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## 2400.00.00 NON-FINANCIAL REQUIREMENTS

This chapter contains the various non-financial eligibility requirements which must be considered depending upon the types of assistance for which an individual is applying. The major sections in this chapter are:

- Citizenship/Immigration Status (Section 2402)
- Requirement to Provide a Social Security Number (Section 2404)
- Residency (Section 2406)
- Age (Section 2410)
- Blindness or Disability (Section 2412)
- SSI Status (Section 2414)
- Medicare Status (Section 2416)
- Household Tax Relationships (Section 2418)
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- Requirement to File for Other Benefits (Section 2432)
- Health Insurance Coverage Considerations (Section 2433)
- Assignment of Medical Rights (Section 2434)
- Health Insurance Premium Payment Program (Section 2435).

The requirements for each of these non-financial factors and their verification requirements are described in this chapter.

### 2402.00.00 CITIZENSHIP/IMMIGRATION STATUS

In order to be eligible for assistance, an individual must be:

- A citizen of the United States;
- a U.S. non-citizen national (a person born in an outlying possession of the United States, American Samoa or Swain's Island);
- an immigrant who is in a qualified immigration status as defined in Section 2402.20, and who meets the specific requirements of each program; or
- an individual who meets other specific requirements for a specific program as defined in the following sections.

## 2402.05.00 DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

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

On the application, each applicant declares whether he is a citizen of the United States or not. A Systematic Alien Verification Entitlements request and response of inaccurate documentation does not serve this purpose. An applicant's statement or any other third party information does not constitute a determination of unlawful status. A worker should not seek to obtain an immigrant's status unless the immigrant requests help in obtaining this verification. A refusal to declare citizenship or immigration status will result in the ineligibility for that individual.<sup>1</sup>

## 2402.10.00 DEFINITION OF U.S. CITIZENSHIP

To be considered a U.S. citizen, an individual must meet one of the following conditions:

- be born in the U.S. or a U.S. territory (2402.10.05);
- be a naturalized citizen (2402.10.10); or
- be born abroad to a U.S. citizen and meet specified criteria (2402.10.15).

### 2402.10.05 Born in the U.S. or a U.S. Territory

An individual is considered born in the U.S. or a U.S. territory if either of the following conditions are met:

- the individual is born in one of the United States or the District of Columbia (D.C.); or
- the individual is born in one of the following current territories:
  - o Puerto Rico;
  - o Northern Marianas;
  - o American Samoa;
  - o Harcon Tract;
  - o Swain's Island;
  - o Guam; or
  - o The Virgin Islands.

### 2402.10.10 Naturalized Citizens

An individual is considered a naturalized citizen when U.S. citizenship is gained after his birth either:

- Through individual naturalization; or
- Derived from a naturalized parent

Women who could have been lawfully naturalized and, prior to September 22, 1922, were married to citizens, or were married to aliens who became citizens before that date, automatically become citizens. An alien married to a U.S. citizen on and after September 22, 1922, must apply for naturalization to become a U.S. citizen.

#### 2402.10.15 Children Born Abroad to U.S. Citizens

In most instances, citizenship is acquired at birth if at least one of the natural parents is a U.S. citizen. It should not be presumed, however, that the child was a citizen at birth unless at least one citizen parent was a previous U.S. resident or lived in a U.S. territory. (Refer to Section 2402.10.05)

For children born before May 24, 1934, U.S. citizenship may only be established in this way for legitimate children through their citizen father who would have had to meet the above-mentioned residency requirement. For children born after May 24, 1934, both parent's U.S. citizenship and residency may serve as the basis for the foreign-born child's own U.S. citizenship.

#### 2402.10.20 Citizenship After Birth

Children become U.S. citizens after birth when all of the following requirements are met:

- At least one parent is a U.S. citizen either by birth or naturalization;
- The child is under 18 years of age; and
- The child is residing in the United States in the legal and physical custody of the United States citizen parent, pursuant to a lawful admission for permanent resident. (If adopted, the child must meet all of the requirement above, as well as satisfy the requirements applicable to adopted children under Section 101(b)(1) of the Social Security Act.)<sup>1</sup>

#### 2402.15.00 VERIFICATION REQUIREMENTS FOR U.S. CITIZENS

Verification of citizenship is required for Medicaid eligibility when applicants declare themselves to be U.S. citizens.

#### 2402.15.10 Verification of U.S. Citizenship

In compliance with federal law (Section 1903(x) of the Social Security Act as added by the Deficit Reduction Act of 2005) documentation of citizenship is required as a condition of eligibility for Medicaid, Hoosier Healthwise, and HIP. The requirement applies to applications filed on and after August 15, 2006 and redetermination interviews occurring on or after August 15, 2006.

Proof of citizenship must be provided to the DFR for persons declaring on the application to be citizens with either documentary evidence or electronic verification through the VLP, except in the following circumstances:

The individual is eligible in the Newborn (MA X) category. Further, citizenship documentation is not required for these children at the time of any future eligibility determinations that occur after the child ages out of the Newborn category.

The individual is an SSI (Supplemental Security Income) recipient. Citizenship would have been documented by SSA, so further proof would not be needed for Medicaid. Verification can be found on DESX or IQSSA in the "Alien Indicator" field;

The individual is a Medicare beneficiary;

The individual receives Social Security benefits based on their own disability;

The individual is a ward of the DCS (Department of Child Services). Federal citizenship requirements for Medicaid are met for wards without verification by the DFR because federal rules allow an exception for them as children receiving assistance with IV-B funds;

The individual is a recipient of foster care or adoption assistance under Title IV-E.

Case record requirements are as follows:

If electronic verification is not available through the VLP, original documents or certified copies of original documents must be viewed and copied for the case file. The copy must be annotated: "Copy of original document" or "Copy of certified copy" as appropriate. Also, a CLRC entry as to the way in which citizenship was documented must be made;

Once completely and acceptably verified, citizenship is not to be re-verified at subsequent reapplications and redeterminations;

While medical coverage is pending for verification of citizenship, the VR field for citizenship on AEIIA should be coded "?";

The *citizenship* verification should be entered on AEIIA, not the *identity* verification. For example, if a birth certificate and a driver's license are presented, "BC" is to be entered as verification on AEIIA, not "DL";

A CLRC entry must be made for every contact made with the client and every action taken by the caseworker regarding citizenship verification. It is important that the comments are specific. Simply indicating that "the client could not get a birth certificate" is not sufficient.

Case processing procedures include:

Providing the "Notification of Requirement to Provide Documentation of Citizenship" (FI 2326 or FI 2326 S, the Spanish version) if citizenship has not been electronically verified



through the VLP. When an application interview is not required (refer to IHCPPM 2005.00.00), the form should be sent when a worker is processing the application. When an application interview is required (refer to IHCPPM 2005.00.00), the form should be sent no later than the day following the required interview. The names of all persons for whom documentation is required should be listed. Each applicant whose name is on the form will have 95 days to provide proof of citizenship beginning the date after the form is sent. Please note, the "Pending Verifications for Applicants/Recipients" (FI 2032) is not to be used in lieu of this form. Giving the applicant a 95 day deadline (on the FI 2326) to provide the documents.

Assisting the family in locating verification sources when necessary. This would include such things as helping to find websites, telephone numbers or mailing addresses so that out-of-state birth certificates can be ordered;

Entering a detailed CLRC comment for each contact made with the client regarding citizenship verification;

If an applicant has provided all required criteria to allow for an eligibility determination, except for fulfilling his citizenship verification requirement, the applicant should be determined eligible without undue delay. If documentation of citizenship was not provided to the DFR by the applicant and electronic verification of citizenship through VLP is not received after 95 days after the applicant received "Notification of Requirement to Provide Documentation of Citizenship", eligibility is to be discontinued. If the person reapplies after being denied for not verifying citizenship, they will only get 13 days to verify citizenship a second time. During that second time, the case will need to remain pending until citizenship is verified.

Referring the case to the supervisor so that an inquiry can be sent to the Policy Answer Line (PAL) if there is uncertainty as to whether benefits should be denied or discontinued for failing to meet the citizenship requirement.

The applicant may request a birth certificate by telephone, mail, or online at <https://www.vitalchek.com/birth-certificates>.

There are two general sources of citizenship documentation: primary, for which one source document is acceptable and secondary, which requires a source document for citizenship and proof of identity.

Primary sources of citizenship documentation are:

A U.S. passport, issued without limitations, even if it is expired. Please note, however, that passports issued to persons born in Puerto Rico must be current. Refer to IHCPPM, Section 2402.15.15;

A Certificate of Naturalization – N-550 or N-570;

A Certificate of Citizenship – N-560 or N-561;

Documentation from a federally recognized tribe. The document must identify the federally recognized Indian Tribe which issued it, identify the individual by name, and confirm the individual's membership, enrollment in, or affiliation with that Tribe. Some examples include Tribal enrollment/membership cards, a certificate of degree of Indian blood issued by the Bureau of Indian Affairs, a Tribal census document, or a document issued by a Tribe indicating an individual's affiliation with the Tribe. These documents are examples of documents that may be used, but do not constitute an all-inclusive list of such documents.

When any of the above documents are submitted as citizenship verification, no further proof of identity is required.

Secondary sources of citizenship documentation are:

A U.S. public birth certificate showing birth in one of the 50 States, District of Columbia, Puerto Rico (if born on or after January 1, 1941), Guam (if born on or after 1899), the U.S. Virgin Islands (if born on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (if born after November 4, 1986);

A Certification of Report of Birth (DS-1350);

A Consular Report of Birth Abroad of a Citizen of the United States (FS-240);

A Certification of Birth Abroad (FS-454);

A United States Citizen Identification Card (I-197);

An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code "KIC";

A Northern Mariana Card (I-873);

A Final Adoption Decree showing the child's name and place of birth in the U.S.;

Evidence of civil service employment by the U.S. government before June 1, 1976;

An official military record of service that shows a U.S. place of birth.

The above sources are preferred secondary sources. The following two sources can be used *only* when the individual has provided a plausible reason as to why the preferred sources are not available:

An extract of a hospital record, on hospital letterhead, established at the time of birth, if created five years before the initial Medicaid application date;

A life, health or other insurance record showing a U.S. place of birth if created at least five years before the initial Medicaid application date;

The following “last resort” documents are to be used rarely and only when the more reliable sources listed previously are not available or cannot reasonably be obtained. Please note that this would not include situations where the individual is unwilling to pay the cost of ordering a birth certificate.

A Seneca Indian tribal census record showing a U.S. place of birth, which was created at least 5 years before the application for Medicaid;

A Bureau of Indian Affairs tribal census record of the Navajo Indians, showing a U.S. place of birth, which was created at least five years before the application for Medicaid;

A U.S. State Vital Statistics official notification of birth registration showing a U.S. place of birth, which was created at least five years before the application for Medicaid;

A statement signed by the physician or midwife who was in attendance at the birth, showing a U.S. place of birth, which was created at least 5 years before the application for Medicaid;

Institutional admission papers from a nursing facility or other institution showing a U.S. place of birth;

Clinic, doctor, or hospital records, created at least five years before the application for Medicaid that indicate a U.S. place of birth. For children under sixteen, the document must have been created near the time of birth, or five years before the application for Medicaid;

A religious record (recorded by a religious organization) in the U.S. created within three months of the individual’s birth. Please note that entries in a family’s personal religious text are not considered to be religious records for the purpose of citizenship verification;

Early school records showing a U.S. place of birth;

A special affidavit signed, State Form 53691, under penalty of perjury, by two individuals (other than the applicant/recipient) who have personal knowledge of the event establishing the person’s citizenship status. At least one of the individuals must be unrelated to the applicant/recipient and both must prove their own citizenship.

As stated previously, when secondary documentation is used, the individual's identity must also be verified. Sources of identity documentation include:

A driver's license with picture or other identifying information;

A school picture ID;

Nursery or day care records for a child not yet in school;

A U.S. military card or draft record;

State, federal, or local government ID containing information identical to that on a driver's license;

A military dependent's ID card;

A U.S. Coast Guard Merchant Mariner card;

A Certificate of Degree of Indian Blood or other U.S. American Indian/Alaska Native tribal document, if it contains a photograph or other identifying information;

Three or more corroborating documents verifying the individual's identity. Examples would be high school and college diplomas from accredited institutions, marriage certificates, property deeds and titles, and employee ID cards;

For children under 16, clinic, doctor and hospital records;

For children under 16 if none of the above records are available, a special affidavit signed under penalty of perjury by the parent, guardian, or caretaker relative is acceptable;

Identity affidavits may also be used for disabled individuals in residential care facilities. They are acceptable only if there is no other means of verifying the individual's identity and should be signed by the residential care facility director or administrator.

Please note that an affidavit cannot be used to verify identity if affidavits were used to verify citizenship.

#### 2402.15.15 Verification of Citizenship for Persons Born in Puerto Rico

The purpose of this section is to explain the effect of legislation enacted in 2009 by the Commonwealth of Puerto Rico on Medicaid and Hoosier Healthwise eligibility. The legislation was enacted by the Commonwealth to reissue certified birth certificates for its residents. This is relevant to the citizenship verification process because, due to its commonwealth status, persons born in Puerto Rico are U.S. citizens at birth.

Individuals born in Puerto Rico and applying for Medicaid for the first time on or after November 1, 2010 are affected by the reissue of Puerto Rican birth certificates. For those individuals, a birth

certificate issued prior to July 1, 2010 cannot be accepted. If using a birth certificate to document citizenship, these applicants will have to obtain a new certified birth certificate. The applicant may request a birth certificate by telephone, mail, or online at <https://www.vitalchek.com/birth-certificates>. Instructions in Spanish, for obtaining a new Puerto Rican birth certificate can be found at [www.prfaa.com/certificadosdenacimiento/](http://www.prfaa.com/certificadosdenacimiento/). The instructions should be printed out for applicants without computer access. It should be noted that the case processing procedures found in IHCPPM, Section 2402.15.10 also apply to persons born in Puerto Rico.

As with other individuals declaring U.S. citizenship, a passport issued to a person born in Puerto Rico is a primary source of citizenship documentation. However, the policy regarding passports of persons of Puerto Rican birth differs in that the passport cannot have expired. If the applicant's passport has expired, an alternate document, as listed in IHCPPM, Section 2402.15.10, will need to be obtained.

