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# 34th Annual Medicaid in Indiana for the Elderly and Disabled

Indiana Continuing Legal Education Forum (ICLEF)

# MEDICAID FOR THE ELDERLY AND DISABLED IN INDIANA

**by**

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**MEDICAID IN INDIANA FOR THE ELDERLY AND DISABLED - 2022**

**Table of Contents**

## Appendices

## ABOUT THE AUTHORS

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## ABOUT THIS MANUAL

The Senior Law Project has conducted an annual training on Medicaid in Indiana for the Aged and Disabled for thirty three years. This Manual has been updated and expanded yearly for use in this training. It also serves as a reference for Indiana lawyers on Indiana Medicaid law as it applies to applicants and recipients. Although it does not cover every rule, it covers many that will not be covered in the training. If you have corrections or suggestions for improving this Manual, or if you would like to contribute a form for the Appendix, please contact Dennis Frick at Dennis.Frick@ilsi.net.

# Year 2022 Indiana Public Benefits Updates

| **MEDICARE** (Changes each year on Jan. 1) | 2022 | 2021 |
|---|---|---|
| Part A premium for those not automatically covered | 499/274[1] | 471/259[1] |
| Part B premium | 170.10[2] | 148.50[2] |
| Part B deductible | 233 | 203 |
| Hospital deductible | 1,556 | 1,484 |
| Hospital copay for days 61-90 | 389 | 371 |
| Hospital copay for 60 lifetime reserve days | 778 | 742 |
| Skilled nursing facility copay days 21-100 | 194.50 | 185.50 |
| Part D Premium–Indiana benchmark | 29.65 | 29.61 |
| Medicare D Deductible | 480 | 445 |
| Medicare D Initial Coverage Limit | 4,430 | 4,130 |
| Medicare D Out of Pocket Threshold | 7,050 | 6,550 |
| Medicare D Extra Help w/ Inc. < 100% FPL generics/brand | 1.35/4.00 | 1.30/4.00 |
| Medicare D Extra Help w/ Inc > 100% FPL generics/brand | 3.95/9.85 | 3.70/9.20 |

| **MEDICAID** | | |
|---|---|---|
| Income standard for household of 1 | 1,133[4] | 1,074[4] |
| Income standard for household of 2 | 1,526[4] | 1,452[4] |
| Special Income Level for A & D waiver and NH residents | 2,523[3] | 2,382[3] |
| Max room & board cost for waiver recip in Assisted Living | 841[9] | 794[9] |
| Allocation for Essential Person or Non-recip Minor Child | 421 | 397 |
| HIP income limit for household of 1 / 2 | 1,507/2,030[4] | 1,428/1,931[4] |
| QMB income for household of 1 | 1,699[4] | 1,610[4] |
| QMB income for household of 2 | 2,289[4] | 2,178[4] |
| SLMB or QI for household of 1 | 2,096[4] | 1,986[4] |
| SLMB or QI for household of 2 | 2,823[4] | 2,686[4] |
| Resource limits for single/married for QMB, SLMB, QI | 8,400/12,600 | 7,970/11,960 |
| MEDWORKS - Max. Inc. (Based on countable inc.) | 3,964[4] | 3,757[4] |
| MEDWORKS for household of ½ - No Premium | 1,699/2,289[4] | 1,610/2,178[4] (Based on gross inc.) |
| BPHC Waiver | 3,398[4] | 3,220[4] |
| QDW - Qualified Disabled Worker | 2,265[4] | 2,147[4] |
| Home Equity Limit | 636,000 | 603,000 |
| Spousal impoverishment floor (community spouse share) | 27,480/29,480[8] | 26,076/28,076[8] |
| Spousal impoverishment ceiling (community spouse share) | 137,400/139,400[8] | 130,380/132,380[8] |
| Community spouse income allowance (eff. July 1) | 2,289[5] | 2,178[5] |
| Community excess shelter deduction (eff. July 1) | 687[5] | 653[5] |
| Maximum community spouse income share | 3,435 | 3,260 |
| Nursing Home Ave. Rate for Transfer Penalties | | 6,873[6] |
| Long Term Care Ins. max benefit for no asset limit | 451,515[7] | 430,014[7] |

Standard Utility Deduction: 5/01/2022 - $447/mo if heating or cooling exp.; $266 if no heating or cooling but two other utility exp.; $59 if one utility exp. but no heating, cooling, or telephone; $32 if telephone only exp.

1 Cost for voluntary enrollees with less than 30 quarters of coverage / with 30 -39 quarters of coverage

2 Premium is income adjusted if adjusted gross income over $88,000, over $91,000 in 2022(over $176,000 for joint return, over $182,000 in 2022); some people may pay less because Soc. Sec. benefits cannot decrease due to an increase in the premium.

3 Must use Miller income trust if above the limit.

4 The amounts listed are the income limits, which are effective March 1. Note that $20 of a person's income is disregarded before comparing income to the limit.

5 These change July1 of each year based on poverty income guidelines released in January. 2022 #s are not confirmed; shelter deduction could vary by $1 due to rounding

6 Applies to applications filed on or after July 1 of that year. For recipients, use divisor in effect when approved.

7 Only with qualified Partnership Policy; total asset protection plans may be eliminated in 2022.

8 2nd number includes $2,000 institutional spouse share added on.

9 This is max charge for base room. AL may be able to charge more for larger unit, other services, etc.

## Year 2022 Indiana Public Benefits Updates Continued

| **SSI** | 2022 | 2021 |
|---|---|---|
| Maximum award for household of 1 | 841 | 794 |
| Maximum award for household of 2 | 1,261 | 1,191 |
| | | |
| **SSA** | | |
| COLA increase | 5.9% | 1.3% |
| Annual Earnings limit | | |
| Retirement Age & above NONE, except yr reaches | 4,330/mo | 4,210/mo |
| Under full retirement age | 19,560 | 18,960 |
| Substantial Gainful Activity Amt. Non-Blind/Blind | 1,350/2,260 | 1,310/2,190 |
| Trial Work Period | 970/mo | 940/mo |
| | | |
| **VA** | | |
| Veteran Pension - Basic Benefit | 1,230 | 1,161 |
| Veteran Pension - Housebound without dependents | 1,502 | 1,418 |
| Veteran Pension - Aid & Attendance without dependents | 2,051 | 1,936 |
| Veteran Pension - Aid & Attendance with one dependent | 2,431 | 2,295 |
| Survivor's Pension - Basic Benefit | 825 | 778 |
| Survivor's Pension - Housebound without dependents | 1,008 | 951 |
| Survivor's Pension - Aid & Attendance without dependents | 1,318 | 1,244 |
| Survivor's Pension - Aid & Attendance with one dependent | 1,572 | 1,484 |
| Net worth limit | 138,489 | 130,773 |

**Prepared by Senior Law Project of Indiana Legal Services – March 7, 2022**

# KEY DATES FOR MEDICAID IN INDIANA

| | |
|---|---|
| 1965 | Medicaid enacted as Title XIX of the Social Security Act |
| January 1, 1972 | As a 209(b) state, Indiana's eligibility rules cannot be more restrictive than they were on this date. |
| September 30, 1989 | Effective date of spousal impoverishment rules. "Snapshot" date is first continuous period of institutionalization of thirty or more days beginning on or after this date. |
| August 11,1993 | OBRA '93 enacted, making significant changes in trust rules, claims against estates, and transfer of asset penalties. Trust rules apply to certain trusts established on or after this date. |
| May 1, 2002 | FSSA's ability to file claims against non-probate transfers does not apply to assets transferred out of probate estate before this date. |
| June 1, 2002 | Annuities purchased on or after this date must meet new rules which prohibit balloon annuities and private annuities. |
| June 30, 2002 | FSSA can file claim against recipient's interest in real estate held as a joint tenant with rights of survivorship if interest established after this date. |
| January 1, 2003 | For funeral trust to be exempt, Medicaid or estate must be named to receive any amounts remaining after paying for funeral and burial. |
| | OMPP given authority to file liens against real estate in some situations. |
| May 1, 2005 | Annuities purchased on or after this date are subject to estate recovery. |
| January 1, 2006 | Medicare D begins. "Dual eligibles" must obtain prescriptions through Medicare D, not Medicaid. |
| February 8, 2006 | DRA enacted. It makes significant changes in transfer of asset penalties. It is not implemented in Indiana until November 1, 2009. |
| July 1, 2006 | 300% of SSI adopted as income standard for Aged & Disabled Waivers |
| December, 2006 | Governor Mitch Daniels signed a ten year, $1.16 billion contract with the "IBM Coalition" for it to "modernize" and privatize the eligibility process. |
| March 19, 2007 | About 1,400 state workers in county DFR offices transferred to ACS. |
| October 29, 2007 | The first major service center opened in Marion (Grant County) as part of modernization/privatization plan covering 12 counties |
| July 1, 2008 | American Recovery and Reinvestment Act of 2009 (ARRA), the federal economic stimulus package, prohibits a state accepting increased Medicaid |

| | |
|---|---|
| | funding from the federal government from using more restrictive eligibility rules than are in effect on this date. This expires December 31, 2010. |
| October 1, 2009 | De minimis rule implemented so that $1,200 total of gifts per calendar year to family members or to nonprofit corporations are not penalized. |
| November 1, 2009 | Implementation of DRA in Indiana |
| December 14, 2009 | Governor Daniels terminates modernization/privatization contract with IBM; "hybrid" system will now be piloted |
| February 20, 2012 | Region 5, which is Marion County, is added to "hybrid" system, completing expansion of the hybrid system to the entire state |
| January 1, 2014 | Federal Affordable Care Act is in full force. Indiana residents can purchase health insurance through federal marketplace. Indiana does not adopt Medicaid expansion with 100% federal payment. Indiana granted approval to extend Healthy Indiana Plan for through end of year. |
| June 1, 2014 | Indiana converts from 209(b) state to an SSI state and enters 1634 agreement with Social Security Administration to accept its disability decisions. |
| February 1, 2015 | Healthy Indiana Plan (HIP) 2.0 approved by CMS and implemented as a replacement to HIP. This is Indiana's version of "Medicaid expansion" under the federal Affordable Care Act. It provides health care coverage to persons with income under 138% of the federal poverty level who do not have other health coverage. |
| April 1, 2015 | Hoosier Care Connect implemented. This is a managed care program applying to Medicaid recipients who are not on Medicare and not on a waiver program or in an institution. |
| December 13, 2016 | For (d)(4)(A) special needs trusts established on or after this date, the trust can be established by the disabled individual. |
| Summer, 2017 | ABLE accounts become available in Indiana. |
| April 29, 2019 | IEDSS computer eligibility system begins to be piloted. |
| January 31, 2020 | HHS declares national public health emergency, effective January 27, 2020 due to COVID-19. |
| March 31, 2020 | Medicaid terminations and reductions halted due to COVID-19 until emergency ends. |
| August, 2020 | FSSA implements IEDSS computer eligibility system in all areas. |
| March 1, 2021 | FSSA resumes processing increases in nursing home and waiver liabilities. |

## List of Abbreviations

AAA - Area Aging Agency
ABLE - Achieving Better Life Experience Accounts
ACA - Affordable Care Act, Patient Protection and Affordable Care Act, Pub. Law 111-148.
ALJ - Administrative Law Judge
BCCP Breast and Cervical Cancer Treatment Program
BDDS - Bureau of Developmental Disabilities Services
BPHC - Behavioral and Primary Healthcare Coordination Program
CHIP - Children's Health Insurance Program
CMS - Center for Medicare and Medicaid Services
CSV - Cash Surrender Value of a Life Insurance Policy
DFR - Division of Family Resources
DRA - Deficit Reduction Act of 2005, Pub. Law 109-171
ES - Eligibility Specialist
FFS - Fee for Service
FPL - Federal Poverty Level
FSSA - Family and Social Services Administration
HCBS - Home and Community Based Services
HHS - Department of Health and Human Services
HIP - Healthy Indiana Program
ICF/IID - Intermediate Care Facility for Individuals with Intellectual Disabilities
IEDSS - Indiana Eligibility Determination and Services System
IHCPPM - Indiana Health Coverage Program Policy Manual
IVAP - Income for VA Purposes
IVR - Interactive Voice Response
MAGI - Modified Adjusted Gross Income
MAPR - Maximum Annual Pension Rate for the VA Non-Service Connected Pension
MCCA - Medicare Catastrophic Coverage Act of 1988
MCE - Managed Care Entity
MFP - Money Follows the Person
MRT - Medical Review Team
NAELA - National Academy of Elder Law Attorneys
NSCP - Non-Service Connected Pension for VA Benefits
OALP - Office of Administrative Law Proceedings
OBRA 93 - Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66, August 10, 1993)
OMPP - Office of Medicaid Policy & Planning
PA - Prior Authorization or Prior Approval
PAL - Policy Answer Line
PACE - Program of All-Inclusive Care for the Elderly
PHE - Public Health Emergency
PNA - Personal Needs Allowance
QI - Qualified Individual
QIT - Qualified Income Trust (Miller Trust)
QMB - Qualified Medicare Beneficiary
RBMC - Risk-Based Managed Care
RCAP - Residential Care Assistance Program
RCC - Regional Change Center
SAPN - Supplemental Assistance for Personal Needs
SEC - State Eligibility Consultant
SIL - Special Income Level
SLMB - Specified Low-Income Medicare Beneficiary
SSA - Social Security Administration
SSI - Supplemental Security Income
TBI - Traumatic Brain Injury

# MEDICAID GLOSSARY

**"209(b) Option"** : (Pub. L. No. 92-603, **§209(b)**, 42 U.S.C. §1396a(f)). Under this option, states could elect to provide Medicaid assistance just to those individuals who met the eligibility requirements for the state administered programs for the aged, blind, and disabled on January 1, 1972, rather than providing Medicaid to all SSI recipients. Indiana was a 209(b) state until June 30, 2014.

**ARC of Indiana Master Trust**: a pooled trust managed by the ARC of Indiana for disabled persons. This type of trust is an exempt resource for purposes of the Medicaid resource eligibility calculation.

**Bureau of Developmental Disabilities Services (BDDS)**: A part of the Division of Disability and Rehabilitative Services (DDRS) of FSSA which administers a variety of services for persons with developmental disabilities, including the Autism, the Developmental Disabilities, and the Support Services Waiver. There are eight District Offices serving specific counties.

**Centers for Medicare and Medicaid Services (CMS):** The division of the Department of Health and Human Services which administers the Medicaid and Medicare programs. This division was formerly known as HCFA, the Health Care Financing Administration.

**Division of Aging (DA):** the division of FSSA which operated the Medicaid nursing home level of care waiver services programs, the CHOICE program, RCAP, and the nursing home pre-admission screening program.

**Division of Family Resources (DFR)** is the division of FSSA responsible for processing applications and making eligibility decisions. County Offices of Family Resources administer the program at the local level.

**Deficit Reduction Act of 2005 (DRA)**: This Act, enacted on February 8, 2006, makes several changes to the Medicaid program, including several changes increasing penalties for transfers of assets or income on or after February 8, 2006. Most provisions have not yet been implemented in Indiana as of August, 2008.

**Document Center:** FSSA office in Marion, Indiana where workers process all documents submitted and save them in electronic case files.

**Eligibility Specialist (ES)**: A worker in a county DFR office or a service center who is an employee of a private contractor rather than the state of Indiana. An ES can process information and interview applicants and recipients but cannot make a final determination of benefits.

**Estate Claim:** A claim which FSSA can file against the estate of a Medicaid recipient after the recipient's death. FSSA can in some circumstances also file a claim against the estate of a spouse of a recipient who dies after the recipient.

**Exempt Resources**: those resources which are not counted when Medicaid does its resource eligibility calculation.

**Family & Social Services Administration (FSSA):** The umbrella agency which is ultimately responsible for the administration of the Medicaid program in Indiana.

**Fiat**: a process used to override the IEDSS computer system, typically to provide retroactive benefits.

**First Day of the Month Rule**: Medicaid rule which dictates that eligibility for a calendar month depends on the amount of the resources owned on the first moment of the first day of the calendar month.

**IBM Coalition:** The entity which contracted with FSSA to modernize and privatize the public benefits eligibility determination and review process.

**Income Spend Down**: This has mostly been eliminated. Until 2014, if one's income was above the Medicaid income limit but there were high medical expenses, then one could be eligible for Medicaid to pay part of the medical expenses after a "spend down" requirement was met.

**Indiana Client Eligibility System (ICES)**: the Division's former computerization project with each county's computers connected to a main computer in Indianapolis. This system has now been replaced by IEDSS.

**Indiana Eligibility Determination and Services System (IEDSS)**: the Division's new computerized eligibility system which replaced ICES, with implementation begun in 2019 and completed in 2020.

**Indiana Health Coverage Program Policy Manual (IHCPPM):** the computerized manual (with hard copies available) covering Medicaid, AFDC, and Food Stamps. It is available at www.in.gov/fssa/ompp/4904.htm.

**Liability:** For a nursing home resident, it is the amount of the monthly income the resident is to pay to the nursing home each month from income. For a waiver recipient with income above the SIL, it is the amount of medical expenses the recipient is responsible for paying out of the recipient's income.

**Lien:** a claim which FSSA can sometimes file against a Medicaid recipient's real estate during the recipient's lifetime which prevents the recipient from selling the real estate without first reimbursing FSSA for Medicaid benefits received.

**MCCA (Medicare Catastrophic Coverage Act)**: the 1988 Act that made substantial revisions to the Medicaid program, particularly in the area of prevention of spousal impoverishment.

**MED Works:** Medicaid for Employees with Disabilities includes two categories of Medicaid eligibility designed to remove barriers to employment for persons with disabilities. MADW is the basic MED Works category for persons who meet the Medicaid disability definition without regard to their employment. MADI is the medically improved category for persons who lose eligibility in the basic disability category because of an improvement in their medical condition.

**Methodology**: the method the state uses for determining how much countable income and resources a person has. (See definition of standard for comparison.)

**Miller Trust:** This is also known as a Qualified Income Trust, an income only trust used for a nursing home resident or a waiver services applicant or recipient with income above the Special Income Level (SIL). It is referred to as a "Miller" trust because it was first approved in a Colorado lawsuit brought by Mr. Miller.

**Modernization**: FSSA's label for its process of changing the system for how public assistance benefits are administered. The system is "modernized" because one can use a computer to apply. Rather than having an assigned caseworker in a county office, the system is administered through service centers, with different staff assigned for different functions.

**Medical Review Team (MRT)**: a group at the state Medicaid office responsible for deciding if applicants/recipients are disabled.

**Office of Medicaid Policy and Planning (OMPP)** is the division of FSSA responsible for setting policy, including coverage and reimbursement rates, for Indiana's Medicaid program.

**Omnibus Budget Reconciliation Act (OBRA)**: An Act which often contains amendments to the Medicaid program. OBRA 93 severely curtailed pre-Medicaid planning opportunities for the middle class elderly.

**Personal Needs Allowance:** The amount of income a nursing home resident or a waiver recipient can keep to meet the recipient's personal needs not covered by Medicaid. Most nursing home residents have an allowance of $52, though some veterans have an additional $90 allowance. For a waiver recipient, the allowance equals the SIL.

**Policy Answer Line (PAL):** FSSA Policy staff which respond to requests from DFR workers concerning policy issues. Some documents must always be presented to PAL for review.

**Privatization:** A label used by many to refer to FSSA's utilization of private contractors to perform functions previously performed by the state. In December, 2006 Governor Mitch Daniels signed a ten year, $1.16 billion contract with the "IBM Coalition" for it to "modernize" and privatize the eligibility determination and review process. On March 19, 2007 about 1,400 state workers in county DFR offices, about two-thirds of the staff, became employees of a private contractor.

**Qualified Individual (QI):** Category of limited Medicaid benefits, paying only the Medicare Part B premium. When enacted by Congress, this program was approved only for five years through December 31, 2002. It has been extended to September 30, 2005 and will need to be reenacted to continue beyond then. The coverage under this category is identical to that under SLMB but is listed separately because of the possibility it may be discontinued.

**Qualified Medicare Beneficiary (QMB)**: Category of Medicaid benefits, sometimes referred to as "buy-in." For persons eligible, Medicaid will pay the Part B (and Part A, where applicable) Medicare premium and any Medicare deductibles or coinsurance.

**Residential Care Assistance Program (RCAP):** a solely state funded Medicaid benefit to cover residential care. Very few persons are covered.

**Snapshot**: the process of assessing the resources of a couple as of the first day of the first continuous period of institutionalization of at least thirty days on or after September 30, 1989. The "snapshot" applies to only those Medicaid applicants who enter a nursing home or hospital on or after September 30, 1989 and have a spouse at home.

**Special Income Level (SIL)**: Higher income standard used for nursing home residents, waiver applicants and recipients, and PACE applicants and recipients. The SIL is equal to three times

the maximum SSI benefit. A recipient with income above the SIL must use a Miller Trust to be income eligible.

**Specified Low Income Beneficiary( SLMB )**: a more limited category of Medicaid benefits than QMB, paying only the Medicare Part B premium.

**Standard**: the dollar limit of how much income or resources one is allowed to have in order to qualify for Medicaid. (See definition of methodology for comparison.)

**State Eligibility Consultant (SEC):** A DFR staff person who continues to be a state employee after privatization. A final eligibility determination or change must be made by an SEC.

**Waiver Liability Down Summary Notice:** a notice mailed to a waiver recipient with income above the SIL who has a waiver liability. The notice is mailed on the 2nd business day of a month listing expenses processed the previous month and applied to the waiver liability.

**Waiver Services**: non-medical services such as homemaker, respite care, case management, home delivered meals, home modification, adaptive aids or devices, personal/attendant care, assisted living, and adult day care. They are referred to as "waiver services" because Indiana needed to obtain a waiver from HHS to provide them.

## TABLE OF CASES

**Federal Cases**: **Location by Section**

**Indiana State Cases:**

**Other State Cases:**

## I. Introduction

Medicaid is an important source of health care coverage for many elderly and disabled persons in Indiana. This Manual discusses who qualifies in Indiana, what services are covered, how eligibility is determined and processed, and how advocates can assist their clients to obtain benefits.

Health care is expensive. Fidelity Investments estimates that a 65-year-old couple retiring in 2021 with Medicare insurance will need $300,000 to pay for medical expenses throughout retirement, **not including long term care, such as nursing home care**. Additional funds are needed for long term care expenses. https://www.fidelity.com/viewpoints/retirement/retiree-health-costs-rise. In 2021, nursing home care in Indiana cost an average of $7,230 per month for a semi-private room and $8,700 per month for a private room, while an assisted living facility cost $4,283 per month. Genworth 2021 Cost of Care Survey, www.genworth.com/aging-and-you/finances/cost-of-care.html.

It is no secret that the population of older persons and the need for long term care are increasing. Over the past ten years, the population age 65 and over increased by 30%. About one in seven Americans is now an older American. *A Profile of Older Americans: 2016*, Administration on Aging of U.S. Department of Health and Human Services. The Centers for Disease Control and Prevention (CDC) provided the following statistics in a February, 2016 report:

> The number of people using nursing facilities, alternative residential care places, or home care services is projected to increase from 15 million in 2000 to 27 million in 2050. Most of this increase will be due to growth in the older adult population who need such services. Although people of all ages may need long-term care services, the risk of needing these services increases with age. Results from the National Health and Aging Trends study show that, of the 10.9 million older adults who reported receiving help with daily activities in a given month in 2011, about 3 in 10 received paid help. Projections estimate that among people who reach age 65, more than two-thirds will need long-term care services during their lifetime, and they have a 46% chance of spending time in a nursing home. More recent projections using microsimulation modeling estimate that, on average, an American turning 65 today will incur $138,000 in future long-term care services costs.
>
> The number of Americans over age 65 is projected to more than double from 40.2 million in 2010 to 88.5 million in 2050. Those aged 85 and over are projected to almost triple, from 6.3 million in 2015 to 17.9 million in 2050 and will account for 4.5% of the total population. This "oldest old" population tends to have the highest disability rate and highest need for long-term care services, and is also more likely to be widowed and without someone to provide assistance with daily activities. Decreasing family size and increasing employment rates among women may reduce the traditional pool of family caregivers, further stimulating demand for paid long-term care services. Among persons who need long-term care services, adults aged 65 and over are more likely than younger

> adults to receive paid help. Recent studies project that the number of older adults using paid long-term care services will grow substantially.

"Long-Term Care Providers and Services Users in the United States: Data From the National Study of Long-Term Care Providers, 2013–2014," published by the U.S. Dep't of Health & Human Services, Centers for Disease Control and Prevention, Vital and Health Statistics, Series 3, No. 3 (Feb., 2016), available at www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf.

Many people do not have sufficient savings and insurance to meet their health care needs. Even those with substantial assets will often need Medicaid if they need long term care for an extended period. About two-thirds of the residents in Indiana nursing homes are covered by Medicaid. Long term care services in the community are also expensive. Medicaid is covering and promoting alternatives to nursing home care as part of an effort to "re-balance" the amount of its long term care budget it spends on nursing home care, but Indiana continues to lag other states in this process.

Medicaid began in 1972, and for years it served primarily as a health care program for poor people. That began to change in 1988 when Congress responded to public concern about "spousal impoverishment." The Medicare Catastrophic Coverage Act of 1988 (MCCA) revised Medicaid to protect significant assets and income for a spouse at home with an institutionalized spouse. Medicaid became a viable planning option for persons with assets when long term care is needed or foreseen. Although the focus of MCCA was to prevent the older or disabled person's spouse from becoming impoverished as a result of the cost of long term care, many planning strategies used to protect assets for couples can also be used for single persons.

Since 1988, the Medicaid program has periodically undergone significant changes. The Omnibus Reconciliation Act of 1993, commonly known as OBRA 93 (P.L. 103-66, August 10, 1993), curtailed some Medicaid planning opportunities for the middle class elderly. While a married applicant with a spouse at home can still use the spousal impoverishment provisions of MCCA, OBRA 93 changed the treatment of certain trusts, transfers of assets, and claims against estates. The Deficit Reduction Act of 2005 (DRA), actually enacted on February 8, 2006, severely increased transfer penalties and made other significant changes. Indiana was slow in implementing most of the Act's provisions. It finally implemented major provisions of the Act on November 1, 2009.

In 2007, the Indiana legislature enacted the Indiana Check-Up Plan to provide coverage to Hoosiers between the ages of 18 and 65 who had been uninsured for at least six months and with income less than 200% of poverty. This plan was implemented in 2008 under the name Healthy Indiana Plan, commonly known as HIP. Indiana's current plan is known as HIP 2.0.

In March, 2010, Congress enacted major health care reform designed to eventually provide nearly universal health care coverage. The Patient Protection and Affordable Care Act (ACA), Pub. Law 111-148. The United States Supreme Court upheld the constitutionality of the Act except that it ruled that Congress could not penalize states for not adopting Medicaid expansion. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 132 S. Ct. 2566 (2012). The Supreme Court again upheld the ACA from a challenge by more than a dozen states, including

Indiana, by ruling that the states did not have standing. *California v. Texas*, 141 S. Ct. 2104 (2021).

Indiana did not initially adopt Medicaid expansion, but it implemented HIP 2.0 effective February 1, 2015 as its version of Medicaid expansion.

After the national changes made by the ACA, Indiana substantially reworked its Medicaid system effective June 1, 2014, discussed below in Section IV.

The Trump Administration and many Republicans in Congress wanted to repeal and replace the ACA, but Congress could not agree on an alternative. Parts of the Act were amended, but it still remains. The Biden Administration supports the ACA.

Indiana continues to attempt to "rebalance" its Medicaid long term care budget to lessen the usage of nursing home care and increase alternatives. Indiana continues to overly rely on nursing home care but is improving. A September, 2020 report from AARP, www.longtermscorecard.org/~/media/Microsite/State%20Fact%20Sheets/Indiana%20Fact%20Sheet.pdf, based on 2019 pre-pandemic data, shows that Indiana is ranked 44th overall among all states and the District of Columbia for "Long-Term Services and Supports." This is an improvement from the May, 2018, report, which ranked Indiana as 49th. The 2020 report found that in 2016 Indiana spent 18.4% percent of its Medicaid and state-funded long-term care funding on home and community based care. For comparison, New Mexico spent 73.5% of its long term care funding on home and community based services. The Report ranked Indiana 41st in affordability and access, 48th in choice of setting and provider, 19th in quality of life and quality of care, 51st (last) for support of family caregivers, and 25th for Effective Transitions. The full report, Long-Term Services and Supports State Scorecard 2020 Edition Reference Edition, published by the AARP Public Policy Institute, is available at http://www.longtermscorecard.org/~/media/Microsite/Files/2020/LTSS%202020%20Reference%20Edition%20PDF%20923.pdf.

FSSA's Division of Aging is well aware of Indiana's rankings and is working to "rebalance" Indiana's system. Its goal is that a person suddenly needing long term services will be able to obtain expedited eligibility and begin receiving services within 72 hours. The Division is currently piloting an Expedited Medicaid Eligibility, discussed in Section VI(D)(4), below. The Division also plans to implement managed care with managed care entities receiving capitated payments, with the goal of simplifying the process, improving administrative and service coordination between Medicaid and Medicare, and increasing monitoring and evaluation activities. The 2021 Indiana legislature added section (d) to I.C. § 12-15-5-17.5 to prohibit FSSA from entering into a final contract for managed care before January 31, 2023, but FSSA still plans to proceed with a managed care plan.

The COVID pandemic resulted in emergency changes to many programs, including Medicaid, with the result that most recipients of Medicaid cannot have their coverage terminated until HHS determines that the COVID Public Health Emergency has ended. See Section VII(G)(2). The number of persons receiving Medicaid in Indiana has risen by about 583,000 during the pandemic.

## II. Sources of Law

Medicaid is a cooperative program between federal and state government, with both federal and Indiana sources of law.

### A. Federal Law

Federal law sets various minimum requirements which state Medicaid programs must follow, but federal law also gives each state options in deciding who to cover, what eligibility limits to set, and what medical services to provide. Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq*., establishes Medicaid. 42 U.S.C. §1396a sets requirements which a state Medicaid plan must meet. This Section is lengthy, 58 pages when printed. Section 1396a(a) has 83 subsections, many of them with multiple subsections, listing requirements for state Medicaid plans.

The federal statute is very important, but it is often difficult to read. The Indiana Court of Appeals described it as follows:

> This case requires us to once again delve into what we have previously referred to as the "unfortunately convoluted and complex" and "Byzantine" Medicaid system. *Legacy Healthcare, Inc. v. Barnes & Thornburg*, 837 N.E.2d 619, 622 & n.2 (Ind. Ct. App. 2005), trans. denied; see also *Schweiker v. Gray Panthers*, 453 U.S. 34, 43, 101 S. Ct. 2633, 69 L. Ed. 2d 460 (1981) (referring to the Social Security Act, of which the Medicaid system is a part, as having a "Byzantine construction" that "makes the Act 'almost unintelligible to the uninitiated.'") (quoting *Friedman v. Berger*, 547 F.2d 724, 727, n. 7 (2d Cir. 1976)).

