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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:

- Income Budgeting Principles (Section 3405);
- Budgeting Self-Employment Income (Section 3410);
- Budgeting Boarder Income (Section 3415);
- Rental Income (Section 3420);
- Budgeting Educational Income (Section 3430);
- Lump Sum Calculation (Section 3435);
- Contract Sale of Real Property (Section 3437);
- Benefit Calculation (MED 1) (Section 3455);
- Benefit Calculation (MED 2) (Section 3460);
- Benefit Calculation (MED 3) (Section 3465);
- Benefit Calculation (MED 4) (Section 3470);
- 1619 Medicaid Budgeting (Section 3475); and
- Buy-In Procedures and Effective Dates (Section 3480).

3405.00.00 INCOME BUDGETING PRINCIPLES

Financial eligibility is based on the best estimate of income and circumstances which will exist in the month for which the assistance is being considered. This estimate should be founded upon the most complete information available to the DFR as of the authorization date. This eligibility determination requires knowledge of an individual's and/or AG's current, past or anticipated future circumstances. A presumption that current or historical trends will continue in the future cannot be made. Use of historical trends is appropriate if there is reason to believe, with supporting documentation, that the trends will continue.

Prospective budgeting rules require that the AG's assistance for a given month be based on the income expected to be received

during that month.¹ Actual income is budgeted for each of the three retroactive months prior to the month of application.²

For MAGI-based income methodology, when determining eligibility at initial application, financial eligibility is based upon current monthly income and family size. When determining current monthly income, the DFR will include a prorated portion of the reasonably predictable increase in future income and/or family size. The DFR must also account for a reasonably predictable decrease in future income and/or family size. At all other times (ex: Redeterminations), MAGI income should be annualized as much as possible.

To calculate monthly amounts, the frequency and budgeting method of the income must first be determined.

3405.05.00 INCOME FREQUENCY

Frequency is defined as how often income is received. Amounts may be received weekly, bi-weekly, semi-monthly, monthly, quarterly, semi-annually, annually, or less often than monthly.

3405.10.00 BUDGET METHODS

Once the frequency of an income is determined, the method of budgeting the amount is determined.

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

3405.10.05 Regular Budget Method

Regular income is income received in the same amount each pay period with no variances.

The monthly amount is determined using the appropriate conversion factor as follows:³

The gross amount of income received weekly is to be multiplied by 4.3.

The gross amount of income received biweekly is to be multiplied by 2.15.

¹ 405 IAC 2-5-1

² 405 IAC 2-5-1(b)

³ 405 IAC 2-5-1(a)(1)

The gross amount of income received semimonthly is to be multiplied by 2.

3405.10.10 Fluctuating Budget Method

Income which varies each pay is to be converted to a monthly amount using the "fluctuating budget method" unless the client requests that the "averaging" method be used.

Fluctuating (F) method:

The payments received during the months being reviewed are added together and the total is divided by the number of payments; then, the appropriate conversion factor as explained in Section 3405.10.05 is applied. A pay which is unusually high or unusually low should not be included in the calculation. The budget method "S-SKIP" should be entered for a pay which is not reflective of what can be expected to be received in the future.

If "S-SKIP" is used in an application month, the pay amount will be included for the application month calculation but will be skipped for months past the application month.

3405.10.15 Averaging Budget Method

The Average (A) budget method may be used with income received weekly, bi-weekly, semi-monthly or monthly. Averaging may only be used when complete monthly amounts are available and there are two or more months of history.

An AG has the option of choosing this budget method. However, if complete monthly amounts are not provided, it may not be used.

3405.10.20 Prorated Budget Method

The Prorated (P) budget method distributes an income over the period of time associated with the income or expense. This budget method is only used with the frequency LO - less often than monthly. Educational income is a common example of income which is often calculated using this frequency and budget method. This entry is used by the ICES calculator to determine how many months by which to divide the income amount. This budget method is not used for earned income.

3405.10.25 Beginning/Terminating Budget Method

Income is projected when an individual has just begun working, has changed jobs, or has had a change in rate of pay. If the person has just begun to work, verified earnings to the date of the budget computation are to be used. Otherwise, an estimate of anticipated earnings can be obtained and used as a basis for projection on a monthly basis.

When the 'B' budget method is used, that budget month will use all the 'B' income or expenses as actual 'B' amounts with no conversion. If the beginning pay is not reflective of future months, a new amount and budget method must be entered.

The 'B' budget method should only be used if all of the following 3 statements are true about the income (or expenses):

The job is a new job or the source of income is new, and

The income will not be received for every frequency (a full month's income) in the month the job/income source begins, and

The same month the income source begins also needs to have this income included (new job starts in October, income of new job is budgeted for October) in the budget for that month. This usually would occur at a new application point or for add a program.

3405.10.30 Annual Budget Method

The amount of money that an individual, business, or asset will earn over the course of a year. Annualized income can be calculated with less than 12 months of income because in some cases the client only works 8-9 months a year and the income is intended to meet the household's needs for the entire year. To calculate the annual income for the household you would add all the income received for the specific calendar year and then divide by 12 months.

EXAMPLE :

A client applies on 7/10 with a new app. and has a job where he will receive his first pay on 7/22. The worker verifies the information that the client will receive a partial pay of \$50 and then \$100 a week there after. The income on AEINC should be listed as follows:

RCVD DATE	FREQ	BGT MTD	GROSS AMT
07/22	WK	B	50.00
07/29	WK	B	100.00

July's budget will be \$150 (50 + 100) and August and thereafter will be \$430 (100 X 4.3)

If this same situation was new information reported at a 7/10 redet, these pays would then be listed as 'S' for the first pay and 'R' for the second pay since all 3 criteria for the 'B' budget method were not met. (3rd criteria not met as the July budget is already in effect without the new earnings.)

While rare, the client could report at a 7/10 redet that he will be starting a job in August and will be paid bi-weekly with the only one check being received in late August. The worker would correctly project the one actual pay for August since the August budget is not in effect yet and this situation meets the criteria for using the 'B' budget method. (Notice this is not a new application or add a program situation where most 'B' situations will occur.)

RCVD DATE	FREQ	BGT MTD	GROSS AMT
08/22	WK	B	100.00

August would be budgeting \$100 (actual) and September would be budgeting \$430 (100 X 4.3).

When an employed person loses his employment, which includes being laid off or on strike, an evaluation is to be made of the expected length of time without income.

If the period without income is expected to be at least one month, a new budget showing loss of income is to be computed.

This is done by using the 'T' budget method. No 'T' entry is ever carried into the budget beyond the month it was received.

EXAMPLE:

The client reports on 10/20 that he will only be working until the end of the month and will receive 2 more pays in November for \$100 each. The income should be listed on AEINC as follows:

RCVD DATE	FREQ	BGT MTD	GROSS AMT
11/1	WK	T	\$100
11/8	WK	T	\$100

If the worker authorizes this before the 11/1/ pulldown, the November budget will reflect \$200. If authorized after pull-down, no income will appear in the December budget. An auxiliary benefit would be needed for November (calculated manually).

3410.00.00 BUDGETING SELF-EMPLOYMENT INCOME

Self-employment budgeting procedures are outlined in the following sections. Self-employment income is generally determined by subtracting allowable expenses from the gross income.

3410.05.00 DEFINITION OF SELF-EMPLOYMENT

The determination of whether an individual is self-employed will generally be verified by federal income tax returns and there is no need to further question the existence of a trade or business. However, in some instances, it may be necessary to inquire further into the situation to determine if a person is self-employed when tax returns are not a definitive measure. Consider the following when determining that a person is self-employed:

The good faith intention of making a profit or producing income as a regular occupation;

The holding out to others as being engaged in a business of selling of goods or services;

The continuity of operations or regularity of activities;

The lack of an "employer" relationship in the regular sense of the word in which the employer pays wages and or provides benefits;

The existence of documentation in the person's possession that supports his or her claim of self-employment;

Being a member of a business or trade association;

A single factor is not always sufficient to determine whether a person is self-employed or not, nor must all of the above factors be met. Workers must apply the factors listed as well as others that may exist, to determine whether an income producing activity is self-employment. In some cases it may be necessary to distinguish self-employment from a hobby. Also persons working as contractors or subcontractors may or may not be self-employed.

A person is not self-employed if he or she receives a W-2 form showing wages paid, the employer pays FICA taxes, or the person is paid a salary from a corporation or individual.

Some business owners may pay themselves a wage as an employee and also receive a portion or all of the net profits gained from the business. When this occurs, it is necessary to separate the income received from wages as an employee of the company from the income received from the business profits (or loss).

The net profit from self-employment income may be determined through a review of past books or records of the previous year's Federal Income Tax Report.

3410.10.00 ESTABLISHING ANNUAL SELF-EMPLOYMENT INCOME

Current income from self-employment may be determined by using the individual's tax return filed for the previous year if a review of his current business records indicates no substantial variance. If the previous year's tax return is not an accurate reflection of current income, his recent records are to be used to project the annual income.

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

When he is engaged in a new business and records are not yet available or the business has been going on for some time but no records were kept, annual income is determined by using the

individual's best estimate. If approved for assistance, the individual must keep records and after no longer than two months actual income must be verified.

