Indiana Health Coverage Program Policy Manual
Chapter 3400 BUDGETING AND BENEFIT CALCULATION Sections 3400.00.00 – 3480.00.00

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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:

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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 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.

For MED 1, 2 and 4, 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. Current income can be used to establish retro eligibility, for MAGI only, when IEDSS forms such coverage.[3] Unless there is a significant difference in income received in the retro months, use current monthly income for retro MAGI coverage. If actual income is non-reflective of current or future income, LO may use annual earnings to calculate current monthly income. LO office must explain income calculations in case notes.

Note: For MAGI applications, if the applicant does not state/verify the income was different in the retro months, the verified income for the application month must be copied/entered for each retro month to avoid incorrectly determining eligibility for those months based on zero income. If a new job is reported on application and pay records are outside of retro months, the income for retro period is considered questionable. A 2032 should be mailed for prior and current employment income. If client is unable to get requested verification, a written statement is acceptable (Refer to 2025.05.05 and 2025.10.00). For non-MAGI groups, income for each month being determined must be provided.

When determining current monthly income, the DFR will include a prorated portion of the reasonably predictable increase in future income and/or family 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.

Note: MAGI income must be entered on applicable pages (i.e., Unearned Income, Earned Income/and/or Self-employment Income) and the MAGI Income Details page. Worker must select "Add MAGI Income" on the MAGI Income-Summary page for self-employment records to appear on the MAGI Income Details page. Workers should always review the Income-Summary and Income Details pages to verify that income amounts are captured accurately, prior to authorization.

Self-employment income for MAGI households considers net income. Business income and expenses should be requested and verified during application process and at redetermination, unless otherwise provided (Refer to 3410.05.00 and 3410.15.00).

IEDSS automatically calculates a monthly and annual amount based on values entered in amount and frequency fields.

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, daily, hourly, irregular, or one-time only.

Note: Annual frequencies of 10, 11, or 13 are available under MAGI income section only (Refer to 3405.10.05).

3405.10.00 BUDGET METHODS

Once the pay frequency and amount of income is determined, IEDSS calculates monthly income using the values entered in these fields. IEDSS defaults to a fluctuating budget method, unless members specifically request for income to be averaged at which time, IEDSS will use the averaging budget method.

The following sections list the IEDSS budget methods and the circumstances under which they are used.

3405.10.05 REGULAR BUDGET METHOD

The monthly income is calculated by values entered in the Frequency and Amount fields. Additional pay record details that impact income budgeting principles include, type, income date, amount, actual/anticipated, reason to exclude from average, and if applicant/member requested income to be averaged. Actual income refers to pay that have been received. Anticipated income refers to pays that must be projected.

Regardless of income type, the monthly amount is determined using the appropriate frequency conversion factor as follows:

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 semi-monthly is to be multiplied by 2.

The gross amount of income received quarterly is to be divided by 3.

IEDSS automatically calculates a monthly and annual amount based on values entered in the amount and frequency fields. Annual calculation includes 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.

Example:

Member 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 IEDSS uses the income received for the specific calendar year and then divides it by 12 months.

3405.10.10 FLUCTUATING BUDGET METHOD

Actual (all or some of pay records that have been received and verified) or Anticipated (used when income must be projected) income is converted to a monthly amount in IEDSS using the "fluctuating budget method" unless the client requests that the "averaging" method be used.

Fluctuating method:

IEDSS defaults to the Fluctuating Budget method unless Averaging Methods are selected. The actual or anticipated 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 payment that is unusually high or low, infrequent, or irregular should be excluded in the budget calculation. The budget factor "Excluded" needs to be entered for a pay which is not reflective of what is expected in the future.

The reason for exclusion MUST be documented in case notes and at least one pay must be budgeted.

3405.10.15 AVERAGING BUDGET METHOD

The Average 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, there are two or more months of history, and the AG chooses this option.

Note: IEDSS will only calculate income using this budget method if worker answers "yes" to the question: Did the client request their income to be averaged (located at the bottom of worksheet).

