

<p>Indiana Health Coverage Program Policy Manual</p> <p>Chapter 3800</p> <p>TRANSITIONAL MEDICAL ASSISTANCE</p> <p>Sections 3800.00.00 – 3820.00.00</p>

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3800.00.00 TRANSITIONAL MEDICAL ASSISTANCE HISTORY AND OVERVIEW

The Transitional Medical Assistance (TMA) program began when Medicaid for low-income families was tied to AFDC (Aid to Families with Dependent Children, colloquially known as “welfare”) cash assistance. TMA required a four-month extension of Medicaid coverage when AFDC families experienced an increase in countable income from child support, spousal support, or new or increased wages. The Family Support Act of 1988 expanded the program by allowing low-income families whose income increased specifically due to employment or self-employment to maintain their Medicaid assistance for up to twelve months under certain conditions.

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 replaced AFDC with Temporary Aid to Needy Families (TANF) and delinked Medicaid from cash assistance, but TMA still uses TANF eligibility rules for household composition. The four-month TMA extension is not currently used as child and spousal support is not countable in a MAGI budget per IRS rules (as of 2018) and any increase will not affect the Medicaid budget. The expanded 6-to-12-month TMA provisions previously required annual reauthorization by Congress but were made permanent in the Medicare and Chip Reauthorization Act (MACRA) of 2015.

The income test for Medicaid for Low-Income Parent Caretakers is called the MAGI-converted need standard. These levels are based on a snapshot of TANF standards as of PRWORA passage, and unlike the FPL they do not increase every year. When a family has been under this limit and then earned income increases, they may qualify for TMA.

Caretaker/Dependent Household Size	1	2	3	4	5	6	7	8
Indiana MAGI-Converted Need Standard	\$152	\$247	\$310	\$373	\$435	\$498	\$561	\$561

Historically, Indiana has used separate non-MAGI budgeting for families in the TMA program. Continued TMA eligibility and budgeting was based on reports that families had to complete and turn in every three months along with actual documentation of family income and expenses for each of three months included on the current report.

3800.05.00 CHANGES DUE TO HEALTHY INDIANA PLAN WAIVER RENEWAL

Effective August 2018, Indiana will operate its TMA program using modified eligibility rules approved in an amendment to the Healthy Indiana Plan (HIP) 1115 Waiver.

TMA will continue to exist to ease low-income families’ transition into a new employment status and/or earnings level by protecting their Medicaid from closing solely due to the income increase for up to 12 months.

However, TMA will be reserved for these families which are in danger of *losing coverage altogether* due to exceeding the 133% Federal Poverty Level (FPL) MAGI income limit. This will allow these members time to transition to employer or marketplace coverage more appropriate to their employment status.

TMA will *not* apply to families where the total countable income for the household does not put them in danger of losing their HIP/Medicaid coverage.

TMA households will continue to be built per TANF rules; however, once TMA begins, all income for TMA household members will be counted using MAGI rules.

TMA reports will no longer be sent or required. Reasonable compatibility rules will be used in determining when/whether a family needs to verify income.

3805.00.00 TMA ELIGIBILITY

TMA is not applicable for any non-HIP categories, or for the following individuals in HIP/HIP-related coverage:

- Undocumented immigrants
- Suspended individuals
- Pregnant or in a postpartum period
- Native Americans in MANA coverage (opted out of HIP)
- HIP State Plan Plus with copays (MAPC)
- Members in conditional status when the income increases
- A “caretaker” who is not a specified relative per TANF rules is not eligible to be counted as a Low-Income Parent/Caretaker and is not eligible for TMA.

Other TMA eligibility rules are described in the following sections.

3805.05.00 FORMER LOW-INCOME PARENT/CARETAKER STATUS

Up to 12 months of full medical coverage under the TMA category is available to families when a qualified HIP Low-Income Parent/Caretaker would otherwise fail financial eligibility due to new or increased earned income from a job or from self-employment. TMA does not apply when income increases only from unearned sources such as child support or state/federal benefits.