Seasonal self-employment income which is intended to meet the household's needs for only part of the year should be prorated over the period of time the income is intended to cover. For example, clients who are self-employed only during the summer months to supplement their annual income will have their summer self employment income prorated over the summer months.

Seasonal employment which is intended to meet the household's needs for the entire year, including self-employment, is annualized to establish a monthly amount.

3410.15.00 ALLOWABLE SELF-EMPLOYMENT COSTS

Examples of allowable costs for producing self-employment income are:

Wages, commissions, and mandated costs relating to the wages for employees of the self-employed;

The cost of shelter in the form of rent, the interest on mortgage or contract payments, taxes, and utilities;

The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments;

Insurance on the real and/or personal property involved;

The cost of any repairs needed; and

The cost of any travel required. Please, see IHCPMM 2810.30.05 for more information.

For all categories of assistance, except MA R and MA Q, allowable expenses include those allowable under the Internal Revenue Code from gross income.⁴

Please refer to Chapter 2800 and Section 3460.05.00.

⁴ 405 IAC 2-3-3; 42 CFR 435.603

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

If the self-employment costs are greater than the self-employment income, then the following rules apply:

- For MED 1, 2, 4: the countable income from self-employment is \$0. The loss cannot be carried over for the total countable income.
- For MED 3: MAGI budgeting allows self-employment losses to be carried over in the budgeting calculation for other income when determining total countable income. The total countable income, however, cannot be less than \$0.
 - o For example, Steve, who is the sole owner of his own business, pays himself a monthly wage of \$1,500 as an employee. His business is not making a net profit and is losing \$500 per month. His total countable income is \$1,000.
 - o For example, John, who is a sole owner of his own business, pays himself a monthly wage of \$500 as an employee. His business is not making a net profit and is losing \$1,000 per month. His total countable income is \$0.
 - o For example, Mary, who is the sole owner of her own business, is married. Her spouse receives \$900 per month for his Social Security Disability. They have 2 children, Courtney age 5, and Ben age 4. Neither child has income of any kind. Mary does not pay herself any wages as an employee. Her business is losing \$200 per month. The total countable income for under MED 3 budgeting is \$700 for each person. Because John is disabled, when determining his eligibility under MED 1 and before applying other deductions under MED 1 budgeting rules, his countable income is \$900.

3415.10.00 BUDGETING ROOMER AND BOARDER INCOME (MED 1, 4)

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

In a roomer and boarder situation, net rental income is determined by deducting allowable expenses (see Section 3420.05.05) proportionately to the number of rooms (excluding bathrooms) in a private house or by the number of people living

in the house. Examples of roomer and boarder situations are as follows:

The applicant owns a seven room house (excluding bathrooms) and rents one bedroom. The roomer pays \$100 a month. All allowable expenses equal \$400 a month. One-seventh of those expenses (\$57.14) is deducted from gross rental income. \$42.86 is budgeted as net rental income.

The applicant and his wife have a five room house (excluding bathrooms) and rent one room with meals provided. The roomer and boarder pays \$200 a month. Allowable income producing costs equal \$200 a month and food costs equal \$300. One-fifth of \$200 = \$40. One-third of \$300 = \$100. \$140 is deducted from gross rental income. \$60 is budgeted as net rental income.

3420.00.00 RENTAL INCOME

Rental income is payment for the use of real or personal property. Rental payments may be received for the use of land (including farm land), for land and buildings, for a room, apartment, or house, or for machinery and equipment.

3420.05.00 BUDGETING RENTAL INCOME

Rental income may be considered either unearned or earned income. Regardless, income from rental property is determined by the costs of doing business being deducted from the gross income.

For MED 2: Rental income is unearned unless the production of income includes some type of personal involvement and effort on the part of an AG member.

For MED 3: Rental income is either unearned or earned income. The income (or loss) is determined by allowable IRS deductions from the gross income.

For MED 1 and 4 (except MA R): Rental income is unearned income unless the AG owns multiple rental properties so that there is a rental business; that situation is considered self-employment earned income.

3420.05.05 Allowable Rental Expenses

Allowable rental expenses include costs allowed by the Internal Revenue Service.⁵ Please, refer to Chapter 2810.30.00 and Section 3460.05.00.

Examples of rental expenses allowed under all categories are:

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

The following examples are costs allowed by the Internal Revenue Service but not allowable under MA R and MA Q:

- Depreciation;
- Insurance to pay off the mortgage in the event of death or disability; and
- Capital expenditures.

3430.00.00 BUDGETING EDUCATIONAL INCOME

If an AG member has both exempt and non-exempt income (see Chapter 2860.05.00), allowable educational expenses are deducted from exempt income first. All remaining allowable expenses are then deducted from the non-exempt income. If any non-exempt income remains, it is prorated over the number of months it was intended to cover and counted as unearned income. **Note:** The second step only applies to non-exempt educational income received directly by the student. If the entire amount is received and retained by the school, it is completely excluded from the budgeting process. If the school receives the income directly and refunds any unused portion to the student, only the

⁵ 42 CFR 435.603(e)

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:

<u>Financial Aid</u>	<u>Educational Expenses</u>
\$3000 Perkins Loan (Exempt income)	\$4000 Tuition, fees \$ 500 Books, supplies
\$3500 Kiwanis Scholarship (Non-exempt income)	\$ 100 Transportation \$ (Actual)

Step One: Subtract expenses from exempt educational income:
\$3000
- 4600
- \$1600 (unmet educational expenses)

Step Two: Establish what portion, if any, of the non-exempt scholarship money is accessible to the student. It has been verified that the scholarship funds are sent directly to the school. The financial aid office verifies that a refund check for \$2500 will be sent to Mr. Smith. \$1000 of the total scholarship money is excluded from consideration since it was retained by the school and is not available to the recipient/student. This leaves \$2500 available non-exempt income.

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

\$2500 available non-exempt educational income
- 1600 unmet educational expenses
\$ 900 countable educational income is prorated over the month it was intended to cover and budgeted as unearned income to the AG.

3430.05.00 ALLOWABLE EXPENSES FROM EDUCATIONAL INCOME

Allowable expenses for undergraduates and graduate students include tuition, mandatory fees, supplies, books and transportation. Mandatory fees include the costs of rental or purchase of equipment, materials and supplies related to the pursuit of the course of study involved for all programs.

Transportation is allowed at 56.5 cents per mile if the actual cost cannot be determined.

Miscellaneous personal expenses (other than normal living expenses) are also allowable deductions if they are incidental to attending the school, institution or program. Such expenses could include such things as subscriptions to educational publications or dues for a professional association. Normal living expenses which are not allowable would include such items as food, rent, board, clothes, laundry, haircuts and personal hygiene items.

3435.00.00 BUDGETING LUMP SUM INCOME

A lump sum includes such items as retroactive RSDI or VA benefits, refunds of Medicare Part B premiums, and inheritances. A lump sum is considered as income in the month of receipt. An SSI lump sum is disregarded as income in the month of receipt.

The policies stated in this section apply to the MA A, MA B, MA D, MA G, MA L, MA J, and MA I categories of assistance.

For MED 3, under MAGI-based income methodology, an amount received as a lump sum is counted as income only in the month received.⁶

3437.00.00 CONTRACT SALE OF REAL PROPERTY

For the MED 1 and 4 categories, when property is sold on contract, the monthly land contract payments, less ownership expenses, are counted as income. Payments received on a basis other than monthly are to be prorated to establish a monthly amount.

For the MED 3 categories, any payments of interest and any gains on the sale received as a result of the sales contract (including that portion of any periodic payment) is to be budgeted as income in the month of receipt.

3455.00.00 BENEFIT CALCULATION (MED 1)

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

Eligibility for MA with regard to income is based on the countable income of the individual and his financially

⁶ 42 CFR 435.603(e)(1)

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. The individual with income in excess of the income standard will pass financial eligibility with a monthly spend-down. Effective June 1, 2014, eligibility determinations made for months on and after June 1 2014 do not include a spend-down. Instead, eligibility will be determined under 100% of the federal poverty level, refer to section 3455.10.30.

Beginning on June 16, 2008, a policy change was implemented relative to the eligibility determination for applicants and recipients with countable income in excess of the applicable income standard. There is no longer a requirement that the individual show proof of ongoing and or anticipated medical expenses as a condition of eligibility for Medicaid with a spend-down. Once approved for Medicaid with a spend-down, the recipient must meet the spend-down, as explained in Section 3455.10 in order for Medicaid to reimburse for services.

3455.05.05 Budgeting Income Of Applicant/Recipient And Spouse (MED 1)

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

The non-exempt income of the applicant/recipient and the non-exempt income of his spouse who is not receiving TANF are counted together in the eligibility budget computation. This does not apply when one spouse is in a long term care (LTC) facility or receiving HCBS waiver services; the spouses are budgeted separately in that instance.

