non-MAGI (MED 1, 2, 4) AGS. Effective June 1, 2014, combat pay is not to be considered as income. For MAGI (MED 3) AGs, these benefits are not considered taxable income, so are not included in the calculation of MAGI for household income.

2845.65.00 AMERICORPS PROGRAM (MED 1)

Payments made from the Americorps Program to Americorps participants or on their behalf are excluded as income.

2845.70.00 NATIONAL FLOOD INSURANCE PROGRAM (MED 1)

Assistance received under the National Flood Insurance Program for flood mitigation activities with respect to property is not considered income or as a resource for the property owner.

2845.75.00 ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM (MED 1)

Lump sum payments made under the Energy Employees Occupational Illness Compensation Program for employees who suffered as result of work in the nuclear weapons industry and their survivors are exempt.

2850.00.00 DIVIDENDS, INTEREST AND ROYALTIES

Payments of dividends, interest, and royalties are considered unearned income for non-MAGI (MED 1, 2, 4) AGs AGs unless stated otherwise in this chapter and are included as taxable income for MAGI (MED 3) AGs. This includes interest on checking accounts and trust accounts. For MED 1 and 4, interest earned on exempt resources (refer to Chapter 2600) is exempt.

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[41] Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33)

Dividends that the household has the option of either receiving as income or reinvesting in the trust stock or bond are to be considered as income in the month they become available to the household.

For the MED 1 and 4 categories, dividends paid on life insurance policies are exempt. Refer to IHCPPM 2825.00.00.

For the MED 1 and 4 categories, royalties are generally considered unearned income unless they are received as part of a trade or business or received by the individual in connection with any publication of his/her work.[42]

2850.05.00 INTEREST ON INDIVIDUAL DEVELOPMENT ACCOUNTS

For non-MAGI (MED 1, 2, 4) AGs, interest income that is earned on an Individual Development Account (IDA) under the Assets for Independence Act (AFIA), Public Law 106-554, is excluded from income. (See also ICES Program Policy Manual (IPPM) 2630.95.00, which states IDA's are exempt as resources.)

For MAGI (MED 3) AGs, interest income that is earned on an IDA is taxable income, so will be included in the MAGI calculation for household income.

2855.00.00 REIMBURSEMENTS

Reimbursements for past or future expenses are exempt if they do not exceed actual expenses and do not represent a gain or benefit. To be exempt, these payments must be specifically intended and used for expenses other than normal living expenses. Normal living expenses include the amount spent for rent or mortgage, personal clothing, and food eaten at home.

Any part of the reimbursement amount that exceeds the actual expense is included as income. However, reimbursements are not considered to exceed actual expenses, unless the AG or the provider indicates the amount is excessive.

Reimbursements for normal household living expenses such as rent or mortgage, personal clothing, or food eaten at home are a gain or benefit and, therefore, are included as income. Reimbursements from employers over and above the basic wages for necessary job related expenses are exempt unless reimbursements

[42] 20 CFR 416.1121(c)

are in excess of such job related expenses and the employee did not return the excess amount to the employer.

2860.00.00 EDUCATIONAL INCOME DEFINITION

Educational income includes, but is not limited to, grants, scholarships, fellowships, work-study, veterans educational benefits, and deferred educational loans (loans received for educational expenses which are to be repaid at a later date, usually after graduation), that is used for tuition and mandatory fees at an institution of post-secondary education, including correspondence schools at that level or a school at any level for the physically or mentally handicapped.

Wages from graduate assistantships are not treated as educational income if they are subject to taxation and are available for meeting the individual's non-educational living expenses; they are budgeted as earned income.

A loan on which repayment must begin within 60 days after receipt is not considered a deferred loan.

For MED 3 AGs, all scholarships, awards, or fellowship grants used for educational purposes and not for living expenses are not taxable income and are not utilized in the calculation of MAGI. All scholarships, awards, or fellowship grants used for non-educational expenses, such as living expenses, are taxable income and are utilized in the calculation of MAGI, unless they are specifically exempted by federal or state law.[43]

2860.05.00 EXEMPT EDUCATIONAL INCOME (MED 1, 2, 4)

Grants, awards, scholarships and work study income received under Title IV of the Higher Education Act or the Bureau of Indian Affairs (BIA) programs are exempt. For MED 1, 2, 4 AGs, they are exempt only for undergraduate students. Included are the following:

Basic Educational Opportunity Grants (BEOG or PELL Grants);

Presidential Access Scholarships (Super PELL Grants);

Supplemental Educational Opportunity Grants (SEOG);

State Student Incentives Grants (SSIG);

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[43] 42 CFR 435.603(e)(2)

Federal Work Study Funds (NOTE: Not all federal work study funds come under Title IV of the Higher Education Act.) (Refer to IHCPPM 2860.15.00);

TRIO Grants (Go to organizations or institutions for students from disadvantaged backgrounds):

Upward Bound (Some stipends go to students);
Student Support Services;
Robert E. McNair Post-Baccalaureate Achievement.

Robert C. Byrd Honors Scholarship Program;

College Assistance Migrant Program (CAMP) for students whose families are engaged in migrant and seasonal farm work;

High School Equivalency Program (HEP);

National Early Intervention Scholarship and Partnership Program.

Federally funded educational loans are exempt for all students (undergraduate and graduate) for all programs. They include the following:

Federal Direct Student Loan Programs (FDSLP) (formerly GSL and FFELP);

Federal Direct Supplemental Loan Program (provides loans to students);

Federal Direct PLUS Program (provides loans to parents);

Federal Direct Stafford Loan Program; and

Federal Consolidated Loan Program.

Direct loans to students in institutions of higher education (Perkins Loans, formerly NDSL).

2860.10.00 NON-EXEMPT EDUCATIONAL INCOME (MED 1, 2, 4)

Student financial assistance received from a source not listed in IHCPPM 2860.05.00 is considered as non-exempt income. However, it is not necessarily budgeted as income to the AG. Non-exempt educational income is included only to the extent that it is accessible for meeting the AG's general living

expenses. When educational income is inaccessible (received directly by the school in an amount less than or equal to the student's educational expenses as verified by the financial aid office), it is excluded from budgeting. Non-exempt educational income sent directly to the student or refunded by the school after tuition and fees have been paid is budgeted. However, any remaining allowable educational expenses are deducted from it. This applies to undergraduate and graduate students alike. Non-exempt educational income includes assistance provided under the Carl D. Perkins Vocational Educational Act. Programs under this Act include the following:

- Indian Vocational Education Program;
- Native Hawaiian Vocational Education Program;
- State Vocational and Applied Technology Education Program which contains:
  - State Program and State Leadership Activities;
  - Program for Single Parents, Displaced Homemakers, and Single Pregnant Women;
  - Sex Equity Program;
  - Programs for Criminal Offenders;
  - Secondary School Vocational Education Program;
  - Post-secondary and Adult Vocational Education Program;
  - State Assistance for Vocational Education Support Programs by Community Based Organizations;
  - Consumer and Homemaking Education Program;
  - Comprehensive Career Guidance and Counseling Program;
  - Business-Labor-Education Partnership for Training Program;
- National Tech-Prep Education Program;
- State-administered State Grants for Facilities and Equipment and Other Program Improvement Activities;

Community Education Employment Centers Program;

Vocational Education Lighthouse Schools Program;

Tribally Controlled Post-secondary Vocational Institutions Program;

Vocational Education Research Program;

National Network for Curriculum Coordination in Vocational and Technical Education;

National Center or Centers for Research in Vocational Education;

Materials Development in Telecommunications Program;

Demonstration Centers for the Training of Dislocated Workers Program;

Vocational Education Training and Study Grants Program;

Vocational Education Leadership Development Awards Program;

Vocational Educator Training Fellowships Program;

Internships for Gifted and Talented Vocational Education Students Program;

Business and Education Standards Program;

Blue Ribbon Vocational Education Program;

Educational Programs for Federal Correctional Institutions;

Vocational Education Dropout Prevention Program;

Model Programs of Regional Training for Skilled Trades;

Demonstration Projects for the Integration of Vocational and Academic Learning Program;

Cooperative Demonstration Programs;

Bilingual Vocational Training Program;

Bilingual Vocational Instructor Training Program;

Bilingual Materials, Methods, and Techniques Program.

2860.15.00 WORK STUDY (MED 3)

For MAGI, work-study educational income is received for the performance of work. Income received for a work study program is considered taxable income, so it is included in the calculation of MAGI for purposes of determining household income.

2860.20.00 EMPLOYER EDUCATIONAL ASSISTANCE (MED 3)

For MAGI, up to $5,250 of qualified employer-provided educational assistance can be excluded from taxable income and not included in the calculation of MAGI for determining household income.

2860.25.00 SCHOLARSHIPS AND FELLOWSHIPS (MED 3)

A scholarship is an amount paid to or for the benefit of a student (undergraduate or graduate) at an educational institution to assist in the pursuit of a degree. A fellowship is an amount paid to a student to assist with the pursuit of study or research. Qualified scholarship and fellowship payments may be excluded from taxable income and will not be included in the calculation of MAGI for household income. A qualified scholarship or fellowship consists of any payment an individual receives that is for tuition and fees for enrollment in an eligible educational institution or course related expenses, such as required fees, books, and equipment. Any scholarship or fellowship amount used for non-educational expenses (*e.g.*, room and board, travel, research or clerical help) or any amount in excess of educational expenses is considered taxable income so will be included in the calculation of MAGI for household income.

If any part of a scholarship or fellowship that represents payment for teaching, research or other services required to receive the scholarship or fellowship is considered taxable income it will be included in the calculation of MAGI. Exceptions to this rule include any scholarship or fellowship amounts received from the National Services Corps Scholarship Program or the Armed Forces Health Professions Scholarship and Financial Assistance Program.

Example: An individual receives a scholarship of $5,000.00, and the scholarship was not received from the National Services Corps Scholarship Program or the Armed Forces Health Professions Scholarship and Financial Assistance Program. The individual is required to work as a teaching assistant in order to receive the scholarship. $2,000.00 of the scholarship represents payment for teaching. $2,000.00 is used for qualified

Scholarship prizes won in a contest that do not require the winner to use the prize for educational purposes are considered taxable income so will be included in the calculation of MAGI for household income.

Pell grants and other Title IV need-based education grants are treated the same as scholarships and fellowships. Any amount received for qualified educational expenses as explained above is not considered taxable income and will not be included in the calculation of MAGI.

Any amounts received from the Department of Veterans Affairs for education are not considered taxable income and will not be included in the calculation of MAGI.

2860.30.00 Qualified Tuition Reduction (MED 3)

A tuition reduction is when an individual is allowed to study at no cost or for a reduced tuition. A qualified tuition reduction is not considered taxable income unless a portion of the reduction represents payment for teaching, research or other services. In order for a tuition reduction to be qualified it must be received from and used at an eligible educational institution (an institution that maintains a regular faculty and curriculum and has a regularly enrolled student body at the location where it provides its educational activities). The tuition reduction does not have to be used at the same eligible institution that provided the reduction if it is for a college-level or above degree. Therefore, a tuition reduction that falls within the aforementioned parameters will not be included in the calculation of MAGI for household income.

If an individual receives a tuition reduction for education below the college-level (primary, secondary or high school), one of the following requirements must be met in order for the reduction to not be considered taxable income and not included in the calculation of MAGI:

1) The individual is an employee of the educational institution;

2) The individual was an employee of the educational institution, but retired or left on disability;

3) The individual is a widow or widower whose spouse died while an employee of the educational institution or who retired or left on disability; or

4) The individual is the dependent child or spouse of an individual described in requirements 1 through 3 above.

2860.35.00 EDUCATION EXPENSE DEDUCTIONS (MED 3)

The following sections discuss the deductions allowed for the calculation of MAGI for household income.

2860.35.05 STUDENT LOAN INTEREST DEDUCTION (MED 3)

If an individual’s MAGI is less than $75,000 there is a special deduction of up to $2,500 allowed for interest paid on student loans. This special deduction is allowed when the following requirements are met:

1) The student loan was taken out solely to pay qualified education expenses.

2) The student loan was not from a related person or made under a qualified employer plan.

3) The student is the individual applying for Medicaid or his or her spouse or dependent.

4) The student is enrolled at least half-time in a degree program.

The deduction is allowed for both required and voluntary interest payments.

2860.35.10 TUITION AND FEES DEDUCTION (MED 3)

Qualified education expenses up to $4,000 can be deducted from an individual's taxable income if the qualified education expenses are for higher education, the individual pays the expenses for an eligible student, and the eligible student is the individual, the spouse or tax dependent of the individual. This deduction cannot be utilized if an individual is married filing separately, if another person can claim the individual as a tax dependent, or the individual or spouse is a nonresident alien.

An eligible educational institution is any college, university, vocational school, or other postsecondary institution that participates in a U.S. Department of Education student aid program.

Qualified education expenses include tuition, student activity fees, and expenses for course-related books, supplies and equipment as long as such expenses are paid to the institution as a requirement for enrollment or attendance.

2865.00.00 LOANS

For MED 1, 2, 4 AGs, a loan in the month of receipt is exempt providing there is a verifiable repayment schedule in effect.

A source with which to repay the loan need not exist for the loan to be exempt.[44]

When income proceeds are received as repayment on a loan only the amount received as interest is considered countable.[45]

For MED 3 AGs, loans are not taxable income. However, if a loan is canceled or forgiven, other than a gift, the amount canceled or forgiven is considered taxable income and is included in the calculation of MAGI for household income.

2865.05.00 STUDENT LOAN CANCELLATIONS AND REPAYMENT ASSISTANCE (MED 3)

Student loan cancellation and student loan repayment assistance may not be considered taxable income if certain requirements are met.

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[44] 405 IAC 2-3-11; 470 IAC 10.1-3-4; 7 CFR 273.9(c)(4)

[45] 20 CFR 416.1103(f)

The cancellation of a student loan will not be considered taxable income and not be considered in the calculation of MAGI if:

1) The loan was made by a qualified lender to assist the individual in attending an eligible educational institution:

    a. A qualified lender is the United States, a State, a tax exempt state/county/municipal hospital whose employees are considered public employees under state law, an eligible educational institution (if the loan was made as part of an agreement with one of the aforementioned lenders or was made under a program designed to encourage students to serve in occupations with unmet needs or areas with unmet needs).

2) A condition of the loan was that all or part of the loan would be cancelled if the individual worked for a certain period of time, in a certain profession, and for any of a broad class of employers.

The cancellation of a student loan does not qualify as tax-free if the loan was made by an educational institution and is canceled because of services performed for the educational institution.

Student loan repayments made to an individual are not considered taxable income if received from any of the following:

1) The National Health Service Corps Loan Repayment Program;

2) A state education loan repayment program eligible for funds under the Public Health Service Act;

3) Any other state loan repayment programs that is intended to provide for an increased availability of health services in underserved or health professional shortage areas.

2866.00.00 REVERSE MORTGAGES

A reverse mortgage is a mortgage contract that allows a homeowner, age 62 or older, to borrow a percentage of the appraised value of his home. The homeowner then receives either

a periodic payment or a line of credit which does not have to be repaid as long as he lives in the home.

2866.05.00 REVERSE MORTGAGES (MED 1, 2, 4)

The proceeds from a reverse mortgage are not counted as income in the month received. However, if they are retained into the following month, they must be evaluated as resources. Another reverse mortgage arrangement consists of the purchase of an annuity and is called a reverse annuity mortgage (RAM).

Annuity payments from a reverse annuity mortgage are counted as unearned income.

2866.10.00 REVERSE MORTGAGES (MED 3)

For MAGI, the IRS does not distinguish between the different types of reverse mortgages when determining taxable income but sets forth that the monthly advances received from a reverse mortgage are not taxable income, so they are not included in the calculation of MAGI for purposes of determining household income.

2870.00.00 CONTRIBUTIONS - DEFINITION

All direct money payments from any source that represent a gain or benefit to the individual, with no obligation to repay.

2870.05.00 CONTRIBUTIONS (MED 1, 2, 4)

Cash contributions are included as unearned income.

2870.10.00 CONTRIBUTIONS (MED 3)

For MAGI, cash contributions are not considered taxable income and are not included in the calculation of MAGI for purposes of determining household income. Exceptions to this rule include:

1) The cash contribution is from property income; or

2) The cash contribution is from an employer and is not nominal in nature.

2875.00.00 REAL ESTATE INCOME

Income from real estate includes any funds resulting from property ownership. This income can be earned or unearned, depending on the program involved and the individual's management activity.

The following sections describe income received from rental property, sales contracts on property, and room and board.

2875.05.00 RENTAL INCOME

Rental income is any payment for using real or personal property. Examples of rent include payments for the use of:

Land;
Buildings;
An apartment, room, or house; or
Machinery or equipment.

2875.05.05 Rental Income (MED 3)

Income received from the rental of real estate is considered earned taxable income and is included in the calculation of MAGI for determining household income.

Expenses related to rental income that can be deducted when calculating MAGI include all allowable IRS deductions such as:

1) Depreciation;

2) Advertising;

3) Auto and travel expenses;

4) Commissions;

5) Insurance;

6) Interest;

7) Legal and other professional fees;

8) Local transportation expenses;

9) Management fees;

10) Mortgage interest paid to bank;

11) Taxes;

12) Utilities;

13) Repairs to keep property in good working condition but do not add value;

14) Operating expenses; and

15) Uncollected rents (cannot deduct if a cash basis taxpayer – only report actual cash collected).

2875.05.10 Rental Income (MED 1, 2, 4)

Rental income that is payment for the use of real or personal property is unearned income. Rental payments may be received for the use of land (including farm land), for land and buildings, for a room, apartment, or house, or for machinery and equipment.

Another type of rental situation occurs when an individual owns multiple rental units, so that he is actually administering a rental business. That situation is considered self-employment, and the resulting income is earned income. Refer to IHCPPM 2810.30.00

2875.10.00 INCOME FROM CONTRACT SALES

Income from land contract sales is paid in installments. The following sections discuss the treatment of payments from contract sales.

2875.10.05 Income from Contract or Installment Sales (MED 3)

A contract or installment sale of property is where an individual receives at least one payment for the property after the tax year of the sale. This type of sale applies to personal and real property. Any payment of interest and any gain on the sale received as a result of the sales or installment contract is taxable income and included in the calculation of MAGI for determining household income.

2875.10.10 Income from Contract Sales (MED 1, MED 4)

When real property is sold on contract, the monthly contract payments are considered unearned income.[46] Allowable ownership expenses are deducted to determine the amount to be budgeted. Payments received on a basis other than monthly are to be prorated to establish a monthly amount. The down payment is considered a resource.

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[46] 405 IAC 2-5-1(a)(3)

Allowable ownership expenses for a land contract are:

interest on mortgage;

insurance on property and equipment;

principal on the mortgage; and

property taxes

2880.00.00 LUMP SUM PAYMENTS

A lump sum is any type of cumulative payment made to an individual. A payment of retroactive benefits such as SSI, Social Security, Veterans' benefits, or a refund of Medicare Part B premiums is considered a lump sum. Insurance settlements, inheritances, and lottery winnings are also examples of lump sum payments. When evaluating a lump sum, the worker must carefully determine whether it is a recurring payment or a non-recurring payment. Non-recurring means the payment is a one-time payment and is not expected to be received from the same source for the same reason as a lump sum again. Conversely, if a payment is expected to be received again from the same source, it is considered to be a recurring lump sum payment.

2880.05.00 LUMP SUM PAYMENTS (MED 1, 2, 4)

Any lump sum payment received in a month prior to the month in which authorization of the application takes place, is income in the month of receipt. However, for an active AG, an unanticipated non-recurring lump sum payment does not affect eligibility in the month of receipt, and Medicaid benefits paid during the month of receipt are not recoverable. Recurring lump sum payments are budgeted as income. Any portion of the lump sum remaining after the month of receipt is a resource for non-MAGI (MED 1, 2, 4) AGs.

2880.10.00 LUMP SUM PAYMENTS (MED 3)

For MAGI, any amount received as a lump sum is counted as income only in the month received.[47] SSI lump sum payments are considered exempt.

2885.00.00 DEEMED INCOME (MED 1 and 4)

Deemed income refers to a special budgeting calculation in which a portion of an individual's income is considered available to participating AG members. Deemed income is considered as unearned income in the budget.

For additional information regarding deeming, refer to IHCPPM 3455.05.20

2890.00.00 VERIFICATION OF INCOME

All income must be documented and verified.

For MED 1, 2, 4 AGs, income can be verified through an electronic interface or database or a written, telephone, or personal collateral contact with the employer or source of income. When verifying income, the date and source of verification and the receipt date and amount of income received must be recorded.

The worker is responsible for obtaining and verifying all pertinent information regarding the financial situation of the applicant/recipient in order to make accurate determinations of initial and continuing eligibility. The applicant/recipient must supply required documents and records and must assist in obtaining verifications if such information cannot be obtained electronically through an interface or database. All paper documentation must be completed and signed by the appropriate individuals (for example, the employer, the client).

For MAGI, an applicant must attest to income on the application. The income provided by the applicant is then verified by electronic sources or paper documentation.

If an individual attests to income below the Medicaid or CHIP income standard and electronic data on the income is unavailable or conflicts with the amount attested, further documentation will be requested from the applicant.

If an individual attests to income above the Medicaid or CHIP income standard and the electronic data verification amount

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[47] 42 CFR 435.603(e)(1)

indicates income below the applicable threshold, the individual is determined ineligible with no additional information requested. The individual will then be screened for eligibility in other insurance affordability programs available on the Federal Marketplace and the application transferred to the Federal Marketplace for a determination of qualified health coverage, Advance Premium Tax Credit (APTC), and Cost Sharing Reduction (CSR).

If the difference between the attested amount and the electronic data verification amount results in the placement in a different benefit package or cost sharing amount, further documentation will be requested from the applicant.

Documentation that may be requested includes, but is not limited to, a signed contract for employment, wage receipts, wage statements, employment verification form or pay stubs.[48]

For time standards and responsibility for verification refer to IHCPPM sections 2025.00, 2215.15.00 and 2220.00.

2890.05.00 VERIFICATION OF EARNED INCOME

All earned income must be verified.

Acceptable forms of verification include, but are not limited to, the following:

- wage receipts;
- wage statements;
- pay stubs;
- employment verification form or written statements containing the required information;
- information obtained from the Work Number;
- collateral contact with employer;
- work calendar (for tips and daily cash payments).

For MAGI (MED 3) AGs, the applicant will attest to earned income on the application, and the worker will verify the earned income

[48] 42 CFR 435.948

via electronic sources, if available. If there are discrepancies between the income information provided by the applicant and the electronic data or electronic data is not available, the worker will request paper documentation as set forth in IHCPPM 2890.00.00, which includes but is not limited to, the above mentioned documents.[49]

2890.05.05 Verification of Self-Employment Income/Expenses

Self-employed individuals must verify earned income. In addition, these individuals must make all business records which are necessary to verify income and/or expenses available to the caseworker. Examples of business records include documentation on:

income tax records necessary to determine gross income and deductible expenses;

purchases;

sales;

salaries;

capital improvements; and

utility, transportation, and other operating costs.

For MAGI (MED 3) AGs, the applicant will attest to self-employment earned income on the application, and the worker will verify the earned income via electronic sources. If there are discrepancies between the income information provided by the applicant and the electronic data or electronic data is not available, the worker will request documentation as set forth in IHCPPM 2890.00.00, which includes but is not limited to, the above mentioned documents.[50]

2890.10.00 VERIFICATION OF UNEARNED INCOME

All unearned income must be verified. The following sources may be used to verify unearned income:

BENDEX or SDX;

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[49] 42 CFR 435.948

[50] 42 CFR 435.948

SSA award letters;

TPQY computer cards;

VA award letter;

pension check or award letter;

correspondence with the payor;

Unemployment Compensation award letter;

support court statement and/or current statement from payor; and

interest on bank account statements.

The agencies and the type of match(es) they provide are as follows:

Internal Revenue Service (IRS):

Unverified Unearned Income Data Exchange (UUIDX) (TRAN:DEUX)

Social Security Administration (SSA):

Beneficiary Earnings Exchange Record (BEER) (TRAN:DEBR)

Beneficiary Data Exchange (BENDEX) (TRAN:DEBN)

State Data Exchange (SDX) (TRAN:DESK)

Indiana Department of Employment and Training (IDETS):

Wage Data Exchange (WDX) (TRAN:DEWX)

Unemployment Insurance (UI) (TRAN:DEUI)

More information concerning Data Exchange is found in IPPM:

IPPM Section 4430.05.00 - BEER
IPPM Section 4430.10.00 - BENDEX
IPPM Section 4430.15.00 - SDX
IPPM Section 4430.35.00 - WDX
IPPM Section 4430.30.00 - UI

IPPM Section 4430.40.00 – UIDEX

For MAGI (MED 3) AGs, the applicant will attest to unearned income on the application, and the worker will verify the unearned income via electronic sources. If there are discrepancies between the income information provided by the applicant and the electronic data or electronic data is not available, the worker will request documentation as set forth in Section 2890.00.00, which includes but is not limited to, the above mentioned documents.[51]

2890.10.05 Verification of Child Support Payments (MED 1, 2, 4)

Verification of support payments must be obtained. The following sources may be used to verify support.

Verification from the County Clerk's Office if paid through the court;

If the absent parent does not pay through the County Clerk's Office, a signed statement showing the amount paid and how often it is paid must be obtained from the absent parent; or

Case Payment Information (DECB)

2890.10.10 Verification of Supplemental Security Income (SSI) (NON-MAGI, MED 1, 2, 4)

Sources of verification of SSI include:

SDS, DESX;
IQSSA;
the entitlement letter; or
the benefit check, which will be the net payment.

If the individual does not appear on the SDX, the following sources may be used:

Form SSA 1610;
TPQY computer cards.

IQSSA lists all persons receiving SSI benefits. IQSSA displays the same information that is on DESX. IQSSA is updated daily and will, therefore, have the latest benefit information for

[51] 42 CFR 435.948

each SSI recipient. Since information is accessible on individuals who are not on any of Indiana's assistance programs confidentiality guidelines (see IHCPPM 1425.00.00) must be strictly followed.

Refer to IHCPPM 2835.35 for discussion on inclusion or exclusion of SSI income.

2890.10.15 Verification of Social Security Income

The Social Security Administration rounds down the entitlement amount to the nearest whole dollar. The amount of all Social Security checks (with a few rare exceptions) are in whole dollars.

When verifying Social Security benefits, the "unrounded gross benefit amount" and the "net payment amount" (Medicare Part B is withheld) are required. The "gross payment amount" is the unrounded amount with the cents dropped and is the amount of the benefit check for an individual who does not have the Medicare Part B deducted.

Sources of verification of Social Security include:

- the un-cashed benefit check (by itself) if:
  - the individual does not have Medicare Part B coverage; or
  - the individual is on Buy-In.
- form SSA-1610 - request verification of the "unrounded gross benefit amount" and the "net payment amount".
- TPQY computer cards;
- BENDEX (DEBN); or
- the entitlement letter, if the unrounded gross benefit and "net payment amount" are clearly specified.

For MAGI (MED 3) applicants, the applicant will attest to the Social Security benefit income on the application. If there are discrepancies between the income information provided by the applicant and the electronic data or electronic data is not available, the worker will request documentation as set forth in IHCPPM 2890.00.00, which includes but is not limited to, the above mentioned documents.[52]

2890.10.20 Verification of Veterans' Benefits (NON-MAGI, MED 1, 2, 4)

Verification of Veterans' Benefits generally has to be obtained by contacting the Department of Veterans' Affairs. If the veteran has no dependents, the amount can be verified by the benefit check or entitlement letter. However, if the benefit includes an allowance for dependents, the worker must request a breakdown of the benefit. If the Department of Veterans' Affairs will not provide such breakdown, the entire amount is considered income to the veteran. Refer to IHCPPM 2840.10.00.

2890.10.25 Verification of Railroad Retirement

Verification of the gross monthly entitlement must be obtained. This is the full entitlement amount without the deduction of the Medicare Part B premium. Sources of verification include:

Railroad Retirement Board; or
the entitlement letter.

Railroad retirement benefit is combined with the Social Security amount and contained in one check for most railroad retirement recipients.

For MAGI (MED 3) AGs, the applicant will attest to the railroad retirement benefit income on the application, and the worker will verify the income via electronic sources. If there are discrepancies between the income information provided by the applicant and the electronic data or electronic data is not available, the worker will request documentation as set forth in IHCPPM 2890.00.00, which includes but is not limited to, the above mentioned documents.[53] Refer to IHCPPM 2840.15.00.

2890.10.30 Verification of Black Lung Benefits

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[52] 42 CFR 435.948

[53] 42 CFR 435.948

Sources of Black Lung benefit verification include:

the benefit check;

the SSA District Office for benefit checks received on the third of the month;

for benefits paid on the 15th of the month, contact the United States Department of Labor, Division of Coal Mine Workers Compensation, 121 East State Street, Columbus, Ohio 43215 - Telephone: (614) 469-5227

2890.10.35 Verification of Pensions

Verification of the gross amount of a pension payment must be obtained. Viewing the check will not provide accurate information since optional deductions, such as federal income taxes and health insurance premiums, are often withheld. The worker must verify if any deductions are mandatory or optional. Sources of verification include:

notices regarding benefit amounts, deductions, and payments in the possession of the individual; and

correspondence from the payor.

Verification of the gross amount of a federal pension can be obtained by writing to the Office of Personnel Management, Insurance and Retirement Programs, Washington, D.C. 20415. The request for information must contain the individual's name and Civil Service Annuitant (CSA) number.

For MAGI (MED 3) AGs, if the applicant’s pension benefits are counted in the calculation of MAGI, the applicant will attest to the benefit income on the application, and the worker will verify the income via electronic sources. If there are discrepancies between the income information provided by the applicant and the electronic data or electronic data is not available, the worker will request documentation as set forth in IHCPPM 2890.00.00, which includes but is not limited to, the above mentioned documents.[54] Refer to IHCPPM 2840.20.00.

2890.10.40 Verification of Unemployment Compensation Benefits (UCB)

[54] 42 CFR 435.948

An automatic request for verification of Unemployment Compensation Benefits (UCB) is accomplished through data exchange. This request is completed for all AG members, age 16 and over, at application and for ongoing cases. The information from the Indiana Department of Workforce Development includes wage and unemployment verification from the prior month. If only part of the maximum benefit is being paid out there may be a deduction for child support, recoupment or part-time earnings. Refer to IHCPPM 2840.25.00 and IPPM 4430.30.00.

For MAGI (MED 3) AGs, if the applicant’s unemployment benefits are counted in the calculation of MAGI, the applicant will attest to the income on the application, and the worker will verify the income via electronic sources. If there are discrepancies between the income information provided by the applicant and the electronic data or electronic data is not available, the worker will request documentation as set forth in IHCPPM 2890.00.00.[55] Refer to IHCPPM 2840.25.00.

2890.10.45 Verification of Worker's Compensation (NON-MAGI, MED 1, 2, 4)

Inquiries regarding entitlement to benefits are to be directed to the Industrial Board, Indiana Government Center South, 402 West Washington Street, Room W-196, Indianapolis, Indiana 46204.

Verification of the amount of such payment, payment receipt date intervals, and the length of time for which payments are approved is to be obtained by viewing the award notice in the possession of the individual, or by contacting the Industrial Board. When contacting the Industrial Board, the name of the employee, the date of injury, and the name of the employer should be given.

If a portion of the award is verified as being designated for medical, legal, or related expenses paid or deducted at the source and is not controlled by the individual, that portion is to be deducted from the amount of the award when determining the amount of the payment that is available to the individual. Refer to sections under IHCPPM 2840.30.

2890.10.50 Verification of Educational Income

All student income from educational grants, scholarships, and loans must be verified and documented. For non-MAGI (MED 1, 2, 4) AGs, documentation must include the name of the educational

[55] 42 CFR 435.948

institution and the amounts of any grants, scholarships, and loans; the type of assistance, the dates covered and expenses covered (earmarked by each source of income). If the income includes grants or scholarships which are not automatically exempt (see IHCPPM 2860.65.00), the school must also verify whether the funds are sent directly to the school or to the student. If the school receives the educational income directly and the amount exceeds the student's documented educational expenses, a financial aid administrator must be questioned as to whether the school expects to refund the difference to the student at some point. (See IHCPPM 2860.10.00 for additional information on non-exempt educational income.)

Verification may be obtained in writing or by telephoning the school or loan office. A written agreement with the lending institution which contains the necessary dates and that is signed by the individual will also serve as documentation.

For MAGI (MED 3) AGs, only scholarships, awards, or fellowship grants used for non-educational expenses, such as living expenses, are taxable income and are utilized for the calculation of MAGI.[56] The applicant will attest to the income on the application, and the worker will verify the income via electronic sources. If there are discrepancies between the income information provided by the applicant and the electronic data or electronic data is not available, the worker will request documentation as set forth in IHCPPM 2890.00.00.[57]

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[56] 42 CFR 435.603(e)(2)

[57] 42 CFR 435.948

3000.00.00 ELIGIBILITY STANDARDS

3005.00.00 RESOURCE LIMITS

3005.10.00 RESOURCE LIMITS (MED 1)

3005.10.05 HOME EQUITY RESTRICTION (MED 1)

3005.15.00 RESOURCE LIMITS (MED 3)

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3010.20.15 Special Income Level Used For Waiver Services (MED 1)

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3010.25.00 INCOME STANDARDS (MED 2)

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3010.30.05 Income Standards/Low-Income Parents or Caretakers, Children Age 19, 20 and Children in Psychiatric Facilities (MED 3)

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3010.30.15 Income Standards/Child Age 6 - 18 (MED 3)

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3010.30.25 Income Standards/Child Under 19 (MED 3)

3010.30.30 Pregnant Women, Infants Under Age One (MED 3)

3010.30.40 Certain Children / Premiums, and (MED 3)

3010.35.00 INCOME STANDARDS (MED 4)

3010.35.05 QMB Income Standards (MED 4)

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3040.00.00 GENERAL INCOME DISREGARD (MED 1, 4)

3041.00.00 MEDICARE PART D BENCHMARK (MED 1)

3045.00.00 GENERAL EARNED INCOME DISREGARD (MED 1 MED 4)

3046.00.00 SUBSTANTIAL GAINFUL ACTIVITY AMOUNT (MED 1)

3047.00.00 MINIMUM EARNINGS FOR M.E.D. WORKS IMPROVED CATEGORY (MED 1)

3000.00.00 ELIGIBILITY STANDARDS

Each program has separate standards established by law or regulation which must be used to determine eligibility for assistance. This chapter includes information on the following:

Resource Limits (Section 3005);
Facility Private Pay Rate (Section 3006);
Income/Need Standards (Section 3010);
MA Earned Income Disregard (Section 3035);
General Income Disregard (Section 3040);
Medicare Part D Benchmark (Section 3041);
General Earned Income Disregard (Section 3045);
Substantial Gainful Activity (Section 3046); and
Minimum Earnings for M.E.D. Works Improved Category (Section 3047)

3005.00.00 RESOURCE LIMITS

The resource limit is the maximum value of nonexempt resources which an assistance group (AG) may retain in order to be eligible for assistance.

3005.10.00 RESOURCE LIMITS (MED 1)

The resource limit is dependent upon the category of assistance and the composition and living arrangement of the AG.[1]

Effective June 1, 2014, the resource limits for Aged, Blind, and Disabled categories (MA A, MA B, and MA D) are as follows:

$2000 for an applicant/recipient, who is unmarried, separated from his spouse for reasons other than medical, or whose spouse qualifies as a "community spouse". [For months prior to June 1, 2014, the resource limit is $1,500].

[1] 405 IAC 2-3-15; 405 IAC 2-9-4; IC 12-15-2-24

$3000 for an applicant/recipient and his spouse (whether or not the spouse is an applicant/recipient) if the couple is living together, or separated only for medical reasons and the spousal impoverishment provisions do not apply. [For months prior to June 1, 2014, the resource limit is $2,250].

For the applicant/recipient who is under age 18 and living with his parents, the resource limit for his parents is as follows, unless the child is approved for Home and Community Based Services. Under these waivers, parental resources are not considered.

- $2000 for a biological or adoptive parent who is unmarried or separated from his spouse [prior to June 1, 2014, the limit is $1,500]; or

- $3000 for biological or adoptive parents living together, or who are separated only for medical reasons [prior to June 1, 2014, the limit is $2,250].

Effective June 1, 2014, the resource limits for M.E.D. Works (MADW, MADI) are:

$2,000 for an applicant/recipient, who is unmarried, separated from his spouse for reasons other than medical, or whose spouse qualifies as a community spouse. [For months prior to June 1, 2014, the resource limit is $1,500].

$3,000 for an applicant/recipient and his spouse (whether or not the spouse is an applicant/recipient if the couple is living together, or separated only for medical reasons and the spousal impoverishment provisions do not apply. [For months prior to June 1, 2014, the resource limit is $2,250].

Parental resources are exempt for applicant/recipient children.

When an institutionalized individual has a community spouse, the community spouse resource limit is the greatest of the following amounts effective January 1, 2017:[2]

- The state standard of $24,180 effective 1/1/17; ($23,844 effective 1/1/15; $23,448 effective 1/1/14; $23,184 effective 1/1/13; $22,728.00 effective 1/1-12; $22,728 effective 1-1-12; $21,912 effective 1/1/09 through 12/31/11; $20,880 effective 1/1/08 through 12/31/08);

[2] 405 IAC 2-3-15; Social Security Act (SSA) 1924(f)(2)(A)

- The spousal share, up to a maximum of $120,900 effective 1/1/17; ($119,220 effective 1/1/15; 117,240 effective 1/1/14; $115,920 effective 1/1/13; $113,640 effective 1/1/12; $109,560, effective 1/1/09 through 12/31/11; $104,400 effective 1/1/08 through 12/31/08);

- Any amount of resources ordered by a court against the institutionalized spouse for the support of the community spouse;

- The amount established by an Administrative Law Judge as the result of an appeal; or

- The above standards were not adjusted effective 1/1/10 through 1/1/11 as usual because the CPI did not increase.

3005.10.05 HOME EQUITY RESTRICTION (MED 1)

An applicant will be ineligible for long-term care services, if the applicant's equity interest in the real property is greater than $560,000 effective 1/1/2017.

- From 1/1/2016 to 12/31/2016 the limit was $552,000
- From 1/1/2015 to 12/31/2015 the limit was $552,000
- From 1/1/2014 to 12/31/2014 the limit was $543,000
- From 1/1/2013 to 12/31/2013 the limit was $536,000
- From 1/1/2012 to 12/31/2012 the limit was $525,000
- From 1/1/2011 to 12/31/2011 the limit was $506,000
- From 1/1/2009 to 12/31/2010 the limit was $500,000.

3005.15.00 RESOURCE LIMITS (MED 2)

This section is applicable to MA Q (Refugee Medical Assistance) only.

The resource limit is $1,000 for applicants.

3005.20.00 RESOURCE LIMITS (MED 3)

There are no resource limits for any of the MED 3 categories of assistance. Any amount of resources may be retained by an AG.