*Indiana FSSA v. Patterson*, 119 N.E.3d (Ind. Ct. App. 2019), transfer denied 127 N.E.2d 229 (Ind. 2019), cert. denied Dec. 16, 2019. A federal judge described the federal statute in similar terms:

> The Medicaid Act is actually a morass of interconnecting legislation. It contains provisions which are circuitous and, at best, difficult to harmonize. The Act has been called "an aggravated assault on the English language, resistant to attempts to understand it." See *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981). The Medicaid Act has been characterized as one of the "most completely impenetrable texts within human experience" and "dense reading of the most tortuous kind." *Rehabilitation Ass'n of Va. v. Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994). The court has nothing but sympathy for officials who must interpret or administer the Act.

*Mertz by Mertz v. Houstoun*, 155 F.Supp.2d 415, 420 at fn. 6 (E.D. Pa. 2001).

Because the federal law gives states many options from which to choose, Medicaid varies widely from state to state. Case law from other states may or may not apply to Indiana, depending on the issue and option involved.

The federal regulations implementing Medicaid are in 42 CFR Parts 430 - 456. Of particular interest are 42 CFR § 431.200 *et seq*. concerning appeal rights for applicants and recipients and 42 CFR 435 concerning Medicaid eligibility requirements. The Centers for Medicare and Medicaid Services (CMS), the federal agency which administers Medicaid, has issued a State Medicaid Manual. It has useful explanatory materials concerning many Medicaid issues. It is available on the internet at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927. It is difficult to navigate, as it contains a zip file for each Chapter. One can access the various sections as Word documents. Although the State Medicaid Manual is a non-legislative agency manual, a court will give it "a great deal of persuasive weight." *Woodruff v. Ind. FSSA*, 947 N.E.2d 934 (Ind. Ct. App. 2011), vacated by transfer on other grounds, *Woodruff v. Ind. FSSA,* 964 N.E.2d 784 (Ind. 2012).

### B. Indiana Law

The Indiana statute appears primarily at Ind. Code. 12-15. Although it sets some eligibility requirements, substantial authority to set eligibility requirements is delegated to the Indiana Family and Social Services Administration (FSSA). I.C. §12-15-1-1; I.C. § 12-8-6.5-5. The Secretary of FSSA is authorized by I.C. § 12-15-21-2 to promulgate regulations. 405 IAC 2 contains all promulgated eligibility requirements, 405 IAC 5 contains regulations governing services covered by Medicaid, and 405 IAC 1.1 contains the rules for administrative appeals.

The Indiana State Medicaid plan contains plan documents filed with and approved by CMS. It is in a template provided for states by CMS. provider.indianamedicaid.com/ihcp/StatePlan/state_plan.asp.

In addition to its promulgated regulations, the Office of Medicaid Policy and Planning (OMPP) publishes a manual which Division of Family Resources (DFR) staff use to implement the program. In 2015 OMPP published a new Manual covering health coverage under Medicaid, Hoosier Healthwise, and the Healthy Indiana Plan. It also covers State Burial Assistance. Its official name is *The Indiana Health Coverage Program Policy Manual* (IHCPPM). It contains eligibility and administrative policies based on state and federal laws and regulations that govern the programs. In these materials the Program Policy Manual is cited as the IHCPPM. It is available on the internet at www.in.gov/fssa/ompp/4904.htm. It is in a PDF format and requires Adobe Acrobat Reader software, which can be downloaded free of charge from Adobe's website.

The IHCPPM also includes system procedures using the Indiana Eligibility Determination and Services System (IEDSS). IEDSS is a computer system that was implemented beginning in 2019 with full implementation in all regions in August, 2020. IEDSS replaced the Indiana Client Eligibility System (ICES), which is the computer system previously used to administer the programs. The IHCPPM is "on-line" for DFR staff to use.

The IHCPPM is regularly being revised. Changes to the Manual are listed in Transmittals posted at www.in.gov/fssa/ompp/5247.htm. This site also lists upcoming changes to be implemented in the next month. The Transmittal lists the Sections changed, a brief summary of the change, and the date the change was made. The DFR typically updates the Transmittal at the beginning of the month.

The DFR may notify workers of changes by an electronically transmitted "flash bulletin" before changes are made to the IHCPPM.

The IHCPPM is much longer than the regulations, as it contains instructions and examples which are not in the regulations. Not all of the Sections in the IHCPPM apply to each Medicaid program. The title for each section typically lists the programs to which it applies. A section may apply to only some of the Medicaid categories. Section V(A), below, lists the category abbreviations which the IHCPPM and the IEDSS system use. DFR lower level staff and supervisors typically use only the "on-line" manual and are often not familiar with the federal and state statutes and regulations. It is important for advocates to be familiar with the relevant sections of the IHCPPM to effectively discuss a case with DFR staff.

In reviewing a client's case, it is useful to start by reviewing the IHCPPM. If the client cannot meet the provisions of the IHCPPM, one should consider whether there is any basis to challenge the IHCPPM provisions at issue. Any substantive eligibility provision in the Manual which has not been published in the Indiana Administrative Code is arguably invalid because it was not promulgated in accordance with the Indiana Administrative Procedures at I.C. § 4-22-2. Also, any Indiana eligibility requirement which violates any mandatory provision of the federal Medicaid statute or regulations is invalid, as the Supremacy Clause of the U. S. Constitution makes federal law superior over state law.

FSSA has a Medical Policy Manual which contains its medical policy for coverage of various procedures. www.in.gov/medicaid/files/medical%20policy%20manual.pdf. Other Provider Reference information for providers on prior authorization and claims processing is at www.in.gov/medicaid/providers/469.htm.

### C. FSSA Must Use Formal Rulemaking When it Changes Policy Not Required by an Existing Regulation.

**Even if uses formal rulemaking, during the current COVID Public Health Emergency FSSA cannot adopt eligibility standards, methodologies, or procedures that are more restrictive than what was in place on January 1, 2020. This continues until the end of the quarter in which the public health emergency ends. Families First Coronavirus Response Act, Pub. L. No. 116-127 (2020)§ 6801(b)(1).**

Although FSSA has a set of regulations in the Indiana Administrative Code that address various aspects of Medicaid, FSSA frequently makes significant changes in policy by modifying its IHCPPM without promulgating a rule change. Indiana's Administrative Procedure Act determines when rulemaking is needed.

Ind. Code § 4-22-2 sets forth the procedures which a state agency must follow for rulemaking. I.C. § 4-22-2-13(a) provides that the chapter "applies to the addition, amendment, or repeal of a rule in every rulemaking action." Subsection (c)(1) provides that the rulemaking requirements do not apply to "a resolution or directive of any agency that relates solely to internal policy, internal agency organization, or internal procedure and does not have the effect of law." I.C. § 4-22-2-3 provides the following definitions:

> (b) "Rule" means the whole or any part of an agency statement of general applicability that:
>
> (1) Has or is designed to have the effect of law; and
> (2) Implements, interprets, or prescribes:
> (A) Law or policy; or
> (B) The organization, procedure, or practice requirements of an agency.
>
> (c) "Rulemaking action" means the process of formulating or adopting a rule. The term does not include an agency action.

For rulemaking actions, I.C. § 4-22-2 provides a detailed set of procedures designed to afford the public notice of the proposed change and the opportunity to comment on the proposed changes. Both the Attorney General and the Governor must approve any rule or amendment to a rule.

The Indiana Supreme Court addressed agency authority and action in *Indiana State Bd. of Pub. Welfare v. Tioga Pines Living Ctr.*, 622 N.E.2d 935 (Ind. 1993), when nursing homes sued to challenge rules on nursing home rate reimbursement. The Court stated at p. 939:

> It is elementary that the authority of the State to engage in administrative action is limited to that which is granted it by statute and that administrative action within such limitation has the force of law. *Blue v. Beach* (1900), 155 Ind. 121, 56 N.E. 89. Administrative action is often categorized as either rulemaking or adjudicatory. *Blinzinger v. Americana Healthcare Corp.* (1984), Ind. App., 466 N.E.2d 1371. Rulemaking includes the process of formulating or adopting a rule. I.C. § 4-22-2-3 (Burns 1993).

When adjudicatory action is not involved, the change FSSA is making is rulemaking. In *Blinzinger v. Americana Healthcare Corp.*, 466 N.E.2d 1371 (Ind.App. 1984), a nursing home challenged a directive from state Medicaid freezing the rates of facilities involved in decertification proceedings. The court found that this was a rule and thus invalid. It stated that rulemaking looks to the future. The directive was applied prospectively to all providers similarly situated, it was applied as though it had the effect of law, and it affected the substantive rights of providers, so the court concluded that it was a rule which was invalid because not promulgated. The court also stated that the directive did not relate solely to internal policies. Compare this with *Gorka v. Sullivan*, 671 N.E.2d 122 (Ind.App. 1996), where the court ruled that rates for transportation providers did not need to be promulgated; only the rulemaking method needed to be promulgated.

When FSSA seeks to make a significant change in policy that is not consistent with an already promulgated regulation, then it is obligated to make the change through the rulemaking process. For example, FSSA has broad regulations at 405 I.A.C. § 2-1.1-5 and 8 that for the aged, blind, and disability category it will utilize the SSI income and resource definitions and exclusions as set forth in the SSI statute and regulations. Thus, FSSA can make changes in policy to continue to apply the SSI rules to this category. But when FSSA makes other changes in policy that go beyond its existing regulations, it should be obligated to use formal rulemaking and obtain public comment.

### D. Useful Internet Sites

There are many sites with useful information on the Internet. Some of these include:

**Governmental Sites**

**IHCPPM Manual**: www.in.gov/fssa/ompp/4904.htm
**Various DFR Forms**:
www.in.gov/fssa/dfr/forms-documents-and-tools/forms
**Medicaid Information Designed for Members, Providers, and Business Partners:** www.in.gov/medicaid
**Indiana Long Term Care Insurance Program**: www.in.gov/iltcp
**Federal Medicaid and Medicare Program Manuals:** cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/index.html
**Medicaid Information on Federal CMS Site:** www.medicaid.gov

**Sites for Advocates**

**National Academy of Elder Law Attorneys (NAELA):** www.naela.org
**Indiana Chapter of NAELA:** innaela.org
**Justice in Aging**: justiceinaging.org
**National Health Law Program**: healthlaw.org/our-work/policy/medicaid
**National Center for Law and Economic Justice:**
nclej.org/key-issues/health-care-health-reform
**Sargent Shriver National Center on Poverty Law:**
www.povertylaw.org/healthcare
**Elder Law Answers** newsletter:
attorney.elderlawanswers.com/home/email-updates

**Sites Discussing Policy Issues**

**Center on Budget & Policy Priorities:** www.cbpp.org/topics/medicaid-and-chip
**Families USA:** familiesusa.org/issues/medicaid
**Kaiser Family Foundation:** kff.org/medicaid

The Elder Law Section of the Indiana State Bar Association and the Indiana Chapter of the National Academy of Elder Law Attorneys (NAELA) each has a list serve group where elder

law attorneys can post questions or comments about elder law issues, including Medicaid. Medicaid practitioners should join the Elder Law Section of the ISBA, NAELA, and NAELA's Indiana Chapter and participate in the list serve groups.

## III. Organization of the Federal and Indiana Medicaid Agencies

### A. The Federal Agency

The Department of Health and Human Services (HHS) is the federal agency responsible for administering Medicaid. Xavier Becerra is the Secretary of HHS. The Centers for Medicare & Medicaid Services (CMS) is the section of HHS responsible for administering Medicaid and Medicare. Chiquita Brooks-LaSure is the Administrator of CMS.

CMS has ten Regional Offices. The Regional Office covering Indiana is the CMS Region 5 Office in Chicago, located at 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601. edit.cms.gov/About-CMS/Agency-Information/RegionalOffices/Downloads/ChicagoRegionalOffice.pdf

For further information on CMS, see www.cms.gov or www.medicaid.gov.

### B. Organization of Indiana's Medicaid Agency

#### 1. At the State Level

The Family and Social Services Administration (FSSA) is the agency responsible for the Medicaid program in Indiana. The office of the secretary of FSSA is designated as the "single state agency" for administration of the state Medicaid program. I.C. § 12-8-1.5-10.5. Dr. Dan Rusyniak is the Secretary of FSSA. Leslie Huckleberry is the General Counsel of the Office of General Counsel. A partial directory of FSSA staff in the central office with telephone numbers and links to e-mail addresses is at www.in.gov/fssa/3441.htm. A directory for all FSSA employees (and other state employees) containing telephone numbers and e-mail addresses is at www.in.gov/apps/iot/find-a-person.

The Office of Medicaid Policy and Planning (OMPP), a division of FSSA, is responsible for developing and coordinating Indiana's Medicaid policy under the direction of the FSSA Secretary. I.C. § 12-8-6.5-4. Allison Taylor is the Director of OMPP and Indiana's State Medicaid Director.

The Division of Family Resources (DFR) is the division of FSSA responsible for processing applications and making eligibility decisions. I.C. § 12-15-1-4; I.C. § 12-13-5-1(1). Adrienne Shields is the Director.

The Division of Aging is the division of FSSA which operates the Medicaid waiver services program, residential care assistance (RCAP), and the nursing home pre-admission

screening program. Sarah Renner is the Director. Local area aging agencies handle the initial requests for waiver services.

FSSA and OMPP contract with private entities to perform various functions. Gainwell Technologies processes Medicaid payment claims and makes prior approval determinations, and Optum Rx processes pharmacy claims for fee for service programs and is the Pharmacy Benefit Manager.

A Quick Reference Guide at www.in.gov/medicaid/providers/files/quick-reference.pdf contains contact information.

### 2. Throughout the State

For many years, every applicant or recipient was assigned to a single caseworker in the county office. Originally, the county offices were "county welfare department" offices, later renamed as DFR offices. In December, 2006 Governor Mitch Daniels signed a ten year, $1.16 billion contract with the "IBM Coalition" for it to "modernize" and privatize the eligibility process. The plan was for the Coalition to utilize service centers to replace most of the functions previously performed by caseworkers in the county DFR offices, though the county offices were to remain in place with a reduced staff to provide some assistance to persons who prefer to walk into a local office.

The IBM Coalition consisted of several companies, with the largest being Affiliated Computer Services, Inc. (ACS), which was hired to manage service centers and employ about 1,500 DFR employees previously employed by DFR.

Although the plan was for DFR offices to remain in every county, the bulk of the case processing was conducted through service centers. Applicants and recipients were no longer assigned to a caseworker, but instead various tasks were assigned to various staff for processing. Rather than limiting applications to paper applications, technology was to be used to allow applicants to apply by the internet. All documents were scanned so that case files are electronic. Two major service centers, in Marion, Indiana and in Lake County, were to eventually serve as call centers for the entire state and to also handle various other tasks. There were also minor service centers located in South Bend, Fort Wayne, Indianapolis, Terre Haute, New Albany, and Evansville. These offices were to perform other various "back office" tasks, such as application processing, redetermination processing, change reporting, benefit recovery, and hearing preparation.

The initial plan was for the new system to be phased in, with a pilot project to begin in August, 2007 and with a "steady state" to be achieved by May, 2008. "Steady state" was the plan's name for full implementation of the new system. The process began on March 19, 2007, when about 1,400 state workers in county DFR offices became employees of ACS. These employees are labeled "Eligibility Specialists" (ESs). An ES can interview applicants/recipients and enter information into the computer system but cannot make final determinations of benefits. 682 staff remained as state employees as "State Eligibility Consultants" (SECs).

There were numerous problems with the system. It was "rolled out" in only 59 counties, accounting for 35% of the statewide caseload, but it was never rolled out statewide.

FSSA suspended further roll out of the new system in the summer of 2008 after many complaints about the new system were raised. Cases were not being processed timely, callers to the service centers had long hold times and often could not get answers, and documents to be scanned often were lost. Many people had great difficulty navigating the new system. On March 13, 2009 FSSA requested the IBM Coalition to develop Corrective Action Plans to address several issues. On July 2, 2009 the IBM Coalition submitted a Plan which FSSA accepted. The Plan included a 50 plus page document listing various action steps. For the first time, FSSA Secretary Anne Murphy publicly stated that cancelling the contract was a possibility.

The State Budget Committee then began reviewing the implementation of the project in the summer of 2009. In October, 2009 Governor Daniels announced he was terminating the contract with IBM on December 14, 2009. IBM's contract was terminated, and litigation ensued. The Indiana Supreme Court held that IBM materially breached the contract and remanded the case back to the trial court. *State v. IBM*, 51 N.E.3d 150 (Ind. 2016). Upon remand, the Marion Superior Court ruled that IBM owes the State over $78 million. The judgment was modified with some adjustment of interest. *IBM v. State*, 131 N.E.3d 609 ( Ind. 2019).

The state continued its contract with ACS, now Xerox, so it did not abandon "privatization." FSSA continues to use several private contractors which it now manages itself. FSSA also did not abandon its "modernization" project. FSSA modified it through what it called a "hybrid" system.

In January, 2010 FSSA began a "hybrid" system, which it continues to use today. It retains some of the features of the "modernization" plan, such as on-line applications, electronic case files with scanning at the service center, and calls routed through one 800 number, while performing more functions at the county level. ESs and SECs continue to be used for case processing. Aspects of the current system include:

- Most cases are processed by a worker or a team in the county.

- A different employee approves benefits from the employee that processes the case.

- Callers typically have their calls automatically transferred to their local county office rather than a centralized call center.

- Clients can have documents scanned at the local county office; documents can now be uploaded on the FSSA Portal.

- Clients can call the Interactive Voice Response (IVR) System to receive information on their case 24 hours a day, 7 days a week.

- Clients can apply on the internet and complete their application by using the electronic signature.

- Change processing occurs in regional change centers.

There are offices in each county. The county offices are supervised by regional managers. A map showing the regions and the regional managers' names and e-mail addresses is at Appendix A. See also www.in.gov/fssa/files/DFR_Map_and_County_List.pdf. Marion County is divided between four regions, as follows Marion County North office - Region 9; Marion County West office - Region 6; Marion County Central and South offices - Region 5; and Marion County East office - Region 10.

All offices and workers are reached at 1-800-403-0864. Cases are not assigned to a single worker, but most initial case processing takes place in local offices. One calls the central 1-800-403-0864. After entering the zip code the call is directed to a local office. Change processing occurs in regional change centers. E-mailing the regional mailbox continues to be an effective way to address errors. If a worker provides his or her telephone extension number, then that worker can be reached at 1-855-673-0193 and then entering the four digit extension. If a worker provides his or her full name, the email address can be located at www.in.gov/apps/iot/find-a-person.

## IV. For Many Years Indiana Was a "209(b) State;" On June 1, 2014 Indiana Became an "SSI State."

### A. As a 209(b) State Through May, 2014, Indiana Could Not Have Eligibility Rules More Restrictive than its Rules on January 1, 1972.

To fully understand how Medicaid is administered in Indiana, to understand how it differs from other states, to understand the potential legal arguments which can sometimes be made to challenge restrictive eligibility provisions, it is useful to briefly review the history and background of Medicaid.

Medicaid is a cooperative program involving both the federal government and state governments. Both the federal and state governments share the cost and responsibility for Medicaid. In Indiana, the federal government has typically paid about two-thirds of the cost of Medicaid, while Indiana pays the remaining costs.

When Congress originally enacted the Medicaid program in 1965, it required states participating in the program to provide Medicaid to the "categorically needy" --- individuals who received cash payments under any of four joint federal/state welfare programs administered by the states: Old Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to Families with Dependent Children (AFDC). States had some discretion to set eligibility criteria for these programs, and Indiana tended to have restrictive criteria.

In 1972, Congress replaced three of these four programs with a new federal program titled Supplemental Security Income (SSI). 42 U.S.C. §1381 *et seq*. Only AFDC was preserved, though it was later changed to Temporary Assistance to Needy Families (TANF). In many states, including Indiana, more persons qualified for SSI than qualified under the three programs for the aged, blind, and disabled which SSI replaced. Congress was concerned that some states might

opt out of the Medicaid program if they were required to provide Medicaid to everyone eligible for SSI. So Congress gave states the option to provide Medicaid to everyone receiving SSI (a state doing this is commonly referred to as an "SSI state") or to not provide Medicaid to everyone eligible to receive SSI. **This latter option is commonly known as the 209(b) option**. Pub. L. No. 92-603, §209(b), 42 U.S.C. §1396a(f). Under the 209(b) option, a state could elect to provide Medicaid assistance just to those individuals who met the eligibility requirements for the state administered programs on January 1, 1972, rather than providing Medicaid to every person receiving SSI benefits.

**SSI** is a needs based program of the Social Security system. An aged (age 65 or older), blind, or disabled person who does not have enough work credits to qualify for Social Security retirement or disability benefits, or whose Social Security benefits are low, can potentially qualify for SSI benefits. The maximum SSI benefit for a single person is $841 per month, while the maximum benefit for a married couple is $1,261 per month. SSI's resource limits are $2,000 for a single person and $3,000 for a couple. SSI's income and

**Indiana was one of eleven states which chose to administer its Medicaid program under the 209(b) option and was thus known as a 209(b) state**. I.C. § 12-15-2-6. See *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981), *Indiana Dep't of Public Welfare v. Payne*, 622 N.E.2d 461 (Ind. 1993), and *Roloff v. Sullivan*, 975 F.2d 333 (7th Cir. 1992), for more discussion of this history.

Federal law sets some limits on a 209(b) state's eligibility rules. Although a 209(b) state can have rules which are more restrictive than the rules for SSI, a 209(b) state's rules cannot be more restrictive than the rules which were in effect in that state on January 1, 1972. 42 CFR § 435.121(a)(2). However, the 1972 rules cannot be used to compel a state to provide Medicaid to a person who does not meet the SSI eligibility requirements. *Roloff*, *supra*; *Payne*, *supra*. Also, in return for being able to select the 209(b) option, the state must deduct incurred medical expenses when counting income, with the result being that the state must allow "income spend down" eligibility for those persons with income above the SSI income limit but otherwise eligible for Medicaid.

Although the 209(b) option is designed to allow a state to have more restrictive rules than are used in SSI, 209(b) states may if they wish use less restrictive income or resource eligibility methodologies than are used in the SSI program. 42 U.S.C. § 1396a(r)(2).

### B. FSSA Converted Indiana to an SSI State on June 1, 2014.

The federal Patient Protection and Affordable Care Act (ACA), Public Law 111-148 (2010), sought to obtain nearly universal health care coverage for legal residents. The way the Act seeks to accomplish this is to encourage states to provide Medicaid to all legal residents with income below 138% of the federal poverty line (FPL), while persons with income above 138% of the FPL are required to purchase health insurance. (Although the ACA refers to a 133% FPL

threshold, there is a 5% disregard, so that the effective FPL rate is actually 138%.) For the first three years, the federal government paid for all of the benefits for persons newly eligible due to expansion, gradually reducing its match to 90% in 2020. The 2021 American Rescue Plan Act provides an additional match for two years to states that did not have expansion in place when the Act was enacted. Persons with incomes between 100% and 400% of the FPL receive subsidies to assist them to purchase health insurance.

The United States Supreme Court ruled that Congress cannot penalize states for not adopting Medicaid expansion. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 132 S. Ct. 2566 (2012). Thus, Indiana had an option whether to expand Medicaid to cover all citizens with income less than 138% FPL. The Indiana legislature did not mandate that Indiana adopt expansion. Instead it allowed FSSA and the Governor to apply to CMS to allow Indiana's Healthy Indiana Plan (HIP) (HIP is described in Section V(L), *below*), or a modified version of it to serve as Indiana's means of expanding Medicaid. HIP 2.0 was finally implemented on February 1, 2015 to be used as Indiana's method to provide Medicaid expansion to persons with income under 138% FPL.

Indiana proceeded with other major changes in its Medicaid programs in 2014 even though HIP 2.0 was not yet in place. These changes were made at least in part because health insurance with subsidies through the federal Marketplace were available to persons with income over 100% FPL who are terminated from Medicaid and do not have other insurance. This allowed Indiana to almost completely eliminate its spend down system, which was expensive to operate and often difficult for recipients to understand and to navigate. I.C. § 12-15-1-5 authorized FSSA to enter into an agreement (known as a 1634 agreement, as allowed by Section 1634 of the Social Security Act, 42 U.S.C. § 1383c) with the Social Security Administration (SSA) to determine eligibility for Indiana Medicaid. The legislative authority in I.C. § 12-15-2-6 to be a 209(b) state expired December 31, 2013. FSSA converted Indiana from a 209(b) state to an SSI state on June 1, 2014.

The conversion resulted in the following changes to Medicaid in Indiana:

• Persons receiving SSI benefits automatically qualify for Medicaid.

• Indiana entered a 1634 agreement with SSA for it to determine disability. SSA decisions on disability are binding for Medicaid.

• The income spend down system was eliminated, except for some persons on a kidney transplant list.

• The income limit for Medicaid for non-institutionalized aged, blind, or disabled persons is 100% of FPL. Aged and disabled persons with income below 100% FPL qualify for Medicaid with no spend down; those above 100% FPL do not qualify, unless institutionalized or on a waiver.

• Persons in an institution (nursing home or hospital) and persons on a waiver are subject to an income eligibility test of 300% of SSI, which is $2,523 in 2022. Persons with gross income above this must have a Miller Trust to be eligible.

• Persons with a severe mental illness who have income less than 300% FPL can qualify for full Medicaid under a Behavioral and Primary Healthcare Coordination (BPHC) program.

• The income limits for the Medicare Savings Programs (QMB, SLMB, QI) were increased to 150 % FPL for QMB and 185% for SLMB/QI.

Various groups were affected as follows:

| **Group** | **Change** |
|---|---|
| SSI recipients not previously enrolled in Medicaid | Automatically enrolled in full Medicaid |
| Persons on Medicaid with a spend down and with income at or below 100% FPL | Received full Medicaid with no spend down |
| Persons with a severe mental illness and income between 100 and 300 % FPL | Could qualify for new BPHC program |
| Persons on Medicaid with a spend down and income above 100 % FPL, not in an institution or on a waiver, and without other insurance | Terminated from Medicaid except for some persons on kidney transplant list |
| Dual eligibles (Medicare and Medicaid) with income between 100 and 150% FPL | Converted from spend down to Medicaid - QMB |
| Dual eligibles (Medicare and Medicaid) with income between 150 and 185% FPL | Converted from spend down to Medicaid - SLMB or QI |
| Dual eligibles (Medicare and Medicaid) with income above 185% FPL | Terminated from Medicaid unless in an institution or on a waiver |

## V. Persons Covered by Medicaid

### A. Categories of Coverage

There are several categories of Medicaid covering various groups of persons. In general, the coverage groups include the elderly, the disabled, low-income children, pregnant women, adults in families with dependent children, and catch-all categories under the Healthy Indiana Plan. I.C. § 12-15-2 establishes the categories covered in Indiana. The IHCPPM now lists 38 categories. Arguably, there are at 40 categories, as the IHCPPM does not list either persons on a kidney transplant list or the Behavioral and Primary Healthcare Coordination program as a category.

Chapter 1600 of the IHCPPM contains a brief description of each category. Here are the categories along with the applicable IEDSS codes for each category which are used in IEDSS notices and in the IHCPPM:

Medical Assistance for the Aged, Blind, and Disabled

MED 1 Program Group

SSI Recipients (MA SI)
Aged (Age 65 or older) (MA A)
Blind (MA B)
Disabled (MA D)
MED Works for disabled persons who are working (MA DW)
MED Works for disabled persons whose condition has improved (MA DI)
RCAP (Residential Care Assistance Program, formerly known as RBA (Room and Board Assistance) (MA R)

MED 4 Program Group

Qualified Medicare Beneficiary (QMB) (MA L)
Specified Low-Income Medicare Beneficiary (SLMB) (MA J)
Qualified Individuals (QI) (MA I)
Qualified Disabled Worker (QDW) (MA G)

Breast and Cervical Cancer Treatment Program (BCCP) (MA 12)

Hoosier Healthwise

MED 2 Program Group

Refugees (MA Q)

MED 3 Program Group

Newborns (MA X)
Child Under One (MA Y)
Child Under Six (MA Z)
Child Six to Nineteen (MA 2)
Children One to Nineteen (MA 9)
Children's Health Plan for Children Birth to Nineteen (MA 10)
Children Under 19 with Adoption Assistance (MA 8)
Foster Children (MA 4)
Former Foster Children 18 to 20 Who Were Wards at age 18 (MA 14)
Former Foster Children 18 to 26 enrolled in Medicaid at age 18 (MA 15)
Parents or Caretakers of Dependent Children (MA GF)
Transitional Medical Assistance (MA F)
Pregnant Women (MA GP)

Family Planning (MA E)
Child in Psychiatric Hospital (MA O)

HIP Healthy Indiana Plan

Regular Basic (MA RB)
Basic - State Plan (MA SB)
Regular Plan Plus (MA RP)
State Plan Plus (MA SP)
State Plan Plus with Co-pays (MA PC)
Pregnant Women (MA MA)
American Indian / Alaska Native (MA NA)

www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-monthly-enrollment-reports gives monthly enrollment reports showing how many people are enrolled in each category. There are also reports showing enrollment by age, by county, by type of waiver, and numbers of dual eligible Medicare/Medicaid members by county. The most recent report for March, 2022 shows a statewide Medicaid enrollment of 2,030,603. This is 582,838 more than were enrolled in February, 2020 as the COVID pandemic was beginning. Enrollment numbers range from 385,748 for children ages 6 - 19 to one person enrolled in MED Works for disabled persons whose condition has improved (MA DI).

A chart at www.in.gov/fssa/ompp/files/Aid-Category.pdf lists the categories with a brief description, the age limits, income limits, whether it is fee for service (FFS) or Risk-Based Managed Care (RBMC), the level of coverage, whether cost-sharing is requiring (most cost sharing is not in effect during the pandemic Public Health Emergency), whether Modified Adjusted Gross Income (MAGI) is used to determine income eligibility, and whether a person in the category can receive Home and Community Based waiver Services.

FSSA's category chart in the previous paragraph lists the categories in a "hierarchy," which is also discussed in IHCPPM § 2035.30.00. If an applicant qualifies under more than one category, then the applicant will be placed into the category higher on the list, unless the applicant expresses a preference for a lower category. "The hierarchy is designed so that the applicant is first considered under the category which provides the most comprehensive scope of coverage in the most expeditious manner." IHCPPM § 2035.30.00. Usually an applicant can only receive benefits in one category. Exceptions are the Medicare Savings Program categories QMB (MA L) and SLMB (MA J), which are discussed at Sections V(K) and XI.

