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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.

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 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

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.