As with citizenship issues involving American born applicants, questions can be submitted to the Policy Answer Line (PAL). Similarly, you are encouraged to contact PAL before denying or discontinuing benefits because the individual has not obtained a new birth certificate from Puerto Rico.

Please note that persons of Puerto Rican birth who are reapplying for medical assistance or whose eligibility is being redetermined are not to be required to obtain new birth certificates if their citizenship has been documented previously.

#### 2402.20.00 IMMIGRANTS

Individuals who are not citizens of the United States may qualify for assistance based on their status granted by the U.S. Citizenship and Immigration Service (USCIS). Listed below are "qualified" immigrants as defined in federal law. However, the eligibility of these immigrants varies among the programs and is based on certain factors as explained in the following sections. Do not authorize or deny assistance based solely on this list. Read the following sections to understand the distinctions in program eligibility and benefits. Immigrants in any other USCIS classification are not eligible for full coverage Medicaid, but can be eligible for emergency Medicaid coverage.

1. Lawful Permanent Resident under the Immigration and Naturalization Act (INA).
2. Asylees under Section 208 of the INA.
3. Refugees under Section 207 of the INA.
4. Parolees under Section 212(d)(2) of the INA if paroled for at least one year.
5. Persons whose deportation is withheld under Section 243(h) of the INA.
6. Conditional entrants under Section 203(a)(7) of the INA in effect prior to April 1, 1980.
7. Cuban and Haitian entrants.
8. Amerasians admitted pursuant to Section 584 of P.L. 100-202 and amended by P.L. 100-461.

The eligibility provisions are mandated by federal law: Title IV of the Personal Responsibility and Work Opportunities Reconciliation Act (P.L. 103-193) as amended by the Balanced Budget Act of 1997 (P.L. 105-33), the Agricultural Research, Extension and Education Reform Act of 1998 (P.L. 105-185), and the Farm Security and Rural Investment Act of 2002 (P.L. 107-171).

#### 2402.20.05 Lawfully Admitted For Permanent Residence

Under the Immigration and Nationality Act (INA), a Lawfully Admitted Permanent Resident (LPR) is one who has been lawfully accorded the privilege of permanently residing in the U.S. as an immigrant in accordance with Section 101(a)15 and 101 (a)20 of the INA, with such status not having changed since admission.

Lawful Permanent Residents should present USCIS Form I-551 as documentation of their immigration status. Caseworkers should check the coding on the I-551 for code, RE-6, RE-7, RE-8, or RE-9. This denotes entry as a refugee with subsequent adjustment to LPR status. Refer to Section 2402.20.15 concerning eligibility of refugees.

Lawful Permanent Residents who were residing in the U.S. prior to 8/22/96 are eligible for full Medicaid coverage. However, LPRs who enter the U.S. on and after 8/22/96 are eligible for emergency coverage only for 5 years unless they are honorably discharged U.S. veterans or in active duty in the U.S. military. Further, spouses or dependent children of veterans or military personnel who die during active military duty can be eligible for full coverage (Refer to Section 2402.20.45). At the end of the 5 year period, LPRs can be eligible for full coverage.

#### 2402.20.05.05 American Indians Born In Canada

A North American Indian born in Canada may freely enter and reside in the U.S. and is considered to be lawfully admitted for permanent residence if he is of at least 50% American Indian blood. This does not include the spouse or child of such an Indian nor a non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50% American Indian blood.

Sources of verification are:

- Birth or baptismal record issued on a reservation;
- Tribal records;
- Letter from the Canadian Department of Indian Affairs; or
- School records.

#### 2402.20.10 Conditional Entrant Refugee

Section 203(a)(7) of the Immigration and Nationality Act (INA) in effect before April 1, 1980 provides conditional entrant refugee status for persons who, because of persecution or fear of persecution on account of race, religion, or political opinion, have fled from a Communist or Communist-dominated country or from the area of the Middle East or who are refugees from

natural catastrophes. (Section 203(a)(7) of the INA was replaced by Section 207 effective April 1, 1980.)

Individuals with this status can be eligible for full Medicaid coverage. (Note a person entering the U.S. on and after 8/22/96 will not be given this USCIS status, since it is no longer in effect.)

Verification is established by viewing USCIS Form I-94, Arrival-Departure Record, bearing the stamped legend "Refugee - CONDITIONAL ENTRY" and citing the section of the INA under which they were admitted, or USCIS Form I-688B annotated "274a.12(a)(3)" or I-766 annotated "A1", "A3".

#### 2402.20.15 Refugees Under Section 207

Individuals admitted as refugees under Section 207 of the INA are eligible for full coverage Medicaid once they obtain this status. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the U.S.

Refugees will have USCIS Form I-94 annotated with a stamp showing entry as refugee under Section 207 and date of entry, USCIS Form I-688B annotated "274a.12(a)(3)", or I-766 annotated "A3". USCIS Form I-571 also indicates status as a refugee, but does not reflect the date of admission. If Form I-94 is not available, verification must be obtained from the USCIS.

#### 2402.20.20 Parolees Under Section 212(d)(5)

Individuals who were granted parole under Section 212(d)(5) for at least one year, and who entered the U.S. prior to 8/22/96 can be eligible for full Medicaid coverage. Those who enter the U.S. on and after 8/22/96 can be eligible for emergency Medicaid only, unless they are veterans of the U.S. military or in active duty in the U.S. military. Veterans and military personnel can be eligible for full Medicaid coverage. (Refer to Section 2402.20.45 concerning veterans and active duty military.)

Verification is established by viewing USCIS Form I-94 annotated with a stamp showing granting of parole under Section 212(d)(5) of the INA and a date showing granting of parole for at least 1 year- or Form I-688B annotated "274a.12(a)(4), 274a.12(c)(11) or Form I-766 annotated "C11" or "A4".

#### 2402.20.25 Asylees under Section 208 and Victims of Trafficking

Asylees can be eligible for full-coverage Medicaid.

Verification of the asylee status includes USCIS Form I-94 annotated with a stamp showing granting of asylum under Section 208 of the INA or a grant letter from the Asylum Office of the USCIS. Forms I-688B annotated "274 a.12 (a)(5)" or I-766 annotated "A5" indicate status as an asylee. The date of the form does not reflect when the status was granted. Request Form I-94, the grant letter, or the person's copy of a court order. Verify with USCIS if none of these are available.

Victims of trafficking who are non-U.S. citizens are eligible for full-coverage Medicaid under the Trafficking Victims Protection Act of 2000 (Public Law 106-386). Severe forms of trafficking in persons is defined as Sex Trafficking which is the recruitment, harboring, transportation, provision or obtaining of a person for the purpose of a commercial sex act induced by force, fraud or coercion, or in which the person is forced to perform such act is under the age of 18 years; or Labor Trafficking which is the recruitment, harboring, transportation, provision or obtaining of a person for labor or services, through the use of force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery. In addition, minor children, spouses and in some cases the parents and siblings of victims of severe trafficking may also be eligible for benefits.

Victims of trafficking are issued T Visas by U.S. Citizenship and Immigration Service (USCIS). Eligible relatives of trafficking are entitled to visas designated as T-2, T-3, T-4 or T-5 (Derivative T Visas). In the case of an immigrant who is awarded a T Visa, and who is under 21 years of age on the date the T Visa was filed, Derivative T Visas are available to the immigrant's spouse, children, unmarried siblings under 18 years of age on the date on which the immigrant's-Visa application was filed as well as the parents of the immigrant victim. In the case of an immigrant who is awarded a T Visa and was 21 years of age or older; on the date the T Visa application was filed, the Derivative T Visas are available to the immigrant's spouse and children.

#### 2402.20.30    Deportation Withheld Under Section 243(h)

Individuals with a deportation withheld order are eligible for full-coverage Medicaid.

An immigrant who has had deportation withheld under this status will have an Order of an Immigration Judge showing deportation withheld under Section 243(h) of the INA and date of the grant. USCIS Forms I-688B annotated "274a.12(a)(10)" or I-766 annotated "A10" indicate deportation was withheld under Section 243(h) or removal withheld under Section 241(b)(3), but normally do not reflect the date of withholding. Request the person's copy of the court order. If not available, verification must be obtained from the USCIS.

#### 2402.20.35    Amerasian Immigrants

Certain Amerasians from Vietnam, with their close family members, have been allowed entry into the U.S. in immigrant status through the Orderly Departure Program beginning March 20, 1988.

They can be eligible for full coverage Medicaid. Acceptable documentation of this status is:

- I-94 indicating codes AM1, AM2, or AM3;
- I-551 indicating codes AM6, AM7, AM8;
- Vietnamese Exit Visa, Vietnamese Passport, or U.S. passport if stamped by the USCIS with the codes AM1, AM2, or AM3;



- Temporary I-551 stamp in foreign passport; or
- I-571 Refugee Travel Document

#### 2402.20.40 Cuban and Haitian Entrants

Cuban and Haitian entrants, as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, can be eligible for full coverage Medicaid.

#### 2402.20.45 Veteran or Active Duty Member of the Armed Forces

As explained in the previous sections, immigrants with certain USCIS classifications who would otherwise be subject to assistance limitations can be eligible if they are veterans, are on active duty in the military, have served minimum active duty service requirements, or are spouses or dependent children of veterans or military personnel who die during active military duty. The exemption for veterans also applies to individuals who served in the Philippine Commonwealth Army during World War II or as Philippine Scouts following the war.

An eligible veteran is a person who served in the active U.S. military, naval, or air service, and was released with a discharge characterized as honorable and not on account of alienage. Veterans should have received a full copy of DD Form 214 (Certificate of Release of Discharge from Active Duty) that contains the necessary information. An honorable discharge is denoted by the entry of "Honorable" in the "Character of Service" block of DD Form 214. If the evidence characterizes the discharge as anything other than "Honorable", such as "Under Honorable Conditions", the individual and family members cannot be determined eligible based on the veteran exception. Eligibility based on veteran status cannot be established if the reason for discharge was based on alien status, lack of U.S. citizenship or other "alienage" reasons, or if the "Separation Code" block contains an entry JCP, KCP, SCP, or YCP. Those codes establish discharge based on alienage. If the individual states that he or she meets the veteran requirements but is unable to present the appropriate discharge papers as documentation, the worker should contact the Veterans Affairs Regional Office.

The eligibility exception for veterans also applies to the Hmong and other Highland Lao tribal people who fought on behalf of the U.S. Armed Forces during the Vietnam conflict.

Persons who fulfill the minimum active duty service requirements or their un-remarried surviving spouse and dependent children are also exempt from other alien requirements. Minimum active duty served by a person who initially enters service after 9/7/80 is 24 months of continuous active duty or the full period for which the person was called or ordered to active duty.

A person who is on active duty in the U.S. Armed Forces (other than active duty for training) is also not subject to the assistance limitations placed on immigrants in his particular classification. Documentation of active duty status is the individual's Armed Forces of the United State Geneva Conventions Identification Common Access Card (CAC). The CAC, a "smart" card about the size of a credit card, is the standard identification for active duty uniformed service personnel. Other

types of verification of active duty status include, but are not limited to: a copy of the soldier's orders indicating active duty status, an enlistment contract, or a letter from the soldier's commanding officer. A blue (retiree) or beige (dependent) card is not evidence of active duty.

#### 2402.20.49 Iraqi And Afghani Special Immigrants

Certain Iraqi and Afghan nationals have special immigrant status under section 101(a)(27) of the Immigration and Nationality Act (INA) and may be eligible for Medicaid and Hoosier Healthwise. Iraqi and Afghani Special immigrants are eligible for all benefits available to the same extent and for the same period of time as refugees pursuant to Section 207 of the Immigrations and Nationality Act.

Both Iraqi and Afghani special immigrants will either enter the U.S. as Lawful Permanent Residents (LPRs) with the special immigrant visa or will adjust to special immigrant status after entering the U.S. under another immigration status (such as an asylee or parolee). Therefore, unless the immigrant is a qualified alien and is eligible under current program rules, the date of eligibility may or may not coincide with the special immigrant's date of entry.

This policy is based on the Department of Defense Appropriations Act of 2010 (Section 8120, P.L. 111-118) enacted on December 19, 2009.

#### 2402.20.50 Other Immigrants, Visitors, and Non-Immigrants

Any other immigrants, including those who lack immigration documentation or whose immigration status cannot be verified, who are not specified in the previous sections can be eligible for emergency Medicaid coverage only if they meet all other requirements of the category in which they qualify. However, eligibility for emergency services only may not be approved under the MA 10 category. A child who is undocumented or a visitor or non-immigrant as described in paragraph four below, is not eligible for Hoosier Healthwise Benefit Package C, regardless of family income. It is important to remember that the eligibility restrictions and prohibitions apply only to the applicant's immigration status, not other family members. For example, a child who is a U.S. citizen may have parents who lack immigration documentation or whose immigration status cannot be verified. The child in this circumstance can be eligible for health coverage, if all other requirements are met, without regard to parents' status.

If an immigrant alleges to be in a qualified immigrant status as defined in the previous sections, but is unable to present documentation, the Local Office is to advise them in writing of their obligation to contact the USCIS to obtain the documentation if not obtainable through using SAVE. If the verification cannot be obtained through SAVE and the applicant does not provide documentation from the INS, they are eligible only for emergency Medicaid coverage only. If such an applicant has provided all required criteria to allow for an eligibility determination, except for fulfilling his immigration verification requirement, the applicant should be determined eligible without undue delay. If they do not verify immigration status within the 90-day

timeframe from notice to provide immigration status was sent and the immigration status is not electronically verified within 95-days from when the form was sent, then the eligibility must be changed to emergency services only.

Certain visitors and non-immigrants, as described below, may be eligible for emergency Medicaid coverage.<sup>3</sup> They must meet all eligibility requirements except the factor of citizenship/immigration status and Social Security numbers.

These non-citizens would have the following types of documentation:

- I-94, Arrival - Departure Record;
- I-185, Canadian Border Crossing Card;
- SW-434, Mexican Border Visitor's Permit;
- I-186, Non-Resident Alien Mexican Border Crossing Card;
- I-95A, Crewman's Landing Permit; or
- I-184, Crewman's Landing Permit and Identification Card.

Note, that these individuals may not meet the State residency requirement and would not be eligible for health coverage:

Visitors, tourists, foreign students, temporary workers, crewmen on shore leave, diplomats, members of foreign information media, exchange visitors, and so forth, who are lawfully admitted for specific periods of time and with no intention of establishing a permanent residence in the U.S.