3005.25.00 RESOURCE LIMITS (MED 4)

The resource limits for the QMB, SLMB, QDW, and QI

categories are:[3]

$7,390 effective 1/01/17 for an applicant/recipient who is unmarried or not living with his spouse;

$11,090 effective 1/01/17 for an applicant/recipient and his spouse if the couple is living together.

3006.00.00 FACILITY RATE USED TO CALCULATE PENALTY PERIOD (MED)

The average monthly private pay rate for nursing facilities in the statewide geographic region to be used in computing transfer penalties as explained in Section 2640.10.35 is $6,078. This amount is in effect for applications filed on and after July 1, 2016.

For applications filed on or after:
7-1-15 through 6-30-16, $5923;
7-1-14 through 6-30-15, $5733;
7-1-13 through 6-30-14, $5449;
7-1-12 through 6-30-13, $5353;
7-1-11 through 6-30-12, $5139;
7-1-10 through 6-30-11, $4826;
7-1-09 through 6-30-10, $4611;
7-1-08 through 6-30-09, $4456;
7-1-07 through 6-30-08, $4249;
7-1-06 through 6-30-07, $3960;
7-1-05 through 6-30-06, $3898;
7-1-04 through 6-30-05, $3817;
7-1-03 through 6-30-04, $3667;
7-1-02 through 6-30-03, $3,598

For applications filed 11-1-98 through 6-30-02, the amount for the appropriate geographic region below is to be used.

Region I	$ 3,405.21
Region II	$ 3,422.07
Region III	$ 3,267.05

COUNTY	REGION	COUNTY	REGION
ADAMS	I	LAWRENCE	III
ALLEN	I	MADISON	II
BARTHOLOMEW	III	MARION	II
BENTON	II	MARSHALL	I
BLACKFORD	II	MARTIN	III
BOONE	II	MIAMI	I
BROWN	III	MONROE	III

[3] SSA 1905(p)(1)(C)

CARROLL	II	MONTGOMERY	II
CASS	I	MORGAN	II
CLARK	III	NEWTON	I
CLAY	III	NOBLE	I
CLINTON	II	OHIO	III
CRAWFORD	III	ORANGE	III
DAVIESS	III	OWEN	III
DEARBORN	III	PARKE	III
DECATUR	III	PERRY	III
DEKALB	I	PIKE	III
DELAWARE	II	PORTER	I
DUBOIS	III	POSEY	III
ELKHART	I	PULASKI	I
FAYETTE	II	PUTNAM	III
FLOYD	III	RANDOLPH	II
FOUNTAIN	II	RIPLEY	III
FRANKLIN	II	RUSH	II
FULTON	I	ST. JOSEPH	I
GIBSON	III	SCOTT	III
GRANT	II	SHELBY	II
GREENE	III	SPENCER	III
HAMILTON	II	STARKE	I
HANCOCK	II	STEUBEN	I
HARRISON	III	SULLIVAN	III
HENDRICKS	II	SWITZERLAND	III
HENRY	II	TIPPECANOE	II
HOWARD	II	TIPTON	II
HUNTINGTON	I	UNION	II
JACKSON	III	VANDERBURGH	III
JASPER	III	VERMILLION	III
JAY	II	VIGO	III
JEFFERSON	III	WABASH	I
JENNINGS	III	WARREN	II
JOHNSON	II	WARRICK	III
KNOX	III	WASHINGTON	III
KOSCIUSKO	I	WAYNE	II
LAGRANGE	I	WELLS	I
LAKE	I	WHITE	I
LAPORTE	I	WHITLEY	I

3010.00.00 INCOME/NEED STANDARDS

Income and Need Standards are the maximum income or expense consideration that is given to an AG in order to determine financial eligibility. For some programs, both a gross income and net income comparison are necessary. The specific income or need standards of each program are discussed in the following sections.

3010.20.00 INCOME STANDARDS (MED 1)

The income standards used in determining eligibility for MA A, MA B, and MA D AGs are based on AG size, composition, and

living arrangement. The following sections list the income standards to be utilized in a given case.

All of the income standards that normally increase based on the annual Social Security cost of living adjustment (COLA) effective in January 2011 remained at the 2009 level since there was no COLA in 2010 or 2011. COLA resumed effective January, 2012.

3010.20.05 Eligibility Income Standards (MED 1)

The monthly income standards listed in this section are used in the eligibility determination. These standards are effective March 1, 2016.

$990 - unmarried applicant/recipient of any age; or applicant/recipient not living with a spouse

$1335 - married couple, either or both of whom are applicants/recipients

3010.20.05.05 Additional Eligibility Income Standards (MED 1)

The monthly income standards listed in this section are used in the eligibility determination. These standards are effective January 1, 2017.

$368 - a dependent child; applicable for a child not in an MA assistance group or one who is in an MA assistance group other than MA B or MA D;

$368 - an essential person;

$735 - one parent of the child applicant/recipient;

$1103 - two parents of the child applicant/recipient; and

$368 - stepparent.

3010.20.10 Post-Eligibility Standards (MED 1)

The policies stated in this section apply only to the MA A, MA B, and MA D categories of assistance.

The purpose of post-eligibility is to determine the institutionalized applicant's/recipient's liability to the facility. This determination also establishes the amount of the institutionalized applicant's/recipient's income which is allocated to meet the needs of his community spouse and certain other family members. The following standards are used in the post-eligibility calculation:

Personal needs allowance:

- $52[4]

  Effective 7-1-02 ($50 effective 7-1-99) this is the minimum amount allowed for all applicants/recipients except as stated below for certain veterans.
  If the person is receiving long term care services through a home-and-community based waiver (HCBS), the personal needs allowance is equal to the Special Income Level (SIL). Refer to 3010.20.15.

- $90[5]

  This is the maximum amount of the reduced VA benefit payable to a single veteran or veteran's widow in a nursing facility. The amount of the reduced VA benefit is the personal needs allowance for the individual.

- In specific situations, an additional individual amount for increased personal needs is to be deducted. Refer to Section 3455.15.10.

Spousal allocation[6] based on:

- Spousal Income Standard - $2003 effective 7-1-16 ($1992 effective 7-1-15 through 6-30-16; $1967 effective 7-1-14 through 6-30-15; 1939 effective 7-1-13 through 6-30-14; $1892 effective 7-1-12 through 6-30-13; $1839 effective 7-1-11 through 6-30-12; corrected to $1822 effective 1-1-11 through 6-30-11); $1823 effective 7-1-09 through 12-31-10; $1751 effective 7-1-08 through 6-30-09)

- Shelter Standard - $601 effective 7-1-16; ($597 effective 7-1-15 through 6-30-16; $590 effective 7-1-14 through 6-30-15; $582 effective 7-1-13 through 6-30-14; $568 effective 7-1-12 through 6-30-13; 552 effective 7-1-11 through 6-30-12; $547 effective 7-1-09 through 6-30-11; $526 effective 7-1-08 through 6-30-08)

- Maximum Maintenance Standard - $3,023 effective 1-

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[4] 405 IAC 2-3-21; 405 IAC 2-3-17

[5] Section 3203 of Title 38 U.S.C. as amended by OBRA-90 (P.L. 101-508)

[6] 405 IAC 2-3-17; SSA 1924(d)

1-17; ($2,981 effective 1-1-15; $2,931 effective 1-1-14: $2898 effective 1-1-13; $2841 effective 1-1-12; $2739 effective 1-1-09 through 12-31-11; $2610 effective 1-1-08)

Family allocation[7] based on:

- 1/3 of the difference between a family member's income and $2003 effective 7-1-16 ($1992 effective 7-1-15 through 06-30-16; $1967 effective 7-1-14 through 6-30-15; $1939 effective 7-1-13 through 6-30-14; $1892 effective 7-1-12 through 6-30-13; $1839 effective 07-01-11 through 6-30-12; $1822 corrected effective 01-01-11 through 06-30-11; $1823 effective 07-01-09 through 12-31-10; $1751 effective 07-07-08 through 06-30-09)

3010.20.15 Special Income Level Used For Institutional Residents and Waiver Services (MED 1)

The Special Income Level (SIL) used in determining eligibility for Institutional Residents and for certain HCBS waivers is 300% of the SSI Maximum Benefit Rate. Effective 1-1-17, the SIL is $2,205 (effective 1-1-15, the SIL is $2,199; effective 1-1-14, the SIL is $2,163; effective 1-1-13, $2,130; effective 1-1-12, $2,094; 1-1-09 through 12-31-11, the SIL was $2,022).

The income standard for the Behavioral and Primary Healthcare Coordination Waiver (BPHC) is 300% of the Federal Poverty Level, or, $2,970 effective 3-1-16.

3010.20.20 Income Standard/Premiums for M.E.D. Works

The income standard for MADW and MADI is 350% of the Federal Poverty Level. Effective March 1, 2016 the standard is $3,465. Premiums are listed in the following table.

PREMIUMS						
Family Size	**Monthly Gross Income Premium Amount**					
1	$1485 to $1733 $48	$ $1734 to $1980 $69	$1981 to $2475 $107	$2476 to $2970 $134	$2971 to $3465 $161	$ $3466 and over $187

[7] 405 IAC 2-3-17; SSA 1924(d)

2	$2003 to $2336 $65	$2337 to $2670 $93	$2671 to $3338 $145	$3339 to $4005 $182	$4006 to $4673 $218	$4674 and over $254

3010.25.00 INCOME STANDARDS (MED 2)

The MED 2 income standards are based on the TANF standards.

This chart lists the monthly income standards to be used for the MA Q category of assistance.[8]

AGs with income exceeding the standard may be eligible for Medical Assistance under the spend-down provision.

AG WITH A PARENT INCLUDED

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	139.50	6	463.50
2	229.50	7	522.00
3	288.00	8	580.50
4	346.50	9	639.00
5	405.00	10	697.50
Each Additional Member + $58.50		Each Additional Member + $58.50	

AG WITH CHILDREN ONLY

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	139.50	6	432.00
2	198.00	7	490.50
3	256.50	8	549.00
4	315.00	9	607.50
5	373.50	10	666.00
Each Additional Member + $58.50		Each Additional Member + $58.50	

3010.26.00 TRANSITIONAL MA STANDARDS (MA F)

There is no income standard for the first six months of eligibility. Beginning with the seventh month, the AG's average gross monthly earnings (minus child care expenses)

[8] 45 CFR 233.20(a)(2)

must be equal to or less than 185% of the Federal Poverty Level for TMA eligibility to continue.[9] The income standards effective 03/01/16 are shown below:

TMA STANDARDS			
AG SIZE	**EARNINGS**	**AG SIZE**	**EARNINGS**
1	$1832	5	$4385
2	$2470	6	$5023
3	$3108	7	$5663
4	$3747	8	$6304
For each additional member, add $641			

3010.30.00 INCOME STANDARDS (MED 3)

The income standards for the MA 2, MA Y, MA Z, MA 9, MA T, MA O, MAE, MAZ, MASB, MASP, MARB, MASB, MAGP, MA 14, and MA 10 categories of assistance are based on the Federal Poverty Guidelines. The size of the AG determines the income standard to be used. Gross income and net income may not exceed the standards in order for financial eligibility to exist. The following sections list the standards to be used in the consideration of income.

3010.30.05 Income Standards/Low-Income Parents or Caretakers, Children Age 19, 20 and Children in Psychiatric Facilities (MED 3)

This chart lists the monthly income standards to be used for low-income parents or caretakers (MAGF), Children Age 19 or 20 (MA T), and Children Age 18 and under 22 (MA O).

AG WITH A PARENT INCLUDED			
AG SIZE	**NET INCOME STANDARD**	**AG SIZE**	**NET INCOME STANDARD**
1	152	6	498
2	247	7	561
3	310	8	624
4	373	9	687
5	435	10	750
Each Additional Member + $63			

3010.30.10 Income Standards HIP

[9] SSA 1925

This chart lists the monthly income standards to be used for uninsured adults who are at least 19 years old and less than 65 years old (MASP, MARP, MANA, MAPC, and MAHL). The income standard is based on 133% of the Federal Poverty Level (FPL), effective March 1, 2016.

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	1317	5	3153
2	1776	6	3611
3	2235	7	4071
4	2694	8	4532
For each additional member, add $461			

This chart lists the monthly income standards to be used for uninsured adults who are at least 19 years old and less than 65 years old (MASB and MARB) who fail to make required financial contribution to a POWER Account and are eligible for HIP Basic coverage. MASB for Transitional Medical Assistance (TMA) recipients are exempt from this chart. The income standard is based on 100% of the FPL, effective March 1, 2016.

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	990	5	2370
2	1335	6	2715
3	1680	7	3061
4	2025	8	3408
For each additional member, add $347.			

* The 5% disregard does not apply to allow someone to be eligible for Basic. Refer to Section 35xx.yy.zz.

3010.30.10.05 Income Standards Low-Income Parent Caretaker

This chart lists the monthly income standards to be used for Low-Income Parent Caretakers aged between 19 and 64 (MASP and MASB) and for low-income parent caretakers who are eligible for Medicare or eligible to receive an HCBS Waiver (MAGF).

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	152	5	435
2	247	6	498
3	310	7	561
4	373	8	624

For each additional member, add $63.

3010.30.10.10 Income Standards HIP TMA

For HIP TMA adults aged at least 19 years old and less than 65 years old (MASP and MASB), refer to 3010.26.00.

3010.30.15 Income Standards/Child Age 6 - 18 (MED 3)

This chart lists the monthly income standards to be used for children 6 years old and through the age of 18 (MA 2) effective March 1, 2016. Financial eligibility exists if net income is less than or equal to the standards per AG size.[10] The income standard is based on 106% of the Federal Poverty Level.

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	1050	5	2513
2	1416	6	2878
3	1781	7	3245
4	2147	8	3612

For each additional member, add $368

3010.30.20 Income Standards/Child Age 1 - 5 (MED 3)

This chart lists the monthly income standards for the following groups: children age 1 through 5 (MA Z) and family planning services (MA E), effective March 1, 2016.[11] The income standard is based on 141% of Federal Poverty Level.

[10] SSA 1902(l)(2)

[11] SSA 1902(l)(2)

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	1396	5	3342
2	1883	6	3829
3	2369	7	4316
4	2856	8	4805

For each additional member, add $489

3010.30.25 Income Standards/Child Under 19 (MED 3)

This chart lists the monthly income standards to be used for the following groups: children age 1-5, 141-158% FPL; children age 6-18, 106-158% FPL. The category is MA 9. The standards are effective March 1, 2016.[12] (Refer to Section 1620.86 for an explanation of this category). The income standard is based on 158% of Federal Poverty Level.

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	1565	5	3745
2	2110	6	4290
3	2655	7	4837
4	3200	8	5384

For each additional member, add $548

3010.30.30 Pregnant Women, Infants Under Age One (MED 3)

This chart lists the monthly income standards for pregnant women (MAGP) and infants under age one (MA Y). These standards are based on 208% of the Federal Poverty Level and are effective March 1, 2016.

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	2060	5	4930
2	2777	6	5648
3	3495	7	6367
4	4212	8	7088

For each additional member, add $721

3010.30.35 Foster Care Independence (MED 3)

This chart lists the monthly income standards for children who were in foster care on the 18th birthday in a state other

[12] IC 12-15-2-14

than Indiana and are less than 21 years old (MA 14). These standards are based on 210% of the Federal Poverty Level and are effective March 1, 2016.

AG SIZE	NET INCOME STANDARD	AG SIZE	NET INCOME STANDARD
1	2079	5	4977
2	2804	6	5702
3	3528	7	6428
4	4253	8	7156

For each additional member, add $728

3010.30.40 Certain Children / Premiums, and (MED 3)

This chart lists the income standards for children from birth through 18 years of age (MA10), which is Package C, Children's Health Plan. The standard is based on 250% of the Federal Poverty Level (FPL) and effective March 1, 2016. For children with income above 158% FPL standard and below the 250% FPL standard, there are tiers to determine the premium amount, which will also take into account the number of children covered.

AG SIZE	MONTHLY LIMIT TIER 1 (175% FPL)	MONTHLY LIMIT TIER 2 (200% FPL)
1	$ 1733	$ 1980
2	$ 2337	$ 2670
3	$ 2940	$ 3360
4	$ 3544	$ 4050
5	$ 4148	$ 4740
6	$ 4752	$ 5430

MONTHLY PREMIUMS		
NUMBER OF CHILDREN	TIER 1	TIER 2

1	$ 22.00	$ 33.00
2 or More	$ 33.00	$ 50.00

AG SIZE	MONTHLY LIMIT TIER 3 (225% FPL)	MONTHLY LIMIT TIER 4 (250% FPL)
1	$ 2228	$ 2475
2	$ 3004	$ 3338
3	$ 3780	$ 4200
4	$ 4557	$ 5063
5	$ 5333	$ 5925
6	$ 6109	$ 6788

	MONTHLY PREMIUMS	
NUMBER OF CHILDREN	**TIER 3**	**TIER 4**
1	$ 42.00	$ 53.00
2 or More	$ 53.00	$ 70.00

3010.35.00 INCOME STANDARDS (MED 4)

Income standards for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Disabled Worker (QDW), and Qualified Individual (QI) are based on the Federal Poverty Income Guidelines. The size of the AG determines the income standard to be used. If countable income exceeds the standard, the applicant/ recipient is not financially eligible.[13]

3010.35.05 QMB Income Standards (MED 4)

[13] SSA 1905(p)(2)

This chart lists the monthly income standards to be used for the QMB (MA L) category of assistance effective March 1, 2016. This standard is based on 150% of the Federal Poverty Income Guidelines.

AG SIZE	INCOME STANDARD	AG SIZE	INCOME STANDARD
1	1485	5	3555
2	2003	6	4073
3	2520	7	4592
4	3038	8	5112
Family Member Standard: $520			

3010.35.10 SLMB Income Standards (MED 4)

This chart lists the monthly income standards to be used for the SLMB category of assistance effective March 1, 2016. This standard is based on 170% of the Federal Poverty Income Guidelines.

FAMILY SIZE	INCOME STANDARD	FAMILY SIZE	INCOME STANDARD
1	1683	5	4029
2	2270	6	4616
3	2856	7	5204
4	3443	8	5793
Family Member Standard: $590			

3010.35.15 QDW Income Standards (MED 4)

This chart lists the monthly income standards to be used for the QDW (MA G) category of assistance effective March 1, 2016. This standard is based on 200% of the Federal Poverty Income Guidelines.

FAMILY SIZE	INCOME STANDARD	FAMILY SIZE	INCOME STANDARD
1	1980	5	4740
2	2670	6	5430
3	3360	7	6122
4	4050	8	6815
Each Additional Member: $694			

3010.35.20 QI Income Standards (MED 4)

This chart lists the monthly income standards to be used for the QI (MA I) effective March 1, 2016. This standard is based on 185% of the Federal Poverty Levels.

FAMILY SIZE	MA I INCOME STANDARD	FAMILY SIZE	INCOME STANDARD
1	1832	5	4385
2	2470	6	5023
3	3108	7	5663
4	3747	8	6304
Each Additional Member: $642			

3040.00.00 GENERAL INCOME DISREGARD (MED 1, 4)

Prior to 6/1/2014, the general income disregards for MA A, MA B, MA D, MADW and MADI AGs was $15.50.

Effective 6/1/2014, the general income disregard for these categories increased to $20.00.

For MA L (QMB), MA J (SLMB), MA G (QDW), MA I (QI-1) and AGs it is $20.00.

3041.00.00 MEDICARE PART D BENCHMARK (MED 1)

The Medicare Part D Benchmark effective 01-01-17 is $32.06 (01-01-16 was $31.90; 01-01-15 was $31.79; 01-01-14 was $34.95; 01-01-13 was $37.22; 01-01-12 was $35.92; 01-01-11was $36.44; 01-01-10 was $35.75; 01-01-09 was $33.95; 1-1-08 was $33.50).

3045.00.00 GENERAL EARNED INCOME DISREGARD (MED 1 MED 4)

In the eligibility determination, $20 per month of all earned income, plus 1/2 of the remaining earned income, is disregarded. The earned income disregard is applied once to the AG's combined total earned income.[14]

3046.00.00 SUBSTANTIAL GAINFUL ACTIVITY AMOUNT (MED 1)

Substantial Gainful Activity (SGA) is the limitation on gross earnings that is used to determine categorical eligibility. The amount is $1,170 effective January 1, 2017 (effective 1-1-16, $1,130; 1-1-15, $1,090; 1-1-14, $1,070; $1,040 effective 1-1-13, $1,040; 1-1-12, $1,010; 1-1-10 through 12-31-11 was $1,000; effective 1-1-09, $980; effective 1-1-08, $940).

3047.00.00 MINIMUM EARNINGS FOR M.E.D. WORKS IMPROVED CATEGORY (MED 1)

The monthly minimum earnings amount for MADI is $290. This

[14] 405 IAC 2-3-3

is calculated by multiplying the federal minimum wage, currently as of July 24, 2009, $7.25 times 40.[15]

[15] 405 IAC 2-9-5(b)

3200.00.00 ASSISTANCE GROUPS

3205.00.00 ASSISTANCE GROUP DEFINITION

3205.05.00 MAGI ASSISTANCE GROUP DEFINITION

3205.10.00 BASIC MAGI RULES FOR DETERMINING THE AG OF A TAX FILER

3205.15.00 BASIC MAGI RULES FOR DETERMINING THE AG OF A TAX DEPENDENT

3205.20.00 BASIC MAGI RULES FOR DETERMINING THE AG OF AN INDIVIDUAL WHO IS NEITHER A TAX FILER NOR A TAX DEPENDENT

3206.00.00 PRIMARY RESIDENCE (MED 2, MED 3)

3210.00.00 MEDICAID ASSISTANCE GROUPS (MED 1)

3210.05.00 NON-INSTITUTIONALIZED APPLICANT/RECIPIENT (MED 1)

3210.10.00 APPLICANT/RECIPIENT IN LONG TERM CARE (MED 1)

3210.15.00 CHILDREN APPROVED FOR CERTAIN HCBS WAIVERS (MED 1)

3210.20.00 RCAP MEDICAID AG MEMBERS (MED 1)

3215.00.00 MEDICAID ASSISTANCE GROUPS (MED 2)

3215.10.00 REFUGEE MEDICAL ASSISTANCE GROUPS (MED 2)

3215.10.05 Refugee Mandatory Participating AG Members (MED 2)

3215.10.10 Refugee Optional AG Participants (MED 2)

3215.10.15 Refugee Mandatory Nonparticipating AG Members (MED 2)

3215.10.20 Refugee Excluded Members (MED 2)

3218.00.00 TRANSITIONAL MEDICAL ASSISTANCE

3220.00.00 MEDICAID ASSISTANCE GROUPS (MED 3)

3220.05.00 LOW INCOME PARENTS/OTHER CARETAKER RELATIVES AND ADULTS (MED 3)

3220.10.00 AG DETERMINATION/CHILDREN (MED 3)

3220.15.00 AG DETERMINATION/PREGNANT WOMEN (MED 3)

3220.20.00 AG DETERMINATION/NEWBORNS

3220.25.00 AG DETERMINATION/FAMILY PLANNING SERVICES

3225.00.00 QMB/QDW/SLMB/QI ASSISTANCE GROUPS (MED 4)

3200.00.00 ASSISTANCE GROUPS

This chapter contains the following sections:

Assistance Group Definition (Section 3205);
Medicaid Assistance Groups (MED 1) (Section 3210);
Medicaid Assistance Groups (MED 2) (Section 3215);
Medicaid Assistance Groups (MED 3) (Section 3220);
QMB/QDW/SLMB Assistance Groups (MED 4) (Section 3230).

The program-specific sections will discuss policy on composition of the assistance groups.

3205.00.00 ASSISTANCE GROUP DEFINITION

The assistance group (AG) is an individual or group of individuals whose income, resources, needs, and/or expenses are considered together in the eligibility determination for an assistance category. For categories of assistance subject to the modified adjusted gross income (MAGI) methodology for income and household size, the AG determination is aligned with tax filing rules, in accordance with the requirements laid out in the Affordable Care Act (ACA) of 2010.[1] For categories of assistance not subject to MAGI methodology, the AG determination is based upon relationship and living arrangement. Within the AG for non-MAGI categories of assistance, individuals may be participating or nonparticipating members, depending upon each program's eligibility requirements.

Participating members are individuals for whom eligibility for a benefit is considered. Nonparticipating members are those individuals whose needs, income, expenses and/or resources are considered in determining the eligibility and benefit level of the participating members, but who are not eligible for benefit consideration on their own behalf. Household members who are not, according to specific program regulations, eligible for membership in the AG as participants or non-participants, are excluded from consideration in the eligibility determination; as such, they are also excluded from any requirement to provide

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[1] 42 U.S.C. § 1396a(e)(14)

personal demographic or financial information to the agency.[2] Please, refer to IHCPPM 2404.00.00. Further, non-applicant/recipient household members who are mandatory non-participating members are not required to provide a Social Security Number (SSN)[3], but this does not relieve any applicable requirement to have any financial and/or non-financial information of the mandatory non-participating AG member verified to determine eligibility for the applicant/recipient. For example, a parent who has applied for medical assistance for a child but not for himself is not required to provide his SSN, but he is required to provide proof of his income to determine his child's eligibility.

When applying for Medicaid coverage, an applicant's AG is defined differently depending on the category of assistance under which he or she is being considered for eligibility. An applicant's AG may change as the application moves through the Medicaid eligibility hierarchy and she is considered for different eligibility categories. Some categories are subject to MAGI methodology for determination of the applicant's AG and some are not.

The ACA did not change the AG determination rules for applicants being considered for eligibility for a non-MAGI category of assistance.

3205.05.00 MAGI ASSISTANCE GROUP DEFINITION

The types of individuals who would be likely to be considered for eligibility under categories of assistance subject to the MAGI household size (AG) determination methodology are as follows:

Children under one year of age (MA Y);

Children one to five years of age (MA Z);

Children six to nineteen years of age (MA 2, MA 9, MA 10);

Children 19-20 who meet the low-income converted AFDC standard (MA T);

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[2] 42 CFR 435.907
[3] 42 CFR 435.907

Children between nineteen and twenty-one residing in an inpatient psychiatric facility (MA O);

Former foster children up to twenty-one years of age (MA 14);

Parents or caretaker relatives (MAGF);

Pregnant women (MAGP); and

Family Planning Services (MA E).

For eligibility under the Healthy Indiana Plan for uninsured adults between ages 19 and 64, please, refer to IHCPPM Chapter 3500.

A child or adult who is disabled or blind and applying for Medicaid coverage will also be considered for eligibility under a category of assistance that is not subject to MAGI household size (AG) determination rules. Additionally, children under the age of 19 with adoptive assistance, foster children, and former foster children up to age 26 who were enrolled in Medicaid on their 18th birthday are eligible under categories of assistance that are not subject to MAGI household size (AG) determination rules.

Under MAGI methodology, the basic rules for who is counted as part of the household size (AG) of the applicant are aligned with federal tax filing rules. There are different rules for determining the AG of applicants who are tax filers, applicants who are tax dependents and applicants who are neither tax filers nor tax dependents.

3205.10.00 BASIC MAGI RULES FOR DETERMINING THE AG OF A TAX FILER

A “tax filer” as used herein applies to an individual

- Who actually filed a tax return and was not claimed as a tax dependent by anyone else in the year for which eligibility is determined or renewed; or

- Who expects to file a tax return and does not expect to be claimed as a tax dependent by anyone else in the year for which eligibility is determined or renewed. A tax filer’s AG when being considered for a MAGI category of assistance

consists of himself/herself and any person(s) that will be claimed as his or her tax dependent(s).[4]

In the case of married couples living together, each spouse will be counted in the other's AG. This rule applies regardless of whether the couple expects to file a joint tax return or whether one spouse expects to claim the other as a dependent.[5]

The types of individuals that could be claimed as a taxpayer's dependents and therefore included in his or her AG include the following:

Taxpayer's spouse;

Taxpayer's biological, adopted, or step child(ren);

Other qualifying children or relatives.[6]

3205.15.00 BASIC MAGI RULES FOR DETERMINING THE AG OF A TAX DEPENDENT

A "tax dependent" as used herein applies to an individual:

- Who was actually claimed as a dependent by someone else in the year for which eligibility is determined or renewed; or
- Who expects to be claimed as a tax dependent in the year for which his or her eligibility is determined or renewed.

Except as set forth below, the general rule for a tax dependent's AG for a MAGI category is the same as that of the tax filer that will claim him or her as a dependent. Generally, the tax dependent's AG will include the tax filer claiming him as a dependent and all other tax dependents claimed by that tax filer. Also, if a person files taxes but is still claimed as a dependent by another person, the person is still considered a tax dependent for MAGI purposes.

There are several exceptions to this general rule. If any of the below listed exceptions apply, the tax dependent's AG is determined in accordance with the rules for individuals who are neither tax filers nor tax dependents

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[4] 42 CFR § 435.603(f)

[5] 42 CFR § 435.603 (f)

[6] 26 U.S.C § 152(c) & (d)

(see Section 3205.20.00).[7]

(A) The individual to be claimed as a tax dependent is claimed by someone other than the spouse or a parent (biological, adopted, or step).

For example, if a grandparent claims a grandchild as a tax dependent, the grandchild's AG would be determined in accordance with the rules for individuals who are neither tax filers nor tax dependents.

(B) The individual to be claimed as a tax dependent is under the age of 19 and lives with both parents who do not expect to file a joint tax return, and will be claimed by one parent only as a dependent.

For example, if a mother and her partner live together with their child, the parents may not file a joint tax return since they are not married, and the child can be claimed only by one parent as a tax dependent. In that case, the child's AG would be determined in accordance with the rules for individuals who are neither tax filers nor tax dependents.

(C) The individual to be claimed as a tax dependent is under the age of 19 and will be claimed by a non-custodial parent.

For example, if a child's parents are divorced and the child spends most nights with his father, but his mother will claim him as a tax dependent, the child's AG would be determined in accordance with the rules for individuals who are neither tax filers nor tax dependents.

3205.20.00 BASIC MAGI RULES FOR DETERMINING THE AG OF AN INDIVIDUAL WHO IS NEITHER A TAX FILER NOR A TAX DEPENDENT

This section applies for the purposes of determining the AG of:

(A) An individual who does not expect to be claimed by anyone else as a tax dependent in the year for which eligibility is being determined or renewed;

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[7] 42 CFR 435.603 (f); 405 IAC 2-2.5-2(e)

(B) An individual who does not expect to file a federal tax return;

(C) A tax dependent who fits one of the exceptions listed in 3205.15.00;[8] or

(D) Also, when an individual neither expects to file taxes for the year in which eligibility is being determined or renewed nor expects to be claimed as a dependent in the year for which eligibility is being determined or renewed.[9]

In these cases, the individual's AG for a MAGI category consists of himself, and, if living with the individual:

The individual's spouse;

The individual's children (biological, adopted, or step) under the age of 19;

In the case of individuals under the age of 19, the individual's parents (biological, adopted, or step) and siblings under the age of 19 (biological, adopted, or step).

3206.00.00 PRIMARY RESIDENCE (MED 2, MED 3)

When determining the Assistance Group deciding who "lives" together is taken into account.

Sometimes this means that the worker must determine the residence of an individual. The residence of an individual is the address reported by that individual.

Some assistance groups may include members who have multiple addresses, such as children in school or under joint physical custody.

The primary residence is the location where the individual spends the majority of time during the month.

An individual who spends the majority of his/her time away from the residence of the assistance group but who has no consistent alternative location due to employment which requires frequent

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[8] 42 CFR 435.603(f); 405 IAC 2-2.5-2(e)

[9] 42 CFR 435.603(f); 405 IAC 2-2.5-2(e)

travel, is considered a member of the assistance group. However, if the individual establishes a residence away from the assistance group, then he/she would not be considered as a member. This also applies to students who live away at school and only return home on weekends.

When the entire assistance group has multiple residences, the primary residence is determined in the manner described above.

3210.00.00 MEDICAID ASSISTANCE GROUPS (MED 1)

The MED 1 categories of assistance are not subject to MAGI methodology for the determination of income and household size (AG). For the MED 1 categories, there is one participating AG member. Nonparticipating members are those individuals whose income, resources, and/or expenses must be considered in the eligibility determination and/or in the post-eligibility calculation.

3210.05.00 NON-INSTITUTIONALIZED APPLICANT/RECIPIENT (MED 1)

The policy contained in this section only applies to the MA A, MA B, and MA D categories of assistance.

When the applicant/recipient (participating member) is in a living arrangement other than a Medicaid certified long-term care facility, the AG consists of the applicant/recipient and the nonparticipating members listed below:

The spouse of the applicant/recipient if the couple is living together or separated only for medical reasons;[10]

A spouse receiving HCBS Waiver services will be excluded from non-waiver spouse applicant/recipient;

The biological or adoptive parent(s) of a child applicant/recipient who resides with the parent(s) and who does not qualify for certain Home and Community Based Services (HCBS) waivers as specified in Section 3220.15.00;

The biological, adoptive, or step child of the applicant/recipient who is living in the same home;[11]

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[10] 405 IAC 2-1-1
[11] 405 IAC 2-1-1

A child who is a sibling of the child applicant/recipient who lives with the applicant/recipient and his biological or adoptive parent;[12]
The stepparent of a child applicant/recipient living with the applicant/recipient and his biological parent; and

An essential person other than a spouse or parent who lives with the applicant/recipient and who provides essential care and services to him.[13]

As used in this section a "child" is a person who is under the age of 18 or who is a student age 18 – 21.[14]

For a complete understanding of the way in which income and resources of nonparticipating AG members are considered, refer to Sections 3455.00 (Budgeting), 2600 (Resources), and 1610.00 (Category description).

3210.10.00 APPLICANT/RECIPIENT IN LONG TERM CARE (MED 1)

The policy stated in this section only applies to the MA A, MA B, and MA D categories of assistance when the applicant/recipient resides in a Medicaid certified facility.

The AG of an applicant/ recipient in long term care consists of:

The applicant/recipient;

The applicant's/recipient's spouse who also resides in a long term care facility or hospital if the couple is separated only for medical reasons;[15]

The applicant's/recipient's spouse who does not live in a hospital, nursing facility, ICF/MR, CRF/DD, or psychiatric facility (referred to as the community spouse);[16]

The following individuals who live with the community spouse of the applicant/recipient residing in a Medicaid certified facility:

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[12] 405 IAC 2-1-1
[13] 405 IAC 2-1-1
[14] 405 IAC 2-1-1
[15] 405 IAC 2-1-1
[16] Social Security Act (SSA), Section 1924

- Biological or adoptive child under age 21 of either spouse;

- Biological or adoptive child age 21 and over who is claimed as a tax dependent;

- Parents of either spouse, who are claimed as tax dependents; and

- Siblings of either spouse who are claimed as tax dependents.

3210.15.00 CHILDREN APPROVED FOR CERTAIN HCBS WAIVERS (MED 1)

The policy contained in this section only applies to the MA D and MA B categories of assistance.

The only member of the AG is the applicant/recipient if he is under age 21 and approved for Home and Community Based Services (HCBS) under any of Indiana's waivers. Please, refer to IHCPPM 3305.00.00 for waiver types

3210.20.00 RCAP MEDICAID AG MEMBERS (MED 1)

The policy contained in this section only applies to the MA R category of assistance.

The AG consists of the applicant/recipient who has been determined eligible for Residential Care Assistance Program (RCAP) and his/her spouse if the couple is living together or separated only for medical reasons. The spouse's resources are considered in the Medicaid eligibility determination.

3215.00.00 MEDICAID ASSISTANCE GROUPS (MED 2)

The only category of assistance under MED 2 is MA Q, Refugee Medical Assistance (RMA).

3215.10.00 REFUGEE MEDICAL ASSISTANCE GROUPS (MED 2)

Refugee eligibility is determined on the basis of need. A refugee AG is comprised of one or more related refugees of any age who live together. The following sections discuss additional AG requirements.

3215.10.05 Refugee Mandatory Participating AG Members (MED 2)

The Refugee Cash Assistance eligibility determination must include the following mandatory AG participants who live together:

The applicant/recipient;

The applicant's/recipient's dependent child under age 18;

The applicant's/recipient's spouse who has refugee status; and

The parent of the dependent child if he has refugee status.

3215.10.10 Refugee Optional AG Participants (MED 2)

Any legal or blood relative with refugee status, who is either a dependent child or a caretaker living with the AG, who is not mandatory, may be included in the AG.

3215.10.15 Refugee Mandatory Nonparticipating AG Members (MED 2)

Individuals who live with the AG and are excluded from the AG include:

Individuals who would be mandatory participating members but who are serving a period of ineligibility due to the receipt of a lump sum payment;

Sanctioned individuals;

Non-recipient stepparents;

Stepparent's dependent child;

Non-recipient parent of a minor parent; and

The refugee's spouse who does not have refugee status.

The income of these individuals is counted in the eligibility determination. The resources of lump sum ineligible members, sanctioned members, and a non-refugee spouse are also counted. However, resources of the remaining AG members are not counted.

3215.10.20 Refugee Excluded Members (MED 2)

Individuals who live with the AG, but are excluded from

participation in the AG, include:

SSI recipients;

A child receiving IV-E payments; and

Children for whom foster care maintenance or adoption assistance payments are made, whether provided by a federal, state, or local agency. This does not apply to children receiving adoption assistance if their exclusion results in a reduction in the AG's benefits.

The income, needs, expenses, and resources of these individuals are not counted in the Refugee Cash Assistance eligibility determination.

3218.00.00 TRANSITIONAL MEDICAL ASSISTANCE

Transitional Medical Assistance (TMA) is available to adults who no longer qualify for MAGF due to earnings and certain children who were living with the adult who lost MAGF eligibility while he was receiving MAGF. Please, refer to IHCPPM Chapter 3800. The category for TMA is MA F, which is not considered MED 2 or MED 3. MA F, however, is considered a Hoosier Healthwise category.

3220.00.00 MEDICAID ASSISTANCE GROUPS (MED 3)

Individuals whose eligibility is being considered under the MED 3 categories of assistance are subject to MAGI methodology for determination of household size (AG). Refer to sections 3205.05.00, 3205.10.00, 3205.15.00, and 3205.20.00 for the MAGI rules for determining the AG for tax filers, tax dependents, and individuals who do not qualify as either tax filer or tax dependents under this chapter.

3220.05.00 LOW INCOME PARENTS/OTHER CARETAKER RELATIVES AND ADULTS (MED 3)

Low-income parents and caretakers and other adults that are being considered for eligibility under the MAGF, MAHC, MAHN or categories of assistance are subject to MAGI rules for determination of their AG.

Generally, for adult Medicaid applicants or recipients who plan to file a federal tax return, the AG consists of him/herself and all other individuals to be claimed as tax dependents. If the applicant or recipient is married, the AG also includes the spouse regardless of whether the couple will file a joint return

or whether the spouse will be claimed as a tax dependent by the applicant/recipient.

If the adult Medicaid applicant or recipient is to be claimed as a tax dependent, please, refer to IHCPPM 3205.15.00.

