Indiana Health Coverage Program Policy Manual

Chapter 3300
MEDICAID WAIVERS
Sections 3300.00.00 – 3380.20.00

Contents

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.[1] Sections 3305.00 through 3349.00 explain the eligibility requirements that apply to individuals who have been approved for HCBS.[2] 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 four home and community-based services (HCBS) waivers:

- Community Integration and Habilitation
- Family Supports
- Health and Wellness (formally known as "Aged and Disabled")
- Traumatic Brain Injury
- PathWays (formally known as "Aged and Disabled")

The Medicaid waivers each have a specific number of slots that can be filled in each 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 the level of care and cost comparison criteria to receive waiver services.

If an applicant/recipient is eligible for both a HCBS waiver and BPHC, then the waiver budgeting would apply.[3]

If the member fails the waiver budgeting, but qualifies for BPHC, and the member wishes to voluntarily withdraw from the waiver while pursuing the BPHC, then it is best practice to get the voluntary withdraw in writing. In this situation, members should be referred to their waiver care manager. The eligibility system will continue to build the waiver budget if the HCBS waiver is interfaced.

To qualify for services under one of the approved waivers, an individual must meet the waiver criteria above and 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 care 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 care managers. Waiver information can be found in the eligibility system. Medicaid eligibility for a person on a wait list or who will be placed on a wait list is determined by 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 people in moving from a nursing facility or hospital to a residential setting in the community.[4]

To participate in the MFP Program, the individual must:

- Have lived in a nursing facility or hospital for a certain period,
- 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 Developmental Disabilities, Health and Wellness, PathWays or Traumatic Brain Injury waiver.

The MFP Program will provide transitional services for 365 days, after which time, the Developmental Disabilities, Health and Wellness, PathWays or Traumatic Brain Injury 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 to receive waiver services. The permissible Medicaid categories for the waivers are:

- SSI (MASI)
- Aged (MA A)
- Blind (MA B)
- Disabled (MA D)
- MEDWorks (MADW, MADI)
- Low-income Caretakers (MAGF)
- Foster Care (MA 15)
- Children under Age 1 (MA Y)
- Children Aged 1-5 (MA Z)

- Children Aged 1-18 (MA 2, MA 9)
- Transitional Medical Assistance (MA F)
- IV-E FC Foster Care children (MA 4)
- Children in the Adoption Assistance Program (MA 8)

If an individual receives 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 are applicable.

Note that there are several Hoosier Healthwise (HHW) categories that are permissible for waivers. A child's waiver application should not be delayed pending a MRT determination if the HHW can be authorized. Unless specifically requested by the legal guardian, and if eligible, the HHW should be authorized and then the MA D can be explored. If the child is approved under a HHW category, the SIL budget will not be applied (see IHCPPM 3315.00.00).

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.[5] The SIL eligibility test applies to all the waivers. Refer to Section 3325.05.00 for SIL budgeting procedures.

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

- For the Community Integration and Habilitation, Family Supports, Health and Wellness, Traumatic Brain Injury and PathWays waivers, the applicant/recipient must pass the SIL test to be considered eligible for Medicaid.
- The spousal impoverishment protection resource provisions explained in Sections 2635.10.10 through 2635.10.10.15 are used if the waiver applicant/recipient has a community spouse. Spousal impoverishment protection is not used for any of the other waivers.
- 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.
- For children under 18 applying for a blind or disabled category, parental income is exempt in the SIL test and if the child passes the SIL test, parental resources are exempt. If Medicaid coverage is needed prior to the start date of waiver services, retroactive coverage can be approved using regular eligibility rules for those months, including parental deeming as appropriate for the child's category. If the parents

request Medicaid coverage to coincide with the waiver start date, the parents are not required to provide any information regarding their income or resources.

3320.00.00 RESOURCE LIMITS AND METHODOLOGIES

All 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 waivers listed in Section 3315.00.00.

An individual must pass the SIL test to be considered categorically eligible for Medicaid.

In determining whether spousal impoverishment protection applies in each 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 Health and Wellness, PathWays, Traumatic Brain Injury, or MFP services.

Example:
The married applicant was hospitalized on May 10 and then discharged on May 30 to a nursing home. The waiver was approved on December 1, and the member was released from the facility on the same day. The 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 date of the initial service plan approval (in the eligibility system, this displayed as *PEND FOR AID AND ELIGIBILITY*, 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. Trust is established for the benefit of a waiver applicant/recipient whose eligibility is being determined using the Special Income Level test. The terms of the trust must specify the following:

- The trust is to be funded only by the income of the individual including accumulated interest on that income.
- Trust will not be funded with the individual's resources, nor the income or resources of other people.
- 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 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 more than the SIL to become Medicaid eligible.[6] It is a statutorily permissible work-around of the inflexible income cap of the SIL. 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.