Under no circumstances, are immigrants who lack immigration documentation or whose immigration status cannot be verified, who are applying for or receiving traditional Medicaid or Hoosier Healthwise, to be reported by the Division of Family and Children to the U.S. Citizenship and Immigration Service (USCIS). This also applies to family members of such applicants.

#### 2402.20.50.05 Definition of Emergency Services

This section applies to all categories except MA 10, MARP, MASP, and MASB. The classifications of immigrants who qualify for emergency services only (see Section 2402.20.50) are not eligible for MA 10, MARP, MASP, and MASB.

Emergency services are defined as services required for a medical condition (including labor and delivery) manifesting itself by acute symptoms (including severe pain) serious enough that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

A non-citizen eligible only for emergency services will receive a Hoosier Health Card. When providers use their Eligibility Verification System, the enrollee's limited coverage will be reported. Providers are alerted to this coverage limitation, and have information on the definition of an emergency and claims payment restrictions. The DFR is not expected to address

claims payment difficulties or disputes concerning the emergency nature of an illness. Providers are to be referred to Provider Assistance at the Fiscal Contractor.

#### 2402.20.55 Systematic Alien Verification for Entitlements (SAVE)

In addition to obtaining documentation from the AG or through an electronic interface or batch process(as discussed in Section 2402.20.05), the DFR is required to verify each alien's immigration status with Systematic Alien Verification for Entitlements (SAVE)if the verification is not obtained electronically or through a batch process from the appropriate citizenship or immigration source. SAVE was established by the Immigration and USCIS to implement a provision of the Immigration Reform and Control Act of 1986 which mandated direct verification of alien immigration status with USCIS.

NOTE: SAVE procedures are not to be initiated for individuals who declare that they are U.S. citizens by birth or naturalization. (Verification requirements for citizens are discussed in Sections 2402.15.00 and 2402.15.05.)

All alien applicants must present original documentation of alien registration or another form of documentation which is reasonable evidence of their status if the immigration status is not able to be verified through an electronic interface or batch process. Aliens without documentation should be referred to the local CIS office prior to using SAVE procedures. Most alien applicants will present documentation that contains an Alien Registration Number (A-number). The seven or nine digit number preceded by the letter "A" is unique for each individual.

The DFR requests SAVE verification by utilizing the Policy Answer Line (PAL). A SAVE request must include the case name and number and each alien case member's:

- name;
- alien registration number; and
- program choices.

The name of the person making the request should also be included.

Upon receipt of a SAVE request, Central Office staff accesses the SAVE database for the following information:

- Verification number (this number must be documented in the case record);
- Last name;
- First name;
- Date of birth (mm/dd/yy);
- Employment eligibility statement;
- Immigration status;
- Country of birth;
- SSN if known;
- Alternate ID number, if known; and
- Date of entry (mm/dd/yy).

The data is then transmitted to the Local Office from the Policy Answer Line (PAL).

Through access of the SAVE database by Central Office staff, we may receive a response from SAVE indicating "Additional Verification Required". If this occurs, Central Office staff will respond to the Local Office with a request for further information that will include:

I-94 Number

Eligibility system Case Number

Document Type (Examples of which could include):

I-327 - Re-entry Permit

I-551 - Permanent Resident Card

I-571 - Refugee Travel Document

I-688 - Temporary Resident Card

I-688A - Employment Authorization Card

I-688B - Employment Authorization Document

I-766 - Employment Authorization Card

I-94 - Arrival/Departure Record Card

Other - use document description

Unexpired Foreign Passport

Document Date

Document Expiration Date

Date of Birth

Upon receipt of this additional information, Central Office staff will submit the information to SAVE. This secondary request to SAVE takes approximately 3-7 business days for CIS to research. The response from SAVE will either note the requested alien status or will request the need for a Documentation Verification Request (Form G-845) to be sent.

The G-845 is to be sent to CIS with a copy of the original documentation provided by the AG. This material is sent to the following address:

U.S. Citizenship and Immigration Services

10 Fountain Plaza, 3rd Floor

Buffalo, NY 14202

Attn: Immigration Status Verification Unit

NOTE: If the original alien documentation presented by the AG does not contain an alien registration number, the Local Office must contact CIS as indicated above. Central Office staff cannot access the SAVE database without the alien registration number.

When the Form G-845 has been returned to the Local Office, any necessary changes to the Alien/Refugee Information screen AEICZ should be made.

NOTE: Normal case processing is to continue once the AG has provided the initial verification of alien status. Benefits are not to be delayed, denied, or reduced on the basis of pending SAVE verifications. If an applicant has provided all required criteria to allow for an eligibility determination, except for fulfilling his immigration verification requirement, the applicant should be determined eligible without undue delay. If he does not verify immigration status within the 90-day timeframe from when notice to provide immigration status was sent and the immigration status cannot be verified electronically, then his eligibility must be discontinued.<sup>2</sup>

#### 2403.00.00 NATIVE AMERICANS/ALASKAN INDIANS (MA 10)

Children who are Native Americans or Alaskan Indians (NA/AI) are exempt from the cost-sharing requirements of the Children's Health Plan, Package C of Hoosier Healthwise. (f4a) A child must be a member of a federally recognized tribe or have received a service from the Indian Health Services, a tribal health program, or urban Indian health program, or through a referral from one of these programs in order to receive the exemption. Any individual claiming Native American racial-ethnic heritage for a child applicant or recipient should be asked whether the child is a member of a federally recognized tribe or the child received a service as mentioned above. If it is alleged that the individual is a member of a recognized tribe, membership must be verified in order for the exemption to apply. Verification is accomplished by viewing the I.D. card or tribal letter issued to each enrolled member. The I.D. card or letter should specifically state that the child is an enrolled member and that the tribe is recognized by the federal government. If the documentation has been lost, the parent/caretaker may provide the telephone number of the tribal administrative office so that the child's membership can be verified. If the parent declares potential membership but the child has never been formally enrolled, he/she is not eligible for the cost sharing exemption.

The only tribe currently recognized in Indiana is the Pokagon Band of the Potawatomi Indians. The tribe's I.D. card features a red tribal emblem (an eagle on a branch) and an enrollment number, and shows the child as a member of the Pokagon Band of the Potawatomi Tribe as certified by the tribal chairman. If the parent indicates that the child is an enrolled member, but written documentation has been lost or stolen, enrollment may be verified by calling the Pokagon Band Administrative Offices at 1-888-782-1001. Although the Pokagon Band is the only certified tribe in Indiana, it is important to remember that members of federally recognized tribes may be living anywhere. A child who is an enrolled member of any federally recognized tribe is entitled to the exemption, if otherwise eligible for MA 10.

Since these individuals are not to be required to pay a premium or co-payments, it will be necessary to fiat MA 9 eligibility once it has been established that the child qualifies in all other respects for MA 10. The situation must be fully documented on CLRC (Running Record Comments).

#### 2404.00.00 REQUIREMENT TO PROVIDE SOCIAL SECURITY NUMBER

The policy stated in this section does not apply to MA Q or MA X or to individuals who are eligible for emergency services only under Medicaid.

Each applicant must, as a condition of eligibility, furnish his Social Security Number (SSN).<sup>3</sup> A verbal statement from the individual or his authorized representative is sufficient to meet this requirement. If the SSN is unknown or has never been obtained, the individual must apply for a SSN through the local Social Security Administration (SSA) office. The procedure to apply for a number is outlined in Section 2404.10.00.

Household members who are not applying for Medicaid do not have to provide their SSN as a condition of eligibility. The determination of eligibility is not to be delayed, denied, or discontinued due to the waiting on an SSN to be issued.

Certain applicants, because of well-established religious objections, may refuse to obtain an SSN and would not be required to obtain one as a condition of eligibility for Medicaid. The term *well established objections* mean that the applicant:

- i) Is a member of a recognized religious sect or division of the sect; and
- ii) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.<sup>4</sup>

The caseworker must request that AG members whose income or resources are included in the budget, but who are not participating members of the AG, provide their SSN for purposes of data exchange. These individuals are not required to comply with this request. Refer to Section 3205.00.<sup>5</sup>

If any applicant/recipient shows multiple cards for himself to the Local Office, it is to be reported to the local SSA District Office for investigation. The same procedure applies if it is suspected that multiple SSNs exist.

#### 2404.10.00 COMPLETION OF SOCIAL SECURITY NUMBER REFERRAL

The policy stated in this section does not apply to MA Q, MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

An applicant/recipient who does not have an SSN or who cannot remember the SSN, must contact the SSA and apply for a number. The web address for the Social Security Administration is as follows.

<https://www.ssa.gov/ssnumber>

[www.ssa.gov/forms/ss-5.pdf](http://www.ssa.gov/forms/ss-5.pdf)

#### 2404.10.05 Social Security Number Referral Follow-Up

The policy stated in this section does not apply to MA Q, MA X, or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

If an individual has fully complied with the SSA's requirements for an SSN application and is otherwise eligible, the Local Office is not to deny assistance, delay granting assistance, or discontinue assistance pending issuance of the SSN.<sup>6</sup>

#### 2404.15.00 HOSPITAL ENUMERATION

The policy stated in this section does not apply to MA Q, MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

The notice provided by hospitals indicating that an individual applied for a SSN is sufficient verification of compliance with eligibility requirements only if the notice (SSA-2853) contains the applicant's name and is signed and dated by a hospital representative and includes the title of the representative.

#### 2404.25.00 REFUSAL TO COMPLY WITH SOCIAL SECURITY NUMBER REQUIREMENT

The policy stated in this section does not apply to MA Q or MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

Penalties may be assessed when an individual does not apply for, or provide, a SSN. These penalties are discussed in the following sections.

##### 2404.25.10 Penalties for SSN Non-Compliance

The policy stated in this section does not apply to MA Q or MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting non-citizens.

The refusal of an applicant to provide or apply for an SSN results in his ineligibility.<sup>7</sup> This ineligibility will continue until the applicant who has failed to comply comes into compliance with the SSN requirement.

When the ineligible individual is a parent or sibling required to be included in the AG, his income and resources must be considered when determining the financial eligibility of the remaining AG members.<sup>8</sup>



## 2404.30.00 VERIFICATION OF SOCIAL SECURITY NUMBER

The policy stated in this section does not apply to MA Q, MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting aliens.

Eligibility system complete a data exchange with the SSA for the purpose of verifying SSNs. When a SSN is verified, the eligibility system will be automatically updated with "DE" to reflect the verification on screen AEIID.

### 2404.30.05 Social Security Numbers Not Verified Through Data Exchange

The policy stated in this section does not apply to MA Q, MA X or immigrants who lack immigration documentation or whose immigration status cannot be verified or visiting aliens.

If verification does not occur through data exchange, eligibility system will generate alert number 708, SSA Numident Match DISCRP-DENB. The caseworker must obtain verification of the individual's SSN to ensure the correct number is being submitted for verification. The following documentation is acceptable:

- Social Security card;
- correspondence from SSA containing the individual's name and account number (if the number has an A, J, M, or T suffix, this is the SSN);
- a Social Security check issued on the individual's own account number;
- a Medicare card issued on the individual's own account number (if the number has an A, J, M, or T suffix, this is the SSN); or
- a SSA certificate of award which will contain a claim number (if the number has an A, J, M, or T suffix, this is the SSN).

The caseworker must establish that Social Security coverage is provided under the individual's own account number and not someone else's with the individual as a beneficiary.

Once verification is obtained, the caseworker enters a verification code on the DENB screen.

## 2406.00.00 RESIDENCY

In order to receive assistance, an applicant must be a resident of Indiana.

### 2406.05.00 RESIDENCY OF HOMELESS INDIVIDUALS

Homeless individuals and residents of public or private nonprofit shelters for the homeless and/or Domestic Violence victims located in Indiana meet Indiana residency requirements. An otherwise eligible individual must not be required to reside in a permanent dwelling or have a fixed mailing address.

## 2406.20.00 RESIDENCY REQUIREMENTS

Federal regulations regarding residency specifically prohibit states from denying MA to any individual on the grounds that he has not resided in the state for a specific period of time, or did not establish residence in the state prior to entering an institution. However, workers must make sure those individuals who were not approved are not Indiana residents according to the eligibility rules.<sup>9</sup>

In determining whether or not an individual meets the residency requirement, "capability of indicating intent" is a factor. An individual is considered incapable of indicating intent if he:

Has an I.Q. of 49 or less, or a mental age of seven or less;

is judged legally incompetent; or

is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of mental retardation.

### 2406.20.05 Residency of Non-Institutionalized Individuals

Individuals under age 21:

The state of residence is the state where the individual is currently living.

If the individual is emancipated from his parents or married, and is capable of indicating intent, the state of residence is the state where he is living with the intention to live there permanently or indefinitely.<sup>10</sup>

Individuals age 21 and over, the state of residence is the state where the individual is:

Living with the intention to remain there permanently or indefinitely;

Living and where he entered with a job commitment or seeking employment (whether or not currently employed); or

Living, if incapable of indicating intent.<sup>11</sup>

## 2406.20.10 Residency of Institutionalized Individuals

### Individuals under age 21:

For any institutionalized individual who is neither married nor emancipated, the state of residence is:

The parents' state of residence at the time of the individual's placement in the institution (if a legal guardian has been appointed and parental rights are terminated, the guardian's state of residence is used instead of the parents');

The current state of residence of the parent who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

The state of residence of the person who filed the application if the individual has been abandoned by his parents, does not have a legal guardian, and is institutionalized in that state.<sup>12</sup>

If the individual is emancipated from his parents or married, and is capable of indicating intent, the state of residence is the state where he is living with the intention to live there permanently or indefinitely.

### Individuals age 21 and over:

For an institutionalized individual who is capable of indicating intent, the state of residence is the state where he is living with the intention to remain there permanently or indefinitely.