EXAMPLE #1

Jenny, who does not plan to file a federal tax return, is applying for Medicaid eligibility, and lives with her husband Shawn, who also does not plan to file. Jenny and Shawn live with their three children: Anna, Joe, and Peter. Anna and Joe are their shared biological children. Peter is Shawn's biological son from a previous relationship. Jenny also has another biological son, David, who does not live with them.

Since neither adult plans to file a federal tax return and are not claimed as tax dependents, their AGs are determined in accordance with the rules for non-filers and non-dependents.

Jenny's AG consists of herself, Shawn, Anna, Joe, and Peter. Her two biological children and one stepchild living with her are all included, but since her other son David does not live with her, he is not.

Shawn's AG consists of himself, Jenny, Anna, Joe, and Peter. His three biological children living with him are all included, but since his stepson David does not live with him, he is not included.

EXAMPLE #2

Karen and her husband Stan live with Karen's elderly and disabled mother, Susan, their 18-year old daughter, Emma, and Emma's infant son, Jeffrey. Karen plans to file a federal tax return and will claim all of them as her dependents.

Karen is applying for coverage for herself and for Jeffrey. Since Karen is a tax filer, her AG consists of herself and all those she will claim as dependents: Susan, Stan, Emma, and Jeffrey. As Karen's tax dependents, Susan, Stan and Emma would all have the same AG as Karen if any of them were to be considered for Medicaid eligibility under a MAGI category of assistance.

Jeffrey, however, has a different AG than Karen because he falls into one of the exceptions for tax dependents, as he is a dependent claimed by someone other than his biological, adopted, or step parent or spouse. His AG is determined in accordance with the rules for non-filers and non-dependents. Therefore, Jeffrey's AG consists of only himself and his mother Emma, since she lives with him and he is under the age of 19.

EXAMPLE #3

Bill and his partner Kim live together with their four children, all under the age of 19: their two shared biological children Lisa and Gabriel, Kim's biological daughter Cindy, and Bill's biological son Levi.

Bill and Kim each plan to file separate federal tax returns. Bill claims Levi and Gabriel as tax dependents, so his AG consists of himself and his two sons. Kim is not a part of his AG because the two are not married. Kim claims Cindy and Lisa as her tax dependents, so her AG consists of herself and her two daughters. Bill is not a part of her AG because the two are not married.

Levi and Cindy's AGs are the same as Bill's and Kim's, respectively, because they are claimed as their parents' tax dependents. However, the AG for Gabriel and Lisa must be determined in accordance with the rules for non-filers and non-dependents. As the two shared biological children of the relationship, Gabriel and Lisa fall into one of the exceptions a tax dependent as "individuals under age 19 living with both parents who do not plan to file a joint return and expect to be claimed as a dependent only by one parent". Therefore, Gabriel's AG consists of himself, both of his parents, and his three siblings with whom he lives (since he is under 19). Similarly, Lisa's AG consists of herself, both of her parents, and her three siblings with who she lives (since she is under 19).

3220.10.00 AG DETERMINATION/CHILDREN (MED 3)

The policy discussed in this section refers to the following Medical Assistance categories:

Children under one year of age (MA Y);

Children one to five years of age (MA Z);

Children six to nineteen years of age (MA 2, MA 9, MA 10);

Children 19-20 who meet the converted AFDC low-income standard (MA T);

Children between nineteen and twenty-one residing in an inpatient psychiatric facility (MA O); and

Former foster children up to twenty-one years of age (MA 14).

All of these categories of assistance are subject to MAGI methodology for household size and composition. Again, there are different rules for tax filers, tax dependents, and those who are neither filers nor dependents.

Most children eligible for Medicaid under these categories of assistance will be subject to the MAGI household size (AG) determination rules for tax dependents, or the rules for those who are neither tax filers nor dependents. These rules are described in Sections 3205.15.00 and 3205.20.00.

Some examples of the AG composition of applicants/recipients eligible under the children's categories of assistance follow. They primarily concern cases in which children are not tax filers nor tax dependents or fall into one of the exceptions for dependents, as these situations are more complex than if the children are simply dependents of their parents.

EXAMPLE #1

Ryan, age nine, and Cora, age seven, are brother and sister and live with their aunt and uncle, Sally and Doug. Sally and Doug have not legally adopted the children, but they claim them as tax dependents. Even though these children are claimed as tax dependents, their AG is not determined in accordance with the rules for tax dependents. This is because they fall into the exception of children who expect to be claimed as tax dependents by someone other than a biological, adoptive, or step parent. Ryan and Cora's AGs are determined using the same rules for people who are non-filers and non-dependents.

According to these rules, the AG includes the individual, and, if living with the individual, his or her spouse; biological, adopted, and step children and parents, and biological, adopted, and step siblings, since they are under the age of 19. Therefore, Ryan's AG consists of himself and his sister Cora, and Cora's AG consists of herself and her brother, Ryan.

EXAMPLE #2

Jill is one year old and lives with her brother, Derek, who is four years old, and her mother, Lori. Lori does not expect to file a federal tax return, so she will not claim her children as tax dependents. Neither will anyone else. Therefore, Jill and Derek’s AGs will be determined in accordance with the rules for non-filers and non-dependents. According to these rules, the AG includes the individual, and, if living with the individual, his or her spouse; biological, adopted, and step children; and biological, adopted, and step parents and siblings (if they are under the age of 19).

Jill’s AG will consist of herself, her mother, and her brother Derek, since Derek is under the age of 19 and she lives with them both. Similarly, Derek’s AG will consist of himself, his mother, and his sister Jill.

EXAMPLE #3

Carol and Steve are divorced and have three year old twins, Molly and Jason. Carol is the custodial parent, as determined by the court, for both of the children, but she allows Steve to claim Molly as a tax dependent. Carol plans to file a federal tax return and will claim Jason. Although Molly is a tax dependent, she is claimed by a non-custodial parent and therefore falls into one of the exceptions. Her AG will be determined in accordance with the rules for non-tax filers and non-dependents.

Molly’s AG consists of herself, her mother Carol, and her brother Jason, because they all live together and she is under the age of 19. Jason’s AG is the same as Carol’s, since she is his custodial parent and will claim him as a tax dependent.

EXAMPLE #4

Mike, age 20, lives with his wife Angela, 19, their infant daughter Madison, and his 15-year old brother, Murray. Mike plans to file a federal tax return and claim Angela, Madison, and Murray as his dependents. Therefore, Mike's AG consists of four people—himself and his three dependents. Angela and Madison's AGs are the same as Mike's AG.

Murray's AG, however, is different. Although he is a tax dependent, he is being claimed by his brother—someone other than his spouse or biological, adopted, or step parent. Therefore, Murray's AG is determined in accordance with the rules for non-filers and non-dependents. Murray's AG consists only of himself—although he is living with his brother Mike, Mike is 20, and siblings are only included in the AG of non-filers and non-dependents if they are under the age of 19.

EXAMPLE #5

Sam, age 6, lives with his parents, Debbie and Duane, and his brother, Tommy, age 4. Duane expects to file a federal tax return. Debbie will not, and Duane cannot claim Debbie as a dependent nor include her in his AG, since the two are not married. Duane will claim both Sam and Tommy as dependents.

Although they are being claimed as dependents, the children fall into the exception of living with both parents who do not expect to file a joint tax return and expect to be claimed only by one parent. Therefore, their AGs are determined in accordance with the rules for non-filers and non-dependents.

Sam's AG consists of himself, both of his parents, and Tommy, and Tommy's AG consists of himself, both of his parents, and Sam. Duane's AG consists of himself and his two sons, since he is a tax filer claiming them. Debbie is a non-filer and non-dependent, so she is subject to those rules. Her AG consists of herself and her two sons, with whom she lives, but it would not include Duane since the two are not married.

3220.15.00 AG DETERMINATION/PREGNANT WOMEN (MED 3)

The policy discussed in this passage refers only to the MAGP category of assistance.

Pregnant women being considered for Medicaid eligibility under MAGP are subject to MAGI methodology for determination of

household size (AG). If the pregnant woman is a tax filer, her AG is determined in accordance with the rules for tax filers; if she is a tax dependent, her income is determined in accordance with the rules for tax dependents, and if she is neither a filer nor a dependent, her AG will be determined in accordance with those rules.

An unborn child or children can only be counted in the AG of the pregnant woman. The unborn child(ren) cannot be counted as a part of the AG of the father or siblings, even if the father and mother are married and the other children all live together. Additionally, if the pregnant woman is claimed as a dependent, the unborn child(ren) cannot be counted in the AG of the filer that claims her.

Some examples of the AG composition of applicants/recipients eligible under MAGP follow.

EXAMPLE #1

Charlotte is pregnant with twins and lives with her parents, Anne and Jack, who file a joint return and claim her as a tax dependent. They also claim her younger brother, Cory, as a dependent. As a tax dependent, Charlotte’s AG is the same as the tax filers that claim her. In addition, because she is pregnant, her AG will include her unborn children. Charlotte’s AG consists of herself, both of her parents, her brother Cory, and her unborn children.

Anne and Jack are tax filers, so their AG consists of themselves and their dependents, Charlotte and Cory. They cannot include Charlotte’s unborn children in their AGs.

EXAMPLE #2

Emily is pregnant with her fourth child and lives with her husband, Scott, and their other three children. Scott and Emily file taxes jointly, so Emily's AG is determined in accordance with the rules for tax filers. Her AG consists of herself, her husband Scott, their three children who they claim as tax dependents, and her unborn child.

Scott's AG consists of himself, Emily, and his three children. He cannot count his unborn child in his AG.

The three children's AGs consist of both of their parents and their siblings. Their mother's unborn child cannot be counted in their AGs.

3220.20.00 AG DETERMINATION/NEWBORNS

The policy in this section applies to the MA X category. (Refer to Sections 1620.75.00 and 2428.00.00 for category description and eligibility information).

The AG consists only of the newborn child.

There is no financial eligibility determination for this category.

3220.25.00 AG DETERMINATION/FAMILY PLANNING SERVICES

The policy in this section applies to the MA E category. (Refer to Section 1620.80.00 and 2410.05.05).

The AG consists of the person requesting Family Planning Services. If the person requesting services is an adult, please, refer to Section 3220.05.00. If the person requesting services is a child, please, refer to Section 3220.10.00.

3225.00.00 QMB/QDW/SLMB/QI ASSISTANCE GROUPS (MED 4)

The members of a Qualified Medicare Beneficiary (QMB), (refer to 1610.30.00 for category description); Qualified Disabled Worker (QDW), (refer to 1610.40.00 for category description); Specified Low-Income Medicare Beneficiary (SLMB) (refer to 1610.35.00 for category description) and Qualified Individuals (QI) (refer to 1610.45.00 for category description) AGs are as follows:

The applicant/recipient;

The spouse of the applicant/recipient when they are living in the community together;

The applicant's/recipient's biological, adoptive, and step child under age 18 or an 18-21 year old student, living with the applicant/recipient; and

The applicant's/recipient's essential person as defined in section 3220.05.00.

For a complete understanding of the way in which income and resources of nonparticipating members are considered in determining eligibility, refer to Chapters 3400 (Budgeting) and 2600 (Resources).

3300.00.00 OVERVIEW OF MEDICAID WAIVERS

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3350.20.00 RESOURCES

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3375.00.00 End-Stage Renal Disease (ESRD)

3375.05.00 Basic Eligibility Criteria

3375.10.00 Coverage and Benefits

3375.15.00 Special Processing

3375.20.00 Redeterminations

3375.30.00 Budgeting

3375.40.00 End of ESRD Eligibility

3375.50.00 ESRD Eligibility Issues

3375.60.00 ESRD "Perceived" Donut Hole

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.

3305.00.00 GENERAL INFORMATION ABOUT HCBS WAIVERS

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

Aged and Disabled (A&D)
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 under CA-PRTF, thus the waiver will phase out by attrition. None of the special waiver eligibility rules apply to PRTF waivers.

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. An electronic interface was created to assist in the coordination between DFR and waiver case managers. Waiver information appears on DEWR, AEIMW, and AEOMW. 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.

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 prior to discharge from the institution;

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:

SSI (MASI);
Aged (MA A);
Blind (MA B);
Disabled (MA D);
MED Works (MADW, MADI)
Low-income Caretakers (MAGF)
Foster Care (MA 15)
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.

Effective 6/1/2014, when the SIL test is applicable, there are other specific eligibility provisions that apply as follows:

> If the individual passes the SIL test during the eligibility step, then a post-eligibility budget is done to determine the amount, if any, of the HCBS Waiver Liability. If the person fails to pass the SIL test, the person is ineligible for assistance.
>
> 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.

Prior to 6/1/2014, if a person fails the SIL test the individual may remain eligible for Medicaid under regular spend-down budgeting rules that applied.

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 listed in Section 3315.00.00.

Prior to 6/1/2014, if the waiver spouse fails the SIL test, regular resource rules and limits apply. The spousal impoverishment protection rules do not apply.

Effective 6/1/2014, however, an individual must pass the SIL test to be considered categorically eligible for Medicaid.

In determining whether spousal impoverishment protection applies in a given circumstance, waiver services are considered in the same manner as institutionalization, except in cases where the waiver applicant/recipient has an institutionalized spouse. 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 waiver applicant/recipient is considered a community spouse.

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 either the date of application or the date on which the waiver Cost Comparison Budget (CCB) is approved, whichever is later.

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;
>
> If the right to receive the income is assigned or otherwise transferred in title to the trust, the QIT exception is nullified.

The Miller trust should be irrevocable thereby making accumulated funds in the trust 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 for home and community-based services. 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.

Effective 6/1/2014, a person whose eligibility is determined under the Aged, Blind, or Disabled categories must pass the SIL test to be considered categorically eligible for Medicaid. The "regular budgeting" method will become inapplicable to the aforementioned provisions as of 06/01/2014.

Once a person passes the SIL test, a post-eligibility calculation is completed to determine the spend-down amount if the applicant/recipient is eligible under the Special Income Level. Effective 6/1/2014, the spend-down amount will be referred to as the "HCBS waiver liability".

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

If an applicant or recipient meets the waiver criteria to receive services under an approved waiver (refer to IPPM 3305.00.00) and the person's eligibility is being determined under a category that is not MED 1, then the SIL test will not apply. Such a person will have eligibility determined under the financial rules of the other category

that is not MED 1.

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 HCBS Waiver Liability. Prior to 6/1/2014, this amount was referred to as a spend down

Effective 6/1/2014, an applicant or recipient whose eligibility is being determined under MED 1 with a waiver must pass the SIL test.

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. 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.

Effective 6/1/2014, any applicant or recipient whose countable income is over the applicable standard for the SIL test must establish an approved Miller Trust and must be place income into the trust to allow the person to pass

the SIL test. Otherwise, the person would be considered categorically ineligible for Medicaid on and after 6/1/2014.

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 is exempt in the SIL test, but this amount 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:

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

- Court ordered guardianship fees paid to the applicant/recipient’s legal guardian, not to exceed $35 per month, are to be deducted. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney fees for which the guardian is liable.

- Medical expenses which are not subject to payment by a third party and are not covered by Medicaid are deducted, except nursing facility expenses or HCBS waiver expenses incurred during an imposed transfer of property penalty. Prescription drugs not covered by Medicare Rx are allowed as deductions in post-eligibility if Medicaid does not cover them.

The DFR will allow a deduction for an incurred medical expense not covered by Medicaid and not subject to payment by Medicare or other insurance, if an actual provider-generated bill, or copy of such a bill, is submitted to the worker. This bill must indicate the date and type of service that was provided and must clearly show the amount that the recipient owes after any third party has paid. If

the recipient has third party insurance that does not show as a payer on the bill, the recipient or provider must submit either an EOB documenting denial of payment or some other documentation of why the insurance was not billed or did not pay. No other documentation is acceptable. DFR Offices are not to sign any documents or “agreements” to “deviate the liability”. If proper documentation is submitted, the expense is to be entered on ICES as code NM and it will be deducted in the post-eligibility calculation. The worker is to enter reason code 066 when authorizing the reduction/elimination of the patient liability. If it takes more than one month to meet the expense, workers must have fail-safe monitoring procedures to ensure that the expense is removed at the proper time. CUMED is not to be used for this purpose unless it is necessary to correct an error made by the worker, that for some reason cannot be accommodated in future months. Recipient change reporting guidelines apply to institutionalized recipients in the same manner as other recipients.

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. Effective 6/1/2014, the amount remaining is referred to as the HCBS waiver liability. The HCBS waiver liability for claims processing will operate the same as under spend-down prior to 6/1/2014.

3325.15.00 REGULAR BUDGETING

Prior to 6/1/2014, regular spend-down 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.

Effective 6/1/2014, an applicant or recipient must pass the SIL test to be determined eligible under MED 1. If eligibility is being determined under either MED 2 or MED 3, the financial rules for those categories will be applied.

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 BEHAVIORAL & PRIMARY HEALTHCARE COORDINATION

Individuals who have severe psychiatric needs but have the ability to reside in the community rather than an institutional setting can receive Medicaid services through an approved waiver under Section 1915(i) of the Social Security Act.

Sections 3350.00 through 3350.25.00 explain the eligibility requirements that apply to individuals who have been approved for Behavioral & Primary Healthcare Coordination (BPHC). Certain provisions are special for BPHC and provide an additional eligibility methodology as an option to regular eligibility in the Aged, Blind, and Disabled categories.

3350.05.00 GENERAL INFORMATION ABOUT BPHC

Behavioral and Primary Healthcare Coordination (BPHC) provides behavioral and primary healthcare coordination services to individuals with serious mental illness who demonstrate impairment in self-management of health services, which includes coordination of healthcare services to manage the healthcare needs of the recipient including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case and linkage to appropriate services.

Eligibility for the BPHC services is handled and determined by the Division of Mental Health and Addiction (DMHA) based upon the demonstrated needs of the applicant. Individuals wishing to apply for BPHC services should consult a Community Mental Health Center (CMHC) about submitting a

BPHC application with DMHA. An application for BPHC services is not considered an application for Medicaid.

There are not any specific number of slots that can be filled in a given time period. BPHC services are provided to people who reside in the community, have a primary mental health diagnosis (including but not limited to schizophrenic disorder, major depressive, disorder, bipolar disorder, delusional disorder, or psychotic disorder), and has specific needs requiring the service as determined by DMHA.[1]

To be approved, an individual must meet the “BPHC” criteria described above and also must meet Medicaid eligibility requirements.

3350.10.00 AGE REQUIREMENT

The minimum age requirement is 19 years.

3350.15.00 PERMISSIBLE BPHC CATEGORIES

The permissible Medicaid categories for BPHC services include MAGF, MA F, MA14, MA15, MASI, MA A, MA B, MA D, and MADW.

Special eligibility rules apply in the Aged, Blind, and Disabled categories for waiver individuals and are explained in the following sections. If a person determined able to receive BPHC services is eligible under normal Medicaid eligibility rules, the person may remain eligible under that category BPHC services in another category, the person may remain eligible in that category. Special budgeting rules apply under the MA A, MA B, and MA D categories when a person eligible to receive BPHC services is ineligible for all categories including normal budgeting rules for MA A, MA B, and MA D.

3350.20.00 RESOURCES

There is no resource test under special budgeting procedures for BPHC.

3350.25.00 INCOME

The income standard used for an individual eligible for BPHC is 300% FPL. The special income standard used for BPHC

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[1] 405 IAC 5-21.8-4

is only applicable under the MA A, MA B, and MA D categories. Individual income is determined in the following manner: The nonexempt unearned income of the applicant/recipient is determined first. The nonexempt unearned income of the applicant/recipient is determined first. The general income disregard of $20 is subtracted. Allocations to dependent children of the applicant/recipient or to an essential person are then subtracted. (Refer to IHCPPM 3455.05.10 and 3455.05.15). The resulting amount is the countable unearned income of the applicant/recipient. If deductions are greater than the total unearned income, the remaining amount is deducted from any earned income. The total earned income (including self-employment) of the applicant/recipient is determined. Any remaining general income disregard is then subtracted. Any remaining allocations to a dependent child or essential person are subtracted. The earned income disregard of $65, plus impairment-related work expenses (IRWEs) as explained in IHCPPM 3455.07, plus one-half of the remaining income is subtracted. The resulting amount is the countable earned income. The countable unearned income is then combined with the countable earned income and any amount under an approved Plan for Achieving Self-Support (PASS) for a blind applicant/recipient is deducted. The total income is compared to 300% FPL for a single person to determine eligibility. If the individual is married and his or her countable income is over 300% FPL, spousal impoverishment rules apply to potentially deduct the individual’s countable income described in IHCPPM 3455.15.10.10 and 3455.15.10.15. If the individual’s income is underneath 300% FPL after allowing for the allocations, the individual is considered Medicaid eligible.

3375.00.00 End-Stage Renal Disease (ESRD)

In June 2014, individuals with End Stage Renal Disease (ESRD) were at risk of losing access to kidney transplant services due to the elimination of the Spend Down provision. These individuals were provided extended Medicaid coverage with an applied liability instead of a Spend Down.

3375.05.00 Basic Eligibility Criteria

Individuals must meet all the program requirements to be eligible for the ESRD provision:

- Current diagnosis of End-Stage Renal Disease
- Approved to receive Medicare part A and B
- Resources under $1500 for an individual, under $2250 for a couple
- Non-MAGI income is over 150% FPL, with no upper limit for members who were **on Medicaid with a spend down as of May 31, 2014**
- Non-MAGI income is between 150% and 300% FPL if **not on Medicaid with a spend down as of May 31, 2014**
- Not institutionalized
- Meet all non-financial Medicaid eligibility requirements
- Not eligible for any other Medicaid

3375.10.00 Coverage and Benefits

ESRD members are covered in a Med 1 category (A/B/D) which meets the requirements for MEC (minimal essential coverage). Medicare will be the primary payer for the ESRD member, with Medicaid as the secondary coverage. Eligible expenses not covered by Medicare will be paid at the Medicaid rate. The benefit package is Package A (State Plan), delivered through the fee-for-service or traditional Medicaid model, and includes non-emergency medical transportation (NEMT). Enrollees are subject to the same cost sharing requirements and 5% cap as all other A/B/D members. If an ESRD enrollee is admitted to a skilled nursing or other long term care (LTC) facility for any length of time, or approved for a HCBS waiver, the individual must be disenrolled from the ESRD waiver demonstration and evaluated for eligibility using existing LTC rules. The individual can be assessed for re-enrollment into the demonstration if discharged from the facility or if HCBS waiver approval ends.

3375.15.00 Special Processing

ESRD members are coded in ICES with institution type “17” to prevent accidental closure of benefits. All financial calculations (income, resources, spend down amount, allocations) must be completed offline. If the member passes eligibility, coverage must be FIATed using reason code 425 so the population can be identified for mandatory CMS waiver reporting.

3375.20.00 Redeterminations

Members with Non-MAGI income over 150% FPL, with no upper limit for members who were on Medicaid with an spenddown as of May 31, 2014 will maintain ESRD eligibility during annual redetermination as long as they meet the following criteria:

- Meet the eligibility criteria in effect May 31, 2014 for the aged, blind and disabled groups, including use of a spend down;
- Continue to have a physician-verified ESRD diagnosis;
- Are not institutionalized;
- Do not qualify for Medicaid on another basis.

Members with Non-MAGI income between 150% and 300% FPL if not on Medicaid with a spend down as of May 31, 2014 will maintain ESRD eligibility during annual redetermination as long as they meet the following criteria:

- Have been diagnosed with ESRD;
- Have a household income below 300 percent of the federal poverty line (FPL);
- Have resources below $1,500 for an individual or $2,250 for a couple
- Are not institutionalized;

- Meet all other Medicaid non-financial eligibility criteria; and

- Are not Medicaid eligible on another basis.

3375.30.00 Budgeting

All ESRD members will have a **spenddown**, not a liability. The amount entered on AEWFT must be marked **S** and not **L**. All income for the ESRD member should be entered on the appropriate screens so that it is counted for other programs and family members. ESRD members may qualify for MCCA spousal impoverishment provisions and/or a spousal or dependent allocation. Any spouse/dependent allocation would also be calculated offline and deducted from the overall spend down amount which is entered on AEWFT.

3375.40.00 End of ESRD Eligibility

Social Security Agency rules say that if a person receives Medicare only because of an ESRD diagnosis, the coverage will end when one of these conditions is met:

- 12 months after stopping dialysis treatments, or

- 36 months after receiving a kidney transplant

When ESRD Medicare coverage ends, the special Medicaid provisions and processing no longer apply. When ESRD Medicaid coverage ends the member should be evaluated for continuing coverage in another category.

3375.50.00 ESRD Eligibility Issues

If the ESRD member is included on a SNAP application, the correct AG won’t form due to the institutional listing on AEIII—but normal purchase/prepare rules apply. If the correct AG would fail SNAP eligibility, deny SNAP and send a manual notice; if the AG would pass, contact the Help Desk for further instructions.

Spouse and child allocations must be determined by the eligibility worker. Because manual budgeting is used, any allocation must be added to the AEFUI screen for the spouse

or child so it will correctly be included as countable unearned income for other programs. Allocations should *not* be added to AEMWS for the spouse/child. The same income will already be counted or not counted in their budget based on the tax relationship with ESRD member.

3375.60.00 ESRD "Perceived" Donut Hole

Members with an ESRD diagnosis who are at or below 100% FPL can receive Med 1 and Med 4 coverage with normal budgeting rules, and Med 1 is available for those with income over 150% FPL through the ESRD waiver (they will not financially qualify for QMB coverage).

Workers may receive questions about those who are between 101% and 149%, and why they appear to be left out. The members at this in-between income level will have Medicare to cover ESRD treatment, but will have a very high amount of out-of-pocket expenses. While they will not qualify for Med 1, they should qualify for QMB. If they apply and are approved, then Medicaid would remove their burden to pay premiums, deductibles, copays, and coinsurance.

3400.00.00 BUDGETING AND BENEFIT CALCULATION

3405.00.00 INCOME BUDGETING PRINCIPLES

3405.05.00 INCOME FREQUENCY

3405.10.00 BUDGET METHODS

3405.10.05 Regular Budget Method

3405.10.10 Fluctuating Budget Method

3405.10.15 Averaging Budget Method

3405.10.20 Prorated Budget Method

3405.10.22 Annual budget Method

3405.10.25 Beginning/Terminating Budget Method

3410.00.00 BUDGETING SELF-EMPLOYMENT INCOME

3410.05.00 DEFINITION OF SELF-EMPLOYMENT

3410.10.00 ESTABLISHING ANNUAL SELF-EMPLOYMENT INCOME

3410.15.00 ALLOWABLE SELF-EMPLOYMENT COSTS

3415.10.00 BUDGETING ROOMER AND BOARDER INCOME (MED 1, 4)

3420.00.00 RENTAL INCOME

3420.05.00 BUDGETING RENTAL INCOME

3420.05.05 Allowable Rental Expenses

3430.00.00 BUDGETING EDUCATIONAL INCOME

3430.05.00 ALLOWABLE EXPENSES FROM EDUCATIONAL INCOME

3435.00.00 BUDGETING LUMP SUM INCOME

3437.00.00 CONTRACT SALE OF REAL PROPERTY

3455.00.00 BENEFIT CALCULATION (MED 1)

3455.05.00 ELIGIBILITY BUDGETING (MED 1)

3455.05.05 Budgeting Income Of Applicant/Recipient And Spouse (MED 1)

3455.05.05.05 Disregard Of RSDI 20% COLA In October 1972 (MED 1)

3455.05.05.10 Disregard Of RSDI COLA In Transition Months (MED 1, 4)

3455.05.05.15 Plan For Achieving Self-Support (PASS) (MED 1, 4)

3455.05.05.20 Earned Income Deductions for the Blind (MED 1)

3455.05.05.25 Darling v. Bowen Special Income Disregard (MED 1)

3455.05.10 Allocation To Dependent Child (MED 1)

3455.05.15 Allocation To Essential Person (MED 1)

3455.05.20 Parental Deemed Income (MED 1)

3455.05.25 Eligibility Budgeting Procedures for Spend-Down (MED 1)

3455.05.30 ELIGIBILITY BUDGETING PROCEDURES UNDER 100% FEDERAL POVERTY LEVEL (MED 1)

3455.06.00 ELIGIBILITY BUDGETING PROCEDURES FOR M.E.D. WORKS

3455.07.00 DEDUCTION OF IMPAIRMENT-RELATED WORK EXPENSES (MED 1)

3455.08.00 PREMIUM AND CATEGORY CHANGES IN M.E.D.WORKS (MED 1)

3455.09.00 M.E.D. WORKS CONTINUATION WHEN EMPLOYMENT IS LOST

3455.10.00 ELIGIBILITY UNDER THE SPEND-DOWN PROVISION (MED 1, 2)

3455.14.00 INSTITUTIONAL AND HCBS WAIVER ELIGIBILITY BUDGETING UNDER THE SPECIAL INCOME LEVEL (MED 1)

3455.15.00 POST-ELIGIBILITY BUDGETING (MED 1)

3455.15.05 Exempt Income In Post-Eligibility Budgeting (MED 1)

3455.15.10 Deductions From Income In Post-Eligibility (MED 1)

3455.15.10.05 Sheltered Workshop Earnings/Post Eligibility (MED 1)

3455.15.10.10 Spousal Allocation Deduction (MED 1)

3455.15.10.15 Family Allocation Deduction (MED 1)

3455.15.15 Liability Exceeds Facility Private Rate (MED 1)

3455.15.15.05 Liability Exceeds Medicaid Rate (MED 1)

3455.15.20 Medicare Involved In Nursing Facility Payment (MED 1)

3455.20.00 FINANCIAL ELIGIBILITY FOR RBA-RELATED MEDICAID (MED 1)

3455.25.00 BUDGETING INCOME-IN-KIND (MED 1, MED 4)

3460.00.00 BENEFIT CALCULATION (MED 2)

3460.05.00 REFUGEE TANF AND CASH ASSISTANCE (MED 2)

3465.00.00 BENEFIT CALCULATION (MED 3)

3465.05.00 MEDICAL ASSISTANCE BUDGETING FOR MAGI CATEGORIES (MED 3)

3470.00.00 BENEFIT CALCULATION (MED 4)

3470.05.00 QMB/QDW/SLMB/QI BUDGETING PROCEDURE (MED 4)

3475.00.00 1619 MEDICAID BUDGETING (MED 1)

3480.00.00 BUY-IN PROCEDURES AND EFFECTIVE DATES (MED)

3400.00.00 BUDGETING AND BENEFIT CALCULATION

This chapter discusses the budgeting of income, income deductions, and the calculations necessary to determine financial eligibility. Specific information includes:

Income Budgeting Principles (Section 3405);
Budgeting Self-Employment Income (Section 3410);
Budgeting Boarder Income (Section 3415);
Rental Income (Section 3420);
Budgeting Educational Income (Section 3430);
Lump Sum Calculation (Section 3435);
Contract Sale of Real Property (Section 3437);
Benefit Calculation (MED 1) (Section 3455);
Benefit Calculation (MED 2) (Section 3460);
Benefit Calculation (MED 3) (Section 3465);
Benefit Calculation (MED 4) (Section 3470);
1619 Medicaid Budgeting (Section 3475); and
Buy-In Procedures and Effective Dates (Section 3480).

3405.00.00 INCOME BUDGETING PRINCIPLES

Financial eligibility is based on the best estimate of income and circumstances which will exist in the month for which the assistance is being considered. This estimate should be founded upon the most complete information available to the DFR as of the authorization date. This eligibility determination requires knowledge of an individual's and/or AG's current, past or anticipated future circumstances. A presumption that current or historical trends will continue in the future cannot be made. Use of historical trends is appropriate if there is reason to believe, with supporting documentation, that the trends will continue.

Prospective budgeting rules require that the AG's assistance for a given month be based on the income expected to be received during that month.[1] Actual income is budgeted for each of the three retroactive months prior to the month of application.[2]

For MAGI-based income methodology, when determining eligibility at initial application, financial eligibility is based upon current monthly income and family size. When determining current monthly income, the DFR will include a prorated portion of the reasonably predictable increase in future income and/or family

[1] 405 IAC 2-5-1
[2] 405 IAC 2-5-1(b)

size. The DFR must also account for a reasonably predictable decrease in future income and/or family size. At all other times (ex: Redeterminations), MAGI income should be annualized as much as possible.

To calculate monthly amounts, the frequency and budgeting method of the income must first be determined.

3405.05.00 INCOME FREQUENCY

Frequency is defined as how often income is received. Amounts may be received weekly, bi-weekly, semi-monthly, monthly, quarterly, semi-annually, annually, or less often than monthly.

3405.10.00 BUDGET METHODS

Once the frequency of an income is determined, the method of budgeting the amount is determined.

The following sections list the various budget methods and the circumstances under which they are used.

3405.10.05 Regular Budget Method

Regular income is income received in the same amount each pay period with no variances.

The monthly amount is determined using the appropriate conversion factor as follows:[3]

> The gross amount of income received weekly is to be multiplied by 4.3.
>
> The gross amount of income received biweekly is to be multiplied by 2.15.
>
> The gross amount of income received semimonthly is to be multiplied by 2.

3405.10.10 Fluctuating Budget Method

Income which varies each pay is to be converted to a monthly amount using the "fluctuating budget method" unless the client requests that the "averaging" method be used.

Fluctuating (F) method:

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[3] 405 IAC 2-5-1(a)(1)

The payments received during the months being reviewed are added together and the total is divided by the number of payments; then, the appropriate conversion factor as explained in Section 3405.10.05 is applied. A pay which is unusually high or unusually low should not be included in the calculation. The budget method "S-SKIP" should be entered for a pay which is not reflective of what can be expected to be received in the future.

If "S-SKIP" is used in an application month, the pay amount will be included for the application month calculation but will be skipped for months past the application month.

3405.10.15 Averaging Budget Method

The Average (A) budget method may be used with income received weekly, bi-weekly, semi-monthly or monthly. Averaging may only be used when complete monthly amounts are available and there are two or more months of history.

An AG has the option of choosing this budget method. However, if complete monthly amounts are not provided, it may not be used.

3405.10.20 Prorated Budget Method

The Prorated (P) budget method distributes an income over the period of time associated with the income or expense. This budget method is only used with the frequency LO - less often than monthly. Educational income is a common example of income which is often calculated using this frequency and budget method. This entry is used by the ICES calculator to determine how many months by which to divide the income amount. This budget method is not used for earned income.

3405.10.22 Annual Budget Method

The amount of money that an individual, business, or asset will earn over the course of a year. Annualized income can be calculated with less than 12 months of income because in some cases the client only works 8-9 months a year and the income is intended to meet the household’s needs for the entire year. To calculate the annual income for the household you would add all the income received for the specific calendar year and then divide by 12 months.

3405.10.25 Beginning/Terminating Budget Method

Income is projected when an individual has just begun working, has changed jobs, or has had a change in rate of pay. If the person has just begun to work, verified earnings to the date of

the budget computation are to be used. Otherwise, an estimate of anticipated earnings can be obtained and used as a basis for projection on a monthly basis.

When the 'B' budget method is used, that budget month will use all the 'B' income or expenses as actual 'B' amounts with no conversion. If the beginning pay is not reflective of future months, a new amount and budget method must be entered.

The 'B' budget method should only be used if all of the following 3 statements are true about the income (or expenses):

The job is a new job or the source of income is new, and

The income will not be received for every frequency (a full month's income) in the month the job/income source begins, and

The same month the income source begins also needs to have this income included (new job starts in October, income of new job is budgeted for October) in the budget for that month. This usually would occur at a new application point or for add a program.

EXAMPLE:

A client applies on 7/10 with a new app. and has a job where he will receive his first pay on 7/22. The worker verifies the information that the client will receive a partial pay of $50 and then $100 a week there after. The income on AEINC should be listed as follows:

RCVD DATE	FREQ	BGT MTD	GROSS AMT
07/22WK	B		50.00
07/29WK	B		100.00

July's budget will be $150 (50 + 100) and August and thereafter will be $430 (100 X 4.3)

If this same situation was new information reported at a 7/10 redet, these pays would then be listed as 'S' for the first pay and 'R' for the second pay since all 3 criteria for the 'B' budget method were not met. (3rd criteria not met as the July budget is already in effect without the new earnings.)

While rare, the client could report at a 7/10 redet that he will be starting a job in August and will be paid bi-weekly with the only one check being received in late August. The worker would correctly project the one actual pay for August since the August budget is not in effect yet and this situation meets the criteria for using the 'B' budget method. (Notice this is not a new application or add a program situation where most 'B' situations will occur.)

RCVD DATE	FREQ	BGT MTD	GROSS AMT
08/22WK	B		100.00

August would be budgeting $100 (actual) and September would be budgeting $430 (100 X 4.3).

When an employed person loses his employment, which includes being laid off or on strike, an evaluation is to be made of the expected length of time without income.

If the period without income is expected to be at least one month, a new budget showing loss of income is to be computed. This is done by using the 'T' budget method. No 'T' entry is ever carried into the budget beyond the month it was received.

EXAMPLE:

The client reports on 10/20 that he will only be working until the end of the month and will receive 2 more pays in November for $100 each. The income should be listed on AEINC as follows:

RCVD DATE	FREQ	BGT MTD	GROSS AMT
11/1	WK	T	$100
11/8	WK	T	$100

If the worker authorizes this before the 11/1/ pulldown, the November budget will reflect $200. If authorized after pull-down, no income will appear in the December budget. An auxiliary benefit would be needed for November (calculated manually).

3410.00.00 BUDGETING SELF-EMPLOYMENT INCOME

Self-employment budgeting procedures are outlined in the following sections. Self-employment income is generally determined by subtracting allowable expenses from the gross income.

3410.05.00 DEFINITION OF SELF-EMPLOYMENT

The determination of whether an individual is self-employed will generally be verified by federal income tax returns and there is no need to further question the existence of a trade or business. However, in some instances, it may be necessary to inquire further into the situation to determine if a person is self-employed when tax returns are not a definitive measure. Consider the following when determining that a person is self-employed:

The good faith intention of making a profit or producing income as a regular occupation;

The holding out to others as being engaged in a business of selling of goods or services;

The continuity of operations or regularity of activities;

The lack of an ‘‘employer’’ relationship in the regular sense of the word in which the employer pays wages and or provides benefits;

The existence of documentation in the person’s possession that supports his or her claim of self-employment;

Being a member of a business or trade association;

A single factor is not always sufficient to determine whether a person is self-employed or not, nor must all of the above factors be met. Workers must apply the factors listed as well as others that may exist, to determine whether an income producing activity is self-employment. In some cases it may be necessary to distinguish self-employment from a hobby. Also persons working as contractors or subcontractors may or may not be self-employed.

A person is not self-employed if he or she receives a W-2 form showing wages paid, the employer pays FICA taxes, or the person is paid a salary from a corporation or individual.

Some business owners may pay themselves a wage as an employee and also receive a portion or all of the net profits gained from the business. When this occurs, it is necessary to separate the income received from wages as an employee of the company from the income received from the business profits (or loss).

The net profit from self-employment income may be determined through a review of past books or records of the previous year's Federal Income Tax Report.