3405.10.20 PRORATED BUDGET METHOD

The Prorated budget method distributes an income over the period associated with the income or expense. Educational income is a common example of income which is often calculated using this frequency and budget method (Refer to 2810.40.00 and 3430.00.00). IEDSS automatically calculates monthly and annual income/expenses based on the frequency and amount.

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 are 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 started working, changed jobs, or has had a change in rate of pay. IEDSS uses Circumstances Start/Change Dates (CSCD), End, and/or Reported On dates to determine eligibility. Additional dates that must be updated include Client Became Aware of (cannot be a future date) and Verification Received on.

The CSCD date automatically pre-populates to the first of the month, three months prior to the month of application. When new income is reported, the CSCD should be changed to the start

date of employment. The Reported-On date pre-populates to the application date during intake. ***During intake, the application date should only be used if the income was reported on the application.*** If income is reported during the interview, the data collection date should be used; if member is reporting a change, the actual date change was reported should be used. The Date the Client Became Aware is the employment start or termination date. The Verification Received On date is a mandatory field and must coincide with application date during intake (if income was reported at interview) or physical date information was received.

If the person has just started to work, has an increase/decrease in income, or income has terminated, the CSCD should match the date of the actual circumstance start and/or change. Pay records should be entered as anticipated, actual, or excluded. Anticipated pay should be used when income must be projected. For example, applicant/member started a new job and has not received a paystub. Actual pay should be used when income has been received and verified. For example, member/applicant provided paystubs. Excluded pay should be used when member receives a partial pay. For example, applicant/member started working half-way through pay period.

The system automatically calculates the *actual* amount for the income "start month". If the beginning pay is not reflective of future months, that amount should be excluded from averaging income that is budgeted for ongoing months. Because all income received in the application month must be counted in the budget, it may be necessary to create a new worksheet for ongoing months. The type and pay frequency are mandatory fields. If all pays for 30 days are available income should be averaged for the month. If there are missing pay periods in the month, IEDSS will budget the actual income for that month. Normally, the most recent 30 days of income prior to interview should be verified. Additionally, all income in the month of application must be verified.

IEDSS will only apply the conversion factor if income is received for every frequency in the month. If an individual does not have a pay record for one of the frequencies as due to employment beginning or ending, IEDSS will budget actual income for that month **(Example 2).**

- Note: For MAGI (MED 3) assistance groups, the 2032 request for verifications form instructs the applicant that if income was the same in the retro months as in the application month, it does not need to be provided. Workers should enter the same income for retro months if this is the case, so that retro months do not have zero income listed in error. If a new job is reported on application and pay records are outside of retro months, the income for retro period is considered questionable. A 2032 should be mailed for prior and current employment income. If client is unable to get requested verification, a written statement is acceptable (Refer to 2025.05.05

and 2025.10.00). For non-MAGI groups, income for each month being determined must be provided.

Example: 1

A client applies for HIP on 1/10 with a new app and reports a new a new job with start date of 1/5/22. Applicant will receive first pay on 1/22 and pay frequency is weekly. The worker verifies recipient will receive a partial pay of $50 and then $100 a week there after. The CSCD date on the {Person Information/Earned Income Details screen defaults date to the first of the month, three months prior to the Application File Date (10/1), Since income has been verified, but not received the anticipated amount, type, and frequency should be updated. The earned income work sheet should contain $50 for first payment and $100 for second payment. The number of hours and verification fields are mandatory and must be completed on the Earned Income Worksheet Details screen.

Income Date	Amount	Actual/Anticipated	Reason to Exclude	Number of Hours	Verification
1/22	50.00	Anticipated			Unverified
1/29	100.00	Anticipated			Unverified

January's budget will be $150 (50 + 100) and February and thereafter will be $430 (100 X 4.3)

If this same situation were new information reported at a 1/10 redet, these pays would then be listed as "Excluded" for the first pay and Anticipated for the second pay.

