

<b>Indiana Health Coverage Program Policy Manual</b>	
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**2000.00.00 APPLICATION PROCESSING**

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

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

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

The following sections are contained in this chapter:

The Interview (Section 2005);

RESERVED (Section 2010);

Responsibilities of the Applicant/Recipient (Section 2015);

Application Time Standards (Section 2020);

Verification (Section 2025);

Concluding the Interview/Providing Information (Section 2030);

Determination of Initial Eligibility (Section 2035);

Reapplications (Section 2040); and

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

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

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

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

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

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

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

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

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

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

**2005.05.10            Who Can Be Interviewed**

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

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

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

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<sup>1</sup> 405 IAC 2-1-2

<sup>2</sup> 405 IAC 2-1-2

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

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

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

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

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

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

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

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<sup>3</sup> IC 29-3-3-5

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

#### **2015.00.00            RESPONSIBILITIES OF THE APPLICANT/RECIPIENT**

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

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

#### **2015.05.00            PROVIDE PROOF OF INFORMATION**

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

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

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

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

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<sup>4</sup> 470 IAC 2.1.-1-2

<sup>5</sup> 470 IAC 2.1.-1-2

<sup>6</sup> 470 IAC 2.1.-1-2

**2015.10.00 UNDERGO MEDICAL EXAMINATION (MED 1)**

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

**2015.15.00 COOPERATE IN TREATMENT PLAN (MED 1)**

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

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

The treatment is contrary to the applicant's religious beliefs;

Previous surgery of the same type recommended was unsuccessful;

The recommended treatment is very risky because of its magnitude or unusual nature; or Amputation of a major limb is involved.<sup>11</sup>

**2015.20.00 REPORT CHANGES IN CIRCUMSTANCES**

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

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

**2020.00.00 APPLICATION TIME STANDARDS**

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

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<sup>7</sup> 470 IAC 2.1.-1-2

<sup>8</sup> 470 IAC 2.1.-1-2

<sup>9</sup> 470 IAC 2.1.-1-2

<sup>10</sup> 470 IAC 2.1.-1-2

<sup>11</sup> 470 IAC 2.1.-1-2

<sup>12</sup> 470 IAC 2.1.-1-2

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

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

#### **2020.15.00 APPLICATION TIME STANDARDS (MED)**

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

45 days for all MA categories except the Disabled categories (MA D and MADW), which is 90 days.

The time standard covers the period from the date of application to the date the eligibility notice is mailed.<sup>14</sup>

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

#### **2020.20.00 APPLICATION PROCESSING DELAY**

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

#### **2020.20.10 EXCEPTIONS TO APPLICATION TIME STANDARDS**

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

Awaiting documentation of life insurance cash value from life insurance company;

Awaiting medical or visual information from the examining physician;

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<sup>13</sup> 42 CFR 435.911

<sup>14</sup> 42 CFR 435.911

<sup>15</sup> 42 CFR 435.911

<sup>16</sup> 42 CFR 435.911

No extenuating circumstances;

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

**2025.00.00 VERIFICATION**

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

Non-financial factors of eligibility;

Resources;

Income; and

Claimed expenses

These factors will vary by program.

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

**2025.05.00 VERIFICATION REQUIREMENTS**

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

Verifications may be secured by one of the following methods:

Electronically (if an interface or data exchange is available)

Telephone contact;

Personal contact (including home visits); or

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

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

The eligibility factors verified;

The name of the contact person;

The date of the contact; and

The information obtained from the contact.

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

#### **2025.05.05 Verification of Questionable Information**

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

Statements made by the applicant;

Information on previous applications; or

Information available to the worker

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

A report of expenses that exceed income;

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

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

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

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

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

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

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

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

#### **2025.05.10 Collateral Contacts**

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

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

#### **2025.10.00 RESPONSIBILITY FOR OBTAINING VERIFICATION**

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

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

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

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

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

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

### **2025.15.00 REQUESTS FOR INFORMATION**

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

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

The date the information is due; and

Information on the consequences of not returning additional information by the due date.<sup>17</sup>

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

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

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

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<sup>17</sup> 470 IAC 2.1.-1-2

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

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

**2025.20.00 TIME STANDARDS FOR PROVIDING INFORMATION**

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

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

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

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

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

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

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

That there is an Appeals and Hearings process available;

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

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

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

The applicable timeline standards to determine eligibility for the application;

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

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

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

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

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

#### **2030.10.00 PROVIDING INFORMATION TO APPLICANTS**

The following information must be provided:

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

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

Annual redeterminations of eligibility are required for all enrolled persons.

