3455.15.10 DEDUCTIONS FROM INCOME IN POST-ELIGIBILITY (MED 1)

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

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

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

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

- Sheltered workshop earnings and earnings which are part of a habilitation plan are budgeted in a special manner. Note that this deduction is called an increased personal need in Indiana's approved Medicaid State Plan; however, it is reflected in the computation of net earned income as explained in Section 3455.15.10.05.
- Court ordered guardianship fees paid to the members legal guardian, not to exceed $35 per month, are to be deducted. Guardianship fees include all services and expenses required to perform the duties of a guardian. Within this context, attorney fees would be included as a guardianship fee.
- Federal, state, and local taxes on the members unearned income which are owed and paid are to be deducted. This deduction is allowable on a one-time basis per year in the next month after the member provides documentation of the payment of the annual tax liability on unearned income. Enter the amount paid as a deduction from income on the Income Deductions-Details page. The correct code is "IT-Income taxes paid by person in institution". The worker must then be sure to remove the deduction for the following month.
- A spousal allocation as explained in Section 3455.15.10.10 is deducted.
- A family allocation as explained in Section 3455.15.10.15 is deducted.
- Health insurance premiums which the member pays for verified health insurance coverage (including Medicare prior to Buy-In) are deducted from the income. If the premium is paid less often than monthly, it is to be prorated over the appropriate number of months. This deduction is only allowed for health insurance policies which limit the benefits and the purposes for which the benefits can be used to pay for medical care.

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

  Premiums for indemnity policies are not allowed.
- Unpaid medical expenses provided by a certified licensed medical practitioner which are not subject to payment by a third party and are not subject to payment by Medicaid are deducted, except for HCBS or nursing facility expenses incurred during

an imposed transfer of property penalty. These expenses incurred during a transfer penalty are not allowed regardless of when the transfer penalty was imposed. Medical bills that have been paid in full are not eligible for a liability deviation.

Services provided under an approved HCBS waiver care plan are to be billed through the Medicaid billing portal and any allowable services will be credited to the Medicaid waiver liability. These services include attendant care arranged and approved by the waiver case manager and/or through the "Structured Family Caregivers" program. These types of services are not to be entered in the Eligibility system as they will be credited to the liability through the automated billing system.

Allowable expenses include:

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

Unallowable expenses include:

- Emergency response systems
- Special diets and nutritional supplements
- Medical bills that have been paid
- Non-medical home care such as companions, attendants, and homemakers which have not been deemed medically necessary under the waiver care plan[15]

If there is question if a medical expense should be credited in the Eligibility System, please contact PAL.

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 member owes after any third party (including Medicare) has paid. If the member has third party insurance that does not show as a player on the bill, the member 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 is not to sign any documents or ‘‘agreements’’ to ‘‘deviate the liability’. If proper documentation is submitted, the expense is to be entered on the Medical Expenses – Details page in the eligibility system as non-Medicaid covered expense and it will be deducted in the post-eligibility calculation. 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. A FIAT can be used to implement a deviation when the deviation request was not processed timely. Change reporting guidelines apply to institutionalized members in the same manner as other members (IHCPPM 2220.05.00).

NOTE: The member is responsible for paying these expenses on their own; Medicaid will give an equivalent deviation if applicable, but Medicaid does not pay these expenses.

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[15] 42 CFR 435.726 (c)(4)(ii)