This Manual focuses on the eligibility of the elderly (age 65 or older) and disabled categories established in I.C. §§ 12-7-2-66 and 12-14-15-1. Medicaid categories MED 1 and MED 4 are discussed, while the eligibility rules for MED 2 and MED 3 are not covered in this Manual. A brief overview of HIP is provided.

### B. SSI Recipients (MA SI)

Persons receiving SSI benefits automatically qualify to receive Medicaid for the Aged, Blind, and Disabled. The Social Security Administration reports the approval of SSI eligibility to FSSA; the SSI recipient does not need to separately apply for Medicaid.

### C. Persons Treated as If They Are SSI Recipients and Thus Eligible for Medicaid

Because receiving SSI benefits provides automatic Medicaid eligibility in an SSI state, including Indiana, Congress added protections for persons who at one time received SSI benefits but for some reason no longer receive SSI. Congress wants these former SSI recipients to be treated as if they still receive SSI. The following Sections describe three groups who are protected.

**Advocacy Tip: Ask your client if he or she ever received SSI benefits in the past. If so, consider whether your client fits any of the categories in this Section. FSSA does not have effective procedures to identify persons who fit into these categories.**

#### 1. Loss of SSI Due to Receipt of Child's Disability Benefits

An adult 18 years of age or older can receive child's disability benefits based on a parent's Social Security record if the child is disabled with a disability that began before age 22, if the parent has worked enough to be insured under the Social Security system, and if the parent is deceased or is receiving Social Security retirement or disability benefits. 42 U.S.C. § 1383c(c) provides that if a child receiving SSI disability benefits loses eligibility because that child becomes eligible for child's disability benefits, then that child should be treated as if he or she is still receiving SSI benefits and thus eligible for full Medicaid benefits.

FSSA has implemented this at IHCPPM § 2414.10.10. The only test should be whether the child had SSI benefits at any age which were then lost due to being found eligible for Social Security child's disability benefits.

Example:

> Fred receives SSI benefits for a disability which began before age 22. When Fred is 45, his father retires and starts receiving Social Security retirement benefits. Fred learns that he can receive child's disability benefits of $1,200 per month based on his father's work record. Once he receives these benefits, his SSI benefits will end. Even though his new income is above the Medicaid income standard of $1,133 per month, he is to be treated as if he is still eligible for SSI, and he continues to be eligible for Medicaid disability benefits.

### 2. Loss of SSI Due to Receipt of Social Security Disabled Widow or Widower Benefits

42 U.S.C. § 1383c(d) provides similar protection for disabled widows and widowers who lose SSI benefits due to the receipt of Social Security Disabled Widow or Widower Benefits and who are not entitled to Medicare Part A when they become eligible for the widows' or widowers' benefits. See IHCPPM § 2414.10.20.

Example:

> Maude has been receiving SSI benefits. She turned 60 and contacted the Social Security Administration concerning widow's benefits, as her husband previously died. SSA. She received her award letter from Social Security telling her she will receive $1,636 per month widow's benefit, which will make her ineligible for SSI and which is substantially above the Medicaid income limit for a single disabled person. So long as she is not eligible for Medicare Part A, IHCPPM § 2414.10.20 provides that she is automatically eligible for Medicaid. Her countable income will be treated as if she is still receiving $841 per month, the maximum SSI benefit.

### 3. "Pickle People" - Social Security Cost of Living Increases Deducted

**Advocacy Tip: Ask your client if he or she ever received SSI benefits in the past. If so, consider the information in this Section to see if your client is a "Pickle person."**

A person can receive both SSI and other Social Security benefits, if the Social Security benefits are less than the maximum SSI benefit plus the $20 SSI disregard. For example, for a single person, the maximum SSI benefit is currently $841 per month. If an otherwise SSI eligible person has Social Security benefits of less than $861 ($841 plus $20 disregard), then that person can receive SSI benefits to supplement the Social Security benefits. In 1976, at P.L. 94-566, Title V, § 503, Congress enacted a Section to protect persons who lost SSI benefits due to cost of living increases in Social Security benefits. This provision is not codified, but instead is a note to 42 U.S.C. § 1396a. This Amendment to the Medicaid law is referred to as the "Pickle Amendment" in honor of Congressman Pickle, who sponsored it.

After litigation challenging how the federal government and states were interpreting this Amendment, HHS adopted 42 CFR § 435.135 to govern how this Amendment is applied. It provides that if a state provides Medicaid to SSI recipients, which Indiana does, it must provide Medicaid to a person who:

- Now receives Social Security benefits;

- Was eligible for SSI after April, 1977 but then became ineligible for SSI; and

- Would still be eligible for SSI if one deducted from current income the Social Security cost-of-living increases paid after the last month after April 1977 during which the person was eligible for and received SSI and was entitled to Social Security benefits.

Although the purpose of the Amendment was to protect persons who lost SSI due to Social Security benefit cost of living increases, the impact is broader. If the person received both SSI and Social Security benefits, or received SSI benefits the month before becoming eligible for Social Security benefits, then one can deduct all Social Security cost of living increases received since the last month in which the person was eligible for both Social Security and SSI benefits. healthlaw.org/resource/a-quick-and-easy-method-of-screening-for-medicaid-eligibility-under-the-pickle-amendment-2022-update provides step by step instructions on how to screen clients and do this calculation. It includes a chart one can use to deduct Social Security cost-of-living increases.

It provides the following screening questions:

• Are you now receiving Social Security benefits? If yes, go to the next step.

• After April, 1977, did you ever receive SSI at the same time as Social Security, or did you receive SSI in the month just before your Social Security started? If yes, go to the next step.

• What is the last month you received SSI? (It may be difficult for clients to remember this or to have verification of this, but it should be available from the SSA.)

• Look up the month the person last received SSI in the table in "A Quick and Easy Method ... ." Multiply the multiplier for that month times current Social Security benefits to get countable Social Security income under the Pickle Amendment.

• Add the adjusted Social Security income to any other income. If the resulting income would qualify the person for SSI, then the person qualifies for Medicaid under the Pickle Amendment.

An example will help demonstrate how this provision works.

Maude's only income is Social Security disability benefits of $1,500 per month. She lives alone in her home and does not meet the criteria for a waiver slot. She has Medicare, but she does not have transportation. She needs full Medicaid coverage to cover transportation to her many medical appointments. She applied for Medicaid and was denied because her income is above the income standard for a household of one of $1,133. She was approved for Medicaid - QMB, but that will not cover transportation. In questioning her, you learn that she became disabled in 1994. She initially received SSI benefits in 1994, but they stopped in late 1994 after she started receiving Social Security Disability benefits. She qualifies for the application of the Pickle Amendment because she lost her SSI benefits due to receiving Social Security benefits. The multiplier to use from the table in "A Quick and Easy Method ..." is .531. Multiply her current Social Security benefits of $1,500 by .531 and the result is $796.50. This is the amount her Social Security benefits would be if she had not received cost of living increases. If she now had Social Security income of $796.50, she would currently qualify for SSI benefits. ($20 is disregarded; her countable income of $776.50 is

less than $841.) Thus she must be treated as if she still qualifies for SSI, and thus she should qualify for full Medicaid, even though her current income is over the Medicaid income standard. She should appeal and show that she meets this criteria.

FSSA provides for this group at IHCPPM § 2414.10.15, but it does not provide workers any instructions on how to do this calculation. If a client is receiving Social Security benefits and is not income eligible for Medicaid, ask the client if the client ever received SSI benefits. If so, then conduct the screening to determine if this Section will apply. It is very unlikely that FSSA on its own will identify cases where this may apply.

### D. Aged (MA A)

The Aged category includes anyone who is age 65 or older. A person who turns age 65 during a month is eligible under the aged category for the entire month. IHCPPM § 2410.15.00. Age is most often proved by a birth certificate, but alternate verifications can be presented if a birth certificate is not available. IHCPPM § 2410.05.25. Although that Section title only references the MED 3 categories, it should also apply to MA A.

### E. Blind (MA B)

An applicant must meet specific vision criteria to qualify under the Blind (MA B) category. An applicant must have "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." 405 IAC 2-2-2(a); IHCPPM § 2412.05.00.

### F. Disabled (MA D)

Effective June 1, 2014 Indiana converted to an SSI state, so it now uses SSA's decisions on disability. The test for SSI disability is the same as for Social Security Disability. I.C. § 12-15-1-5 authorized FSSA to enter into an agreement (known as a 1634 agreement, as allowed by Section 1634 of the Social Security Act, 42 U.S.C. § 1383c) with SSA to determine eligibility for Indiana Medicaid. Indiana has a 1634 agreement with SSA.

FSSA still has a Medical Review Team (MRT) that decides disability in some situations, but with a couple of exceptions discussed below SSA's decision of disability is determinative.

For new disability applicants, an SSA decision on disability is determinative. If SSA has found the applicant to be disabled, that is conclusive. If SSA has found the applicant to be not disabled, that also is conclusive, except as discussed below. If a Medicaid applicant has not previously or currently applied for SSI or SSD benefits, FSSA will require the applicant to also apply for SSI / SSD benefits within 45 days unless the applicant is under 18 years of age or unless there is another acceptable reason for not applying. IHCPPM § 2025.20.00. Persons, such

as the Amish, with a recognized religious objection to applying for federal benefits should not be required to apply for SSI / SSD.

There will be some cases when there is no Social Security decision and the MRT must decide disability. For example, a person may not have a sufficient work record to qualify for Social Security disability benefits and may not financially qualify for SSI. Then, the MRT must determine disability. An FSSA eligibility worker should obtain a completed report from the applicant's doctor (Form 251A) and should also obtain all medical records for the past 12 months. See IHCPPM §2412.30.10. The DFR then sends the medical information, together with a social summary (Form 251B), to the MRT at the state Office of Medicaid Policy & Planning. The MRT has doctors on staff and is responsible for deciding whether the applicant is disabled. The MRT reports its decision to the DFR. The MRT is sometimes more willing than SSA to accept the opinion of the treating physician. Medicaid does not routinely provide for any consultative medical examinations, even though it can upon request. IHCPPM § 2412.30.10. It is important that an applicant or his or her advocate gather the needed medical information and, when needed, insist that a consultative examination be scheduled.

If SSA does not make a disability decision within ninety days of the Medicaid application, FSSA must make a disability decision, as it must act on the application within ninety days. 45 CFR § 435.541(c)(2); 405 IAC 2-1.1-3(c)(2). That may mean FSSA will wait until almost ninety days to issue its decision in order to give SSA time to act. If SSA finds the applicant not disabled before Medicaid acts but the applicant timely appeals the SSA denial, then the MRT will still determine eligibility, pending the outcome of the SSA appeal. IHCPPM §§ 2412.25.00 and 2412.50.00. If FSSA finds the applicant to be disabled and SSA later finds the person to be not disabled, then the SSA decision will control and Medicaid benefits will be terminated if the recipient does not file a timely appeal of the SSA decision. If a timely SSA appeal is filed, then Medicaid benefits will continue until a final SSA decision is made.

Even when SSA has found a person to be not disabled, there are some situations where FSSA still needs to make its own disability decision. FSSA will still decide on disability when:

> • SSA denied disability more than a year ago and the applicant alleges that his or her condition has changed or deteriorated since that SSA determination.
>
> • SSA denied disability less than a year ago and the applicant alleges that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
>
> > (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
> >
> > (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

See also 45 CFR § 435.541(c)(4) and 405 IAC 2-1.1-3. The applicant will also need to file a new application with SSA or seek reconsideration or reopening.

Because of the long delays in the SSA appeal process, the initial SSA disability decision is critical. Disabled applicants must present all of their conditions and all medical records to SSA. However, some applicants will not know their own conditions. Persons suffering from mental illness may not recognize or report their symptoms and condition. Many applicants will not have extensive medical records because they have not had health insurance. Elder law attorneys may want to connect with Social Security Disability attorneys for assistance in this area.

Because the SSA determination of disability is decisive, an appeal from a Medicaid denial based on a SSA decision will usually be futile. However, it may be necessary to appeal the Medicaid denial and try to keep the appeal pending while an SSA appeal pends in order that full retroactive Medicaid can be obtained if the SSA appeal is successful. It is unknown if FSSA will allow one to indefinitely continue an administrative appeal while waiting for an SSA appeal to be completed. It may be necessary to file for agency review and judicial review to keep the Medicaid appeal alive.

If a recipient of both Medicaid and Social Security or SSI disability benefits is found by SSA to no longer be disabled, the Medicaid benefits will be terminated only after the Social Security or SSI appeal time period has expired without appeal or after no appeal is still pending. That is, the Medicaid benefits will continue until SSA's decision is final with no further chance for appeal. IHCPPM § 2412.50.00.

### G. End Stage Renal Disease

Because of concerns about the impact for persons on a kidney transplant list of losing Medicaid, FSSA obtained approval from CMS to continue coverage for about 360 persons who were subject to losing Medicaid coverage on June 1, 2014. The program also covers new applicants who fit the criteria. The program assists about 300 persons a year. This program is discussed at IHCPPM § 3375.00.00 forward. IHCPPM § 3375.00.00 explains that to receive coverage, a person must:

- Be approved for Medicare;

- Have income between 150 percent and 300 percent of the federal poverty level, except that persons who were on Medicaid on May 31, 2014 with a spend down are not subject to the 300% limit;

- Not be institutionalized;

- IHCPPM § 3375.00.00 still lists the original resource limits that were in effect as of May 31, 2014 of $1,500 for an individual and $2,250 for a married couple, but the most recent CMS approval letter approves Indiana's request to increase the resource limits to $2,250 for an individual and $3,000 for a couple. FSSA will be corrected this; and

- Not be eligible for full benefits under another Medicaid coverage option.

Coverage is only available for persons on Medicare. Persons with income under 150% of FPL are not covered because they qualify for QMB. See Section K, below. Persons above 300% FPL will be required to purchase insurance through the exchange unless on Medicaid with a spend down on May 31, 2014. Persons who qualify under this exception are subject to the old spend down system that was otherwise eliminated on June 1, 2014.

FSSA obtained approval from CMS for this exception as a "section 1115 waiver demonstration program" as an amendment to the Healthy Indiana Plan. This apparently was how Indiana could obtain the quickest approval from CMS while it worked to obtain longer range approval for this group. On December 17, 2021, CMS approved a temporary extension to the program through December 31, 2022. FSSA's application to renew the program through 2025 is pending with CMS.

This only covers persons on a kidney transplant list. Other transplant patients are not covered.

### H. Breast and Cervical Cancer Treatment Program (BCCP) (MA 12)

This category assists women with breast or cervical cancer. I.C. § 12-15-2-13.5. A woman under age 65 who does not qualify for Medicaid under any other category or a woman over age 65 who does not have Medicare Part B, who is uninsured or under insured, and who needs treatment for breast or cervical cancer, qualifies for Medicaid if her family income is less than 200% FPL. Eligibility lasts as long as treatment is needed. I.C. § 12-15-2.3 *et seq*. also provides that certain providers are authorized to award presumptive eligibility to a woman with breast or cervical cancer such that Medicaid will immediately go into effect until the Division of Family Resources makes the final eligibility determination.

The program is administered by the Indiana State Department of Health. See www.in.gov/isdh/24967.htm and www.in.gov/isdh/19859.htm for more information on the screening program. The Indiana Breast and Cervical Cancer Program can be contacted by contacting a regional coordinator listed at www.in.gov/isdh/19853.htm or at (317) 233-7901.

See IHCPPM § 1621.00.00 for further information.

### I. Behavioral and Primary Healthcare Coordination (BPHC)

This program began June 1, 2014 as part of Indiana's SSI transition. The program, Behavioral and Primary Healthcare Coordination (BPHC), is used to coordinate healthcare services for individuals with mental illness. It is designed to assist individuals with serious mental illnesses who do not otherwise qualify for Medicaid and do not have other third-party insurance coverage for the level of services they need to function safely in the community. provider.indianamedicaid.com/ihcp/Publications/providerCodes/Behavioral_and_Primary_Healthcare_Coordination_Codes.pdf lists eligible diagnoses. The BPHC program provides supportive and intensive community-based services to individuals who are impaired in self-managing their healthcare needs due to mental illness.

The BPHC program is available to persons who have been found eligible for Medicaid under one of the categories listed in IHCPPM § 3350.15.00. A person who is 19 years of age or older and has been diagnosed with a serious mental health condition who is not already eligible under one of these categories can qualify with income below 300% of the federal poverty level ($3,220 for a single person). There is no resource limit. See IHCPPM §§ 3350.20.00 and 3350.25.00. See also www.in.gov/fssa/dmha/2883.htm for more information.

### J. Disabled Persons Who Are Working (MED WORKS) (MA DW and MA DI)

The Medicaid Buy-In Program for Working Individuals with Disabilities, referred to as MED Works, is found at I.C. § 12-15-41 and 405 IAC 2-9. It is also described at IHCPPM §1610.26.00. This category allows working individuals with disabilities to buy Medicaid coverage at a modest cost. This coverage was authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999, codified at 42 U.S.C. § 1396a(a)(10)(A)(ii)(XV) and (XVI). At first glance, this category seems inconsistent with the definition of disability, which considers a person's ability to work. A person who is able to work is not considered disabled for purposes of Medicaid disability (MA D), as discussed above in Subsection F. MED Works is designed to assist working disabled persons who may otherwise not be able to obtain health insurance. The test is whether the individual would medically qualify as disabled if the individual did not have the earnings. 405 IAC 2-9-6. An example is a paraplegic who is working despite the obvious disability.

Qualified individuals are listed in one of two categories. MA DW is the MED Works category for persons who meet the Medicaid definition of disability without regard to employment, while MA DI includes persons who lose eligibility for regular Medicaid disability because of an improvement in medical condition which is not a complete recovery, but enough to result in not meeting the regular disability definition.

To be eligible for consideration in this category, I.C. § 12-15-41-4 provides that an individual must:

- have a severe medically determinable impairment;
- be at least 16 years of age but less than 65 years of age; and
- be engaged in a substantial and reasonable work effort (generally this requires monthly earnings of at least $65 and at least $290 (40 times the federal minimum wage) when the person is eligible due to a medical improvement. 405 IAC 2-9-5(a) and (b).

The IHCPPM gives little guidance on determining eligibility for this category. This category is worth considering and pursuing for persons who are working despite a significant impairment. This is an important category because the financial eligibility criteria are much more liberal than for regular Medicaid disability. See Section X, *below*.

## K. Medicare Savings Programs (MED 4)

A Medicare beneficiary who is aged, blind, or disabled according to Medicaid's standards and who meets the Medicaid income and resource eligibility rules can qualify for "regular" Medicaid (Medicaid for the Aged, Blind, or Disabled). A Medicare beneficiary who does not qualify for regular Medicaid may still qualify for Medicaid under one of four special categories in the MED 4 group designed for Medicare beneficiaries. These categories have higher income and resource limits than regular Medicaid but with more limited benefits. See Section XI, *below*, for a discussion of the financial eligibility guidelines and benefits for each of the four categories within this group.

A prerequisite to qualify for these categories is that one receive Medicare. The most common criteria for Medicare coverage is that one be age 65 and insured under the Social Security program or that one have received Social Security disability benefits for two years. Thus, a person who may not qualify for full Medicaid due to excess income or resources may still be able to qualify for one of the savings programs because they have higher income and resource limits. See Section XI, *below*. Persons not automatically eligible for Medicare but who opt to purchase coverage can also qualify. For example, a person over age 65 who does not qualify for Social Security benefits because of an insufficient work record can potentially qualify for QMB as he or she can purchase Part A and Part B coverage.

These programs are sometimes referred to as "buy-in" programs because the state pays ("buys-in") the Medicare premiums for those who are eligible.

## L. Healthy Indiana Plan (HIP)

[Thanks to Amanda Hall of the Indiana Legal Services, Inc. office in Evansville for helping with this Section.]

The Healthy Indiana Plan (HIP) is a demonstration waiver program approved under 42 U.S.C. § 1315 designed for persons who do not have other health insurance. It began on January 1, 2008. The program was revised on February 1, 2015 as HIP 2.0 to serve as the Medicaid expansion vehicle for Indiana. It has now been extended through 2021. The statutory authority for the program is now at I.C. § 12-15-44.5. Regulations for the program are at 405 IAC 10. See IHCPPM § 3500 for the Manual provisions concerning HIP.

Services provided are more limited than under Medicaid for the Aged, Blind, and Disabled, except for those persons who qualify for HIP State Plan. Services are administered by managed care entities (MCEs). A member must choose from one of the four approved MCEs: Anthem, CareSource, Managed Health Services (MHS), or MDwise.

As of March, 2022, 769,891 Hoosiers were enrolled in HIP 2.0.

### 1. Eligibility

To be eligible for HIP, one must meet the following requirements:

• be between nineteen (19) and sixty-five (65) years of age.

• be an Indiana resident.

• have income of not more than 133% of the federal poverty level for the individual's family size: $1,507 for a household of 1; $2,030 for 2. Because income is counted using "Modified Adjusted Gross Income," with 5% of income being disregarded, the true income level is 138% (133 % standard plus 5% disregard) of the federal poverty level.

• not be eligible for Medicare or other Medicaid categories and not have health insurance coverage through the individual's employer.

There is no asset (resource) test for HIP eligibility.

**2. Categories of HIP**

• Presumptive Eligibility (PE). This offers members coverage that is effective immediately. The assistance of a healthcare navigator is required. Navigators that are certified to sign members up for PE are usually located at Federally Qualified Health Centers and hospitals. Less documentation is required than for a full HIP application. Coverage is equivalent to HIP Basic. Members may only enroll in PE once yearly. Coverage lasts until the last day of the month following enrollment in PE. Then, a member who has been found eligible for full HIP coverage may be enrolled into HIP Basic or HIP Plus, depending on the income percentage of FPL and on whether the POWER account contribution has been paid.

• HIP Plus - State Plan (MA SP). This is the benefit received by those persons making POWER account contributions and who qualify as "medically frail" or as low-income parents and caretakers. These persons receive the full Medicaid services in addition to the regular HIP services. HIP recipients determined to be medically frail are exempt from lock out penalties and work requirements. "Medically frail" means an individual who is determined to have any one of the following:

1) A disabling mental disorder
2) A chronic substance abuse disorder
3) A serious and complex medical condition
4) A physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living.
5) A disability determination from SSA but is not eligible for Medicaid for the Aged, Blind, or Disabled due to income or resources.

IHCPPM § 3515.05.00.

• HIP Regular Plus (MA RP). This is received by persons who make POWER account contributions and do not qualify for HIP Plus - State Plan (i.e., they are not medically frail).

• HIP Plus-State Plan with Co-pays (MA PC). This category is for persons with income above 100% FPL who fail to make POWER account payments but are "medically frail."

• HIP Basic - State Plan (MA SB). This is the benefit received by persons with income under 100% FPL who do not make POWER account contributions and who qualify as "medically frail" or as low-income parents and caretakers.

• HIP Regular Basic (MA RB). This is the benefit received by persons with income under 100% FPL who do not make POWER account contributions and who do not qualify as "medically frail" or as low-income parents and caretakers.

• HIP Maternity is for women who are pregnant when they apply or become pregnant while enrolled in another HIP category. It lasts the duration of the pregnancy and sixty days post-partum. They are not subject to cost sharing, including copays and POWER account payments. They receive enhanced benefits, similar to HIP State Plan benefits.

• Parent and caretaker relatives are enrolled in HIP State Plan Plus or HIP State Plan Basic. A member who becomes ineligible due to income, but has qualified under this section, will continue to receive HIP transitional medical assistance for six or twelve months, depending on the income % FPL and childcare expenses. A member who turns 65 and qualifies under this section may continue to receive HIP benefits so long as they continue to meet the definition of a "Section1931" parent or caretaker relative. Members in this category are subject to HIP Plus POWER account payments or HIP Basic co-pays.

• American Indian / Alaska Native (MANA). They are not subject to any cost sharing requirements, including the requirement to make POWER account payments.

### 3. POWER Account Contributions

**POWER account contributions are waived during the COVID-19 national Public Health Emergency.**

The program encourages recipients to contribute to Personal Wellness and Responsibility (POWER) accounts modeled after Health Savings Accounts (HSA) in an effort to require recipients to "have skin in the game." Recipients contribute based on their income with the state funding the difference between the member's annual contribution and $2,500. Required POWER account payments range from $1 to $20, except that tobacco users must pay a 50% surcharge for each payment. See IHCPPM § 3540.05.00 for the payment amounts based on income. Persons with a POWER account receive HIP Plus benefits.

Persons with income below 100% FPL who do not make the required POWER account contributions receive the HIP Basic plan. This plan has fewer services, and members are assessed copayments for some services. There is a cost sharing limit of 2% of annual income which is assessed quarterly. A recipient should keep track of this.

Persons with income above 100% FPL do not have a choice on whether to make POWER account contributions; they will not receive HIP coverage if they do not make their contributions.

Persons with income above 100% FPL who fail to pay their POWER account payments are terminated from HIP and are not allowed to reapply for six months from the notice of nonpayment. This is referred to as a "lockout." A person can also be locked out for six months for failure to turn in documentation. Medically frail persons are exempt from a lockout.

Persons with income below 100% FPL who do not pay their POWER account payments are transferred to HIP State Plan - Basic.

### 4. Effective Date

For individuals meeting all financial and non-financial requirements to be considered HIP eligible, the effective date of eligibility is determined upon whether the person makes a timely financial contribution to the POWER account.

For HIP Regular Plus or HIP State Plus, coverage begins the first day of the month in which the individual makes an initial POWER account contribution. There is no retroactive coverage under HIP PLUS categories. If the member has Presumptive Eligibility, then the full HIP coverage begins the first day of the month following the initial POWER payment, with the PE coverage being in place until that time.

The effective date of HIP Regular Basic or HIP State Basic coverage begins in the month the member, whose income is at or below 100% FPL, fails to make a required contribution to his POWER account within his sixty (60) day payment period. There is no retroactive coverage under HIP Basic categories.

Upon receipt of an application for health coverage but prior to a HIP eligibility determination, a HIP health plan will send the pending HIP applicant a $10 "fast track" prepayment invoice that is due within sixty calendar days. Sometimes all of the plans solicit fast track payments, regardless of which plan was selected. This initial fast track invoice begins the individual's sixty day deadline to make a required contribution to a POWER account. If the applicant makes the $10 fast track payment and is subsequently determined eligible for HIP, the member will have HIP Plus coverage beginning the month the fast track payment was made, and the $10 will be applied toward any remaining amount owed by the member toward their POWER account. If the applicant who makes the $10 fast track payment is subsequently determined ineligible for HIP, the member is entitled to a refund from the managed care health plan that received the $10 payment.

### 5. Changing from HIP to Medicaid for the Disabled

Consider the situation where a person with HIP coverage becomes disabled and enters a nursing home. HIP can cover nursing home care, at least for a limited period, but prior approval by the managed care entity is required. Suppose the HIP member applies to be upgraded to Medicaid for the Disabled category. Due to change processing guidelines, IHCPPM §

2220.05.00 provides that Medicaid for the Disabled will go into effect the month after the change is reported. It cannot be awarded retroactively for those months where HIP was already in place. This arguably is contrary to 42 CFR §435.915, which provides for three months of retroactive coverage.

An applicant who is in a nursing home or in the process of being approved for a waiver who could qualify to be on HIP or on Medicaid for the Disabled should first pursue Medicaid for the Disabled because the HIP coverage will not be removed retroactively. IHCPPM § 2220.05.00.

IHCPPM § 2220.05.00 suggests that the Help Desk / Policy Answer Line can approve retroactive removal of HIP on a case-by-case basis if an actual provider generated bill shows the claim was denied, and the provider has billed the Managed Care Entity. Advocacy will be needed to accomplish this. Acting on a case-by-case basis without standards is arguably a due process violation.

IHCPPM § 2220.05.00 states that once a person is moved to the Medicaid for the Disabled category, a deviation of liability will be allowed for medical expenses incurred in a back month that the recipient was eligible for HIP coverage, if the claim was not a HIP covered service.

### 6. Work Requirement

FSSA approved Indiana's request to add a work requirement, known as "Gateway to Work," to HIP in 2019. This requirement was challenged by recipients in *Rose v. Azar*, Case 1:19-cv-02848, U.S. Dist. Ct. for D.C., Complaint filed September 23, 2019. FSSA agreed to suspend the work requirement while the litigation proceeded. Similar lawsuits challenging work requirements in other states have been successful. *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020), vacated as moot by U.S. Sup. Ct. April 18, 2022, ruled that the Secretary of HHS acted in an arbitrary and capricious manner in approving Arkansas's Medicaid demonstration request because he failed to analyze whether the work requirements would promote the primary objective of Medicaid – to furnish medical assistance. *Gresham* was appealed to the U.S. Supreme Court, which scheduled oral argument to be held in March, 2021, but then cancelled the oral argument after the Biden Administration announced its intention to remove approval for work requirements and eventually found the cases to be moot. CMS then officially revoked its approval for Indiana's work requirements.

## VI. Services Covered by Medicaid

### A. Services Covered

States have some latitude in deciding what medical services to cover under Medicaid. Federal Medicaid law designates some service categories as mandatory, so that any state with a Medicaid program must provide those services. Other categories are designated as optional categories which a state can choose to provide. 42 U.S.C. §1396a(a)(10)(A); §1396d(a). Indiana covers a broad range of medical services, including most of the optional service categories listed

in the federal law, once a person qualifies for Medicaid for the Aged, Blind, or Disabled. Nearly all types of medical services are covered, even including some non-medical services such as transportation expenses. See I.C. § 12-15-5-1 for a list of the services covered in Indiana. Services covered include:

1. Physician services
2. Inpatient and outpatient hospital services
3. Laboratory and x-ray services
4. Nursing home services
5. Intermediate care facility services for the mentally retarded
6. Assisted Living, with a waiver, or through RCAP
7. Adult Family Care, with a waiver
8. Home health services, and other non-medical personal care ("waiver") services
9. Prescribed drugs (but see below for Medicare recipients)
10. Medical supplies, equipment, and prosthetic devices
11. Outpatient mental health services
12. Inpatient psychiatric care for persons under age 21 or over age 65
13. Dental services
14. Family planning services
15. Nurse mid-wife services
16. Community residential care for developmentally disabled
17. Optometric services, including eyeglasses
18. Physical and occupational therapies
19. Speech pathology, audiology, and related supplies
20. Respirators, therapy, and related supplies
21. Private duty nursing services
22. Chiropractic services
23. Podiatric services
24. Hospice Care
25. Transportation for Medicaid-covered medical services
26. Burial assistance ( maximum payment of $1,200 for the funeral director and $800 for cemetery expenses. See IHCPPM §4800.00.00 ff.)