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

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

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

### **2035.00.00 DETERMINATION OF INITIAL ELIGIBILITY**

This section discusses policy for:

Disposition:

- The initial determination of eligibility or ineligibility;

Date of entitlement:

- The initial date of eligibility for assistance.

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

### **2035.10.00 REASONABLE COMPATIBILITY OF INCOME (MED 3)**

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

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

<sup>18</sup> 405 IAC 1-1-2; SSA 1902(a)(23); 42 CFR 431.51

<sup>19</sup> 42 CFR §435.603

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

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

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

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

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

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

**2035.15.00 PRE-ADMISSION SCREENING IS PENDING (MED 1)**

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

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

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

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

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

#### **2035.30.00 DETERMINATION OF MEDICAL CATEGORY (MED)**

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

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<sup>20</sup> 42 CFR 435.404

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

MA SI SSI Recipient - full coverage, HCC or FFS  
MA X Newborn - HHW Package A, full coverage;  
MA Y Children under age one - HHW Package A, full coverage;  
MA Z Children age one through five - HHW Package A, full coverage;  
MA 2 Children age 6 through 18 - HHW Package A, full coverage;  
MAGF Parent/Caretaker - HHW Package A, full coverage;  
MA F Transitional Medical Assistance (TMA) - HHW Package A, full coverage;  
MAGP Pregnant women - HHW Package A, full coverage;  
MA T 19 and 20 year olds - HHW Package A, full coverage;  
MA O Children age 19-21 residing in inpatient psychiatric facilities - full coverage, FFS;  
MA 15 Former Foster Care ages 18 through 25 - full coverage, HCC or FFS;  
MA 14 Independent Former Foster Care age 18, 19, 20 - full coverage, HCC or FFS;  
MA 9 Children age one through 18 - HHW Package A, full coverage;  
MA R RCAP related - full coverage, HCC or FFS;  
MA A Aged - full coverage, HCC or FFS;  
MA B Blind - full coverage, FFS;  
MA D Disabled - full coverage, HCC or FFS;  
MADW MED Works, Basic category - Medicaid for Employees with Disabilities; full coverage, HCC or FFS;  
MADI MED Works, Medically improved category - Medicaid for Employees with Disabilities - full coverage, HCC or FFS;  
MA Q Refugee Medical Assistance (RMA) - full coverage, FFS;

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

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

MA I Qualified Individual (QI) - limited coverage;

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

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

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

#### **2035.30.05           Determination of MA 9 Category (MED 3)**

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

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

#### **2035.30.10           Determination of MA 10 Category (MED 3)**

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

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<sup>21</sup> Title XXI of the Social Security Act

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

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

#### **2035.30.15 Determination Of M.E.D. Works Category**

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

#### **2035.30.20 Determination of MA 14 Category (MED 3)**

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

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

#### **2035.30.25 Determination of MA 15 Category (MED 3)**

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

#### **2035.30.30 Determination of MA E (MED 3)**

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

**2035.31.00            DESIGNATION OF THE PACKAGE C PREMIUM PAYER**

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

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

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

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

**2035.32.00            ENROLLMENT PROCESS FOR MA 10**

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

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

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

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

**2035.33.00            DESIGNATION OF MED WORKS PREMIUM PAYER ENROLLMENT PROCESS**

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

Applicant/recipient age 18 and older

Mother of applicant/recipient under age 18

Father of applicant/recipient under age 18

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

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

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

**2035.35.00            DETERMINATION OF INELIGIBILITY**

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

**2035.40.00            AUTHORIZATION**

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

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



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

**2035.70.00            EFFECTIVE DATE OF QDW MEDICAID (MED 4)**

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

**2035.75.00            EFFECTIVE DATE OF SLMB MEDICAID (MED 4)**

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

**2035.80.00            EFFECTIVE DATE OF QI MEDICAID (MED 4)**

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

**2040.00.00            REAPPLICATIONS**

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

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

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

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

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

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

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

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

**2050.05.00 THE MSP APPLICATION DATE (MED 4)**

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

**Example 1**

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

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<sup>25</sup> SSA 1144(c)(3)

<sup>26</sup> SSA 1925(a)(3)

**Example 2**

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

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

There are 3 possible LIS decision types:

Adjudicated LIS denial:

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

Non-adjudicated LIS denial:

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

LIS approval:

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

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

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

**2050.20.00 VERIFICATION AND ELIGIBILITY DETERMINATION (MED  
4)**

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

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

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

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

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

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

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

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

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

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

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

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