To initially qualify for TMA, the parent/caretaker with new or increased earnings must have received (and been eligible for) coverage in the Healthy Indiana Plan as a Low-Income Parent/Caretaker in three of the six months immediately preceding the ineligibility.

To be counted towards the three of six requirements, a month must have been:

- HIP State Basic or State Plus coverage due to the Low-Income Parent/Caretaker eligibility flag
- Fully open for the entire month (not Presumptive Eligibility, suspended, or conditional)
 - A conditional month which retroactively changes to fully open due to first PAC payment can be counted
- Not have been included in a prior TMA period for the household
- Not have been counted as Low-Income Parent/Caretaker due solely to neglect or delay of the household to report the earned income increase in a timely manner.

3805.10.00 INCREASE IN EMPLOYMENT/SELF-EMPLOYMENT INCOME

Initial financial calculations will be based upon the countable earned income in the parent/caretaker’s MAGI budget. There must be an increase of at least \$1 from employment or self-employment, and MAGI household income must be changing to over 133% FPL (with the 5% MAGI disregard applied) for a family of the same size.

NOTE: New or increased earnings must be reported and verified in a timely manner by the household. If the earnings were not reported/verified in a timely manner, determine whether the family truly meets the three of six months criteria and qualifies for TMA, or if any assistance groups should be closed and/or sent for Benefit Recovery.

Example:

Janet has been receiving HIP State Plan benefits with a Low-Income Parent/Caretaker flag since she was initially opened in January of this year. In May, she applies for SNAP and reports a full-time job. The worker can see from wage quarter reports that Janet has had this job since February but did not report it. Janet’s income is over 133% FPL, and she is forming TMA; but because this is due to Janet not following reporting guidelines, the worker contacts the Helpdesk to have the TMA flag removed so HIP can be closed and referred for Benefit Recovery.

3805.15.00 TMA HOUSEHOLD

TMA provisions will be applied to the parent or caretaker with increased earnings, any co-parent in the household, and all minor dependents of an included parent or caretaker. Rules used for the Temporary Assistance to Needy Families (TANF) program regarding household composition, specified caretaker relatives, mandatory members, and age requirements apply.ⁱ

A TMA household must always have at least one HIP recipient parent/caretaker and a dependent child (under age 18) who receives Medicaid benefits and/or meets minimal essential coverage (MEC) requirements. Parents/caretaker relatives must meet minimal essential coverage (MEC) requirements for all the children in their care to qualify for HIP or TMA HIP.ⁱⁱ

If the last dependent child ages out or leaves the home, or if the last adult changes categories or leaves the home, TMA will be removed, and other eligibility will be explored for all household members. TMA eligibility for a family follows the parent/caretaker whose earnings initially increased, and any other member who moves out loses TMA. ⁱⁱⁱ

A second parent who enters the household after the TMA period has been established may also qualify for TMA, and their income will be counted for the TMA household. Dependent children who enter the household after the TMA period has been established and would be mandatory TANF members also qualify for TMA. All members added after TMA has already begun will join for what time remains in the existing TMA period and will not receive a new/full 12 months of their own.^{iv} A member joining the case late in the TMA period will not be added to a TMA household which already has had the redetermination process begin but will be processed for normal HIP coverage.

3810.00.00 TMA CATEGORY CHANGE & EFFECTIVE DATE

TMA goes into effect on the date when the parent/caretaker would first have been without coverage due to financial failure.

3810.05.00 MEMBERS WHO WOULD HAVE FORMED TMA UNDER PRIOR RULES

Low-Income Parent/Caretakers are guaranteed HIP State Plan benefits only so long as they qualify under that designation. Adults whose income increases above the low-income standard but does not increase to over 133% FPL (plus MAGI disregard) will no longer be placed in TMA. These members will move out of HIP State Plan into HIP Regular Plan unless they are also Medically Frail.

To retain vision and dental benefits, members in HIP Basic coverage will be required to begin or continue paying POWER Account payments in HIP Plus.