When an applicant/recipient has stepchildren living in the home, his spouse's income must first be allocated to meet the needs of the spouse's own biological or adoptive dependent children who are under age 18 or students between age 18 and 21 who are not receiving TANF and who are living with the couple. The amount to be allocated is the income standard minus the child's non-exempt income. The spouse's remaining income is then combined with the applicant's/recipient's income in the budget computation. Income is not allocated from the income of the applicant/recipient to stepchildren.⁷ Income of a stepparent in the household of a child applicant/recipient under age 18 is deemed to the child unless the child's natural/adoptive parent is deceased or the couple is divorced.

Effective June 1, 2014, child support payments made by the spouse of an applicant/recipient in compliance with a court order or Title IV-D are disregarded.

The eligibility budget is displayed on screen AEBMB.

3455.05.05.05 Disregard Of RSDI 20% COLA In October 1972 (MED 1)

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

The amount of the 20% increase in Social Security benefits received in October 1972 under Public Law 92-336 is disregarded if, for the month of August 1972, the non-institutionalized applicant/recipient was a recipient of Old Age Assistance, Blind Assistance, or Disabled Assistance.⁸

3455.05.05.10 Disregard Of RSDI COLA In Transition Months (MED 1, 4)

⁷ 405 IAC 2-3-20

⁸ 42 CFR 435.134

The Cost of Living Adjustment (COLA) received annually in January by Social Security beneficiaries is disregarded until April of the same year for individuals eligible under MA L, MA J, and MA I.⁹ This disregard also applies to individuals eligible for MA A, MA B, and MA D that live in the community and whose income determination is under 100% of the federal poverty level (FPL).¹⁰ This results in the RSDI benefit increase coinciding with the income standard increase which occurs when the new Federal Poverty Guidelines are published. The months of the COLA disregard are referred to as "transition months".

NOTE: The April 1 date is based on the assumption that the Federal Poverty Guidelines are published as usual in February. If, in any given year the poverty guidelines are published in a month other than February, DFR will be notified of the transition months.

3455.05.05.15 Plan For Achieving Self-Support (PASS) (MED 1, 4)

The policies explained in this section apply only to the MA B, MA D, MA G, MA L, MA J, and MA I categories of assistance.

There are two kinds of Plans for Achieving Self-Support (PASS). One is an SSI PASS which is approved by the Social Security Administration for SSI eligibility purposes. The other is a Medicaid PASS which is approved by Office of Medicaid Policy and Planning, Medicaid Eligibility Unit, Central Office, for Medicaid eligibility purposes.

A PASS can be developed for an individual who needs to set aside a part of his income for a specified period of time necessary to achieve an occupational objective. The income could be used for current expenditures or saved for a later planned expenditure to achieve a work-related goal such as education, vocational training, starting a business, or purchasing work-related equipment.

For individuals in the MA B category (SSI recipients and non-SSI recipients) as well as non-SSI recipients in the MA L, MA G, MA J, MA I, and MA K categories, a PASS must be approved by the Office of Medicaid Policy and Planning (OMPP).¹¹ In order for a

⁹ Social Security Act (SSA), Section 1905(p)(2)(D) as amended by OBRA-90.

¹⁰ SSA 1902(m)(2)(c)

¹¹ 405 IAC 2-3-3

PASS to be approved, the DFR must submit a letter to the Central Office containing:

the description and objectives of the plan as discussed with the applicant/recipient;

the source and amount of all income and resources and what amounts of each are to be used in the plan;

the length of time the plan is to operate; and

any other pertinent information including documentation from the Social Security Administration of an SSI recipient's approved PASS.

This letter is to be prepared in triplicate, with two copies sent to the Central Office, OMPP, Medicaid Eligibility Unit, and one retained in the case record. The Central Office will forward a copy to the Blind and Visually Impaired Section of the Division of Aging and Rehabilitative Services for their recommendation. The Central Office will then review the self-support plan and recommendation from the Blind and Visually Impaired Section of the Division of Aging and Rehabilitative Services, and notify the DFR by letter of approval or disapproval. The DFR will then notify the applicant/recipient. If the plan is approved, the amount of income and resources disregarded and time period for the disregard must be documented in the case record. A Medicaid approved PASS is coded in ICES as PM.

In the QMB, QDW, SLMB, and QI eligibility determinations of SSI recipients who have a PASS approved by the Social Security Administration, a separate approval from the Central Office is not required. A copy of SSA's documentation should be obtained and filed in the case record. An SSI PASS is coded in ICES as PS.

A PASS under the MA B or MA D categories can be approved for a period not to exceed 12 months. For MA L, MA G, MA J, and OMA I the PASS exemption will be for at least 18 months and may be extended up to 36 months.

3455.05.05.20 Earned Income Deductions for the Blind (MED 1)

Effective June 1, 2014, this section is only applicable for the MA B category.

A deduction is allowed from the earned income of a person being determined under the Blind category for work-related expenses. Allowable expenses are those which are reasonably attributable to the earning of the income and which are not subject to reimbursement. Examples include:

- Medical services, equipment, and supplies which are not covered by Medicaid or a third party and are essential to enable the individual to work;
- Income and FICA taxes withheld from paychecks;
- Expenses associated with care and maintenance of a guide dog;
- Professional association dues;
- Union dues;
- Mandatory payroll deductions such as pension and disability contributions;
- Meals consumed during work hours;
- Work-related equipment specially designed to accommodate the person's visual impairment;
- Non-medical equipment/services including: air cleaners, air conditioners, child care costs, humidifiers, portable room heaters, posture chairs, safety shoes, tools used on the job, uniforms;
- Vehicle modification;
- Structural modifications to the individual's home to create a work space or to allow the individual to get to and from work;
- Training to use an impairment-related expense to an item reasonably attributable to work; and
- Transportation to and from work.

Examples of non-allowable expenses are:

- Those deducted another provision such as PASS;

- Life maintenance expenses such as meals consumed outside of work hours, self-care items which are cosmetic rather than work-related, general education development;
- In-kind payments;
- Expenses which will be reimbursed; and
- Items furnished by others that are needed in order to work

3455.05.05.25 Darling v. Bowen Special Income Disregard (MED 1)

A special income disregard must be allowed for certain widows(ers) who are receiving RSDI benefits. This disregard is the result of an order issued by the U.S. District Court in the case of Darling v. Bowen. A list of the individuals who were entitled to consideration under Darling v. Bowen was sent to the DFR on February 23, 1990. The disregard would have previously been applied to the affected individuals and is to be continued indefinitely. The disregard consists of the difference between the amount of the individual's RSDI benefit and the current SSI maximum benefit. It is entered on screen AEFUD as an unearned income deduction. If the individual has entered an institution, the special income disregard does not apply.

3455.05.10 Allocation To Dependent Child (MED 1)

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

An allocation is made to a dependent child living with the applicant/recipient if the child's income is less than the applicable income standard in Section 3010.20.05. A dependent child who has nonexempt income equal to or greater than the income standard is not considered in the budget computation.

A dependent child is the applicant/recipient's biological or adoptive child who:¹²

is under age 18, or a student between age 18 and 21 who is regularly attending a school, college, university, or course in vocational or technical training designed to prepare him for gainful employment; and

is not receiving TANF or Adoption Assistance.

¹² 405 IAC 2-1-1

The above definition is also applicable when allocating from the spouse of the applicant/recipient to the spouse's biological or adoptive child. On screen AEBMB, "eligible child" refers to one applying for or receiving MA under the blind or disabled category and "ineligible child" refers to one applying for or receiving MA under a category other than blind or disabled or who is not applying for or receiving MA.)

The amount to be allocated is the applicable income standard for the child minus the child's nonexempt income.¹³

If a student under age 22 has earned income, please, refer to IHCPM 2810.26.00.

3455.05.15 Allocation To Essential Person (MED 1)

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

An essential person is a person other than the applicant's/recipient's spouse or parent who is considered by the applicant/recipient to be essential to his well-being because such person provides services to the applicant/recipient which would have to be paid for otherwise.¹⁴ If a spouse or parent is in the home and able to maintain the home and care for the individual, an essential person cannot be considered in the budget computation.

An allocation is made to an essential person if his nonexempt income is less than the income standard in Chapter 3000.¹⁵ Screen AEIHH gathers information that identifies essential persons when "E" is entered in field TD/EP.

3455.05.20 Parental Deemed Income (MED 1)

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

Income is deemed from the non-recipient biological or adoptive parent's income when the applicant/recipient is:¹⁶

living with the parent; and

¹³ 405 IAC 2-3-20(b)

¹⁴ 405 IAC 2-1-1

¹⁵ 405 IAC 2-3-20

¹⁶ 405 IAC 2-3-19

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.

An allocation is deducted from the income of the parent to his spouse (the applicant's/recipient's stepparent) if the spouse has income of less than the income standard specified for a stepparent in Chapter 3000. The amount to be allocated is the income standard minus the stepparent's nonexempt income remaining after deducting an amount for the stepparent's child (step-sibling of the applicant/recipient) who has income of less than the income standard specified in Chapter 3000. An allocation is not deducted from the income of the applicant's/recipient's parent to the parent's stepchildren.

An allocation is deducted from the parent's income for a biological or adoptive nonrecipient child or child receiving MA under a category other than blind or disabled who:

is under age 18 or age 18 - 21 and a student;

is not receiving TANF or Adoption Assistance;

has income of less than the standard specified in Chapter 3000.