In addition, Medicaid pays the Medicare Part B premium, currently $170.10 per month (more for some persons with a penalty for late enrollment), for all Medicare recipients who receive Medicaid for the Aged, Blind, or Disabled or who qualify under one of the MED 4 categories. This is an important benefit, as the net amount of Social Security benefits a recipient receives increases once the State starts paying the monthly Part B premium. On August 21, 2020 CMS issued a new manual for State Payment of Medicare Premiums, www.cms.gov/files/document/r4spmp.pdf. The manual should be a useful resource for advocates when working with FSSA to resolve buy-in problems that arise for their clients.

Regulations further describing the services covered are at 405 IAC 5. An unpromulgated Medical Policy Manual containing policy for coverage of services is at www.in.gov/medicaid/files/medical%20policy%20manual.pdf.

### B. General Information about Services

A person found eligible for Medicaid receives a Hoosier Health card which he or she must show to the provider when medical care is received. Indiana uses a plastic ID card for Medicaid recipients. The provider must confirm the recipient's status when an ID card is presented. Providers can obtain information through a management information system called CoreMMIS. The system verifies the member's active coverage for one or more benefit plans. The system also provides details and limitations about the member's coverage. See Bulletin BT201728 (April 20, 2017), provider.indianamedicaid.com/ihcp/Bulletins/BT201728.pdf for more information about what information is available to providers through CoreMMIS.

Not all health providers accept Medicaid. A recipient must obtain services from a provider who accepts Medicaid. The provider has an agreement with the state specifying the provider's rights and responsibilities. See Section XI(A) for an exception for Medicaid - QMB recipients.

For services received on or after January 1, 2019, the provider must file its claim for payment with Medicaid within 180 days of the date of service. For services provided before January 1, 2019, providers had one year to file its claim. If one succeeds on an appeal after the time limit, then the provider will have additional time to file a claim.

Not all nursing homes are certified to accept Medicaid recipients, and even those nursing homes that are certified providers do not certify all of their beds for Medicaid. A Medicaid recipient must be residing in a certified bed before Medicaid will cover the care. The certification status of a nursing home is available at the Indiana State Department of Health website at www.in.gov/isdh/reports/QAMIS/ltcdir/index.htm. For each facility, the directory lists the certification status. It uses "SNF" for Medicare only beds, "NF" for Medicaid beds, "SNF/NF" for beds dually certified for both Medicare and Medicaid, "NCC" for beds not certified for either Medicare or Medicaid, and "RES" for residential care, which is not a nursing home level. A Medicaid recipient must be in or move into a NF or a SNF/NF certified bed before Medicaid will pay for the nursing home care. A nursing home in which not all beds are certified for Medicaid must designate which beds are certified for Medicaid. They need to be generally contiguous; they cannot be scattered throughout the facility.

One must be approved by pre-admission screening before entering a nursing home. This screening, established by I.C. § 12-10-12, is conducted by an on-line screening process by a contractor using a program called AssessmentPro. See www.in.gov/fssa/da/5011.htm and maximus.com/svcs/indiana for more information on this system which went into effect July 1, 2016. A nursing home resident who has not been pre-screened or who is denied through pre-screening is ineligible for Medicaid coverage of the nursing home stay for a year after entering the nursing home. I.C. § 12-10-12-33 and 34. A denial can be appealed.

Medicaid's daily payment rates for Medicaid facilities can be found at mslc.com/Indiana/Resources/Documents.aspx by selecting Nursing Facility / Other Reports / Cumulative Rate Listing. Medicaid's payment rate ranges from a low of $124.16/day to a high of $400.36/day, with an average rate of $230.83/day.

Medicaid does not pay for "bed hold" costs. Before February, 2011, Medicaid would pay a nursing home for up to 15 days to hold a bed when a nursing home resident entered a hospital and for up to 30 days a year when a resident left a nursing home for a "therapeutic leave," such as for a visit with family. As a cost savings measure, FSSA by emergency rule eliminated payment to hold a nursing home bed effective February 1, 2011. The Indiana legislature then enacted I.C. § 12-15-14-2.5 to endorse this ban on payment for nursing home bed holds. Similarly, if a person receiving waiver services for assisted living care needs to enter a nursing home temporarily, Medicaid will not pay to hold the bed at the assisted living facility. Even when a nursing home bed is not held, federal law provides that a Medicaid nursing home recipient who enters the hospital or leaves for a therapeutic leave must be allowed to return to the next available Medicaid certified bed in the nursing home. 42 U.S.C. § 1396r(c)(2)(D)(iii). The same protection does not apply to assisted living residents.

Medicaid will only pay for a private room if there is a medical need for a private room. If the recipient does not qualify for Medicaid to provide a single room, the family (or a special needs trust) may pay for the difference between the Medicaid rate for the double room and the private pay rate for a single room so that the recipient can have a private room, if the facility is willing to allow a private room. Some facilities may not be willing to provide a private room because they want to make the room available for another Medicaid recipient.

A Medicaid provider must accept Medicaid as full payment for services; a recipient cannot be billed anything for the services even if the state pays less than the provider's private pay rate. 42 CFR § 447.15; *Banks v. Smith*, 997 F.2d 231 (7th Cir. 1993). The Provider Agreement between the provider and FSSA also provides explicit language that Medicaid payment must be accepted as full payment. If the provider is dissatisfied with Medicaid's payment, its recourse is to seek an adjustment to its payment. This does not apply to copayments, nursing home liabilities, and waiver liabilities for waiver recipients, which are the recipient's share to pay as determined by FSSA. Providers can demand that recipients pay liability amounts. *Robinett v. Shelby County Healthcare Corp.*, 895 F.3d 582 (8th. Cir. 2018) held that a medical services provider could forego Medicaid's guaranteed payment at a lower rate for covered services and opt instead to bill the patient or liable third parties directly. There the recipient was injured in an accident and had a tort claim against the other driver. In Indiana, the Provider Agreement may prevent the provider from doing this.

FSSA has given providers detailed guidance on the requirement to accept Medicaid as full payment in Banner Page BR202111 (March 16, 2021), provider.indianamedicaid.com/ihcp/Banners/BR202111.pdf . This Banner Page provides:

> • A member can be billed for a non-covered service only when the provider documents that the member understood **before** receiving the service that it would not be covered by Medicaid and the member chose to receive the service, understanding that the member would be responsible for the charges. If the provider uses a waiver form, it cannot use a generic waiver form.
>
> • An embellishment or enhancement to basic services can be considered separately from the basic service only if there is a separate procedure code for the enhancement. If a separate code exists, the member can be charged for the

enhancement if the member understands and agrees to the enhancement before receiving it.

• The provider may bill the member if the member does not advise the provider of Medicaid coverage. But if the member notifies the provider of Medicaid coverage within the 180 day period to file a claim, the provider must file its claim with Medicaid and refund to the member any amounts already paid on the bill.

• A hospital may bill a member if the hospital's utilization review committee decides an admission or continued stay is not medically necessary, in accordance with 42 CFR § 482.30. Before billing the patient, the hospital must notify the patient in writing that the patient will be responsible for the costs after the date of the notice.

• A member cannot be billed for missed appointments or for copies or transfers of medical records. This cost is considered to be covered within the Medicaid reimbursement, which is intended to cover overhead expenses.

One can argue that a nursing home cannot charge a Medicaid recipient who is in a non-certified bed the private pay rate, since the nursing home must accept Medicaid's payment, zero if the resident is in a non-certified bed, as full payment. Although the nursing home may argue that these are non-covered services while in a non-certified bed, the services would be covered if in a certified bed, so arguably they are covered services.

For some services the provider may charge a small copayment to the recipient. **The copayments in this paragraph are not owed during the COVID Public Health Emergency.** For transportation, the provider can charge a copayment ranging from $.50 to $2.00 each way. 405 IAC 5-30-2. A pharmacist can charge $3.00 for drugs. 405 IAC 5-24-7. A hospital can charge $3 for non-emergency services provided in an emergency room. 405 IAC 1-8-4. Certain services are exempt from copayments, including services for minor children, services for persons in an institution, and most services to pregnant women. A recipient is not required to pay more than 5% of his or her income for copayments in a calendar quarter. A provider cannot refuse to serve a Medicaid recipient if the recipient cannot afford to pay the copayment.

Indiana uses "managed care" for some of its aged, blind and disabled recipients with a program called Hoosier Care Connect. All Medicaid Aged, Blind, and Disabled recipients who do not have Medicare and are not in a nursing home or receiving waiver services are required to select a Managed Care Entity (MCE) responsible for coordinating the care. Anthem, Managed Health Services, and United Healthcare currently serve as MCEs. Beginning January 1, 2023, United Healthcare will no longer serve as an MCE, while MDwise and CareSource will be added as MCEs. The MCEs enroll doctors who agree to be Primary Medical Providers (PMPs). Beneficiaries sign up with a PMP and a MCE. Recipients can choose an MCE on the enrollment application or within the first sixty days. Recipients can then change plans yearly, or sooner for just cause. For more information on Hoosier Care Connect, see www.in.gov/medicaid/members/26.htm.

FSSA plans to implement managed care for nursing home residents and waiver recipients, possibly in 2023.

For some types of medical care, the provider must obtain prior approval before the services will be covered by Medicaid. 405 IAC 5-3. If the recipient is a member of an MCE, as discussed in the preceding paragraph, then the prior approval request is submitted to the member's MCE. If the member does not belong to an MCE, then the prior approval request is submitted to Gainwell Technologies, except that pharmacy requests are handled by Optum Rx. The provider submits a prior approval request form to the appropriate entity, which then decides whether the medical care is reasonable and necessary. A decision on the request must be made within seven calendar days of receipt of all required documentation; if a timely decision is not made, approval is deemed. 405 IAC 5-3-14. Action on a request can be suspended for up to thirty days while further information is requested from the provider. 405 IAC 5-7-1.

FSSA places limits in some of the service categories on what services are covered. These limits are contained in various rules within 405 IAC 5. In a trio of cases, the Indiana Court of Appeals ruled that the state agency cannot deny approval for services which recipients show are "medically necessary." *Thie v. Davis*, 688 N.E.2d 182 (Ind. Ct. App. 1997) (regulation excluding Medicaid coverage for dentures for persons without natural teeth was invalid); *Coleman v. Indiana FSSA*, 687 N.E.2d 366 (Ind. Ct. App. 1997) (regulation excluding Medicaid coverage for partial dentures was invalid); *Davis v. Schrader*, 687 N.E.2d 370 (Ind. Ct. App. 1997) (regulation excluding Medicaid coverage for orthopedic shoes was invalid). The Court's reasoning was explained in *Thie*. The Court concluded that federal law requires coverage of "medically necessary" services. Thus, with respect to dental services, which is an optional coverage category under federal law, Indiana could choose not to provide any dental services. But once Indiana decided to cover dental services, then it must cover all "medically necessary" dental services. The Court stated that Indiana is free to define "medically necessary" within federal parameters. Indiana has a regulation providing that a "medically reasonable and necessary service" is a service that "is provided in accordance with generally accepted standards of medical or professional practice." 405 IAC 5-2-17. Indiana could not then simply always exclude dentures, even when providing dentures meets current professional standards. The Court left some room for Indiana to adopt a narrower definition of medical necessity, but the Court's ruling shows that it is improper for the state to simply exclude coverage for needed procedures when suitable alternative procedures are not available.

*Bontrager v. Ind. Family & Soc. Servs. Admin*., 697 F.3d 604 (7th Cir. 2012) followed the reasoning in *Thie* and its progeny and affirmed a preliminary injunction invalidating FSSA's dental limit of $1,000 per adult per year.

*Brown v. Ind. FSSA*, 71 N.E.3d 50 (Ind. Ct. App. 2017), at the request of FSSA, remanded a prior approval denial back to FSSA for further hearing on whether the genetic testing which was denied had moved from being a new and experimental treatment not covered under 405 IAC 5-29-1(3) and (4) to now being a medically accepted service in the medical community.

Indiana Medicaid uses a Preferred Drug List to limit the use of prescriptions. See inm-providerportal.optum.com/providerportal/faces/PreLogin.jsp for the list. Prior approval

must be obtained for drugs not on the list. See 405 IAC 5-24-8, 8.5, and 8.6 for the regulations on limitations and prior approval for drugs.

### C. Persons Receiving Both Medicare and Medicaid Receive Prescription Drugs Through Medicare, Not Medicaid.

The Medicare Part D Prescription Drug Plan (PDP) legislation provides that persons with Medicare must receive their prescriptions through Medicare, not Medicaid, even if they have coverage under a Medicaid category that covers prescription drugs. See Section XII, *below*, for more information on this and on auto enrollment or facilitated enrollment for persons not already enrolled in a PDP. Beginning May 4, 2022, Medicaid will not pay for prescription drugs for Medicaid members who have opted out of Medicare Part D.
provider.indianamedicaid.com/ihcp/Banners/BR202213.pdf.

Medicare requires drug plans to cover all, or substantially all, of the drugs in six specific categories. These categories are the antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS categories. All Medicare drug plans must cover all anti-retroviral drugs. This includes single chemical entities as well as combination products. Certain drugs are excluded and cannot be provided as part of standard Medicare prescription drug coverage. Some examples of excluded drugs include drugs for weight loss or gain and drugs for relief of colds. However, except for non-prescription over-the-counter drugs, a plan can choose to cover excluded drugs if the plan offers more than standard coverage. Non-prescription drugs cannot be included. Medications which Part D plans are prohibited from covering, such as over the counter medications covered by Medicaid, are covered by Medicaid if they are otherwise covered by Medicaid.

If a drug is a type that a Part D plan can cover but it is not on the plan's formulary, Medicaid will not cover that drug for a "dual eligible," even if the drug is covered by Medicaid. If the doctor asserts that the particular drug is needed, then the person needs to pursue the Medicare Part D appeals and exceptions process.

### D. Waiver Services

In addition to the medical services covered under Medicaid, Medicaid also offers additional non-medical home and community based services under programs known as "waiver services." Medicaid is considered to be an "entitlement" program. This means that anyone who meets the eligibility criteria can qualify for Medicaid, and any Medicaid recipient can receive any service that is covered under the program. This requirement results in states sometimes deciding not to cover certain services under Medicaid because of the potential cost. To address this concern, Congress allows states to apply for permission to provide some types of services without needing to meet all of the typical requirements, such as providing the service to everyone in the state who needs the service. That is, the federal agency "waives" some of the requirements. 42 U.S.C. §1396n(c); 42 CFR § 440.180; 42 CFR § 441.300 *et seq*. Under a waiver program, the federal agency can grant permission to the state agency to cap the number of people who will be served under that waiver or to only provide services in part of the state.

Waivers are designed as an alternative to institutionalization. Thus, to qualify for waiver services a person must first meet the level of care to receive services in an institution (hospital, nursing home or intermediate care facility for persons with a developmental disability (ICF/IDD)) but choose to receive services in the community. 42 U.S.C. §1396n(c)(1); 42 CFR § 441.300 *et seq.* The total Medicaid cost of serving a recipient on the waiver (waiver cost plus other Medicaid services) should not exceed the total cost to Medicaid for serving the recipient in a nursing home. However, this calculation is done on a programmatic rather than an individual basis. This means that the average cost of all persons served on the waiver program must be less than the cost of nursing home care. See *Noland v. Indiana FSSA*, 750 N.E.2d 401 (Ind. Ct. App. 2001). This should make it difficult to deny services in an individual case based on the cost of the services. FSSA put caps on some services in 2008 but those caps were enjoined. *Chadwell v. Ind. FSSA*, Clay Superior Court, Cause No. 11D01-0808-PL-373, Summary Judgment entered March 8, 2010.

In 2003, the Indiana legislature enacted Pub. Law 274-2003 to promote home care as an alternative to nursing home placement. It added Indiana Code 12-10-11.5 to establish a comprehensive set of Long Term Care Services. Section 3 provides that FSSA shall establish a comprehensive set of long term care services that is not more costly than institutional care. Section 5 gives a broad list of services to be included, such as personal care services, assisted living, adult day care services, and any service provided under the CHOICE program, among others. As some of the provisions of Publ. Law 274-2003 had expiration dates, the 2009 Indiana legislature passed SEA 493 to renew the provisions. The Act requires FSSA to have self directed care as an option under the waiver. I.C. § 12-15-5-9. It also requires FSSA to implement a "money follows the person" program that "allows the amount of Medicaid funds necessary to provide services to follow an individual who is transferring from institutional care to Medicaid home and community based care." I.C. § 12-15-1-20(a).

FSSA is subject to litigation if it does not provide sufficient options for home care. *Vaughn v. Wernert*, 326 F. Supp. 3d 624 (S.D. Ind. 2018) held that FSSA violated the Americans with Disability Act, the federal Rehabilitation Act, and the Medicaid Act when it approved a waiver plan for Vaughn, but no home health care provider agreed to provide services under the plan, and FSSA did not provide any alternative ways for Vaughn to receive services. The Seventh Circuit Court of Appeals reversed at *Vaughn v. Walthall*, 968 F.3d 814 (7th Cir. 2020). It stated:

> Vaughn is entitled to receive at-home care by providers of her choosing only to the extent that, working with the state, she can craft a program that complies with federal and state law and does not deprive Indiana of the ability to receive its share of federal reimbursement through the Medicaid program for services provided. The state is not obligated to reimburse Vaughn's providers at rates above the approved Medicaid caps, nor must it use funds outside the Medicaid program to comply with a rule about accommodation within the program.

968 F.3d at 827. The decision was impacted in part by FSSA's implementation of a pilot program in Ms. Vaughn's zip code to allow self-directed skilled medical care.

Section 9817 of the American Rescue Plan Act of 2021, Pub. Law 117-2, (ARP) provides for a 10% increase in the share the federal government pays through March, 2022 for Medicaid Home and Community Based Services programs. States are permitted to use the increased funding through March 31, 2024. The increased funding must supplement, not supplant, existing funding, and the state must "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program." § 9817(b)(2). CMS issued State Medicaid Director letter #21-003 on May 13, 2021 giving states direction on allowable use of this increased funding. www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf. In addition to giving guidance, the Letter at p. 1 explained that its purpose also was:

> to describe opportunities for states to strengthen the HCBS system in response to the COVID-19 Public Health Emergency (PHE), increase access to HCBS for Medicaid beneficiaries, adequately protect the HCBS workforce, safeguard financial stability for HCBS providers, and accelerate long-term services and supports (LTSS) reform under section 9817 of the ARP. This increased federal funding can help states increase community living options for people with disabilities... .

CMS required states to submit an initial spending plan and narrative, followed by quarterly updates. FSSA submitted its Proposed Spending Plan on July 9, 2021. www.in.gov/fssa/ompp/files/Indiana-HCBS-Enhanced-FMAP-Spending-Plan.pdf. FSSA determined it will have over $877,000,000 available for this project. Its plan includes stabilizing community provider networks, supporting the provider workforce, expanding expedited eligibility statewide, building provider capacity, and providing caregiver training and support. On January 10, 2022, FSSA announced that $172 million of stabilization grants had been awarded to 1,156 providers across the state, with providers required to pass through at 75% of the grants to their workforce.

www.in.gov/fssa/ompp/2549.htm is an FSSA site with information about waivers. There is a Provider Reference Module at www.in.gov/medicaid/ files/da%20hcbs%20waivers.pdf. www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html is a CMS website with waiver documents. Select "Indiana" to locate Indiana's waiver approvals and supporting documents. The ARC of Indiana has information at www.arcind.org/supports-services/medicaid-waivers.

### 1. Waivers Approved in Indiana

Indiana has two types of waiver programs. The first type of waiver is for persons who meet nursing home level of care but choose to receive services in another setting. The waivers available here are:

- Aged and Disabled Waiver (A & D) - This is for aged or disabled recipients who receive services in the community, in an assisted living facility, or in an adult family care home.

- Traumatic Brain Injury Waiver (TBI) - This is designed for persons with traumatic brain injury.

The second type of waiver is for children and adults with developmental disabilities who meet Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care. In *Noland v. Indiana FSSA*, 743 N.E.2d 1200 (Ind.App. 2001), the Court of Appeals held that one need not require 24 hour supervision but instead must require active treatment in order to meet this level of care. The waivers available here are:

- Community Integration and Habilitation Waiver (CIH)

- Family Supports Waiver (FSW)

*Steimel v. Wernert*, 823 F.3d 902 (7th Cir. 2016), addressed Indiana's 2011 policy change which resulted in persons with intellectual disabilities but without skilled medical needs being moved from the Aged & Disabled Waiver to the Family Supports Waiver, with the result that persons lost services, especially services that allowed them to participate in the community. The Seventh Circuit ruled that this change violated the "integration mandate" of the Americans with Disabilities Act. "If those [waiver] programs in practice allow persons with disabilities to leave their homes only 12 hours each week, cooping them up the rest of the time, or render them at serious risk of institutionalization, then those programs violate the integration mandate unless the state can show that changing them would require a fundamental alteration of its programs for the disabled." 823 F.3d at 918.

Indiana has one additional waiver program, the Psychiatric Residential Treatment Facility (PRTF) Transition waiver. This allowed Indiana to transition all eligible children from the CA-PRTF Demonstration Grant to the PRTF Transition Waiver effective October 1, 2012. No new persons are being added to this waiver.

### 2. Services Covered under the Waivers

The Provider Reference Module at www.in.gov/medicaid/files/da%20hcbs%20waivers.pdf includes service definitions for all of the services provided under the Aged & Disabled waiver. The FSSA website at www.in.gov/fssa/ompp/2549.htm contains additional information. The Aged and Disabled waiver provides various services in the home to a person who but for those services would need to be in a nursing home. 42 U.S.C. §1396n(c)(1). A case manager, sometimes also known as a care manager should develop a plan to determine what services are needed for a person to remain at home. Services available under the Aged and Disabled Waiver include:

- Adult day services

- Adult Family Care - Care in an adult family home is covered. This was previously referred to as Adult Foster Care.

- Assisted Living - Care in licensed residential care facilities is covered. The waiver covers the assistance beyond room and board. There are a limited number of residential

facilities in the state which have agreed to accept recipients under this program. There are three levels of per diem payments to the facility, depending on the services needed.

• Attendant care - assistance to meet daily living needs. Examples include help with dressing, eating, bathing, meal preparation, household chores, and supervision.

• Behavior Management / Behavior Program and Counseling

• Care management - assistance to locate, coordinate, and monitor services.

• Community Transition Supports: One-time set-up expenses for a person moving from an institution to the community. Expenses that can be covered include security deposits, furnishings, moving expenses, utility deposits, pest eradication, allergen control or one-time cleaning before occupancy. This is a one time service with a maximum $1,500 allowance.

• Home delivered meals;

• Home Modification Assessment - used to objectively determine the specifications for an environmental modification that is safe, appropriate and feasible in order to ensure accurate bids and workmanship.

• Home Modification - up to $15,000 of modifications to clients who own their homes or live in a family owned home. Includes ramps, railings, bathroom adjustments, etc. General home repairs are not included.

• Home and Community Assistance Service (formerly called homemaker services) : help with general household activities, such as cleaning, laundry, and other chores.

• Integrated Health Care Coordination - medical coordination by a Registered Nurse.

• Non-medical Transportation

• Nutritional Supplements

• Personal Emergency Response System

• Pest Control - Subject to $600 annual limit.

• Residential - Based Habilitation - training to regain skills that were lost secondary to the traumatic brain injury (TBI).

• Respite care - short term care when the family member or primary caretaker cannot be there or needs a break.

• Specialized Medical Equipment & Supplies - Examples include electronic speech devices, portable generators needed for equipment, meal preparation devices, etc.

• Structured Day Program

• Structured Employment

• Structured Family Caregiving - This includes payment to a family member for caregiving. It requires supervision by an agency.

• Vehicle Modifications

Waiver recipients can hire their own attendant care providers, if they desire, rather than being required to hire providers through a home health care agency. The idea is that the recipient is often in the best position to know what care is needed, to select care providers, and to direct their care. A recipient may already have care providers in place before becoming a waiver recipient, and this allows the recipient to retain the same care providers. A personal attendant must be at least 18 years of age and can be a family member, other than a spouse or a parent of a minor recipient. The recipient is the employer, but a fiscal intermediary provided by the state, provides training, maintains records of hours worked, processes payroll, handles tax payments, and assists with obtaining criminal history checks of prospective employees.

The Bureau of Developmental Disabilities Services (BDDS), which administers the development disabilities waivers, is undertaking a waiver redesign "multi-year process to modernize and improve the services and supports array for Home and Community Based Services for individuals with intellectual and developmental disabilities." See www.in.gov/fssa/ddrs/5733.htm. See www.arcind.org/wp-content/uploads/2021/10/Changes-to-Medicaid-Waiver-Case-Managment-10.21.pdf for information on changes to the case management system.

### 3. Obtaining Waiver Services

Eligibility for waiver services is not decided by the Division of Family Resources. Instead, a person desiring assistance under the nursing home level of care waivers applies with the www.in.gov/fssa/da/area-agencies-on-aging. The local area aging agency can be reached at 1-800-986-3505. Persons desiring services under the ICF/IID level of care waivers apply with the local BDDS office. www.in.gov/fssa/ddrs/files/BDDS.pdf. Some AAAs also accept applications for these waivers.

Each of the waivers has a cap on the number of persons who can receive services, which varies with each waiver. There is currently no waiting list for the Aged and Disabled waiver. The only wait now is the amount of time needed to conduct the assessment and obtain waiver approval. Persons who believe they may qualify for this waiver should contact their local Area Aging Agency to request an assessment. A person does not need to be a Medicaid recipient to obtain an assessment. Indiana has approval for 37,604 for the year ending June 30, 2022, and 39,201 for the year ending July 1, 2023. The March, 2022 enrollment report shows 30,354 persons receiving waiver services. Once a slot has been filled, that slot is taken for the remainder of the state fiscal year, which runs from July 1 to June 30. For example, if a waiver recipient dies on July 5, that slot cannot be released to another person until July 1 of the following year.

BDDS has a waiting list for the Family Supports waiver. A person on the wait list or his or her guardian can review and update the contact information and waiver application dates BDDS has on record at www.in.gov/fssa/ddrs/4328.htm. I.C. § 12-15-1.3-19 gives a child of a veteran or active member of the armed forces or national guard a priority when applying for the family supports waiver.

The Traumatic Brain Injury waiver is handled on a calendar year basis rather than on the state fiscal year. The cap for this waiver is 200 persons. In March, 2022, 163 persons were enrolled.

The waiver approval date is the date the waiver Service Plan is approved. Once a person is approved for a waiver slot, then the area aging agency will assist the person to file a Medicaid application if the person does not already have Medicaid. Although the normal rule is that Medicaid benefits can be approved retroactively for the three months before the month of application, Medicaid waiver services will not be covered before the date of the Service Plan approval. A waiver slot expires if Medicaid is not approved within 120 days. If it is taking longer to obtain eligibility, ask the case manager to keep the slot open longer.

The Division of Disability and Rehabilitative Services posts weekly, monthly, and fiscal year statistics on individuals placed on the waivers it administers at www.in.gov/fssa/ddrs/3347.htm.

### 4. Expedited Eligibility Pilot Program

Expedited Eligibility is being piloted to address a serious shortcoming of the current waiver system, which is the time it takes for eligibility to be approved and for services to begin. The typical process requires the following steps:

- Person needing services, family member, other interested person, or other provider contacts the local AAA.

- AAA schedules and conducts an assessment of the applicant to determine if she meets nursing home level of care and can safely receive services. AAA obtains medical information as a part of this process.

- Once AAA determines person is appropriate for waiver, AAA submits to the Division of Aging, which must approve the waiver.

- Once waiver is approved, Medicaid application can be filed and waiver financial eligibility criteria will be applied. Even though for most applications, Medicaid can potentially be approved for the three months before the month of application, Medicaid will not cover waiver services before the date of the waiver approval.

- Once Medicaid application is approved, then waiver providers will begin providing services. Most waiver providers are not willing to provide services until the Medicaid approval is in place.

This entire process can take several months to complete, which may result in the applicant needing to enter a nursing home rather than wait for waiver services to begin. In contrast, many nursing homes are willing to accept a resident as "Medicaid pending." Most nursing homes are larger than waiver providers and can more easily absorb denials. Further, the "deviation of liability" process, discussed in Section IX(D)(5), below, can often be used to eventually obtain payment for a nursing home even if Medicaid is initially, but later, approved. The "deviation of liability" process is not available for most waiver recipients because many waiver recipients do not have a liability. See Section IX(E), below.

To address these delays, FSSA is piloting an Expedited Waiver Eligibility program under which some AAAs and some waiver providers are given the authority to not only assess waiver eligibility but also to assess eligibility for Medicaid. When a waiver provider assesses eligibility, the AAA completes the processing. The AAA can then obtain immediate Medicaid eligibility without going through the full Medicaid application process, though full verification of all eligibility factors will eventually be required. The AAA's goal is to confirm the service plan and obtain approvals within ten days of the assessment.

Eligibility for this expedited process is limited to the following applicants:

- Persons age 65 or above not already receiving Medicaid benefits or who have limited Medicaid, such as coverage under one of the Medicare Savings Programs (see Section V(K), above) . It is not available to younger disabled persons.

- Persons with income below the waiver Special Income Level, currently $2,523.

- Persons who do not have complex financial assets and who have countable resources below $2,000. It is not available to a married person utilizing spousal impoverishment criteria unless the spouse is clearly eligible.

See www.in.gov/fssa/da/expedited-waiver-eligibility for a list of current participating providers.

The Division of Aging reports that the pilot program is going well and expects it to be expanded statewide in the near future.

### 5. Services Must be Provided in a Home and Community Based Setting, not an Institutional Setting.

CMS adopted regulations in 42 CFR 441 designed to assure that waiver services are not provided in an institutional setting. 42 CFR §§ 441.301, 441.530, and 441.710. FSSA's Division of Aging is responsible for assessing facilities and assuring that they complied with the "Settings Rule" by March 17, 2022. The deadline was originally in 2019, but CMS later extended the deadline for compliance until March 17, 2022. FSSA's Statewide Transition Plan - Version 9 Resubmission was published in January, 2020 and is available at

www.in.gov/fssa/da/files/HCBS_STP_v9_resub.pdf. Pages 4-5 of the Plan explain the requirements of the federal regulations as follows:

> The HCBS Final Rule requires that all home and community-based settings meet certain criteria. These include:
>
> • The setting is integrated in and supports full access to the greater community;
> • The setting is selected by the individual from among setting options;
> • Each individual has a right to privacy, is treated with dignity and respect, and is free from coercion and restraint;
> • Provides individuals independence in making life choices; and
> • The individual is given choice regarding services and who provides them.
>
> In residential settings owned or controlled by a service provider, additional requirements must be met:
>
> • The individual has a lease or other legally enforceable agreement providing similar protections;
> • Each individual must have privacy in their living unit including lockable doors;
> • Individuals sharing a living unit must have choice of roommates;
> • Individuals must be allowed to furnish or decorate their own sleeping and living areas;
> • The individual controls his/her own schedule including access to food at any time;
> • The individual can have visitors at any time; and
> • The setting is physically accessible.
>
> Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.
>
> The HCBS Final Rule clarifies settings in which home and community-based services cannot be provided. These settings include: nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals.
>
> It is not the intention of CMS or FSSA to take away any residential options or to remove access to services and supports. The intent of the federal regulation and the Indiana transition plan is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community.