3410.10.00 ESTABLISHING ANNUAL SELF-EMPLOYMENT INCOME

Current income from self-employment may be determined by using the individual's tax return filed for the previous year if a review of his current business records indicates no substantial variance. If the previous year's tax return is not an accurate reflection of current income, his recent records are to be used to project the annual income.

When the individual is engaged in a new business, he must supply business records for his taxable year-to-date and annual income is to be projected.

When he is engaged in a new business and records are not yet available or the business has been going on for some time but no records were kept, annual income is determined by using the individual's best estimate. If approved for assistance, the individual must keep records and after no longer than two months actual income must be verified.

Seasonal self-employment income which is intended to meet the household’s needs for only part of the year should be prorated over the period of time the income is intended to cover. For

example, clients who are self-employed only during the summer months to supplement their annual income will have their summer self employment income prorated over the summer months.

Seasonal employment which is intended to meet the household's needs for the entire year, including self-employment, is annualized to establish a monthly amount.

3410.15.00 ALLOWABLE SELF-EMPLOYMENT COSTS

Examples of allowable costs for producing self-employment income are:

Wages, commissions, and mandated costs relating to the wages for employees of the self-employed;

The cost of shelter in the form of rent, the interest on mortgage or contract payments, taxes, and utilities;

The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments;

Insurance on the real and/or personal property involved;

The cost of any repairs needed; and

The cost of any travel required. Please, see IHCPPM 2810.30.05 for more information.

For all categories of assistance, except MA R and MA Q, allowable expenses include those allowable under the Internal Revenue Code from gross income.[4]

Please refer to Chapter 2800 and Section 3460.05.00.

Net profit is the total income derived from a self-employment enterprise less allowable deductions.

If the self-employment costs are greater than the self-employment income, then the following rules apply:

- For MED 1, 2, 4: the countable income from self-employment is $0. The loss cannot be carried over for the total countable income.

- For MED 3: MAGI budgeting allows self-employment losses to be carried over in the budgeting calculation for other income when determining total countable income. The total countable income, however, cannot be less than $0.

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[4] 405 IAC 2-3-3; 42 CFR 435.603

- For example, Steve, who is the sole owner of his own business, pays himself a monthly wage of $1,500 as an employee. His business is not making a net profit and is losing $500 per month. His total countable income is $1,000.

- For example, John, who is a sole owner of his own business, pays himself a monthly wage of $500 as an employee. His business is not making a net profit and is losing $1,000 per month. His total countable income is $0.

- For example, Mary, who is the sole owner of her own business, is married. Her spouse receives $900 per month for his Social Security Disability. They have 2 children, Courtney age 5, and Ben age 4. Neither child has income of any kind. Mary does not pay herself any wages as an employee. Her business is losing $200 per month. The total countable income for under MED 3 budgeting is $700 for each person. Because John is disabled, when determining his eligibility under MED 1 and before applying other deductions under MED 1 budgeting rules, his countable income is $900.

3415.10.00 BUDGETING ROOMER AND BOARDER INCOME (MED 1, 4)

The policy stated in this section does not apply to MA R.

In a roomer and boarder situation, net rental income is determined by deducting allowable expenses (see Section 3420.05.05) proportionately to the number of rooms (excluding bathrooms) in a private house or by the number of people living in the house. Examples of roomer and boarder situations are as follows:

The applicant owns a seven room house (excluding bathrooms) and rents one bedroom. The roomer pays $100 a month. All allowable expenses equal $400 a month. One-seventh of those expenses ($57.14) is deducted from gross rental income. $42.86 is budgeted as net rental income.

The applicant and his wife have a five room house (excluding bathrooms) and rent one room with meals provided. The roomer and boarder pays $200 a month. Allowable income producing costs equal $200 a month and food costs equal $300. One-fifth of $200 = $40. One-third of $300 = $100. $140 is deducted from gross rental income. $60 is budgeted as net rental income.

3420.00.00 RENTAL INCOME

Rental income is payment for the use of real or personal property. Rental payments may be received for the use of land

(including farm land), for land and buildings, for a room, apartment, or house, or for machinery and equipment.

3420.05.00 BUDGETING RENTAL INCOME

Rental income may be considered either unearned or earned income. Regardless, income from rental property is determined by the costs of doing business being deducted from the gross income.

For MED 2: Rental income is unearned unless the production of income includes some type of personal involvement and effort on the part of an AG member.

For MED 3: Rental income is either unearned or earned income. The income (or loss) is determined by allowable IRS deductions from the gross income.

For MED 1 and 4 (except MA R): Rental income is unearned income unless the AG owns multiple rental properties so that there is a rental business; that situation is considered self-employment earned income.

3420.05.05 Allowable Rental Expenses

Allowable rental expenses include costs allowed by the Internal Revenue Service.[5] Please, refer to Chapter 2810.30.00 and Section 3460.05.00.

Examples of rental expenses allowed under all categories are:

- Property taxes;
- Interest payments;
- Repairs;
- Advertising expenses;
- Lawn care;
- Insurance premium for property only;
- Trash removal expenses;
- Snow removal expenses;
- Water;
- Utilities; and
- Other necessary expenses.

[5] 42 CFR 435.603(e)

The following examples are costs allowed by the Internal Revenue Service but not allowable under MA R and MA Q:

Depreciation;
Insurance to pay off the mortgage in the event of death or disability; and
Capital expenditures.

3430.00.00 BUDGETING EDUCATIONAL INCOME

If an AG member has both exempt and non-exempt income (see Chapter 2860.05.00), allowable educational expenses are deducted from exempt income first. All remaining allowable expenses are then deducted from the non-exempt income. If any non-exempt income remains, it is prorated over the number of months it was intended to cover and counted as unearned income. **Note:** The second step only applies to non-exempt educational income received directly by the student. If the entire amount is received and retained by the school, it is completely excluded from the budgeting process. If the school receives the income directly and refunds any unused portion to the student, only the refunded amount is budgeted as unearned income (after allowable additional educational expenses are deducted).

EXAMPLE:

Mr. Smith is a graduate student. His verified educational income and expenses are listed below:

Financial Aid	Educational Expenses
$3000 Perkins Loan	$4000 Tuition, fees
(Exempt income)	$ 500 Books, supplies
$3500 Kiwanis Scholarship	$ 100 Transportation
(Non-exempt income)	$ (Actual)

Step One: Subtract expenses from exempt educational income:

$3000
- 4600
- $1600 (unmet educational expenses)

Step Two: Establish what portion, if any, of the non-exempt scholarship money is accessible to the student. It has been verified that the scholarship funds are sent directly to the school. The financial aid office verifies that a refund check for $2500 will be sent to Mr. Smith. $1000 of the total scholarship money is excluded from consideration since it was retained by the school and is not available to the recipient/student. This leaves $2500 available non-exempt income.

Step Three: Subtract the unmet expenses in Step One ($1600) from the remaining non-exempt income:

$2500 available non-exempt educational income
- 1600 unmet educational expenses
$ 900 countable educational income is prorated over the month it was intended to cover and budgeted as unearned income to the AG.

3430.05.00 ALLOWABLE EXPENSES FROM EDUCATIONAL INCOME

Allowable expenses for undergraduates and graduate students include tuition, mandatory fees, supplies, books and transportation. Mandatory fees include the costs of rental or purchase of equipment, materials and supplies related to the pursuit of the course of study involved for all programs. Transportation is allowed at 56.5 cents per mile if the actual cost cannot be determined.

Miscellaneous personal expenses (other than normal living expenses) are also allowable deductions if they are incidental to attending the school, institution or program. Such expenses could include such things as subscriptions to educational publications or dues for a professional association. Normal living expenses which are not allowable would include such items

as food, rent, board, clothes, laundry, haircuts and personal hygiene items.

3435.00.00 BUDGETING LUMP SUM INCOME

A lump sum includes such items as retroactive RSDI or VA benefits, refunds of Medicare Part B premiums, and inheritances. A lump sum is considered as income in the month of receipt. An SSI lump sum is disregarded as income in the month of receipt.

The policies stated in this section apply to the MA A, MA B, MA D, MA G, MA L, MA J, and MA I categories of assistance.

For MED 3, under MAGI-based income methodology, an amount received as a lump sum is counted as income only in the month received.[6]

3437.00.00 CONTRACT SALE OF REAL PROPERTY

For the MED 1 and 4 categories, when property is sold on contract, the monthly land contract payments, less ownership expenses, are counted as income. Payments received on a basis other than monthly are to be prorated to establish a monthly amount.

For the MED 3 categories, any payments of interest and any gains on the sale received as a result of the sales contract (including that portion of any periodic payment) is to be budgeted as income in the month of receipt.

3455.00.00 BENEFIT CALCULATION (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

Eligibility for MA with regard to income is based on the countable income of the individual and his financially responsible relatives. Situations in which income is deemed from parents and spouses are identified in the following sections.

The budgeting process consists of two steps: eligibility and post-eligibility. The eligibility step is completed for every AG. Refer to Section 3455.05.00. For individuals in long term care (LTC), the post-eligibility step is also completed to determine the patient liability if the AG has passed the eligibility step. Refer to Section 3455.15.00. More detailed information regarding the circumstances which require a particular budgeting procedure pertaining to situations involving an institutionalized applicant/recipient with a community spouse can be found in Sections 3455.05.05, 3455.15.10, 3455.15.10.10, and 3455.15.10.15. Refer to Section 2635.10.10 for eligibility

[6] 42 CFR 435.603(e)(1)

information regarding an institutionalized applicant/recipient with a community spouse.

3455.05.00 ELIGIBILITY BUDGETING (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

In the eligibility budgeting procedure, the total non-exempt unearned and earned income, less allowable deductions, is compared to the appropriate income standard in Chapter 3000. If the resulting amount is equal to or less than the appropriate income standard, the individual is financially eligible. The individual with income in excess of the income standard will pass financial eligibility with a monthly spend-down. Effective June 1, 2014, eligibility determinations made for months on and after June 1 2014 do not include a spend-down. Instead, eligibility will be determined under 100% of the federal poverty level, refer to section 3455.10.30.

Beginning on June 16, 2008, a policy change was implemented relative to the eligibility determination for applicants and recipients with countable income in excess of the applicable income standard. There is no longer a requirement that the individual show proof of ongoing and or anticipated medical expenses as a condition of eligibility for Medicaid with a spend-down. Once approved for Medicaid with a spend-down, the recipient must meet the spend-down, as explained in Section 3455.10 in order for Medicaid to reimburse for services.

3455.05.05 Budgeting Income Of Applicant/Recipient And Spouse (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

The non-exempt income of the applicant/recipient and the non-exempt income of his spouse who is not receiving TANF are counted together in the eligibility budget computation. This does not apply when one spouse is in a long term care (LTC) facility or receiving HCBS waiver services; the spouses are budgeted separately in that instance.

When an applicant/recipient has stepchildren living in the home, his spouse's income must first be allocated to meet the needs of the spouse's own biological or adoptive dependent children who are under age 18 or students between age 18 and 21 who are not receiving TANF and who are living with the couple. The amount to be allocated is the income standard minus the child's non-exempt income. The spouse's remaining income is then combined with the applicant's/recipient's income in the budget computation. Income is not allocated from the income of the applicant/recipient to

stepchildren.[7] Income of a stepparent in the household of a child applicant/recipient under age 18 is deemed to the child unless the child's natural/adoptive parent is deceased or the couple is divorced.

Effective June 1, 2014, child support payments made by the spouse of an applicant/recipient in compliance with a court order or Title IV-D are disregarded.

The eligibility budget is displayed on screen AEBMB.

3455.05.05.05 Disregard Of RSDI 20% COLA In October 1972 (MED 1)

The policy stated in this section only applies to the MA A, MA B, and MA D categories of assistance.

The amount of the 20% increase in Social Security benefits received in October 1972 under Public Law 92-336 is disregarded if, for the month of August 1972, the non-institutionalized applicant/recipient was a recipient of Old Age Assistance, Blind Assistance, or Disabled Assistance.[8]

3455.05.05.10 Disregard Of RSDI COLA In Transition Months (MED 1, 4)

The Cost of Living Adjustment (COLA) received annually in January by Social Security beneficiaries is disregarded until April of the same year for individuals eligible under MA L, MA J, and MA I.[9] This disregard also applies to individuals eligible for MA A, MA B, and MA D that live in the community and whose income determination is under 100% of the federal poverty level (FPL).[10] This results in the RSDI benefit increase coinciding with the income standard increase which occurs when the new Federal Poverty Guidelines are published. The months of the COLA disregard are referred to as "transition months".

NOTE: The April 1 date is based on the assumption that the Federal Poverty Guidelines are published as usual in February. If, in any given year the poverty guidelines are published in a month other than February, DFR will be notified of the transition months.

3455.05.05.15 Plan For Achieving Self-Support (PASS) (MED 1, 4)

The policies explained in this section apply only to the MA B, MA D, MA G, MA L, MA J, and MA I categories of assistance.

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[7] 405 IAC 2-3-20
[8] 42 CFR 435.134
[9] Social Security Act (SSA), Section 1905(p)(2)(D) as amended by OBRA-90.
[10] SSA 1902(m)(2)(c)

There are two kinds of Plans for Achieving Self-Support (PASS). One is an SSI PASS which is approved by the Social Security Administration for SSI eligibility purposes. The other is a Medicaid PASS which is approved by Office of Medicaid Policy and Planning, Medicaid Eligibility Unit, Central Office, for Medicaid eligibility purposes.

A PASS can be developed for an individual who needs to set aside a part of his income for a specified period of time necessary to achieve an occupational objective. The income could be used for current expenditures or saved for a later planned expenditure to achieve a work-related goal such as education, vocational training, starting a business, or purchasing work-related equipment.

For individuals in the MA B category (SSI recipients and non-SSI recipients) as well as non-SSI recipients in the MA L, MA G, MA J, MA I, and MA K categories, a PASS must be approved by the Office of Medicaid Policy and Planning (OMPP).[11] In order for a PASS to be approved, the DFR must submit a letter to the Central Office containing:

- the description and objectives of the plan as discussed with the applicant/recipient;
- the source and amount of all income and resources and what amounts of each are to be used in the plan;
- the length of time the plan is to operate; and
- any other pertinent information including documentation from the Social Security Administration of an SSI recipient's approved PASS.

This letter is to be prepared in triplicate, with two copies sent to the Central Office, OMPP, Medicaid Eligibility Unit, and one retained in the case record. The Central Office will forward a copy to the Blind and Visually Impaired Section of the Division of Aging and Rehabilitative Services for their recommendation. The Central Office will then review the self-support plan and recommendation from the Blind and Visually Impaired Section of the Division of Aging and Rehabilitative Services, and notify the DFR by letter of approval or disapproval. The DFR will then notify the applicant/recipient. If the plan is approved, the amount of income and resources disregarded and time period for the disregard must be documented in the case record. A Medicaid approved PASS is coded in ICES as PM.

In the QMB, QDW, SLMB, and QI eligibility determinations of SSI recipients who have a PASS approved by the Social Security Administration, a separate approval from the Central Office is not required. A copy of SSA's documentation should be obtained

[11] 405 IAC 2-3-3

and filed in the case record. An SSI PASS is coded in ICES as PS.

A PASS under the MA B or MA D categories can be approved for a period not to exceed 12 months. For MA L, MA G, MA J, and 0MA I the PASS exemption will be for at least 18 months and may be extended up to 36 months.

3455.05.05.20 Earned Income Deductions for the Blind (MED 1)

Effective June 1, 2014, this section is only applicable for the MA B category.

A deduction is allowed from the earned income of a person being determined under the Blind category for work-related expenses. Allowable expenses are those which are reasonably attributable to the earning of the income and which are not subject to reimbursement. Examples include:

- Medical services, equipment, and supplies which are not covered by Medicaid or a third party and are essential to enable the individual to work;
- Income and FICA taxes withheld from paychecks;
- Expenses associated with care and maintenance of a guide dog;
- Professional association dues;
- Union dues;
- Mandatory payroll deductions such as pension and disability contributions;
- Meals consumed during work hours;
- Work-related equipment specially designed to accommodate the person’s visual impairment;
- Non-medical equipment/services including: air cleaners, air conditioners, child care costs, humidifiers, portable room heaters, posture chairs, safety shoes, tools used on the job, uniforms;
- Vehicle modification;
- Structural modifications to the individual’s home to create a work space or to allow the individual to get to and from work;
- Training to use an impairment-related expense to an item reasonably attributable to work; and

- Transportation to and from work.

Examples of non-allowable expenses are:

- Those deducted another provision such as PASS;
- Life maintenance expenses such as meals consumed outside of work hours, self-care items which are cosmetic rather than work-related, general education development;
- In-kind payments;
- Expenses which will be reimbursed; and
- Items furnished by others that are needed in order to work

3455.05.05.25 Darling v. Bowen Special Income Disregard (MED 1)

A special income disregard must be allowed for certain widows(ers) who are receiving RSDI benefits. This disregard is the result of an order issued by the U.S. District Court in the case of Darling v. Bowen. A list of the individuals who were entitled to consideration under Darling v. Bowen was sent to the DFR on February 23, 1990. The disregard would have previously been applied to the affected individuals and is to be continued indefinitely. The disregard consists of the difference between the amount of the individual's RSDI benefit and the current SSI maximum benefit. It is entered on screen AEFUD as an unearned income deduction. If the individual has entered an institution, the special income disregard does not apply.

3455.05.10 Allocation To Dependent Child (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

An allocation is made to a dependent child living with the applicant/recipient if the child's income is less than the applicable income standard in Section 3010.20.05. A dependent child who has nonexempt income equal to or greater than the income standard is not considered in the budget computation.

A dependent child is the applicant/recipient's biological or adoptive child who:[12]

is under age 18, or a student between age 18 and 21 who is regularly attending a school, college, university, or course in vocational or technical training designed to prepare him for gainful employment; and

is not receiving TANF or Adoption Assistance.

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[12] 405 IAC 2-1-1

The above definition is also applicable when allocating from the spouse of the applicant/recipient to the spouse's biological or adoptive child. On screen AEBMB, "eligible child" refers to one applying for or receiving MA under the blind or disabled category and "ineligible child" refers to one applying for or receiving MA under a category other than blind or disabled or who is not applying for or receiving MA.)

The amount to be allocated is the applicable income standard for the child minus the child's nonexempt income.[13]

If a student under age 22 has earned income, please, refer to IHCPPM 2810.26.00.

3455.05.15 Allocation To Essential Person (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

An essential person is a person other than the applicant's/recipient's spouse or parent who is considered by the applicant/recipient to be essential to his well-being because such person provides services to the applicant/recipient which would have to be paid for otherwise.[14] If a spouse or parent is in the home and able to maintain the home and care for the individual, an essential person cannot be considered in the budget computation.

An allocation is made to an essential person if his nonexempt income is less than the income standard in Chapter 3000.[15] Screen AEIHH gathers information that identifies essential persons when "E" is entered in field TD/EP.

3455.05.20 Parental Deemed Income (MED 1)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance.

Income is deemed from the non-recipient biological or adoptive parent's income when the applicant/recipient is:[16]

living with the parent; and

under age 18 and not receiving Home and Community-Based Services under an approved Medicaid waiver.

When the applicant/recipient is a student between the ages of 18 and 21, the parents' income is not deemed. (Effective 1-1-2001)

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[13] 405 IAC 2-3-20(b)
[14] 405 IAC 2-1-1
[15] 405 IAC 2-3-20
[16] 405 IAC 2-3-19

When the applicant/recipient is institutionalized (including hospitalization), income is not deemed from the non-recipient biological or adoptive parents beginning in the month following the month of admission, or beginning in the month of birth if the child remains institutionalized/ hospitalized in the following month.

An allocation is deducted from the income of the parent to his spouse (the applicant's/recipient's stepparent) if the spouse has income of less than the income standard specified for a stepparent in Chapter 3000. The amount to be allocated is the income standard minus the stepparent's nonexempt income remaining after deducting an amount for the stepparent's child (step-sibling of the applicant/recipient) who has income of less than the income standard specified in Chapter 3000. An allocation is not deducted from the income of the applicant's/recipient's parent to the parent's stepchildren.

An allocation is deducted from the parent's income for a biological or adoptive nonrecipient child or child receiving MA under a category other than blind or disabled who:

is under age 18 or age 18 - 21 and a student;

is not receiving TANF or Adoption Assistance;

has income of less than the standard specified in Chapter 3000.

The amount to be allocated is the income standard minus the child's nonexempt income.

The general income disregard of $15.50 is deducted after allocations to dependent children, first from unearned income and then from earned. Effective June 1, 2014, the general income disregard is $20. After the earned income disregards are applied to the parent's earned income, the countable unearned and earned income are totaled and compared to the applicable income standard in Chapter 3000. If the parent's income exceeds the income standard, the excess is deemed as income to the child applicant/recipient. If two or more children are applicants/recipients, a proportionate share of the parent's income is deemed to each. This budget is displayed on screen AEBMP.

3455.05.25 Eligibility Budgeting Procedures for Spend-Down (MED 1)

This section will not be applicable for eligibility determinations made for months including June 2014 and thereafter.

The policies in this section apply to the MA A, MA B, and MA D categories of assistance for spend-down budgeting.

The AG's financial eligibility is displayed on screen AEBMB and is determined by application of the following procedures:

The nonexempt unearned income of the applicant/recipient is determined first.

The amount of the applicant's/recipient's unearned income is added to the amount of the spouse's unearned income remaining after any allocation to a dependent biological or adoptive child of the spouse is subtracted, as explained in Section 3455.05.05.

If the applicant/recipient is a child, any income deemed from his parent, as explained in Section 3455.05.20, is added to his own income.

The general income disregard of $15.50 is subtracted. It is applied only once to a couple even when both members have income.

Allocations to dependent children of the applicant/recipient or to an essential person are then subtracted. The resulting amount is the countable unearned income of the applicant/recipient. If deductions are greater than the total unearned income, the remaining amount is deducted from any earned income.

Next, the total earned income (including self-employment) of the applicant/recipient (and spouse) is determined.

After subtracting any remaining allocations to a dependent child, the spouse's earned income is added to the earned income of the applicant/recipient.

Any remaining general income disregard is then subtracted.

Any remaining allocations to a dependent child or essential person are subtracted.

The earned income disregard of $65, plus impairment-related work expenses (IRWEs) as explained in Section 3455.07, plus one-half of the remaining income is subtracted. The resulting amount is the countable earned income.

The countable unearned income is then combined with the countable earned income and any amount under an approved Plan for Achieving Self-Support (PASS) for a blind applicant/recipient is deducted.

The applicable income standard (individual or couple) specified in Chapter 3000 is subtracted.

If there is no resulting surplus income, the AG is financially eligible for assistance.

If there is a surplus, the amount of allowable health insurance premium(s), as defined below, is deducted and any remaining surplus, rounded down to the next whole dollar amount is the monthly spend-down. The spend-down amount without the health insurance premium deduction is referred to as the gross spend-down amount and the amount after the health insurance premium deduction is referred to as the net spend-down. Net spend-down is the amount known to the recipient as that is the amount he or she must meet in incurred medical expenses as explained in Section 3455.10.00.

Allowable Health Insurance Premiums:

Health insurance premiums incurred by the applicant/recipient and financially responsible relatives whose income is included in the budget are allowed. Financially responsible relatives are the spouse of the applicant/recipient, or, for the applicant/recipient who is a child under age 18, his or her parents.

Premiums for medical and or hospitalization coverage are allowed. This includes the amount of the verified non-covered portion of the Medicare Part D premium above the current Benchmark that is the responsibility of the applicant/recipient to pay. (Refer to Section 3041.00.00 for current Benchmark).

If the insurance premium includes AG members not eligible for the deduction and the eligible AG member’s portion cannot be broken out, a prorated amount for eligible AG member(s) is allowed.

Premiums for health and accident policies such as those payable in lump sum settlements for death or dismemberment, or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled, are not allowed. The premiums paid for indemnity policies that do not limit benefits for the purpose of reimbursement of medical expenses are not allowed.

Effective June 1, 2014, eligibility determinations made for months on and after June 1 2014 do not include a spend-down.

3455.05.30 ELIGIBILITY BUDGETING PROCEDURES UNDER 100% FEDERAL POVERTY LEVEL (MED 1)

Effective June 1, 2014, the policies in this section apply to the MA A, MA B, and MA D categories of assistance.

The AG's financial eligibility is displayed on screen AEBMB and is determined by application of the following procedures:

The nonexempt unearned income of the applicant/recipient is determined first.

If the applicant/recipient is a child who receives child support income, the total amount of support received is reduced by 1/3.

The amount of the applicant's/recipient's unearned income is added to the amount of the spouse's unearned income remaining after any allocation to a dependent biological or adoptive child of the spouse is subtracted, as explained in Section 3455.05.05.

Child-support payments made a non-recipient spouse through a court order or made under Title IV-D are disregarded.

If the applicant/recipient is a child, any income deemed from his parent, as explained in Section 3455.05.20, is added to his own income.

The general income disregard of $20 is subtracted. It is applied only once to a couple even when both members have income.

Allocations to dependent children of the applicant/recipient or to an essential person are then subtracted. The resulting amount is the countable unearned income of the applicant/recipient. If deductions are greater than the total unearned income, the remaining amount is deducted from any earned income.

Next, the total earned income (including self-employment) of the applicant/recipient (and spouse) is determined.

After subtracting any remaining allocations to a dependent child, the spouse's earned income is added to the earned income of the applicant/recipient.
Any remaining general income disregard is then subtracted.

Any remaining allocations to a dependent child or essential person are subtracted.

The earned income disregard of $65, plus impairment-related work expenses (IRWEs) as explained in Section 3455.07, plus one-half of the remaining income is subtracted. The resulting amount is the countable earned income.

The countable unearned income is then combined with the countable earned income and any amount under an approved Plan for Achieving Self-Support (PASS) for a blind applicant/recipient is deducted.

The applicable income standard (individual or couple) specified in Chapter 3010.20.05 is subtracted.

If there is no resulting surplus income, the AG is financially eligible for assistance.

3455.06.00 ELIGIBILITY BUDGETING PROCEDURES FOR M.E.D. WORKS

This section applies to MADW and MADI.

The procedures for determining financial eligibility are as follows:

Income of the spouse is exempt in the eligibility determination. If the applicant/recipient is eligible, the spouse's gross income is then counted in the premium calculation.

a) Determine the countable unearned income of the applicant/recipient.

b) Subtract the general income disregard.

c) Determine the earned income of the applicant/recipient. This is the gross income from employment and self-employment after deducting allowable self-employment expenses.

d) Subtract any remaining amount of the general income disregard from earned income.

e) Subtract $65, any impairment-related work expenses as explained in Section 3455.07.00, and one half of the remainder.

f) Add the amount determined at steps b) and e) to arrive at total countable income.

g) If the countable income does not exceed the M.E.D. Works income standard specified in Section 3010.20.20, the individual is financially eligible. If the countable income is more than the standard, the individual is not eligible.

Procedures for calculating the premium are as follows:

Income of the applicant/recipient and spouse is considered for the premium calculation. All income types exempted in the eligibility determination are countable in the premium calculation except TANF benefits. The premium is calculated by adding the unearned income, gross employment income, net self-employment income (amount after allowable self-employment expenses), and net rental income.

The chart in Section 3010.20.20 is used to determine whether the income is sufficient to require a premium, and if it is, the premium amount. For a single applicant/recipient, the family size of 1 is used, and for the applicant/recipient living with a

spouse, the family size of 2 is used. If both spouses are applying for or enrolled in M.E.D. Works, the premium amount for a family size of 2 according to the income is used, and the premium is a ‘‘couple premium’’. This means that there is a single premium for the couple. This premium must be paid in order for both spouses to remain eligible.

3455.07.00 DEDUCTION OF IMPAIRMENT-RELATED WORK EXPENSES (MED 1)

The policy in this section applies to MA D, MADW, and MADI.

A deduction from the earnings of the applicant/recipient in the eligibility determination is allowed for Impairment-Related Work Expenses (IRWE) under the circumstances explained in this section. In order to be allowed as a deduction from earned income the IRWE must be paid by the applicant/recipient and related to the employment of the applicant/recipient. An expense which is merely incurred but not paid is not allowable. An expense that has been, will be, or could be paid for by Medicaid, other insurance, or any other source including other state programs is not allowable.

Expense payments that are made less often than monthly are prorated. One-time expenses are distributed over the redetermination period. Verification of payment of IRWEs is required. Additionally, if there is any question or inconsistency concerning the person’s need for a service which is being claimed as an IRWE, the worker can require verification of necessity from an individual knowledgeable of the situation.

Attendant care services.

> Due to impairment(s), assistance is needed with personal functions in preparing at home to go to work, traveling to and from work, or while at work with personal or work-related functions. Payments made to a family member will be deducted only if the family member suffers economic loss by terminating employment or reducing hours of employment. (For this purpose, a family member is anyone, who is related to the applicant/recipient by blood, marriage, or adoption, whether or not the family member lives with the applicant/recipient.) Only the portion of the payment for attendant care services that is attributable to work-related expenses can be deducted. For example, an individual pays a personal attendant to help in preparing for work, doing light housekeeping, and assisting the individual in the evening with supper. The attendant works 8 hours a day, Monday through Friday, and 2 hours on Saturdays and Sundays. However, only 2 hours per day, Monday through Friday is spent on work-related assistance, that being the time in the morning preparing for work. Therefore, the allowable IRWE is the portion of the payment to the attendant for 2 hours of work per day, for 5 days a week.

Work-related equipment

Special equipment needed in order for the person to do his or her job. The equipment must be necessary due to the person’s impairment, and be something that the employer is not required to provide in accordance with federal law to accommodate the person’s disabilities.

Residential modifications

Dog Guide

The type of home modifications that are allowable is determined by whether the person works away from home or in his home.

For employment away from home, allowable expenses are those made for the outside of the home permitting the person to access his or her means of transportation to and from work.

Costs for modifications inside the home are not allowable when the recipient works away from home.

For the person who works at home, costs can be allowed for modifying the home in order to create a working space to accommodate the person’s impairment. However, any cost deducted as a business expense on the self-employed person’s income taxes, cannot be allowed as an IRWE.

Training to use an impairment-related expense to an item reasonably attributable to work.

Transportation costs

Transportation costs are allowable IRWEs in the situations explained below. Transportation costs are not allowable for the routine cost of getting to and from work in situations where it is no relation to the person's impairment.

Modification to a vehicle that is critical for the person’s use or operation and directly related to the person’s impairment, plus a mileage allowance in the amount allowed by the IRS. The cost of the vehicle is not allowable.

The person’s impairment requires the use of driver assistance, taxicabs or other hired vehicles in order to work. The cost of the transportation provide is allowed, or if the person’s own vehicle is used, a mileage allowance is permitted.

A mileage allowance is allowed if the person can't use public transportation due to the impairment, and not due to unavailability of public transportation, and must drive his or her unmodified vehicle. The person's inability to use public transportation must be verified by a physician.

Medical devices, prosthetics, drugs and other medical services are generally not allowable because Medicaid will pay for these items. However, medical services, equipment, and supplies which are not covered by Medicaid or a third party and are essential to enable the individual to work are allowable expenses.

3455.08.00 PREMIUM AND CATEGORY CHANGES IN M.E.D.WORKS (MED 1)

Premium Changes

When a M.E.D. Works recipient reports a change that imposes a premium or causes a decrease or an increase in the monthly premium amount, the new premium is to be effective in accordance with change processing rules in Sections 2200.05 and 2220.10. The imposition of a premium for a M.E.D. Works recipient and an increase in the premium are adverse actions requiring timely notice.

Category change to M.E.D. Works

When a Medicaid recipient in any other category becomes eligible for M.E.D. Works with a premium, it is an adverse action requiring timely notice. It is processed as an adverse action even if the recipient had a spend-down that was higher than the M.E.D. Works premium. The current category will be closed and the worker will conditionally approve M.E.D. Works. If the premium is lower than the spend-down, the worker must access CUMED and change the spend-down amount to the amount of the premium for the month following the month of authorization.

If a recipient in another category moves to M.E.D. Works with a premium prior to the adverse action date for the month, M.E.D. Works will begin the following month. Eligibility in the prior category will terminate as of the end of the month. Workers should remind recipients of the importance of paying the premium immediately upon receipt of the invoice so that Medicaid coverage does not lapse.

EXAMPLE 1

Jerry is receiving MA D with a $250 spend-down. He gets a job and MADW is authorized on 10/20, after the adverse action date. The premium is $69 effective 12/1. The worker must notify Jerry that his spend-down for November is $69, and then access CUMED to change it to $69.

EXAMPLE 2

Mary is receiving MA D with a $50 spend-down. She gets a job and MADW is authorized on 10/12, before adverse action date. Her premium is $69 effective 11/1. Her MA D closes 10/31 and MADW is conditional. She must pay her premium before 11/1 so that her Medicaid health coverage does not lapse.

3455.09.00 M.E.D. WORKS CONTINUATION WHEN EMPLOYMENT IS LOST

If a M.E.D. Works recipient loses employment involuntarily due to being fired, laid off, or the employer closed the business, continuation of coverage is possible under the circumstance explained in this section. A person who quits a job or closes his own business is not entitled to M.E.D. Works coverage continuation. Additionally, M.E.D. Works can continue if the recipient goes on temporary medical leave, and his job is being held open by his employer. If a person goes on indefinite or long term disability status, he is not entitled to coverage continuation under this provision.

When employment is lost involuntarily, coverage continuation is possible if the recipient maintains an attachment to the workforce under one of the following circumstances:

Enrollment in a Vocational Rehabilitation Program;

Enrollment or registration with the Department of Workforce Development;

Participation in a transition from school to work program;

Participation with an approved provider of employment services.

When the recipient reports that he is no longer working, the worker must ask him if he is or will remain attached to the workforce under one of the above circumstances. If the recipient is otherwise eligible, and states that he will participate in one of the workforce attachment activities, the worker is to enter the activity on ICES and give the recipient Form 2032, Pending Verifications stating that documentation of the workforce attachment must be submitted within 60 days of the date that

person stopped working. The documentation must be from the agency or service provider with whom the recipient is registered/enrolled. In the situation of medical leave, the recipient must provide a statement from the employer that the medical leave is temporary and the job is being held open for the recipient. If the recipient does not provide this documentation within 60 days after the employment ended, he is no longer entitled to M.E.D. Works. Eligibility must be explored for the other Medicaid categories.

If the recipient provides the initial documentation of workforce attachment, continued verification is required quarterly. The recipient is entitled to 12 months of coverage continuation. If, after 12 months, he is not working, he is no longer eligible for M.E.D. Works. Eligibility under the other Medicaid categories must be considered.

3455.10.00 ELIGIBILITY UNDER THE SPEND-DOWN PROVISION (MED 1, 2)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance. Within MED 2, the policies apply only to MA Q.

Individuals who are approved with a spend-down have access to Medicaid covered services on the first day of every month in which they are enrolled. The spend-down works like an insurance deductible. Medical providers file their claims for services rendered to spend-down recipients and the spend-down amount is deducted from their payment. If the recipient has Medicare or other third party insurance, the provider must bill the third party first. The recipient’s out of pocket cost satisfies spend-down. Certain expenses, referred to as non-claims because they cannot be filed directly to the AIM system, must be submitted to the DFR. Refer to Chapter 3600 for information on the monthly process to satisfy spend-down.

Effective June 1, 2014, eligibility determinations that are made for the MA A, MA B, and MA D categories of assistance will no longer include a spend-down amount.

3455.14.00 INSTITUTIONAL AND HCBS WAIVER ELIGIBILITY BUDGETING UNDER THE SPECIAL INCOME LEVEL (MED 1)

The Special Income Level (SIL) test is a specific financial eligibility determination that applies only to the Aged, Blind, and Disabled categories for individuals who either reside in an institution or are (would be) eligible to receive home and community based services under a waiver.

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.

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

Countable income in the SIL test is as follows:

- Gross earnings (no exemptions, and no employment disregard);
- Net rental income (Section 34.20.05, 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 a Miller trust as defined in IHCPPM 3320.10.00 and/or IHCPPM 2615.75.15, is exempt in the SIL test. The amount of income placed into the trust could be the entire amount or a portion. 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.

- Persons who pass the SIL Test and reside in an Medicaid certified long term care (LTC) facility or hospital

Effective 6/1/2014, any applicant or recipient whose countable income is over the applicable standard for the SIL test must establish an approved Miller Trust and must be place income into the trust to allow the person to pass the SIL test. Otherwise, the person would be considered categorically ineligible for Medicaid on and after 6/1/2014. A person who is serving a transfer property penalty, may be considered categorically eligible for Medicaid by passing the SIL. A person who is or would be serving a transfer property penalty cannot be considered categorically eligible without passing the SIL. When a person serving a transfer penalty passes the SIL, there will not be a post-eligibility budget. Medicaid will not pay for the institutional level of care provided to the member during a transfer penalty.

3455.15.00 POST-ELIGIBILITY BUDGETING (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

A post-eligibility budget is to be completed for the individual who passes the eligibility determination and is in a Medicaid certified long term care (LTC) facility or hospital. Post-eligibility is not completed for the individual who resides in his home not receiving HCBS waiver services or who resides in a non-Medicaid certified facility. Also, a post-eligibility budget is not completed for the individual who is disapproved for

nursing home placement (Level of Care or Preadmission Screening denial) or who is serving a transfer of property penalty. When a M.E.D. Works recipient is subject to post-eligibility budgeting in a Medicaid certified facility, there is no premium charged, because a liability is applicable.

The beginning month of the post-eligibility budget differs depending on whether or not the applicant is subject to the "spousal impoverishment" provisions; for example, the applicant is in an LTC facility and has a community spouse. In these situations, the post-eligibility budget begins with the first month of continuous institutionalization. (Refer to Section 2635.10.10 for further information about continuous periods of institutionalization in spousal impoverishment cases.)

For applicants not subject to spousal impoverishment provisions, the post-eligibility budget is completed when the applicant is institutionalized for a full calendar month. If the applicant enters a facility on the first day of the month, post-eligibility begins with that month. If the applicant enters on a day other than the first, post-eligibility begins with the month following the month of admission.

When a recipient enters a Medicaid certified LTC facility from his home, the post-eligibility budget is completed in accordance with the instructions in Chapter 2200 regarding changes in circumstances. However, the post-eligibility budget can begin no earlier than the month following the month of admission.

For recipients who are discharged from an LTC facility, the eligibility budget is applicable in the month following the month of discharge in accordance with change processing guidelines in Chapter 2200.

When a recipient enters a hospital from his home the DFR will have to determine the anticipated length of his hospital stay. If it is expected that the hospital stay will continue for at least a full calendar month, a post-eligibility budget is required in accordance with change processing requirements in Chapter 2200.

It is a general rule that the surplus income from the post-eligibility budget is a "liability’’.

> A liability is designated for the individual who is residing in an LTC facility or hospital, if the stay will continue for at least 30 consecutive days. The liability is the amount which Medicaid will not pay to the facility each month. If an individual dies prior to reaching 30 consecutive days, the stay will be treated as if the person had resided in the institution for 30 consecutive days beginning the date of the most recent admission.