The amount to be allocated is the income standard minus the child's nonexempt income.

The general income disregard of \$15.50 is deducted after allocations to dependent children, first from unearned income and then from earned. Effective June 1, 2014, the general income disregard is \$20. After the earned income disregards are applied to the parent's earned income, the countable unearned and earned income are totaled and compared to the applicable income standard in Chapter 3000. If the parent's income exceeds the income standard, the excess is deemed as income to the child applicant/recipient. If two or more children are applicants/recipients, a proportionate share of the parent's

income is deemed to each. This budget is displayed on screen AEBMP.

**3455.05.25 Eligibility Budgeting Procedures for Spend-Down
(MED 1)**

This section will not be applicable for eligibility determinations made for months including June 2014 and thereafter.

The policies in this section apply to the MA A, MA B, and MA D categories of assistance for spend-down budgeting.

The AG's financial eligibility is displayed on screen AEBMB and is determined by application of the following procedures:

The nonexempt unearned income of the applicant/recipient is determined first.

The amount of the applicant's/recipient's unearned income is added to the amount of the spouse's unearned income remaining after any allocation to a dependent biological or adoptive child of the spouse is subtracted, as explained in Section 3455.05.05.

If the applicant/recipient is a child, any income deemed from his parent, as explained in Section 3455.05.20, is added to his own income.

The general income disregard of \$15.50 is subtracted. It is applied only once to a couple even when both members have income.

Allocations to dependent children of the applicant/recipient or to an essential person are then subtracted. The resulting amount is the countable unearned income of the applicant/recipient. If deductions are greater than the total unearned income, the remaining amount is deducted from any earned income.

Next, the total earned income (including self-employment) of the applicant/recipient (and spouse) is determined.

After subtracting any remaining allocations to a dependent child, the spouse's earned income is added to the earned income of the applicant/recipient.

Any remaining general income disregard is then subtracted.

Any remaining allocations to a dependent child or essential person are subtracted.

The earned income disregard of \$65, plus impairment-related work expenses (IRWEs) as explained in Section 3455.07, plus one-half of the remaining income is subtracted. The resulting amount is the countable earned income.

The countable unearned income is then combined with the countable earned income and any amount under an approved Plan for Achieving Self-Support (PASS) for a blind applicant/recipient is deducted.

The applicable income standard (individual or couple) specified in Chapter 3000 is subtracted.

If there is no resulting surplus income, the AG is financially eligible for assistance.

If there is a surplus, the amount of allowable health insurance premium(s), as defined below, is deducted and any remaining surplus, rounded down to the next whole dollar amount is the monthly spend-down. The spend-down amount without the health insurance premium deduction is referred to as the gross spend-down amount and the amount after the health insurance premium deduction is referred to as the net spend-down. Net spend-down is the amount known to the recipient as that is the amount he or she must meet in incurred medical expenses as explained in Section 3455.10.00.

Allowable Health Insurance Premiums:

Health insurance premiums incurred by the applicant/recipient and financially responsible relatives whose income is included in the budget are allowed. Financially responsible relatives are the spouse of the applicant/recipient, or, for the applicant/recipient who is a child under age 18, his or her parents.

Premiums for medical and or hospitalization coverage are allowed. This includes the amount of the verified non-covered portion of the Medicare Part D premium above the current Benchmark that is the responsibility of the applicant/recipient to pay. (Refer to Section 3041.00.00 for current Benchmark).

If the insurance premium includes AG members not eligible for the deduction and the eligible AG member's portion cannot be broken out, a prorated amount for eligible AG member(s) is allowed.

Premiums for health and accident policies such as those payable in lump sum settlements for death or dismemberment, or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled, are not allowed. The premiums paid for indemnity policies that do not limit benefits for the purpose of reimbursement of medical expenses are not allowed.

Effective June 1, 2014, eligibility determinations made for months on and after June 1 2014 do not include a spend-down.

3455.05.30 ELIGIBILITY BUDGETING PROCEDURES UNDER 100% FEDERAL POVERTY LEVEL (MED 1)

Effective June 1, 2014, the policies in this section apply to the MA A, MA B, and MA D categories of assistance.

The AG's financial eligibility is displayed on screen AEBMB and is determined by application of the following procedures:

The nonexempt unearned income of the applicant/recipient is determined first.

If the applicant/recipient is a child who receives child support income, the total amount of support received is reduced by 1/3.

The amount of the applicant's/recipient's unearned income is added to the amount of the spouse's unearned income remaining after any allocation to a dependent biological or adoptive child of the spouse is subtracted, as explained in Section 3455.05.05.

Child-support payments made a non-recipient spouse through a court order or made under Title IV-D are disregarded.

If the applicant/recipient is a child, any income deemed from his parent, as explained in Section 3455.05.20, is added to his own income.

The general income disregard of \$20 is subtracted. It is applied only once to a couple even when both members have income.

Allocations to dependent children of the applicant/recipient or to an essential person are then subtracted. The resulting amount is the countable unearned income of the applicant/recipient. If deductions are greater than the total unearned income, the remaining amount is deducted from any earned income.

Next, the total earned income (including self-employment) of the applicant/recipient (and spouse) is determined.

After subtracting any remaining allocations to a dependent child, the spouse's earned income is added to the earned income of the applicant/recipient. Any remaining general income disregard is then subtracted.

Any remaining allocations to a dependent child or essential person are subtracted.

The earned income disregard of \$65, plus impairment-related work expenses (IRWEs) as explained in Section 3455.07, plus one-half of the remaining income is subtracted. The resulting amount is the countable earned income.

The countable unearned income is then combined with the countable earned income and any amount under an approved Plan for Achieving Self-Support (PASS) for a blind applicant/recipient is deducted.

The applicable income standard (individual or couple) specified in Chapter 3010.20.05 is subtracted.

If there is no resulting surplus income, the AG is financially eligible for assistance.

3455.06.00 ELIGIBILITY BUDGETING PROCEDURES FOR M.E.D. WORKS

This section applies to MADW and MADI.

The procedures for determining financial eligibility are as follows:

Income of the spouse is exempt in the eligibility determination. If the applicant/recipient is eligible, the spouse's gross income is then counted in the premium calculation.

- a) Determine the countable unearned income of the applicant/recipient.

- b) Subtract the general income disregard.
- c) Determine the earned income of the applicant/recipient. This is the gross income from employment and self-employment after deducting allowable self-employment expenses.
- d) Subtract any remaining amount of the general income disregard from earned income.
- e) Subtract \$65, any impairment-related work expenses as explained in Section 3455.07.00, and one half of the remainder.
- f) Add the amount determined at steps b) and e) to arrive at total countable income.
- g) If the countable income does not exceed the M.E.D. Works income standard specified in Section 3010.20.20, the individual is financially eligible. If the countable income is more than the standard, the individual is not eligible.

Procedures for calculating the premium are as follows:

Income of the applicant/recipient and spouse is considered for the premium calculation. All income types exempted in the eligibility determination are countable in the premium calculation except TANF benefits. The premium is calculated by adding the unearned income, gross employment income, net self-employment income (amount after allowable self-employment expenses), and net rental income.

The chart in Section 3010.20.20 is used to determine whether the income is sufficient to require a premium, and if it is, the premium amount. For a single applicant/recipient, the family size of 1 is used, and for the applicant/recipient living with a spouse, the family size of 2 is used. If both spouses are applying for or enrolled in M.E.D. Works, the premium amount for a family size of 2 according to the income is used, and the premium is a "couple premium". This means that there is a single premium for the couple. This premium must be paid in order for both spouses to remain eligible.

**3455.07.00 DEDUCTION OF IMPAIRMENT-RELATED WORK EXPENSES
(MED 1)**

The policy in this section applies to MA D, MADW, and MADI.

A deduction from the earnings of the applicant/recipient in the eligibility determination is allowed for Impairment-Related Work Expenses (IRWE) under the circumstances explained in this section. In order to be allowed as a deduction from earned income the IRWE must be paid by the applicant/recipient and related to the employment of the applicant/recipient. An expense which is merely incurred but not paid is not allowable. An expense that has been, will be, or could be paid for by Medicaid, other insurance, or any other source including other state programs is not allowable.

Expense payments that are made less often than monthly are prorated. One-time expenses are distributed over the redetermination period. Verification of payment of IRWEs is required. Additionally, if there is any question or inconsistency concerning the person's need for a service which is being claimed as an IRWE, the worker can require verification of necessity from an individual knowledgeable of the situation.

Attendant care services.

Due to impairment(s), assistance is needed with personal functions in preparing at home to go to work, traveling to and from work, or while at work with personal or work-related functions. Payments made to a family member will be deducted only if the family member suffers economic loss by terminating employment or reducing hours of employment. (For this purpose, a family member is anyone, who is related to the applicant/recipient by blood, marriage, or adoption, whether or not the family member lives with the applicant/recipient.) Only the portion of the payment for attendant care services that is attributable to work-related expenses can be deducted. For example, an individual pays a personal attendant to help in preparing for work, doing light housekeeping, and assisting the individual in the evening with supper. The attendant works 8 hours a day, Monday through Friday, and 2 hours on Saturdays and Sundays. However, only 2 hours per day, Monday through Friday is spent on work-related assistance, that being the time in the morning preparing for work. Therefore, the allowable IRWE is the portion of the payment to the attendant for 2 hours of work per day, for 5 days a week.