For an institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except when another state makes a placement. (Refer to Section 2406.20.10.05 regarding out-of-state placement.)<sup>13</sup>

For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is:

That of the parent applying for Medicaid on the individual's behalf, if the parent lives in a separate state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the legal guardian is used instead of the parent);

The parent's state of residence at the time of the individual's placement in the institution (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);

The current state of residence of the parent who files the application, if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

The state of residence of the person who files the application, if the individual has been abandoned by his parents, does not have a legal guardian, and is institutionalized in that state.<sup>14</sup>

The applicant's intent to remain in Indiana must always be determined. If the applicant is capable of indicating intent according to the criteria in Section 2406.20.00, the worker must ask the applicant if he plans to remain in Indiana permanently or indefinitely. An applicant who intends to return to the state of origin whenever a bed becomes available, or one who will return to the other state after a temporary institutionalization, is not to be considered an Indiana resident.

Be alert to situations in which the family searched for a bed in the other state before resorting to placement in Indiana and when the applicant is on a waiting list for a facility in the other state.

When a person resided in another state prior to placement in an Indiana facility, the worker will need to ask the reason(s) the applicant was placed in Indiana instead of in a facility in the state where the person had resided prior to the placement. In many cases the family member's clear intent may be to move the applicant back to the other state as soon as a bed becomes available. However, it is the applicant's intent that must be determined. If the applicant is incapable of indicating intent, he is considered an Indiana resident unless the other state arranged the placement. Section 2406.20.10.05 explains what constitutes placement by a state.

#### 2406.20.10.05 Out-Of-State Placement In An Institution

The state arranging or actually making a placement is considered as the individual's state of residence. This includes any agency of the state or entity recognized under state law as being under contract with the state for such purposes.<sup>15</sup>

Any action beyond providing information to the individual and his family would constitute arranging or making a state placement. The following actions do not constitute state placement:

- Providing basic information to individuals about another state's Medicaid program, and information about the availability of health care services and facilities in another state; or
- Assisting an individual in locating an institution in another state, provided the individual is capable of indicating intent and independently decides to move.

When a state has made a placement of a competent individual and such individual leaves that facility, the individual's state of residence is where he is physically located. When a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence.

#### 2406.25.00 TEMPORARY ABSENCE FROM INDIANA

Residence is retained until abandoned. Temporary absence from Indiana, with subsequent returns to the state or intent to return when the purpose of the absence has been accomplished, does not interrupt continuity of residence. Assistance cannot be discontinued when an individual leaves the state temporarily and no other state recognizes him as a resident for assistance purposes during the absence.<sup>16</sup>

#### 2406.30.00 PERMANENT ABSENCE FROM INDIANA

If the recipient leaves Indiana with the intent of establishing residence in another state, assistance is to be discontinued.

#### 2406.35.00 RESIDENCY VERIFICATION

Unless questionable, client statement can be accepted for residency. It is appropriate to request verification when residency is in question due to, for example, returned mail or a date exchange record that shows an out-of-state residence for the member/s. Documentation that provides a name and address, such as the following, may be used to verify residency:

- driver's license;
- school records;
- other forms of I.D.;
- employment records;
- church records;
- rent/mortgage receipts and/or utility bills;
- local postal record; or
- written statement from a third party

In the event no written documentation is available, a collateral contact such as the following may be used:

- landlord;
- neighbor;
- utility company;
- school;
- shelter manager; or
- employer.

## 2410.00.00 AGE

Some Medicaid categories have age related requirements. Age may be either a requirement for eligibility, or a requirement for special budget considerations.

## 2410.05.00 DEFINITION OF A CHILD (MED 2, MED 3)

To be considered a child for program eligibility purposes, an individual must be under the age of 18 and unmarried, divorced or separated.

For MA O, there are special age requirements associated with this category. Please, refer to 2410.05.05.

## 2410.05.05 Age Requirements (MED 3)

2 The age requirements for the categories of assistance under MED 3 vary. The age requirements for each category are listed below.

There are no age requirements for the following categories:

MAGF – MA for low income parents or caretakers

MAMA – Full Range HIP Maternity

MAGP - Full Range MA for Pregnant Women;

MA Q (MED 2) - MA for Refugees who are not eligible for any other categories

Medical Assistance available to children under age 18 in the following category:

MA F - Transitional MA (a parent/caretaker would not be subject to an age requirement);

Medical Assistance available to children under age 21 in the following category:

MA O - MA for Children in Psychiatric Hospitals.

Medical Assistance is available for dependent children age 19- 21

The age requirements for the other categories under MED 3 vary, and are listed below:

MA E - There is no age requirement

MA X and MA Y - birth through one year old.

MA Z - a child is at least age one, but not yet age six.

MA 2 - a child at least six years of age but not yet age nineteen.

MA 9 – a child at least age one, but not yet nineteen.

MA 10 – a child aged from birth through age eighteen.

MA 14 – an individual 18, 19, or 20 years of age.

MA 15 – an individual at least age 18 and through age 25.

#### 2410.05.20 Child Attains Age Limit (MED 3)

When a child attains the age limit on the first day of the month, he is ineligible for that month.

When a child attains the age limit on a date other than the first of the month, the child is eligible for the entire month. Ineligibility will begin the first day of the following month.

#### 2410.05.25 Verification of Age (MED 3)

Acceptable sources of verification of age include, but are not limited to, the following:

- Birth certificate or health department records; or other credible sources, including:
- hospital records;
- physician's records;
- Bureau of Vital Statistics;
- baptismal, confirmation, or other church records;
- passport;
- naturalization papers;
- immigration papers;
- alien registration card;
- court records, including adoption records, in which the child's age has been noted;
- records of social agencies (including the Local Office);
- insurance company records; and
- school records

#### 2410.15.00 AGE REQUIREMENT (MED 1)

There is no age requirement for MA B and MA D.

To be eligible for Medicaid under the MA A category, an applicant must be 65 years of age or older.<sup>17</sup> An otherwise eligible individual who turns age 65 during a month is eligible for Medicaid under the aged category for that entire month. An applicant must meet the disability or blind requirements in the month preceding the month in which he becomes age 65 in order to be considered under the blind or disabled category. Refer to Section 2412.25.00.

To be eligible for M.E.D. Works (MADW and MADI) an individual must be at least 16 years of age but less than 65 years of age.<sup>18</sup>

#### 2412.00.00 BLINDNESS OR DISABILITY (MED 1)

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

During the interview, it is important to ask whether each applicant for health coverage is blind and/or disabled, and ensure that the response is correctly reflected in the eligibility system. This will enable the blind and or disabled category to be correctly evaluated even if initially the applicant qualifies under another category.

In order to qualify for assistance as blind or disabled individual, specific medical criteria must be met. These requirements are discussed in the following sections.

#### 2412.05.00 DEFINITION OF BLINDNESS (MED 1)

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

The visual requirement, which must be met to receive MA under the Blind category, is as follows:

An individual is considered blind if he has central visual acuity of 20/200 or less in the better eye with correction or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance of no greater than 20 degrees.<sup>19</sup>

#### 2412.10.00 VERIFICATION OF THE VISUAL REQUIREMENT (MED 1)

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

The visual requirement is verified as follows<sup>20</sup>:

The applicant is receiving Supplemental Security Income (SSI) benefits as a "blind individual", "blind child", or "blind spouse".<sup>21</sup> This is verifiable by the State Data Exchange (SDX); or

If the applicant alleges to be receiving SSI on the basis of blindness, but it is not verifiable through the SDX, the applicant can obtain proof of SSI Blind status from the Social Security Administration. This verification must be directly issued by the SSA and must be current within 30 days; or

The Medicaid Medical Review Team reviews visual information submitted by the eligibility worker and determines that the person meets the definition of blindness.

When blindness cannot be verified by the SDX or statement from the SSA, the MMRT will make a determination of blindness. The policy and procedures outlined below are to be followed by eligibility workers.



If both of the applicant's eyes are missing, a statement from a medical practitioner is required. This is merely corroborating evidence, not a full examination, and can be a certification from any medical professional treating the applicant including the ocularist who fitted the individual's prosthetic eyes. This certification can be a current statement or copy of existing medical records in which the fact that the individual's eyes are missing is noted. In all other situations, the applicant will be required to have an eye examination by an ophthalmologist or optometrist<sup>22</sup> licensed in the State of Indiana.<sup>23</sup> The requirement to have an eye examination is applicable even for the applicant who objects to such on religious grounds.<sup>24</sup> The report must be based on an examination given not more than six months prior to the date of the eye examiner's report.<sup>25</sup>

The findings of the eye doctor must be submitted on Form 45, Physician's/ Optometrist's Report on Eye Examination. The caseworker is to send the eye report to the doctor, or the applicant, if able to do so, may take the forms to the doctor on the date of the appointment. The caseworker should follow up to be sure that the doctor received the forms. If the doctor prefers, he may submit a letter containing the same information as the Form 45. The eligibility worker is responsible for carefully reviewing the eye report to ensure that all items are completed and the form is legible, signed and dated by the doctor. The complete packet of visual information is submitted to the MMRT.

#### 2412.15.00 PAYMENT FOR EYE EXAMINATION (MED 1)

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

The maximum payment for an eye examination necessary to establish initial or continuing eligibility for MA is \$29.<sup>26</sup> The maximum payment for completion of an eye report based on a previous examination for which the doctor has already been paid is \$10.<sup>27</sup>

Providers should be referred to [www.indianamedicaid.com](http://www.indianamedicaid.com) for procedures to submit claims for payment on Medicaid Blind exams or submission of medical records.

#### 2412.15.05 Eye Examination Requirement for Reapplications (MED 1)

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

The guidelines enumerated below are to be followed for reapplications:

If receipt of SSI on the basis of blindness is verified as explained in Section 2412.10, the blindness requirement is met.

If the date previously established by the MMRT for a re-examination of eyesight is in the future, or the MMRT waived further eye examinations in its previous determination, the visual requirement is met. Any future eye examination must be completed for continuing eligibility.<sup>28</sup> If the eligibility worker is aware that the applicant had vision restorative eye surgery since the last eye examination in the case, a current eye report is to be submitted to the MMRT.

#### 2412.15.10 INABILITY TO OBTAIN EYE REPORT (MED 1)

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

In no instance is an application to be denied solely because the eye doctor did not return Form 45 to the Local Office, if the applicant is still interested in pursuing his application. As it is the joint responsibility of the applicant and the caseworker to make every effort to obtain visual information, caseworkers must monitor a pending application closely for receipt of the visual information in accordance with the following guidelines:

If the visual information is not received within 20 days from the date of application, the caseworker should check the notice history (CNHS) to make sure the "Initial Letter to Blind Applicant" has been sent to the applicant to remind him that determination of eligibility cannot be made without the necessary visual information. CM08 is the code on CNHS for the 20 day initial letter.

If the applicant contacts the local office after receiving the initial letter, the caseworker should advise him to personally contact the doctor. The caseworker should also immediately contact the doctor by letter or telephone.

If the visual information has not been received within 30 days from the date of application, the caseworker should check CNHS to ensure that the "Follow-up Letter to Blind Applicant" has been sent to the applicant. CM09 is the code on CNHS for the 30 day follow-up letter.

If the applicant responds within the time period specified in the follow-up letter, the caseworker must:

Personally contact the doctor or, as a last resort,  
refer the applicant to another eye doctor.

If the applicant does not respond to the follow-up letter by the specified date, the application is to be denied.

#### 2412.15.15 Decision Of Medical Review TEAM (MED 1)

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

The MRT will make one of the following decisions regarding the applicant's blindness and enter the decision on AEOMD:

- The applicant meets the definition of blindness and further re-examinations of eyesight are waived;

- The applicant meets the definition of blindness and a re-examination of eyesight is needed at a future specified date;
- The applicant does not meet the definition of blindness; or

Additional visual information is required in order to make a decision as to whether the applicant meets the definition of blindness. If additional medical information is needed from the eye doctor due to omissions or inconsistencies on the eye report, the MRT will secure the requested information directly from the doctor. If a consultative examination is needed to clarify diagnosis, the MRT will contact the applicant to arrange the examination and obtain the eye report.

As of June 1, 2014, a positive determination of blindness made by MRT is no longer considered effective when the SSA has determined blindness for an individual.

- If MRT determines a person to be blind and a later determination is made by SSA that agrees with the MRT decision, there is no change regarding the determination of blindness for that individual.
- If MRT determines a person to be blind and the SSA later determines the person is not blind, the person will no longer be considered blind. The SSA determination supersedes the MRT approval and the MA B must be terminated and the hierarchy should be explored.

If a denial from SSA is received, and there is no appeal displayed in the Eligibility System, then a 2032 form must be sent giving the member 65 days from the date sent requesting verification that the member appealed the SSA denial or termination.

If verification of the appeal was not received, then the Medicaid hierarchy must be explored (see IHCPPM 2412.50.00).

#### 2412.15.20 Required Re-Examination of Eyesight (MED 1)

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

The applicant whose vision might be expected to improve will be required to have a re-examination of eyesight as a condition of continuing MA eligibility.

For recipients who initially met the visual requirement because of receiving SSI on the basis of blindness, the caseworker must verify at each redetermination that the recipient continues to receive such benefits. If, for any reason, the recipient's SSI eligibility has been terminated, he must have an eye examination and an eye report must be submitted to the MRT.

If the worker questions the continued eligibility of a recipient with regard to the visual requirement, arrangements are to be made for the recipient to have an eye examination. A letter of explanation is to be attached to the eye report and submitted to the MRT.

#### 2412.20.00 TREATMENT FOR RESTORATION OF EYESIGHT (MED 1)

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

A blind recipient is required to cooperate in any treatment plan recommended by the examining ophthalmologist and approved for payment by Medicaid which may fully or partially restore his eyesight.<sup>29</sup>

A recipient cannot be required to undergo any treatment if good cause for refusing exists. "Good cause" includes, but is not necessarily limited to:

The treatment is contrary to his religious beliefs;

Previous surgery of the same type recommended was unsuccessful; or

The recommended treatment is very risky because of its magnitude or unusual nature.<sup>30</sup>

If the blind person refuses the recommended treatment without good cause, the worker is to report this fact and the reason(s) for his refusal to the MRT.

The decision to discontinue MA due to the refusal of recommended treatment will be made by the MRT. This determination cannot be made by the eligibility worker.