During a transfer penalty, waiver services are not paid by Medicaid or the waiver service plan; only state plan services, such as doctor visits, are reimbursed.

3325.00.00 INCOME ELIGIBILITY FOR HCBS

There are two eligibility budgeting methods that may apply to waiver applicants, depending on the type of waiver and whether the applicant is a child or an adult, single or married. These methods are the Special Income Level (SIL) test and regular budgeting.

A person whose eligibility is determined under the Aged, Blind, or Disabled categories must pass the SIL test to be considered categorically eligible for Medicaid. Children under 19 can qualify either under regular budgeting rules in a Hoosier Healthwise category or can be determined under the Blind or Disabled category.

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. The waiver liability 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 IHCPPM 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.

An applicant or recipient whose eligibility is 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. The income of parents and income of spouses is not included. The 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.

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.

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 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)
- The 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 provided by a certified or licensed medical practitioner which are not subject to payment by a third party and are not subject to payment by Medicaid are deducted, except for HCBS or nursing facility expenses incurred during an imposed transfer of property penalty. These expenses incurred during a transfer penalty are not allowed regardless of when the transfer penalty was imposed. See 3325.10.00 and 3455.15.10.20 for more information.

Services provided under an approved HCBS waiver care plan is to be billed through the Medicaid billing portal and any allowable expenses will be credited to the Medicaid waiver liability. These services include attendant care arranged and approved by the waiver case manager and/or

through the "Structured Family Caregivers" program. These types of expenses are not to be entered into in the Eligibility system as they will be credited to the liability through the automated billing system. [7]

If there are questions, please contact PAL.

Any amount remaining is the waiver liability amount, subject to all regular waiver liability processing.

3325.15.00 REGULAR BUDGETING

As of June 1, 2014, this section no longer applies.

3325.20.00 REGULAR DISABILITY VS MEDWorks

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 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 (BPHC)

Individuals who have severe psychiatric needs but can reside in the community rather than 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 each 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 have specific needs requiring the service as determined by DMHA.[8]

To be approved, an individual must meet the "BPHC" criteria described above and must meet Medicaid eligibility requirements.

If an applicant/recipient is eligible for both an HCBS waiver and BPHC, then the waiver budgeting would apply.[9] If the member fails the waiver budgeting, but qualifies for BPHC, and the member wishes to voluntarily withdraw from the waiver while pursuing the BPHC, then it is best practice to get voluntary withdraw in writing. Until the waiver is ended, the waiver budget will form. The individual should work with the waiver care manager to withdraw from the waiver.

3350.10.00 AGE REQUIREMENT

The minimum age requirement is 19 years[10].

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, MADW and frail only members on HIP (which would include MASB, MASP and MAPC).

Special eligibility rules apply in the Aged, Blind, and Disabled categories for waiver individuals and are explained in the following sections. A person determined to be eligible under another Medicaid category may receive BPHC services in that category. The special budgeting rules apply ONLY 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[11].

3350.25.00 INCOME AND BUDGETING

The income standard used for an individual eligible for BPHC is 300% FPL.[12] The special income standard used for BPHC 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 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 income earned.

- The total income earned (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 is $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 the individual's countable income is over 300% FPL, spousal impoverishment rules should be applied to potentially deduct the spousal and/or family allocations. 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)

The End-Stage Renal Disease program has expired as of 12/31/24. Members that were on ESRD will be explored for other categories of assistance.

The ESRD population in the demonstration was added in May 2014 to support Medicare beneficiaries in need of supplemental health care coverage. These beneficiaries were able to access kidney transplant and related services that they might not otherwise be able to afford without the additional supplemental benefits. However, there is a new Medicare Advantage enrollment option created by the 21st Century Cures Act allowing ESRD patients to enroll in Medicare Advantage which, unlike traditional Medicare Part A and Part B, acts as an "all in one" plan that includes prescription (Part D) coverage and in some cases additional benefits such as vision, hearing, and dental.[13]

3375.05.00 BASIC ELIGIBILITY CRITERIA

Individuals must meet all the program requirements to be eligible for the ESRD provision[14]:

- 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 dis-enrolled 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

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. Do not complete the ESRD workaround unless the person is at or above 150% of the FPL.

3375.20.00 REDETERMINATIONS

Members with non-MAGI income over 150% FPL, with no upper limit for members who were on Medicaid with a spend-down as of May 31, 2014, will maintain ESRD eligibility during annual redetermination if 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 spenddown as of May 31, 2014, will maintain ESRD eligibility during annual redetermination if 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

ESRD members will have a spend-down, not a liability[13]. Income for the ESRD member must be entered on the appropriate screens so that it is counted for other programs and family members. If eligible, ESRD members will qualify for spend-down spousal or dependent allocations. ESRD members fall under Indiana's 1115 demonstration and do not belong to the HCBS waiver group therefore MCCA provisions do not apply[14].