Work-related equipment

Special equipment needed in order for the person to do his or her job. The equipment must be necessary due to the person's impairment, and be something that the employer is not required to provide in accordance with federal law to accommodate the person's disabilities.

Residential modifications

Dog Guide

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

For employment away from home, allowable expenses are those made for the outside of the home permitting the person to access his or her means of transportation to and from work.

Costs for modifications inside the home are not allowable when the recipient works away from home.

For the person who works at home, costs can be allowed for modifying the home in order to create a working space to accommodate the person's impairment. However, any cost deducted as a business expense on the self-employed person's income taxes, cannot be allowed as an IRWE.

Training to use an impairment-related expense to an item reasonably attributable to work.

Transportation costs

Transportation costs are allowable IRWEs in the situations explained below. Transportation costs are not allowable for the routine cost of getting to and from work in situations where it is no relation to the person's impairment.

Modification to a vehicle that is critical for the person's use or operation and directly related to the person's impairment, plus a mileage allowance in the amount allowed by the IRS. The cost of the vehicle is not allowable.

The person's impairment requires the use of driver assistance, taxicabs or other hired vehicles in order to work. The cost of the transportation provide is allowed, or if the person's own vehicle is used, a mileage allowance is permitted.

A mileage allowance is allowed if the person can't use public transportation due to the impairment, and not due to unavailability of public transportation, and must drive his or her unmodified vehicle. The person's inability to use public transportation must be verified by a physician.

Medical devices, prosthetics, drugs and other medical services are generally not allowable because Medicaid will pay for these items. However, medical services, equipment, and supplies which are not covered by Medicaid or a third party and are essential to enable the individual to work are allowable expenses.

**3455.08.00 PREMIUM AND CATEGORY CHANGES IN M.E.D.WORKS (MED
1)**

Premium Changes

When a M.E.D. Works recipient reports a change that imposes a premium or causes a decrease or an increase in the monthly premium amount, the new premium is to be effective in accordance with change processing rules in Sections 2200.05 and 2220.10. The imposition of a premium for a M.E.D. Works recipient and an increase in the premium are adverse actions requiring timely notice.

Category change to M.E.D. Works

When a Medicaid recipient in any other category becomes eligible for M.E.D. Works with a premium, it is an adverse action requiring timely notice. It is processed as an adverse action even if the recipient had a spend-down that was higher than the M.E.D. Works premium. The current category will be closed and the worker will conditionally approve M.E.D. Works. If the premium is lower than the spend-down, the worker must access CUMED and change the spend-down amount to the amount of the premium for the month following the month of authorization.

If a recipient in another category moves to M.E.D. Works with a premium prior to the adverse action date for the month, M.E.D. Works will begin the following month. Eligibility in the prior category will terminate as of the end of the month. Workers should remind recipients of the importance of paying the premium immediately upon receipt of the invoice so that Medicaid coverage does not lapse.

EXAMPLE 1

Jerry is receiving MA D with a \$250 spend-down. He gets a job and MADW is authorized on 10/20, after the adverse action date. The premium is \$69 effective 12/1. The worker must notify Jerry that his spend-down for November is \$69, and then access CUMED to change it to \$69.

EXAMPLE 2

Mary is receiving MA D with a \$50 spend-down. She gets a job and MADW is authorized on 10/12, before adverse action date. Her premium is \$69 effective 11/1. Her MA D closes 10/31 and MADW is conditional. She must pay her premium before 11/1 so that her Medicaid health coverage does not lapse.

3455.09.00 M.E.D. WORKS CONTINUATION WHEN EMPLOYMENT IS LOST

If a M.E.D. Works recipient loses employment involuntarily due to being fired, laid off, or the employer closed the business, continuation of coverage is possible under the circumstance explained in this section. A person who quits a job or closes his own business is not entitled to M.E.D. Works coverage continuation. Additionally, M.E.D. Works can continue if the recipient goes on temporary medical leave, and his job is being held open by his employer. If a person goes on indefinite or long term disability status, he is not entitled to coverage continuation under this provision.

When employment is lost involuntarily, coverage continuation is possible if the recipient maintains an attachment to the workforce under one of the following circumstances:

Enrollment in a Vocational Rehabilitation Program;

Enrollment or registration with the Department of Workforce Development;

Participation in a transition from school to work program;

Participation with an approved provider of employment services.

When the recipient reports that he is no longer working, the worker must ask him if he is or will remain attached to the workforce under one of the above circumstances. If the

recipient is otherwise eligible, and states that he will participate in one of the workforce attachment activities, the worker is to enter the activity on ICES and give the recipient Form 2032, Pending Verifications stating that documentation of the workforce attachment must be submitted within 60 days of the date that person stopped working. The documentation must be from the agency or service provider with whom the recipient is registered/enrolled. In the situation of medical leave, the recipient must provide a statement from the employer that the medical leave is temporary and the job is being held open for the recipient. If the recipient does not provide this documentation within 60 days after the employment ended, he is no longer entitled to M.E.D. Works. Eligibility must be explored for the other Medicaid categories.

If the recipient provides the initial documentation of workforce attachment, continued verification is required quarterly. The recipient is entitled to 12 months of coverage continuation. If, after 12 months, he is not working, he is no longer eligible for M.E.D. Works. Eligibility under the other Medicaid categories must be considered.

3455.10.00 ELIGIBILITY UNDER THE SPEND-DOWN PROVISION (MED 1, 2)

The policies in this section apply to the MA A, MA B, and MA D categories of assistance. Within MED 2, the policies apply only to MA Q.

Individuals who are approved with a spend-down have access to Medicaid covered services on the first day of every month in which they are enrolled. The spend-down works like an insurance deductible. Medical providers file their claims for services rendered to spend-down recipients and the spend-down amount is deducted from their payment. If the recipient has Medicare or other third party insurance, the provider must bill the third party first. The recipient's out of pocket cost satisfies spend-down. Certain expenses, referred to as non-claims because they cannot be filed directly to the AIM system, must be submitted to the DFR. Refer to Chapter 3600 for information on the monthly process to satisfy spend-down.

Effective June 1, 2014, eligibility determinations that are made for the MA A, MA B, and MA D categories of assistance will no longer include a spend-down amount.

3455.14.00 INSTITUTIONAL AND HCBS WAIVER ELIGIBILITY BUDGETING UNDER THE SPECIAL INCOME LEVEL (MED 1)

The Special Income Level (SIL) test is a specific financial eligibility determination that applies only to the Aged, Blind, and Disabled categories for individuals who either reside in an institution or are (would be) eligible to receive home and community based services under a waiver.

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

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

Countable income in the SIL test is as follows:

- Gross earnings (no exemptions, and no employment disregard);
- Net rental income (Section 34.20.05, 3420.05.05, 3415.10);
- Net self-employment income (Section 3410.15);
- All gross unearned income except SSI.

The amount of any income placed into a Miller trust as defined in IHCPM 3320.10.00 and/or IHCPM 2615.75.15, is exempt in the SIL test. The amount of income placed into the trust could be the entire amount or a portion. Income placed into the Miller trust counts in the post-eligibility calculation.

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

- Persons who pass the SIL Test and reside in an Medicaid certified long term care (LTC) facility or hospital

Effective 6/1/2014, any applicant or recipient whose countable income is over the applicable standard for the SIL test must establish an approved Miller Trust and must place income into the trust to allow the person to pass the SIL test. Otherwise, the person would be considered categorically ineligible for Medicaid on and after 6/1/2014. A person who is serving a transfer property penalty, may be considered categorically eligible for Medicaid by passing the SIL. A person who is or would be serving a transfer property penalty cannot be considered categorically eligible without passing the SIL. When

a person serving a transfer penalty passes the SIL, there will not be a post-eligibility budget. Medicaid will not pay for the institutional level of care provided to the member during a transfer penalty.

3455.15.00 POST-ELIGIBILITY BUDGETING (MED 1)

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

A post-eligibility budget is to be completed for the individual who passes the eligibility determination and is in a Medicaid certified long term care (LTC) facility or hospital. Post-eligibility is not completed for the individual who resides in his home not receiving HCBS waiver services or who resides in a non-Medicaid certified facility. Also, a post-eligibility budget is not completed for the individual who is disapproved for nursing home placement (Level of Care or Preadmission Screening denial) or who is serving a transfer of property penalty. When a M.E.D. Works recipient is subject to post-eligibility budgeting in a Medicaid certified facility, there is no premium charged, because a liability is applicable.

The beginning month of the post-eligibility budget differs depending on whether or not the applicant is subject to the "spousal impoverishment" provisions; for example, the applicant is in an LTC facility and has a community spouse. In these situations, the post-eligibility budget begins with the first month of continuous institutionalization. (Refer to Section 2635.10.10 for further information about continuous periods of institutionalization in spousal impoverishment cases.)

For applicants not subject to spousal impoverishment provisions, the post-eligibility budget is completed when the applicant is institutionalized for a full calendar month. If the applicant enters a facility on the first day of the month, post-eligibility begins with that month. If the applicant enters on a day other than the first, post-eligibility begins with the month following the month of admission.