#### 2412.25.00 DEFINITION OF DISABILITY (MED 1)

In order to qualify as Disabled under MA D, MADW, or MA R, an individual must be determined disabled according to SSI criteria.<sup>34</sup>

Disability for adults is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted, or can be expected to last, for a continuous period of not less than twelve (12) months.<sup>35</sup>

If the individual is a child under the age of 18, the individual will be considered to be disabled if the child has a medically determined physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted, or can be expected to last, for a continuous period of not less than twelve (12) months. No child who engages in substantial gainful activity may be considered disabled.<sup>36</sup>

Effective June 1, 2014, applicants 18 and over stating they are disabled will be required to apply for disability benefits through the Social Security Administration (SSA) within 45 days after the date the 2032 is sent (see IHCPPM 2432.00.00).

Children under the age of 18 are not required to file for disability through SSA; MRT will continue to determine disability for children who are disabled. However, if a child is denied for disability from SSA, then this denial will override the MRT determination.

When a child with an approved MRT determination turns 18, the member is required to verify that an application for disability has been filed with SSA. For children with an approved MRT determination, it is best practice to advise the legal guardian that the child will be required to apply for disability with SSA when they turn 18. If a member turns 18 and fails to apply for disability, then the MED 1 category should be terminated and other categories must be explored.

- If MRT determines a person to be disabled and a later determination is made by SSA that agrees with the MRT decision, there is no change regarding the determination of disability for that individual.
- If MRT determines a person to be disabled and the SSA later determines the person is not disabled, then the SSA determination overrides the MRT approval and the MA D will be reviewed for possible termination of MED 1 benefits.
- If a denial from SSA is received, and there is no appeal displayed in the Eligibility System, then a 2032 form must be sent giving the member 65 days from the date sent requesting verification that the member appealed the SSA denial or termination.

If verification of the appeal is not received, then the Medicaid hierarchy must be explored (see IHCPPM 2412.50.00).

For members with MRT determinations with waived progress reports, verification of filing an application through SSA must be requested at recertification giving the member 45 days to verify the SSA application. If verification is not received, and the recipient does not have a disability approval with SSA, then the MED 1 category should be closed and other categories must be explored.<sup>31</sup>

An individual can qualify for the basic category of M.E.D. Works, MADW, if that person meets the above disability definition except for the fact that they are working.

The above definition also applies to MA R.

A recipient of M.E.D. Works in the basic category, MADW, who becomes ineligible in that category due to medical improvement, can qualify in the medically improved category of M.E.D.

Works, MADI, as long as the medical condition has not been resolved, or the person is not completely recovered.<sup>37</sup>

#### 2412.30.00 VERIFICATION OF THE DISABILITY REQUIREMENT (MED 1)

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

The Disability requirement is verified as follows:

The applicant is receiving Supplemental Security Income (SSI) benefits as a "disabled individual", "disabled child", or "disabled spouse." This is verifiable by the State Data Exchange (SDX); or

The applicant is receiving Social Security Disability (SSDI) as verified by the SSA BENDEX data exchange and the "onset of disability" date is documented; or

If the applicant alleges to be receiving Social Security benefits on the basis of disability, but it is not verifiable through the SDX or BENDEX, the applicant can obtain proof of Disability status from the Social Security Administration. This verification must be directly issued by the SSA, must be current within 30 days of receipt by the DFR , and must specify receipt of benefits on the basis of the individual's disability; or

The Medicaid Medical Review Team reviews medical evidence and social history information submitted by the eligibility worker and determines that the person meets the definition of disability. Additionally, in the above circumstance of proof of disability status from the SSA, the MMRT will record the disability approval in the system upon receipt of documentation from the eligibility worker.

When disability cannot be verified by the SSA data exchanges or statement from the SSA, the MMRT will make a determination of disability. The policy and procedures outlined below are to be followed by eligibility workers. In no situation can the individual be considered as "not cooperating" due to failure to obtain documentation from the SSA regarding disability status. This is an available option for the individual and if this verification is not obtained, the eligibility worker must pursue medical information collection as explained in the following sections.

An individual who has been determined by the SSA to not be disabled, will not meet the Medicaid definition of disability unless the condition has worsened since the SSA denial or the individual has had onset of a new condition not considered by the SSA. In this situation, medical information must be submitted to the MMRT for decision.<sup>31</sup>

#### 2412.30.05 Exceptions when MRT will determine disability

SSA will determine disability for Medicaid except in the following circumstances where MRT will determine disability:

- a) An individual has never applied to the SSA for disability benefits.
- b) An individual has applied to the SSA for disability benefits, but SSA has not yet rendered a decision.
- c) An individual had applied to the SSA and the SSA determination denied disability is more than 12 months old and the individual is currently claiming a change in condition since the SSA denial.
- d) An individual had applied to the SSA and the SSA determination denied disability less than 12 months ago, the individual is currently claiming a change in condition since the SSA denial, and the individual has applied to SSA for reconsideration of its disability decision but the SSA refused to reconsider.

If any condition described in either a), b), or c) the individual will be required to provide proof that the individual also applied for disability to the SSA by the 45<sup>th</sup> day following the date of the individual's submitted application for Medicaid or from the 13<sup>th</sup> day after the mailing date of the pending verification checklist that indicates that the individual must apply for disability benefits, whichever is longer. If there is an SDX match showing a pending application, this requirement would be met.

If a person is required to apply for benefits with the SSA, the person must receive notice of the requirement by being given a 2032 after the interview is held. Refer to IPPM 2005.00.00. Further, workers must not delay requesting medical information needed to determine disability due to this requirement.

For purposes of c) and d), when the individual has appealed the SSA determination, the date considered to be the SSA determination is the date the SSA made its original determination, not the date of the SSA hearing decision.

If the condition described in d) is met, that individual will not be required to apply for disability benefits to the SSA. MRT will make the disability determination.

If the disabled applicant is under 18 years of age, they are not required to apply for disability with SSA until after they turn 18. Children are eligible to receive most services, including waiver services, under a Hoosier Healthwise category (see IHCPPM 3310.00.00).

#### 2412.30.10 Preparation of Medical Packet for MMRT (MED 1)

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

The medical packet submitted to the MMRT consists of the social history summary obtained from the applicant or representative during the interview and medical evidence obtained from the individual's medical providers.

## SOCIAL SUMMARY

The eligibility worker must thoroughly complete the social summary leaving no sections blank. Information includes work history, education, living arrangements, economic status, medical treatment history, SSI/SSDI status and other pertinent information that indicates the extent to which the disability interferes with the applicant's ability to function in his social, family, and economic situation.

If the applicant is a child, the social summary should reflect the developmental and educational achievements (or lack of same) of the child. If the child is not attending school, the eligibility worker should obtain as much information as possible from the parent or representative about the child's development relative to the normal development of a child of his chronological age. If the child is in special education or learning disabled classes, the social summary must contain information about the reason he is in these classes, the degree of learning delay and what classes/subjects are involved.

Treatment history for the previous 12 months must be thoroughly discussed during the interview and recorded on the social summary. If the applicant does not have any medical services to list in the "Treatment History Section", eligibility workers are to enter "none" in this section. Leaving it blank or entering "N/A" is not sufficient for an MMRT decision.

## MEDICAL EVIDENCE

A complete 12-month medical history on the individual is needed unless the documented impairment began less than 12 months prior to application. The eligibility worker is to request copies of all medical records from physicians, clinics, and/or hospitals indicated by the applicant as having treated/examined the applicant for his/her documented impairment(s) since the onset of the condition(s) or 12 months prior to the date of application, whichever is longer. Evidence must include medical history, clinical findings, laboratory findings, diagnosis, treatment, and medical assessment.

The applicant, who is not under the care of a physician, is to be examined by a physician licensed to practice medicine in Indiana or another state.<sup>35</sup> The requirement to have a medical examination is applicable even for the applicant or, in the case of a child, the guardian or parent, who objects on religious grounds.<sup>36</sup> For an applicant who has no physical impairment at all, but whose disability is based solely on mental status, an examination is required by a psychiatrist, psychologist, or mental health professional holding HSPP certification.

If a current physical examination is needed, the Local Office is to forward the Form 251, Authorization for Physical Examination to Determine Disability for Medical Assistance form to the examining physician:

The applicant, if able to do so, and agrees to do so, may take the forms to the doctor. Caseworkers should follow up to be sure the doctor received the forms.



Failure to receive medical evidence is not an acceptable reason for denial of an application if the disabled person is still interested in obtaining Medicaid coverage. As it is the joint responsibility of the applicant and the caseworker to make every effort to obtain the medical information, caseworkers must monitor a pending application closely for receipt of the medical information in accordance with the following guidelines:

Give the applicant a 30-day deadline to arrange for an examination and inform the eligibility worker of the appointment date, with a follow-up 10-day deadline if the applicant does not respond.

When requesting medical records from a provider, give a 20-day deadline; with another follow-up 20-day deadline if the records are not received after the first letter. Telephone contact should be made to the provider with a 3rd 20-day deadline given if the provider indicates intention to submit the records.

When a provider does not respond to any of the requests for medical records, the eligibility worker is to notify the applicant or authorized representative to contact the provider. A 10-day deadline is to be given for the applicant/representative to contact the worker. This step in the process is not a condition of eligibility being imposed on the applicant to obtain the medical records. It is an attempt to engage the applicant's help in obtaining the records, with the only requirement being to contact the eligibility worker.

Partial records may be submitted by the local office to the MRT if all attempts to obtain the medical history documentation have not been successful. The providers who did not respond must be listed in the medical packet.

MRT will request Additional Information from providers and the applicant when additional testing or consultative exam is needed to make the determination of disability.

#### 2412.30.15 Payment for Disability Examinations (MED 1)

The policy stated in this section only applies to the MA D, MADW, MADI, and MA R categories of assistance.

The maximum payment for a disability examination, including completion of the report, is \$65. The maximum payment for completion of a report based on a previous examination for which the doctor has already been paid is \$10.<sup>32</sup> Psychological exams/testing are reimbursed at the rate of \$80 per hour.<sup>33</sup> Additional payments may be allowed for x-rays, tests, and so forth, which are necessary to confirm the primary diagnosis if approved by the MMRT.

Providers should be referred to [www.indianamedicaid.com](http://www.indianamedicaid.com) for procedures to submit claims for payment on Medicaid disability exams or submission of medical records.

2412.40.00                   DISABILITY INFORMATION ON REAPPLICATIONS/CATEGORY CHANGES (MED 1)

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

The guidelines to follow concerning the submission of medical/social information to the MRT for individuals who are reapplying for Medicaid and those whose Medicaid category is changing back to a disability category are outlined below. These guidelines apply when a decision is required by the MRT because the individual's disability is not verifiable through the SSA data exchanges.

A. Medicaid Reapplications

- If the most recent SSA or MRT decision for an applicant is disapproval, new medical and social information must be submitted to the MRT, and the conditions in Section 2412.30.05 are applicable. (Note that the applicant may or may not have last received Medicaid under the MA D category.)
- If an applicant without a disability determination from SSA was previously discontinued under a MED 1 category 48 months or more before the date of the reapplication, new medical and social information is required. If new medical and social information is required to be sent to MRT, the conditions in Section 2412.30.05 are applicable.
- If an applicant last received Medicaid under a MED 1 category and was closed for a non-disability related reason 48 months or less prior to the date of the reapplication, new medical information is not required unless a Progress Report is required by the MRT. The Progress Report is required by the due date previously established by the MRT, but not sooner. The applicant is required to apply for disability benefits through the Social Security Administration with 45 days after the 2032 is sent.

If a denial from SSA is received, and there is no appeal displayed in the Eligibility System, then a 2032 form must be sent giving the member 65 days from the date sent requesting verification that the member appealed the SSA denial or termination. If verification of the appeal is not received, then the Medicaid hierarchy must be explored (see IHCPPM 2412.50.00).

Additionally, if progress report is needed and an improvement in the applicant's condition is noted, a Progress Report should be submitted immediately.

If the disability approval was made by an Administrative Law Judge, Agency Review or court decision in reversing an MRT decision, the above requirements with regard to the time frames are applicable to that decision.

## B. Category Change to MA D, MADW, or MA R

- If 48 months or less have elapsed since the date that the recipient last received Medicaid under MA D, MADW, or MA R, new medical information is not required unless a Progress Report as required by the MMRT is due. The Progress Report is required by the due date previously established by MMRT, but not sooner. If the Progress Report is required, Section 2412.30.05 is applicable. If the person is required to apply to the SSA for a disability determination, the member has 45 days from the date the 2032 is sent to verify that they have applied.
- If more than 48 months have elapsed since the date that the recipient last received Medicaid under MA D, MADW, or MA R, new medical and social information is required, unless the individual is considered disabled according to the SSA. If new medical and social information is required, Section 2412.30.05 is applicable. If the person is required to apply to the SSA for a disability determination, the member has 45 days from the date the 2032 is sent to verify that they have applied.

The above requirements include changes back and forth between QMB/SLMB-also coverage and QMB/SLMB-only coverage.

### 2412.45.00 DECISION OF MEDICAL REVIEW TEAM (MED 1)

The policy stated in this section applies to the MA D, MADW, and MA R categories of assistance.

The Medicaid Medical Review Team, which is comprised of physicians, nurses and consultants,<sup>43</sup> will review the medical evidence and the social information and make one of the following decisions:

- The applicant meets the disability requirement; a progress report is not required.
- The applicant meets the disability requirement; a progress report is required by a date specified by the MRT.
- The applicant does not meet the disability requirement.

Whenever necessary, the MRT will request Additional Information from medical providers and the applicant in order to make a decision as to whether the applicant meets the disability requirement.

The MRT decision and reason for a denial when applicable, is transmitted to the eligibility system. The MRT will issue a detailed explanation for a denial to the applicant and a copy will transmit to the applicant's electronic eligibility file. This letter along with the eligibility decision notice that contains appeal rights should be used in the appeals process.

As of June 1, 2014, a positive determination of disability made by MRT is no longer considered effective when the SSA has determined disability for an individual.

- If MRT determines a person to be disabled and a later determination is made by SSA that agrees with the MRT decision, there is no change regarding the determination of disability for that individual.
- If MRT determines a person to be disabled and the SSA later determines the person is not disabled, then the SSA determination supersedes the MRT approval.
- If a denial from SSA is received, and there is no appeal displayed in the Eligibility System, then a 2032 form must be sent giving the member 65 days from the date sent requesting verification that the member appealed the SSA denial or termination. If verification of the appeal is not received, then the Medicaid hierarchy must be explored (see IHCPPM 2412.50.00).

#### 2412.50.00 PROGRESS REPORTS AND ONGOING ELIGIBILITY (MED 1)

The policy stated in this section only applies to the MA D, MADW, MADL, and MA R categories of assistance.