Whenever a LTC recipient enters a hospital the facility is to collect the liability in the usual manner and apply it toward the nursing home charges for the month. Any remainder is to be shown as a credit on the recipient's account and applied toward subsequent month(s)' charges.

The post-eligibility budget is displayed on screen AEBPL.

3455.15.05 Exempt Income In Post-Eligibility Budgeting (MED 1)

In post-eligibility, the total income of the individual who is institutionalized is counted except as specified below:

SSI payments made to a recipient who is in 1619 status who enters a Medicaid certified facility will not be reduced to $30 and are not to be counted as income for the first two full months of institutionalization.[17]

The SSI payments made for 90 days to recipients who are temporarily institutionalized are exempt. The SSA issues a special notice to these recipients indicating they are receiving benefits under P.L. 100-203. The DFR must retain a copy of this notice in the recipient's casefile, unless it is verified on DESX.

The maximum SSI payment for a recipient in a Medicaid certified facility is $30 unless he is receiving benefits under P.L. 100-203. However, the full benefit amount may be erroneously paid for a few months to an individual just entering a facility. These erroneous payments are exempt if documentation is provided that the individual has repaid SSI for benefits received before the reduction to $30. Otherwise they are budgeted as income in post-eligibility.

The reduced VA benefit of $90 payable to a veteran or veteran's widow in a Medicaid certified facility is exempt.[18]

German reparation payments are exempt.[19]

3455.15.10 Deductions From Income In Post-Eligibility (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

The deductions listed below are to be subtracted from the applicant's/recipient's non-exempt income.

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[17] SSA 1611(e)(1)(E)

[18] 38 USC 5503(d)

[19] SSA 1902(r)(1)

The standard personal needs allowance (Section 3010.20.10) is deducted.[20] This allowance can be spent by the individual in any way he chooses. If a veteran or veteran's widow is receiving the $90 reduced pension and has another source of income, the individual is not entitled to an additional personal needs allowance.

In the specific situations explained below an additional amount for increased personal needs is to be deducted:

Sheltered workshop earnings and earnings which are part of a habilitation plan are budgeted in a special manner. Note that this deduction is called an increased personal need in Indiana's approved Medicaid State Plan; however, it is reflected in the computation of net earned income as explained in Section 3455.15.10.05.

Court ordered guardianship fees paid to the applicant's/recipient's legal guardian, not to exceed $35 per month, are to be deducted. Guardianship fees include all services and expenses required to perform the duties of a guardian. Within this context, attorney fees would be included as a guardianship fee.

Federal, state and local taxes on the applicant's/recipient's unearned income which are owed and paid are to be deducted. This deduction is allowable on a one-time basis per year in the next month after the applicant/recipient provides documentation of the payment of the annual tax liability on unearned income. Enter the amount paid as a deduction from income on AEFUD. The correct code is "IT-Income taxes paid by person in institution". The worker must then be sure to remove the deduction for the following month.

A spousal allocation as explained in Section 3455.15.10.10 is deducted.

A family allocation as explained in Section 3455.15.10.15 is deducted.

Health insurance premiums which the applicant/recipient pays for his health insurance coverage (including Medicare prior to Buy-In) is deducted from his income. If the premium is paid less often than monthly, it is to be prorated over the appropriate number of months. This deduction is only allowed for health insurance policies which limit the benefits and the purposes for which the benefits can be used to pay for medical care. Premiums for indemnity policies are not allowed.

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[20] 405 IAC 2-3-17; 405 IAC 2-3-21

Medical expenses which are not subject to payment by a third party and are not covered by Medicaid are deducted, except nursing facility expenses incurred during an imposed transfer of property penalty. These expenses incurred during a transfer penalty are not allowed beginning 7-01-03 regardless of when the transfer penalty was imposed. Prescription drugs not covered by Medicare Rx are allowed as deductions in post-eligibility if Medicaid does not cover them.

The DFR will allow a deduction for an incurred medical expense not covered by Medicaid and not subject to payment by Medicare or other insurance, if an actual provider-generated bill, or copy of such a bill, is submitted to the worker. This bill must indicate the date and type of service that was provided and must clearly show the amount that the recipient owes after any third party has paid. If the recipient has third party insurance that does not show as a payer on the bill, the recipient or provider must submit either an EOB documenting denial of payment or some other documentation of why the insurance was not billed or did not pay. No other documentation is acceptable. DFR are not to sign any documents or ‘‘agreements’’ to ‘‘deviate the liability’’. If proper documentation is submitted, the expense is to be entered on ICES as code NM and it will be deducted in the post-eligibility calculation. The worker is to enter reason code 066 when authorizing the reduction/elimination of the patient liability. If it takes more than one month to meet the expense, workers must have fail-safe monitoring procedures to ensure that the expense is removed at the proper time. CUMED is not to be used for this purpose unless it is necessary to correct an error made by the worker, that for some reason cannot be accommodated in future months. Recipient change reporting guidelines apply to institutionalized recipients in the same manner as other recipients.

3455.15.10.05 Sheltered Workshop Earnings/Post Eligibility (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

Sheltered workshop earnings and earnings which are part of a habilitation plan are included as earned income. In the eligibility step, sheltered workshop earnings and earnings which are part of a habilitation plan are budgeted exactly the same as any other earned income from employment. The standard earned income disregard is applicable.

In the post-eligibility step, the net income after allowing employment expenses is divided by two to determine the net countable income.[21] Employment expenses are as follows:

$16 employment incentive;

State, local and federal income taxes, including FICA. The amount to be deducted is based on monthly income by using the appropriate state and federal tax charts. The tax deduction is to be determined by using the total number of exemptions to which the applicant/recipient is legally entitled, whether or not they are actually claimed for withholding purposes.

Transportation expenses. A deduction is allowed for expenses directly related to the earning of income. The actual documented expense is allowed for a transportation carrier; $.15 per mile is allowed if the individual drives his own automobile to and from work.

The above listed deductions, including the $16 disregard, must be computed manually and entered on AEINC. For each of the three retroactive months, enter one deduction amount in the "DED" field. After the screen re-appears with the converted 'monthly income' amount displayed, calculate the ongoing deduction using that income amount and enter it in the 'deductions' field. ICES will then compute the earned income to be counted in the post-eligibility budget. It will be displayed as earned income on screen AEBPL.

3455.15.10.10 Spousal Allocation Deduction (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

In the post-eligibility determination of an institutionalized applicant/recipient with a community spouse, an allocation to the community spouse must be computed. The spousal allocation is the amount by which the spousal maintenance standard exceeds the community spouse's countable income. The spousal allocation is determined as follows:

The income designated as owned by the community spouse is identified and entered on the appropriate ICES screens.

The total gross income of the community spouse is established.

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[21] IC 12-15-7-4

The amount, if any, of the excess shelter allowance is computed. This is the amount by which the sum of the community spouse's expenses for shelter and utilities exceeds the shelter standard. Allowable shelter expenses include:

rent or mortgage;

property taxes;

insurance;

maintenance charge on condominium.

Allowable utility expenses include:

basic telephone rate.

gas, electricity, water, oil, sewerage, trash collection.

The community spouse's actual utility expenses are budgeted unless the community spouse chooses the standard utility allowance (SUA) option. If the SUA option is chosen, the appropriate standard utility allowance will be budgeted. verify a utility obligation of a primary heating or cooling expense for the SUA 1. The AG must verify the obligation for the relevant utility types if SUA 2, Single Utility Standard or the telephone standard is allowed. Specific amounts of the obligation are not required. Verification at recertification is not required if there has been no change in residence or obligation for expenses since previously verified. The SUA options are the same used for Food Stamps. See IHCPPM 3020.00.00 for standard amounts.

Four Standard Utility Allowances (SUA) are available:

1. The heating/cooling SUA 1 requires that the AG has a recurring primary heating or cooling expense or that the AG receives an Energy Assistance Payment (EAP) through the Low Income Home Energy Assistance Program (LIHEAP). It is not necessary that the AG have both a heating and a cooling expense. If the AG has only a heating or only a cooling expense obligation and the need for that particular expense has ended solely because the seasonal need for that expense is ended the AG continues to be entitled to the heating/cooling SUA. Also, an AG that has a room air conditioner is entitled to the Heating/Cooling SUA.

a. Persons in private rental housing who are billed by their landlords on the basis of individual usage or who are charged a flat rate separately from their rent are eligible for the heating or cooling standard (SUA 1).

b. Persons in public housing units which have central utility meters and which charge households only for excess heating or cooling costs are entitled to the heating/cooling standard (SUA 1).

2. The non heating/cooling SUA 2 includes electricity and fuel for purposes other than heating or cooling, water, sewerage, well and septic tank installation and maintenance, telephone and garbage or trash collection. In order to qualify for the SUA 2 the AG must be billed for at least two of the expenses included in the SUA 2.

3. A third option, the Single SUA may be used if the AG has a utility expense other than heating/cooling or telephone. For example, AGs that pay for trash removal only would receive the Single SUA.

4. The fourth SUA option is the Telephone Standard. It is allowed for AGs that incur only a telephone expense but do not have a heating or cooling expense.

The spousal income standard and the excess shelter allowance are added, thus arriving at the spousal maintenance standard. The spousal maintenance standard cannot exceed the maximum.

If the community spouse's countable income is equal to or greater than the maintenance standard, there will be no allocation from the income of the applicant/recipient.

If the spouse's countable income is less than the maintenance standard, the difference between the two amounts is the amount of the spousal allocation to be deducted from the income of the applicant/recipient.

If a court has ordered an institutionalized spouse to pay a monthly amount for the support of the community spouse, the monthly spousal allocation cannot be less than the court ordered support.

If a hearing decision results in a revision of the spousal allocation, the additional amount must be budgeted as long as the exceptional circumstances upon which the increase is based continue to exist. Refer to Chapter 4200 regarding appeals.

The spousal allocation from the institutionalized spouse's income will be budgeted only to the extent that it is actually made available to the community spouse. In situations when the community spouse is an applicant/recipient, the amount of the total allocation may impose a spend-down for the community spouse or cause ineligibility for cash assistance and/or Medicaid. When these situations occur, the spouses can arrange for a lower allocation or none at all. The allocation can be modified by the worker on AEIII.

The spousal allocation is displayed on the budget screen AEBPL.

3455.15.10.15 Family Allocation Deduction (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

The following family members may receive an allocation from the institutionalized applicant/recipient if they live with the community spouse and are entered on screen AEIHH. (The allocation is deducted from the institutionalized applicant's/recipient's income regardless of whether or not it is actually given to the family member):

Biological or adoptive children of either spouse who are under 21 and living with the community spouse.

Biological or adoptive children age 21 or over who are claimed as tax dependents by either spouse and living with the community spouse.

Parents of either spouse who are claimed as tax dependents and living with the community spouse.

Biological or adoptive siblings of either spouse who are claimed as tax dependents and living with the community spouse.

The family allocation, for each family member, is calculated as follows:

Subtract from the spousal income standard the countable income of the family member. (Note: an allocation is not permissible if the family member's countable income equals or exceeds the spousal income standard.)

Divide the difference by three. The resulting amount is the family allocation.

Repeat the previous two steps for each appropriate family member to arrive at the total family allocation to be deducted from the income of the institutionalized applicant/recipient.

3455.15.15 Liability Exceeds Facility Private Rate (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

If the liability amount calculated in the post-eligibility determination exceeds the facility's private rate, the AG is subject to the entire payment of the facility’s private rate.

3455.15.15.05 Liability Exceeds Medicaid Rate (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

An applicant/recipient residing in a long term care facility, who has a liability greater than the facility's Medicaid rate but less than the private rate, is not eligible for Medicaid reimbursement of the facility's per diem. The applicant/recipient is eligible for payment of all other Medicaid services, including the facility's ancillary charges.

The facility will collect the individual's liability and apply it toward the private pay rate. The facility can bill the Medicaid program for all covered services except the per diem.

3455.15.20 Medicare Involved In Nursing Facility Payment (MED 1)

The policies in this section apply to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

When Medicare or other insurance covers the nursing home per diem charges for an entire month, or partial month when the non-Medicare covered charges are less than the liability, the post-eligibility budget is still to be used.

3455.20.00 FINANCIAL ELIGIBILITY FOR RBA-RELATED MEDICAID (MED 1)

When an individual has been determined to be eligible for Residential Care Assistance Program (RCAP), the individual is financially eligible for Medicaid. There is no budget for Medicaid eligibility purposes.

When the worker determines that the individual is eligible for RBA, a "Y" should be entered in the 'RBA ELIG' field on AEIIM.

On screen AEIII enter "N" in the response field for the question regarding Medicaid certification of the institution, since an RBA facility is not Medicaid certified. The liability to the RBA facility is not a Medicaid liability and is not computed by ICES or entered into the system. It is computed manually by the worker in accordance with instructions in the Public Assistance Manual for State Assistance Programs, Section 335.

3455.25.00 BUDGETING INCOME-IN-KIND (MED 1, MED 4)

The policies stated in this section apply only to the MA A, MA B, MA D, MA G, MA L, MA J, and MA I categories of assistance.

When someone pays for all of the applicant's/recipient's food, clothing, or shelter, income-in-kind is received. The amount to be budgeted as income is the actual value of the in-kind support and maintenance received not to exceed one-third of the applicable federal benefit rate for SSI. The one-third value is determined by dividing the federal benefit rate for SSI by three. For 2014, the max value is $240.33 for a single individual and $360.66 for a married couple.

3460.00.00 BENEFIT CALCULATION (MED 2)

If a refugee is ineligible for Medicaid under any other category, he can be eligible for Refugee Medical Assistance (RMA) under the spend-down provision if his income exceeds the RCA Standard and his ongoing anticipated medical expenses exceed his surplus income.(f66)

Eligibility for MA Q is based on the MED 2 income standard (see IPPM 3010.25.00). The following rules apply to MA Q:

To determine entitlement for medical assistance first determine the income standard for the AG size and then the amount of countable income.

To calculate the amount of countable income the following rules apply: a parent's income can be used to determine his spouse's, and his child's eligibility; a child's income can be used to determine his own eligibility but not a sibling's or parent's eligibility.

To calculate a parent's countable income:

Determine the amount of the parent's gross income; or

If self-employed, deduct actual business expenses or 40% of the gross income as applicable.

Subtract applicable earned income deductions including:

$90 Work expense disregard; and

Out of pocket dependent care expense in the following manner:

The maximum child care or incapacitated adult care deduction that may be allowed for each dependent participating AG member is based on the age of the dependent and the number of hours of employment per month. The actual cost of care up to the monthly amounts listed below is allowed.[22]

Monthly Employed Hours	**Dependent Under 2 Years of Age**	**Dependent 2 Years of Age or Older**
Over 129 Hours	$200 per member	$175 per member
129 Hours or Less	$199 per member	$174 per member

Allocation to a spouse who is not a member of the AG occurs only when the spouse does not have sufficient income to meet his needs. Allocation up to the full-standard to a child under age 18 who is not a member of the AG always occurs regardless of the child's income. If necessary, allocate to the parent's spouse or child by:

Determining the nonparticipating spouse's gross income;

subtracting the work expense disregard from earned income;

subtracting the total need standard of nonparticipating children in the home under age 18 who are solely the spouse's responsibility;

subtracting the total need standard of the nonparticipating spouse; and

subtract the total need standard of the non-AG child. (A parent allocates to his child regardless of the child's income.)

If the spouse has insufficient income to meet the needs of children who are solely his responsibility, the allocation equals the need standard of the nonparticipating spouse and common children.

The remainder of the parent's income, if any, is counted in the benefit calculation. The parent's countable income is added to the participating child(ren)'s income. If the combined income exceeds the income standard, eligibility is determined by prorating the need standard among all AG members (participating

[22] SSA (a)(8)(A); 45 CFR 233.20(a)(11)(i)

and nonparticipating), allocating a parent's income to his children's unmet needs, and using each member's income and allocated income against his prorated share to determine that person's eligibility. In determining the amount of income a parent can allocate to a child these rules apply:

a) A parent's income is first used to meet their own needs.

b) Any remaining parental income is then used to meet the unmet needs of his spouse in the AG.

c) Any remaining income is then allocated equally between all of the parent's dependents with unmet needs.

1) If this causes a surplus for a child, the surplus is divided equally among the remaining dependents with unmet needs up to the amount of that person's unmet needs.

2) This will continue until all income is allocated or the needs of all individuals in the AG have been met.

If the child's prorated needs are met, the child is not eligible for medical assistance.

3460.05.00 REFUGEE TANF AND CASH ASSISTANCE (MED 2)

Refugee:

All recipients of Refugee Cash Assistance are eligible for medical assistance if they apply for health coverage.

3465.00.00 BENEFIT CALCULATION (MED 3)

The Medicaid financial eligibility determination compares the AG's countable income to the appropriate income standard for the category of Medicaid under consideration.

3465.05.00 MEDICAL ASSISTANCE BUDGETING FOR MAGI CATEGORIES (MED 3)

Financial eligibility for MAGI (MED 3) AG categories, MA Y, MA Z, MA 2, MA 9, MA 10, MA 14, MAGF, MAGP, MAHC, MAHN, MA E, MA O, MA T is based on the sum of the MAGI-based income of every member of the individual’s MAGI household.[23]

This Section does not apply to the following MED 3 AGs: MA X (newborns born to pregnant women that were eligible for Medicaid in the month of birth), MA 4 (foster children), MA 8 (adoption

[23] 42 CFR 435.603

assistance for children under 19), and MA 15 (former foster children 18-25). Income is not taken into account for these AGs.

Please refer to the budgeting methods described in Sections 3405.00.00-3435.00.00 for a description of how income is budgeted into monthly amounts. The following steps describe how to determine Medicaid financial eligibility for an individual who falls within one of MAGI AG categories.

First, the household size and the individuals who are included in a person's AG must be determined according to MAGI tax-filer or non-filer rules. Please refer to Chapter 3200.

Second, all countable income for the individuals included in the AG will be used to determine countable income.

Third, the total all countable income and deductions (refer to IPPM 2810.00.00 and list provided below of income and expenses) from individuals who meet the first two requirements.

Income includes but may not be limited to:

a) Wages and salaries;

b) Rents;

c) Royalties;

d) Gains from dealings in property;

e) Taxable interest;

f) Tax exempt interest;

g) Dividends;

h) State income tax refunds;

i) Alimony received;

j) Business income;

k) Capital gains;

l) Income from life insurance and endowment contracts;

m) Other gains;

n) Taxable IRA distributions;

o) Taxable pensions and annuities;

p) Distributive share of partnership gross income;

q) Estate and trust income;

r) Farm income;

s) Unemployment compensation;

t) Taxable Social Security benefits;

u) Non-taxable Social Security benefits and Tier one Railroad benefits (SSI, however, is excluded);

v) Net operating loss;

w) Gambling earnings;

x) Cancellation of debt;

y) Foreign earned income exclusion; and

z) Foreign earned income.

Deductions include but are not necessarily limited to the following (Please, refer to IPPM 2810.00.00):

a) Educator expenses;

b) Certain business expenses of reservists, performing artists, and fee-basis government officials

c) Health savings account deduction.

d) Moving expenses.

e) Deductible part of self-employment tax.

f) Self-employed SEP, SIMPLE, and qualified plans

g) Self-employed health insurance deduction

h) Penalty on early withdrawal of savings

i) Alimony paid b Recipient’s SSN

j) IRA deduction

k) Student loan interest deduction

l) Tuition and fees.

m) Domestic production activities deduction.

Fourth, add lump sum income received in the month of receipt only

Fifth, add any countable non-exempt educational income. Please, refer to IPPM 3430.00.00 and 3430.05.00.

Sixth, the AG’s countable income is converted to a monthly amount.
Seventh, a 5 percent income disregard will apply for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard. If the applicant/recipient whose eligibility is being determined would otherwise financially fail for a category but would qualify to receive assistance under highest income standard for that person, income will be disregarded for that person equal to 5% of the income standard for that category. If the applicant/recipient is a child under 19, the 5 percent disregard will first be applied to Medicaid but then can be applied to CHIP, if the child is still ineligible for one of the Medicaid categories based on the 5 percent disregard.

Use of household income and MAGI-based methodologies will not be applied when determining ongoing eligibility for Medicaid beneficiaries determined eligible for Medicaid to begin on or before December 31, 2013 until either March 31, 2014 or the next regularly scheduled renewal of eligibility, whichever is later.

3470.00.00 BENEFIT CALCULATION (MED 4)

Financial eligibility for the Qualified Medicare Beneficiary (QMB), Qualified Disabled Worker (QDW), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individual's (QI) programs is determined by comparing the countable income of the AG to the appropriate income standard. Refer to Chapter 3000 for the income standards.

3470.05.00 QMB/QDW/SLMB/QI BUDGETING PROCEDURE (MED 4)

The earned and unearned income of the AG is considered in the eligibility determination of an individual who qualifies for Medicare Part A and who meets other resource and non-financial requirements. The AG consists of the applicant/recipient and his spouse when they are living together, and the applicant's/recipient's dependent biological, adoptive, and step child(ren) in the home whose monthly income is less than the applicable income standard. The applicant's/recipient's essential person whose monthly income is less than the applicable income standard is also considered in the AG.

Income that is disregarded according to instructions in Chapter 2800 is not considered. Also, child support payments made by the spouse of an applicant/recipient in compliance with a court order or Title IV-D are disregarded.

A general income disregard of $20 is allowed for the AG. This disregard is to be applied only once to a couple even when both

members have income. It is applied to both earned and unearned income, but must be deducted first from unearned income.[24]

A general earned income disregard of $65 is next allowed from the total of the couple's net self-employment income and other earned income. One-half of the remainder is also disregarded. Additionally, the earned income disregard is applied to the earned income of any other member of the AG. Special sheltered workshop budgeting does not apply to the institutionalized applicant/recipient.

From the total countable income of the AG, any income of a disabled individual (or the individual's spouse) which has been set aside under an approved plan for achieving self-support (PASS) is also disregarded. Refer to Section 3455.05.05.15.

> NOTE: The Social Security COLA received annually in January is disregarded until April of the same year (three months disregard). Refer to Section 3455.05.05.10.

The total countable income of the AG is compared to the applicable income standard for the AG's family size. If the countable income equals or is less than the appropriate income standard, the applicant/recipient is financially eligible. There is no spend-down provision in the determination of eligibility under these categories.

QMB eligibility begins with the month following the month of the QMB eligibility determination.

QDW eligibility begins with the effective date of the Premium Part A but no earlier than three months prior to application. The effective date for a Medicaid recipient who is already bought in is the first day of the month following Medicaid termination. An applicant/recipient is not eligible for QDW if he is otherwise eligible for Medicaid.[25]

SLMB and QI eligibility can begin no earlier than the first of the third month prior to the month of application.

3475.00.00 1619 MEDICAID BUDGETING (MED 1)

The policies stated in this section apply to the MA A, MA B, and MA D categories of assistance.

Section 1619 of the Social Security Act provides an incentive to the blind or disabled SSI recipient to continue work when his

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[24] SSA 1905(p)(1)
[25] SSA 1905(s)(4)

earned income reaches levels that would otherwise jeopardize eligibility. Individuals in 1619(a) status receive reduced SSI benefits, while individuals in 1619(b) status receive no SSI benefits. Blind or disabled SSI recipients who are in 1619(a) or 1619(b) status for SSI purposes can be eligible for continued Medicaid coverage without regard to any Medicaid eligibility requirements, except residency. Special 1619 Medicaid coverage is granted if the recipient was on Medicaid in the month immediately preceding the month in which the individual's 1619 status last began.[26] There is no requirement to meet a spend-down in the month prior to entering 1619 status. Special 1619 Medicaid coverage continues as long as the recipient's 1619 SSI status is in effect. If the residency requirement is met, all other Medicaid eligibility requirements, including income and resources, are suspended while the individual remains in 1619. However, the special exclusion of income applies only in the eligibility step, not to the post-eligibility budget of recipients in Medicaid facilities.

SSI payments made to recipients who are in 1619 status and who enter public institutions and Medicaid certified facilities (hospital, ICF, SNF, ICF/MR, or CRF) are not reduced to the $30 cap for the first two full months of institutionalization. These SSI payments are disregarded as income in the Medicaid eligibility determination and are disregarded as income in the post-eligibility budget of the individual only in the first two full months of institutionalization.[27]

If a progress report is due for a disabled person who has 1619 status, the Medicaid Medical Review Team (MMRT) should be notified of the recipient's 1619 status. If 1619 status is subsequently lost, a progress report must be submitted immediately to the MMRT. If a re-examination of eyesight is required for a blind recipient in 1619 status, notification to the MMRT is unnecessary. However, an eye report is required immediately upon termination of 1619 status.

A recipient's 1619 status is verified through data exchange. ICES automatically updates an individual's SSI status on the AEIDC screen and notifies the worker of the update through an alert.

3480.00.00 BUY-IN PROCEDURES AND EFFECTIVE DATES (MED)

Buy-In is the process by which the state pays the Medicare premium for Medicaid recipients.

For money grant recipients, the Medicare Part B Buy-In effective date is determined as follows:

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[26] SSA 1619(b)(3)
[27] SSA 1611(e)(1)(E)

Recipients are considered to be money grant recipients if they receive all or any part of their monthly income from any of the following sources:

SSI (Supplemental Security Income);
TANF (Temporary Assistance For Needy Families); or
RBA (Room and Board Assistance)

The Part B Buy-In effective date for money grant recipients, regardless of QMB status, is the latest of the following dates:

Medicaid effective date;
Medicare effective date; or
Money-grant effective date.

For non-money grant recipients, Medicare Part B Buy-In effective date is determined as follows:

for new Medicaid AGs, the Part B Buy-In effective date for non-money grant, non-QMB recipients is the second month following the month in which the worker authorized the recipient's Medicaid eligibility.

EXAMPLE:

On 10/5 Ann Smith is determined eligible for Medicaid retroactive to 6/1. She began receiving Medicare on 5/1. Part B Buy-In effective date is 12/1, the first day of the second month following the month in which her Medicaid eligibility was authorized.

For new, non-money grant, QMB recipients, the Part B Buy-In effective date is the QMB effective date established by ICES.

For a continuing Medicaid AG, the Part B Buy-In effective date is the first of the month in which the Medicaid recipient's Medicare eligibility begins, regardless of the money grant or QMB status.

For SLMB and QI recipients, the effective date of Medicare Part B Buy-In is the date of eligibility for SLMB or QI. It will be no earlier than the first of the third month prior to the month of application.

Individuals, who apply for Medicaid and are not receiving Medicare although they are entitled to it, must be advised to contact SSA and apply. When the Medicare application is approved and the worker has documented it, Buy-In can take place.

If an individual has applied for Medicare at the SSA but is not receiving Part B, Buy-In will be accomplished by ICES in the usual manner.

The Medicare Part A Buy-In effective date is determined by ICES. The QMB or QDW effective date established by ICES also determines the Part A Buy-In effective date.

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3505.00.00 OVERVIEW OF THE HEALTHY INDIANA PLAN (HIP)

The Healthy Indiana Plan (HIP) is a demonstration waiver approved under Section 1115(a) of the Social Security Act effective January 1, 2008, and it was authorized to continue through January 31, 2014.

HIP 2.0 is a demonstration waiver approved under Section 1115(a) of the Social Security Act effective February 1, 2015, and is authorized to run for 3 years and is subject to renewal. The authority for this program is derived from the Special Terms and Conditions approved by the Centers for Medicare and Medicaid Services (CMS), along with regulations at 405 Indiana Administrative Code 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 recommended preventive care.

The following sections of this chapter explain the eligibility requirements and methodologies used by the Division of Family Resources to determine HIP 2.0

eligibility and the policies regarding POWER account contributions. Additional information about HIP 2.0 and how to apply can be found on the website www.in.gov/fssa/HIP/.

3515.00.00 GENERAL ELIGIBILITY REQUIREMENTS: AGE AND HEALTH INSURANCE

To qualify for HIP, an individual must[1]

(1) Be at least age 19 but not yet age 65

(2) Not be enrolled in or eligible for enrollment in the federal Medicare program.

(3) Not be eligible and not enrolled in another Medicaid assistance category, except for HIP members who become Pregnant.

(4) Have countable household income equal to or less than 133% of the federal poverty level (FPL).

An applicant who may be eligible both for HIP and another Medicaid category will first have his/her eligibility assessed for the other category of Medicaid. An individual may be enrolled in HIP only if she is ineligible for the other aid category. However, a person claiming to be disabled may be approved for HIP pending a determination for Medicaid disability. If later found eligible for another Medicaid category, HIP must be discontinued to allow for the person's eligibility to be transferred to the other category the following month.

3515.05.00 Medically Frail

Medically frail means an individual who is determined to have any one of the following:

1) A disabling mental disorder
2) A chronic substance abuse disorder
3) A serious and complex medical condition
4) A physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living.[2]
5) A disability determination from SSA but is not eligible for MA A, MA B or MA D due to income or resources

HIP health plans will confirm the member's frailty within 60 days of the member's authorization to receive HIP benefits. Effective January 1, 2016, HIP health plans will confirm the member's frailty within 30 days of the member's

[1] 405 IAC 10-4-1.
[2] 405 IAC 10-2-1

authorization to receive HIP benefits.

3515.05.00 Other Medicaid and Medicare Coverage

An eligible Medicaid recipient enrolled in another category cannot choose to voluntarily withdraw from another Medicaid category for the purpose of enrolling in HIP. However, a HIP recipient that becomes eligible for another Medicaid category (excluding pregnancy, refer to 3515.05.10) must have HIP discontinued so that the recipient is eligible in the other Medicaid category. Additionally, DFR must evaluate whether the person is entitled to any retroactive coverage under the other Medicaid category, since HIP benefit begin dates are determined upon financial contribution to a POWER account.

Medicare beneficiaries are categorically ineligible for HIP. If a HIP member becomes eligible for Medicare, including eligibility for retroactive Medicare benefits that overlap HIP eligibility, HIP eligibility shall cease to allow for advanced notice of adverse action (see section IHCPPM 2232.00.00). However, the health plan is prevented from recovering any payment for services, where there was overlapping Medicare and HIP coverage, when the member's overlapping Medicare coverage is limited to Part A only.

3515.10.00 Minimum Essential Coverage of Dependents

This section is not applicable to low-income parent/caretakers, TMA, and low-income 19/20 year-olds.

HIP applicants/recipients, who are either a parent or other caretaker relative of a dependent under 19 are required to have their dependents covered under Medicaid, CHIP, or other minimum essential coverage. This is considered verified through attestation by the applicant/recipient parent/caretaker. Such dependents that have applied for or are receiving Medicaid or CHIP meet this requirement.

3515.15.00 OTHER GENERAL HIP ELIGIBILITY REQUIREMENTS

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

Requirement to provide a Social Security Number;

State residency;

Assignment of medical rights and medical support cooperation (does not apply to pregnant women and HIP TMA eligible recipients);

Citizenship status, including the documentation requirements;

Emergency-services-only health coverage is available for eligible immigrants who categorically qualify for HIP. Refer to section 3515.00.00. Immigrants who categorically qualify for HIP with limited emergency-services-only will be placed under the MARB category, and the effective date of coverage will be the month benefits are authorized by DFR. Immigrants eligible under MARB with limited emergency-only coverage will not be placed into managed care with a HIP health plan. Immigrants who categorically qualify for HIP with limited emergency-services-only are not required to make any financial contribution to a POWER account. The month of authorization is viewed as the month the payment would have been made had the person been subject to POWER account contributions. DFR must not delay authorization of benefits when an immigrant has met and verified all financial and non-financial requirements to be determined eligible for MARB with limited emergency-services-only. There is no retroactive coverage for any individual receiving emergency services under HIP.

3520.00.00 CATEGORICAL ELIGIBILITY FOR HIP

The following subsections explain the categorical requirements for each HIP category.

3520.05.00 American Indian/Alaska Native

This category is identified in ICES as MANA.

An American Indian or Alaska Native eligible for MARP or MASP will also have the option to Opt-out to MANA. Coverage under MARP or MASP is a managed-care health plan, but MANA provides fee-for-service coverage that is equivalent to Package A, but specific to the HIP program. Once an eligible American Indian/Alaskan Native is authorized under HIP Plus or HIP State Plan Plus they will have the option to Opt-out into MANA. An American Indian/Alaskan Native who meets the eligibility requirements for HIP eligibility shall not be subject to any cost-sharing requirements under any HIP category.[2] In order to be eligible for no cost-sharing the individual must be a ‘‘verified’’ American Indian/Alaska Native. Please refer to section 2403.00.10 for a list of acceptable documents.

3520.10.00 HIP Plus-State Plan (MED 3)

This category is identified in ICES as MASP.

To be eligible for MASP an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age and have income less than 133% of the FPL,

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[2] **405 IAC 10-4-7**

unless the person qualifies for TMA. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program. Participants included are:

1. Low-income parents and caretaker relatives
2. TMA eligible individuals
3. Low-income 19/20 year olds
4. Individuals who qualify as medically frail

HIP Plus State Plan requires the member to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department. MASP members who become pregnant or are American Indian/Alaska Natives are not required to make financial contribution to a POWER Account. The HIP PLUS State Plan has no provision for retroactive coverage. The effective date of HIP PLUS State Plan coverage begins the first day of the month in which the individual makes an initial POWER account contribution.[3]

3520.15.00 HIP Basic-State Plan (MED 3)

This category is identified in ICES as MASB.

To be eligible in this category an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age with income at or below 100% FPL, unless the person qualifies for TMA. The individual will be enrolled in HIP Basic State Plan if they fail to make financial contributions towards a POWER account and meet one of the following groups:

1. Low-income parents and caretaker relatives
2. TMA eligible individuals
3. Low income 19/20 year olds
4. individuals that qualify as medically frail

An individual may not be enrolled in or eligible for enrollment in the federal Medicare program. The HIP Basic State Plan has no provision for retroactive coverage. The effective date of HIP Basic State Plan coverage begins in the month in which the 60 days to make a power account contribution has expired.[4] MASB members who become pregnant will no longer be required to make co-pays for services throughout their pregnancy as well as the 60-day post-partum period.

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[3] 405 IAC 10-3-2
[4] 405 IAC 10-3-2

3520.20.00 HIP PLUS-State Plan with Co-pays (MED 3)

This category is identified in ICES as MAPC.

To be eligible in this category an adult must have been eligible under MASP, while being determined medically frail, having income between 100% FPL and 133%FLP, and fail to make ongoing financial contributions to a POWER account. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program. There will be no lockout periods for MAPC AGs. The effective date of MAPC coverage begins in the month in which the 60 days to make a power account contribution has expired. MAPC members who become pregnant will no longer be required to make co-pays or contributions for services throughout their pregnancy as well as the 60-day post-partum period.

3520.25.00 HIP Regular Plus (MED 3)

This category is identified in ICES as MARP.

To be eligible in this category an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible for any other Medicaid category.[5] The income standard is 133% FPL. HIP Regular Plus requires the participant to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department. MARP members who become pregnant are not required to make a financial contribution to a POWER Account throughout their pregnancy as well as the 60-day post-partum period. The HIP PLUS State Plan has no provision for retroactive coverage. The effective date of HIP PLUS coverage begins the first day of the month in which the individual makes an initial POWER account contribution.[6]

3520.30.00 HIP Regular Basic (MED 3)

This category is identified in ICES as MARB.

To be eligible in this category an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age with incomes at or below 100% FPL will be enrolled in HIP Basic after failing to make financial contributions to a POWER account within 60 days of authorization. An individual may not be enrolled in or

[5] 405 IAC 10-4-1

[6] 405 IAC 10-3-2

eligible for enrollment in the federal Medicare program or be eligible under any other Medicaid category.[7] The HIP Basic benefit package applies co-payments to services. The ''HIP Basic'' plan maintains essential benefits, but incorporates reduced benefit coverage and a more limited pharmacy benefit. The HIP Basic plan has no provision for retroactive coverage. The effective date of HIP Basic coverage begins when the client does not make a POWER account contribution within the sixty (60) day payment period.[8] MARB members who become pregnant are no longer required to make co-payments for services throughout the rest of their pregnancy as well as during the 60-day post-partum period.

3525.00.00 HIP EFFECTIVE DATE FOR ELIGIBILITY

For individuals meeting all financial and non-financial requirements to be considered HIP eligible, the effective date of eligibility is determined upon whether the person makes a timely financial contribution to his POWER account.

For HIP Regular Plus or HIP State Plus, coverage begins the first day of the month in which the individual makes an initial POWER account contribution. There is no retroactive coverage under HIP PLUS categories (MARP and MASP).[9]

The effective date of HIP Regular Basic or HIP State Basic coverage begins in the month the member, whose income is at or below 100% FPL, fails to make a required contribution to his POWER account within his sixty (60) day payment period. There is no retroactive coverage under HIP Basic categories (MARB and MASB).[10]

3525.05.00 Fast Track Eligibility (FTE)

Upon receipt of an application for health coverage but prior to a HIP eligibility determination, a HIP health plan will send the pending HIP applicant a $10 fast track prepayment invoice that is due within sixty (60) calendar days.[11] This initial fast track invoice begins the individual's 60-day deadline to make a required contribution to a POWER account.

If the applicant makes the $10 fast track payment and is subsequently determined eligible for HIP, the member will have HIP Plus coverage beginning the month the fast track payment was made, and the $10 will be applied toward any remaining amount owed by the member toward their POWER

[7] 405 IAC 10-4-1
[8] 405 IAC 10-3-2
[9] 405 IAC 10-3-2
[10] 405 IAC 10-3-2
[11] 405 IAC 10-3-3

account.

If the applicant who makes the $10 fast track payment is subsequently determined ineligible for HIP, the member is entitled to a refund from the managed care health plan that received the $10 payment. Please, note it may take up to 60 days for the health plan to issue any refund.

If the applicant does not make a $10 fast track payment and is subsequently determined conditionally eligible for HIP, the member will have the option of either paying the $10 fast track prepayment or paying the amount set forth in the conditional eligibility notice.[12]

3525.05.05 Fast Track Eligibility (FTE) with Credit Card

When an application for health coverage is completed on-line, applicants who meet the following conditions will have the option to make the $10 fast track payment on-line with a credit card:

a) A health plan was chosen on the application
b) The applicant is at least 19 years old and is less than 65
c) The applicant is not eligible for Medicare
d) The applicant is not identified as former foster youth
e) The applicant is not incarcerated
f) The applicant does not have a HIP lock-out penalty period in force (refer to 3550.15.00)

If an applicant makes a $10 fast track on-line payment with a credit card and is subsequently determined eligible for HIP, coverage begins the month the payment was made, which would be the month of application, and the $10 will be applied toward any remaining amount owed by the member toward their POWER account. A maximum of 5 individuals on a single application can be eligible for FTE. The Pre-POWER Account Contribution (PPAC) payment of $10 is required for each individual who is eligible for FTE.

If an applicant who makes a $10 fast track on-line payment with a credit card is subsequently determined ineligible for HIP, the member is entitled to a refund from the HIP health plan that received the $10 payment. Please, note it may take up to 60 days for the health plan to issue any refund.