When a recipient enters a Medicaid certified LTC facility from his home, the post-eligibility budget is completed in accordance with the instructions in Chapter 2200 regarding changes in circumstances. However, the post-eligibility budget can begin no earlier than the month following the month of admission.

For recipients who are discharged from an LTC facility, the eligibility budget is applicable in the month following the

month of discharge in accordance with change processing guidelines in Chapter 2200.

When a recipient enters a hospital from his home the DFR will have to determine the anticipated length of his hospital stay. If it is expected that the hospital stay will continue for at least a full calendar month, a post-eligibility budget is required in accordance with change processing requirements in Chapter 2200.

It is a general rule that the surplus income from the post-eligibility budget is a "liability".

A liability is designated for the individual who is residing in an LTC facility or hospital, if the stay will continue for at least 30 consecutive days. The liability is the amount which Medicaid will not pay to the facility each month. If an individual dies prior to reaching 30 consecutive days, the stay will be treated as if the person had resided in the institution for 30 consecutive days beginning the date of the most recent admission.

Whenever a LTC recipient enters a hospital the facility is to collect the liability in the usual manner and apply it toward the nursing home charges for the month. Any remainder is to be shown as a credit on the recipient's account and applied toward subsequent month(s)' charges.

The post-eligibility budget is displayed on screen AEBPL.

3455.15.05 Exempt Income In Post-Eligibility Budgeting (MED 1)

In post-eligibility, the total income of the individual who is institutionalized is counted except as specified below:

SSI payments made to a recipient who is in 1619 status who enters a Medicaid certified facility will not be reduced to \$30 and are not to be counted as income for the first two full months of institutionalization.¹⁷

¹⁷ SSA 1611(e)(1)(E)

The SSI payments made for 90 days to recipients who are temporarily institutionalized are exempt. The SSA issues a special notice to these recipients indicating they are receiving benefits under P.L. 100-203. The DFR must retain a copy of this notice in the recipient's casefile, unless it is verified on DESX.

The maximum SSI payment for a recipient in a Medicaid certified facility is \$30 unless he is receiving benefits under P.L. 100-203. However, the full benefit amount may be erroneously paid for a few months to an individual just entering a facility. These erroneous payments are exempt if documentation is provided that the individual has repaid SSI for benefits received before the reduction to \$30. Otherwise they are budgeted as income in post-eligibility.

The reduced VA benefit of \$90 payable to a veteran or veteran's widow in a Medicaid certified facility is exempt.¹⁸

German reparation payments are exempt.¹⁹

**3455.15.10 Deductions From Income In Post-Eligibility (MED
1)**

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

The deductions listed below are to be subtracted from the applicant's/recipient's non-exempt income.

The standard personal needs allowance (Section 3010.20.10) is deducted.²⁰ This allowance can be spent by the individual in any way he chooses. If a veteran or veteran's widow is receiving the \$90 reduced pension and has another source of income, the individual is not entitled to an additional personal needs allowance.

In the specific situations explained below an additional amount for increased personal needs is to be deducted:

¹⁸ 38 USC 5503(d)

¹⁹ SSA 1902(r)(1)

²⁰ 405 IAC 2-3-17; 405 IAC 2-3-21

Sheltered workshop earnings and earnings which are part of a habilitation plan are budgeted in a special manner. Note that this deduction is called an increased personal need in Indiana's approved Medicaid State Plan; however, it is reflected in the computation of net earned income as explained in Section 3455.15.10.05.

Court ordered guardianship fees paid to the applicant's/recipient's legal guardian, not to exceed \$35 per month, are to be deducted. Guardianship fees include all services and expenses required to perform the duties of a guardian. Within this context, attorney fees would be included as a guardianship fee.

Federal, state and local taxes on the applicant's/recipient's unearned income which are owed and paid are to be deducted. This deduction is allowable on a one-time basis per year in the next month after the applicant/recipient provides documentation of the payment of the annual tax liability on unearned income. Enter the amount paid as a deduction from income on AEFUD. The correct code is "IT-Income taxes paid by person in institution". The worker must then be sure to remove the deduction for the following month.

A spousal allocation as explained in Section 3455.15.10.10 is deducted.

A family allocation as explained in Section 3455.15.10.15 is deducted.

Health insurance premiums which the applicant/recipient pays for his health insurance coverage (including Medicare prior to Buy-In) is deducted from his income. If the premium is paid less often than monthly, it is to be prorated over the appropriate number of months. This deduction is only allowed for health insurance policies which limit the benefits and the purposes for which the benefits can be used to pay for medical care. Premiums for indemnity policies are not allowed.

Medical expenses which are not subject to payment by a third party and are not covered by Medicaid are deducted, except nursing facility expenses incurred during an imposed transfer of property penalty. These expenses incurred during a transfer penalty are not allowed beginning 7-01-03 regardless of when the transfer penalty was imposed. Prescription drugs not covered by Medicare Rx are allowed as deductions in post-eligibility if Medicaid does not cover them.

The DFR will allow a deduction for an incurred medical expense not covered by Medicaid and not subject to payment by Medicare or other insurance, if an actual provider-generated bill, or copy of such a bill, is submitted to the worker. This bill must indicate the date and type of service that was provided and must clearly show the amount that the recipient owes after any third party has paid. If the recipient has third party insurance that does not show as a payer on the bill, the recipient or provider must submit either an EOB documenting denial of payment or some other documentation of why the insurance was not billed or did not pay. No other documentation is acceptable. DFR are not to sign any documents or "agreements" to "deviate the liability". If proper documentation is submitted, the expense is to be entered on ICES as code NM and it will be deducted in the post-eligibility calculation. The worker is to enter reason code 066 when authorizing the reduction/elimination of the patient liability. If it takes more than one month to meet the expense, workers must have fail-safe monitoring procedures to ensure that the expense is removed at the proper time. CUMED is not to be used for this purpose unless it is necessary to correct an error made by the worker, that for some reason cannot be accommodated in future months. Recipient change reporting guidelines apply to institutionalized recipients in the same manner as other recipients.

3455.15.10.05 Sheltered Workshop Earnings/Post Eligibility (MED 1)

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

Sheltered workshop earnings and earnings which are part of a habilitation plan are included as earned income. In the eligibility step, sheltered workshop earnings and earnings which are part of a habilitation plan are budgeted exactly the same as

any other earned income from employment. The standard earned income disregard is applicable.

In the post-eligibility step, the net income after allowing employment expenses is divided by two to determine the net countable income.²¹ Employment expenses are as follows:

\$16 employment incentive;

State, local and federal income taxes, including FICA. The amount to be deducted is based on monthly income by using the appropriate state and federal tax charts. The tax deduction is to be determined by using the total number of exemptions to which the applicant/recipient is legally entitled, whether or not they are actually claimed for withholding purposes.

Transportation expenses. A deduction is allowed for expenses directly related to the earning of income. The actual documented expense is allowed for a transportation carrier; \$.15 per mile is allowed if the individual drives his own automobile to and from work.

The above listed deductions, including the \$16 disregard, must be computed manually and entered on AEINC. For each of the three retroactive months, enter one deduction amount in the "DED" field. After the screen re-appears with the converted 'monthly income' amount displayed, calculate the ongoing deduction using that income amount and enter it in the 'deductions' field. ICES will then compute the earned income to be counted in the post-eligibility budget. It will be displayed as earned income on screen AEBPL.

3455.15.10.10 Spousal Allocation Deduction (MED 1)

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

In the post-eligibility determination of an institutionalized applicant/recipient with a community spouse, an allocation to the community spouse must be computed. The spousal allocation is the amount by which the spousal maintenance standard exceeds the community spouse's countable income. The spousal allocation is determined as follows:

²¹ IC 12-15-7-4

The income designated as owned by the community spouse is identified and entered on the appropriate ICES screens.

The total gross income of the community spouse is established.

The amount, if any, of the excess shelter allowance is computed. This is the amount by which the sum of the community spouse's expenses for shelter and utilities exceeds the shelter standard. Allowable shelter expenses include:

- rent or mortgage;
- property taxes;
- insurance;
- maintenance charge on condominium.

Allowable utility expenses include:

- basic telephone rate.
- gas, electricity, water, oil, sewerage, trash collection.

The community spouse's actual utility expenses are budgeted unless the community spouse chooses the standard utility allowance (SUA) option. If the SUA option is chosen, the appropriate standard utility allowance will be budgeted. verify a utility obligation of a primary heating or cooling expense for the SUA 1. The AG must verify the obligation for the relevant utility types if SUA 2, Single Utility Standard or the telephone standard is allowed. Specific amounts of the obligation are not required. Verification at recertification is not required if there has been no change in residence or obligation for expenses since previously verified. The SUA options are the same used for Food Stamps. See IHCPPM 3020.00.00 for standard amounts.