When a Progress Report is required by the MRT or an ALJ, or when it is learned that the individual's disabling condition has improved, the caseworker must conduct an interview with the recipient, complete a new social summary, and obtain medical information following the same guidelines listed in Section 2412.30.05.

When a Progress Report is required, section 2412.30.05 applies. The forty-five (45) day timeframe begins the day after the 2032 is sent requesting proof of application for benefits with the SSA. Attempts by DFR to obtain medical documentation should not be delayed due to this requirement.

Upon receipt of the Progress Report medical packet, the MRT will review the information and make a decision on the recipient's continuing disability status. For the recipient who is currently open in MADW, the MRT will determine if the member remains eligible in that category, is eligible under the medically improved category MADL, or has medically recovered to the point at which the disability definition is no longer met. If the member remains eligible, another Progress Report may be required.

When a member has a positive MRT determination with progress report re exam waived, they are still required to apply with the SSA. The SSA is the final determinate when determining eligibility for Medicaid for the Disabled.

When the DFR is notified that SSA benefits have terminated due to loss of disability status, either by the SSA data exchanges or direct documentation from SSA, the member must be contacted to learn whether or not a timely appeal with SSA has been filed.

When a denial from SSA is received, and there is no appeal displayed in the Eligibility System, a 2032 form must be sent giving the member 65 days from the date sent requesting verification that the member appealed the SSA denial or termination. If verification of the appeal is not received, then the Medicaid hierarchy must be explored (see IHCPPM 2412.50.00).<sup>34</sup>

If SSA denies benefits on the basis of disability and a timely appeal is filed, the Medicaid disability requirement continues to be met until the SSA rules on the appeal that the person is no longer

disabled. In this situation, a new progress report is not needed. Please contact the Helpdesk/PAL if disability status needs updated in the eligibility system.

While the actual period to appeal is 60 days, The Social Security Administration allows an additional 5 days for the mailing of the decision notice which, in effect, increases the overall number of days a disability applicant has to get their appeal to their local Social Security offices to 65 days.<sup>35</sup>

Once a final determination regarding disability is made by the SSA, the decision is considered binding whether the appeal upholds the original SSA determination or is fully favorable to the SSA appellant. If the SSA appeal decision finds that the individual is not disabled, the individual cannot be considered disabled for Medicaid purposes. When an individual does not appeal the SSA determination within 65 days, the determination of disability made by the SSA is binding, and the individual will not be considered disabled for purposes of Medicaid eligibility.

If a recipient of MADW is determined to no longer be disabled according to the SSA, a Progress Report is required to determine whether the recipient would remain eligible under MADI and medical records should be sent to MRT. While this Progress Report is being processed, the recipient is to remain eligible for Medicaid under MADW.

#### 2412.55.00 TREATMENT FOR RESTORATION OF PHYSICAL/MENTAL HEALTH (MED 1)

The policy stated in this section applies to the MA D, MADW, MADI, and MA R categories of assistance.

A disabled recipient is required to cooperate in any treatment plan recommended by the examining physician and approved for payment by Medicaid, which may fully or partially restore his physical or mental health.<sup>36</sup>

A recipient cannot be required to undergo any treatment if good cause for refusing exists. "Good cause" includes, but is not necessary limited to:

- The treatment is contrary to his 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>37</sup>

If the recipient refuses the recommended treatment without good cause, the caseworker is to report this fact and the reason(s) for his refusal to the Medical Review Team, Office of Medicaid Policy and Planning.

The decision to discontinue MA due to the refusal of recommended treatment will be made by the MRT.

#### 2414.00.00 SSI STATUS

In some situations, an individual's benefit status with the Supplemental Security Income (SSI) program has an effect on his non-financial eligibility. The following sections discuss these situations.

Effective June 1, 2014, SSI recipients are deemed eligible for Medicaid coverage in Indiana. SSI recipients will be eligible under the MASI category.

The following sections cover special groups of former SSI recipients that are considered eligible for Medicaid.

#### 2414.10.00 SSI 1619 STATUS

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.

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

Blind or disabled SSI recipients who are in SSI 1619(a) or 1619(b) status are eligible for continued Medicaid coverage if they were on Medicaid in the month immediately preceding the month in which an individual's 1619 status last began. The only non-financial requirement that must be met is state residency.

If 1619 status is subsequently lost because the individual is no longer considered disabled, a progress report must be submitted immediately to the MRT to see if the individual qualifies for MEDworks. If a re-examination of eyesight is required for a blind recipient in 1619 status, notification to the MRT is unnecessary. However, an eye report is required immediately upon termination of 1619 status.

Refer to Section 3475.00.00 for additional information about Medicaid eligibility for persons in 1619 status.

#### 2414.10.10 Disabled Adult Children

A Disabled Adult Child (DAC, sometimes known as CDB's or childhood disability beneficiaries) is an individual who is:

- Over the age of 18; and
- Determined, even if retroactively, by the Social Security Administration (SSA) to have had an onset of disability prior to age 22; and
- On the basis of that disability, received Supplemental Social Security (SSI) as a child or would have been eligible to do so.

Who subsequently:

- Becomes eligible for new or increased payment of Retirement, Survivors, and Disability Insurance (RSDI); and
- The new payment occurs during a month when also eligible for SSI; and
- The total compensation from RSDI is more than the SSI benefit the individual would otherwise receive; and
- Therefore SSI payments are reduced to \$0 and the larger RSDI payment becomes the new monthly benefit amount.

These applicants/recipients must be treated as SSI recipients for Medicaid purposes and must not be denied/closed for being in DAC status.<sup>46</sup>

DAC status can be identified by a Social Security Claim Number (CAN) which is different than the individual's own SSN, and ends in the Beneficiary Identification Code (BIC) "C." The member will also have a disability date which was prior to the 22nd birthday, and the Medicaid Eligibility Code received from SSA will indicate referral to the state for Medicaid determination due to entitlement or increase in DAC benefits.

The disability determination remains valid, and income will not count in the Medicaid budget, so long as DAC status remains active. For DAC members residing in the community, and not in an institution or on a HCBS waiver, the entire RSDI amount should be entered as SSI income to ensure that it is disregarded for MED 1 but will be budgeted/excluded correctly for other assistance groups and programs which have different budgeting rules for SSI income and/or DAC status. The modification of unearned income for the DAC needs to be clearly documented in the eligibility system's note section.

These members are not opened automatically into MASI coverage, and should not be placed into the MASI category due to resource requirements and the need for an annual redetermination to verify eligibility factors including continuing DAC status. They must submit an application if not an ongoing recipient of Indiana Medicaid, and applicants/recipients must verify all eligibility factors including resources.

Individuals with DAC status are not eligible for MAGI processing<sup>47</sup> and must receive coverage in another MED 1 category. Receipt of Medicare does not disqualify the DAC from these special provisions, and they are potentially eligible under MED 4 as well.

If a DAC member is in a nursing home or is on an approved HCBS waiver, then the post-eligibility budget will form and the SIL budget applies (see IHCPPM 3455.14.00 and 3010.20.15).<sup>38 39</sup>

In order to get the SIL budget to form correctly, the worker should take the entire RSDI amount, subtract the SSI maximum allotment (see example below) and enter that amount on the UNEARNED INCOME screen in the eligibility system. The remaining amount would then be entered as SSD income. The budget would correctly reflect the liability.

DAC member is receiving \$2000 a month. In 2017, the SSI allotment is \$735. In the Eligibility System, enter SSI income of \$735, and the remaining amount of \$1265 as SSD (total amount of \$2000 - \$735 = \$1265).

#### 2414.10.15 Pickle

Individuals who would continue to receive SSI but for an increase in their in other benefits from the SSA due to the annual cost-of-living-adjustment (COLA) increases are considered eligible for Medicaid.

#### 2414.10.20 Disabled Widows or Widowers

When an SSI recipient who is at least 60 through 64 years of age, is a widow or widower, and loses SSI benefits solely due to receipt of other new or increased benefits from Social Security, and the individual is not entitled to Medicare Part A, the person is automatically eligible for Medicaid.<sup>40</sup> The person's countable income from Social Security should be reduced to the applicable SSI benefit amount.

When an SSI recipient who is at least 50 through 59 years of age, is a widow or widower, and loses SSI benefits solely due to receipt of other new or increased benefits from Social Security, and the individual is not entitled to Medicare Part A, the person's countable income from Social Security should be reduced to the applicable SSI benefit amount.

Individuals who have been receiving the special income disregard under *Darling v. Bowen* in IHCPPM 3455.05.05.25 are entitled to Medicaid eligibility as long as they have been continuously entitled and maintained entitlement to widow's or widower's disability benefits from Social Security.<sup>41</sup>



## 2415.00.00 CATEGORICAL ELIGIBILITY FOR MEDICAID WAIVERS

In order to be eligible under a Medicaid Home and Community-Based Services waiver, an individual must qualify under one of the specific aid categories that are approved for the waiver. Workers must ensure that waiver applicant/recipients are considered for Medicaid in the proper category. Verification of the specific waiver for which an individual is either applying or already approved, must be obtained from the waiver case manager. Please, refer to IHCPPM 3310.00.00 for permissible categories to receive HCBS waivers.

There are various special eligibility provisions that are applicable in certain categories and under certain waivers as explained in Chapters 3300 and 3400.

## 2416.00.00 MEDICARE STATUS (MED 4)

Individuals whose status with the federal Medicare program meets certain requirements, and who also meet other eligibility requirements, can qualify for limited Medicaid coverage. The following four sections specify the categories under which this is possible.

### 2416.05.00 QUALIFIED MEDICARE BENEFICIARY (MED 4)

The policy in this section applies to the MA L category of assistance.

In order to be eligible as a Qualified Medicare Beneficiary (QMB) an individual must be entitled to Medicare Part A. An individual meets this requirement if he is enrolled in Medicare Part A, or is eligible for enrollment if a monthly Part A premium is paid. Medicare Part A enrollment can be verified by viewing the Medicare card, a TPQY, or by correspondence from the SSA. If there is no Medicare Part A enrollment, those who are eligible for Medicare Part A with a monthly premium can be identified as follows:

1. Usually have only SSI income;
2. Are age 65 or over; and
3. Have a HIB number ending in M, J3, J4, K3, or K4, and sometimes T.

Also refer to Page VII-2 of the Medicaid Enrollment Manual Buy-In Section.

No other verification of age is required, nor does the disability requirement applicable to the Medical Assistance for the Disabled category apply to individuals eligible as QMB only.

A QMB must also satisfy the citizenship, residency, SSN, and medical assignment requirements explained in the respective sections of this chapter.

Refer to Section 3010.35.05 for QMB income standards and Section 3005.25.00 for QMB resource standards.

QMB coverage is limited to payment of:<sup>42</sup>

1. The monthly premium for Medicare Part B;
2. The monthly premium for Premium Hospital Insurance under Medicare Part A, for individuals not entitled to free Part A; (These premiums are required of certain persons entitled to hospital insurance benefits only by voluntary enrollment in the premium paying Part A program.); and
3. Medicare Part A and B deductibles and co-insurance. An individual can be simultaneously eligible under another full coverage category and QMB.
4. Co-payments for Medicare Part C (Medicare Advantage plans)<sup>43</sup> (Refer to Section 3465.05.00)

#### 2416.10.00 QUALIFIED DISABLED AND WORKING INDIVIDUALS (MED 4)

The policy in this section applies to the MA G category of assistance.

Disabled and working individuals who lost or will lose Medicare coverage because of their working status, are entitled to enroll in Medicare Part A under the provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89). If they also meet certain other eligibility requirements, they are eligible for the category of assistance entitled Qualified Disabled and Working Individuals (QDW).<sup>44</sup>

QDW coverage is limited to payment of the monthly premium for Medicare Part A only. These individuals may also enroll in Medicare Part B (if they are enrolled in Part A), but they will always be responsible for paying the Part B premium themselves.

The individuals who contact the DFR and wish to apply for the QDW category of assistance should be asked to provide a notice from SSA informing them that they will lose their Medicare because of their working status. The affected Medicare beneficiary will receive such a notice in each of the three months prior to discontinuance of Medicare. An individual whose Medicare was previously terminated should provide a notice he has received from SSA, or some other evidence from SSA, that his Medicare was terminated because he was working.

A QDW must also satisfy the citizenship, residency, SSN, and medical assignment requirements explained in the respective sections of this chapter.

Refer to Section 3010.35.15 for QDW income standards and Section 3005.25.00 for QDW resource standards.

An applicant/recipient is not eligible for QDW if he is otherwise eligible for Medicaid.<sup>45</sup>

#### 2416.15.00 SPECIFIED LOW INCOME MEDICARE BENEFICIARY (MED 4)

The policy in this section applies to the MA J category of assistance.

Persons who are entitled to Medicare Part A may qualify under the Specified Low Income Medicare Beneficiary (SLMB) category. The eligibility requirements are the same as those for

QMB (refer to Section 2416.05.00) except the income standards are higher. (Refer to Section 3010.35.10 for SLMB income standards.) Coverage is limited to payment of the Medicare Part B premium.<sup>46</sup>

An individual can be simultaneously eligible for SLMB and a full coverage category or can be eligible as "SLMB-only". A recipient entitled as "SLMB-only" will not receive a Medicaid ID card. If the individual's countable income exceeds the QMB standard, eligibility for SLMB will be determined. (Refer to Section 3005.25.00 for SLMB resource standards.)

#### 2416.20.00 QUALIFIED INDIVIDUALS (MED 4)

The policy in this section applies to the MA I category of assistance.

Persons who are entitled to Medicare Part A may qualify under the Qualified Individuals category of assistance, QI. An individual eligible under any other Medicaid category cannot be eligible as a QI.

The QI category is designated as MA I in the eligibility system. The non-financial, income, and resource eligibility criteria are the same as for QMB except that the individual's income for the appropriate family size must be between 120% and 135% of the Federal Poverty Level. (Refer to Section 3010.35.20 for QI income standards and 3005.25.00 for QI resource standards.) QI coverage is limited to payment of the Part B Medicare premium.<sup>47</sup>

Qualified Individuals will not receive a Medicaid ID card.