When there is a reason to exclude a paystub from ongoing monthly averaged budget, the reason must be manually entered. Pays that are unusually high, unusually low, or irregular may be excluded from ongoing budget.
While rare, the client could report at a 1/10 redet that he will be starting a job in February and will be paid bi-weekly with the only one check being received in late February. The worker would correctly project the one actual pay for February since the February budget is not in effect yet.

Income Date	Amount	Actual/Anticipated	Reason to Exclude	Number of Hours	Verification
2/22	200.00	Anticipated			Unverified

February would be budgeting $200 (actual), and March would be budgeting $430 (200 X 2.15).

Note: For MAGI categories, in addition to entering income in the other appropriate screens (i.e., Unearned, earned income and/or Self-employment) worker will need to enter the income in the MAGI Income Details page.

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. Termination must be initiated on the Earned Income-Details page. Worker must indicate that employment has been terminated on the Earned Income Details page, which will automatically trigger the Earned Income-Loss of Employment/Strike page. Both sections must be completed using the correct dates. Final Pay amount and Final Payment date fields should only be completed when income has been reported as ended/terminated and the Final Pay amount should be included if the income is ending or has ended in the last three months.

Example: 2

The client goes into the office on 2/12 and reports on 2/10 that his job assignment ends. He provides a statement from employer dated 2/10. He will receive 3 pays-1/21-$200, 2/04-$200, and final pay of 2/18 $220. The Income /Worksheet Detail screens should be updated as follows:

CSCD: 2/10; Reported On: 2/12; Date Client Became Aware: 2/10; Verification Received On: 2/12; Final Pay Amount $200; and Final Payment Date: 2/18

Note: Only enter final payment date and amount if you have verification.

Income Date	Amount	Actual/Anticipated	Reason to Exclude	Number of Hours	Verification
1/21	200.00	Actual			Hard Copy
2/04	200.00	Actual			Hard Copy
2/18	220.00	Anticipated			Hard Copy

Worker will need to enter Termination date, Verification of Termination, and Verification Received date listed under the Earned Income-Loss of Employment/Strike page. If the Verification of Termination field is marked “unverified”, IEDSS will pend case for verification. Worker should review the Earned Income-Summary screen, Earned Income-Monthly page including the final budget that is built on the Earned Income-Payments page. These pages should be reviewed prior to authorization. For a HIP application dated in January, IEDSS would use the actual income of $200 for application month and use the conversion factor (200+220=420)/2x2.15=$451.50 for budget for February.

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.

Note: IEDSS does not allow for self-employment records to directly transfer to MAGI page. MAGI income must be entered on both the self-employment and MAGI pages.

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 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 receive a portion or all 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).

Self-employment income for MAGI households considers net income. Business expenses should be requested and verified during application process and at redetermination (unless otherwise provided) for all reported self-employment income. 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 the current business records indicates no substantial variance. If the previous year's tax return is not an accurate reflection of current income, the recent records are to be used to project the annual income.

When the individual is engaged in a new business, they must supply business records for their taxable year-to-date and annual income is to be projected.

When the member 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.

For information on how to budget seasonal self-employment income, see IHCPPM 2810.40.00.

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[5] (Refer to 2800 and 3460.05.00).

Net profit is the total income derived from a self-employment enterprise less allowable deduction.

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 the same types of income when determining total countable income.
Since MAGI is based on tax information, business losses:

1. Can only be applied to the income of the business itself if no tax return is furnished.

2. Can only be applied to income present on the same tax return if the tax return is furnished.

    • A job started after that tax return was filed or was for a person not included on the return should not have any loss deducted

3. Can in no case reduce the income to less than $0.

If a tax return is furnished to verify household income, the Adjusted Gross Income (AGI) located on Form- 1040 of that return should be used as the member's income. **The Adjusted Gross Income includes all sources of taxable income for the tax household, with allowed deductions already subtracted (including self-employment and all other income shown on separate tax schedules).** AGI should always be used in the calculation of MAGI income when it is available and current.

The Adjusted Gross Income Line found on the Form-1040 is unique to that tax year, therefore it is important that the correct line is used. The AGI line will include in the description: **This is your Adjusted Gross Income**. If the worker is still unsure which line is correct, the IRS website (www.irs.gov) can be used to confirm current and prior tax schedules including the line number which contains AGI information.