Four Standard Utility Allowances (SUA) are available:

1. The heating/cooling SUA 1 requires that the AG has a recurring primary heating or cooling expense or that the AG receives an Energy Assistance Payment (EAP) through the Low Income Home Energy Assistance Program (LIHEAP). It is not necessary that the AG have both a

heating and a cooling expense. If the AG has only a heating or only a cooling expense obligation and the need for that particular expense has ended solely because the seasonal need for that expense is ended the AG continues to be entitled to the heating/cooling SUA. Also, an AG that has a room air conditioner is entitled to the Heating/Cooling SUA.

- a. Persons in private rental housing who are billed by their landlords on the basis of individual usage or who are charged a flat rate separately from their rent are eligible for the heating or cooling standard (SUA 1).
 - b. Persons in public housing units which have central utility meters and which charge households only for excess heating or cooling costs are entitled to the heating/cooling standard (SUA 1).
2. The non heating/cooling SUA 2 includes electricity and fuel for purposes other than heating or cooling, water, sewerage, well and septic tank installation and maintenance, telephone and garbage or trash collection. In order to qualify for the SUA 2 the AG must be billed for at least two of the expenses included in the SUA 2.
 3. A third option, the Single SUA may be used if the AG has a utility expense other than heating/cooling or telephone. For example, AGs that pay for trash removal only would receive the Single SUA.
 4. The fourth SUA option is the Telephone Standard. It is allowed for AGs that incur only a telephone expense but do not have a heating or cooling expense.

The spousal income standard and the excess shelter allowance are added, thus arriving at the spousal maintenance standard. The spousal maintenance standard cannot exceed the maximum.

If the community spouse's countable income is equal to or greater than the maintenance standard, there will be no allocation from the income of the applicant/recipient.

If the spouse's countable income is less than the maintenance standard, the difference between the two amounts is the amount of the spousal allocation to be deducted from the income of the applicant/recipient.

If a court has ordered an institutionalized spouse to pay a monthly amount for the support of the community spouse, the monthly spousal allocation cannot be less than the court ordered support.

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

The spousal allocation from the institutionalized spouse's income will be budgeted only to the extent that it is actually made available to the community spouse. In situations when the community spouse is an applicant/recipient, the amount of the total allocation may impose a spend-down for the community spouse or cause ineligibility for cash assistance and/or Medicaid. When these situations occur, the spouses can arrange for a lower allocation or none at all. The allocation can be modified by the worker on AEIII.

The spousal allocation is displayed on the budget screen AEBPL.

3455.15.10.15 Family Allocation Deduction (MED 1)

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

The following family members may receive an allocation from the institutionalized applicant/recipient if they live with the community spouse and are entered on screen AEIHH. (The allocation is deducted from the institutionalized applicant's/recipient's income regardless of whether or not it is actually given to the family member):

Biological or adoptive children of either spouse who are under 21 and living with the community spouse.

Biological or adoptive children age 21 or over who are claimed as tax dependents by either spouse and living with the community spouse.

Parents of either spouse who are claimed as tax dependents and living with the community spouse.

Biological or adoptive siblings of either spouse who are claimed as tax dependents and living with the community spouse.

The family allocation, for each family member, is calculated as follows:

Subtract from the spousal income standard the countable income of the family member. (Note: an allocation is not permissible if the family member's countable income equals or exceeds the spousal income standard.)

Divide the difference by three. The resulting amount is the family allocation.

Repeat the previous two steps for each appropriate family member to arrive at the total family allocation to be deducted from the income of the institutionalized applicant/recipient.

3455.15.15 Liability Exceeds Facility Private Rate (MED 1)

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

If the liability amount calculated in the post-eligibility determination exceeds the facility's private rate, the AG is subject to the entire payment of the facility's private rate.

3455.15.15.05 Liability Exceeds Medicaid Rate (MED 1)

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

An applicant/recipient residing in a long term care facility, who has a liability greater than the facility's Medicaid rate but less than the private rate, is not eligible for Medicaid reimbursement of the facility's per diem. The applicant/recipient is eligible for payment of all other Medicaid services, including the facility's ancillary charges.

The facility will collect the individual's liability and apply it toward the private pay rate. The facility can bill the Medicaid program for all covered services except the per diem.

**3455.15.20 Medicare Involved In Nursing Facility Payment
(MED 1)**

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

When Medicare or other insurance covers the nursing home per diem charges for an entire month, or partial month when the non-Medicare covered charges are less than the liability, the post-eligibility budget is still to be used.

**3455.20.00 FINANCIAL ELIGIBILITY FOR RBA-RELATED MEDICAID
(MED 1)**

When an individual has been determined to be eligible for Residential Care Assistance Program (RCAP), the individual is financially eligible for Medicaid. There is no budget for Medicaid eligibility purposes.

When the worker determines that the individual is eligible for RBA, a "Y" should be entered in the 'RBA ELIG' field on AEIIM.

On screen AEIII enter "N" in the response field for the question regarding Medicaid certification of the institution, since an RBA facility is not Medicaid certified. The liability to the RBA facility is not a Medicaid liability and is not computed by ICES or entered into the system. It is computed manually by the worker in accordance with instructions in the Public Assistance Manual for State Assistance Programs, Section 335.

3455.25.00 BUDGETING INCOME-IN-KIND (MED 1, MED 4)

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

When someone pays for all of the applicant's/recipient's food, clothing, or shelter, income-in-kind is received. The amount to be budgeted as income is the actual value of the in-kind support and maintenance received not to exceed one-third of the applicable federal benefit rate for SSI. The one-third value is determined by dividing the federal benefit rate for SSI by three. For 2014, the max value is \$240.33 for a single individual and \$360.66 for a married couple.

3460.00.00 BENEFIT CALCULATION (MED 2)

If a refugee is ineligible for Medicaid under any other category, he can be eligible for Refugee Medical Assistance

(RMA) under the spend-down provision if his income exceeds the RCA Standard and his ongoing anticipated medical expenses exceed his surplus income.(f66)

Eligibility for MA Q is based on the MED 2 income standard (see IPPM 3010.25.00). The following rules apply to MA Q:

To determine entitlement for medical assistance first determine the income standard for the AG size and then the amount of countable income.

To calculate the amount of countable income the following rules apply: a parent's income can be used to determine his spouse's, and his child's eligibility; a child's income can be used to determine his own eligibility but not a sibling's or parent's eligibility.

To calculate a parent's countable income:

Determine the amount of the parent's gross income; or

If self-employed, deduct actual business expenses or 40% of the gross income as applicable.

Subtract applicable earned income deductions including:

\$90 Work expense disregard; and

Out of pocket dependent care expense in the following manner:

The maximum child care or incapacitated adult care deduction that may be allowed for each dependent participating AG member is based on the age of the dependent and the number of hours of employment per month. The actual cost of care up to the monthly amounts listed below is allowed.²²

Monthly Employed Hours	Dependent Under 2 Years of Age	Dependent 2 Years of Age or Older
Over 129 Hours	\$200 per member	\$175 per member
129 Hours or Less	\$199 per member	\$174 per member

²² SSA (a)(8)(A); 45 CFR 233.20(a)(11)(i)

Allocation to a spouse who is not a member of the AG occurs only when the spouse does not have sufficient income to meet his needs. Allocation up to the full-standard to a child under age 18 who is not a member of the AG always occurs regardless of the child's income. If necessary, allocate to the parent's spouse or child by:

Determining the nonparticipating spouse's gross income;

subtracting the work expense disregard from earned income;

subtracting the total need standard of nonparticipating children in the home under age 18 who are solely the spouse's responsibility;

subtracting the total need standard of the nonparticipating spouse; and

subtract the total need standard of the non-AG child. (A parent allocates to his child regardless of the child's income.)

If the spouse has insufficient income to meet the needs of children who are solely his responsibility, the allocation equals the need standard of the nonparticipating spouse and common children.

The remainder of the parent's income, if any, is counted in the benefit calculation. The parent's countable income is added to the participating child(ren)'s income. If the combined income exceeds the income standard, eligibility is determined by prorating the need standard among all AG members (participating and nonparticipating), allocating a parent's income to his children's unmet needs, and using each member's income and allocated income against his prorated share to determine that person's eligibility. In determining the amount of income a parent can allocate to a child these rules apply:

- a) A parent's income is first used to meet their own needs.
- b) Any remaining parental income is then used to meet the unmet needs of his spouse in the AG.
- c) Any remaining income is then allocated equally between all of the parent's dependents with unmet needs.

- 1) If this causes a surplus for a child, the surplus is divided equally among the remaining dependents with unmet needs up to the amount of that person's unmet needs.
- 2) This will continue until all income is allocated or the needs of all individuals in the AG have been met.

If the child's prorated needs are met, the child is not eligible for medical assistance.

3460.05.00 REFUGEE TANF AND CASH ASSISTANCE (MED 2)

Refugee:

All recipients of Refugee Cash Assistance are eligible for medical assistance if they apply for health coverage.

3465.00.00 BENEFIT CALCULATION (MED 3)

The Medicaid financial eligibility determination compares the AG's countable income to the appropriate income standard for the category of Medicaid under consideration.