A setting is presumed to be institutional if it is located in a building that provides inpatient institutional treatment, such as nursing home care, or if it is located on the grounds of or immediately adjacent to an institution. A facility can overcome this presumption through a process referred to as "heightened scrutiny" in which it shows that the setting does not have the qualities of an institution but instead has the qualities of home and community based settings. 42

CFR § 441.301(c)(5)(v).

In March, 2017, FSSA sent letters to waiver facilities that it determined were presumed to be institutional. Facilities were given until May 8, 2017 to submit a corrective action / remediation plan. If a plan was submitted, the facility has until March 17, 2023 (originally March, 2019) to complete the corrections. CMS on July 14, 2020 issued additional guidance at www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20003.pdf extending the deadline for compliance until March 17, 2023.

### E. Money Follows the Person Demonstration Grant

The Money Follows the Person (MFP) program is designed to assist nursing home residents to move back into the community. Section 6071 of the DRA authorized CMS to award MFP Demonstration Grants to states designed to increase the use of home and community based care, to eliminate barriers that prevent the flexible use of Medicaid funds, to provide continuity for persons transferring from an institution to the community, and to provide quality assurances. FSSA received $92 million in grants for this program from 2007 until 2019.

Because Congress was only approving short extensions in funding and because Indiana was using up its funds, FSSA stopped approving any new persons after December 31, 2019. Congress has now extended the funding, and the program is being restored in Indiana. Richard Propes of BDDS is now Indiana's MFP Director. BDDS is working with the Division of Aging and "meeting with agency leadership, partners, stakeholders, and others to re-engage and reimagine Indiana's Money Follows the Person Program." www.in.gov/fssa/ddrs/files/Provider-March-2021-Slide-Deck.pdf.

Rather than being used as a separate program as it previously was, MFP is being used as a part of the waiver program. A recipient does not receive additional services through the MFP program; it seems to be a funding mechanism used by the Division of Aging.

FSSA also has a Money Follows the Person - Community Integration and Habilitation (MFP-CIH) program for persons with intellectual and / or developmental disabilities. See the Bulletin at provider.indianamedicaid.com/ihcp/Bulletins/BT201438.pdf for more information.

### F. Program of All-Inclusive Care for the Elderly (PACE)

Program of All-Inclusive Care for the Elderly (PACE) is a program that combines Medicare and Medicaid funding for persons who meet nursing home level of care. 42 U.S.C. § 1395ee, § 1396u-4. It is an alternative to Medicaid waiver services. The program uses an interdisciplinary team to assess needs, develop care plans, and deliver all of the needed services. All of the services are obtained from the PACE program, which receives funding from both Medicare and Medicaid. Typically recipients will have both Medicare and Medicaid coverage, though a person without Medicaid coverage can privately pay for the part that Medicaid would pay. One must reside in the area covered by the PACE program.

Indiana has five approved PACE programs, with an additional program to be added soon. Approved plans include:

- Franciscan Health in southern Marion and Johnson counties
- Franciscan Health in Lake County.
- PACE of Northeast Indiana, located in Ft. Wayne www.pacenein.org
- St. Joseph Hospital in South Bend.
- Reid Hospital in Richmond covering zip codes in Fayette, Franklin, Henry, Randolph, Union, and Wayne counties

To qualify for PACE, a person must:

- Be age 55 or older;
- Be certified by the State to meet nursing home level of care (this is handled like pre-admission screening, and the PACE program receives a 4B form showing level of care);
- Be able to live safely in the community at the time of enrollment; and
- Live in a PACE service area.

The core of the PACE model is an adult day center, where enrollees receive therapy and medical services from members of an interdisciplinary team. Enrollees must use the PACE physician and services. Although enrollees must be able to live in the community at the time of enrollment, enrollees can continue in the program if they later need to enter an assisted living facility or a nursing home. They will need to enter a facility that contracts with the PACE program.

See IHCPPM § 3380.00.00 forward for a discussion of PACE in the IHCPPM.

## VII. Case Processing

### A. Filing the Initial Application

The state uses a hybrid eligibility system combining elements of the previous county caseworker model and the privatized modernization system initially put into place by then Governor Mitch Daniels in 2007. FSSA now uses a computer eligibility system called the Indiana Eligibility Determination and Services System (IEDSS). FSSA completed the transition from its previous ICES computer system in August of 2020. Members (formerly called recipients) were issued new case numbers when their cases were converted from ICES to IEDSS.

Any interested person can file an application. IHCPPM § 1820.00.00. See Section B, below, on who can be interviewed.

If you have not already created an Organizational Authorized Representative (AR) account with FSSA, you should go online at fssabenefits.in.gov/# and click on the Login/Register block to register as an Authorized Representative. Choose the phrase, "If you want to register as an Authorized Representative, click here." This site is password protected, so you will need to follow the instructions to register and to set up your password. Even if you are

filing just one single application, this account is helpful in obtaining information about and monitoring the progress of your case. There is not an option to begin an application from within an AR account.

There are various ways to apply. The best way to apply is on-line, which is explained in detail below. One can apply from any computer, or one can go to a local DFR office and use the computer at the local office. An electronically filed application is considered file once electronically signed and submitted. One can also obtain a paper application form at fssabenefits.in.gov/bp/#/mailPrint/printApplication or by telephoning the Service Center at 1-800-403-0864. If an applicant telephones the service center to start the application process, the service center obtains information and then mails a bar coded application form to the caller. The caller can then sign the form and mail or fax (1-800-403-0864 is also used for faxing) it to the Document Center in Marion, Indiana. The date of application is not the date of the initial call but the date that the service center receives the signed signature page, either by mail or by fax.

An individual can also apply on-line at the FSSA website by going to fssabenefits.in.gov/#. Bookmark that site. On this page, click on ***"Apply for health coverage online."*** Choose start application. The applicant should take the following steps to ensure a successful application process:

1 Throughout the application process, remember that only those sections marked with an asterisk **must** be completed.

2 At the online application process screen, enter all information for client (e.g. name, address, date of birth, and sex).

3 The next screen will be the Rights and Responsibilities statement, and you will scroll down to checkmark the box and hit next.

4 In the "I am applying for" box, choose "on behalf of someone else." If you chose "applying on behalf of someone else," then you will enter the law office which will allow anyone from the law office to be interviewed on behalf of the applicant. Of course, you will also add the law office address and phone number. Make sure to enter "no" when the system asks if you live with the person needing assistance. Click next.

5 At the "Information about the applicant" page, you will need to affirm that the individual wants to apply for health coverage. Enter the client's address if it has not auto-populated. (If the client is in a nursing home, use the nursing home address.) You will be asked how many people live at this address including the applicant. You can simply put "1," if your client is in a facility. This entry is not significant. At the bottom of this page, you will be asked if the applicant has a mailing address different than the home address. **You should enter the law office address here**. If your client has an old case number (including from the spouse's Medicaid case), enter that number on this page.

6 You do not need to fill out additional client information on the next page unless you choose to do so. However, it may be helpful to answer the questions regarding ethnicity, Social Security number, and citizenship. Then click "next."

7 The next screen will be Tobacco Usage information - just skip.

8 On the next screen labeled "More Contact Information," enter your law office information and check "no" when asked whether you want automated calls from FSSA.

9 At the "Additional Information" screen, select whether you want the interview by phone or in a local office. Currently, though, there is no selection for type of appointment - it is automatically set for a telephone interview due to the Covid-19 pandemic.

10 You can skip the screen regarding whether a Navigator has assisted you.

11 You can skip the screen regarding health plan selection.

12 On the screen regarding other household members, if the applicant is single, you will generally answer "no" to other household members and then click "next." For married persons, you will click "yes" and move onto the next screen to enter the community spouse information on this "Household Member Details" screen. Unless you are applying for both members of the couple, you will check "no" to "Does the Applicant Wish to Apply for Benefits" question on this page as it is referring to the community spouse.

13 On the "Additional Information for All Applicants" screen, you should choose whether the applicant is in a nursing home or assisted living facility or at home, needing the Medicaid waiver.

14 Skip the Hoosier Care Connect Health Plan Selection.

15 The next section asks about tax filing status. If you know the answers, you can choose to check appropriate boxes on each page or you can skip these pages by clicking "next."

16 Skip the tax filing info screen.

17 Skip the tax dependent info screen.

18 At the household summary screen, check for accuracy and click next.

19 You can skip the "enter income info" screen.

20 You can skip the "enter resources info" screen.

21 At the application for summary screen, check for accuracy and click next.

22 The next screen is for mailing the authorized representative form and voter registration form. You should check "no" to mailing the form unless you are unable to print and check "no" to voter registration. Then click next.

23 The next screen will be to sign and submit your application. Click sign and submit.

24 The next screen will give you a confirmation number. You should write this down. At the bottom of this page, you will click on the home button at the left. Scroll down to the bottom of the next screen to skip this survey and click on the green home button.

25 You should receive a pop up box for log in or register. Your credentials may already auto populate and if so simply click on log in. At the application linked confirmation box, click on home. Then click the I accept button for the confidentiality agreement.

26 You should now be at the authorized rep home page. Click on the green In progress/completed online applications link right under benefits portal. This should bring you to all of your linked applications where you can then upload your packets. * If your packets are too large you may have to break them up into two parts when uploading.

27 At the "your application for benefits has been received" screen, print this page and include it with the packet of documentation you submit to the FSSA Document Center. You should also include the confirmation number on the letter you submit with the documentation. Near the bottom of the screen, click the "here" link under the authorized representative section to print the bar coded authorized representative forms. Then close the screen as you have finished the online application process. The application confirmation page no longer includes the date stamp so you may want to write this on the confirmation page that you print out.

It **is** possible to get a Document Cover Sheet before you finish the application process. However, **before** you run out of pages that say "save and close" at the bottom of the page, you should click "save and close." At that point, you should be prompted to create a user account or to log in to your existing account to gain access to the "home" screen which, in turn, allows you to access your saved application. You can then print a Document Cover sheet and have access to the same application summary information you would have obtained if you had not exited the original application process. You Tube offers an application process tutorial which inexperienced practitioners may find helpful when first trying to navigate the online system. The following link www.youtube.com/watch?v=MSaGBwdT6wo&feature=youtu.be takes you to the tutorial.

### B. Processing of an Application

Any interested person can sign and file an application. IHCPPM §§ 1820.00.00, 1825.10.00. However, FSSA will require authorization, by way of the Authorized Representative form, before it interviews anyone other than the applicant, "unless medical documentation is presented showing that the applicant is medically unable to provide such authorization." IHCPPM § 2005.05.10. If the applicant is medically unable to provide consent, then a person with knowledge of the applicant's affairs can be interviewed and provide verifications.

Guardians and attorneys-in-fact under a power of attorney may file applications and be interviewed for an applicant provided that the authority given includes applying for Medicaid. A general power of attorney will be accepted, while a limited power of attorney may not be, depending on what power was granted. IHCPPM § 2005.05.10. The 2021 Indiana legislature added a new chapter to the Indiana Code on Health Care Advance Directives. I.C. § 16-36-7-10

gives health care representatives the ability to apply for Medicaid. For purposes of the chapter, a "health care decision" includes the decision to apply for public assistance, which includes Medicaid, to pay for health care. A health care representative appointed under this chapter has the authority not only to apply for Medicaid but also has access to financial and banking records needed to apply, unless the appointment excludes or limits this authority. Under this statute, a proxy decision maker will be able to apply for Medicaid but will not have access to financial records for a patient who is incapacitated but has not appointed a health care representative (or has a representative who is not willing, able, or available to make a decision).

An application must still be processed for a deceased applicant. An authorized representative appointed before death or a personal representative appointed by the probate court can be interviewed and receive information about the application. An interested person who does not have legal authority but has the information needed to process the application can provide information. The DFR will determine if it can obtain the information needed to process the application. IHCPPM § 2005.05.10.

In order to represent an applicant in the Medicaid process, the attorney must be an ***Authorized Representative***. FSSA allows your entire law office to be named as Authorized Representative instead of naming each individual from your office who may have contact with the case. The Authorized Representative form is at Appendix B. Generic, non-bar-coded forms are also available at www.in.gov/fssa/dfr/forms-documents-and-tools/forms.

Once your authorized representative form is on file with FSSA, you **may** be able to obtain the member's bar-coded authorized representative form and cover sheet online so long as you have the client's case number. You typically will not have the case number until you receive the appointment notice. Access to the portal before the interview is inconsistent, though. Once the interview has occurred, access is more reliable. The attorney must have the authorized representative forms on file in order to receive any requests for information from FSSA after the interview. An applicant/member can name more than one authorized representative, such as a family member, a second family member, and the law office. A separate form is needed for each authorized representative with the exception of the law office as noted above. The Eligibility Specialist (ES) or State Eligibility Consultant (SEC) will not talk to anyone other than those persons named on the authorized representative form.

Once the online application is completed, the attorney should receive a call from the Document Center to schedule an interview. This typically happens within two or three days of the submission of the application. Shortly after that call, a written notice of interview is sent. Interviews are most often conducted by SECs or by ESs by telephone or in person. **No in-person interviews are being conducted during the Public Health Emergency (PHE)**. The interview should be scheduled within two weeks of when the application was filed. Often, only short notice is provided. Because of this, you can consider faxing the Authorized Representative forms into the Document Center, always referencing the case number that appears on the written notice of interview.

During the online application process, you can request an in-person interview at the local office to avoid potential problems with the telephone interview process, but an in-person interview is not necessary, and, during the pandemic, is not available. With an online

application, verifications cannot be submitted with the initial application. Instead, you can use the same process described above to access a cover sheet so that you can file the Authorized Representative form prior to the interview. Use one of the methods below to submit other verifications. Typically though, the interviewer will not have the verifications or will not have had a chance to review the verifications prior to the interview.

Verifications can be submitted in the following ways:

• Effective April, 2022, documents can now be uploaded through the Portal. Upon logging into the Portal, the home page lists each pending application and approved case. An application cannot be uploaded. Each case has a link for "Upload Documents." After clicking the link, one can upload a maximum of twenty documents at a time. Documents up to twenty megabytes can be uploaded. The following types of documents can be uploaded: pdf, png, jpg, jpeg, bmp, tiff, tif, gif, and docx. If a document is too large or not an acceptable type, an error message will appear.

• Verifications can be submitted by mail to:

FSSA Document Center
Post Office Box 1810
Marion, Indiana 46952

A Document Cover sheet should be included.

• Verifications can also be faxed to 1-800-403-0864. Include a Document Cover Sheet with any submission. When faxing documents, it is recommended that you number the pages and place the applicant's name and case number or Social Security Number on each page. Some programs such as Adobe Professional and some copiers will do this. Some applicants will choose to wait until after the interview has been completed to submit the verifications.

• Some attorneys have arranged to take the verifications to their local office which then scan small batches of materials. They use UPS to send large batches of materials to the service center to be scanned. The availability of this option will depend upon the cooperativeness of the local office staff. This option should not be needed now that documents can be uploaded on the Portal.

If you have already sent your packet of verifications to the Document Center and have scanned the material to your computer, you should offer during the interview to e-mail your scanned packet to the interviewer. In a meeting that Dennis Frick and Claire Lewis had with the Director of the DFR Central Office, Adrienne Shields, in 2016, Director Shields confirmed that it is acceptable for workers to receive verification packets by e-mail so long as the verifications have already been received by the Document Center. Many regions, though, will still not accept emailed verifications.

Once the interview has been completed, the applicant will then be given a notice called **Pending Verifications** (**Form 2032)** listing any additional information needed to complete the

application process. Sample checklists showing the documents generally needed for a single applicant in a nursing home and for a married couple are included at Appendices C and D.

Although the applicant is responsible for obtaining the information requested, the worker **must** assist the applicant as needed. IHCPPM §§ 2015.05.00, 2025.15.00. If the applicant will need more time to obtain verifications, the applicant should request additional time, as an application can be denied for non-cooperation if requested information is not submitted within the time limit given. If neither FSSA staff nor the applicant can obtain needed information, FSSA should then accept a statement from the applicant. IHCPPM §2015.05.00, §2025.10.00. A written statement must be accepted if information cannot be obtained due to the PHE.

FSSA stated that during the COVID-19 public health emergency, eligibility is granted based on information provided on the application, in the interview, and from the Asset Verification System (see Section C, below), and that supporting documentation is not required. www.in.gov/fssa/files/Changes-to-Indiana-health-coverage-application-processing-during-public-health-emergency.pdf. Despite this memo, the DFR has continued to request verifications, and it is recommended that verifications be provided. But the DFR should be flexible in what verification is required, as some documentation may not be available, or it may not be available within the time limits requested by the DFR.

Documents are scanned in and saved with the electronic file; a hard file is not kept in the local offices or at the Document Center. Applicants are provided with bar coded Cover Sheets that should be sent with any submissions so they can be linked to the proper file. Documents can be faxed or mailed to the service center or taken to a local office for the local office to scan and transmit to the service center.

Applicants (and members) do **not** have an assigned caseworker. Instead, new applications are processed by multiple staff in the county office. A Xerox employee, an ES, can process an application or redetermination, but an SEC employed by FSSA must make the final entry. In many instances, the SEC is doing the phone interview as well as processing the application.

An automated call system is available 24 hours per day. You do not need the case number to use this system. The last four digits of the Social Security number and the date of birth can be used. The automated telephone system will provide the following information:

- whether an application is approved, denied, or pending;
- a list of the documents that still need to be submitted by the applicant;
- authorized and redetermination months, and current and next month benefit amounts.

The easier way to check on case status is to go online at fssabenefits.in.gov/#, choosing either "Manage Your Benefits" or Sign In to enter your user ID (email address) and your password. Once you are signed in, click on the "home page" button. When you are prompted to accept the confidentiality agreement, click "I accept" and then enter the client's last name, ten digit case number (which appears in the top right-hand corner of any Medicaid notice), date of birth, and last four digits of the member's social security number before being able to access the

information. **If your office is not listed as an authorized representative in the system for your client's case, you may not be able to access the case information**, even though you have entered your user name and password. Therefore, it is imperative that you fax your authorized representative forms to the Document Center as soon as possible in every client's case.

The site gives access to the client's personal information file on the website which you can print (and save as a pdf file on your own computer). You can access the Document Cover Sheet and Authorized Representative forms which are bar-coded to the case and list the actual ten-digit case number. In addition, the on-line system provides the following information:

- whether an application is approved, denied, or pending;
- a list of the documents that still need to be submitted by the applicant;
- scheduled interview appointments;
- a list of documents submitted in support of the application.

The initial case processing is handled at the local office and most telephone calls are routed to the local office. A caller to the main number enters the zip code when asked by the auto attendant and then the call is routed to a staff person in the local office, if available. An advocate should enter the zip code of the client about whom you are telephoning. Documents are still scanned into an electronic file, but the scanning can be done at the local office.

"Failure to cooperate" has long been one of the generic reasons given to deny an application. It often seems to be used as a default reason to deny benefits. Rather than taking the time to inquire about information that may be missing, or may have been submitted and misplaced by the county office, or taking the time to assist an applicant to submit needed materials, the Worker processing the case would frequently just deny the application.

The Indiana Supreme Court ruled in *Perdue v. Gargano*, 964 N.E.2d 825 (Ind. 2012) that FSSA's failure to use denial notices that specifically list what documents were allegedly missing violates due process. The denial notices FSSA now uses list what information has not been submitted although the information can still be sketchy. If the application is denied due to income or resource issues, budgets for the various months should be included with the notice, so the notice can be lengthy.

Federal law requires that FSSA accommodate a person with a handicap. Not having one assigned caseworker can cause significant problems for persons with limitations who do not have an attorney or qualified representative. The Indiana Supreme Court in *Perdue*, *supra* also upheld the trial court's ruling that FSSA violated the Americans with Disabilities Act when it denied benefits to Ms. Perdue due to a failure to cooperate without first accommodating her handicap, but it reversed the trial court's judgment that FSSA must provide Ms. Perdue with a caseworker or case management services. The Supreme Court agreed that she was entitled to reasonable accommodations, but it declined to require FSSA to necessarily provide a caseworker or case management services. The Supreme Court did not state what would constitute a reasonable accommodation, so it does not provide much guidance beyond agreeing that a handicapped person is entitled to "reasonable accommodation." FSSA added §§ 1432.00.00 forward to the IHCPPM on its ADA policies. IHCPPM § 1432.05.05 discusses accommodations that must be made by FSSA for those persons who have disabilities, and IHCPPM § 1432.10.00

refers to the DFR ADA Coordinator who will work with FSSA contractors and staff on compliance issues. Applicants and members who need special accommodations should request them in writing.

Some workers request much more information than others. There is still very little consistency in case processing requirements throughout the state. The worker should require only those verifications necessary to ensure accuracy of case processing.

FSSA offers a Registered Agency status. This status gives an agency a single point of entry to access case status for its clients. The agency must submit a Release of Case Status Information signed by the client for each case it seeks to access. FSSA's position has been that a law firm will not be accepted as a Registered Agency.

### C. Asset Verification System (AVS)

As required by 42 U.S.C. § 1396w, in December, 2020, the DFR began using an Asset Verification System (AVS) to search for assets. AVS is explained in IHCPPM § 2612.00.00. AVS uses the applicant's name and Social Security Number to search electronically using records from Experian, the Bureau of Motor Vehicles, and real estate records. AVS searches financial institutions within 65 miles. This is done by Softheon Inc.

For new applications, a five year look back is made. For re-applications, a four month look back is completed. For redeterminations, the AVS reviews assets for one month prior to the redetermination date.

When a worker completes the "wrap-up" in IEDSS, the AVS system is "pinged," and it should return electronic verification within 13 days. The applicant will also be given a 2032 pending verifications form. The application will be processed as follows:

- Even if the applicant provides verifications before 13 days, the worker is not to process the case until the AVS is returned or after 13 days, if the AVS does not produce results within 13 days.

- If an unreported or unverified resource is found by the AVS, the AVS information will be used.

- If the verifications provided by the applicant do not match the AVS, the higher balance is used unless the hard copy verification rebuts the AVS information. The worker must document in notes why AVS information was not used. For example, the AVS first of the month bank balance may include monthly income that was deposited early into a bank account.

- If the applicant does not provide verification but AVS information is received, the AVS information is used.

- If the applicant fails due to AVS information, the application will be denied and an

AVS discrepancy notice will be mailed, giving the applicant an opportunity to provide rebuttal information.

Although the worker is required to wait for an AVS report, this is not a basis for not processing an application within the time limit, discussed in Section F, below. The worker needs to process the case quickly enough so that there is time to receive an AVS report within the processing time limits.

One should carefully interview the applicant to determine if there is information that may be disclosed through AVS that one should verify in advance in an effort to avoid a denial and discrepancy notice. Was a bank or other financial account closed within the past five years? If so, provide verification and an explanation. Was a vehicle sold, gifted, or junked within the past five years? If so, provide verification and an explanation.

The AVS is still relatively new, so there will be issues to be resolved. *Mismatched and Mistaken: How the Use of an Inaccurate Private Database Results in SSI Recipients Unjustly Losing Benefits*, a report by the National Consumer Law Center and Justice in Aging, at www.nclc.org/images/pdf/credit_reports/RptMismatchedFINAL041421.pdf, reports on substantial problems that have arisen with the Social Security Administration's use of Lexis reports on real estate. One hopes that FSSA's use of discrepancy notices before taking action will avoid similar problems, but one should be aware that errors can occur. See Section H, below, for troubleshooting tips.

### D. Citizenship or Immigration Status

Citizenship or immigration status must be verified upon application unless the applicant falls under one of the exempt categories such as being an SSI recipient, Medicare beneficiary, or recipient of Social Security disability income. There was great concern when the DRA was enacted about its citizenship verification requirements. Typically a United States citizen will verify citizenship by producing a birth certificate. But there are a surprising number of older adults who were not born in a hospital and who do not have a birth certificate. They can establish citizenship by presenting alternate documents, such as Social Security records, religious documents, census records, or other documents listed in IHCPPM § 2402.15.10. It was initially thought that the DRA would require a citizen who does not have a birth certificate to produce a driver's license or state identification. The BMV is restrictive on what documentation it will accept for a person whose license or ID has lapsed. But the citizenship verification requirement in the DRA was amended to provide that it does not apply to a person who receives Medicare or SSI, because citizenship has already been verified for the Social Security Administration. The citizenship verification procedures have not changed in Indiana.

Certain legal immigrants can qualify for Medicaid**.** Federal law at 8 U.S.C. § 1611 *et seq*. provides that an alien who is not a "qualified alien" is not eligible for Medicaid (except emergency Medicaid) and other federal public benefits. "Qualified aliens" are listed in 8 U.S.C. § 164. These categories of immigrants are also listed in IHCPPM § 2402.20.00 *et seq*. Although Lawful Permanent Residents (LPRs) can obtain Medicaid, there are limits. An LPR must be in

the U.S. for five years before being able to qualify for full Medicaid. The IHCPPM has detailed information discussing the requirements for the various immigrant categories.

An immigrant who is barred from receiving full Medicaid can only qualify to receive emergency Medicaid services, provided all other eligibility criteria are met. 8 U.S.C. § 1611; IHCPPM § 2402.20.50. Emergency services are defined very narrowly to only include services immediately needed to avoid serious health impairments. IHCPPM § 2402.20.50.05.

### E. Potential Retroactive Eligibility for the Three Months Before the Application Date

The date an application is filed is important because eligibility can be awarded for the three calendar months before the date of application, except that retroactive eligibility is not available for the QMB category. 42 U.S.C. § 1396a(a)(34); IHCPPM § 2035.60.00. The date of filing is the date the application is filed online, received by mail or fax at the FSSA Document Center in Marion, or received by the county DFR office. **An application received after 4:30 P.M. EST or on a non-business day is treated as if filed on the next business day.** IHCPPM §1825.15.00.

Example:

> Ralph mails his signed application to the Document Center on April 30, but it is not received at the Center until May 3. Since the application was filed in May, eligibility can go back to February 1. If Ralph needs eligibility for January, he should hand deliver the application to the county DFR or file an application online on or before 4:30 P.M. EST on April 30.

An applicant whose application is approved will not automatically receive benefits for the three calendar months before the month of application. **The applicant must meet the eligibility requirements for each of the three months**. Eligibility for each retroactive month is separately considered.

Example:

> Maude filed her application in April. Her application is processed in May. The DFR determines that Maude had excess resources on January 1 and March 1 and thus did not qualify for January or March, but that she met all eligibility requirements for February, April, and May. Her application will be denied for the months of January and March, and she will be approved for February and for April forward.

Medicaid will not pay for waiver services before the date that the waiver is approved. In the example above, if Maude was approved for waiver services on April 21, Medicaid will only pay for waiver services for April 21 and forward. I.C. § 12-10-11.5-8(c) provides that FSSA may pay for waiver services beginning on the date of the Medicaid application. It is not known if or when FSSA will implement this. *Price v. Medicaid Dir.,* 838 F.3d 739 (6th Cir. Ohio 2016), held

that federal law did not require the state to pay for assisted-living services rendered before the applicant's service plan was approved because federal law required a written plan of care and an applicant is only eligible for assisted-living services after an individualized service plan is approved.

### F. Time Limits for Processing

The time limit for processing a Medicaid application is 45 days, except that the time limit is 90 days if eligibility is sought based on a disability. The longer time limit allows time for the disability determination to be made by, or at least initiated with, the Social Security Administration (SSA) or by the state Medical Review Team, in the rare cases in which the Medical Review Team still makes these decisions. Most disability decisions will be made by SSA, though. See Section V.

Although there are strict time limits for ruling on applications, cases are not always processed timely. The DFR has improved its processes, but there can still be delays. An applicant's advocate may need to insist that a timely decision be issued. If the DFR will still not issue a timely decision, the applicant's advocate should email the regional manager. See Appendix A for the list of current regional managers. If these avenues fail, it may become necessary to request an administrative appeal, since failing to issue a decision on time can be appealed. Although it will take a lengthy period to obtain a decision on an appeal, the mere act of filing (or threatening to file) an appeal may prompt the DFR to issue a decision. Also, filing appeals on several cases will help to build a record that hopefully will prompt the state office to take action.

### G. Processing after Eligibility Is Established

#### 1. Normal Processing, When Public Health Emergency Not in Effect

**See Section 2, below, for special provisions in effect during the COVID national Public Health Emergency, still in effect as of April, 2022.**

Once a person is approved for Medicaid, changes that will affect eligibility must be reported. The "Notice Regarding Rights and Responsibilities for Health Coverage," available in English and Spanish at www.in.gov/fssa/dfr/forms-documents-and-tools/forms, explains that any changes in the household's income, resources, living arrangements, family circumstances, or any other event which would affect eligibility must be reported within ten days of the date on which the person becomes aware of the change. The Portal contains a Change Report link, though verifications will need to be separately submitted. One can also submit a letter explaining the change with verifications. Once the change is reported, the DFR will determine what if any changes there will be in eligibility. Changes and redeterminations are handled through the Regional Change Centers (commonly called "RCC" by FSSA workers). One may want to notify the regional mailbox of the reported change, particularly if it is a liability change or something relating to a penalty period, to help insure that the change is timely processed.

If the reported change will result in a termination or a reduction (such as an increase in liability or in income spend down) of Medicaid benefits, the DFR must give the member at least ten days advance notice plus allow three days for mailing of a notice. IHCPPM § 2232.00.00. Because Medicaid is handled on a monthly basis, the effective date will always be the first day of a calendar month. Thus, the DFR must send out notice at least thirteen days before the end of the month in order for a change to be effective in the next month. For example, if a member on May 20 reports an increase in income, the earliest that the member's benefits can be affected is July 1, as there is not sufficient time for the DFR to issue a notice before June 1. **See Section 2, below, for an explanation that most terminations cannot occur during the current public health emergency.**

If the DFR determines that the member is no longer eligible for Medicaid under the member's current category, eligibility under all potential categories must be explored. If information in the IEDSS system shows that the member may be eligible under another category, then eligibility for that category must be explored before a termination notice is mailed out. IHCPPM § 2235.00.00. If the system does not show that the member may be eligible under another category, then a termination notice will be issued. The notice will list all of the other potential Medicaid categories of coverage. If the member believes that she may be eligible for Medicaid under another category, then the member should contact the DFR within thirteen days of the date of notice and provide information concerning potential eligibility under another category. Medicaid coverage is to remain in place until a determination is made about eligibility under the possible new category. IHCPPM § 2235.00.00.