Any verified health insurance premiums or spouse/dependent allocation should be calculated and deducted from the overall spend down amount.

3375.35.00 ELIGIBILITY BUDGETING PROCEDURES FOR ESRD USING WAIVER LIABILITY RULES (MED 1)

This section is only applicable for eligibility determinations of ESRD.

The AG's financial eligibility is displayed on Eligibility Determination Budget screen 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 $20.00 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 income earned.
- Next, the total income earned (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 income earned by 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.

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 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.

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 will not form due to the institutional listing on living arrangement/domicile-details page—but normal purchase/prepare rules apply. If the correct AG fails SNAP eligibility, deny SNAP, and send a manual notice. If the AG passes, contact the Help Desk for further instructions.
The eligibility worker must determine spouse and child allocations. Because manual budgeting is used, any allocation must be added to the unearned income-details page for the spouse or child so it will correctly be included as countable unearned income for other programs. Allocations should not be added to MAGI Income-details page for the spouse/child. The same income will already be counted or not counted in their budget based on the tax relationship with ESRD members.

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). Do not complete the ESRD workaround unless the person is at or above 150% of the FPL.

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.

3380.00.00 PACE – GENERAL INFORMATION

The Program of All-Inclusive care for the elderly (PACE) serves people who are age 55 or older who are determined by the state administering agency to need the level of care required under the state Medicaid plan for coverage of nursing facility services.

The PACE applicant must be able to live safely in the community at the time of enrollment and must live in a PACE service area. PACE provides medical and support services to seniors with chronic care needs while maintaining their independence in the home.

The PACE program determines medical eligibility for PACE enrollees, and the DFR determines financial and non-financial eligibility under rules applying to institutional and waiver groups. A PACE participant's Medicaid health benefits will be delivered under managed care and not traditional fee for service (FFS). PACE members will not have a liability established.

If a PACE enrollee enters a nursing home, the PACE program pays for the nursing home stay and continues to coordinate the enrollee's care. If a PACE participant becomes eligible for a waiver or RCAP services, then the member is no longer eligible for PACE services.

The PACE participant can choose to disenroll from the PACE program at any time by contacting their PACE coordinator with disenrollment occurring at the end of the month.

PACE providers are required to submit verification to the DFR informing them that the individual is participating in the PACE program.

The information that they are required to submit includes:

- Name of participant
- RID
- Name of facility
- PACE Pre-Approval Date
- Date left the program (if applicable)

For those ongoing in another Medicaid category, when a member is enrolled in PACE, this is considered a category change request, and a MED 1 category change must be completed.

The only time a member should be added as PACE in the eligibility system is if there is verification from the provider in the case file of participation in the program or a record has been received on the interface.

If there are any questions, please submit them to PAL.

3380.05.00 AGE REQUIREMENT

The minimum age requirement is 55 years.

3380.10.00 PERMISSABLE PACE CATEGORIES

The permissible Medicaid Categories for PACE include MA A, MA B, MA D, MASI MADW, and MADI.

3380.15.00 RESOURCES

The resource limit for Medicaid recipients receiving PACE services is the same as the resource limit for MED 1 which is found under policy section 3005.10.00. The transfer of property

provision is applicable to applicants/recipients who are enrolled in PACE. Please see IHCPPM 2640.10.05.

If the PACE 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.

If the PACE 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 PACE 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.

3380.20.00 INCOME AND BUDGETING

PACE budgeting uses the same budget methods as HCBS waivers. See IHCPPM 3315.00.00 – 3325.10.00. The Special Income level equal to 300% of the SSI Federal Benefit Rate (FBR) is used and the Medicare Catastrophic Coverage rules (MCCA) apply.[14] The Personal Needs Allowance (PNA) will be equal to the Special Income Level (see IHCPPM 3010.20.15 and 3455.14.00).

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[1] IC 12-10-10-6
[2] IC 12-10-10-4
[3] Indiana State Plan Attachment 2.2-A, page 23
[4] P.L. 109-171
[5] 1902(a)(A)(ii)(V)
[6] Social Security Act at Section 1917 (d)(4)(B)
[7] 42 CFR 435.726 (c)(4)(ii)
[8] 405 IAC 5-21.8-4
[9] Indiana State Plan Attachment 2.2-A, page 23
[10] 405 IAC 5-21.8-4
[11] 405 IAC 2-1.1-6
[12] Indiana State Plan Attachment 2.2-A, page 23
[13] 42 CFR 435.121
[14] 1396a(a)(10)(A)(ii)(VI)
[13] Sec. 17006. Allowing End-Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan
[15] Indiana ESRD section 1115(a) Demonstration waiver extension approved July 28, 2016