3525.05.10 Fast Track Eligibility and Presumptive Eligibility

[12] 405 IAC 10-3-3(e)

If an individual is determined presumptively HIP eligible by a qualified provider, a managed care health plan can send an invoice for a $10 fast track payment to a presumptively eligible member.

A member who is presumptively eligible must submit an application for health coverage to DFR prior to the last day in the month following the PE determination or that person loses their presumptive eligibility. A presumptively eligible member that does submit an application for health coverage within 30 days of being determined presumptively eligible by a qualified provider, will keep his presumptive eligibility coverage until a determination of eligibility is made on his application.

A presumptively eligibility member who makes a $10 fast track payment and is subsequently determined eligible for HIP will have managed care coverage beginning in the following month.

A presumptive eligibility member who fails to make a $10 fast track payment and is subsequently determined conditionally eligible for HIP will have his presumptive eligibility end.

A presumptive eligibility member who makes a $10 fast track payment and is subsequently determined ineligible for HIP will be entitled to a refund that may take up to 60 days for the health plan to issue.

A person cannot receive multiple periods of presumptive eligibility in single twelve (12) month cycle.

3530.00.00 FINANCIAL ELIGIBILITY REQUIREMENTS

The income standards for the HIP program are in Section 3010.30.10.

3530.05.00 INCOME ELIGIBILITY REQUIREMENTS

To be eligible for the HIP program, an individual’s countable household income may not exceed 133 percent of the Federal Poverty Level for the appropriate household size, effective February 1, 2015. Household size and income is determined using Modified Adjusted Gross Income (MAGI) methodology. Refer to Chapter 2800 and Chapter 3200 of the IHCPPM for policy surrounding income and assistance group formation.

3530.05.05 Eligibility Requirements for HIP Low-Income Parent-Caretakers

This section applies to MASP and MASB.

To be considered HIP eligible as a low-income parent/caretaker, the HIP adult must be the parent or caretaker relative (refer to sections 2420.05.05 and 2420.10.05) of a dependent less than 18 years of age and have household income that is equal to or less than the standard set in IHCPPM 3010.30.10.05.

HIP low-income parent/caretakers may be eligible to receive coverage for medical services that were received in the ninety (90) calendar days prior to enrollment in HIP. This will be limited to new applicants, defined as those not covered through HIP or Medicaid within the past two years who:

i. Did not gain coverage through presumptive eligibility;

ii. Received medical care within the 90 days prior to the effective date of eligibility; and

iii. Submitted for reimbursement within 90 days of the individual’s receipt of the bill for such care.

3530.05.10 Eligibility Requirements for HIP TMA

This section applies to MASP and MASB.

To be considered HIP eligible for transitional medical assistance (TMA), the HIP adult must have been financially eligible as a low-income parent/caretaker (refer to Section 3530.05.05) in three of the six months immediately preceding ineligibility as a low-income parent/caretaker due to new or increased earnings. This is also applicable to the adult HIP eligible spouse of someone who qualifies for TMA.

HIP TMA coverage can last up to 12 months. For TMA eligibility periods and reporting requirements, refer to Chapter 3800.

Section 3530.05.15 is applicable to TMA recipients also. If the new earnings do not place a TMA member above 100% FPL, the member will remain eligible under HIP State Basic (but will receive a new sequence number for their AG in ICES).

3530.05.15 Eligibility Requirement for Potential Plus

For members eligible under either MASB or MARB who experience a verified change in which the new household income is above 100% FPL, they will be required to switch to either MASP or MARP and will have 60 days to make a required financial contribution to a POWER account.

Members who are required to be switched to MARP and fail to

make a timely payment will be discontinued and may be subject to a 6-month penalty period.[13] Refer to Section 3550.15.00.

3530.05.20 Eligibility Requirements for HIP Low-Income 19/20 year old

This section applies to MASP and MASB.

To be eligible a child must be either age 19 or 20, live in the home of a parent or caretaker relative, not have Medicare or receive HCBS services, and meet the MAGF income requirements. A parent includes biological, adopted, and step-parents. For the definition of a caretaker relative, please, refer to IHCPPM 2420.00.00

3530.10.00 RESOURCE ELIGIBILITY REQUIREMENTS

There is no resource limit for HIP eligibility.

3540.00.00 POWER ACCOUNT CONTRIBUTION ELIGIBILITY REQUIREMENTS

Most members must make monthly contributions to their POWER account to move from conditional to full eligibility status after initial determination. Members must continue to make these contributions in a timely manner to maintain program enrollment. The following sections discuss the specifics of POWER account contribution requirements.

3540.05.00 POWER ACCOUNT CONTRIBUTION AMOUNT DETERMINATION

All HIP members are initially required to help fund the $2,500 deductible by contributing to the POWER account, established by the member’s health plan and jointly funded by the member and the State, unless the person is an American Indian/Alaska Native.[14] The amount of the required member contribution is determined based on the person’s countable household income using MAGI methodology. The difference between the amount of the deductible and the member’s annual contribution is paid by the State. If an individual (at or below 100% FPL) does not make the fast track prepayment nor the initial POWER account contribution for HIP Plus, the client will begin HIP Basic or HIP State Plan Basic benefits, as applicable, on the first day of the month in which the sixty (60) day payment period expires.[15]

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[13] 405 IAC 10-4-9(f)

[14] 405 IAC 10-10-3

[15] 405 IAC 10-3-3

A member’s monthly POWER account contribution shall be determined by multiplying a member's annual household income by two percent (2%) and dividing by twelve (12). In no event shall the member's monthly POWER account payment exceed one hundred dollars ($100) per month or be less than one dollar ($1) per month.[16]

An employer or health care provider or provider-related entity may contribute up to one hundred percent (100%) of a member's annual POWER account obligation.[17] A health care provider or provider-related entity may make a contribution to a member’s POWER account provided:

1) The provider or provider-related entity establishes criteria for providing assistance that do not distinguish between individuals based on whether they receive or will receive services from the contributing provider or providers or class of providers; and

2) The provider or provider-related entity does not include the cost of such payments in either the cost of care for purposes of Medicare or Medicaid cost reporting or as part of a Medicaid shortfall or uncompensated care for any purpose.[18]

Except for the $1 minimum contribution to a POWER account, a member's out-of-pocket cost sharing amount shall not exceed five percent (5%) of the member's annual household income.[19] The 5% maximum contribution value will be calculated by ICES on a quarterly frequency. In the case where two members are married, the combined total of both spouses’ required POWER account contributions cannot exceed two percent (2%) of the monthly household income, subject to the one dollar ($1) minimum contribution amount[20]

A member’s POWER account under either MASP or MARP may change in accordance with change processing policy when changes are verified.

3540.10.00 CHANGE PROCESSING

HIP members are required to timely notify DFR of any changes. (Refer to sections 2220.05.00 and 2220.10.00). Members receive notice of this requirement through the Rights and Responsibilities portion of their application for health coverage.

PLEASE NOTE: During the benefit period, HIP members who do not provide verifications that the State is unable to verify

[16] 405 IAC 10-10-3
[17] 405 IAC 10-10-10
[18] 405 IAC 10-10-4
[19] 405 IAC 10-10-3
[20] 405 IAC 10-10-3

through other means will not be discontinued for failing to provide such information. However, other family members may be discontinued from health coverage if such information is necessary to determine their eligibility in a non-HIP category. HIP closures for the following reasons will be permitted: death, pregnancy opt for MAGP, not an Indiana resident, VW, Medicare, age, non-payment, income over the 138% FPL standard, and citizenship after the 95 day eligibility period. All PAC changes will be acted on if verified information is provided.

An individual who is enrolled into HIP as an eligible member and then becomes pregnant remains HIP eligible, but with additional pregnancy coverage. HIP pregnancy benefits do not require any cost-sharing for services under any HIP category. Refer to Section 2426.00.00. The HIP member may choose to have her eligibility switched prospectively to the pregnancy category, MAGP. Refer to Section 2220.05.00. For pregnant HIP members during redetermination, refer to 3545.10.00.

3540.15.00 POWER ACCOUNT CONTRIBUTIONS IN MULTIPLE-MEMBER HOUSEHOLDS

For households in which two members are enrolled in HIP, each enrollee will have his/her own POWER account. However, for a married couple, the total of both enrollees' POWER account contributions may not exceed two percent (2%) of the family's household income as specified in Section 3550.05.00 of this Chapter. This does not apply to unmarried couples.

3540.20.00 POWER ACCOUNT CONTRIBUTIONS AND INITIAL ELIGIBILITY

After an individual meets all eligibility requirements for the HIP program, he or she is ''conditionally eligible'' until the first POWER account contribution is made to the health plan, unless an FTE payment had already been made (refer to 3525.05.05). If the individual fails to make this initial payment, he or she is no longer conditionally eligible for HIP PLUS. If the individual income is at or below 100% FPL he/she will be enrolled in HIP Basic after failing to make the first POWER account contribution.

The effective date of HIP coverage is the first day of the month in which the health plan receives the first contribution and establishes the member's POWER account.[21]

3540.25.00 POWER ACCOUNT CONTRIBUTIONS AND CONTINUED ELIGIBILITY

Members must continue to make POWER account contributions in

[21] 405 IAC 9-10-6(b)

a timely manner to remain enrolled in HIP Plus. If an enrollee fails to make a required contribution within 60 days after the due date, he or she will be terminated from HIP Plus. If the individual income is at or below 100% FPL he/she will be enrolled in HIP Basic.

If an individual is dis-enrolled for failing to make a required contribution, he or she will be ineligible for six (6) months.

3545.00.00 HIP REDETERMINATIONS

Sections 2205.00.00, 2205.05.00, 2205.10.00, and 2205.15.00 are applicable to HIP members.

HIP Plus members (MASP or MARP) are required to continue making contributions to their POWER account during their redetermination, and if redetermined eligible for HIP will be re-enrolled as HIP Plus members (MASP or MARP).

HIP TMA recipients are exempt from being required to complete an annual redetermination. Refer to Section 3530.05.10.

3545.05.00 BASIC POTENTIAL PLUS AT REDETERMINATION

Members that are eligible under either MASB or MARB during their annual redetermination and are re-enrolled into HIP with household income less than 100% FPL will have the potential to switch to either MASP or MARP if they make a financial contribution to a POWER account.[22]

3545.10.00 PREGNANT HIP MEMBERS AT REDETERMINATION

When it is time for a pregnant HIP member to go through an annual redetermination of eligibility, the pregnant member will automatically be switched to MAGP. Due to her pregnancy, the member is not required to complete the annual redetermination. The switch from HIP to MAGP is to occur automatically upon the woman’s redetermination date.

3550.00.00LOSS OF ELIGIBILITY

When an eligible HIP recipient loses eligibility for HIP, the member may or may not be subject to a 6-month penalty period depending on the reason for termination. If a member has eligibility terminated for 1) failing to make a required contribution if over 100% FPL or 2) failing to complete a redetermination, the member will be subject to a 6-month penalty period, in which the individual cannot be considered eligible for HIP. Members whose benefits are terminated for

[22] 405 IAC 10-4-9(e)(2); 405 IAC 10-4-9(e)(4)

other reasons will not be subject to any 6-month penalty.

3550.05.00 LOSS OF ELIGIBILITY

In addition to the failure to make required POWER account contributions in a timely manner, there are several other reasons a member may lose HIP eligibility within the 12 month coverage period:

(1) The individual is no longer an Indiana resident;

(2) The member is enrolled or is otherwise eligible for enrollment in the federal Medicare program.

(3) The individual becomes eligible for another Medicaid category, except for pregnant women (refer to section 2220.05.00);

(4) The member has household income above one hundred percent (100%) of the FPL and is discontinued for failing to make the required POWER account contributions.

(5) The member or the member's duly authorized representative requests in writing that coverage be terminated (voluntary withdrawal).

(6) The State discovers that the individual has falsified information on the application. In this case, the individual may be held financially responsible for the amount of payments made on his behalf by the State, including POWER account contributions.

(7) The member turns 65 years old.

(8) Except for a member eligible for transitional medical assistance, the member's household income exceeds one hundred thirty-three percent (133%) of the FPL.

(9) The member fails to verify citizenship or immigration status within 95 days of being determined eligible for HIP or conditionally eligible for HIP. (Refer to Sections 2402.15.10 and 2402.20.50).

(10) The member dies.

(11) The member does not complete a redetermination timely. Refer to Section 3550.10.00.

3550.10.00 LOSS OF ELIGIBILITY AT REDETERMINATION

In order to continue HIP participation, members must complete a renewal process every 12 months. If the agency is unable to redetermine the eligibility of the individual with already available information the member is sent an Eligibility Review Form. If the member does not follow the renewal process and return all documentation requested by the agency within 45 days (before the end of the individual’s 12 month coverage period), he will be dis-enrolled.

3550.15.00 SIX MONTH PENALTY PERIOD

When a member is discontinued from HIP eligibility for failing to make a required financial contribution toward a POWER account (refer to section 3550.05.00) or the member/the member's duly authorized representative requests in writing that coverage be terminated (voluntary withdrawal), the member is subject to a 6-month penalty period, in which the member is ineligible for HIP. The penalty period will begin the first day of the month following the month the individual was discontinued and will last for 6 months.

3550.15.05 Exceptions to the Six-Month Penalty Period

When a member is subject to a penalty period (refer to Section 3550.15.00), the person may have that penalty period lifted under the following circumstances.

If the reason for discontinuance was due to failing to make required financial contributions toward a POWER account, the following exceptions are applicable[23]:

a) the member is confirmed to be frail;

b) the member obtained and subsequently lost private insurance coverage;

c) the member had a loss of income after disqualification due to increased income; (nonpayment or voluntary withdrawal was due to loss of income)

d) the member took up residence in another state and later returned to Indiana;

e) the member was a victim of domestic violence; or

[23] 405 IAC 10-10-13

3560.00.00 RESERVED

3570.00.00 HIP ID CARDS

A HIP card will be issued from the assigned managed care health plan within five (5) calendar days of a new member's full enrollment.

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3600.00.00 BENEFIT ISSUANCE

This chapter presents policy regarding benefit issuance. The chapter covers:

MA Identification Cards (Section 3615).

3605.00.00 REPRESENTATIVES AND PROTECTIVE PAYEES

An AG may designate an authorized representative to present medical expense verification for Medicaid spend-down eligibility purposes for purposes of submitting non-claims. (Refer to IHCPPM 3618.05.00 and 3618.10.00.

The Medicaid spend-down will no longer be in effect on 6/1/2014. The non-claim process will still be applicable, however, for recipients eligible under a HCBS Waiver (see IHCPPM Chapter 3300) who have a HCBS Waiver Liability.

3605.05.05 Withdrawal of Authorization

The authorized representative authorization is valid only for the current entitlement period. The payee or another responsible AG member may withdraw the authorization at any time. Withdrawal of authorization will be made upon request in writing for Medicaid. Written requests will be placed in the case record.

3605.05.15.05 Evidence of Misrepresentation

When evidence is obtained that an authorized representative has misrepresented an individual’s circumstances and has knowingly provided false information the representative may be disqualified from participating as an authorized representative. This disqualification may be for a period of up to one year.

A written notice must be sent to the affected AG and the authorized representative 30 days prior to the date of disqualification. This notification will include:

The proposed action;
The reason for the action;

The AG's right to request a fair hearing; and
The telephone number of the Local Office (1-800-403-0864).

Disqualification of representatives does not apply in the case of drug/alcohol treatment centers and those group facilities which act as authorized representatives for their residents. In these instances, the facility is liable for any overissuance which may occur.

3605.20.00 AUTHORIZED REPRESENTATIVE FOR SPEND-DOWN ELIGIBILITY

If the recipient has authorized in writing a representative to apply for MA on his behalf, that representative may also provide verification of incurred medical expenses without a separate authorization. Additionally, the recipient may authorize a different individual to provide medical expense documentation for purposes of submitting non-claims. (Refer to IHCPPM 3618.05.00 and 3618.10.00. The signed authorization may be time limited or indefinite.

The Medicaid spend-down will no longer be in effect on 6/1/2014. The non-claim process will still be applicable, however, for recipients eligible under a HCBS Waiver (see IHCPPM Chapter 3300) who have a HCBS Waiver Liability.

3615.00.00 MA IDENTIFICATION CARDS

Section 3615.10.00 discusses identification cards.

3615.10.00 MEDICAID IDENTIFICATION CARDS (MED)

The Medicaid Identification Card also known as the Hoosier Health Card is the authorization by which the individual secures Medicaid benefits. The card is a permanent plastic ID card expected to be retained by the recipient during his/her lifetime. It contains the Recipient ID (RID) number, name, date of birth, and sex. The ID card does not denote a specific eligibility period. The recipient must present the ID card to each Medicaid provider from whom he requests medical services, and the provider is responsible for verifying eligibility through the automated verification process. DFR is not responsible for verifying recipient eligibility periods for providers. Providers are responsible for either seeing the ID card or obtaining the RID from the recipient and verifying eligibility in order to file their claims for services. If there is a delay or

problem in the generation of the ID card, DFR should provide the RID to the recipient or to providers who inquire.

3615.10.05 Issuance Of Medicaid Cards (MED)

From the date a new recipient is first approved and authorized, it will take approximately two weeks for the recipient to receive the card. Generally, within four days of authorization, IQMA will reflect the generation of the card. It then takes an additional three days to produce the card and at least another three days for mailing. If, after four days from the date of authorization, IQMA does not show the card generation, the Policy Answer Line should be contacted.

Individuals who are eligible for Medicaid under the spend-down provision will receive an ID card the same as non-spend-down recipients. However, their eligibility is determined on a month by month basis in accordance with Section 3615.15.05.

3615.10.05.05 Issuance of Medicaid Cards to Homeless Individuals (MED)

For a recipient who has no fixed address, specific arrangements must be made with him regarding the issuance of his Medicaid card.

The card will be mailed to the address specified by the recipient, such as:

The local DFR office;
A friend or relative;
Social service agency;
Church; or
Shelter for the homeless.

3615.10.10 Replacement of ID Cards (MED)

A Medicaid ID Card which has been lost, stolen, or damaged can be replaced by accessing screen BIMD. However, a replacement cannot be requested if IQMA does not show that an original card has been generated. Before requesting a replacement, it is necessary to wait a full seven days from the date on IQMA indicating card generation. This allows the appropriate length of time to produce and mail the card. If, within the full seven days, the client still has

not received the card, the worker must check the recipient's address on AEICI or AEIII as appropriate, and make sure it is entered correctly before requesting a replacement.

3618.00.00 THE PROCESS OF SATISFYING SPEND-DOWN (MED 1, MED 2)

Effective June 1, 2014, this section is no longer applicable for MED 1.

This section applies to MA A, MA B, MA D and MA Q.

The spend-down process works basically like an insurance deductible. Recipients have access to Medicaid covered services at the first of every month in which they are enrolled. Medicaid will reimburse claims once the spend-down amount is satisfied.

Providers will submit recipient claims to IndianaAIM just as they do for all fee-for-service members. The spend-down amount will be applied to claims for Medicaid covered services and will be deducted from the amount, if any, that Medicaid reimburses on the claim. For example, a recipient with a $50 spend-down goes to his pharmacy to get his prescription refilled. The cost of the prescription is $75 and the Medicaid co-payment is $3. The member is responsible for $50, which includes the Medicaid co-payment, and Medicaid covers the remainder in accordance with Medicaid reimbursement rules. Later in the month, his doctor gives him a new prescription which he takes to the pharmacy. Because his spend-down is already satisfied, Medicaid reimburses the pharmacy. The recipient owes the $3.00 co-pay and it will be automatically carried forward to the next month to satisfy spend-down. Certain allowable medical expenses cannot be filed as claims directly to IndianaAIM. These expenses are referred to as non-claims and must be submitted to the Local Division of Family Resources Office. Refer to Section 3618.05.00 which explains how non-claims are to be considered. These expenses are transmitted electronically to AIM to satisfy spend-down.

Providers must first bill any third party insurance of the recipient before billing Medicaid. A medical expense that is subject to payment by a third party will not be considered for satisfying spend-down until the third party adjudicates the claim. The amount that can credit spend-

down is the amount owed by the recipient after the third party payment. For recipients who also have QMB (MA L) coverage, their Medicare coinsurance and deductibles will not credit spend-down, since QMB Medicaid pays those costs.

The Medicaid spend-down for MA A, MA B, and MA D will no longer be in effect as of June 1, 2014.

3618.05.00 NON-CLAIMS SUBMITTED TO DFR (MED 1, MED 2)

This section applies to MA A, MA B, MA D, and MA Q.

Certain medical expenses apply to spend-down and must be submitted to the DFR because they cannot be filed directly by providers to the AIM system. These expenses are called non-claims and are as follows:

1. Medical services paid for by a state or local program such as CHOICE or Township Trustee assistance. For these expenses, documentation from the provider of the service must be submitted and it must contain a statement from the provider that he or she will bill the state or local program, not Medicaid. A state or local program is one which is funded 100% by state or local funds.

   Any service which is paid for by the CHOICE program must be an allowable medical expense in order for the expense to be entered as a non-claim and allowed to satisfy spend-down. For example, home health care provided by a licensed home health agency is an allowable expense. However, in addition to medical home health care, the CHOICE program pays for non-medical in-home services that can’t be used to satisfy spend-down. Therefore, specific documentation is required in order to allow a non-claim for an expense that the provider will bill to CHOICE. The documentation from the provider must list the specific service provided and the procedure code. The allowable home health services and their procedure codes are listed below:

Licensed Home Health Aide	99600
Registered Nurse (RN)	99600TD
Licensed Practical Nurse (LPN)	99600TE
Physical Therapy	G0151
Occupational Therapy	G0152
Speech Therapy	G0153

This information is required in order for the services to be correctly considered for spend-down. If the documentation presented lists other service types or procedure codes for home health services, the expense must be entered as a disallowed non-claim.

Documentation submitted from providers must indicate that the services will be billed to CHOICE, not Medicaid. If this statement does not appear on the bill/statement, the expense is not allowed. The preferred documentation is a copy of the provider's invoice to the Area Agency on Aging.

2. Medical services received from a provider who does not participate in the Medicaid program. DFR must contact the provider and verify that s/he is not a Medicaid provider if that information is not documented on the bill/receipt received by the DFR.

3. Medical services received by non-recipient spouses and parents whose income was used to determine the spend-down.

4. Bills for medical services received before the recipient became eligible for Medicaid.

5. Co-payments required by other insurance coverage and Medicare.

A non-claim will be applied to spend-down in the month following the month the DFR receives the receipt/bill, unless the recipient wants it to be applied to the month of the medical service or to the month the expense is submitted to the DFR. DFR must maintain fail-safe controls that ensure that no non- claim expense is ever counted for spend-down more than once. Hard copies of the documentation must be retained subject to regular record retention rules.

All expenses that the DFR receives must be entered in ICES except a bill for a service that should be filed as a claim to Medicaid. These are not non-claims and the DFR must notify the provider (if faxed to the DFR) or the recipient of the proper procedure to follow.

Allowable Medical Expenses:[1]

Listed below are the types of medical expenses that can credit spend-down. Medical services of the recipient must be billed to the AIM system except in the circumstances described above for non-claims. At the end of this section are verification requirements for non-claims.

1. Medical care provided by physicians, psychiatrists, and other licensed medical practitioners;

2. Laboratory testing, x-rays, and other diagnostic procedures;

3. Dental services including dentures provided by a licensed dentist;

4. Hospitalization and outpatient treatment;

5. Nursing facility services and rehabilitative services;

6. Respiratory, occupational, speech, physical, and audiology therapy services;
7. Prescription drugs and over the counter medication (including insulin) when prescribed by a licensed medical practitioner who is authorized under State law to prescribe legend drugs. For Medicare beneficiaries, this includes drugs that are excluded from coverage under Medicare Rx. Excluded drugs **include** barbiturates, benzodiazepines, and over-the-counter drugs that are Medicaid covered. A Prescription Drug Plan may choose to cover a Medicare excluded drug, in which case the cost of the drug is not an allowable medical expense in the Medicaid budget. An excluded drug under Medicare Rx is different from a non-formulary drug. Refer to 3618.05 for a list of non-allowed medical expenses.

8. The cost of postage incurred by the individual for mail-order prescriptions;

9. Medical supplies if ordered in writing by a licensed physician or dentist for treatment of a medical condition;

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[1] 405 IAC 2-3-10

10. Durable medical equipment if ordered in writing by a licensed physician;

11. Home health care provided by a licensed home health agency;

12. Nursing services provided by a registered nurse or licensed practical nurse;

13. Audiology services and hearing aids if ordered in writing by a physician;

14. Prosthetic devices other than those dispensed for purely cosmetic purposes, if ordered in writing by a physician, optometrist, or dentist;

15. Vision care services, including eyeglasses, examinations, and diagnostic procedures;

16. Cost of transportation to obtain medical services that are allowable medical expenses. If transportation is provided by a business transportation carrier, the verified carrier's charge will be allowed. If the individual or friend, or family member drives the individual to medical services, mileage costs is allowed at the rate per mile established for state employee business travel. The state employee business travel rate of $0.40 will be allowed for medically-related transportation expenses incurred on or after 10-1-09. (If incurred 7-1-08 through 9-30-09, the allowed amount was $0.44 per mile; if incurred prior to 7-1-08, the allowed amount was $0.40 per mile.)

17. The premium of the recipient's spouse who is on MED Works (MADW);

18. Co-payments required by other health insurance that covers the individual, including Medicare Rx co-payments. The Medicaid co-payments are allowable medical expenses when the recipient is satisfying spend-down and will be credited to spend-down by the AIM system when the claim is filed by the provider.

19. Any waiver service approved for the individual who is approved under one of the Medicaid Home and Community-Based Services (HCBS)

20. Targeted case management services provided to pregnant women, individuals with HIV, and individuals receiving services from a community mental health center under the Medicaid rehabilitation option.

VERIFICATION OF NON-CLAIM MEDICAL EXPENSES:

Verification of non-claim medical expenses will include the type and amount of the expense, the date the expense is incurred, whether or not it is reimbursable by a third party, and the reimbursed amount. Medical expenses and third party reimbursed amounts can be verified by the following:

Bill from a provider;
Receipt from a provider;
Written statement from a provider; and/or
Telephone contact with the provider, as a last resort.

Verification must show whether a third party has or will be billed, and if a third party has paid, the amount of the payment must be shown so that the DFR staff can determine the individual's out-of-pocket expense.

Medicare or other insurance reimbursement can also be verified by the Medicare Summary Notices that Medicare sends to beneficiaries and other explanation of benefit notices from insurance payers.

For transportation expenses incurred from a non-business carrier, a record of the provider's name, address and date of service for the expense must be provided. MapQuest or similar website can be used by the DFR staff to determine the distance traveled.

3618.10.00 DISALLOWED NON-CLAIMS (MED 1, MED 2)

This section applies to MA A, MA B, MA D, and MA Q.

If an expense is subject to payment by a third party that has not yet adjudicated the claim, the expense is to be entered into the system as disallowed. DFR staff must follow the ICES data entry procedures very carefully. This will ensure that proper information is given to the recipient on the monthly Spend-down Summary Notice. If the third party has adjudicated the claim when it is submitted to the DFR, the portion that the individual owes, the out-of-pocket cost is the allowable amount.

Non-allowed expenses include the following and will not credit spend-down:

1. Special diets and nutritional supplements.

2. Emergency response systems.

3. Non-medical home care such as companions, attendants, homemakers, etc.

4. Home and vehicle repairs/modifications to accommodate a handicapped individual.

5. For Medicare beneficiaries, drugs that are not on the Prescription Drug Plan’s formulary.

Non-allowed claims will be listed on the Spend-down Summary Notice as not being applied to spend-down.

3618.15.00 SPEND-DOWN SUMMARY NOTICE (MED 1, MED 2)

On the second business day of every month the IndianaAIM system generates the monthly Spend-down Summary Notices. A notice will be issued to every spend-down recipient for whom claims or non-claims were applied to spend-down during the month. A copy of the notice will be sent to authorized representatives. In the case of a recipient couple, each member of the couple will receive a notice. More than one month of claims activity may be listed on the notice. The notice reports claims and non-claims processed during the month without regard to the date(s) of the service.

The Spend-down Summary Notice is a very important document for spend-down recipients. The notice informs them of how and to what services their spend-down was applied. The notice informs them of the amount of their spend-down that they owe to each medical provider. Except for pharmacies, medical providers may not collect payment from their spend-down patients, until the patient is notified via the Spend-down Summary Notice of the amount of the bill that was applied to the patient’s spend-down. Because of the point of service billing device used by pharmacies to submit Medicaid claims, they know the amount of the spend-down that was credited to their claim when the prescription is dispensed.

DFR staff should stress to recipients and their authorized representatives the importance of retaining these notices.

The notices are important for the client’s personal record keeping. If recipients have questions about a certain amount that is shown as being owed to a certain provider, they should contact the provider first. Providers are notified via a weekly Remittance Advice (RA) statement of how much of a spend-down was applied to their claim. The provider’s notification and the recipient’s should match. If questions cannot be resolved with the provider, the recipient should contact Member Services. DFR does not receive copies of the Spend-down Summary Notices and do not have information available to them that would allow them to answer questions or resolve any problems relative to the information on the Notice. Refer to Section 3618.20.00 regarding Member Services.

Recipients have the right to appeal any information on the Spend-down Summary Notice with which they do not agree.

3618.20.00 MEMBER SERVICES (MED 1, MED 2)

DFR staff members are responsible for informing applicants and recipients and their representatives about spend-down and how the process works. However, specific questions about the Spend-down Summary Notice and individual Medicaid claims must be addressed to Member Services. For these issues Local DFR Offices are to tell recipients and their representatives to call Member Services at (317)713-9627 or toll-free at (800)457-4584.

3800.00.00 TRANSITIONAL MEDICAL ASSISTANCE

3805.00.00 TMA ELIGIBILITY

3805.05.00 TMA EFFECTIVE DATE

3805.10.00 TMA ELIGIBILITY PERIODS

3805.15.00 TMA REPORTING REQUIREMENTS

3805.20.00 THE PERIODIC REPORTING SUBSYSTEM

3805.20.05 Processing The Periodic Report Form (PR Form)

3805.25.00 COMPLETE TMA REPORTS

3805.35.00 PR FORM NOT RECEIVED OR INCOMPLETE

3805.40.00 DISCONTINUANCE AS A RESULT OF PERIODIC REPORT

3805.40.05 Periodic Report Not Received

3810.00.00 ENDING TMA REPORTING

3800.00.00 TRANSITIONAL MEDICAL ASSISTANCE

This chapter includes policy and procedures on the following topics:

TMA (Transitional Medical Assistance) Eligibility (Sections 3805.00.00 through 3805.10.00);

TMA Reporting Requirements (Section 3805.15.00);

The Periodic Reporting Subsystem (Section 3805.20.00);

The Processing and Evaluation of TMA Reports (PR Forms) (Sections 3805.20.05 through 3805.35.00);

Discontinuance of TMA (Sections 3805.40.00 and 3810.00.00)

3805.00.00 TMA ELIGIBILITY

Up to 12 months of full medical coverage under the Transitional Medical Assistance (TMA) category is available to families when a caretaker relative was discontinued from or denied MAGF because of the earnings. To qualify for TMA, the caretaker relative must be ineligible for MAGF due to new or increased earnings.[1]

To initially qualify for TMA, the caretaker with new or increased earnings must have received and been eligible for MAGF in Indiana in three of the six months immediately preceding the ineligibility. NOTE: MAGF eligibility from an application retro period counts towards the three of six months.

At the point of initial eligibility, the TMA AG will include all persons who were participating or non-participating members of the MAGF AG during the month in which eligibility was lost. Caretaker relatives who enter the household after the TMA period has been established may qualify for TMA, if the new caretaker relative would have also qualified for MAGF in the month the original caretaker relative lost MAGF eligibility was lost due to earnings. Dependent children who enter the household after

[1] Social Security Act (SSA), Section 1925

the TMA period has been established and would have been non-participating members of the MAGF may also qualify for TMA.

Eligibility of a family for this provision follows the caretaker. A unit member, other than the caretaker, who moves out of the unit, loses TMA beginning with the first of the month following the month of departure from the family residence.

3805.05.00 TMA EFFECTIVE DATE

TMA goes into effect on the date of discontinuance of MAGF or on the date on which the AG first becomes ineligible, whichever is earlier.[2]

3805.10.00 TMA ELIGIBILITY PERIODS

TMA is available for two six-month periods. In addition to the criteria listed in Section 3800.05.00, the AG must also meet the following additional eligibility guidelines:

- The AG will continue to be eligible for TMA throughout the first six months provided at least one child under age 18 continues to live in the household.
- The AG will continue to be eligible for TMA for an additional six months provided the following requirements are met:
    - A child under age 18 from the original MA C eligible AG continues to live in the household;
    - The caretaker has earnings in each month or has good cause for not having earnings due to involuntary loss of employment or illness;
    - The AG meets the reporting requirements included in this chapter; and
    - The AG's average gross earned income less out-of-pocket child care expense does not exceed 185% of the Federal Poverty Level for a family of comparable size.[3]

3805.15.00 TMA REPORTING REQUIREMENTS

Families receiving Transitional Medical Assistance (TMA) must report their earnings by completing a Periodic Reporting Form (PR Form).[4]

ICES automatically send a report form to the AG payee. Forms are generated during the third, sixth, and ninth month of

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[2] SSA 1902(d)(1)(A)
[3] SSA 1925(b)(3)
[4] SSA 1925(b)(3)

eligibility. If a form is lost or damaged, the worker may request another form by using the client notice reprint process.

The family must return the report by the first business day following the 20th day of the month and must report the earnings of the TMA AG members. Unearned income need not be reported for TMA purposes. However, the AG should be informed that income reporting and verification responsibilities will continue for any other types of assistance it is receiving.

In addition, recipients who have an out of pocket dependent care expense must provide verification in order to receive a dependent care deduction when income is calculated. Only the earned income of a caretaker relative is considered for budgeting purposes. Please, refer to IHPPM 3010.26.00.

3805.20.00 THE PERIODIC REPORTING SUBSYSTEM

Through the ICES Periodic Reporting Subsystem, PR Forms are logged and the information on them is recorded for the determination of continuing TMA eligibility. The subsystem performs the following functions:

- Generates the Periodic Reporting Form which is mailed from a central location four days prior to the end of the third, sixth and ninth months of TMA;
- From the date entered from the returned report, determines the AG's eligibility for further assistance under the TMA category;
- Discontinues TMA when the AG (without good cause) fails to submit a timely report; and
- Generates notices to the AG of incomplete or missing reports.

NOTE: The Periodic Reporting Subsystem is self-contained. Changes in income and resources which are entered onto its screens will not appear in the general system. Therefore, if a TMA AG receives other benefits as well, any changes reported for TMA must also be entered on the appropriate Application Entry screen.

3805.20.05 Processing The Periodic Report Form (PR Form)

The subsystem includes four screens which are accessed upon receipt of a PR Form.

PRRG:

The form may be logged in on the Periodic Reporting Registration Screen (PRRG) by clerical staff. An alert will be generated to inform the worker that it has been registered and should be reviewed. This alert will not regenerate and should not be deleted until the PR Form has been reviewed. The supervisor is sent an alert if the form has not been reviewed within 10 days of the registration date.

PRES:

If the PR Form is received directly by the worker without having been registered, PRRG may be bypassed and the received date entered on the Periodic Reporting Earnings Screen (PRES). It is on this screen that:

- the earnings information on the PR Form is captured; and
- the worker indicates the results of the review (whether the form is considered to be complete, incomplete with good cause, or incomplete without good cause). Good cause considerations are discussed in Section 3805.35.00.
- NOTE: If a PR Form is coded as received on PRRG, but the worker has not reviewed it and updated PRES, ICES will allow the benefit to continue regardless of the AG's current eligibility.

PRCC:

Any information on out-of-pocket child care expenses is entered on the Periodic Reporting Child Care (PRCC) screen. If the AG pays the provider a TCC copayment fee, the amount is entered on this screen.

PRHI:

The Periodic Reporting History (PRHI) screen displays a summary (for each report quarter) of the information captured on the other PR screens.

After the data has been entered on the appropriate screens, ED/BC is run and the benefit, if correct, is authorized.

3805.25.00 COMPLETE TMA REPORTS

For the report to be complete, the earnings of each employed family member must be verified. When there are missing pay entries, the report will not be considered incomplete if the correct earnings for the period in question can be calculated from year-to-date amounts.

The worker determines continued eligibility for TMA by evaluating the periodic TMA report as instructed in the following sections.

3805.30.00 EVALUATION OF TMA REPORTS (PR FORMS)

A child under the age of 18 who was a participating member of the formerly eligible TANF AG must continue to reside in the household throughout the report period for TMA eligibility to continue. If a child no longer resides in the household, ICES must be updated with this information.

The second step in the report evaluation is to determine whether the caretaker had earnings in each month of the report period. If not, a good cause determination must be made. Good cause for failing to have earnings in each month is limited to an involuntary loss of employment (lay-off or firing) or illness.

Income information from the PR Form is used to determine continuing eligibility for TMA. If the AG's average gross income less out-of-pocket child care expenses does not exceed 185% of the Federal Poverty Guidelines,[5] the family continues to be eligible for TMA.

3805.35.00 PR FORM NOT RECEIVED OR INCOMPLETE

ICES terminate TMA for any AG which fails to return a completed form by the due date.

If a report has been received, but is incomplete, the worker updates ICES by entering the status code of incomplete on the PRES screen.

If the family had good cause for not submitting a report, submitting an incomplete report, or submitting a late report, the worker is to enter the code cause indicator and reason code on the PRES screen. Good cause situations include the following if verified:

- Illness;
- Injury;
- Death of immediate family member;
- Natural disaster;
- Circumstances beyond client's control (includes non-recipient of the original report form);
- Administrative error; and
- Hearing request.

[5] SSA 1925(b)(3)

The codes for these reasons may be found by entering RFDI in the TRAN field and TPRR in PARMS. A determination that good cause exists will prevent automatic case closure.

If the client informs the DFR that the original periodic report form was not received, the worker may request issuance of a second report form by using the client notice reprint process or may provide a hard copy of the form (Report of Transitional Medical Assistance). This action should only take place if the client can submit evidence which substantiates a history of problematic mail delivery or the worker has confirmed that the original report was not returned by the post office to the DFR as undeliverable. The client must be advised, in writing, that a period of no more than thirteen (13) working days from the date the second form was generated by ICES or presented manually, will be allowed for completion and submission to the DFR. Appeal rights must also be reiterated.

Documentation to be presented at an appeal hearing should include:

- A copy of the notice history detail screen (CNHD)
- A copy of the case information screen (AEICI)
- Verification of issuance of a second report form
- A copy of the TMA closure notice.