#### 2418.00.00 Household Tax Relationships (MED 3)

Applicants or recipients whose eligibility is reviewed must attest whether they have filed or expect to file taxes or whether they have been claimed or expect to be claimed as a tax dependent in the year eligibility is being determined or re-determined. A person's tax filing status will determine the AG formation for that individual. Please, refer to IHCPPM 3200 for specific policy for MAGI categories.<sup>48</sup>

When MAGI does not apply, an applicant or recipient's eligibility should not depend upon the tax filing status of that individual.

#### 2420.00.00 RESIDENCE IN THE HOME OF A SPECIFIED RELATIVE (MED 3)

The following policy is limited to MAGF. For MA F, please, refer to IHCPPM 3800.

For MAGF relationships generally control. Refer to IHCPPM 3205.05.00 through 3205.20.00. When the non-filing rules apply (refer to IHCPPM 3205.20.00) for that applicant/recipient whose eligibility is being determined under these categories, the applicant/recipient must be living with a person having a specified degree of relationship, in a place of residence. The MAGF

applicant/recipient must be considered the caretaker relative for another person under the age of 18.<sup>49</sup>

The individual with whom the person resides must be related to the applicant/recipient as specified in the following groups:

1. Any blood relative within the fifth degree of relationship, including, but not limited to, those of half-blood, including first cousins, first cousins once removed, nephews, nieces, uncles, aunts, and individuals of preceding generations as denoted by prefixes of grand, great, great-great, or great-great-great; or
2. Legal spouses of any individuals named above, even though the marriage was terminated by death or divorce.<sup>50</sup>

A guardian may receive assistance only when such person is a relative listed above and the child lives with that person.

#### 2420.05.05 Verification of Relationship (MED3)

The following policy is limited to MAGF.

It is the responsibility of the applicant/recipient to assist the worker to verify the degree of relationship between an applicant/recipient and a specified relative.

The relationship of a child to a relative listed in the previous section, except for an alleged father, is verified when the caseworker either:

- Sees the child's birth certificate; or
- Obtains verification from two of the sources listed below, when the birth certificate is not seen:
  - Hospital records established at the time of birth (including a hospital issued birth certificate);
  - Physician's records;
  - Marriage records;
  - Court records, including adoption records;
  - Social Security Administration records;
  - Church documents, such as baptismal certificates;
  - Passport;
  - Immigration records;
  - Naturalization records;
  - School records;
  - Records of social agencies (including the Local Office); or

- Signed statement from an unrelated reliable person having specific knowledge about the relationship of the child to the specified relative

#### 2420.10.05 Verification of Living With (MED 3)

The following policy is limited to MAGF.

The "living with" requirement may be satisfied by the applicant's/recipient's statement, unless discrepant information exists.

If there is a question whether the child is living with his relative, verification may be obtained from other sources based on the individual situation. Such sources include, but are not limited to:

- Seeing the child in the home;
- School records;
- Child care provider's records;
- Landlord's statement;
- Hospital, clinic, or physician's records;
- Social Security or other benefit records;
- Church records;
- Court support order;
- Child welfare records; and
- Signed statement from a reliable individual having personal knowledge of the child living with the specified relative.

#### 2420.15.00 TEMPORARY ABSENCE FROM THE HOME (MED 3)

When MAGI rules apply for all MED 3 categories, absence of the recipient child or parent/caretaker relative from the home for limited periods of time does not affect eligibility, provided that the absent member intends to return to the home.<sup>51</sup>

#### 2422.00.00 INSTITUTIONAL STATUS

An institution, as defined by federal regulation, is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.<sup>52</sup>

#### 2422.10.00 RESIDENTS OF INSTITUTIONS

The Medicaid eligibility of an individual who resides in an institution is governed by the type of institution, in addition to the other eligibility factors. A public institution is an institution that is

the responsibility of a municipal, county, state, or federal governmental unit, or over which such a governmental unit exercises administrative control.

Individuals who are serving time for a criminal offense and incarcerated in public correctional institutions such as jails, prisons, and detention facilities including those for juveniles, are not eligible for Medicaid/Hoosier Healthwise.<sup>60</sup> These individuals are defined as “inmates of public institutions”. An individual on parole, or sentenced to home detention except during those times when reporting to a prison for an overnight stay, individuals living voluntarily in a detention center, jail, or county penal facility after their case has been adjudicated and other living arrangements are being made for them (such as a transfer to a community residence) and infants who are permitted to stay in a correctional facility with their inmate mothers are examples of persons who can be eligible for Medicaid if they meet all of the other program requirements.

The following individuals are not eligible for Medicaid:

- individuals (including juveniles) who are being held involuntarily in detention centers awaiting trial;
  - inmates involuntarily residing at a wilderness camp under governmental control;
  - inmates involuntarily residing in half-way houses under governmental control;
  - inmates receiving care as an outpatient;
  - inmates receiving care on premises of a prison, jail, detention center, or other penal setting;
- and
- Individuals involuntarily living in state or local corrections-related supervised community residential facilities (operated by a governmental entity or a private entity; i.e.: work release facilities).

If the individual does not have freedom of movement and association while residing at the facility then the individual does not qualify for Medicaid.

Freedom of movement includes the ability for residents to use community resources (such as libraries, grocery stores, recreation, education, and so on) at will. These individuals are able to leave in the morning from these facilities and are just required to return by a specific time in the evenings.

The ability to move at will means the residents are able to go about the community with freedom of movement but still abide by the facilities’ house rules.

Structured movement means the residents are only allowed to leave the work release facility for work, court appearances or court ordered programs. These individuals are not able to be in the community at will and are held to a strict time schedule and are also subject to being monitored by program staff while out in the community.

Individuals may be eligible for Medicaid while residing in the types of institutions listed below, public and private, if they are not inmates as described in the above paragraphs. (Special eligibility considerations for persons in psychiatric facilities are explained in Section 2422.10.05.)

- Nursing facilities providing skilled and/or intermediate levels of care;
- Acute care hospitals;
- Intermediate Care Facilities for the Mentally Handicapped/Developmentally Disabled (ICF/MR, or CRF/DD);
- Public institutions designed to serve no more than 16 persons and which provide services beyond food and shelter, such as social services, help with personal living activities, or training in socialization and life skills <sup>61</sup>;
- Public educational or vocational training institutions such as Indiana Schools for the Blind and Deaf and Silvercrest Developmental Center;
- Medicaid certified state institutions, or portions thereof, under the direction of the Indiana Family and Social Services Administration, Division of Mental Health; (note section 2422.10.05)
- Public residential care institutions such as county homes;
- Any other type of privately owned group living arrangement such as a foster home or group home;
- Former inmates with freedom of movement, (i.e.: halfway house, work release, etc.) even if there is a curfew in effect, are prohibited from certain locations and sleep in a lock down facility. These residents still have the freedom of movement during the day hours and would qualify for Medicaid;
- Home detention or electronic monitoring in a private home; and
- Out of State TBI facilities which are Medicaid certified (note section 2406.20.10.05).

#### 2422.10.05 Residents of Psychiatric Facilities

Residents of psychiatric facilities (public or private) may be eligible for Medicaid under the conditions specified below.

A psychiatric facility, or institution for mental diseases (IMD) as referred to in federal regulations, is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care to persons with mental diseases, including medical care, nursing care, and related services.<sup>53</sup>

Individuals residing in an IMD, as defined above, can be eligible for MA, if they are:

- Age 65 or older; or
- Under age 21, reside in a Medicaid certified facility, and have an approved Certification of Need, Form 1261A. Refer to Section 2422.10.10.

Additionally, if a recipient is receiving approved inpatient services prior to age 21, coverage continues until services are no longer required or the recipient reaches age 22, whichever comes first.<sup>54</sup>

#### 2422.10.10 Certification of Need/Inpatient Psychiatric Care

In order for individuals under the age of 21 to be eligible for Medicaid in a Medicaid certified psychiatric facility, an approved certification of need, the Form 1261A, Certification-Plan of Care for Inpatient Psychiatric Hospital Services, is required. If the Plan of Care is disapproved for an applicant/recipient, the individual is ineligible for Medicaid while residing in the facility. In order for individuals age 65 and older to be eligible for Medicaid reimbursement of inpatient psychiatric services, an approved Form 1261A is required; however, such an individual is eligible for all other Medicaid services while residing in the psychiatric facility.

The facility is responsible for the completion and submission of the Form 1261A to the appropriate reviewing authority. State facilities submit the Form 1261A to the Medical Review Team, Office of Medicaid Policy and Planning; privately owned facilities submit the Form 1261A to the prior authorization unit of the Medicaid fiscal contractor.

Following approval or disapproval of the plan of care, the original of the Form 1261A will be returned to the facility and a copy will be forwarded to the Local Office for retention in the case file. Copies of the signed Form 1261A are not to be forwarded to the Medical Review Team by the Local Office.

For individuals under age 21, facilities are instructed to submit the Form 1261A prior to the admission of a Medicaid recipient. Caseworkers are not to initiate case action until a copy of the approved or disapproved Form 1261A is received. If the Form 1261A is approved, an institution budget is to be completed. If the Form 1261A is disapproved, action to suspend Medicaid should be proposed if the recipient remains in the facility; if the recipient leaves the facility, eligibility is to be determined as appropriate, based on the new living arrangement.

For Medicaid applicants, facilities are instructed to submit the Form 1261A within 10 days after the applicant has been determined eligible for Medicaid. Therefore, caseworkers are to complete the application process in the usual manner, using post-eligibility budgeting procedures. If the Form 1261A is approved, no further case action is required. If the Form 1261A is disapproved, action to suspend should be proposed if the recipient remains in the facility. This is done by entering SUSP on AEWAA and authorizing. If the recipient leaves the facility, eligibility is to be determined as appropriate based on the new living arrangement.

#### 2422.10.15 Persons Age 65 and Older/Inpatient Psychiatric Care

For applicants/recipients age 65 and older who are admitted to Medicaid certified psychiatric facilities, the procedures explained above are applicable except that a disapproved Form 1261A does not render the person ineligible for Medicaid. Disapproval indicated on screen AEIII means that Medicaid will not provide reimbursement to the facility for inpatient psychiatric services. If the recipient remains in the facility, community budgeting is to be used. Refer to Section 2422.10.10.



#### 2424.00.00 LEVEL OF CARE/PREADMISSION SCREENING

A Medicaid applicant/recipient who enters a nursing facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), or Community Residential/Developmentally Disabled (CRF/DD) must first undergo preadmission screening to determine whether the individual requires the level of care provided by a nursing facility or is entitled to reimbursement on his behalf in an ICF/MR or CRF/DD. When completing AEIII, the caseworker will assume preadmission screening/level of care is approved unless there is information to the contrary. The preadmission screening field should be completed by entering "S" - screened, followed by the date that the individual entered the nursing facility. (The date that the preadmission screening was actually completed may be used, if it is known.) The caseworker may then proceed with the eligibility determination, including authorization if the individual passes eligibility.

In the event that preadmission screening and/or level of care is denied for the individual, the DFR will receive a Form 450B, Physician's Certification for Long Term Care Services, which indicates a denial. The worker should monitor the Forms 450B that are received by the DFR. When a denial is received, the worker should change the preadmission screening field on screen AEIII from "S" to "D" - denied. The individual's eligibility will then be redetermined by eligibility system without the post-eligibility budget.

#### 2426.00.00 PREGNANCY (MED 3)

Within the MED 3 category, the policy stated in this section applies only to MAMA and MAGP (For definition, see Section 1620.50.00).

To qualify for assistance under these categories, the pregnant woman must self-attest that she is pregnant.<sup>58</sup> These categories are calculated with MAGI methodology and a woman must be found income eligible in the month of application to be eligible for retro and ongoing coverage. (42 CFR 435.831(1) & 42 CFR 435.603)

Pregnant women may receive assistance under other categories of assistance, if otherwise eligible, per the rule of first category (i.e. MASI, MA D, MADW, MADI).

**Once determined eligible, in any Medicaid category, a pregnant woman's coverage is maintained throughout the pregnancy (without regard to changes in income) and until the end of the 60-day postpartum period.**

#### 2428.00.00 NEWBORN STATUS (MED)

The policy stated in this section only applies to MA X child born to a woman, who is eligible for traditional Indiana Medicaid or Hoosier Healthwise under any benefit package except Package C (MA 10), on the date the child is born, is eligible for 12 continuous months as long as the child continues to live in Indiana. This also includes infants born to mothers who are eligible for emergency Medicaid services only.<sup>55</sup> An application is not required and the only eligibility factor at the time of the birth is that the infant's birth mother was eligible for Medicaid when the infant

was born. The 12-month eligibility period will end before the 12th month only due to loss of Indiana residency, a written voluntary withdrawal from the caretaker/parent, or death of the child.

Refer to Section 2225.10.00 for case processing information and Information about adding a newborn to the case. The newborn must be enrolled in Medicaid without delay.

As long as the mother is determined eligible for Medicaid/Hoosier Healthwise for the month of the child's birth, the child is eligible in the Newborn category even when the mother applies for Medicaid after the child is born. If the child is born during a month of the mother's retroactive coverage and she is eligible for that month, the baby eligible for the Newborn category.

Coverage in the Newborn category continues for the 12 month period if the child goes to live with someone other than the birth mother, including adoption when the child leaves the hospital and goes directly to live with the adoptive parent(s). However, if the identity and location of the adoptive parent(s) are not known, or the child is adopted by parents living out of state, benefits under the Newborn category are provided for the birth month through discharge and removed the subsequent month. If the infant has not been named, the name assigned to the child by the hospital for identification purposes may be used. If the child is adopted by parents living out of state, newborn coverage in Indiana is approved for the birth month only.

#### 2432.00.00 REQUIREMENT TO FILE FOR OTHER BENEFITS (MED 1, MED 4)

Individuals must apply for all other benefits for which they may be eligible, as a condition of eligibility unless good cause can be shown for not doing so. Benefits that must be applied for include, but are not limited to.<sup>56</sup>

- Annuities
- Pensions from local, state, or federal government;
- Required Minimum Distributions from Retirement benefits;
- Disability;
- Social Security benefits;
- Veterans' benefits;
- Unemployment compensation benefits;
- Military benefits;
- Railroad retirement benefits;
- Workmen's Compensation benefits; and
- Health and accident insurance payments.