3465.05.00 MEDICAL ASSISTANCE BUDGETING FOR MAGI CATEGORIES (MED 3)

Financial eligibility for MAGI (MED 3) AG categories, MA Y, MA Z, MA 2, MA 9, MA 10, MA 14, MAGF, MAGP, MAHC, MAHN, MA E, MA O, MA T is based on the sum of the MAGI-based income of every member of the individual's MAGI household.²³

This Section does not apply to the following MED 3 AGs: MA X (newborns born to pregnant women that were eligible for Medicaid in the month of birth), MA 4 (foster children), MA 8 (adoption assistance for children under 19), and MA 15 (former foster children 18-25). Income is not taken into account for these AGs.

Please refer to the budgeting methods described in Sections 3405.00.00-3435.00.00 for a description of how income is budgeted into monthly amounts. The following steps describe how to determine Medicaid financial eligibility for an individual who falls within one of MAGI AG categories.

²³ 42 CFR 435.603

First, the household size and the individuals who are included in a person's AG must be determined according to MAGI tax-filer or non-filer rules. Please refer to Chapter 3200.

Second, all countable income for the individuals included in the AG will be used to determine countable income.

Third, the total all countable income and deductions (refer to IPPM 2810.00.00 and list provided below of income and expenses) from individuals who meet the first two requirements.

Income includes but may not be limited to:

- a) Wages and salaries;
- b) Rents;
- c) Royalties;
- d) Gains from dealings in property;
- e) Taxable interest;
- f) Tax exempt interest;
- g) Dividends;
- h) State income tax refunds;
- i) Alimony received;
- j) Business income;
- k) Capital gains;
- l) Income from life insurance and endowment contracts;
- m) Other gains;
- n) Taxable IRA distributions;
- o) Taxable pensions and annuities;
- p) Distributive share of partnership gross income;
- q) Estate and trust income;
- r) Farm income;
- s) Unemployment compensation;

- t) Taxable Social Security benefits;
- u) Non-taxable Social Security benefits and Tier one Railroad benefits (SSI, however, is excluded);
- v) Net operating loss;
- w) Gambling earnings;
- x) Cancellation of debt;
- y) Foreign earned income exclusion; and
- z) Foreign earned income.

Deductions include but are not necessarily limited to the following (Please, refer to IPPM 2810.00.00):

- a) Educator expenses;
- b) Certain business expenses of reservists, performing artists, and fee-basis government officials
- c) Health savings account deduction.
- d) Moving expenses.
- e) Deductible part of self-employment tax.
- f) Self-employed SEP, SIMPLE, and qualified plans
- g) Self-employed health insurance deduction
- h) Penalty on early withdrawal of savings
- i) Alimony paid b Recipient's SSN
- j) IRA deduction
- k) Student loan interest deduction
- l) Tuition and fees.
- m) Domestic production activities deduction.

Fourth, add lump sum income received in the month of receipt only

Fifth, add any countable non-exempt educational income. Please, refer to IPPM 3430.00.00 and 3430.05.00.

Sixth, the AG's countable income is converted to a monthly amount.

Seventh, a 5 percent income disregard will apply for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard. If the applicant/recipient whose eligibility is being determined would otherwise financially fail for a category but would qualify to receive assistance under highest income standard for that person, income will be disregarded for that person equal to 5% of the income standard for that category. If the applicant/recipient is a child under 19, the 5 percent disregard will first be applied to Medicaid but then can be applied to CHIP, if the child is still ineligible for one of the Medicaid categories based on the 5 percent disregard.

Use of household income and MAGI-based methodologies will not be applied when determining ongoing eligibility for Medicaid beneficiaries determined eligible for Medicaid to begin on or before December 31, 2013 until either March 31, 2014 or the next regularly scheduled renewal of eligibility, whichever is later.

3470.00.00 BENEFIT CALCULATION (MED 4)

Financial eligibility for the Qualified Medicare Beneficiary (QMB), Qualified Disabled Worker (QDW), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individual's (QI) programs is determined by comparing the countable income of the AG to the appropriate income standard. Refer to Chapter 3000 for the income standards.

3470.05.00 QMB/QDW/SLMB/QI BUDGETING PROCEDURE (MED 4)

The earned and unearned income of the AG is considered in the eligibility determination of an individual who qualifies for Medicare Part A and who meets other resource and non-financial requirements. The AG consists of the applicant/recipient and his spouse when they are living together, and the applicant's/recipient's dependent biological, adoptive, and step child(ren) in the home whose monthly income is less than the applicable income standard. The applicant's/recipient's essential person whose monthly income is less than the applicable income standard is also considered in the AG.

Income that is disregarded according to instructions in Chapter 2800 is not considered. Also, child support payments made by the spouse of an applicant/recipient in compliance with a court order or Title IV-D are disregarded.

A general income disregard of \$20 is allowed for the AG. This disregard is to be applied only once to a couple even when both members have income. It is applied to both earned and unearned income, but must be deducted first from unearned income.²⁴

A general earned income disregard of \$65 is next allowed from the total of the couple's net self-employment income and other earned income. One-half of the remainder is also disregarded. Additionally, the earned income disregard is applied to the earned income of any other member of the AG. Special sheltered workshop budgeting does not apply to the institutionalized applicant/recipient.

From the total countable income of the AG, any income of a disabled individual (or the individual's spouse) which has been set aside under an approved plan for achieving self-support (PASS) is also disregarded. Refer to Section 3455.05.05.15.

NOTE: The Social Security COLA received annually in January is disregarded until April of the same year (three months disregard). Refer to Section 3455.05.05.10.

The total countable income of the AG is compared to the applicable income standard for the AG's family size. If the countable income equals or is less than the appropriate income standard, the applicant/recipient is financially eligible. There is no spend-down provision in the determination of eligibility under these categories.

QMB eligibility begins with the month following the month of the QMB eligibility determination.

QDW eligibility begins with the effective date of the Premium Part A but no earlier than three months prior to application. The effective date for a Medicaid recipient who is already bought in is the first day of the month following Medicaid termination. An applicant/recipient is not eligible for QDW if he is otherwise eligible for Medicaid.²⁵

²⁴ SSA 1905(p)(1)

²⁵ SSA 1905(s)(4)

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.²⁶ There is no requirement to meet a spend-down in the month prior to entering 1619 status. Special 1619 Medicaid coverage continues as long as the recipient's 1619 SSI status is in effect. If the residency requirement is met, all other Medicaid eligibility requirements, including income and resources, are suspended while the individual remains in 1619. However, the special exclusion of income applies only in the eligibility step, not to the post-eligibility budget of recipients in Medicaid facilities.

SSI payments made to recipients who are in 1619 status and who enter public institutions and Medicaid certified facilities (hospital, ICF, SNF, ICF/MR, or CRF) are not reduced to the \$30 cap for the first two full months of institutionalization. These SSI payments are disregarded as income in the Medicaid eligibility determination and are disregarded as income in the post-eligibility budget of the individual only in the first two full months of institutionalization.²⁷

If a progress report is due for a disabled person who has 1619 status, the Medicaid Medical Review Team (MMRT) should be notified of the recipient's 1619 status. If 1619 status is

²⁶ SSA 1619(b)(3)

²⁷ SSA 1611(e)(1)(E)

subsequently lost, a progress report must be submitted immediately to the MMRT. If a re-examination of eyesight is required for a blind recipient in 1619 status, notification to the MMRT is unnecessary. However, an eye report is required immediately upon termination of 1619 status.

A recipient's 1619 status is verified through data exchange. ICES automatically updates an individual's SSI status on the AEIDC screen and notifies the worker of the update through an alert.

3480.00.00 BUY-IN PROCEDURES AND EFFECTIVE DATES (MED)

Buy-In is the process by which the state pays the Medicare premium for Medicaid recipients.

For money grant recipients, the Medicare Part B Buy-In effective date is determined as follows:

Recipients are considered to be money grant recipients if they receive all or any part of their monthly income from any of the following sources:

SSI (Supplemental Security Income);
TANF (Temporary Assistance For Needy Families); or
RBA (Room and Board Assistance)

The Part B Buy-In effective date for money grant recipients, regardless of QMB status, is the latest of the following dates:

Medicaid effective date;
Medicare effective date; or
Money-grant effective date.

For non-money grant recipients, Medicare Part B Buy-In effective date is determined as follows:

for new Medicaid AGs, the Part B Buy-In effective date for non-money grant, non-QMB recipients is the second month following the month in which the worker authorized the recipient's Medicaid eligibility.

EXAMPLE :

On 10/5 Ann Smith is determined eligible for Medicaid retroactive to 6/1. She began receiving Medicare on 5/1. Part B Buy-In effective date is 12/1, the first day of the second month following the month in which her Medicaid eligibility was authorized.

For new, non-money grant, QMB recipients, the Part B Buy-In effective date is the QMB effective date established by ICES.

For a continuing Medicaid AG, the Part B Buy-In effective date is the first of the month in which the Medicaid recipient's Medicare eligibility begins, regardless of the money grant or QMB status.

For SLMB and QI recipients, the effective date of Medicare Part B Buy-In is the date of eligibility for SLMB or QI. It will be no earlier than the first of the third month prior to the month of application.

Individuals, who apply for Medicaid and are not receiving Medicare although they are entitled to it, must be advised to contact SSA and apply. When the Medicare application is approved and the worker has documented it, Buy-In can take place.

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

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