If the tax return includes MAGI exceptions for income (child support, veteran's benefits, etc.) or there are other questions, the worker can send the information to the policy answer line (PAL) to verify how to enter the information.

Note: Tax returns outside of 12 months from application or recertification date should not be used as current income. If current tax records are unavailable, current business records (income/expense for the last year) should be requested.

Examples:

- Steve, who is on HIP, is the sole owner of his own business and takes in $1,500 a month from the business. He is not making a net profit and is losing $500 per month. His total countable income is $1,000.
- John, who is on HIP, is the sole owner of his own business and takes in $500 a month from the business. He is not making a net profit and is losing $1,000 per month. His total countable income is $0.
- 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 aged 4. Neither child has income of any kind. Mary does not take in any money from her business, and it is losing $200 per month. The total countable income for MED 3 budgeting is $900 for each person because negative income cannot be subtracted from another AG. The income received for Mary would be $0 and you cannot subtract the -$200 loss from her spouses' income.
- Joe, who has a job he works that he earns $200 and has self-employment income of -$600. Since these two types of income are not the same, we cannot subtract the self-employment loss from the job income. Joe's countable income would be $200.

If it appears the budget is not calculating this correctly, send the case into the Help Desk/PAL for review.

3415.00.00 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 pay $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 farmland), 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.[4] Please, refer to Chapter 2810.30.00 and Section 3460.05.00.

Examples of rental expenses allowed under all categories include:

- Property taxes
- Interest payments
- Repairs
- Advertising expenses
- Lawn care
- Insurance premium for property only
- Trash removal expenses
- Snow removal expenses
- Water
- Utilities
- Other necessary expenses.

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
- 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

Perkins's loan (exempt income) $3000.00
Kiwanis Scholarship (non-exempt income) $3500.00

Educational Expenses

Tuition and Fees $4000.00
Books and Supplies $500.00
Transportation $100.00

Step One: Subtract expenses from exempt educational income:

$3000.00
- 4600.00
- $1600.00 (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 $2500.00 will be sent to Mr. Smith. $1000.00 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 $2500.00 available non-exempt income.

Step Three: Subtract the unmet expenses in Step One ($1600) from the remaining non-

exempt income:

$2500.00 available non-exempt educational income
- 1600.00 unmet educational expenses
$ 900.00 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, and books. 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. 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. Expenses for sports, games, hobbies, or non-credit courses do not qualify for the education credits or tuition and fees deduction, except when the course or activity is part of the student's degree program.[5]

3435.00.00 BUDGETING LUMP SUM INCOME

A lump sum is a non-recurring payment that includes such items as retroactive RSDI or VA benefits, refunds of Medicare Part B premiums, insurance settlements, and inheritances. An SSI lump sum is disregarded as income in the month of receipt.

For MED 1, 2 and 4 budgeting, 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. Any portion of the lump sum remaining after the month of receipt is a resource. Recurring lump sum payments are budgeted as income.

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 real property is sold on contract pursuant to a properly executed land sale contract, only the interest portion of the payments are counted as income[6]. When payments are received on a basis other than monthly, the interest payments 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 because 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 regarding 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 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.

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 too 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 non-recipient spouse of an applicant/recipient in compliance with a court order or Title IV-D are disregarded.

The eligibility budget is displayed on Non- MAGI Initial Budget page.

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.[7]

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.[8] 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).[9] 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 assumes 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.

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 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).[10] In order for a PASS to be approved, the DFR must submit a letter to the Central Office containing the following:

- 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 periods for the disregard must be documented in the case record. A Medicaid approved PASS is coded in IEDSS (Indiana Eligibility Determination Services 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 IEDSS (Indiana Eligibility Determination Services System) 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, childcare 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 workspace 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
- Transportation to and from work.