In some cases, individuals who are already receiving benefits may be eligible for increased benefits due to a change in their circumstances (for example, veterans' benefits). Individuals are required to apply for all increased benefits for which they may potentially qualify. However, they are not required to apply for Social Security retirement benefits, individuals may wait until age 65 to apply.

If the individual is eligible to receive payments but elects not to, they are ineligible due to failure to file for other benefits to which they are entitled.

#### 2432.05.00 REQUIREMENTS FOR REFUGEES (MED 2)

A refugee's eligibility for MA is first considered for all categories of assistance other than Refugee Medical Assistance.<sup>57</sup> The eligibility system automatically determines a refugee's eligibility in this manner to comply with federal regulations. (Refer to Section 1620.05.00)

Newly arrived refugees will not be placed into HIP 2.0 since this category does not provide immediate coverage at the level which they require. Because these individuals and families arrive in the country with the increased need for additional screenings and services, the conditional period would be a hardship for them and could delay the effective date of their coverage for up to 60 days.

Whenever possible refugees will be placed in another Medicaid category with no conditional period, so that Medicaid will be effective beginning three months retroactive to the month of application or as of the date they first arrived in the country, whichever is later.

Low income parent/caretaker refugees who qualify financially will be covered under MAGF in the fee-for-service delivery model for up to eight months after arriving in the country.

Members who do not qualify for any other Medicaid but pass eligibility for MA Q will be covered in that category so that they may get coverage on the day that they apply.

Only members who do not initially qualify for any other Medicaid, but also fail financial eligibility for MA Q, will be allowed to be authorized conditionally in a HIP 2.0 category. Because this will only be applicable for members who are over the low income parent/caretaker income standard, they will receive Regular coverage unless Medical Frailty is confirmed. This will not afford them services, for the most part, on the day they applied; but will provide them some coverage to them as soon as the initial POWER Account payment is made.

In addition, the worker must refer refugees who are 65 years of age or older, or who are blind or disabled, to the SSA to apply for assistance under the SSI program. Cash Assistance is to be furnished to eligible refugees until eligibility under the SSI program is determined.

#### 2433.00.00 HEALTH INSURANCE COVERAGE CONSIDERATIONS (MA 10)

There are certain limitations to eligibility under Hoosier Healthwise Package C relative to the coverage or possible coverage of the children under other insurance<sup>58</sup> as follows:

Access to the State of Indiana Health Insurance Plan:

- Children whose parents, caretakers or spouses can cover them under the State of Indiana's health coverage plans offered to State employees are not eligible for MA 10. This prohibition applies even if the State employee has chosen not to cover the child, and regardless of whether or not an open enrollment period is available to the employee at the time of the application. The prohibition does not apply if it is a non-custodial parent who is the State employee.

If the requirements for coverage under the State benefit package appear to be met but the State employee maintains that the child in his or her care cannot be covered, the employee must present or obtain verification from the agency's health plan administrator. The application should pend awaiting this verification.

Coverage by other health insurance:

- Children who are covered by comprehensive health insurance (hospital and medical or major medical) are not eligible for MA 10, this differs from the limitation above as the issue is verified coverage, not merely access. If a child has health insurance, the MA 10 eligibility determination must pend for verification of the insurance benefit types.

Dropping health insurance coverage:

- Children whose health insurance coverage has been dropped voluntarily may not receive MA 10 for no more than 90 days following the month of termination. The application asks for information concerning the reason for the termination of coverage. If "could not afford" is indicated as the reason, the insurance is considered to have been terminated voluntarily and the child is subject to the 90-day waiting period. Termination of insurance due to loss of employment (even if the loss was due to a voluntary quit) does not affect the child's eligibility for MA 10. If the family lists a reason that is not on the application or the eligibility system table, and the worker is uncertain as to whether the termination should be considered voluntary, the Policy Answer Line should be contacted.

The following reasons for health insurance being dropped will not cause CHIP coverage to be subject to a 90 day waiting period:

- loss of employment
- coverage limit reached
- non-custodial parent dropped insurance coverage
- divorce/death of parent
- employer ended insurance coverage

- insurance premium is more than 5 percent of the family income for the child's coverage
- cost of family insurance coverage is more than 9.5 percent of family income
- child has special health care needs
- withdrawing from FFM Coverage because now eligible for Medicaid or CHIP (must present verification/letter that FFM coverage has ended; cannot have dual coverage)

#### 2434.00.00 ASSIGNMENT OF MEDICAL RIGHTS

As of July 1, 2011, in support of P.L.153-2011, the assignment of medical rights became operational by State law. This means that no separately executed assignment of rights is required for Medicaid eligibility.

Cooperation in identifying and providing information about responsible third parties, including absent parents, as well as cooperation in obtaining third party payments and medical support, is required unless the applicant/recipient establishes good cause.<sup>56</sup>

#### 2434.05.00 MEDICAL SUPPORT COOPERATION REQUIREMENTS

This section does not apply to pregnant women (MAGP), Transitional Medical Assistance (MA F), or applicant/recipient children under 18 whose eligibility is being determined under a category other than MAGF.

The applicant/recipient is required to cooperate, unless good cause is established, in obtaining medical support and payments for medical care as follows:<sup>57</sup>

- Provide the DFR with all information regarding existing and future medical insurance coverage;
- Advise the DFR of any existing or future court orders which provide support for medical care;
- Advise the DFR of any legal action taken or intended to be taken against a third party for injuries he has sustained in an accident; (this also applies to any other applicant/recipient for whom he is legally responsible);
- Assist in obtaining any support for medical care available to him under any order of a court or administrative agency;
- Assist in obtaining any third party payments which may be available; and
- Pay to the Central Office or DFR any money from any third party who is paid directly to him for medical services which were or will be paid by Medicaid.

#### 2434.10.00 IV-D SANCTION REQUEST

When an IV-D sanction request is received, it must state that the custodial parent or legal guardian failed to cooperate in obtaining medical support. Information regarding policy subsequent to the receipt of an IV-D sanction request is found in Section 2434.20.00.

#### 2434.15.00 IDENTIFICATION OF MEDICAL RESOURCES

The DFR must secure information from the applicant and any other knowledgeable source such as a parent, authorized representative or legal guardian on medical resources that are available or were available during the retroactive period to pay for the applicant's medical expenses.

Medical resources include, but are not limited to:

- Health insurance policies, including health insurance policies from the Federal Marketplace, carried by the applicant or carried for the applicant by an employer or relative;
- Government financed health programs, such as:
  - o Medicare - Parts A and/or B;
  - o CHAMPUS (Civilian Health and Medical Program of the Uniformed Services);
  - o CHAMPVA (Civilian Health and Medical Program of the Veterans Administration);
  - and
  - o Veterans' benefits;
  - o Tricare;
  - o Workman's compensation (for employment related accidents); and
  - o Automobile insurance (for automobile accidents).

It is crucial that all medical resources be identified so that, if the applicant is determined to be eligible for MA, the Medicaid Fiscal Contractor, when processing provider claims, can seek payment from these resources before payment is made by Medicaid.

#### 2434.20.00 THE RIGHT TO CLAIM GOOD CAUSE - MEDICAL SUPPORT

Upon receipt of a medical sanction request from IV-D, a Medical Assignment Good Cause Notice (FI 2009) must be sent to the client prior to any enforcement of a sanction. The Good Cause notice gives the client 20 days to come into compliance with the medical support obligations by:

Claiming good cause by returning the form, along with evidence supporting their claim, to the DFR. If the form is not returned within the 20 days, the sanction is enforceable. If the form is

returned within 20 days, the sanction is not enforceable, pending the good cause decision. A copy of the notice must be retained in the case record.

Please note that a good cause notice must also be given to an applicant/recipient who is deciding whether or not to claim good cause.

Good cause is defined as any circumstances in which cooperation would result in serious physical or emotional harm to the individual for whom medical support is sought. The evidence needed to substantiate a good cause claim is specified on the good cause notice.

If the client returns the Good Cause Notice to the local office, the form and any other related documentation should be sent to Central Office for review. While Central Office is making a determination, benefits cannot be delayed, denied, or discontinued, as long as all other financial and non-financial eligibility requirements have been met.

If Central Office determines that Good Cause has been established, the sanction is not enforceable.

If Central Office determines that Good Cause was not met, the sanction is enforceable.

A sanctioned person who reapplies for medical assistance must be given another opportunity to comply with the medical support requirements. Consequently, there should be no automatic denial of assistance. If the applicant is otherwise eligible, the benefit is to be provided and the individual should be referred to the IV-D office again.

#### 2434.20.05 Medical Support Good Cause Determination

The Central Office will notify the DFR in writing of the decision on the recipient's good cause claim. If the decision is that good cause does not exist, the DFR must notify the recipient and give him the opportunity to cooperate. Continued refusal to cooperate will result in the discontinuance of Medicaid except in the case of minor applicants/recipients, who are not penalized for their caretaker's refusal to cooperate.

#### 2434.20.10 DFR Review Of Good Cause Determination

At the time of each redetermination, the DFR must review the good cause claim. If the determination of the existence of good cause was based on a circumstance which has changed so that good cause may no longer exist, the DFR must notify the Central Office of such change and recommend that the good cause finding be rescinded.<sup>58</sup>

#### 2434.25.00 PENALTIES FOR MEDICAL SUPPORT NON-COMPLIANCE

This section does not apply to pregnant women (MAGP), Transitional Medical Assistance (MA F), or applicant/recipient children under 18 whose eligibility is being determined under a category other than MAGF.

Medicaid must be denied or terminated for any competent adult applicant/recipient who refuses, without good cause, (Section 2434.20.00), to cooperate in obtaining medical support.

IV-D sanctioned TANF recipients do not automatically lose Medicaid eligibility due to the TANF sanction. The reason for the sanction must be reviewed to determine if the sanctioned individual is out of compliance with his/her medical support requirements before discontinuing Medicaid eligibility.

#### 2434.30.00 CIRCUMSTANCES WHEN PENALTIES ARE NOT APPLIED

An individual can prevent a sanction by coming into compliance with the medical support obligations within the 20 days given by the Medical Assignment Good Cause Notice (FI 2009). In addition to successfully claiming good cause a person can demonstrate compliance within the 20 days by providing proof of a scheduled appointment with the IV-D office.

Also, please note that Medicaid eligibility must be approved/continued for the minor applicant/recipient whose custodial parent or legal guardian refuses, without good cause, to cooperate in obtaining medical support.

EXAMPLE: A recipient father refuses to cooperate in obtaining medical support for his recipient child; the father is not eligible for Medicaid, but the child is.

#### 2435.00.00 HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

Indiana Medicaid through the Health Insurance Premium Payment (HIPP) Program is required to purchase (wherever available and cost effective) employer-based group health insurance on behalf of covered Medicaid recipients. The enrollment in such insurance plans is a condition of the covered recipients' Medicaid eligibility.

Please refer to the Administrative Letter regarding the Health Insurance Premium Payment Program, dated February 10, 1995, and the Caseworker Training Guide for HIPP on the procedures to follow for this program.

#### 2436.00.00 FOOTNOTES

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<sup>1</sup> 8 CFR 320.2

<sup>2</sup> 42 CFR 435.911

<sup>3</sup> 42 CFR 435.910

<sup>4</sup> 42 CFR 435.910

<sup>5</sup> 42 CFR 435.910

<sup>6</sup> 42 CFR 435.910

<sup>7</sup> 42 CFR 435.910

<sup>8</sup> 42 CFR 435.910

<sup>9</sup> 42 CFR 435.403

<sup>10</sup> 42 CFR 435.403

<sup>11</sup> 42 CFR 435.403



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<sup>12</sup> 42 CFR 435.403  
<sup>13</sup> 42 CFR 435.403  
<sup>14</sup> 42 CFR 435.403  
<sup>15</sup> 42 CFR 435.403  
<sup>16</sup> 42 CFR 435.403  
<sup>17</sup> 405 IAC 2-2-1  
<sup>18</sup> 1902(a)(10)(A)(ii)(XV) and 1902(a)(10)(A)(ii)(XVI) of the Social Security Act  
<sup>19</sup> 405 IAC 2-2-2  
<sup>20</sup> 42 CFR 435.531  
<sup>21</sup> 42 CFR 435.531; 405 IAC 2-2-2  
<sup>22</sup> SSA 1902(a)(12); 42 CFR 435.531  
<sup>23</sup> 405 IAC 2-2-2  
<sup>24</sup> 42 CFR 440.270  
<sup>25</sup> 405 IAC 2-2-2  
<sup>26</sup> 405 IAC 2-2-4  
<sup>27</sup> 405 IAC 2-2-4  
<sup>28</sup> 405 IAC 2-2-2  
<sup>29</sup> 470 IAC 2.1-1-2  
<sup>30</sup> 470 IAC 2.1-1-2  
<sup>31</sup> 42 CFR 435.541  
<sup>32</sup> 405 IAC 2-2-4  
<sup>33</sup> 405 IAC 2-2-4  
<sup>34</sup> 20 CFR 404.909  
<sup>35</sup> 20 CFR 404.909  
<sup>36</sup> 470 IAC 2.1-1-2  
<sup>37</sup> 470 IAC 2.1-1-2  
<sup>38</sup> 42 U.S. Code § 1382 (e) (1) (G)  
<sup>39</sup> 42 CFR §435.725  
<sup>40</sup> 42 CFR 435.138  
<sup>41</sup> 42 CFR 435.137  
<sup>42</sup> SSA 1902(a)(10)(E)  
<sup>43</sup> SSA 1905(p)(1)  
<sup>44</sup> SSA 1902(a)(10)(E)  
<sup>45</sup> SSA 1905(s)(4) as added by P.L. 101-239  
<sup>46</sup> SSA 1902(a)(10)(E)(iii)  
<sup>47</sup> SSA 1902(a)(10)(E)  
<sup>48</sup> 42 CFR 435.603  
<sup>49</sup> Social Security Act, Section 406(a)(c)  
<sup>50</sup> 45 CFR 233.90  
<sup>51</sup> 45 CFR 233.90  
<sup>52</sup> 42 CFR 435.1009  
<sup>53</sup> Social Security Act, Section 1905(i)  
<sup>54</sup> 42 CFR 441.151  
<sup>55</sup> Social Security Act, Section 1902(e)(4)  
<sup>56</sup> 42 CFR 435.608  
<sup>57</sup> Social Security Act, Section 1912(a);  
<sup>58</sup> 42 CFR 433.147