3805.40.00 DISCONTINUANCE AS A RESULT OF PERIODIC REPORT

When a PR Form is not returned, is returned late, or is incomplete, if good cause is not indicated. TMA is discontinued at the end of the sixth, eighth or 11th month when report requirements are not met. (See Section 3805.10.00)

ICES will send the worker alert 370. The worker should review PRES (also the periodic report form and verification if necessary) to determine if the TMA should close. If the closure is correct, the worker should run AEABC and the system will determine if the individuals on TMA qualify for any other category of medical assistance.

If the report is complete, but income exceeds the TMA guidelines, which are 185% of the Federal Poverty Level, ICES initiates the following adverse action procedures: (Refer to Section 3805.10.00)

- sending an alert to the worker to run ED/BC;
- discontinuing the TMA AG; and

- Generating an adverse action notice to the AG if eligibility under another category is not established.

Once lost, TMA eligibility can only be regained by again qualifying for and being discontinued from MA C in accordance with TMA eligibility requirements.

3805.40.05 Periodic Report Not Received

A periodic report form may be issued to the client in instances where circumstances beyond the control of the client prevented timely completion (EXAMPLE: hospitalization, return of the report to the DFR by the postal authority). Unsubstantiated allegations by the client that the report was not received do not constitute a valid reason for sending a second report form.

The worker may request issuance of a second report form by using the client notice reprint process. The client must be advised, in writing, that a period of no more than thirteen (13) working days from the date the form was generated will be allowed for completion and submission to the DFR. Appeal rights must also be reiterated.

A copy of the ICES history screen detailing issuance of the report must be submitted at any appeal hearing. Any additional hard copy documentation of transactions between the worker and the client which relates to the appeal must also be submitted for consideration.

To re-form a case in ICES which has auto-closed for failure to meet the report deadline, the worker must enter a good cause or hearing reason and run ED/BC.

3810.00.00 ENDING TMA REPORTING

Periodic TMA reporting is ended for an AG whenever the AG is closed for any reason. If an AG is closed after a report is sent out by ICES, the report is not tracked through ICES.

Prior to the end of the 12th month of TMA eligibility, ICES sends an alert to the worker to run ED/BC so that eligibility under other categories of assistance is explored.

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4200.00.00 APPEALS AND FAIR HEARINGS

This chapter presents information relating to appeals and fair hearings, and includes:

Appeals (Section 4205);
Fair Hearings (Section 4210).

4205.00.00 APPEAL REQUEST

An appeal is a request for a fair hearing before a representative of the FSSA Office of Hearings and Appeals (OHA) for the purpose of deciding whether the action taken or proposed by the agency is correct. An appeal is any clear, written expression by the applicant/recipient, or individual authorized to act for him, stating that he wants an opportunity to appeal.[1] If a verbal request is made, the request is to be noted and the applicant or recipient informed that the request must be made in writing.

Appeal requests must be filed with the Division of Family Resources (DFR) in one of the following ways:

i. Mail or fax to the FSSA document center; or

ii. File in person at the Local DFR Office.

An Administrative Law Judge (ALJ) of OHA will conduct a fair hearing on the action(s) under appeal and will render a decision on the findings of the hearing.[2] This decision is binding on the DFR.[3]

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[1] 470 IAC 1-4-3; 42 CFR 431.201

[2] 42 CFR 431.240; 42 CFR 431.244

[3] IC 12-15-28-7

4205.05.00 RIGHT TO APPEAL

All individuals must be informed in writing at the time of application and when action is taken which affects their benefits, of:

The right to a fair hearing; and

The method for requesting a hearing.[4]

This information is contained in the Rights and Responsibilities listing which is given to applicants, and is also on all eligibility notices.

An individual's freedom to make a request for a fair hearing must not be limited or interfered with in any way.[5]

4205.05.05 Assistance in Exercising the Right to Appeal

The DFR is responsible for assisting an unsatisfied individual so that he may fully exercise his right to appeal.[6] Any time an individual expresses a disagreement with any action taken, he must be verbally reminded of the right to request a fair hearing. Assistance is to be provided to the individual who is having difficulty in preparing the written request for an appeal.

The individual is to be informed that he may represent himself at the hearing or be represented by an attorney, a relative, a friend, or any other spokesman of his choice.[7] Information and referral services should also be provided to help the unsatisfied individual make use of any free legal services that are available in the community. This information is included on the eligibility notices.

4205.10.00 APPEALABLE ACTIONS

In accordance with Indiana Code §12-15-28-1, any action with which an applicant for or recipient of Medicaid is dissatisfied may be appealed. An applicant may appeal and

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[4] 42 CFR 431.206

[5] 42 CFR 431.221(b)

[6] 470 IAC 1-4-3; 42 CFR 431.221(c)

[7] 42 CFR 431.206(b)(3)

have a fair hearing when his application for medical assistance is denied or not acted upon with reasonable promptness.[8] A recipient may appeal when he believes the agency has taken erroneous action to reduce, suspend or discontinue assistance.[9] An individual can also appeal the level of benefits for which he is receiving.

4205.10.05 Spousal Impoverishment Specified Appealable Issues (Med 1)

For institutionalized individuals with community spouses (eligibility that is determined under the spousal impoverishment provisions), there are certain specific issues which are appealable, and criteria are set forth by which an Administrative Law Judge (ALJ) can establish a higher community spouse resource standard and spousal allocation.[10]

The resource issues that are subject to appeal are as follows:

The computation of the spousal share;

If either spouse or their representative alleges that the spousal share was computed inaccurately, they may appeal if an application for MA has been filed on behalf of the institutionalized spouse. For example, an applicant might appeal the spousal share because he disagrees with the DFR's determination of the availability of a resource or because the couple neglected to disclose the existence of a particular resource at the time of the assessment.

The computation of the community spouse resource standard;

An appeal of the resource standard could be related to the couple's disagreement with the spousal share computation. For example, the community spouse would be entitled to a higher

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[8] SSA 1902(a)(3)

[9] 42 CFR 431.220; IC 12-15-28-1

[10] SSA 1924(a)(3)

resource standard if the spousal share was determined too low.

The computation of the amount of resources to be transferred to the community spouse;

Hearings on this issue must be held within 30 days of the date of the appeal request. Therefore, it is important that the DFR specifically notify the Hearings and Appeals Section of the nature of such an appeal when forwarding it to them.

The income issues that are subject to appeal are as follows:

The ownership of income;

The institutionalized spouse may rebut through the fair hearing process the ownership of income as determined by the DFR.

The amount of the spousal income allocation;

The couple or their representative may appeal the amount of the income allocation budgeted by the DFR. Absent a calculation error by the DFR, the couple must establish that the community spouse needs a higher allocation due to exceptional circumstances resulting in extreme financial duress. Exceptional circumstances are those in which the community spouse is required to pay an expense beyond what is recognized in the establishment of the maintenance standard. An example might be a medical expense which the community spouse cannot be expected to pay out of the amount established for maintenance needs.

An ALJ ruling in which a higher allocation is granted will be conditioned upon the existence of exceptional circumstances which will cause extreme financial duress. Therefore, it is the responsibility of the DFR to monitor the case to determine whether the exceptional circumstances continue to exist. The necessary frequency of this monitoring will depend on the individual circumstances involved, but generally the

frequency should not be less often than quarterly.

When the DFR has determined that the exceptional circumstances which substantiated the higher income allocation granted by the ALJ no longer exist, a desk review must be completed. The DFR is to calculate the spousal allocation as explained in Chapter 3400 and provide timely notice to the individual and his representative. If the individual disputes the DFR's determination, they may appeal.

Note that a higher spousal income allocation based on financial duress can be established only by an ALJ, not the DFR. The DFR's role in this matter is to monitor the case after the ALJ's ruling to determine if and when the documented exceptional circumstances no longer exist.

4205.15.00 GROUP APPEALS

OHA may respond to a series of requests for hearings by providing group hearings in cases in which the sole issue involved in the cases is one of federal or state law or regulation.[11] Similarly, a group of individuals who wish to appeal some aspect of policy may request to be heard as a group. If there is disagreement as to whether the issue is one of federal or state law or regulation or the facts of an appellant's personal situation, OHA will make the decision as to whether his appeal may be included in a group hearing.

The ALJ may limit the discussion in a group hearing to the sole issue under appeal. When an appellant's request for a hearing involves additional issues to the one serving as the basis for the group hearing, his appeal will be handled individually. An appellant scheduled for a group hearing may choose to withdraw and be granted an individual hearing regardless of whether his grievance is limited to the sole issue involved in the group hearing.

Policies governing the conduct of individual hearings are pertinent to group hearings. Each appellant will be given

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[11] 42 CFR 431.222

full opportunity to present his case or have his case presented by a representative at the group hearing.

4205.20.00 TIME LIMITS FOR REQUESTING APPEALS

Appeals must be received by close of business not later than 33 days from the date of the action or issue being appealed.[12] Close of business is 4:30 P.M., local time on the business day where the appeal is received. For recipients, the 33 day period is measured from the effective date of the action as recorded on the notice. For actions taken on applications, the 33 day period is measured from the date the notice of agency action is sent. For purposes of this Chapter 4200, “sent” means to be delivered by mail or in electronic format consistent with 42 CFR §435.918.[13] Additionally, if the last day of the 33-day time period falls on a non-business day, the appeal request is considered timely if it is received by close of business on the next business day.[14]

In cases involving a delay in acting on the application, the time limit for appealing begins as follows:

- 45 days after the date of application for all MED categories except Disability;
- 90 days after the date of application for the Disability categories (regular Disability and MEDWorks).

In cases in which action has not been taken on a reported change in circumstances, the time limit for appealing begins with the first day of the second month following the month in which the change in circumstances was reported to the DFR.

If the appeal request is not received within the required time limits, the appeal is invalid, and a hearing will not be scheduled. The determination that an appeal is untimely

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[12] 405 IAC 1.1-1-3

[13] 42 CFR 431.201

[14] 405 IAC 1.1-1-3

and therefore invalid is made by Central Office Hearings and Appeals, not the DFR.[15]

4205.25.00 RESERVED

4205.26.00 CONTINUED BENEFITS WHILE APPEAL IS PENDING

Benefits must continue without change if an appeal is received by the DFR not later than close of business on the day prior to the effective date of the proposed adverse action.[16] If the day before the effective date is a non-business day, the appeal is timely if received by the next FSSA business day. Close of business is 4:30 P.M. local time where the appeal is received.

The only exceptions to continued benefits are (1) the recipient declined continued benefits specifically in his appeal request, or (2) the reason for discontinuance was failure to pay any applicable Medicaid or CHIP premium or failure to pay the POWER account payment required to remain eligible for the Healthy Indiana Plan.[17]

Once continued benefits are allowed, benefits are not to be reduced or terminated, for the reason under appeal, prior to receipt of the official hearing decision. Benefits can be reduced or terminated during an appeal only if there is another reason that causes a reduction or termination in benefits during the continued benefit period, other than the reason for why there is an appeal in the first place. The appeal, however, must continue.

4205.27.00 FAILURE TO ISSUE NOTICE OF ADVERSE ACTION

If an adverse action is taken against an applicant or recipient without the required notice being issued, a notice must be sent to the applicant or recipient and authorized representative(s) immediately upon knowledge of the situation. Benefits are not reinstated/restored at this point. If an appeal of the action is received by the DFR within ten (15) days of the mailing date of the notice, benefits are to be reinstated at the level prior to the

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[15] 405 IAC 1.1-1-3

[16] 42 CFR 431.230

[17] 405 IAC 9-4-5; 405 IAC 9-5-3

adverse action. The appeal must be received by close of business on day 10 after the date of receipt. If day 10 is a non business day, the appeal must be received by close of business on the next FSSA business day.[18] If the appellant can demonstrate that he did not receive the notice within fifteen (15) days of the mailing date, benefits must be reinstated if the appeal request is received within ten (10) days of the date the appellant demonstrated that he received the notice.

4205.30.00 APPEAL PROCEDURES

All written appeals filed with the DFR are to be immediately forwarded to the OHA.

The DFR should inform OHA if a hearing request is received from the applicant or recipient that plan to move, such as farm workers, so that the request can be expedited to enable a decision to be reached before the applicant or recipient leaves the area.

4205.35.00 THE HEARING NOTICE

The Hearings and Appeals Section sends a notice acknowledging the appeal to the applicant or recipient (appellant) and the DFR.[19] The notice:

- Includes a statement of the date, time, place, and nature of the hearing which is always conducted in the appellant's county of residency[20] or via telephone

- Advises the appellant of the name, address, and telephone number of the person to notify in the event it is not possible for him to attend;

- Specifies that the hearing request will be dismissed if the appellant fails to appear for the hearing without good cause;[21]

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[18] 42 CFR 431.231

[19] IC 12-15-28-3; 470 IAC 1-4-3; 405 IAC 1.1-1-3;

IC 4-21.5-3-20

[20] 42 CFR 431.240

[21] 42 CFR 431.223

- Specifies that the appellant may request a continuance of the hearing if good cause is shown;

- Includes the appellant's rights, information, and procedures to provide the appellant with an understanding of the hearing process; and

- Explains that the appellant may examine the case record prior to the hearing.

This notice is sent out so that it reaches the appellant at least 10 days prior to the hearing.

4205.40.00 REQUEST FOR CONTINUANCE FROM THE APPELLANT

A written request for a continuance is to be directed to the OHA. Good cause must exist for a continuance to be granted. Good cause is defined as a valid reason for the appellant's inability to be present at the scheduled hearing such as a death in the family, personal injury or illness, or a sudden and unexpected emergency.[22] If good cause exists and a continuance is granted, the hearing is rescheduled.

4205.40.05 Request for Continuance from the Appellant for Medical Evidence

If disability or blindness was denied by the FSSA Medical Review Team (MRT), a continuance may be requested to allow the appellant time to obtain additional medical evidence on his condition.[23] If the ALJ orders an additional medical assessment, it must be made at the expense of FSSA and made part of the record when the issue under appeal is:

Decision that the visual requirement is not met;

Decision that the disability requirement is not met; or

Denial or limitation of medical services under the Medicaid program.[24]

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[22] 405 IAC 1.1-1.3(d)

[23] 42 CFR 431.223

[24] 42 CFR 431.240

The written request for a continuance on a medical-related issue must be submitted to the OHA within 10 days of the date that the hearing notice was sent. The additional medical evidence on the visual and disability requirement must be submitted to the DFR within 30 days of the date the hearing notice was sent unless a written request for an extension of time is received by the OHA within the 30 day period. The denial or limitation of medical services must be submitted to the OHA within 30 days of the mailing of the prehearing order unless a written request for an extension of time is received by the Central Office within the 30 day period.

The DFR is to forward the original or most legible copy of the additional medical evidence to the OHA and retain a copy for the appellant's case record. The DFR will forward said evidence to the Medical Review Team (MRT).

The additional medical information on incapacity is submitted to the DFR for review.

The granting of a continuance to the appellant extends the time frame by which the hearing decision must be issued.

4205.40.10 Request for Continuance from the DFR

Although the DFR may also request a continuance, one should not be routinely requested. Unlike the continuance given to an appellant, the granting of a continuance to the DFR does not extend the time frame by which the hearing decision must be issued.

4205.45.00 REVIEW OF ACTION BY DFR

When an appeal request is received, the proposed action is reviewed to determine whether the action is appropriate.

The DFR should carefully review the appellant's situation to determine whether the action on the case was correct or any adjustment is indicated. The appellant and the DFR worker should discuss the issue under appeal.

Important: this review must not in any way interfere with a prompt continuation of benefits in accordance with Section 4205.26.00 if a timely appeal of an adverse action is received by the DFR.

4205.45.05 RESERVED

4205.50.00 DISPOSAL OF APPEAL WITHOUT A FAIR HEARING

An appeal request may be disposed of without holding a fair hearing in the situations discussed in the following sections.

4205.50.05 Adjusting Action by DFR

If, after review of the appellant's situation, the DFR realizes that the adverse action proposed or taken on the case was incorrect, the DFR must take adjusting action to correct the error. The appellant and the OHA are to be promptly notified in writing that the incorrect action is being withdrawn or rescinded.

4205.50.10 Withdrawal of Appeal by Appellant

If the appellant wishes to withdraw his appeal, he is to be assisted by the DFR in promptly notifying the OHA in writing of his decision. No pressure is to be exerted on the applicant/recipient to withdraw his appeal. The withdrawal will be acknowledged in writing. The appeal is then dismissed.[25]

4205.50.15 Abandonment

An appeal is abandoned when the appellant or his representative, without good cause, does not appear at a scheduled hearing. The appeal will be dismissed and the appellant so notified.[26]

4210.00.00 THE FAIR HEARING

A fair hearing is an administrative review of the action taken or proposed concerning an individual's eligibility and/or level of benefits. An Administrative Law Judge (ALJ), who is a State employee of FSSA, is designated to hold fair hearings and to issue findings of fact and decision on an appeal request.

A fair hearing allows the unsatisfied applicant/recipient an opportunity to present his grievance and to describe his circumstances and needs in his own words. He may also be

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[25] 42 CFR 431.223(a)

[26] 42 CFR 431.223(b); IC 4-21.5-3-24

represented by legal counsel, relatives, friends, or any other spokesman of his choice. DFR staff involved in the protested action also attend the hearing and present the facts on which the action was based.

4210.05.00 PREPARATION FOR HEARING BY APPELLANT

As the appellant prepares for the hearing, he or his representative is to be given an opportunity to:

Discuss the issue being appealed with the DFR;

Examine his entire case record and all documents and records that will be used by the DFR at the hearing; and

Obtain, free of charge, copies of all exhibits that will be used as evidence by the DFR at the hearing.

The appellant is to be advised of any legal services available that can provide representation at the hearing.

4210.10.00 PREPARATION FOR THE HEARING BY DFR

The most important factor behind an ALJ's decision to sustain a DFR action is correct application of federal or state law or regulation to the appellant's situation. It is important that the DFR representative presents thorough support at the hearing for the action of the DFR.

The person testifying for the DFR at the hearing should be very familiar with the appellant’s case, understand what is under appeal, and be able to argue the facts of the case and State’s position.

To prepare for the hearing, the DFR representative is to:

Review the case record and recheck all eligibility factors and all issues that led to the action being appealed;

Discuss the issue being appealed with the appellant or his representative if at all possible, and definitely if a discussion is requested by the appellant. If requested, allow the appellant or his representative to examine the entire case record.

Identify and label all documents that are pertinent to the issue under appeal and label them (for example, DFR Exhibit A, and so forth). Make one copy for the ALJ and one copy for the appellant (unless already given to the appellant). A duplicate copy of the notice sent to the appellant advising him of the proposed action should be included as part of the documentation.

Additionally, for MED 1, if the spousal allocation is appealed, the spousal allocation budget, AEBCA, is to be submitted as pertinent documentation at the hearing.

Prepare a written outline that can be used as a tool in presenting the testimony of the DFR at the hearing. Bear in mind that when preparing the outline, that the ALJ knows nothing about the situation. The outline should focus on:

- Identification of the staff representative by name and position;

- The period of time the representative worked directly or indirectly with the appellant;

- A one sentence explanation of the issue under appeal;

- The important information concerning how the DFR determined that the action proposed or taken was appropriate; and

- Federal and state laws and regulations that were the basis for the action.

Include the labeled exhibits at the appropriate point in the presentation outline.

EXAMPLE:

Personal Identification:

Name
Position
Months/years as an employee of DFR or its contractor

Issue:

Discontinuance of Medicaid effective April due to earnings from employment

Sources of Information:

Copy of letter from recipient dated February 20 reporting employment beginning February 3 (DFR Exhibit A);

Copies of three check stubs dated February 22, February 18, and February 25 showing gross wages of $225 per week from XYZ Manufacturing Company (DFR Exhibit B);

ICES screens showing the computation of the budget for April (DFR Exhibit C).
Explain the entire budget computation from the number in the household to the final calculation of ineligibility.

Notice of Action sent on March 8 informing appellant of the proposed action (DFR Exhibit D).

Request for appeal received on March 14 (DFR Exhibit E).

4210.15.00 CONDUCT OF THE HEARING

The ALJ conducts the hearing. Both the appellant and the DFR have the opportunity to:

Present the case or have it presented by legal counsel or another person;

Present testimony of witnesses;

Introduce relevant documentary evidence;

Establish all pertinent facts and circumstances;

Present any arguments without interference;

Question or refute any testimony or evidence presented by the other party, including the opportunity to confront and cross-examine any adverse witnesses; and

Examine the appellant's entire case record and all documents and records used by the DFR at the hearing.[27]

The parties are advised at the close of the hearing that they will be informed in writing of the ALJ's findings and decision on the appeal as soon as possible.

4210.15.05 DFR's Responsibility at Hearing

The DFR representative at the hearing is to:

Present the testimony of the DFR according to the outline prepared prior to the hearing;

Limit his remarks to facts (not speculation or guessing);

Avoid the use of jargon used only by DFR employees;

Offer labeled exhibits into evidence at appropriate points in the testimony and explain what they are and how they relate to the issue; and

Offer the labeled exhibits to the appellant and/or his representative for examination and objections (if any).

The DFR representative should be prepared to question the appellant about any statements made that which he feels need further explanation.

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[27] 42 CFR 431.242

4210.20.00 CONTINUANCE OF HEARING

If the ALJ determines that further evidence is needed to reach a decision, the decision is delayed until such further evidence is obtained. The hearing may also be reconvened, if necessary, to obtain additional testimony. The parties will be notified of this and of the time and method for obtaining this evidence. Any evidence submitted must be copied and given to the appellant, who then has the opportunity for rebuttal.

4210.25.00 THE HEARING RECORD

The hearing record is an official report containing the substance of what transpired at the hearing, together with all papers and requests filed in the proceeding, and the decision of the ALJ. This record shall be available to the appellant at a place accessible to him or his representative at a reasonable time.

4210.30.00 THE FAIR HEARING DECISION

A written copy of the ALJ's hearing decision is sent to the appellant and the DFR. The decision includes:

The findings of fact and conclusion regarding the issue under appeal; and

Supporting laws and regulations.

In all cases the decision of the ALJ is based solely on the evidence introduced at the hearing and the appropriate federal and state laws and regulations. The finding of fact and decision is signed by the ALJ. The decision is to be explained to the appellant upon request.[28]

Unless a continuance has been granted in accordance with law as set forth in Section 4205.40.00, the final hearing decision must be made by the ALJ and communicated to the appellant and the DFR within 90 calendar days of the hearing request.[29]

4210.30.05 RESERVED

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[28] 42 CFR 431.244

[29] 42 CFR 431.244

4210.30.10 Action Required as a Result of the Hearing Decision

The decision of the OHA shall be binding upon the DFR and is to be enacted by the DFR even if one of the parties requests an Agency Review.[30] Such decisions do not preclude modifying the benefit thereafter to meet changed conditions.

4210.30.10.05 Action Is Sustained

No further action or response is required by the DFR if the hearing decision sustains an adverse action which was not appealed in a timely manner.

If the hearing decision sustains an adverse action and continued benefits were received pending the hearing in accordance with Section 4205.26.00 of this Chapter 4200, the DFR must immediately take appropriate corrective action to institute recovery procedures against the applicant or beneficiary to recoup the cost of such services by establishing a claim for benefits the beneficiary received pending the hearing decision.[31] Additionally, action to implement the correct budget should be taken.

4210.30.10.10 Action Is Modified

DFR actions which are modified by the hearing decision must be immediately corrected as directed by the hearing decision. This may require a claim for incorrectly issued benefits or a restoration if benefits received were not at the correct level.

4210.30.10.15 Action Is Reversed

If the hearing decision reverses the DFR's action, and continued benefits were received, no further action is required. However, if the hearing decision reverses the DFR's action, and continued benefits were not received, immediate corrective action must be taken. Please refer to Section 4205.26.00.

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[30] IC 12-15-28-7; 42 CFR 431.230(b)

[31] 42 CFR 431.230(b)

4210.35.00 AVAILABILITY OF AGENCY REVIEW

The appellant or the DFR may request an Agency Review of the case by the Family and Social Services Administration if dissatisfied with the decision made by the ALJ. The agency review is explained to the appellant in the decision.[32] The request must be made in writing to the OHA within 10 days following receipt of the hearing decision.[33]

4210.35.05 Agency Review

Once an Agency Review is requested, the Hearings and Appeals Section writes to the DFR and the appellant to acknowledge receipt of the request and to provide information concerning the review.

The parties may choose to submit a written Memorandum of Law for consideration. The Memorandum of Law must be submitted within twenty (20) days of the date of hearing decision. The Agency Review's decision will be sent to appropriate parties by certified mail.

Action required by the hearing decision must be enforced while awaiting the Agency Review.

Any party aggrieved by the decision of the Agency Review may file a petition for Judicial Review in the appropriate court by following the procedures required by IC 4-21.5-5-5 et seq.

4210.40.00 LAWSUITS

When an applicant/recipient (plaintiff) sues the DFR and/or the Central Office (defendant) and DFR staff are subsequently contacted by the plaintiff's attorney, the attorney should be advised to contact the defendant's attorney of record. The defendant's attorneys of record would be the Deputy Attorney General. These attorneys are known to the plaintiff's attorney through the pleadings filed in the case.

4215.00.00 RESERVED

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[32] IC 4-21.5-5-16

[33] 470 IAC 1-4-6; 42 CFR 431.245(b)

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4600.00.00BENEFIT RECOVERY

This chapter presents policy and procedures on the following:

Identifying Over Issuances (Section 4605);

Types of Over Issuances (Section 4610);

Over Issuance Calculation (Section 4620);

Initiating Collection Action (Section 4630);

Recovery Methods (Section 4635);

Transmittal of Repayment (Section 4640);

Claim Against Estate (Section 4650).

4605.00.00 IDENTIFYING OVER ISSUANCES

An over issuance exists when an AG received benefits when it was not eligible to receive benefits, or in the case of spend down or liability, when the AG received benefits in an amount greater than it was eligible to receive. Benefit recovery will not be pursued if the correct information would only have affected the amount of monthly premiums or POWER Account contributions.

Benefit recovery will be pursued for assistance groups where the member failed to report or falsified information which would have made them completely ineligible for the assistance they received. This means that income reporting would not affect categories such as MA X, MAGP, MA 4, MA 8, MA 15, and MA Q.

The claims process begins with the identification of an over issuance. This occurs when the eligibility worker receives or discovers information which appears to contradict information previously used to determine eligibility. The worker may receive information that an over issuance has occurred as a result of:

An untimely reported change;

Information from individuals inside/outside the AG;

Fair hearing decision found unfavorable to client;

Transfer Penalties;

Quality Control (QC) referral;

Management Evaluation (ME) review;

Office of Inspector General (OIG) investigation/audit report (referred through Central Office); or

Central Office referral.

The source reporting information may have already conducted a case file review and obtained documentation to resolve the discrepancy and determine the time period and amount of any over issuance.

The eligibility worker may also discover information contrary to what is in the case record from review of reports from one of the following sources:

Department of Workforce Development (through data exchange);

Social Security Administration (SSA) (through data exchange);

Internal Revenue Service (IRS) (through data exchange);

Bureau of Motor Vehicles (BMV); or

Financial institutions.

4605.05.00 STAFF RECOVERY RESPONSIBILITIES

Recovery responsibilities of the eligibility worker and supervisor, the benefit recovery (BV) worker and BV supervisor and the Fraud Referral Coordinator are provided in the following sections.

4605.05.05 Eligibility worker Responsibilities

When a possible over issuance is identified, the worker must gather and record the following information in running record comments:

The cause of the over issuance;

How the over issuance was discovered;

The date the agency became aware of an over issuance;

Who received the income/resource/status change;

The date the income or change started and/or stopped;

The estimated length of over issuance;

Any explanation given for failure to provide information accurately or in a timely manner; and

Corrective action taken and the date such action was taken.

Before completing a referral to the BV unit the worker must review the above information to determine what further information/verification is still needed and take the actions listed below.

Obtain verification necessary to determine the time period and the amount of over issuance;

Adjust the current benefit, if appropriate, prior to referral to Benefit Recovery;

Verify that the individual was actually receiving assistance, during the time the claim of over issuance was presumed;

Advise the AG in writing that a discrepancy exists, that the source of the discrepancy is from outside the AG and that a referral to BV will be made regarding the overpayment if the discrepancy cannot be resolved. If discrepancy is identified through the data exchange (DE) subsystem, the discrepancy notice can be generated through the DE screen.

If the over issuance is referred to the prosecutor, do not discuss the possibility of repayment with any member of the AG before the final court disposition.

The AG will be allowed 10 days to rebut the allegation prior to referral to BV. The eligibility worker must allow the AG an opportunity to provide information which clarifies the situation.

The eligibility worker must also:

Complete the Benefit Recovery Referral (BVBR) screen within 30 calendar days of the day the agency became aware of the overpayment (refer to Section 4620.00.00, completing the Benefit Recovery Referral);

Respond to the BV unit requests for any additional information within 10 calendar days;

If notified that a payment has been received and no referral exists, determine if over issuance occurred and enter information on BVBR (refer to Section 4620.00.00, completing the Benefit Recovery Referral);

If notified that a payment has been received and no over issuance exists, the payment must be returned to the individual;

When notified that attendance is required, prepare for appearance in court or at a hearing.

If over issuance was discovered as a result of Data Exchange, follow the policy in Section 4415.05.00, IEVS Compliance Tracking, prior to referral to Benefit Recovery (BV).

4605.05.10 Benefit Recovery Worker Responsibilities

The Benefit Recovery (BV) caseworker is responsible for the establishment of all over issuance claims and the maintenance of recovery activities except the receipt of any repayments.

4605.05.15 Fraud Referral Coordinator/BV CODY user Responsibilities

Certain BV workers also serve as the contact for all fraud, investigation and referral activity.

The responsibilities of the Fraud Referral Coordinator/BV CODY user are:

Review all claims purported to be fraud before they can be opened. Decide on further action.

Monitor all fraud referral and investigation activities conducted within DFR.

Serve as contact for Central Office staff on matters related to claims, collections, adjudications and investigations.

Maintain all fraud activity records including Fraud Hotline Referrals, other program abuse complaints, referrals for investigations, prosecutions, and criminal court results. Assign CODY investigation numbers to all referrals to be investigated by BV or Compliance Division.

Review all referrals for investigation. When appropriate, make a referral to the Compliance Division.

Review all completed investigations to determine the appropriate action to be taken on the case. Whenever possible, seek adjudication. Review resulting claims and enter in CODY along with adjudication results.

4610.00.00 TYPES OF OVER ISSUANCES

Once an over issuance is identified, the reason for the over issuance must be identified.

An over issuance may be the result of:

Client Error;
Intentional Program Violation (fraud); or
Combination of the above.

A Medicaid claim cannot be adjudicated as IPV in an Administrative Disqualification Hearing, and even if a Medicaid claim is part of a Prosecution case found guilty, it must be entered in ICES as 'CE'. (See Section 4610.10.00.)Benefit recovery will not be pursued for agency errors which resulted from worker error. These types of errors are accounted for through Medicaid Quality Control and PERM review processes.

4610.05.00 AGENCY ERROR DEFINITION

An Agency Error (AE) is an action or failure to take action by the Division of Family and Children.

Examples of agency error may include:

A misapplication of policy;

A calculation error;

A computer processing error;

Failure to take prompt action on available information;

Some other error over which DFR has control.

4610.10.00 CLIENT ERROR DEFINITION

Client error is an over issuance caused by a misunderstanding or an unintended error on the part of the AG. Eligibility workers can help to eliminate this type of error by making sure the client understands what is needed and by what date. Eligibility workers can also help by being well organized, so that reported changes are always acted upon and never lost. ICES coding remains unchanged. A Medicaid error of this type is coded CE. A client error can occur as a result of:

AG failure to provide correct or complete information;

AG failure to report required changes in the AG's circumstances; and

AG receipt of benefits (or more benefits than it was entitled to receive) pending a fair hearing decision.

4610.15.00 SUSPECTED FRAUD DEFINITION

Fraud is the act whereby a person willfully and deliberately makes false statements or suppresses facts or gives information which misrepresents the true circumstances regarding himself or others for the purpose of receiving assistance to which there is not entitlement.

Suspected fraud over issuances can occur as a result of the AG:

Misrepresenting information;

Concealing information;

Withholding information pertinent to determining eligibility, including untimely reporting;

Failing to report a change in order to continue to receive benefits for which the AG was not entitled; or

Intentionally altering or changing documents to obtain benefits to which the AG was not entitled.

Fraud, in all of its aspects, is a matter of legal determination. Therefore, fraud does not exist until this legal determination has been made through the criminal court.

Once the suspected fraud claim has been calculated **but not yet opened**, the entire claim case will be submitted to the Bureau of Investigations for review and approval.

4610.15.10 Deterrents Against Fraudulent Activity

The DFR is to establish deterrents against fraudulent activity through:

Skilled investigation;

Careful explanation of all eligibility requirements to applicants/recipients;

Diligent use of collaterals and other sources of information;

Verification of facts;

Alertness to possible misunderstandings;

Follow-up investigations where indicated;

Establishment of procedures for handling cases of suspected fraud to ensure thorough investigation and proper referrals to the County Prosecutor.

Cooperation with the news media in publicizing cases prosecuted for welfare fraud.

4610.15.15 Establishment and Investigation of Possible Fraud

Documentation of the applicant's/recipient's apparent ability or inability to understand questions regarding eligibility, especially with regard to income and resources, must be entered in the running record comments. It is unlikely that fraud can be established and substantiated if the documentation shows that the individual's mental or physical condition resulted in his inability to understand eligibility requirements and his responsibility to provide information to the DFR.

The eligibility worker may suspect fraud exists within an AG. Some clues which may indicate unwarranted receipt of assistance are:

- Purchase of items which indicate that more income exists than is known;
- Living at a higher standard than known income would permit;
- Unexplained absences or difficulty in seeing the recipient to complete necessary redeterminations;
- Reluctance to provide needed information about income and/or resources;
- Unexplained and continued refusal to have certain pertinent references or relatives contacted; or
- Complaints or remarks of other persons.

The worker should be alert to any information that can lead to the identification of a case discrepancy. If such information becomes available, the worker should take the action listed in Section 4605.05.05, Caseworker Responsibilities, then enter a referral to the BV unit on BVBR if appropriate.

The worker is responsible for completing all investigations that can be done from the office: By phone, mail or interview. This includes data matches. Use Subpoena (Form FI0018/State Form 48133) to obtain needed verification when a signed client "Release of Information" is not available or appropriate. If it appears that the investigation cannot be completed by the eligibility worker, a suspected fraud task can be created to the Benefit Recovery Unit who can make a referral to the Bureau of Investigation.

4610.15.20 Investigation of Possible Fraud

If the AG is currently eligible, assistance is not to be discontinued solely because an investigation of suspected fraud is being conducted, nor is the worker to discuss an investigation by the Bureau of Investigation with the client.

The DFR is required to pursue suspected fraud. It is the responsibility of the eligibility worker to do the initial investigation and then, if appropriate, create a suspected fraud task for Benefit Recovery. Based on the BV worker and the B of I investigator's findings, and if the case meets the Local Prosecutor's criteria, the individual may be referred for prosecution to the County Prosecutor.

The methods used in investigating possible fraud should be adapted to the situation of the AG and the eligibility factors concerned. The investigation must be conducted in such manner that:

The legal rights of the AG are preserved;

The privacy of the home is not invaded without consent;

Search and seizure are not committed;

The AG's right to due process of law is protected;

The right to legal counsel is not obstructed; and

Confidential information is used only for the administration of assistance.

4610.15.25 Report of Fraud Investigations and Adjudications

When the investigation is completed, a report of all facts in the case is to be made. If the report reveals no basis for the suspicion of fraudulent activity, such decision is to be entered in the case record. Exoneration of the innocent is as important as prosecution of the guilty. If the report indicates a basis for suspected fraud, the period of time during which it is believed that the AG fraudulently obtained assistance is to be made a part of the record.

It is important that **all** investigations for **all** programs be entered in CODY System. The Benefit Recovery worker’s initial investigations should be entered as well as referrals to the Bureau of Investigation. Update and add information as changes occur.

All individuals referred for prosecution or an ADH must be reported in CODY. CODY must be updated as each case progresses through the legal system.

4610.15.30 Referral to County Prosecutor

The Bureau of Investigation (B of I) will decide whether to refer a case for prosecution. The County Prosecutor has the final word concerning the type and number of cases against which criminal charges will be filed or whether criminal charges will be filed at all. The DFR should have an agreement with the Prosecutor and knowledge of the documents

and procedures which the Prosecutor will request. All available evidence must be provided with the referral. Repayment of a claim must never be discussed with the AG pending the outcome of the Criminal Court action therefore; claims intended for prosecution should not be opened until adjudication is completed.

Once the decision has been made to refer the claim(s) for prosecution, 'prosecutor information' must be entered on BVRC. Then change the claim status from 'PD' (pending) to 'RP' (referred for prosecution). When the adjudication process is completed, the results must be entered on BVRC and the claim is opened (established) by changing the status to 'OA" (open awaiting client response).

A specific criminal statute exists for acts of welfare fraud committed September 1, 1984 or after, and is applicable for all programs. There are five separate areas of welfare fraud and abuse listed.

The accused person must knowingly or intentionally:

Obtain public relief (or assistance) by impersonation, false statement or other means;

Acquire, possess, use, transfer, sell, trade, issue or dispose of public relief or an authorization document used to obtain public relief;

Use, transfer, acquire, issue or possess a blank or incomplete authorization document to secure public relief;

Counterfeit or alter an authorization document to receive public relief or use, transfer, acquire or possess a counterfeit or altered authorization document; or

Conceal information for the purpose of receiving public relief or assistance.

4610.20.00 EVIDENCE USED TO SUBSTANTIATE FRAUD

When preparing a case for a court, evidence is necessary in order to prove the DFR's allegation of fraud. Evidence can include written records or statements or verbal testimony. Information received through Data Exchange is not verified unless the agency providing the information is the source of the payment. It is necessary to secure verification directly from the employer, bank or other source of the income.

It is also necessary to prove the intent to fraud. Verification that the AG member understood his responsibility for reporting the information in question may

be used to substantiate intent. This verification could include:

The completed Rights and Responsibilities form;

The signed application;

Previously submitted Change Report forms; or

Recorded and/or verified instances of other changes reported by the AG which could or did affect the benefits received.

An application or Change Report form submitted during the period fraud is suspected which omits the information that resulted in the over issuance may be used to substantiate intent.

Recorded instances which indicate that the AG visited/called the office during the period fraud is suspected and did not report the change which resulted in over issuance may be used to substantiate intent. These instances might include a record of the dates benefits were issued to the AG, redetermination interviews with applications, signed Notice of Rights and Responsibilities or Personal Responsibility Agreement, or reports of beneficial changes but not the adverse change.

These examples are not all inclusive; other types of evidence of intent may also be used.

4610.25.00 COURT DETERMINATION OF FRAUD

Fraud must be determined by a court of appropriate jurisdiction. This may be through criminal court. The court may designate a repayment schedule. This schedule may be in conjunction with probation. If this occurs the judge may order repayment be made through the County Court or probation system. If the ordered restitution is less than the claim, unless the court order strictly forbids any further collection after the restitution is paid, the balance should be collected. Court Probation (CP) must be entered on BVCP under "repayment method".