Examples of non-allowable expenses include:

- 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
- Items furnished by others that are needed 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 Income Deduction-Detail page 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:[11]

- 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

The above definition is also applicable when allocating from the spouse of the applicant/recipient to the spouse's biological or adoptive child. On Non-MAGI Initial Budget page, "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.[12]

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 who would have to be paid for otherwise.[13] 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.[14] Relationship-Summary page gathers information that identifies essential persons when the answer is entered on the Relationship-Details page.

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:[11]

- Living with the parent/s; 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).

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. If the newborn institutionalized child passes away prior to the 30th day of institutionalization, it is assumed to the child would have remained institutionalized for more than 30 days and the parent's income would not be deemed.

See IHCPPM 2406.20.10 regarding residency for individuals under 21 years of age.

The institutionalized child must have a valid MRT decision or Social Security disability determination.

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 (stepsibling 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. 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 the Non-MAGI Income Budget page.

3455.05.25 RESERVED

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 Non-MAGI Initial Budget page 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 persons 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 MEDWorks

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.

1. Determine the countable unearned income of the applicant/recipient.
2. Subtract the general income disregard.
3. Determine the earned income of the applicant/recipient. This is the gross income from employment and self-employment after deducting allowable self-employment expenses.
4. Subtract any remaining amount of the general income disregard from earned income.
5. Subtract $65, any impairment-related work expenses as explained in Section 3455.07.00, and one half of the remainder.
6. Add the amount determined at steps b) and e) to arrive at total countable income.
7. If the countable income does not exceed the MEDWorks 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 MEDWorks, 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 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.

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 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 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:

- 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 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.
- Dog Guide: The type of home modifications that are allowable is determined by whether the person works away from home or in his home.

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 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 cannot 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 MEDWorks (MED 1)

Premium Changes: When a MEDWorks 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 MEDWorks recipient and an increase in the premium are adverse actions requiring timely notice.

Category change to MEDWorks: When a Medicaid recipient in any other category becomes eligible for MEDWorks with a premium, it is an adverse action requiring timely notice. The current category will be closed, and the worker will conditionally approve MEDWorks. If a recipient in another category moves to MEDWorks with a premium prior to the adverse action date for the month, MEDWorks 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 $250.00 spend-down. He gets a job and MADW is authorized on 10/20, after the adverse action date. The premium is $69.00 effective 12/1. The worker must notify Jerry that his spend-down for November is $69.00, and then access CUMED to change it to $69.00.

Example 2:
Mary is receiving MA D with a $50.00 spend-down. She gets a job and MADW is authorized on 10/12, before adverse action date. Her premium is $69.00 effective 11/1. Her MA D closes 10/31 and MADW is conditional. She must pay her premium before 11/1 so that the Medicaid health coverage does not lapse.

3455.09.00 MEDWorks CONTINUATION WHEN EMPLOYMENT IS LOST

If a MEDWorks 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 MEDWorks coverage continuation.

MEDWorks 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 they are no longer working, the worker must ask him if them if they will remain attached to the workforce under one of the above circumstances. If the recipient is otherwise eligible, and states that they will participate in one of the workforce attachment activities, the worker is to enter the activity in IEDSS (Indiana Eligibility Determination Services System) 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, they are no longer entitled to MEDWorks. 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, they are not working, they are no longer eligible for MEDWorks. Eligibility under the other Medicaid categories must be considered.

3455.10.00 ELIGIBILITY UNDER THE SPEND-DOWN PROVISION (MED 1)

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

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 and German Reparations[12] Payments.

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. This applies to persons who pass the SIL Test and reside in a 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 MEDWorks recipient is subject to post-eligibility budgeting in a Medicaid certified facility, there is no premium charged, because a liability is applicable.

The rules for when to apply the Special Income Limit (SIL) are same for married or single applicants who meet any of the following criteria:

- Have been in a Medicaid-certified facility for at least 30 days
- Are expected to be in such an institution for at least 30 days
- Are approved for one of the HCBS Waivers listed in 3305.00.00.

The SIL budget should apply beginning with the month where a member had at least one day where they met A-C criteria (above), or the first month being explored for retroactive eligibility, whichever is later.