Any adult in Basic coverage when Low-Income Parent/Caretaker status is lost will be given a Potential Plus opportunity with 60 days to make their first PAC payment and transition to Plus. If the member does not pay the PAC, then normal no-pay processes will be applied, and HIP will be closed unless income is at or under 100% FPL.

3810.10.00 MA F FOR CHILDREN AND TMA BUDGETING

Minor dependents switching to TMA coverage will all be placed into the “MA F” category. MA F should never have any adult payees, who instead will show as non-participating adults. If any child is not receiving minimal essential coverage (MEC), TMA will not form for the family. At least one child must be receiving Medicaid for TMA to form.

MA F may show some or all children listed as non-participating if they are not receiving Medicaid due to other minimally essential coverage (MEC), for instance if a non-custodial parent is

carrying one child on their health insurance and the child is not receiving Medicaid, but a sibling is on Medicaid; or if the children are covered in categories such as MA X or MASI which are at the top of the Medicaid hierarchy. MA F formation is needed to provide a budget which will pull in all required members and count all their income when determining continued TMA eligibility.

During TMA, childcare expenses paid by the household for the dependent children can be added as a deduction on the MAGI income screen for their parent or non-parental caretaker. When TMA ends, the deduction does not affect MAGI budgeting any longer.

For the first six (6) months of TMA, there is no income limit for the family. After that time, the income limit is 185% FPL (MAGI 5% disregard will not apply).

3810.15.00 POWER ACCOUNT CONTRIBUTION (PAC) AND TMA

All members who qualify for TMA will be placed into HIP State Plan Plus coverage. Members are responsible for paying their PAC amounts each month during the TMA period; however, no closure action will be taken for non-payment of PAC until after the member has received a full six (6) months of TMA coverage. If the member's MCE sends a no-pay record in the protected initial 6-month period, the record will be rejected.

The PAC amount for TMA members will be set at \$20, the maximum PAC tier. Because TMA protection is given to a member who was otherwise over income for the HIP program, the PAC will not fluctuate along with income during a TMA period. Any tobacco-use surcharge will be based on the \$20 TMA PAC and added by the MCE.

NOTE: The member can request to be removed from the TMA protections if their income decreases and they can no longer afford the \$20 PAC. This would need to be called into the Help Desk to remove the TMA indicator.

Married TMA couples will have their PAC split if both members remain on TMA. If one parent leaves the TMA household but the second parent retains TMA, the second parent will be responsible for the full TMA PAC amount.

Unmarried parents will not receive the couple split, per normal HIP rules.

3815.00.00 TMA ELIGIBILITY PERIODS

To receive TMA coverage for the maximum twelve (12) months, in addition to the criteria already listed, the family with TMA HIP and MA F must also meet the additional eligibility guidelines listed below.

Members who lose all eligibility due to reasons other than noncompliance or voluntary withdrawal will be electronically sent to be considered for eligibility through the Federally Facilitated Marketplace (FFM). Members may voluntarily withdraw from TMA HIP and/or MA F

at any time without penalty and should promptly do so if they gain coverage on their own through the FFM, so that they do not have to pay back Advanced Premium Tax Credits (APTCs) due to having duplicate FFM and Medicaid coverage for any months during the calendar year.

Members whose new employment offers health insurance may have both employer-sponsored insurance and HIP if they continue to meet other eligibility criteria and pay their PAC payments. HIP will be the payer of last resort, and will only pay for Medicaid-eligible services, and only up to the Medicaid limit.

3815.05.00 CIRCUMSTANTIAL ELIGIBILITY FACTORS

In this context, circumstantial eligibility factors are TMA-specific requirements which are not technically noncompliance reasons, and do not broadly apply to all Medicaid or HIP. Failure to qualify according to these factors will cause TMA protections to be removed for the entire family, but all adult and child members will be explored for alternative eligibility via the Medicaid hierarchy.