Medicaid eligibility will be reviewed at least once a year. IHCPPM § 2205.05.00. 42 CFR § 435.916(a)(2) requires Medicaid agencies to redetermine eligibility without requiring information from the recipient if it can do so based on information in the recipient's records or from other available information, such as from the AVS. If the AVS and other available information shows that the recipient remains eligible, then the DFR will mail out a notice that coverage has been auto-renewed and that the recipient only needs to respond if there are changes to report. If the DFR cannot obtain enough information to determine ongoing eligibility, the recipient will be asked to complete an Eligibility Review Form ("Medicaid Mailer") and provide information to show continuing eligibility. In the past, the Eligibility Review Form has been mailed to the member, which has been problematic for those members who are nursing home residents. After receiving many complaints about this practice, FSSA now sends these notices out to the member and all authorized representatives on the case. The member must cooperate with the requirement to complete the Mailer, as the recipient can be terminated for non-cooperation if she does not provide the information requested.

Redeterminations are still occurring, but as explained in the following Section, most terminations cannot be acted upon until the public health emergency ends.

### 2. Processing During and After the Current Public Health Emergency (PHE)

Even though Indiana has stopped extending its state COVID emergency declarations, HHS' Public Health Emergency (PHE) has remained in effect. FSSA cannot terminate or reduce Medicaid benefits for current recipients until the month after the HHS PHE ends.

On January 31, 2020 HHS declared a national Public Health Emergency (PHE), effective January 27, 2020, as a response to COVID-19. An HHS PHE expires in 90 days unless extended. HHS has renewed its PHE several times, most recently on April 12, 2022, effective April 16, 2022. aspr.hhs.gov/legal/PHE/Pages/COVID19-12Apr2022.aspx. HHS has stated that it will give states sixty days' notice prior to terminating the PHE. aspr.hhs.gov/legal/PHE/Pages/Letter-to-Governors-on-the-COVID-19-Response.aspx. States have asked that they be given 90 to 100 days' advance notice of the ending of the PHE, while disability advocates have asked for 120 days of notice. Mid-July, 2022 appears to be the earliest that the PHE may be allowed to expire, though it could be later. If the most recent extension is allowed to run for a full 90 days and is not extended, then the PHE would end July 15, 2022.

Indiana is receiving a temporary increase of 6.2% in the Federal Medical Assistance Percentage (FMAP), which is the share of expenses that the federal government pays. This increase continues until the end of the calendar quarter in which the public health emergency as declared by HHS ends. (§ 6008, Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127 (2020). Indiana's FMAP is now 76.31% (70.11% + 6.2%).

**No Medicaid cases are being terminated effective March 31, 2020 until the end of the month in which the public health emergency ends**. The only cases being terminated are due to death, voluntary withdrawal, moving out of the state, or a child aging out of a category based on age. § 6008(b)(3), FFCRA. Persons receiving benefits pending appeal as of March 18, 2020 are also protected from termination during the emergency. The requirement to continue benefits has now been promulgated in 42 CFR § 433.400.

In addition to not terminating benefits, Medicaid benefits must be maintained and not reduced. 42 CFR § 433.400. Initially, FSSA was not making any adjustments in nursing home or waiver liabilities even when there was a change a change of income. Because 42 CFR § 433.400 allows changes to be made in liabilities, effective March 1, 2021 FSSA is now adjusting liabilities for recipients.

Because of the requirements in Medicaid's rules, 42 CFR § 431.211, that advance notice must be given of any adverse action to terminate or reduce benefits, FSSA acknowledges that it will not be able to take retroactive action against recipients once the PHE ends. For example, suppose that the emergency ends July 15, 2022, and the DFR is aware that Samantha had excess resources from April 1, 2020 forward. The DFR can issue a notice terminating Samantha's benefits effective August 1, 2022, but it cannot take any action, including processing an overpayment claim, against her for being over resources from April, 2020 through July, 2022.

CMS has directed states to plan for the "unwinding" of the PHE. CMS has provided guidance to states on this process, most recently in a lengthy letter dated March 3, 2022. www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf. CMS requested that each state develop a comprehensive "unwinding operational plan" explaining how the state will unwind from the COVID provisions. Because FSSA has not been able to terminate or reduce benefits during the PHE, FSSA will have many changes to process once the PHE ends. Before processing changes, in most cases FSSA will need to obtain updated information. CMS has directed that states initiate all renewals, as well as post-enrollment verifications and

redeterminations, within 12 months after the end of the PHE, and that states complete the unwinding by processing all changes and redeterminations within 14 months after the end of the PHE.

FSSA has not yet completed its final unwinding plan. In a preliminary unwinding plan presented to the Medicaid Advisory Committee in November, 2021, www.in.gov/fssa/ompp/files/PHE-Unwinding-MAC-Nov-2021.pdf, FSSA reported that every member who has remained eligible will receive four advance notices before a final notice of negative action will be issued:

| | |
|---|---|
| Postcard 1 | Alert Hoosiers that they could lose coverage and remind them to update incorrect or outdated information with DFR, and to watch their mail for further notices. |
| Pre-PHE End Informational Notice | Gives the official federal PHE end date and informs member of what information is needed for them to potentially remain eligible |
| Postcard 2 | Second reminder to update incorrect or outdated information with DFR, and to watch their mail for further notices |
| Post-PHE End "Redetermination" Mailer | Informs member what information is missing or currently makes them ineligible, gives at least 30 days to respond with new information to potentially keep their coverage |
| Final Notice of Negative Action | If no response to Mailer, or person remains ineligible, they will receive a standard notice of negative action with all appeal rights included |

The presentation to the Medicaid Advisory Committee stated that "disenrollments and downgrades" would be effective seven months after the end of the PHE. As the enhanced federal funding will end once the PHE ends, unless Congress provides additional funding, there may be pressure on the state to process cases more quickly rather than waiting seven months after the end of the PHE. It is not yet known whether any terminations or reductions, such as the application of transfer penalties withheld during the PHE, will be implemented within the first seven months after the end of the PHE. All renewals must comply with Medicaid and constitutional due process requirements. healthlaw.org/resource/unwinding-the-covid-19-public-health-emergency-checklist-for-redeterminations.

## H. Troubleshooting

You should attempt to anticipate issues that may arise with an application or case and provide information to attempt to avoid a problem. When an issue arises, such as an incorrect denial, an incorrect calculation of the liability amount to be paid to a nursing home, an incorrect calculation of a transfer penalty, or even an award of benefits for a month or months for which the applicant is not eligible, there are steps short of a formal appeal that can be used to try to resolve the problem.

If you know which worker is processing the case, you can contact the worker. You can locate the worker's email address at www.in.gov/apps/iot/find-a-person if you know the worker's full name. If a worker provides his or her telephone extension number, then that worker can be reached at 1-855-673-0193 and entering the four digit extension. You also may be able to resolve an issue by telephoning the general phone number, 1-800-403-0864.

If you cannot resolve the issue, then you can contact the regional mailbox, the email address for the region that is processing the case. See Appendix A for the email addresses. When an email is sent, one typically receives an automated message saying that a response will be received within three to five work days, though sometimes a quicker response is provided. A supervisor or experienced worker will review the situation and respond, provided that you are an authorized representative or have consent to receive information.

If a legal issue is involved and you have authority to show why policy in the IHCPPM is contrary to law, then you can contact the FSSA General Counsel to seek a resolution.

## I. Overpayment Claims

Chapter 4600 of the IHCPPM addresses Benefit Recovery, also referred to as overpayment claims. FSSA will not seek recovery of any overpayment in benefits that occurred due to agency error resulting from worker error, IHCPPM § 4610.00.00, even though federal law appears to allow collection of such claims. The overpayment amount is the amount paid by FSSA to providers during a period when the member was not eligible. It could also be an overpayment due to a too low spend down or liability. This can include benefits paid pending an appeal decision that was ultimately decided in favor of the agency, benefits incorrectly paid because a change was not reported timely, or agency error.

FSSA has become more active in identifying and requesting repayment of overpayments. When FSSA identifies an overpayment, it sends out a demand letter requesting monthly repayments of $50 or 3% of the overpaid amount, whichever is higher. Even though the notice makes it appear that these repayments must be made, FSSA cannot compel repayment. If the overpaid individual does not voluntarily make payments, FSSA cannot terminate or reduce future benefits. FSSA can intercept state tax refunds. It cannot offset any portion of the member's Social Security benefits. FSSA can file a lawsuit to seek recovery, but it is unlikely to do so in the absence of fraud. Fraud can also be the subject of criminal charges.

Any payments made should be mailed to FSSA Claim Repayment, P.O. Box 621007, Indianapolis, IN 46262-1007.

The notice of overpayment is subject to appeal.

### J. Audits by Bureau of Program Integrity

FSSA uses a "quality control" process to periodically audit cases where benefits have been approved. (It is not clear if cases where benefits were denied are ever audited.) These audits are conducted by the Bureau of Program Integrity. Reviewers will frequently request complete financial records for five years, either the past five years or the five years prior to application, or the Bureau will ask for releases from the member to obtain this information. Tax returns are also requested to determine if there are other sources of income. If taxes were not filed, verification of that from the IRS will be requested.

A natural question is what authority the reviewer has to demand documents and what the consequences will be if a member does not cooperate. Because not cooperating may lead to a more detailed investigation, it is not advisable to refuse to cooperate. Since obtaining records can be time consuming and costly, it should be sufficient to give releases to the reviewer and have the reviewer obtain the documentation, at least to the extent that the member cannot easily retrieve the requested documents.

You will not be notified of the results of the audit unless a problem is discovered. One can contact the reviewer a month or two after verifications are submitted to follow up on the status.

## VIII. Resource Principles and Rules for Medicaid for the Aged, Blind, and Disabled.

A person who fits one of the coverage categories must meet financial and non-financial eligibility requirements to be eligible for Medicaid. The financial eligibility requirements include an income test and possibly a resource (asset) test. There are some categories, such as HIP and those in the MED 3 Group (primarily children and pregnant women) that do not have a resource test. The MED 1 and MED 4 groups have a resource test. This section covers the resource rules for Medicaid for the Aged, Blind, and Disabled. The rules that apply to a nursing home resident with a spouse at home and to a married person receiving waiver services are discussed separately. The resource limits and some of the resource rules vary for the Medicare savings programs and for MED Works; differences for these categories are discussed in Sections X and XI, *below*.

When Indiana became an SSI state on June 1, 2014, Indiana for the most part began using SSI's resource rules and limits. The SSI resource rules are at 20 CFR 416, Subpart L, § 416.1201 forward. See also SSA's Program Operations Manual System (POMS) Subchapter SI 011, available at secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=05011. The POMS is SSA's manual for its workers, similar to the IHCPPM for FSSA.

## A. General Rules

### 1. Resource Limits

Medicaid places limits on the amount of personal property a person can own. There is no limit on the amount of real estate a person can own. See Section C, *below*, for the rules concerning real estate. The limit on non-exempt personal property is $2,000 for a single person and $3,000 for a married couple. The married couple limit applies where both spouses live in the community, both spouses live in a nursing home, or both spouses receive waiver services. (See Section E.1 below for a discussion of the position that the spousal impoverishment rules should apply when both spouses receive waiver services.) I.C. § 12-15-3-1; 405 IAC 2-3-15.

The resources of both husband and wife are counted even if only one of them is applying for Medicaid, unless the applicant is not in a nursing home or on a waiver and the couple is separated for non-medical reasons. IHCPPM §3210.05.00. See Section E below for special resource limits and rules for married couples where one spouse is institutionalized and the other is not or where one spouse is receiving waiver services and the other spouse is not (and arguably when both are receiving waiver services).

### 2. Only Available Resources Are Counted.

Only property which is "available" to the applicant or recipient is counted. Property is considered available if one "has the right, authority **or** ability to liquidate the property, or his share of the property." 405 IAC 2-3-14(a)(1)(emphasis added); IHCPPM § 2605.15.00. See Section VIII(B)(11) for a discussion of how the availability rule is applied to annuities. Applying this rule, *Williford v. N.C. HHS*, 792 S.E.2d 843 (N.C. Ct. App. 2016) held that $46,000 placed in a workers' compensation Medicare set-aside account was not a countable resource because the funds could not be used for support or maintenance. FSSA has followed this and treated Medicare set-aside accounts as unavailable.

For a few years after 2014, the DFR classified personal property as liquid or non-liquid, with non-liquid property being property one likely could not liquidate within four weeks. It then gave applicants a grace period of 90 days to dispose of non-liquid personal property, with the property not counted as a resource during that time. The DFR discontinued this policy in 2018, and by February 15, 2019 it eliminated from the IHCPPM any remaining references to additional time to liquidate non-liquid property. (The one exception is that IHCPPM § 2615.15.00 provides that a retirement account that requires more than twenty working days to liquidate is not available until it can be liquidated.) If one has the right, ability, or authority to liquidate personal property, even if it will take time to do so, the property is a countable resource.

An owner's lack of capacity to transfer property does not make that property unavailable, since there are procedures such as guardianship by which the property can be transferred. *Marsh by Steadman v. Vigo Co. Dept. of Public Welfare*, 553 N.E.2d 1234 (Ind. Ct. App.1990).

If one is not aware he owns an asset, it should not be counted until he becomes aware of it. The SSI POMS at SI 01110.117 provides that for SSI an asset is not countable as a resource during a period when the individual was unaware of his ownership. (This SSI POMS section

provides that the value of the asset counts as income in the month of discovery.) The DFR has not included this rule in its IHCPPM but as an SSI state is obligated to follow this policy.

### 3. Resources Are Valued on the First Day of the Month.

Resources are valued on the first day of the month. This is commonly referred to as the **"first day of the month rule**." 405 IAC 2-3-15(a). **Eligibility for an entire calendar month depends on the amount of the resources owned on the first day of the calendar month**. This is interpreted to mean the first moment of the first day, so that income received on the first day of the month does not affect the resource calculation. IHCPPM §2605.20.00. In explaining this concept to clients, it is often simplest to refer to the amount of resources at the end of the previous month. For example, for a single person to be resource eligible in May, that person must have no more than $2,000 in countable resources at the end of the day on April 30th.

There are two important exceptions to the first day rule. If a "direct deposit" benefit check, such as Social Security, which is intended to be paid early in the month, is recorded as a deposit late in the previous month rather than early in the next month, the deposit is not counted as a resource, even though it was on deposit on the first day of the month. IHCPPM § 2615.10.05. If the payment is routinely received at the end of a month, it will be counted as a resource in the following month. IHCPPM § 2605.20.00. Second, if a person writes a check before the end of the month, but the check has not cleared the bank by the first of the month, that amount will not be counted, even though it is in the bank on the first of the month. *Id*. It will be necessary to verify when the check was actually written.

Examples:

Mary, single, has $1,000 in countable personal property on April 1. On April 10, she wins $25,000 in the lottery. Feeling lucky, she catches the first flight to Las Vegas to "invest" her winnings. She loses it all. On May 1, she has $1,000 in countable personal property. She meets the resource limits for April and May. (The DFR may request receipts or other documentation to verify that she does not still have her lottery winnings.)

Maude receives direct deposit Social Security benefits of $1,600 per month, normally paid on the 3rd of the month. Suppose January 3 is on a Sunday. SSA will deposit the funds into her account on December 31, since January 1 is a holiday and January 2 is on a weekend. The direct deposit of $1,600 on December 31 is not counted as a part of Maude's resources on January 1.

Bob, single, has $2,001 in the bank on April 1, but $100 worth of checks written in March are outstanding. He meets the resource limit for April, as his countable resources on April 1 are $1,901.

### B. Countable and Exempt Personal Property

In determining whether personal property is counted towards the resource limits listed above, the DFR applies rules to determine if property is countable or is "exempt" from being counted. These rules can be found at 405 IAC 2-3-15 and in Chapter 2600 of the IHCPPM.

#### 1. Cash (IHCPPM § 2615.05.00)

Cash on hand always counts as a resource, except that in the month of receipt it is not counted as a resource if it is counted as income. For example, suppose one's Social Security check arrives on June 1. It does not count as a resource in June, because it is counted as income for June. However, if any of it remains on July 1, it will then be counted as a resource.

#### 2. Financial Accounts (IHCPPM §2615.10.00)

##### a. Personal Accounts (IHCPPM § 2615.10.05)

Bank accounts in the name of the applicant/recipient or spouse count as a resource. Accounts, such as certificates of deposit, are valued at the net amount available after any early withdrawal penalties or fees are deducted. IHCPPM § 2615.10.10. Any checks outstanding on the first of the month are to be subtracted from the bank balance. The DFR always requests a copy of monthly bank statements, which it uses to calculate the first of the month balance. If any checks are outstanding, one must produce verification and request the DFR to deduct the outstanding checks.

When one has legal access to a joint account, the DFR begins with the presumption that all of the funds in the account are countable. If the applicant/recipient can establish that part or all of the funds are owned by the other party, then only the amount of the account owned by the applicant/recipient is counted. The applicant/recipient and the third party will then be required to separate their funds into separate accounts. IHCPPM § 2605.10.05.

Examples:

> Millie has a checking account jointly with her daughter. All of the money in the account is Millie's, and her daughter is on the account only so that she can sign checks. All of the money in the account counts as a resource for Millie.
>
> Bob and his brother Bill live together. They have one account in both names into which they both deposit their income. If they can trace, through deposits and withdrawals, what share belongs to each, then Bob should only have his portion of the account counted as a resource for him, as he can rebut the presumption that all the funds belong to him. Bob and Bill will then be required to separate their funds into separate accounts.

Virtual currency, also known as cryptocurrency, such as Bitcoin, is countable. IHCPPM §§ 2605.05.00, 2615.10.05.15.

### b. Business Accounts (IHCPPM § 2615.10.05.05)

A "business account" is an account established to hold funds for the operation of a business. IHCPPM § 2615.10.05.05 requires that the account be "properly identified" as a business account. No further direction is given in this section. One should label the account to identify it. For example, a farm account can be labeled as the "Old McDonald Farm Account."

The funds in the account are not a countable resource. One can accumulate funds in the account to pay the expenses of the business without affecting the eligibility for Medicaid.

A business account must truly be used only for the business. If the account is used for personal expenses, or is not identified in some way as being a business account, then the funds in the account will be counted as a resource.

## 3. Pre-paid Debit Accounts (IHCPPM § 2615.05.05)

The balance on a pre-paid debit card is a countable resource. The DFR does not consider whether the card can be liquidated.

The DFR makes an exception for the Direct Express debit card, which can be used for the deposit of federal benefits such as Social Security benefits. Although one would expect that the balance on the card at the end of a month, before the deposit of the next month's income, would be a countable resource, IHCPPM § 2615.05.05 states that the balance on the card does not need to be verified.

## 4. Retirement Accounts (IHCPPM § 2615.15.00)

"Retirement accounts" include IRAs, 401k plans, Keogh plans, and other qualified work related pension plans. IHCPPM § 2615.15.00. This does not include annuities purchased outside of a qualified retirement account.

### a. Retirement Accounts Owned by an Applicant or Recipient

The DFR changed its policies in 2018 and 2019 concerning how retirement accounts are treated for Medicaid applicants and recipients. Until June 15, 2018, IHCPPM § 2615.15.00 provided that retirement accounts owned by the applicant or recipient were countable to the extent they were available. The retirement account was countable if it could be liquidated. An account or funds that could not be withdrawn without leaving employment was unavailable and not countable. The countable value was the amount that could currently be withdrawn minus any penalty for early withdrawal. Taxes due or withheld were not deducted when determining the countable value.

By a transmittal change issued June 15, 2018, the DFR changed its policy to make qualified retirement accounts exempt if regular, periodic payments were being made from the account. IHCPPM § 2615.15.00 as amended June 15, 2018, provided:

> When regular, periodic payments are being received on a retirement account, the account is no longer a countable resource and the payments are considered unearned income. If the IRA has sporadic withdraws, then this is a conversion of resources and is not income but remains a resource.[18]
>
> [18] [20 CFR] § 416.1121 [SSI regulation on "Types of unearned income."]

Under this revised policy, if one was receiving regular (relatively equal) payments periodically, whether that be monthly, quarterly, or annually, then the account was exempt as a resource and the payments were treated as countable income. This policy was applied to any regular, periodic payments, not just qualified minimum distributions.

On May 1, 2019, the DFR reverted to its pre-June 15, 2018 policy for new applications filed on or after May 1, 2019. For applications filed before May 1, 2019, it retained the June 15, 2018 policy exempting retirement accounts issuing regular, periodic payments The Section as amended does not clearly state what policy applies for applications filed before May 1, 2019 and what policy applies to applications filed on or after that date. But DFR policy staff has stated that the intent is to change the treatment of accounts with regular, periodic payments. The DFR has reverted to its pre-June 15, 2018 policy on retirement accounts for new applications filed on or after May 1, 2019 and treats retirement accounts as countable, even if income is being received, if the account can be liquidated. The DFR is not applying the policy change to persons already receiving Medicaid on May 1, 2019 whose account was exempted or to persons with an application pending on May 1, 2019.

The DFR decided that the SSI rules do not require that retirement accounts producing regular income be treated as exempt. The language in the SSA POMS § SI 01120.210 is fairly vague. Two federal courts have found retirement accounts to be countable for SSI. *Blaylock v. Harris*, 531 F.Supp. 24 (W.D. Mo. 1981) (a liquid resource cannot be excluded as essential for the self support of an SSI claimant); *Johns v. Astrue*, 2011 U.S. Dist. LEXIS 65906 (E.D. Ark. 2011) ("Although the Court appreciates his father's concerns about the consequences of making a premature withdrawal from an IRA, ... it is clear that a retirement account is a 'resource.'")

Even though FSSA on October 15, 2018 issued transmittal changes deleting language that since 2014 had given applicants and recipients an opportunity to dispose of "non-liquid" personal property that could not be liquidated within twenty workdays, IHCPPM § 2615.15.00 retains a paragraph stating that if verification is provided showing that the processing time for withdrawing funds from a retirement account is more than twenty working days, then the account is only considered available "after the individual agrees to withdraw the funds from the account and documented time frame has passed." The non-liquid property rule has been retained for retirement accounts. This appears to be intentional, as a transmittal on February 15, 2019 deleted a reference to the IHCPPM section on presumption of liquidity but retained the twenty day test.

### b. Retirement Accounts Owned by an Ineligible Spouse

Retirement accounts, including funds held in IRAs, in work-related pension plans administered by an employer or union, or in Keogh plans for self-employed persons, that are owned by an ineligible spouse are not counted. IHCPPM § 2615.15.00, 20 CFR §

416.1202(a)(1). The SSI regulation at 20 CFR § 416.1202(a)(1) refers to an ineligible spouse who is living with an eligible spouse.

Example:

> Joe, age 82, and Jill, age 78, are married and live together. Joe and Jill apply for standard Medicaid for the Aged, Blind, and Disabled. They are not seeking waiver services. Jill has a 401k account containing $50,000. Her 401k account counts as a resource for her application and will make her ineligible for Medicaid. Her 401k account will not be counted when considering Joe's eligibility for Medicaid.

See Section VIII(E)(4)(a), *below*, for a discussion of how this applies to a community spouse in "spousal impoverishment" assessments.

### 5. Stocks, Bonds, and U. S. Savings Bonds (IHCPPM §2615.45.00)

Stocks and bonds count as a resource at the current market value less any legitimate expenses of disposing of them, such as a broker's fee for selling stocks.

A U.S. savings bond counts as a resource when they can be cashed in. Series EE and I bonds are not countable during the first 12 months after purchase, since they cannot be cashed in during the first 12 months. EE and I bonds are considered immediately available in the 13th month after the date of purchase. IHCPPM § 2615.45.00.

The maximum amount of EE and I savings bonds which can be purchased is $10,000 per calendar year per Social Security number. Note that joint bonds using the joint account holder's Social Security number can be purchased. However, Treasury Direct's method of requiring that a primary owner be listed when there are joint owners may create difficulty with FSSA.

Example:

> Fred enters a nursing home on April 24 for rehabilitation. He has $31,000 in his bank account and no other countable resources. Before the end of April Fred purchases a $10,000 EE bond using his Social Security number, a $10,000 EE bond jointly with his son using his son's Social Security number, and a $10,000 EE bond jointly with his daughter using his daughter's Social Security number. On May 1 he has $1,000 in countable resources and meets the Medicaid resource limit, though FSSA may seek to count the jointly owned bonds. The bonds will be countable resources in April of the following year.

The Treasury Department website, www.savingsbonds.gov, contains a calculator one can use to determine the current value of savings bonds.

**Advocacy Tip: The purchase of EE and / or I bonds can be useful for a community spouse or for a person who does not expect to need Medicaid for more than a year. The purchase of bonds for a person who expects to need Medicaid long term will be**

**problematic because the bonds will cause the person to be ineligible in the 13th month after purchase.**

### 6. Life Insurance (IHCPPM §2615.25.05 *et seq.*)

This is an area where many applicants encounter problems, as the cash surrender value of most life insurance policies counts as a resource, and most people do not know the cash surrender value of their policies. One usually cannot determine the cash value from examining the policy itself; the information must be obtained from the life insurance company.

The cash value counts only if the applicant/recipient or spouse is the owner of the policy. If someone else owns the policy, its value is not counted. If a policy is irrevocably assigned or transferred to a third party, then it is no longer be counted as a resource, though there may be a transfer penalty as a result of the transfer. See Section XIII, *below*. If the insured has no legal right to cash in the policy, then it is not an available resource.

The cash value of life insurance is exempt if the total face value of all life insurance policies on a person does not exceed $1,500, regardless of who is listed as the beneficiary, as this is exempt for SSI. IHCPPM § 2615.25.05.15; 20 CFR § 416.1230(a). For a married couple, this is applied individually. If a spouse's life insurance face value(s) does not exceed $1,500, that spouse's life insurance is not counted.

If a funeral home is the owner of a policy or if a policy is irrevocably assigned to a funeral home, then the value of the policy does not count. I.C. § 12-15-2-17(f) and IHCPPM § 2615.25.05.15 state that this exemption applies only if the State of Indiana or the applicant's or recipient's estate is designated to receive any amounts remaining after payment of all services and merchandise under the funeral contract, to the extent of Medicaid benefits provided after age 55. If the estate is designated to receive any excess funds, then the state will need to pursue estate recovery as discussed in Section XV, below. Unless a substantial amount is involved, the state is unlikely to pursue recovery.

The DFR has reviewed older funeral plans upon recertification, and at times FSSA has claimed a policy to be a countable resource if there is no provision to pay any excess to the state or the estate. If the recipient does not own the policy or cannot cash it in, the DFR should not be counting it as a countable resource. At most it should consider whether an impermissible transfer of assets was made when the policy was transferred to the funeral home.

The DFR has eliminated the exemption that existed for many years for a policy owned by an applicant/recipient with a **face value** of $10,000 or less with the beneficiary as the insured's estate or the funeral director who will provide funeral services. To be exempt, a policy must meet the criteria in the preceding paragraph. If it meets that criteria, policies are not limited to a face value of $10,000.

See the following subsection concerning the irrevocable assignment of a life insurance policy to fund a funeral trust.

### 7. Funds in Reserve for Burial (IHCPPM §2615.20.00)

A revocable account which is identified as being set aside for burial, either by the title of the account or a signed statement by the owner, is exempt. This is consistent with the SSI rules, which only exclude $1,500 set aside for burial. 20 CFR § 416.1231. As $1,500 is generally not adequate, most persons will want to establish an irrevocable plan, which is not limited to $1,500.

A valid **irrevocable** funeral trust established under I.C. § 30-2-10 is exempt, no matter its value. IHCPPM § 2615.20.15. Note that 405 IAC 2-4-3, finalized in 2021, appears to set a limit of $10,000 on funeral trusts, but that limit is not applied in the IHCPPM and is not applied by DFR.

Although a funeral trust must normally remain revocable for the first thirty days, I.C. § 30-2-13-12.5(h) allows one to make a funeral trust immediately irrevocable to obtain favorable treatment for Medicaid. If one is funding a funeral trust to reduce resources before the first of a month, language waiving the revocability period **must** be included in the funeral trust, as IHCPPM §2615.20.10 provides that funds used to fund a funeral arrangement are countable as a resource during the first thirty days if the trust is revocable during that time.

I.C. § 12-15-2-17(f) provides that effective January 1, 2003 in order for a funeral trust to be exempt, the applicant or recipient must designate his or her estate or state Medicaid to receive any remaining amounts after payment of funeral and burial expenses. If the estate is designated to receive any excess funds, then the state will need to pursue estate recovery as discussed in Section XV, below. Unless a substantial amount is involved, the state is unlikely to pursue recovery.

The DFR is now referring all funeral trusts to Legal for review. It is also sending funeral trusts to Legal upon redetermination if the trust was not previously reviewed. Legal is specifically reviewing whether the trust properly designates the estate or the state to receive any remaining funds. See Appendix E for a Certification which has been used to fix a deficient funeral trust by having the funeral director certify that any excess funds will be paid to FSSA.

**Advocacy tip: Review funeral trusts to be certain they provide that any excess funds are payable to the state or to the estate. If benefits are needed in the month after the trust was funded, be certain that the 30 day revocability period is waived**.

If the DFR determines that a funeral trust contains a technical defect, then 405 IAC 2-3-16 requires that the applicant must be given twenty days to correct the defect. If corrected within that time, then the trust shall be deemed to be valid from its establishment.

Life insurance can be irrevocably assigned in order to fund a funeral. When this type of funding is used, the DFR will verify both the date of execution of the assignment as well as the date the insurance company accepts the assignment. The date the assignment was executed is the date the cash surrender value of the policy becomes unavailable as a resource for Medicaid eligibility purposes so long as the assignment is accepted by the company. IHCPPM §2615.20.10.

One should be aware that FSSA may not exempt insurance policies where funds are set aside for a funeral, with the purchase of services to be made after death. In *St. Bd. of Funeral and Cemetery Service v. Settlers Life Ins. Co.*, 5 N.E.3d 1170 (Ind.Ct.App. 2014), the Indiana Attorney General sought to bar Settlers Life Insurance Company from selling its funeral policies in Indiana. Settlers sold a $10,000 insurance policy which the purchaser then had the option to assign to a National Guardian Life (NGL) trust. The NGL trust only allows the proceeds to be spent on burial goods and services, but the goods do not need to be selected in advance. Instead the beneficiaries can choose the burial goods upon the death of the insured. The DFR treated the Settlers policy as a countable resource because it was not owned by or assigned to a funeral home and did not meet Indiana's pre-need act. Even though irrevocable, Settlers transferred the policy from the trust to a funeral home to satisfy DFR. The Court of Appeals did not address the Medicaid issue. It refused to enjoin Settlers' sale of these policies because it sells an at-need product that does not fall within the scope of the Pre-Need Act. Appendix F contains a form NGL uses to resolve DFR's concerns by irrevocably assigning the proceeds to a funeral provider who agrees to pay any excess funds to the State.