Liability will be applied as of the first month where the member was in the facility on the 1st day of that month.

For example, if a member entered a nursing facility on 09/15/17, a Medicaid application was submitted 12/01/17 and approved for all retro months. A zero liability would be displayed for 09/01/17 with the liability forming 10/01/17 ongoing.

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.

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.[13]
- 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 they are 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.[14]
- German reparation payments are exempt.[15]

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 member's non-exempt income.

The standard personal needs allowance (See IHCPPM 2840.10.10 and 3010.20.10) is deducted and can be spent by the individual in any way the member chooses.

An additional amount may be deducted in the specific situations explained below:

- 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 members 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 members 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 member provides documentation of the payment of the annual tax liability on unearned income. Enter the amount paid as a deduction from income on the Income Deductions-Details page. 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 member pays for verified health insurance coverage (including Medicare prior to Buy-In) are deducted from the 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.

To be credited for the premiums, verification of the out-of-pocket premiums (such as a bill or bank statement) must be submitted to the DFR.

Premiums for indemnity policies are not allowed.

- Unpaid medical expenses provided by a certified 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. Medical bills that have been paid in full are not eligible for a liability deviation. For additional information, please refer to 3455.15.10.20.

Services provided under an approved HCBS waiver care plan are to be billed through the Medicaid billing portal and any allowable services 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 services are not entered into the Eligibility system as they will be credited to the liability through the automated billing system.

Allowable expenses include:

- Unpaid medical bills provided by a licensed medical provider that were incurred prior to Medicaid coverage
- Dental services not covered by Medicaid or other third-party insurance, such as dentures
- Audiology services and hearing aids if ordered in writing by a physician

Unallowable expenses include:

- Emergency response systems
- Special diets and nutritional supplements
- Medical bills that have been paid
- Assisted Living services, including room and board
- Ancillary charges which are additional fees for services that support a patient's care beyond room and board. Some examples of these charges include items such as Kleenex and gloves.

- Non-medical home care such as companions, attendants, and homemakers which have not been deemed medically necessary under the waiver care plan

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 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.[16] 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 they are 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 Earned income-payment page. 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. IEDSS (Indiana Eligibility Determination Services System) will then compute the earned income to be counted in the post-eligibility budget. It will be displayed as earned income on post eligibility page.

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 or an applicant/recipient who is on a home and community-based services waiver with a

community spouse[1], 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 IEDSS (Indiana Eligibility Determination Services System) screens.

The total gross income of the community spouse is established.

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 as described below.

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 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 based on 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. 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 or HCBS waiver 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. All spousal support court orders must be sent to PAL for review.

If a hearing decision results in a revision of the spousal allocation, the additional amount must be budgeted if the exceptional circumstances upon which the increase is based continue to exist. Refer to Chapter 4200 regarding appeals.

The spousal allocation from the institutionalized or HCBS waiver recipient spouse's income will be budgeted only to the extent that it is made available to the community spouse. In situations where the community spouse is the applicant/recipient, the amount of the total allocation will count as income in the budget, this could cause Medicaid ineligibility for the community spouse.

The spousal allocation is displayed on the Eligibility budget screen.

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 or HCBS waiver applicant/recipient if they live with the community spouse and would be entered on the Person Household Summary screen. [2] (The allocation is deducted from the institutionalized or HCBS waiver applicant's/recipient's income regardless of whether it is 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 aged 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:

1. 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.)
2. Divide the difference by three. The resulting amount is the family allocation.
3. 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 or HCBS Waiver applicant/recipient.

3455.15.10.20 LIABILITY DEVIATIONS (MED 1)

The policies in this section apply to the MA A, MA B and MA D categories of assistance.

A liability deviation allows unpaid medical expenditures, which are not covered by Medicaid or other third-party insurance, to be entered as a countable expense and temporarily lower the

liability amount. Upon approval of a liability deviation request, the liability will be reduced giving the member the opportunity to pay the unpaid medical expense.