- The last minor dependent leaves the household or ages out of TMA (18th birthday)
- The last TMA HIP parent or caretaker leaves the household (including incarceration)
- After month six (6) the MAGI income, less out-of-pocket child-care expenses, exceeds 185% FPL
- The caretaker no longer has earned income and has no good cause for not having earnings
- The TMA period expires after the end of twelve (12) months

Those who qualify for any other coverage such as Hoosier Healthwise for children or non-TMA HIP for adults (whose income has decreased to back under the HIP limit) will transition to the new categories without being required to file a new application. If there is no passing category, the member's benefits will be closed.

3815.10.00 CATEGORICAL ELIGIBILITY FACTORS

Categorical eligibility factors are due to normal changes in eligibility between Medicaid categories. Adults will be moved out of TMA HIP if eligible for a non-HIP category, but if a second parent still qualifies for TMA HIP when this occurs, TMA protection will continue for that parent and the dependent child/ren. These changes could occur due to:

- Age (65th birthday)
- Receipt of Medicare
- Blindness (MA B)
- Disability (MASI, MA D/DW/DI)
- Pregnancy

- Native American chooses to opt-out of HIP into MANA

If there is not a second TMA parent, then TMA will end, and children will be explored for eligibility in Hoosier Healthwise.

3815.15.00 COMPLIANCE ELIGIBILITY FACTORS

If any adult in TMA HIP fails to comply with these eligibility requirements, TMA protections will be lost for the entire family even if a second TMA parent is also in the household.

Adults may be subject to a period of excluded eligibility due to a lockout penalty based on the reason why their HIP was closed and would need to file a new application and meet normal HIP eligibility requirements to again receive HIP coverage. Children will always be explored for possible eligibility in a Hoosier Healthwise category.

- The household must comply with any requests for further information or verification of factors which could cause ineligibility. For example, because TMA has no income limit in the first six (6) months, not providing income verification would not cause closure during that time but could after the end of the sixth month. Failure to verify that at least one open and eligible child and/or one eligible adult remains in the household could cause closure at any time.
- All minor children in the household must have MEC or be open in Medicaid. If a child does not have MEC (or Medicaid), the parent is no longer eligible for coverage.
- POWER Account payments must be paid as invoiced for all TMA adults. If a TMA adult fails to pay the PAC, they will be subject to closure at any time after the sixth month of TMA. If the household is back under 100% FPL, all adults in the household will lose TMA protection but may change to HIP Basic coverage. Unless the adult is Frail, they will lose State Plan benefits if a no-pay happens.
- A Frail member who stops paying their PAC and is above 100% FPL will transition to MAPC. The worker will be alerted to re-run eligibility, and if the member is not under ~138% FPL, HIP will be closed
- A member who is not frail and stops making payments will be subject to a Lockout period.

Note: Lockouts for non-payment of HIP Power Account Contributions were suspended effective 3/20/22 and removed from the HIP program effective 7/1/21.

3820.00.00 TMA REPORTING/REDETERMINATION

Families receiving Transitional Medical Assistance (TMA) no longer must report their earnings by

completing quarterly Periodic Reporting Forms.

After a family has been determined eligible for TMA coverage, they will be set for a potential twelve (12) month TMA period. Their next redetermination will be set to coincide with the end of the maximum TMA period.

If the family still has TMA coverage when their redetermination process begins, they will receive a Must-Return Mailer to verify their current income. Because there is no periodic reporting, this is required so the members may be accurately evaluated for continued non-TMA coverage.

TMA members will be allowed to participate in Open Enrollment (the time when they may select a new MCE) just as all other HIP members are.

ADDENDUM

Policy Sources for this chapter include:

Statute:	Social Security Act, SSA §1925; §1931
Regulation:	Code of Federal Regulations, 42 CFR §435.110; §435.220
Code:	Indiana Code, IC 12-15-44.5
Rule:	Indiana Administrative Code (HIP Rule) 405 IAC 10
Waiver Authority:	<i>Amendment Request to HIP Section 1115 Waiver Extension Application (2017)</i>
State Plan:	<i>IndianaMedicaid.com</i>

ⁱ Social Security Act 1931

ⁱⁱ 42 CFR §435.110; §435.220

ⁱⁱⁱ Social Security Act 1925

^{iv} Social Security Act 1925