See Section XIII(F)(1), *below*, for a discussion of whether the purchase of a funeral trust or burial space for immediate family members is exempt from a transfer penalty.

### 8. Vehicles (IHCPPM §2615.60.20.05)

One vehicle of any value is exempt if it is used for transportation of the applicant or for a member of the household.

For second and other vehicles, the equity value counts as a resource. The vehicle with the highest equity value is the one that is exempt. If the vehicle is used to produce income, then it is exempt as income producing personal property. IHCPPM § 2615.35.00.

IHCPPM § 2605.25.05 states that vehicle values in the Kelley Blue Book can be used. Its values can be located at www.kbb.com. IHCPPM § 2605.25.05 says that the lowest wholesale value is to be used. Websites do not typically list a wholesale price. An on-line article at www.auto-broker-magic.com/car-value.html (last accessed on April 14, 2022) asserts that the wholesale price and trade in value are one and the same. One can use trade in values and list the vehicle as being in fair condition. FSSA has accepted this valuation method. An applicant/recipient can also submit a written statement from a licensed automobile dealer, especially if asserting that the value is less than the book value.

IHCPPM § 2605.25.05 has a useful provision for handicap equipped vehicles. If a vehicle is especially equipped with apparatus for the handicapped, then the book value is to be determined as if the vehicle were not so equipped.

IHCPPM § 2615.60.25 provides that campers, trailers, and boats are counted at their equity value unless they serve as a home, at which point the real property rules on homes apply. This means that a mobile home which no longer serves as a home is counted as a resource.

### 9. Trusts (IHCPPM §§ 2615.75.00 *et seq.*)

#### a. General Principles

OBRA 93 enacted rules which apply to certain trusts established on or after August 11, 1993. The pre-OBRA 93 rules still apply to trusts set up prior to August 11, 1993. The previous rules also still apply to previously established trusts even for assets placed into the trust on or after August 11, 1993, so long as the trust was established before August 11, 1993.

Under the pre-OBRA 93 rules, if the applicant/recipient or spouse is the grantor who funds the trust and is also the beneficiary, then the amount of principal counted as a resource is the maximum amount available if the trustee were to exercise full discretion for distribution of the funds. That is, if the trustee has the discretion to distribute any of the principal, whatever amount of principal the trustee has the discretion to distribute is counted as a resource even if the trustee does not distribute it. This test is essentially the same as the test provided under OBRA 93.

The OBRA 93 trust provisions which apply to certain trusts established on or after August 11, 1993 are located at 42 U.S.C. §1396p(d) and discussed at IHCPPM §2615.75.10. Indiana's regulations at 405 IAC 2-3-22 merely repeat the federal statutory language and provide no additional guidance. The federal agency published explanatory materials in HCFA Pub. 45-3, Transmittal No. 64 (Nov. 1, 1994), which are now in § 3259 of the CMS State Medicaid Manual. The OBRA 93 provisions apply to any nontestamentary trust funded with the applicant's or applicant's spouse's assets and established after August 10, 1993 by any of the following:

- the applicant or recipient;
- his or her spouse;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the applicant or the applicant's spouse;
- a person, including a court or administrative body, acting at the direction or upon the request of the applicant or the applicant's spouse.

The last provision raises serious questions about trusts established by third parties using funds transferred from the applicant or spouse. If a person transfers funds to a third party and the third party voluntarily establishes a trust benefitting the transferor, then those funds should not count as a resource of the original transferee. But if the original transferor requested the transferee to establish a trust, then the assets in the trust could be determined to still be a countable resource for the original transferor.

The general concept of the OBRA 93 rules is that assets placed in a trust are either considered as an available resource or are considered to have been transferred. Assets are considered as an available resource if there are **any circumstances** under which payment could be made to the individual. If there are **no** circumstances under which the individual could benefit, then the assets are not an available resource and are treated as transferred when the trust

was established. See Section XIII, *below*, for more information on transfer penalties. Assets counted as a resource are reviewed using the rules that apply to that type of property. For instance, income producing real property in a revocable trust is reviewed using the rules that apply to income producing real property.

Neither the pre-OBRA 93 rules nor the OBRA 93 rules apply to testamentary trusts. They also do not apply to trusts set up by a third party not acting at the direction of the applicant or the applicant's spouse, provided that none of the applicant's or spouse's funds are deposited into the trust. FSSA may review the trust to make sure that only the third party's funds are in the trust. One may want to include language in a third party trust stating it cannot be funded with the beneficiary's funds so that FSSA will not seek to review the source of the funds in the trust. Provided that none of the applicant's funds are in the trust, these trusts will be reviewed by determining the "availability" of the trust. IHCPPM §2615.75.20. If the trustee has the sole discretion to distribute third party funds to an applicant or recipient, the trust is not a resource. I.C. §§ 30-4-2.1-14 and 14.5 define what constitutes a "discretionary" trust under Indiana trust law.

The Nebraska Supreme Court held that OBRA 93 did not apply to a testamentary trust established by the applicant's deceased husband. *Pohlmann v. Nebraska HHS*, 710 N.W.2d 639 (Neb. 2006). The Court stated that a discretionary trust, where the beneficiary cannot compel distributions, is not a countable resource, while a support trust, where the beneficiary can compel distributions for support, is a countable resource. *Id*. at 645. See also *Donna G. v. HHS*, 920 N.W.2d (Neb. 2018), which found a discretionary testamentary trust was not a countable resource.

### b. Revocable Trusts

The rules for a revocable trust established by an applicant or recipient are straightforward. **A trust is considered to be revocable if there are any circumstances under which it can be revoked, even if it is labeled as being irrevocable.**

- The corpus of the trust is an available resource.

- Payments to a third party which are not for the benefit of the individual are treated as transfers when they are paid to the third party.

- Payments from the trust to or for the benefit of the individual are counted as income to the individual.

IHCPPM § 2615.75.10; 42 U.S.C. §1396p(d)(3)(A). Indiana treats property in a revocable trust as if it maintains its underlying nature. It looks through the trust to the property in the trust. For example, real property in a revocable trust is still treated as real property, and the rules on real property are applied to that property. However, one should be aware that § 3259.6(f) of the CMS State Medicaid Manual states that placing the home of an institutionalized person in a trust results in the home becoming a countable resource.

### c. Irrevocable Trusts

The rules for an irrevocable trust are more complex. 42 U.S.C. § 1396p(d)(3)(B)(I) states:

> [I]f there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual....

Conversely, §1396p(d)(3)(B)(ii) states:

> [A]ny portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual ....

See also IHCPPM § 2615.75.10. This means that if a trust is established so that neither the corpus nor the income can **under any circumstances** benefit the individual, then the trust corpus will not be treated as an available resource and will be treated as having been transferred when the trust was established or funded. The effect on an "income only" trust, where the individual cannot benefit from the corpus but will receive the income, is less clear from the language. CMS has affirmed that if no portion of the trust corpus can be distributed, the corpus will not be counted as a resource to the individual. Thus, no part of an "income only" trust should be counted as a resource, but instead the trust corpus will be treated as having been transferred when the trust was established. Actual payments to the Medicaid recipient **will** be counted as income in the Medicaid budgeting process.

Those portions of an irrevocable trust which can under some circumstances be used to benefit the individual are treated as an available resource unless and until they are transferred to a third party. An irrevocable trust which gave the trustee discretion to distribute principal and income for the needs of the grantor was a countable resource for the grantor. *Ark. Dep't of Human Servs. v. Hogan*, 2020 Ark. App. 134 (Ark. Ct. App. 2020). Those portions of an irrevocable trust which cannot ever be used to benefit the individual are not considered as an available resource but instead are considered to have been transferred when the trust was established, or if later, the date upon which payment to the individual was foreclosed.

The result of this is that a trust being labeled as “irrevocable” does not by itself determine whether the assets in the trust are available and countable as a resource. One needs to review the trust to see if there are any circumstances under which the grantor can benefit from the assets. To the extent the answer is yes, the assets are available and countable as a resource.

In *Brown v. Ind. FSSA*, 45 N.E.3d 1233 (Ind. Ct. App. 2015), the Court of Appeals reviewed an appeal in which Mr. and Mrs. Brown transferred their home to a trust in 2000, shortly thereafter made it irrevocable, and continued to live in the home. In 2010 the home was sold and the proceeds placed into the irrevocable trust. FSSA assessed a transfer penalty against

Mrs. Brown, who then appealed. The Court stated that because Mrs. Brown "was able to benefit from the Trust, the Trust assets were resources available to her." 45 N.E. 3d at 1238. The Court did not explain this reasoning but apparently relied on the Browns' ability to continue to live in the home as making the home in the trust an available resource. Although not the primary issue in the case, this decision suggests that a home transferred into an irrevocable trust will still be considered as available to the grantors if they continue to live in the home. But see *Daley v. Secretary of the Executive Office of Health and Human Services*, 74 N.E.3d 1269, 477 Mass. 188 (Mass. 2017), which ruled that neither retaining a life estate nor retaining the right to use and occupy the home made the equity in the home a countable resource.

*Hegadorn v. Dep't of Human Servs. Dir*., 503 Mich. 231, 931 N.W.2d 571 (Mich. 2019), held that an irrevocable "sole benefit trust" funded by the spouse of an applicant, where the trust provided that the trustee would distribute principal to the spouse with the expectation that all the assets would be used during the spouse's lifetime, was not a countable resource for the applying spouse because the trust assets were available for use only by the non-applicant spouse. The Court read "individual" in 42 U.S.C. § 1396p(d)(3)(B) as referring to the Medicaid applicant, and thus an irrevocable trust which only benefitted the non-applying spouse was not an available resource for the applicant spouse.

*Heyn v. Director of the Office of Medicaid*, 89 Mass. App. Ct. 312 (Mass. App. Ct. 2016), held that funds in an irrevocable trust were not a countable resource. The Court explained the history of the rules on irrevocable trusts as follows:

> The legislative history and case law concerning the treatment of self-settled trusts reflect awareness of the possibility that comparatively affluent individuals might avail themselves of such trusts as an estate planning tool, in order to qualify for benefits. The resulting law reflects a compromise, with provisions for so-called "look back" periods for transfers of assets preceding an application for benefits, see 42 U.S.C. § 1396p(c)(1)(B)(i) (2012), and strict requirements governing the extent to which assets must be made unavailable to the settlor in order to avoid being treated as "countable assets" for purposes of Medicaid eligibility. Nonetheless, it is settled that, properly structured, such trusts may be used to place assets beyond the settlor's reach and without adverse effect on the settlor's Medicaid eligibility.

89 Mass. App. Ct. at 313 (internal case citations omitted). The Court found that the trust was not a countable resource even though the Medicaid agency objected to the fact that the grantor retained a power of appointment and the grantor had the power to require the trustee to transfer any trust assets in exchange for assets of equivalent value. For further information, see *Limiting State Medicaid Agency Attempts to Expand the "Any Circumstances" Test: An Analysis of Massachusetts' Multiyear Legal Battle Over the Use of Irrevocable Trusts in Long-Term Care Planning*, NAELA Journal, Spring, 2017, Vol. 13, No. 1, p. 35.

### d. Trusts for a Disabled Person With the Disabled Person's Own Assets

This Section discusses trusts that are established using the disabled person's own funds. This Section does not apply to a third party special needs trust established for the benefit of a disabled person. Two types of trusts containing the assets of disabled persons receive special consideration so that assets in the trust are not counted as a resource when determining eligibility for Medicaid. The first type is an individual special needs trust, commonly referred to as a "d(4)(A)" trust. The second is a "pooled trust" where the funds of many disabled persons are pooled together and managed by a nonprofit entity.

#### (1). The "d(4)(A)" Trust (IHCPPM § 2615.17.15)

The trust rules do not apply to special needs trusts established for the benefit of a disabled individual **under age 65** if the State will receive all amounts remaining in the trust upon the recipient's death up to the total amount of Medicaid assistance paid out on behalf of the individual. This type of trust is often referred to as a "d(4)(A)" trust because it is permitted by 42 U.S.C. §1396p(d)(4)(A). **The statute does not allow this type of trust to be established for a person over age 65.** Although estate recovery is limited to benefits received after age 55 (see Section XV(B)), there is no age limit on the required pay back from a d(4)(A) trust. The state is entitled to payment from a d(4)(A) trust of a person who dies before age 55 and from a person who dies after age 55 for benefits received before age 55.

*In re Guardianship of Robbins*, 107 N.E.3d 1080 (Ind. Ct. App. 2018), held that the trial court erred in refusing to place the full amount of a disabled person's tort settlement into a special needs trust simply because the trial court disagreed with the plan to place assets into the trust and obtain Medicaid. The Court of Appeals recognized that the requirement to pay back the state upon death meant that the plan was not designed to benefit family members or the guardian.

**Effective for trusts established on or after December 13, 2016, a disabled person can now establish his or her own d(4)(A) trust.** For trusts established before December 13, 2016, the statute and the IHCPPM referred to a d(4)(A) trust containing the assets of a disabled person which was set up by the disabled person's parent, grandparent, legal guardian, or by a court. The language did not allow a disabled person to establish his or her own trust, but required that a court or one of the persons listed must set up the trust. 42 U.S.C. §1396p(d)(4)(A); IHCPPM §2615.75.15. Once the trust was established, the disabled person was not prohibited from placing funds into the trust. The 21st Century Cures Act, Pub. L. 114-255, Div. A, Title V, § 5007(b), amended §1396p(d)(4)(A) to provide that a trust can be established by "the individual, a parent, grandparent, legal guardian of the individual, or a court." The amendment is effective for trusts established on or after the date of the Act, December 13, 2016. This change is discussed in IHCPPM §2615.75.15.

Bob Fechtman has provided a sample special needs trust. See Appendix G. For more information, see articles on Special Needs Trust in the ICLEF's annual Elder Law Institutes and *Third-Party and Self-Created Trusts: Planning for the Elderly and Disabled Client*, 3rd Ed., by Clifton B. Kruse, Jr., available through the American Bar Association.

Even though the State must receive all amounts remaining in a d(4)(A) special needs trust upon the death of the recipient, the Indiana Court of Appeals ruled that claims which could have been paid during the recipient's lifetime could be paid from the trust after the recipient's death. *State v. Hammans*, 870 N.E.2d 1071 (Ind. Ct. App. 2007). The parents of a severely disabled recipient held off on filing claims for payment for their services hoping that the funds in the trust could be used to pay for medical care once medical advancements occurred. After the son died suddenly, the parents filed a claim for their services, and the trial court approved their claim. The Court of Appeals affirmed payment of the claim since the claim could have legitimately been paid during the son's lifetime.

The 2009 Indiana legislature added I.C. § 30-4-3-25.5 to reverse the result in *Hammans*. It only allows payment of federal and state taxes before payment of the State's claim. Note that POMS SI 01120.203 also allows payment of reasonable fees for administration after death. *Ala. Medicaid Agency v. Britton*, 2020 Ala. Civ. App. LEXIS 41, 2020 WL 1482650 (Ala. Civ. App. 2020) ruled that trustee fees could be paid after death before payment of the state's claim. This decision also noted that the state had not objected to payment of attorney fees. A trustee should pay claims promptly during the beneficiary's lifetime as a trustee will not be able to pay claims other than taxes after the beneficiary's death until after Medicaid has been reimbursed for what it has paid out for the beneficiary. It is questionable whether fees can be paid after death in light of the limits in I.C. § 30-4-3-25.5.

Special needs trusts, especially d(4)(A) trusts, are part of a constantly changing area of law. They are often used for SSI beneficiaries, and the Social Security Administration periodically questions provisions which it accepted for many years. www.specialneedsalliance.org has helpful materials on-line on special needs trusts, including a link to search for attorneys practicing in this area. Its website includes an instructive manual for trustees of special needs trust that can be downloaded at www.specialneedsalliance.org/special-needs-101/free-trustee-handbook. Stetson University School of Law in St. Petersburg, Florida provides high-quality seminars on special needs trusts. Anyone serious about practicing in this area should attend its conferences.

### (2). Pooled Trusts (IHCPPM § 2615.17.15)

The second type of trust which receives special protection is a pooled trust managed by a nonprofit association for disabled persons, where any funds remaining in the trust at the recipient's death can be retained by the trust to benefit other disabled persons.

The federal statute allows pooled trusts to be used for disabled persons and does not contain the additional language that the disabled person must be under age 65. Thus, a disabled person over age 65 can enroll in a pooled trust and funds in the pooled trust will not be countable as a resource in determining eligibility. FSSA may request verification that the person was in fact disabled when placing funds into the trust. Although FSSA may request verification that the person was disabled before age 65, the federal statute does not require that the disability began before age 65. If a person over age 65 who is not disabled transfers funds to a pooled trust, those funds will still be counted as a resource.

See Section XIII(D)(4) for a discussion of whether the transfer to a pooled trust by a person over age 65 may trigger a transfer penalty.

The ARC of Indiana has one of the best developed pooled trusts in the nation, as it manages over 100 million dollars in its trusts. Its Master Trust I was established in 1988 as a way for families who have a loved one with a disability to provide for that disabled family member. The ARC sets a spending target for a disabled person based on the amount in the Trust and the actuarial life expectancy of the disabled person. There is no mandatory remainder to the ARC but it can be designated to receive all or a part of any funds remaining after the death of the disabled person. Those funds can be used for disabled persons who outlive the funds in their account.

ARC designed its Trust II specifically to allow a disabled person to establish a special needs account with a lump sum, such as a personal injury award, a retroactive Social Security award, or an inheritance. The disabled person can establish an account with ARC. Medicaid payback applies upon the death of the disabled person to the extent funds remain in the account, except that the ARC retains 50% of the remainder. It will accept accounts for persons age 65 and over, as well as for younger disabled persons.

For more information about the ARC trusts, contact the ARC trust office at 1-800-382-9100 or 317-977-2375, see www.thearctrust.org, or its annual 2020 report at www.thearctrust.org/wp-content/uploads/2021/04/The-Arc-Master-Trust-2020-Annual-Report.pdf.

SWIRCA & More, the area aging agency in southwest Indiana, operates a pooled trust that is open to residents in Indiana, not just residents of it service area. It will accept accounts for persons age 65 and over, as well as for younger disabled persons. It requires a $10,000 minimum deposit. For further information, see swirca.org/special-needs-pooled-trust or contact Jillian Hall, 812-492-7441, *jhall@swirca.org*.

Pooled trusts are also available in Indiana from the Life's Plan in Chicago. For more information, contact Life's Plan at 630-628-7189 or www.lifesplaninc.org.

Military parents can assign Survivor Benefit Plan payments for a dependent son or daughter with disabilities to a d(4)(A) or pooled trust. The special needs trust must be "for the sole benefit of a dependent child." If a pooled trust is used, it will require that the pooled trust provide for full payback to the state for Medicaid benefits received. See www.dfas.mil/retiredmilitary/provide/sbp/special-needs-trust.html for more information.

### 10. Promissory Notes, Mortgages, Loans, and Land Sale Contracts

The right to receive payments owed by a third party can sometimes be a countable resource. IHCPPM §2615.50.00 provides that **a negotiable** mortgage, loan, or promissory note held by an individual **is a countable resource**. IHCPPM § 2615.55.15 applies these same rules to land sale contracts. Although the real property is not a countable resource, the principal balance of the payments owed on the land sale contract is a countable resource unless the contract is non-negotiable.

When a person can sell the right to receive the future payments, that right has some value, which is a countable resource. There may not be an active market for such notes, but it has some value. Although IHCPPM § 2615.50.00 states that the countable value is the principal balance, one should be allowed to rebut this if there is not a market where the note or loan can be sold for the principal balance.

**If the promissory note, loan, mortgage, or land sale contract is non-negotiable**, IHCPPM §2615.50.00 (IHCPPM § 2615.55.15 for land sale contracts) provides that **it is not counted as a resource**. Notes, loans, and mortgages will be reviewed by FSSA's Legal department to determine if the agreement is negotiable. A sample Non-Negotiable Promissory Note is at Appendix H.

Although a promissory note should be valid even if signed only by the borrower, FSSA has at times found a promissory note to be invalid if not also signed by the lender. The sample Note in the Appendix has a line for the lender to approve it. Some attorneys prepare a loan or purchase agreement in addition to the note. The loan or purchase agreement states that the obligation of the borrower or purchaser is evidenced by the promissory note which is executed on the same date as the loan or purchase.

A negotiable note can be converted to a non-negotiable note to make it non-countable. This can be referred to as a novation or a substitution. One can rephrase the original note with language to make it non-negotiable. One can then include language showing that it is a novation or substitution: "This note is a novation or substitution for the remaining indebtedness of Borrower to Lender evidenced by Promissory Note from Borrower to Lender dated x date." This should not be treated as a transfer of assets because the amount to be paid remains the same.

In considering what interest rate to use, many attorneys use the applicable federal rate used by the Internal Revenue Service, available at www.irs.gov/applicable-federal-rates.

*Rose v. Brown*, No. 20-6132, 2021 U.S. App. LEXIS 29238 (10th Cir. Sep. 28, 2021), reversed the decision of the Oklahoma Medicaid agency that Ms. Rose's promissory notes were not made in good faith and counted as a resource. In 2017, Ms. Rose loaned $304,000 to her daughter-in-law for two promissory notes. When her daughter-in-law made an annual payment of $66,508 in 2018, Ms. Rose then loaned an additional $37,700 for an additional third promissory note. The agency concluded this was a deferral that turned the 2017 promissory notes into resources. The federal district court ruled that Ms. Rose had not entered into the 2018 promissory note in good faith and it resembled a trust. The Tenth Circuit reversed and remanded to the district court for further fact finding, to determine if the daughter-in-law was able to make the repayments and whether the loaned funds were to be held to benefit Ms. Rose.

See Section XIII(F)(4) for a discussion of when a transfer of funds in return for a promissory note or land sale contract is treated as a penalizable transfer. Promissory notes that are not a penalizable transfer can be a useful planning tool. They are often used to produce a stream of income sufficient in amount and length to help pay the monthly cost of long term care during a penalty period. Since only the interest on a promissory note is counted as income, a promissory note can also be used as a part of a spend down of resources to provide additional monthly funds to help improve the individual's life. For example, a person in assisted living who

is spending down resources might utilize a promissory note to be able to pay for a larger room or to have more monthly spending money.

### 11. Annuities

An "annuity" is a contract between an individual and an insurance company or other financial company in which the individual pays money, either in a lump sum or over time, to a company which either immediately, or at a later time, repays the individual in regular installment payments. The installment payments may be made for a definite period, for the life of the annuitant, or for the joint lives of the annuitant and a survivor, typically the spouse. Some annuities combine this and pay for the life of the annuitant, but not less than some defined period, so if the annuitant dies before the end of the guaranteed period, a named beneficiary draws the remaining payments. Although an annuity is typically a commercial product, one can arrange for a private annuity.

There are two basic types of annuities. An immediate annuity involves payment of a lump sum payment in return for periodic annuity payments beginning immediately. A deferred annuity involves one or multiple payments with payments deferred until a later time, typically until sometime after retirement.

The income tax rules at 26 U.S.C. § 72 encourage the use of deferred annuities for retirement.

- There is no tax deduction for monies used to purchase an annuity, unless an annuity is purchased within an employer retirement plan or within an IRA. This type of annuity is referred to as a "qualified annuity." Investments in non-qualified annuities are made with post-tax funds.

- Income generated by an annuity is not taxed until received.

- When payments are annuitized and paid after age 59 ½, a formula is used to determine what portion of each payment is considered income, which is taxable. The portion of payments which are a return of the investment is not taxed.

- When funds are withdrawn from an annuity before the annuity payment starting date, amounts withdrawn are fully taxable until all income earned to date has been withdrawn. This is an "income first" rule.

- Similar to other tax deferred retirement plans, a ten per cent penalty is imposed on withdrawals made before age 59 ½ unless an exception applies.

Annuities may provide for fixed or variable payments. A variable annuity can provide various returns depending on the management of principal by the insurance company. Annuity payments can be level pay or can vary. Some annuities provide small income payments followed by balloon payments.

Although applicants are generally required to disclose all information affecting eligibility, there is a specific disclosure requirement concerning annuities. 42 U.S.C. § 1396(e)(1) requires that an applicant "shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset." This requirement is also listed in 405 IAC 2-1-2(i). Likewise, the Notice Regarding Rights & Responsibilities for Health Coverage notifies the applicant that "you are specifically required by federal law to provide all information about annuities which you or your spouse owns."

The IHCPPM addresses annuities under § 2615.15.00 "Retirement Accounts." This Section explains how an annuity is counted as a resource:

> The value of a retirement account [including an annuity] is the amount that the individual can currently withdraw less any penalty for early withdrawal. Taxes due are not deducted from the retirement account's value. Verification is to be obtained from the administrator of the retirement plan. If there is a delay in payment due to reasons beyond the individual's control because of the financial organization processing time frame, it would affect the availability of the resource.

The key is whether any amount of the principal can be withdrawn. If not, then it is not a countable resource. An immediate annuity which cannot be cashed in or assigned is not a countable resource; it is only a "stream of income."

Although the next to last paragraph of IHCPPM § 2615.15.00 states that "retirement accounts," which might include annuities, owned by an ineligible spouse are not a countable resource, the Section as a whole shows that this only applies to funds in an IRA or in a work-related pension plan, such as a 401(k) plan, as provided by 20 CFR § 1202(a)(1). An annuity of an ineligible spouse that is not in a qualified plan is a countable resource to the extent the funds can be withdrawn or assigned. See Section VIII(E)(4)(a), *below*, for a discussion of the treatment of qualified annuities owned by a community spouse in "spousal impoverishment" assessments.

Some states have taken the position that irrevocable annuities are available because there is a secondary market for them, as some companies may be willing to pay cash in return for the income stream. This position was rejected by *Ross v. Dept. of Public Welfare*, 936 A.2d 552 (Pa. Cmwlth. 2007); *Weatherbee v. Richman*, 595 F.Supp.2d 607 (W.D.Pa. 2009). But see *N.M. v. Div. of Med. Assistance & Health Servs.*, 405 N.J.Super. 353, 964 A.2d 822 (N.J.App.Div. 2009), which held that the existence of a secondary market made an annuity countable. 42 U.S.C. § 1396p(d)(6) allows HHS to apply its rules on trusts to annuities to the extent specified by the Secretary of HHS. HHS has not addressed this. FSSA has not counted non-assignable annuities as a countable resource.

A Single Premium Immediate Annuity will typically have a "free look" period of at least ten days during which the consumer can cancel the contract. This can cause a problem for Medicaid, as FSSA can potentially treat an otherwise unavailable resource as being available during the free look period. One can address this by signing an irrevocable waiver of any right to rescind the annuity contract.

See Section XIII(F)(3)(b), *below*, concerning requirements to name the state as a beneficiary of certain annuities in order to avoid a transfer penalty. Whether the state is correctly named as a beneficiary does not affect whether an annuity is countable as a resource.

### 12. Household Goods and Personal Effects (IHCPPM §2615.30.00)

These are exempt. Valuable collectible items, such as stamp and coin collections, will likely not be accepted as exempt. Some DFR staff more closely examine whether items truly fit the definition. For example, if jewelry is purchased but never used, it may not be accepted as a personal effect, as the IHCPPM defines personal effects as items a person wears or carries.

### 13. Income Producing Personal Property (IHCPPM §2615.35.15)

Personal property used to produce income, such as property used in a business or farm equipment, are exempt. This exemption does not apply to financial assets that produce income.

### 14. Proceeds from Casualty Insurance (IHCPPM §2615.25.10)

Proceeds derived from damage or loss to exempt property are not counted for up to nine months if they are being used to repair or replace the exempt property.

### 15. Federal Tax Refund (IHCPPM § 2630.70.00)

IHCPPM § 2630.70.00 lists this disregard. 26 U.S.C. § 6409 provides that a federal tax refund is disregarded as a resource for twelve months after receipt. It is also disregarded as income in the month of receipt. This exclusion was initially added as a temporary provision in 2010, but the Taxpayer Relief Act of 2012, 112 Public Law 240 (Jan. 2, 2013) extended this exclusion permanently.

A federal tax refund received in the last twelve months is deducted from current resources. One need not be able to trace the proceeds and show that the applicant / recipient still has the funds. This is an important exception. The IHCPPM contains the following example:

Example:

> Applicant, single, applies today, April 27, and has total resources of $4,000. Applicant verified receipt of a federal refund in the amount of $3,287 received in January of this year. This federal refund amount is deducted from the total resources because it was received within 12 months. The difference of $713 is countable as a resource.

In this example, the applicant meets the resource test even though initially appearing to be substantially above the resource limit.

The COVID "stimulus" payments which most persons received in 2020 and 2021 were a credit against taxes. These payments were considered to be federal tax refunds and were treated as explained in this Section.

**Advocacy Tip: If a client is over resources, one should always ask the client if she received a tax refund or recovery rebate in the last twelve months, since it can be deducted. Provide verification to FSSA showing when any tax refund or stimulus payment was deposited.**

### 16. Social Security or SSI Retroactive Benefits (IHCPPM § 2615.65.00)

A lump sum award of retroactive Social Security or SSI benefits is exempt for nine months following the month of receipt. IHCPPM § 2615.65.00, based on 20 CFR § 416.1233. Although not addressed in the IHCPPM, the SSI regulation at § 416.1233(d) provides that the funds must be identifiable, and only the unspent portion of the award is not countable. § 416.1233 provides:

> Unspent money from a retroactive payment must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds but, if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount will count toward the resource limit described in § 416.1205.

Although one is not required to keep the lump sum back payment in a separate account, that is preferable so that the funds can be tracked. Note that this treatment is different than the treatment of a federal tax refund, which does not need to be separately tracked.

### 17. Health Savings Accounts (IHCPPM § 2627.00.00)

Health savings accounts are exempt as a resource if the account is restricted to use for qualified medical expenses only.

### 18. ABLE Accounts for Disabled Persons With Disability Beginning Before Age 26

The Achieving Better Life Experience (ABLE) Act of 2014, Pub. Law 113-295, codified at 26 U.S.C. § 529A, was enacted on December 19, 2014. The Act is designed to encourage and assist individuals and families in saving private funds for the purpose of supporting individuals with disabilities to maintain health, independence, and quality of life. Act, Div. B, § 101. The Act allows disabled persons whose disability began before age 26 to have a tax exempt savings account which will not effect eligibility for public benefits. An ABLE account cannot hold more than the state's limit for 529 accounts, which is $450,000 for Indiana. All of the funds in an ABLE account are exempt as a resource for Medicaid, while only the first $100,000 in the account is exempt as a resource for SSI.

The Department of Treasury published final regulations at 85 Fed. Reg. 74,010 (November 19, 2020). The regulations are at 26 CFR § 1.529A. See www.ablenrc.org/wp-content/uploads/2020/10/ABLENRCKeyTakeaways-IRSFinalABLERule.pdf for a summary of the final regulations.