Members potentially eligible for a liability deviation include those who have a liability obligation and:

1. Reside in a facility that provides 24-hour medical care for those with significant complex medical needs (this does not include room and board for Assisted Living or other such facilities)
2. Are on an approved HCBS waiver

A member who does not have a liability obligation is not eligible to receive a liability deviation.

Documentation of the unpaid medical expenses is required and must include an actual provider generated bill, or a copy of such bill, which details the date(s) of service, type(s) of service, and clearly shows the amount that the member owes after any third-party payment, including Medicare. A medical expense which is already paid in full or was previously approved for a deviation cannot be deviated. The bill must clearly indicate who is responsible for the cost. If the member is not the party responsible, the liability deviation is not allowable.

If the dates of services for Medicaid covered expenses were during a month the member received Medicaid, the liability deviation cannot be approved. However, if a member was in a LTC facility and was on HIP, a deviation may be completed for medical expenses incurred in a retro month that the member was eligible for HIP coverage, if the claim was not a HIP covered service. Verification that HIP denied the claim is required. See section 2220.05.00 for additional information.

If the dates of service on the bill were during a transfer of property penalty period, the deviation request cannot be approved. Furthermore, if the member is currently in a transfer of property penalty period, a deviation is not allowable. See Section 2640.00.00 for additional information.

If the member has any Third-Party Insurances, including Medicare, who were not payors on the bill, verification from the insurer, which clearly documents the reason for non-payment, is required. Acceptable verifications include an Explanation of Benefits (EOB) documenting denial of payment or, in cases where the provider did not bill the insurer, documentation from the insurer showing that the specified services are not covered.

When documentation is missing or incomplete, the worker must send a written request which clearly advises the member, and their authorized representative(s) of the information needed and gives a deadline of 13 days from the date the request is mailed. The worker shall attach a copy of the submitted deviation request to the Pending Verifications for Applicants/Recipients (DFR Form 2032).

If the member refuses or fails to provide the requested documentation within the designated 13-day period, the worker will, on the first day following the expiration of the 13-day period, mail a

manual notice which indicates the reason for denial of the deviation request. Medicaid eligibility shall not be discontinued for failure to provide necessary documentation related to a deviation request.

If the requested information is provided, and deemed valid, the worker will take appropriate action to process the liability deviation. A deviation request calculator is available for worker use in *IEDSS Online Help* under Resources. A liability deviation is calculated as follows:

1. Divide the total allowable expense amount by the member's current liability amount to arrive at the length of the deviation. The number before the decimal is the total number of months where the member will have a $0 liability, also referred to as "whole months."
2. Multiply the whole number of months by the member's current liability amount to arrive at the amount of the expense that will be paid in the months with $0 liability.
3. Subtract the amount of expenses that will be paid in the whole months from the total allowable unpaid expense amount. The remaining amount of the expense will be used to reduce the liability for the final deviation month, also referred to as "partial month."

Liability deviations are processed according to change reporting guidelines and are regarded as a positive change. The effective date of the change is the first of the month following the month in which the change was both reported and verified. If the Eligibility System does not form the correct reduced liability of as of the first following month, then the case should be reviewed for a possible liability override or fiat. Refer to sections 2220.00.00 through 2220.20.00 for additional information. Once the liability deviation has been processed and the change authorized, the worker must send manual notice indicating approval of the liability deviation request.

Examples of allowable medical expenses that can be deviated include (but are not limited to):

- Room and Board for nursing home level care
- Unpaid medical bills incurred prior to Medicaid eligibility

Examples of nonallowable medical expenses include (but are not limited to):

- Ancillary services or products, such as gloves and tissues
- Long term care services during a transfer of property penalty period
- For HCBS waiver members, non-medical care such as companions, attendants and homemakers that are not deemed medically necessary under the waiver care plan
- Copayments for dual eligible members
- Over the counter medication
- Medical bills already paid by the applicant, member or a third party
- Assisted Living expenses

Any questions about validity of a liability deviation should be sent to PAL for review.

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 RCAP RELATED MEDICAID (MED 1)

The income standard used in determining eligibility for MA R is 100% the FPL and are the same as those listed in section 3010.20.05 and 3010.20.05.05.