Since June 1999, Small Claims Court can no longer be used to determine fraud but it can be utilized to assist in collection efforts (See Section 4635.25.00). If there is a judgment from Small Claims Court, "SC" must be added on BVCP under "repayment method" (see Section 4635.40 for more information).

4620.00.00 COMPLETING THE BENEFIT RECOVERY REFERRAL

Once it has been determined that an over issuance referral is necessary and that the over issuance occurred within the appropriate time period as listed in the previous section, the eligibility worker is to complete the Benefit Recovery

Screen BVBR including the comments screen which is accessed by using the PF2 key. Refer to Section 4605.05.05, Eligibility worker Responsibility, as to the necessary information which must be entered on the comment screen. If incorrect dates are entered, the BV worker can correct these dates later on BVRC.

4620.05.00 ASSIGNING THE REFERRAL TO THE BENEFIT RECOVERY WORKER

After a BV referral has been made a task is generated for a BV worker. All claim referrals are to be assigned to a worker within ten working days of the referral being made.

4620.05.10 Total Ineligibility

Failure to meet certain eligibility requirements will render an AG totally ineligible, thus negating the necessity for individual monthly calculations. These eligibility factors are:

State residency;

Excess resources;

Excess gross income;

Entire AG made up of individuals who fail to comply with SSN requirements;

AG's refusal to provide requested information/verification (use Form 2244) concerning AG composition, income, or resources.

4620.35.00 DETERMINING THE AMOUNT OF OVERPAYMENT (MED)

The total amount of Medicaid benefits paid during a period in which the AG was ineligible for MA is recoverable from the recipient or his estate.[1] For a member who was covered in a managed care program, this would be the monthly capitation paid by the state for each ineligible month, not the paid claims. (For information regarding the filing of a claim against an estate, refer to Section 4650.00.00) Recovery can be pursued even when there is no suspicion of fraud. Medicaid benefits paid in error pending receipt of a hearing decision are to be recovered.

A recipient who acquires excess resources is totally ineligible. The amount which is recoverable is the total

[1] IC 12-15-2-19

Medicaid expenditures for the month in which the recipient was ineligible.

An overpayment of Medicaid benefits may occur as a result of budgeting an incorrect amount of income; however, consideration of the income may result in the imposition of or increase in spend-down or liability rather than total ineligibility.

The calculation of the Medicaid overpayment is done off-line. However, BVMC is available for the manual calculation of claim amounts when entering more than one month. The issued benefit amounts and the correct benefit amounts should be entered on BVMC. Press PF16 to have the system calculate and display the claim amount. This information is then entered into the system to proceed with the benefit recovery process.

For the individual whose liability should have been higher, the amount to be recovered is the difference between the correct and incorrect liability or the amount of Medicaid expenditures for the month, whichever is less. When entering liability/spend-down situations on BVMC, the order must be reversed. Enter corrected liability/spend-down amount in the "Issued" field and the previous amount in "Correct" benefit field.

For the individual whose spend-down should have been higher, the amount to be recovered is determined as follows:

(a) Subtract the incorrect spend-down from the correct spend-down.
(b) From that difference, subtract the individual's "out of pocket" expenses and his spouse's/parent(s)' out of pocket expenses incurred that have not already been entered into the system as non-claims.
(c) The resulting amount or the amount of the Medicaid expenditures for the month, whichever is less, is the amount to be recovered.

When requesting the claim history of all Medicaid expenditures the DFR should use State Form 6533 OMPP 1042 (revised 7-03) and follow the procedures below:

For medical expenditures involving recipient Third Party Liability (TPL), requests should be addressed to EDS, third party liability, PO Box 68762, Indianapolis, IN 46268-8762.

Requests for Medicaid expenditures involving recipient fraud, estate recovery and all other Medicaid expenditure requests involving reimbursement should be addressed to the Office of Medicaid Policy and Planning (OMPP) Attn: Estate Recovery, 402 W. Washington, Room W-382 MS 07, Indianapolis, IN 46204 (FAX 317-232-7382).

EXAMPLE 1:

The DFR verified that as of April the AG had $500 in excess resources, which had not been reported. As of May 1st, the AG's resources were within the resource limitation. Medicaid expenditures for April were verified to be $750. The amount to be recovered is $750.

EXAMPLE 2:

Based on the AG's reported income, he had a spend-down of $34. In March he began receiving rental income. This was discovered in July and a $100 increase in his spend-down was budgeted effective August 1st. Recovery is for the months of May through July.

Incorrect spend-down amount	$ 34
Correct spend-down amount	134
Difference	$100

Month	Out of Pocket Expenses			Medical Expenditures
May	5/11	- $10	- wife	$150
	5/20	- 25	- recip.pd.	
		$35		
June	6/10	- $40	- wife	$ 50
July	None			$200

For May:

$100 (difference between correct and incorrect spend-down)
- 35 (recipient's "out of pocket" expenses and his wife's expenses)
$ 65 (recovery amount because it is less than expenditures)
$150 Medicaid expenditures

For June:

$100 (difference between correct and incorrect spend-down)
- 40 (wife's expenses)
$ 60 (recovery amount)
$ 50 Medicaid expenditures; Recovery amount

For July:

$100 (difference between correct and incorrect spend-down)
The recovery amount is $100

The total recovery amount is $215.

4630.00.00 INITIATING COLLECTION ACTION

Collection activity will begin when the BV worker changes the status code on screen BVRC to OA, Open Awaiting Client Response. This will generate the demand notice (BV01) to the payee of the AG for repayment of the claim.

Claims against an AG with multiple claims will be collected in sequence. When a collection is received, the payment will be posted on the ‘‘01’’ claim until it is paid in full, then the ‘‘02’’ claim, etc. It is possible to rearrange the sequence for repayment on ICES screen BVCA.

4630.25.00 NOTIFICATION OF MEDICAID OVER ISSUANCE

After the benefit recovery referral has been investigated and established as a claim, code OA should be entered in the status field of BVRC to open the claim. When the code is entered the system automatically generates a notice of Medicaid over issuance (BVO1). The notice lists the amount of the overpayment, available repayment methods and appeal

4635.00.00 RECOVERY METHODS

Recovery of amounts of over issuance will be made by one or more of the following methods:

Lump sum and/or installment payments;

Interception of lottery winnings;

Federal pay and/or State tax refund interceptions; or

A combination of the above.

The BV worker must notify the overpaid AG of the amount and cause of over issuance as well as the various repayment methods available. This is done when opening the claim by putting it in 'OA' status on BVRC. ICES then generates the BV01, Notice of Overpayment. Sections 4635.05.00 through 4635.10.30 describe methods of repayment.

4635.05.00 LUMP SUM AND INSTALLMENT PAYMENTS

AGs will be given the option of repaying an over issuance either in a lump sum or in regular installments. This includes former AGs who are under court order to repay, as long as the order does not require repayment in a specific manner.

The BV unit will negotiate a payment schedule with the AG and accept regular installments for repayment of any amounts of the over issuance not repaid through a lump sum payment. Any payment will be accepted and credited to the claim, but unless the repayment plan is acceptable, it will not prevent the claim from being delinquent. Payments are due by the 28th of each month. If the minimum acceptable payment is not made by that date, the claim is delinquent. If the client has both a TANF and/or a Medicaid and a SNAP overpayment and does not specify to which claim a repayment should be applied, the payment is to be divided equally between each program.

Minimum acceptable payments will repay any claim within three years. Screen BVPC records lump sum and installment payments made by the individual against an over issuance claim. When the claim is paid in full, the system will automatically close the claim and send an alert to the worker. All payments can be seen on screen BVTH. Through screen BVTR, Financial Management can reverse any payment that has already been posted. For example, if an incorrect payment amount was entered by the Accounting Section, payment reversals entered on BVTR will automatically debit claim payments and adjust the claim balance.

4635.10.00 Social Security Benefits

Medicaid benefit recovery cannot be made from active members of RSDI or SSI benefits provided by the Social Security Administration. The federal government is only allowed to pursue garnishment of benefits in the following situations:

1) Payments for child support or alimony;

2) Payments for court-ordered victim restitution;

3) Levy for unpaid federal taxes.

4635.25.00 CIVIL ACTION

All steps necessary to institute civil action are taken when the BV unit determines that such action is required to recover over issuances from former AGs.

If a case is returned indicating that civil action cannot be taken against an AG, the BV unit will notify the referring caseworker that there is an unpaid over issuance which cannot be collected at this time. If the former AGs receive Food Stamp or TANF benefits at a later date, appropriate recoupment action must be taken.

4635.30.00 VOLUNTARY REPAYMENT/CIVIL RECOVERY

After determining that a Medicaid overpayment has occurred and repayment is appropriate, the DFR is to discuss with the AG the reason recovery is necessary and whether or not he will voluntarily make repayment. If the AG is willing to repay, he must sign a repayment agreement.

Cases are to be referred to Small Claims Court when AGs refuse to sign the repayment agreement or fail to make repayment within the specified period of time. The DFR must present to the judge all necessary evidence, including the legal basis, substantiating that benefits were paid incorrectly in behalf of the individual. Additionally, the DFR must present documentation showing potential sources from which recovery can be made.

Recovery cannot be made from SSI benefits provided by the

Social Security Administration.[2] However, Small Claims Court can still issue a judgment if the AG has no available income or assets or his MA case has been discontinued.

When the DFR receives a favorable judgment in a Small Claims Court, the judgment is to then be entered on the Circuit Court docket as a permanent court record since this is not done by a Small Claims Court. Through this recording an individual can be pursued on the judgment through a lien on real property.

The FSSA Office of General Counsel is to be consulted for specific information and/or assistance regarding Small Claims Court procedures and other legal matters which may arise when pursuing recovery.

4635.35.00 HEARING REQUESTED ON OVER ISSUANCE

When an AG requests a fair hearing regarding the circumstances of an over issuance, the amount of over issuance, or the repayment plan established by the BV unit, the Request for Hearing Screen HERQ must be completed. When the individual's request is in writing, a copy must be sent to Hearings and Appeals, 402 West Washington Street, Room E034, Indianapolis, IN 46204. A copy may also be faxed to 317-232-4412.

When an AG requests an appeal of the claim, the BV worker needs to code BVCP with a repayment agreement type of ‘‘AP’’ to show the claim is under appeal. When the hearing decision is issued, an alert will be generated so the worker is aware of the results. If the county is sustained, the worker will request a new notice be generated to the AG giving them another 30 days to sign a repayment agreement and make their first payment. If the county is not sustained, the claim will need to be terminated and any payments that had been collected will need to be refunded. The Administrative Law Judge may remand it back to the county to make adjustments in which case a new Notice of Overpayment (BV01) would be sent.

When the final hearing decision is received, repayment will begin the following month in the amount specified by the hearing decision.

4640.00.00 TRANSMITTAL OF REPAYMENT

Payments must be mailed to:

FSSA Claim Repayment
P.O. Box 1007
Indianapolis, IN 46262-1007

All checks or money orders should be made payable to ‘‘State of Indiana’’. The person’s name, claim number, RID number

[2] 42 CFR 433.36

or Social Security Number should be on the payment. The check and/or money order are receipts of payment. Financial Management will post all payments.

If no referral has been made prior to the repayment, an eligibility worker must complete the referral screen BVBR immediately so the claim can be established and repayments can be accepted.

4650.00.00 CLAIMS AGAINST THE ESTATE

Under the provisions of the Social Security Act (42 USC 1396p) the state is required to recover certain Medicaid benefits correctly paid on behalf of an individual from the individual's estate.[3]

The circumstances under which a recovery claim must be filed are explained in this and the following sections.

Upon the death of a Medicaid recipient, the total amount paid for medical coverage, except as explained in Section 4650.05 and Section 4650.20.10, is allowed as a preferred claim against the estate of such person in favor of the state. All assets owned by the deceased individual at the time of death, including both real and personal property, become a part of the estate, even if no probate proceedings are initiated in court. The estate does not include property held jointly with rights of survivorship, property held in trust, or life insurance proceeds paid to the deceased's survivors or other beneficiaries.

The claim provision is applicable to all categories of MA, including the categories providing limited coverage, except for SLMB (MA J) and QI (MA I and MA K). This exception applies to recipients who die on and after May 1, 1999 and is applicable to the state's payment of the Medicare premiums. Amounts paid for Medicare premiums under any MA Category will not be recovered from the recipient's estate. For recipients whose death occurred before October 1, 1993, the claim includes benefits paid for services provided after the recipient became 65 years of age. For recipients whose death occurs after October 1, 1993, the claim includes benefits paid for services provided

1) After the recipient became age 55 if the services were provided after October 1, 1993, and

2) After the recipient became age 65, if the services were provided before October 1, 1993.

In addition, a claim against the estate can be filed for the amount of Medicaid benefits "incorrectly paid" on behalf of

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[3] IC 12-15-9-1; Social Security Act, Section 1917(b)(1)

a recipient regardless of age.[4]

It is not required that there be a previous court judgment as to the amount of Medicaid benefits incorrectly paid. However, the existence of such a court judgment would expedite the probate proceedings when the claim against the estate is filed.

4650.05.00 NON-ENFORCEMENT OF CLAIM

If a spouse survives the recipient, recovery shall be made after the death of the surviving spouse. Only those assets that were included in the recipient's probate estate are subject to recovery after the surviving spouse's death.[5]

If the recipient (or the recipient's spouse upon his or her death) is survived by a dependent child, no recovery shall be made while the child is under age twenty-one (21) or is a dependent who is non-supporting due to blindness or disability by SSI standards.[6]

In addition a claim may not be enforced against the personal effects, ornaments, or keepsakes of the deceased.[7]

Resources that are protected under the Indiana Long Term Care Program (ILTCP) are not subject to recovery from the recipient's estate. Refer to Section 2615.25.15 concerning the ILTCP.[8] A claim may be waived if it is not cost effective to pursue the claim. If the cost of collection is equal to or exceeds the amount that can be collected, then it is not cost-effective to pursue the claim.

4650.10.00 FILING THE CLAIM

Estate administration may be accomplished using one of the following three procedures: supervised administration (the normal procedure), unsupervised administration, or by a "no administration" procedure. The process for filing claims depends on the type of estate administration procedures used.

When estates are administered under the supervised and unsupervised administration procedures, the probate court first appoints a personal representative to administer the estate. The personal representative then "opens" the estate. Once an estate is opened for probate, a notice to

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[4] IC 12-15-2-19

[5] IC 12-15-9-5

[6] IC 12-15-9-2

[7] IC 12-15-9-2

[8] 405 IAC 2-8-1(e)(2)

creditors is published in the legal notices of a local newspaper of general circulation. After published notification, there is a five-month period during which creditors of the deceased individual may submit claims against the estate. While the five-month time limit does not apply to governmental entities, it is important for the DFR to submit claims as soon as possible. The DFR should file the claim within five-months whenever possible.

A systematic and regular review of the legal notices and the probate docket of the county probate court are to be made by the DFR to ascertain whether or not an estate has been opened for any deceased MA recipients. As soon as the DFR learns that an estate has been opened, the DFR should initiate the process for filing a claim with the probate court.

Estates with a gross value under $50,000 and meeting certain other legally established conditions, may be settled using the "no administration" procedure. In these cases, there are no probate court proceedings, and a claim by small estate affidavit may be used to claim assets.

A claim by small estate affidavit cannot be made until forty-five (45) days have elapsed since the death of the decedent. The affidavit must be made by or on behalf of the DFR and state the following: 1)the value of the gross probate estate wherever located (less liens and encumbrances) does not exceed fifty thousand dollars ($50,000); 2) forty-five (45) days have elapsed since the death of the decedent 3)no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction; and 4) the claimant is entitled to payment or delivery of the property.[9]

When preparing a claim, the DFR is to request from the Office of Medicaid Policy and Planning (OMPP), via State Form 6533, Medicaid Expenditures Request, and the total amount of Medicaid expenditures paid on behalf of the individual. The address is: OMPP, ATTN: Estate Recovery, 402 W. Washington, Room W-382 MS 07, Indianapolis, IN 46204. The claim against the estate should be filed with the Clerk of the Probate Court as soon as possible. (However, when a small estate claim affidavit is used, it is presented to whoever is holding assets of the deceased, and is not filed with the Clerk of Probate Court). The form on which the claim is filed may be obtained from the

4650.10.05 Recovery from Special Needs Trusts

Funds remaining in a "special needs trust", as defined in Section 2615.75.20.05, are to be recovered after the recipient's death.

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[9] IC 29-1-8-1

These claims will not require the preparation of an affidavit or filing with the probate court. Because the terms of the trust require the trustee to pay any remaining funds to the state up to the amount of Medicaid expenditures, the state's claim is to be presented to the trustee for payment. This is accomplished by letter to the trustee signed by the local DFR office manager with documentation of expenditures attached. The claim includes all Medicaid expenditures on behalf of the deceased, regardless of age.

4650.15.00 OPENING AN ESTATE

If an estate is not opened and the heirs have no intention of doing so, any interested party (such as a creditor) may petition the court to open an estate and to request the appointment of an administrator. Prior to petitioning the court, these cases should be evaluated by the DFR in conjunction with an FSSA attorney, to determine if there are sufficient assets in the estate to offset the cost of opening and administering the estate. If not, opening an estate should not be initiated.

Cases in which there are sufficient assets should be referred to the FSSA attorney to prepare and file with the court, a petition to open an estate and appoint an administrator.

4650.20.00 PRIORITY OF THE CLAIM

Payment of debts from resources in the estate of the decedent is made in accordance with legally-established priorities. Priority in the payment of claims is important whenever the estate of the deceased is insolvent (such as when the total amount of all claims against the estate exceeds the assets of the estate). If the amount of the DFR claim is not satisfied in full after distribution of the estate assets, such debt must be considered cancelled.

The FSSA attorney should be consulted regarding the order of priority of the DFR claim in relation to that of other claimants.

4650.20.05 Compromise Of Claims

IC 4-6-2-11 provides "No claim in favor of the state shall be compromised without the written approval of the governor and the attorney general, and such officers are hereby empowered to make such compromise when in their judgment, it is the interest of the state so to do."

This applies to situations where the State agrees to accept less than the amount that is available and to which it is legally entitled. If the estate is insolvent and the State will receive the entire balance of the estate after payment of claims that have higher priority, that is not a

compromise and it does not require the approval of the governor and attorney general.

The settlement must be in the State's best interest. In most cases for which a compromise is approved, there is some reason that the claim would be risky to pursue. Some examples are when 1) another claim arguably has priority such as expenses of last illness, 2) there is a dispute as to the amount of the claim, or 3) the asset is a land contract or other asset that is not easily liquidated and the State agrees to accept cash in a lesser amount.

Procedure for Approval

The DFR or the FSSA attorney should submit to the Office of Medicaid Policy and Planning (OMPP), attn: Estate Recovery Specialist, in writing, the following information: 1) the amount of the claim, 2) available assets in the estate, 3) the proposed settlement, and 4) the reason for settlement, and 5) why it is in the best interest of the state to accept the settlement. OMPP will forward the information to the collection section of the attorney general's office for final action.

4650.20.10 Waiving Estate Claims For Undue Hardship

The Medicaid program's claim against the estate of a deceased recipient must be waived if enforcement of the claim would result in undue hardship for an heir.[10]

The decision to approve or deny an application for a waiver of the estate recovery claim will be made by the Office of Medicaid Policy and Planning based on information provided by DFR staff and the FSSA attorney in accordance with the following procedures.

1. At the time a claim is filed, a notice is to be included with the claim, explaining the undue hardship provisions and the process for applying for a waiver of the state's claim. An application (State Form 48259/OMPP 003) is to be provided upon request to an heir who wishes to apply for a waiver.

2. The hardship applicant will complete the form and return it, along with supporting documentation, to the attorney or designated local DFR office staff person. The applicant must indicate one of four situations as the basis for his claim:

    a. Enforcement of the state's claim will cause the applicant to become eligible for public assistance;

[10] IC 12-15-9-6; 405 IAC 2-8-2

b. Enforcement of the state's claim will cause the applicant to remain dependent on public assistance;
c. Enforcement of the state's claim will result in the complete loss of the applicant's sole source of income and the beneficiary's income does not exceed the Federal Poverty Level (FPL);
d. Other compelling circumstance (the applicant must describe).

3. If the applicant indicates only the last category, other compelling circumstances, the application is to be immediately forwarded to the Office of Medicaid Policy & Planning, attn: Estate Recovery Specialist, Indiana Government Center South, 402 West Washington St., Indianapolis, IN 46204. If any of the other three situations are checked by the applicant, the local DFR office must make the appropriate determination, attach all documentation to the application and forward it to the OMPP.

4. If the applicant specifies hardship category 2a or 2b, the DFR must determine if the hardship applicant would be eligible for TANF, Medicaid, Food Stamps, or SSI if he/she loses access to the asset(s) in the deceased recipient's estate. The caseworker's determination must show the eligibility result as if the applicant owned the asset and as if he did not own it. For example:

A recipient and his non-disabled son live together on a farm. The son works on the farm and his father shares the farm income with him. The property is in the recipient's name only and when he dies the property becomes subject to estate recovery. The son, who is beneficiary of the estate, applies for a hardship waiver claiming that without the income from the property, he will become eligible for Food Stamps. The DFR must make a Food Stamp eligibility determination. (The son does not need to actually file a Food Stamp application.) The caseworker determines that if the applicant were to own the farm, he would not be eligible for Food stamps due to the income he would have from the farm. Without the farm and its income, he meets Food Stamp eligibility requirements. Therefore, if the state enforces its claim against the estate, the son would become eligible for assistance.

In the above example, assume that father and son do not live together. The son is employed and he and his family receive Food Stamps. When his father dies, he files a hardship application claiming that if he could be allowed to inherit the farm he would no longer need Food Stamps. The

caseworker's determination shows that if he owned the farm he would lose Food Stamp eligibility.

The hardship applicant is responsible for providing all necessary verifications. Caseworkers should apply the usual verification requirements in a hardship determination, and inform the applicant in writing of the documentation that he must provide to substantiate the hardship claim. The caseworker will need to inform the applicant of the various types of acceptable verification; however, the responsibility for obtaining the verification rests solely with the applicant. The determination must be made within 30 days of receipt of the application and forwarded to the OMPP. If the applicant does not provide necessary verification within 30 days, the caseworker must indicate such in a letter accompanying the application to the OMPP. The letter should specify the verifications that the applicant failed to submit and a copy of the caseworker's notification to the applicant concerning the need for verifications should be included.

5. If a hardship applicant claims that his only source of income comes from the property in the estate, the caseworker must determine whether or not that income is less than the FPL. The standards effective 2/24/98 are as follows:

Family Unit	Annual Standard
1	$ 8,050
2	10,850
3	13,650
4	16,450
5	19,250
6	22,050
7	24,850
8	27,650
Each additional, add	2,800

For this determination, "family unit" is defined as a group of persons related by birth, marriage, or adoption who live together. In determining the amount of income to compare to the standard, the caseworker will consider: 1) gross income from employment, 2) all unearned income, and 3) net self-employment income and rental income in accordance with the methodologies used for the aged, blind, and disabled Medicaid categories. The applicant is responsible for providing the necessary verifications.

6. The Office of Medicaid Policy and Planning will make a decision to approve or deny the application and will issue a Notice of Action, State Form 48260/OMPP 0004, to the applicant within 45 days of the application date. A copy of the notice will be sent to the FSSA attorney. An applicant has the right to appeal the decision.

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4800.00.00 BURIAL ASSISTANCE (MED 1)

This chapter includes policy and procedures on the following:

Estate of the Deceased (Section 4805)

Maximum Payments for Burial Expenses (Section 4810)

Submission of Burial Claims to DFR (Section 4815)

Consideration of Burial Claims by DFR (Section 4820)

Verification by DFR of Burial Contributions (Section 4825)

Payment for Burial Expenses (Section 4830), and

Insurance Settlements (Section 4835)

Burial Assistance is available to recipients in the Medicaid Aged, Blind, and Disabled categories (MA A, MA B, MA D, MASI, MADW, or MA R) who die on or after 7-1-99. Burial Assistance is not available to recipients in the Disability Improved (MADI) category. It is 100% state funded. Recipients in any other Medicaid category are not eligible for Burial Assistance.

A recipient is eligible for Burial Assistance regardless of where their death occurs or whether the funeral and interment takes place in Indiana or elsewhere.

An individual who was receiving Medicaid for the Aged, Blind, or Disabled, at the time of death, or who applied for benefits prior to his death and was subsequently determined eligible for one of these categories, is eligible for Burial Assistance.[1]

[1] IC 12-14-17-2

4805.00.00 ESTATE OF THE DECEASED (MED 1)

The estate consists of all assets, including both real and personal property, owned by the deceased recipient. An estate need not be established by formal legal proceedings. However, the value of the estate may be established by FSSA and a determination made of the total amount payable for burial expenses.

4805.05.00 RESOURCES OF THE DECEASED (MED 1)

The resources of the deceased recipient, such as a burial trust, bank account, or personal funds remaining on account in a nursing home, shall be used to meet burial expenses. The funeral director and/or cemetery representative must obtain these funds as payment for burial expenses in accordance with Indiana Probate Code (IC 29-1-1 et seq.).

Nursing home administrators should be guided by their own legal counsel regarding the disposition of deceased residents' resources.

4810.00.00 MAXIMUM PAYMENTS FOR BURIAL EXPENSES (MED 1)

The maximum allowable burial assistance payments are $1,200 for the funeral director's expenses[2] and $800 for cemetery expenses,[3] for a total of $2,000. The age of the deceased is not a factor in the amount of any payment.

4810.05.00 PAYMENT FOR FUNERAL DIRECTOR'S EXPENSES (MED 1)

If there are no other resources, payment not to exceed $1200 (including sales tax) will be paid to meet the expenses of the funeral director.[4]

The funeral director's expenses include:

Reasonable expenses connected with preparation of the body, including cremation

Purchase of necessary clothing

Purchase of a casket

Funeral services

Transportation of the body, and

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[2] IC 12-14-17-2(b)
[3] IC 12-14-17-3
[4] IC 12-14-17-2(b)

Professional services of the funeral director

4810.05.05 Computation of Funeral Director's Payment (MED 1)

Relatives and/or friends may contribute as much as they wish toward the funeral expenses of the deceased recipient. However, all contributions and the resources of the deceased must be considered when determining the amount, if any, of the funeral expenses to be paid by the Division.

An amount of $1,750 in contributions and resources is exempted in the computation of the amount of the payment to the funeral director.[5] Contributions and payments made from the estate of the deceased recipient in excess of the $1,750 exclusion are subtracted from the statutory maximum of $1,200. The balance of the funeral director's unpaid expenses, up to the statutory maximum of $1,200, will be paid.

4810.05.05.05 Contributions/Resources Of $2,950 Or More (MED 1)

If all contributions, plus the resources of the deceased, total $2,950 or more, none of the funeral director's expenses will be paid.

4810.05.05.10 Contributions/Resources Of $1,750 To $2,950 (MED 1)

If all contributions plus the resources of the deceased exceed $1,750, but are less than $2,950, the $1,200 maximum payment from state funds to the funeral director will be reduced dollar for dollar by the amount in excess of $1750. The funeral director will be paid up to $1,200 or the amount of his unpaid expenses, whichever is less.

EXAMPLE 1:
Contributions = $1,850 Funeral Expenses = $3,000

$1,850 - $1,750 (exclusion) = $100
$1,200 (maximum payment) - $100 = $1,100

Payment to Funeral Director = $1,100

[5] IC 12-14-17-5

EXAMPLE 2:
Contributions = $1,850 Funeral Expenses = $2,000 - $1,850 paid = $150 still owed

$1,850 - $1,750 (exclusion) = $100
$1,200 (maximum payment) - $100 = $1,100

Payment to Funeral Director = $150
(Unpaid balance of funeral expenses.)

4810.05.05.15 Contributions/Resources Of $1,750 Or Less (MED 1)

If all contributions plus the resources of the deceased total $1,750 or less, the funeral director's payment will be $1,200 or the amount of his unpaid expenses, whichever is less.

EXAMPLE 1:

Resources = $1,750 Funeral Expenses = $2,200 - $1,750 paid = $450 still owed

$1,750 - $1,750 (exclusion) = $0

Payment to Funeral Director = $450
(Unpaid balance of expenses.)

EXAMPLE 2:

Contributions = $1,500 Funeral Expenses = $2,700

$1,500 - $1,750 (exclusion) = $0

Payment to Funeral Director = $1,200(Maximum)

4810.10.00 PAYMENT FOR CEMETERY EXPENSES (MED 1)

Cemetery expenses include all expenses connected with the interment of the body or remains in a cemetery, such as:

Purchase of a burial plot

Opening and closing the grave

Purchase of a cemetery vault

Purchase of a special wooden box or concrete slab when required by cemetery authorities

The cost of renting a lowering device, and

Tent and artificial grass, if required by cemetery authorities

Cremated remains must be buried in a cemetery in order to receive payment for burial expense. A cremation vault on its own will not be considered a cemetery expense. A signed burial transit permit must accompany all cemetery expense claims.

A monument or headstone is not considered a cemetery expense.

If there are no other resources, payment not to exceed $800 shall be paid to meet the cemetery expenses.[6]

4810.10.05 Computation of Cemetery Payment (MED 1)

Relatives and/or friends may contribute as much as they wish toward the cemetery expenses of the deceased recipient. However, all contributions and the resources of the deceased must be considered when determining the amount, if any, of the funeral expenses to be paid.

An amount of $400 in contributions from friends and/or relatives and resources of the deceased is exempted in the computation of the amount of the payment to the cemetery.[7] Contributions and payments made from the estate of the deceased recipient in excess of the $400 exclusion are subtracted from the statutory maximum of $800. The balance of the cemetery's unpaid expenses, up to the statutory maximum of $800, will be paid.[8]

4810.10.05.05 Contributions/Resources Of $400 Or More (MED 1)

If all contributions plus the resources of the deceased total $1,200 or more, the cemetery representative's expenses will not be paid.

4810.10.05.10 Contribution/Resources Of $400 To $1,200 (MED 1)

If all contributions plus the resources of the deceased exceed $400 but are less than $1,200, the $800 maximum payment from state funds to the cemetery will be reduced dollar for dollar by the amount in excess of $400. The cemetery representative's payment will be up to $800 or the amount of his unpaid expenses, whichever is less.

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[6] IC 12-14-17-3
[7] IC 12-14-17-5
[8] IC 12-14-17-3

EXAMPLE 1: Contributions = $500 Cemetery Expenses = $1,200 $500 - $400 (exclusion) = $100 $800 (maximum) - $100 = $700 payment to cemetery

4810.10.05.15 Contributions/Resources Of $400 Or Less (MED 1)

If all contributions plus the resources of the deceased total $400 or less, the cemetery representative's payment will be $800 or the amount of his unpaid expenses, whichever is less.

EXAMPLE 1: Resources = $300 Cemetery Expenses = $1,500 $300 - $400 (exclusion) = $0 Payment to cemetery = $800 (maximum)

4815.00.00 SUBMISSION OF BURIAL CLAIMS TO FSSA (MED 1)

Except as provided in Subsection 4815.05.00, the funeral director and the cemetery representative are to file separately for payment of the deceased recipient's burial expenses.[9] The form used for this purpose is State Form 35937 Medicaid Recipients Claim to Defray Burial Costs.

Effective July 1, 2014, any claim under this section must be submitted with the signed claim form and all necessary supporting documentation to the FSSA office within ninety (90)days of the date of death. Failure to submit all documents within 90 days of the date of death may result in denial of such claim by the FSSA.

4815.05.00 SUBMISSION OF CEMETERY CLAIM BY FUNERAL DIRECTOR (MED 1)

A funeral director may file and receive payment for cemetery expenses if he attaches proof to the claim that:

he is the cemetery representative, or

[9] IC 12-14-17-5

he has been designated such by the cemetery representative

In addition, the funeral director must attach a signed receipt verifying the cemetery expenses have been paid. If there was no charge for opening and closing the grave, a notation to this effect must be entered on the claim by the funeral director. If the funeral director is designated as the cemetery representative, cemetery claims submitted by any other party will not be paid.

4820.00.00 CONSIDERATION OF BURIAL CLAIMS BY FSSA (MED 1)

The payment of funeral and cemetery expenses is based upon the charges for burial expenses, the existence of other funds to meet such expenses, and the legal maximum payments from public funds. If other resources are determined to be available a summary of those resources should be listed on the reverse side of the burial claim form. The amounts paid by all other sources toward burial expenses should be verified by the FSSA before a recommendation for payment is made.

If the FSSA determines that payments made toward burial expenses are insufficient to cover the costs, and payment of the claim is to be approved by the FSSA, the FSSA Authorized Designee shall:

- Certify that State Form 35937 is in proper form and that the amount being recommended for payment is correct based on information submitted by the funeral director or the cemetery representative
- Sign the form, and
- file the original copy and submit a copy to Accounts Payable

4825.00.00 VERIFICATION BY FSSA OF BURIAL CONTRIBUTIONS (MED 1)

In the event inaccurate information was recorded on the funeral and/or cemetery claim regarding the amount of the individual contribution, the FSSA will follow up. If it is determined that there was collusion, misrepresentation, or apparent fraud on the part of the funeral director and/or the cemetery representative to obtain more payment, the FSSA will refer the case for prosecution.

4830.00.00 PAYMENT FOR BURIAL EXPENSES (MED 1)

Recommendations for payment of funeral and cemetery expenses of deceased recipients of Medicaid for the Aged, Blind, and Disabled (MA A, MA B, MA D, MASI), Disabled Working (MADW), or Residential Care Assistance Program (MA R) are to be

submitted for final approval to the Medicaid Medical Review Team, Office of Medicaid Policy and Planning, 402 W. Washington St.- MS07, Room 374, Indianapolis, IN 46204-2739. After final approval, claims will be submitted for payment to FSSA Administrative Services-Burials, 402 W. Washington St.- MS 29, Room E436, Indianapolis, IN 46204. Any business receiving payment from the Auditor of State must have a Vendor Information Form, State Form 53788 (R2/10-09), Request For Taxpayer Identification Number and Certification, on file in the State Auditor's office. If a business has never received payment through the State Auditor's office, a State Form 53788 (R2/10-09) W-9 must be attached to each business' initial claim form. Remittance will be made directly to the claimant.

Reimbursements of burial expenses are made to vendors by direct deposit in the account on file through completed vendor information form, State Form 53788 (R2/10-09).

4835.00.00 INSURANCE SETTLEMENTS (MED 1)

A surviving relative of a deceased recipient may be the beneficiary of a cash settlement from a life insurance policy on the deceased.

The insurance settlement is the income or resource of the surviving relative. However, if all or part of the insurance settlement is used to meet the burial expenses of the deceased recipient, the funds used for burial expenses are to be considered a contribution from a relative.

If the surviving relative is also an applicant or recipient, the insurance settlement may affect his eligibility depending on the program involved.

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5000.00.00 OVERVIEW OF SUPPLEMENTAL ASSISTANCE FOR PERSONAL NEEDS

Supplemental Assistance for Personal Needs payments, established by Indiana PL 294-2001, became effective July 1, 2002. With this enactment, eligible individuals residing in health care facilities could receive a supplemental payment from the state in an amount up to $22 per month.

Prior to October 2009, all SAPN payments were issued as checks (warrants). Payments were primarily made by direct deposit from October 2009 through December 2010 when the Auditor of State's Office authorized the return to issuance of payments by warrant (check).

5005.00.00 SAPN ELIGIBILITY

To be eligible for Supplemental Assistance for Personal Needs payments, individuals must be receiving Medicaid, residing in a Medicaid-certified health care facility throughout the calendar month for which the benefit is issued, and receiving a $30 reduced SSI benefit.[1] For recipients who no longer meet these qualifications, ineligibility begins the month following the month in which any one of these criteria is no longer met. A deceased SAPN recipient is entitled to payment for the month of the death.[2]

5005.05.00 BENEFIT CALCULATION

SAPN payments are not countable income in the Medicaid determination. The payments are not counted in the eligibility step or in the post-eligibility calculation of the liability.[3]

The SAPN benefit can range from $1.00 to $22.00 and is based on the calculation of budgeted earned and unearned income

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[1] 405 IAC 7-1-1(a), IC 12-15-7-1
[2] 405 IAC 7-1-1(e)
[3] IC 12-15-32-6.5, 405 IAC 7-1-1(b)

subtracted from the $52.00 Medicaid Personal Needs Allowance.[4]

5005.10.00 BENEFIT ISSUANCE

Recipients are eligible for SAPN payments beginning the later of the following: 1) the month in which their SSI is reduced from the community rate to the $30 amount allowed for SSI beneficiaries in health care facilities, or 2) the month after the individual's Medicaid eligibility has been authorized with a post-eligibility budget.[5]

The SAPN benefit amount determination and issuance authorization is accomplished systematically. The worker's responsibility with this program is to establish and maintain the Medicaid case properly.

To ensure proper and timely issuance of payments, adherence to the change processing guidelines in Chapter 2220.00.00 is essential.

5010.00.00 SAPN PAYMENT METHOD

Prior to October 2009, SAPN payments were issued to individuals as checks (warrants). Beginning in October 2009, the primary method of payment became direct deposit. Effective January 2011, with authorization from the Auditor of State's Office, FSSA Management Services reinstated paper (warrant) payments and terminated direct deposit for all SAPN clients.

5010.05.00 CHECKS / WARRANTS

SAPN payments are issued to the eligible individual. If the recipient elects to have payments sent to a Protective Payee, State Form 51042 (R/1-03) / FI 0045 – Representative Payee Agreement for Supplemental Assistance for Personal Needs must be completed and retained in the case file. Any other form is not acceptable to allow someone other than the eligible individual to receive the SAPN payment.

5010.05.05 LOST OR STOLEN WARRANTS

If staff is notified of the loss or theft of a recipient's SAPN check, first determine that the check was mailed to the correct address and that adequate time has been allowed for delivery. Once it has been confirmed that all information was

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[4] IC 12-15-32-6.5, 405 IAC 7-1-1(c)
[5] 405 IAC 7-1-1(d)

correct, sufficient time has been allowed for delivery, and the check cannot be located, FSSA Management Services is to be contacted.

FSSA Management Services must wait 30 days from the date the check was written before taking further action. If it is found that the check has not been cashed, Administrative Services staff will mail State Form 45735 – Affidavit for Lost or Not Received Warrant to the recipient or Protective Payee for completion. The form or any questions regarding this process are to be addressed to:

FSSA Claims Info
ClaimsInfo@fssa.in.gov
(317)233-4465 – Claims Line

To rewrite the check, the State Auditor's Office must receive the original affidavit. A photocopy or fax is not acceptable.

The recipient/Protective Payee should be informed that the affidavit must be completed and signed before a replacement warrant will be issued and that failure to immediately execute the affidavit will delay replacement.

Under no circumstances should the DFR refuse to allow a payee to execute the affidavit when he requests to do so. If fraud is suspected, DFR should conduct an investigation. However, the issuance of a replacement check is not to be delayed because of the fraud investigation.