The resource limits used in determining eligibility for MA R are the same as listed in section 3005.10.00.

When the worker determines that the individual is eligible for RCAP, a "Y" should be entered in the correct field on the Living Arrangement/Domicile – Details screen.

On Living Arrangement/Domicile – Details screen enter "N" in the response field for the question regarding Medicaid certification of the institution, since an RCAP facility is not Medicaid certified. The liability to the RCAP facility is not a Medicaid liability and is not computed by the eligibility system.

3455.25.00 BUDGETING INCOME-IN-KIND (MED 1)

The policies stated in this section apply only to the MA A, MA B, and MA D categories of assistance.

When someone pays for all the applicant's/recipient's 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. The federal benefit rate for SSI can be found at https://www.ssa.gov/oact/cola/SSIamts.html.

Gift card/Gift certificates received by the applicant/recipient is income in the month received if it is used to purchase shelter; or can be resold. Any unspent balance remaining on a gift card/certificate is a resource beginning the month following the month the gift card/certificate was received[17].

3460.00.00 BENEFIT CALCULATION (MED 2)

If a refugee is ineligible for Medicaid under any other category, he could be eligible for Refugee Medical Assistance (RMA).

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 childcare 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.[18]

Monthly Employed Hours	Dependent Under 2 Years of Age	Dependent 2 Years of Age or Older
Over 129 Hours	$200.00 per member	$175.00 per member
129 Hours or Less	$199.00 per member	$174.00 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
- 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 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 parent's income is first used to meet their own needs.
- Any remaining parental income is then used to meet the unmet needs of his spouse in the AG.
- Any remaining income is then allocated equally between all the parent's dependents with unmet needs.
    - 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. 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)

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, MAGF, MAGP, MA E, MA O, MANA, MAPC, MARB, MASB, MARP AND MASP is based on the sum of the MAGI-based income of every member of the individual's MAGI household.

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 (children under 19 in the adoption assistance program), and MA 15 (former foster children 18-25). Income is not considered for these AGs.

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 stepchild(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. When one spouse is on an HCBS waiver or in a facility, the income and resources of the spouses will not be included in each other's MED 4 budget.

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.26

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. When the AG includes children and if the child's income is making the member over the standard, then the child's income is not counted in the AG. If the child's income is not putting the member over the MA L/J/I standard, then the child and their income is counted in the AG.

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.

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 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.[19]

There is no requirement to meet a spend-down in the month prior to entering 1619 status. Special 1619 Medicaid coverage continues if 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/IID, 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.[20]
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. IEDSS (Indiana Eligibility Determination Services System) 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:

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)
- 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
- 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 IEDSS (Indiana Eligibility Determination Services System).

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.

If an individual has applied for Medicare at the SSA but is not receiving Part B, Buy-In will be accomplished by the eligibility system in the usual manner.

The Medicare Part A Buy-In effective date is determined by the eligibility system. The QMB or QDW effective date established by the eligibility system also determines the Part A Buy-In effective date.

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[1] 405 IAC 2-5-1
[2] 405 IAC 2-5-1(b)
[3] 42 CFR435.603
[4] 42 CFR 435.603(e)
[5] https://www.irs.gov/credits-deductions/individuals/qualified-ed-expenses
[6] https://www.irs.gov/credits-deductions/individuals/qualified-ed-expenses
[7] 42 CFR 435.134
[8] Social Security Act (SSA), Section 1905(p)(2)(D) as amended by OBRA-90.
[9] SSA 1902(m)(2)(c)
[10] 405 IAC 2-3-3
[11] 42 CFR 435.403
[12] 1902(r)(1)of the Act
[13] SSA 1611(e)(1)(E)
[14] 38 USC 5503(d)

[15] SSA 1902(r)(1)
[16] IC 12-15-7-4
[17] 20 CFR 416.1103 (g)
[18] SSA (a)(8)(A); 45 CFR 233.20(a)(11)(i)
[19] SSA 1619(b)(3)
[20] SSA 1611(e)(1)(E)