Indiana enacted legislation authorizing the establishment of ABLE accounts in Indiana. I.C. § 12-11-14. The Indiana program is administered by an ABLE Board. Accounts became available in Indiana in 2017. Indiana joined a consortium of states, known as the National ABLE Alliance. The Alliance's website is savewithable.com. Indiana's plan is INvestABLE Indiana. For information on Indiana's plan, see savewithable.com/in/home.html.

Key points for ABLE accounts include:

• The accounts can only be used by disabled persons whose disability began before age 26. Disability needs to be recertified each year. The program can allow the disabled person to certify under the penalties for perjury that the disability continues.

• A disabled person can have only one ABLE account.

• A disabled person living in Indiana can open an ABLE account in Indiana or in another state that offers ABLE accounts. Some attorneys prefer the account offered in another state, such as the Ohio STABLE account.

• Anyone, including the disabled person, can deposit funds into the ABLE account. Beginning in tax year 2024, a taxpayer will be entitled to a credit against adjusted gross income tax equal to the least of: (1) 20% of the amount of the total contributions made by the taxpayer to an account or accounts of an indiana able savings plan during the taxable year; (2) $500; or (3) the amount of the taxpayer's adjusted gross income tax for the taxable year, reduced by the sum of all allowable credits. I.C. § 6-3-3-12.1, added by Pub. Law 122-2022.

• The total of all deposits into an ABLE account in a year cannot exclude the annual gift tax exclusion, $16,000 in 2022, except that account owners who work and earn income are allowed to contribute more than the gift tax exclusion under certain circumstances.

• Only cash funds can be deposited into an ABLE account. Until December 31, 2025, funds in a 529 education savings account can be rolled over to an ABLE account without penalty, up to the annual maximum contribution, provided that the ABLE account is owned by the designated beneficiary of that 529 account or a member of the designated beneficiary's family.

• Funds in an ABLE account are not a countable resource for Medicaid. They are not countable for SSI as long as the account does not exceed $100,000.

• Funds in an ABLE account can be used for "any expenses related to the eligible individual's blindness or disability which are made for the benefit of an eligible individual who is the designated beneficiary, including the following expenses: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses, which are approved by the Secretary under regulations and consistent with the purposes of this section." 26 U.S.C. §

529A(e)(5). Funds used for these allowable expenses are not counted as income to the recipient. The ability to use funds in the account for housing expenses is a big advantage over other special needs trusts.

• When the disabled person is no longer eligible as a disabled person due to medical improvement, the ABLE account remains as an ABLE account. Contributions may continue through that calendar year. Distributions after the loss of eligibility are not qualified disability expenses.

• Upon death of the disabled person, any funds remaining in the account are payable to Medicaid up to the amount of Medicaid payments made. This applies even if the funds were contributed by a third party.

The Plan Disclosure Documents for the INvestABLE plan are at cdn.unite529.com/jcdn/files/UABLE/pdfs/in-programdescription.pdf. No minimum amount is required to open an account. There is a $15 quarterly maintenance fee, reduced by $3.75 with electronic delivery of statements and confirmations. One can choose a checking option with a $2 monthly service fee, or one can choose one of six investment options ranging from aggressive to conservative, with an asset based fee ranging from 0.34% to 0.37%. The account may be accessed by check or debit card. The recipient may establish and manage his own account, or a parent, guardian, or attorney-in-fact may establish and manage the account for the recipient.

CMS State Medicaid Director Letter 17-002, at www.medicaid.gov/federal-policy-guidance/downloads/smd17002.pdf gives additional guidance on contributions to and distributions from an ABLE account.

An ABLE account gives a simple alternative for setting aside funds for a disabled person which are not countable as a resource. One needs to be aware of the pay-back requirement. It is also important that good records be kept of deposits and expenditures. For larger amounts of funds, a third party, such as a family member, will prefer to use a third party special needs trust, where no Medicaid pay back is required. For smaller amounts, or for setting aside funds of the recipient, the ABLE account can be an attractive option for persons who qualify because it can be simple and inexpensive to establish and because expenditures from the account, even for housing, are not countable as income. Third parties can assist a disabled person through deposits to an ABLE account that will not be treated as income when expended for a qualified expense. One could transfer funds from another special needs trust to the ABLE account to obtain the benefits of the ABLE account. The special needs trust should include language allowing transfer to an ABLE account.

### 19. 529 Plans

Funds in a 529 education savings plan are not countable as a resource in determining eligibility. I.C. § 12-15-3-8; 405 IAC 2-3-25; IHCPPM § 2615.10.20.

Any money withdrawn from a 529 plan that is not used for eligible educational expenses for the designated beneficiary will be considered a converted resource countable in the month of the withdrawal unless the converted resource is otherwise exempt. 405 IAC 2-3-25(c)(2).

### C. Real Property

There is no limit on the amount of real property a person can own and receive Medicaid, except for the home equity limit discussed below. Instead, if the real property is not exempt, one must offer the real property for sale or rent at current market value as a condition of receiving Medicaid. 405 IAC 2-3-15(e), (f); IHCPPM §2620.20.10. Offering the property for sale or rent requires posting a sign in a conspicuous location on the property or listing the property with a realtor. On-line listing is not listed as an option. There are special rules concerning the treatment of real property in spousal situations where one spouse is in a nursing home or one spouse receives waiver services. These rules are discussed in Section E, *below*.

There was concern that the real property rules would change in June, 2014 when Indiana converted to an SSI state, because SSI only exempts the first $6,000 of the equity of income producing real property. However, FSSA included in its State Plan Amendment submitted to CMS a request to retain its pre-June 1, 2014 real property rules. There was no change in the real property rules after June 1, 2014.

Real property owned jointly with rights of survivorship is unavailable. A joint owner should not be required to offer jointly owned property for sale or rent since the applicant does not have the unrestricted right to dispose of his or her share of the property. This applies so long as the other joint owner is not financially responsible for the applicant, that is, not a parent of a minor child or a spouse. The DFR will require that statements be obtained from the joint owners concerning their willingness to agree to sell the property. So long as the joint owners state that they are not willing to sell the property, it should not be considered available. If the joint owners are willing to agree to sell the property, then it must be listed for sale. IHCPPM §2605.10.05. See also SSA POMS § SI 01130.130, which provides "the value of an individual's ownership interest in jointly owned real property is an excluded resource for as long as sale of the property would cause undue hardship, due to loss of housing, to a co-owner."

An applicant or recipient with a life estate interest that is not exempt, because it is not the home and is not producing income, will need to place the life estate interest for sale or rent at fair market value. Although it typically will not be possible to find a purchaser for a life estate, a good faith effort must still be made. It may be necessary to find a renter to at least cover the costs of owning the property.

A question can arise about how real property held in another entity, such as a trust or corporation is treated. IHCPPM § 2605.05.00 defines real property as "land, including buildings or immovable objects attached permanently to the land. Real property also includes life estates, remainder interests, and mineral rights." This Section does not address real property held in a trust or a corporation. Appendix I is a 1998 letter from an FSSA staff attorney stating that farm property in a closely held farm corporation is treated as real property, not as stock. Elder law attorneys have relied on this letter to submit that the rules on real property should be applied to real property held in a corporation or trust.

### 1. Home (IHCPPM §2620.15.10)

The home is exempt when it is the principal residence of the applicant/recipient or spouse, minor children, adult disabled or blind children, or parent(s) if the applicant/recipient is a minor.

The home is defined as the shelter, the land on which the shelter is located, and related outbuildings. Surrounding land must be adjacent to the plot on which the home sits, though it can be separated by a road. The shelter can be either a house or a house trailer. A mobile home sitting on a rented lot will be treated under this Section so long as it serves as the home. See IHCPPM § 2615.60.25.

The home remains exempt if one of the persons listed above intends to return to live there. If a person enters a nursing home, the home continues to be exempt for so long as that person intends to return home. There is no time limit on this type of exemption. The DFR can, however, require verification from the person's doctor that return to the home is a possibility. It should be sufficient if the doctor verifies in writing that it is possible that the person will be able to return home. If it is not possible that the person will ever be able to return home, then the home is no longer exempt and must be offered for sale or rent. Although not always consistent, the DFR at times has been unwilling to extend this protection to a mobile home on a rented lot, taking the position that it is countable as personal property when it is no longer serving as the current residence.

There is a limit on home equity for some persons. 42 U.S.C. § 1396p(f), added by the DRA, provides that a person is not eligible for Medicaid to pay for nursing home care or waiver services if the person's equity in the home exceeds $500,000, as adjusted by the consumer price index. The cap for 2022 is $603,000. IHCPPM § 3005.10.05. States have the option to raise the cap to as much as $750,000, but Indiana has not chosen a higher cap. The cap does not apply if the individual's spouse or minor, blind, or disabled child is living in the home. The cap is implemented at IHCPPM § 2640.10.15.06. This is processed like a transfer penalty, as a notice is issued that Medicaid is approved but payment will not be made for nursing home care or for waiver services. The period of ineligibility for payment for nursing home care or waiver services continues for so long as a home with equity above the limit is owned.

42 U.S.C. § 1396p(f)(4) directs HHS to establish a process whereby the home equity cap can be waived in the case of a demonstrated hardship, but HHS has not developed a process. Since FSSA treats this limit like a transfer of property penalty, one can submit that the Transfer Penalty Hardship Exception in IHCPPM § 2640.10.40 should apply to home equity penalties. The home equity cap is a high cap which should affect few Hoosiers.

There is no limit on the equity of real property which is not the home.

### 2. Income Producing and Other Exempt Real Property (IHCPPM §2620.15.20 and §2620.20.00)

Real property is exempt if it produces income greater than the expenses of ownership. Expenses include real property taxes, home owner's insurance, repairs, and interest (but not

principal) payment on indebtedness. IHCPPM §3420.05.05. No minimum net income is required; the property need not be producing fair market rent. However, if property is rented for less than fair market value, a transfer penalty can be assessed. See Section XIII(F)(9), *below*. The interest payments under a land sale contract are considered as income, so property sold by a land sale contract is considered to be income producing property. The down payment is counted not as income, but only as a resource. The interest portion of ongoing payments are counted as income, while the principal portion of ongoing payments once received are a resource. IHCPPM § 2615.55.15.

Real property which is used to produce food for home consumption is exempt. IHCPPM §2620.15.25.

Burial plots are exempt. IHCPPM §2615.20 .20.10.

### D. Long Term Care Insurance Program (IHCPPM § 2615.25.15)

The Long Term Care Insurance Program is designed to encourage Hoosiers to purchase long term care insurance policies, with the goal of lessening the burden on Medicaid for covering long term care expenses. The Program provides incentives to purchase policies by exempting some assets when determining Medicaid eligibility, and exempting those assets from estate recovery, for persons purchasing qualified policies, commonly referred to as "Partnership" policies. Persons can currently receive either dollar for dollar or total asset protection, which is discussed below.

**The 2021 Indiana legislature enacted a new Program that does not include total asset protection polices. This Program, described below, has not yet been implemented; it will only be implemented if approved by CMS.**

Although FSSA now has a very good Long Term Care Insurance Program, the current market for long term care insurance policies is depressed. Prices for new policies have increased. The increased rates are the result of low interest rates, lower lapse rates than estimated, and overall mis-pricing. Policies blending long term care and life insurance have become more popular. Persons who already have long term care insurance policies will receive benefits, but policies may not be feasible for new customers. Only a few stand-alone policies are now being sold. Nationally, 516,809 policies including long term care coverage were sold in 2019, but only about 57,000 of those policies were policies with stand-alone long term care coverage. brokerworldmag.com/2021-milliman-long-term-care-insurance-survey.

#### 1. The Current Program

**FSSA, as required by I.C. § 12-15-1.3-22, has asked CMS to approve a new program, described in Section 2, below, to replace the current program. I.C. § 12-15-1.3-22(a)(3) provides that FSSA is to seek the explicit concurrence of CMS that policies purchased under the current program, including total asset protection policies, will still receive the intended asset protection even once the current program is ended. If CMS does not approve this, then FSSA is not to proceed with the new program; instead FSSA and the**

**Department of Insurance are to study ways to improve the affordability and cost effectiveness of the current program.**

Indiana was a national leader in adopting a Long Term Care Insurance Program. The 1991 Indiana legislature approved an "asset disregard" for persons who purchase a qualified long term care insurance policy approved by the Indiana Department of Insurance. I.C. § 12-15-39.6. For every dollar of benefits paid out under an individual's long term care policy for Medicaid eligible long term care services, that person's resource limit increases by the same amount. Indiana's plan, approved by HHS, went into effect May 1, 1993.

After Indiana adopted its program, federal law was changed to prohibit other states from adopting similar programs. For many years, Indiana, California, Connecticut, and New York were the only states with this type of Program.

The 1998 Indiana legislature amended the program to provide for "total asset protection," so that a person who purchases a qualified policy with a certain maximum benefit would have no resource limit when applying for Medicaid after the policy had paid out the maximum benefits provided by the policy. Originally, to receive total asset protection, a policy was required to provide maximum benefits of at least $140,000 and provide that the daily benefit increases by at least 5% per year. Beginning January 1, 1999, the maximum benefit amount needed to obtain total asset protection increased by five per cent a year compounded annually. I.C. § 12-15-39.6-10. A person who purchases a qualified policy meeting the maximum benefit criteria has no resource limit once the policy has paid out the maximum benefit amount. The maximum benefit amount required to obtain total asset disregard is:

| | | | | | |
|---|---|---|---|---|---|
| 1998 | $140,000 | 2008 | $228,045 | 2018 | $371,462 |
| 1999 | $147,000 | 2009 | $239,447 | 2019 | $390,035 |
| 2000 | $154,350 | 2010 | $251,419 | 2020 | $409,537 |
| 2001 | $162,068 | 2011 | $263,990 | 2021 | $430,014 |
| 2002 | $170,171 | 2012 | $277,190 | 2022 | $451,515 |
| 2003 | $178,679 | 2013 | $291,050 | 2023 | $474,091 |
| 2004 | $187,613 | 2014 | $305,603 | | |
| 2005 | $196,994 | 2015 | $320,883 | | |
| 2006 | $206,844 | 2016 | $336,927 | | |
| 2007 | $217,186 | 2017 | $353,773 | | |

One could reach the 2022 maximum benefit threshold by purchasing a policy that will pay at least $250 per day for 5 years. Insurance companies typically offer daily benefit amount options in increments of $10.

Example:

John, single, wants to be able to protect $100,000 of assets should he need long term care. He purchases a qualified Partnership policy with a $100,000 maximum benefit. He enters a nursing home and his policy pays out $100,000 for his nursing home care. Once the policy pays out $100,000, his resource limit when he applies for Medicaid will now be $102,000 rather than $2,000. He will be eligible

for Medicaid when his countable resources are less than $102,000 on the first day of a month. If John has a million dollars and wants to protect all of his assets, he could instead purchase a policy that will qualify for total asset protection once the policy has paid out the maximum benefit.

The 2015 Indiana legislature addressed an issue related to the treatment of resources of married persons with a "Partnership" policy. A "Partnership" policy protects not only the assets of the policy holder, but also those of the policy holder's spouse. I.C. § 12-15-39.6-10(b)(2) provides that "if the assets owned by the individual's spouse are included in the individual's eligibility determination, include the assets of the individual's spouse in the asset disregard adjustment." IHCPPM § 2615.25.15 applies asset protection to a policy owned by a spouse. Both spouses of a married couple need to have policies in order to have full protection. If only one spouse has a policy, and the spouse without a policy needs long term care, then there will be no asset protection.

The asset protection provided by Partnership policies applies to the home equity limitation discussed in Section C(1), *above*. IHCPPM § 2640.10.15.06 states: "Additionally, the amount of [home] equity that would fall under the asset protection of a long term care partnership policy reduces the amount of the [home] equity in excess of the limitation." Thus, a person with full asset protection is not subject to the home equity limitation.

Not every long term care insurance policy qualifies for asset protection. Only policies which meet the requirements listed in 760 IAC 2-20 qualify. The policy must state whether it qualifies under this program. Only two insurance companies, Bankers Life and Casualty Co. and Thrivent, are currently selling Partnership Policies. Genworth Life Insurance Company and TransAmerica Life Insurance previously sold approved policies.

The Indiana Department of Insurance determines which policies qualify, and policies must state whether they qualify for protection under the program. Some of the requirements for qualified policies include:

- Policy must cover at least a year of nursing home care;

- Home and community care, as well as nursing home care, must be offered, though the purchaser can choose to exclude home and community care;

- Maximum policy benefits must be stated in dollars, not days;

- Daily nursing home benefits must be at least 75% of the average private pay rate, while daily home care benefits must be at least 50% of the daily nursing home benefit;

- The policy must include inflation protection. If CMS does not approve the new Program, the Department will likely propose changes to the inflation protect for dollar-for-dollar protection policies in an effort to make those policies less costly.

• Premiums must be based on the issue age of the policyholder and cannot increase strictly due to the policyholder's advancing age.

Once benefits begin to be paid out under a qualified policy, the insurance company must keep track of the amount of additional assets the policyholder can protect and must regularly report that to the policyholder. The policyholder can then regularly determine his or her resource limit, as that limit rises as benefits are paid out.

The DRA amended federal law at 42 U.S.C. §1396p(b)(1) and (5) to allow any state to adopt a partnership plan. Every state except Alaska, Massachusetts, Mississippi, and Vermont have adopted a plan. Federal law now only provides for dollar-for-dollar asset protection, not total asset protection as permitted in Indiana. Indiana's total asset protection is protected by a grandfather clause but is not honored in reciprocity agreements Indiana has joined the National Reciprocity Compact to grant total reciprocity for mutual asset protections for states that belong to the Compact. See nyspltc.health.ny.gov/reciprocitymap.htm for a map of the states which accept reciprocity. All states with plans except for California belong to the Compact. An Indiana resident with a Partnership Plan with total asset protection who moves to another Compact state will receive dollar for dollar protection but not total asset protection. If a person with a partnership plan moves to another state that does not belong to the Compact and loses Indiana's asset protection, the policy will still pay benefits.

The most recent statistics available are from 2017. As of December 31, 2017, 57,982 partnership policies had been sold in Indiana, with 42,408 still in force then. Only 93 policies were sold in 2017. 184 policyholders had exhausted policy benefits, with 50 or more of those going onto Medicaid. The program states that $230,222,052 of assets have been protected by partnership policies. Unofficial figures show just 78 policies sold in 2018, 81 policies sold in 2019, and 29 policies sold during the first nine months of 2020.

Further information is available from the Indiana Long Term Care Program office at 1-866-234-4582 or on its web site at www.in.gov/iltcp.

### 2. New Program Proposed by 2021 Indiana Legislature

Because of concerns that Indiana's current program has too stringent of requirements for policies, limiting the numbers of policies marketed and sold in Indiana, the 2021 Indiana legislature enacted Pub. Law 196-2021 to establish a new long term care insurance program. The new Program will go into effect only if and when it is approved by CMS. As of publication of this Manual, it is not known if CMS will approve the new Program, due to its concerns about not allowing new customers to purchase total asset protection policies while grandfathering in previously purchased total asset policies.

Pub. Law 196-2021 provides the following:

• FSSA was directed to apply for approval of the long term care insurance program described in new chapter I.C. § 12-15-39.8.

• The current program provided under I.C. § 12-15-39.6 will be discontinued if and when the new program is fully implemented.

• FSSA is to seek the explicit concurrence of CMS that policies purchased under the current program, including total asset protection policies, will still receive the intended asset protection even once the current program is ended. If CMS does not approve this, then FSSA is not to proceed with the new program; instead it and the Department of Insurance are to study ways to improve the affordability and cost effectiveness of the current program.

• The new program was to apply to policies issued or renewed after June 30, 2022, but that date appears unlikely because CMS approval has not yet been received.

• Policies sold under the new program must meet the definition of a qualified long term care insurance contract under 26 U.S.C. § 7702B and meet the model regulations and requirements of the model act of the National Association of Insurance Commissioners.

• For inflation protection, a policy sold to a person under age 61 must include compound inflation protection, a policy sold to a person between ages 61 and 76 must contain "some level of inflation protection," and a policy sold to a person over age 76 need not contain inflation protection.

• FSSA is to administer the program in accordance with the provisions of the DRA.

It is disappointing that the new program, if approved, will not allow total asset protection policies.

### E. Spousal Impoverishment Rules for Married Institutionalized Persons and for Married Persons Receiving Waiver Services with a Community Spouse.

The federal Medicare Catastrophic Coverage Act of 1988 (MCCA) contains provisions designed to protect a spouse living at home (community spouse) from becoming impoverished before the spouse in a nursing home can receive Medicaid. Even though the Medicare provisions of that Act were later repealed, the Medicaid provisions were retained. Congress made these provisions mandatory for all states. These provisions are referred to as the **"spousal impoverishment"** rules. These rules are much more favorable to applicants and recipients than the regular resource rules. These rules only apply when one spouse is in the community (not in a nursing home or hospital) and the other spouse is in a nursing home or hospital or receiving waiver services.

42 U.S.C. § 1396r-5 as originally enacted made it optional for states to apply spousal impoverishment rules to married persons receiving or applying for waiver services. Although optional, Indiana has for many years applied the spousal impoverishment rules to waiver services. Congress has now made this mandatory for the states.

Same sex married couples are entitled to the benefits provided by the spousal impoverishment rules.

### 1. Applies Where There is an "Institutionalized Spouse" and a "Community Spouse."

The federal statute at 42 U.S.C. § 1396r-5 establishes the "spousal impoverishment" rules. Section 1396r-5(h) defines "institutionalized spouse" and "community spouse" as follows:

> (h) Definitions. In this section:
>
> > (1) The term "institutionalized spouse" means an individual who--
> >
> > > (A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI) [42 U.S.C. § 1396a(a)(10)(A)(ii)(VI)], and
> > >
> > > (B) is married to a spouse who is not in a medical institution or nursing facility;
> > >
> > > but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.
> >
> > (2) The term "community spouse" means the spouse of an institutionalized spouse.

The reference in 42 U.S.C. § 1396r-5(h)(1)(A) to section 1902(a)(10)(A)(ii)(VI) [42 U.S.C. § 1396a(a)(10)(A)(ii)(VI)] is a reference to a waiver program such as Indiana's Aged & Disabled Waiver. Indiana includes persons on the Aged & Disabled, the Traumatic Brain Injury, the Community Integration and Habilitation, and the Family Supports Waivers as "institutionalized spouses." Since a person must meet nursing home level of care to qualify for a waiver, it makes sense to apply these rules to persons on the waiver. Persons on the Money Follows the Person program or in a PACE program also qualify as institutionalized. A "medical institution" is a hospital or psychiatric facility. Most persons do not have a hospital stay of more than thirty days, but such stays qualify as an institutionalization for the spousal impoverishment rules.

FSSA states that the spousal impoverishment rules apply when one spouse is in a nursing home or on a waiver and the other spouse is in the community (not in a nursing home) and not on a waiver. The spousal impoverishment rules do not apply if both spouses are in a nursing home, both spouses are on a waiver, or one spouse is in a nursing home and the other spouse is on a waiver. IHCPPM § 3005.10.00.

An argument can be made, based on the definitions of "institutionalized spouse" and "community spouse" in 42 U.S.C. § 1396r-5(h), that the spousal impoverishment rules should apply when one spouse is in a facility and the other spouse is on a waiver or when both spouses are on a waiver. Although it seems odd, when both spouses are on a waiver, the definitions seem to say that each spouse is an "institutionalized spouse" and each spouse is a "community spouse"

to the other spouse. That is, it appears that each spouse qualifies as both an "institutionalized spouse" and a "community spouse." FSSA does not accept this position. FSSA's policy is potentially subject to challenge, but there may be little gained from a successful challenge, as a spend down of resources would still be required after initial eligibility was established.

The community spouse does not need to be in a residence in the community to be a community spouse. Suppose both spouses are in the same apartment in an assisted living facility with one spouse having been approved for the waiver. The non-waiver spouse qualifies as a community spouse. The same result does not apply if both spouses are in a nursing home, with one spouse approved for Medicaid, because a spouse in a nursing home cannot be a community spouse. But see below where a community spouse who is only temporarily institutionalized can still be treated as a community spouse.

To be considered "institutionalized," the institutionalized spouse must be institutionalized for at least thirty days or at least be likely to be in a facility at least that long. IHCPPM §2635.10.10. Where a person does not remain in the facility for thirty days, such as because of death or an unexpected fast recovery, but was expected at the beginning of the stay to remain for thirty days, the test is met. CMS State Medicaid Manual §§ 3260 and 3260.1.

One meets the test of being "institutionalized" even if one is not in a certified Medicaid bed. *Gee v. Dep't of Soc. Servs.*, 207 S.W.3d 715, (Mo.App. 2006). Neither IHCPPM § 2635.10.10 nor 42 U.S.C. §1396r-5 requires that the nursing home or the bed itself be certified for Medicaid. Although Medicaid will not cover the nursing home per diem expenses unless one is in a Medicaid certified bed, one can still be approved for Medicaid to cover other expenses.

The rules do not protect a spouse when both spouses are living at home, unless one of the spouses is receiving waiver services. As explained above, an argument can be made that the rules should also protect spouses when both spouses are receiving waiver services.

Similarly, the spousal impoverishment rules do not apply if both spouses reside in a nursing home. But see *Maples v. Dept. of Social Services*, 11 S.W.3d 869 (Mo.App. 2000), where the court held that the spousal impoverishment rules continued to apply even after the community spouse was institutionalized. *Maples* did not base its reasoning on whether the community spouse only intended to remain in a nursing home temporarily or indefinitely. In either situation, *Maples* says the community spouse continues to be a community spouse after institutionalization and the spousal impoverishment rules still apply. This decision has been followed by Indiana Administrative Law Judges where the community spouse entered a nursing home temporarily but planned to return home. ALJs have accepted the position that a community spouse who intends to return home continues to be a community spouse during the temporary nursing home stay. It is not clear if Indiana ALJs would be willing to apply this reasoning where the community spouse does not intend to return home.

Even if the spouses were separated for non-medical reasons before the institutionalization, the DFR applies the spousal impoverishment rules, since the federal definitions do not account for a separation. 42 U.S.C. § 1396r-5(h). This is different than when both spouses are in the community, where they are treated as if they are single if they are separated for non-medical reasons.

Example:

Fred and Wilma have been separated for several years because they have gone their separate ways, but they are still married. Fred applies for Medicaid while living at home, not on a waiver. Wilma's assets are not considered, and Fred is treated the same as if he were single, with his eligibility determined based on his resources. However, if he enters a nursing home, now Wilma is considered as a community spouse, and FSSA will request information on her assets. If Fred is already on Medicaid when he enters a nursing home, the DFR may not identify this as a "spousal" case until an annual review is held.

If a person on the BPHC program, which has no asset limit, is approved for the waiver program, the individual must meet the waiver resource rules discussed below in order to qualify for Medicaid coverage of waiver services. IHCPPM §§ 3305.00.00 and 3350.05.00.

**2. Applies to a Married Person Institutionalized on or after September 30, 1989**

States must apply the spousal impoverishment resource rules when a spouse at home ("community spouse") has a spouse who begins a "continuous period of institutionalization" on or after September 30, 1989. §303(g)(1)(B) of MCCA, reprinted as note to 42 U.S.C. §1396r-5. A "continuous period" is thirty consecutive days. MCCA does not define how long a person must be out of institutional care to break a continuous period of institutionalization. Indiana requires thirty days out of institutional care to break a continuous period. Someone who entered a nursing home before September 30, 1989 and who has remained there can gain the benefits of the spousal impoverishment rules only by leaving the facility for at least a thirty day period.

An institution includes a nursing home or a hospital. A person at home receiving waiver services is also treated as being in an institution.

**3. The "Snapshot Date" Must be Determined.**

The rationale for the spousal impoverishment rules is that the amount of resources the community spouse can keep depends on the amount of resources the couple has when the institutionalized spouse first enters an institution or is approved for a waiver. The process of assessing the resources is referred to as taking a "snapshot" of the resources on the day of institutionalization.

Resources are counted (or a "snapshot" of resources taken) at the beginning of a continuous period of institutionalization. 42 U.S.C. §1396r-5(c)(1)(A). This is true whether or not the resident is then applying for Medicaid. IHCPPM §2635.10.10.05 states that resource values must be assessed "as of the first date of continuous institutionalization, whether it is in a hospital or nursing facility." So, if a person enters a hospital and then a nursing home, the resources are to be assessed upon the date of admission to the hospital, not the nursing home.

A snapshot is only taken for the resident's **first** institutionalization of at least thirty days beginning on or after September 30, 1989. Earlier institutionalizations are not considered in

determining the snapshot date. Suppose a person enters a nursing home after September 30, 1989, establishes a resource amount for the community spouse, reduces resources, qualifies for Medicaid, and then improves and returns home. If that person needs to later reenter the nursing home, must that person again go through the same process to establish Medicaid eligibility, potentially resulting in a one-half reduction of the community spouse's resource allowance? Section 1396r-5(c)(1) states that only one snapshot is taken. This applies even if the person did not apply for Medicaid for the first institutionalization. Suppose Bob, married, went into a hospital for thirty one days in 1990 and then lives at home until 2021, when he enters a nursing home. His snapshot date is the date he was hospitalized in 1990, not when he entered the nursing home in 2021. **Therefore one should carefully question applicants about any periods of institutionalization lasting thirty days or more and beginning on or after September 30, 1989.**

If the person has a snapshot date in the distant past, it can be difficult to verify the snapshot amount of resources. Financial records are often not readily available, even from financial institutions. If the records are not available, then the DFR should accept the applicant's statement as to the value on the snapshot date. IHCPPM §2015.05.00; §2025.10.00.

**Advocacy Tip: If one is meeting with a client and learns that the client had an institutionalization of more than thirty days beginning on or after September 30, 1989, advise the client to obtain and keep records showing the snapshot date resource amount if there is any possibility the client may need to apply for Medicaid in the future.**

If the wife has been institutionalized and later returns home, and then the husband enters a nursing home, does the wife's earlier entry date qualify as the snapshot date, or is the snapshot date the date when the husband is first institutionalized? Although it would be logical to use the wife's snapshot date for the husband, the federal law and the IHCPPM base the snapshot date on the first period of institutionalization of the "institutionalized spouse," which in this example is the husband.

For a waiver services recipient or applicant, determining the "snapshot" date is more complicated. If the person is already in a nursing home or has a prior nursing home, or hospital, stay of at least thirty days that began on or after September 30, 1989, then the beginning of that institutionalization is the snapshot date. If the person does not already have a snapshot date, then the snapshot date is the date the waiver Service Plan is approved or the date the Medicaid application is filed, whichever is later. IHCPPM §3320.05.00 (this Section refers to the date the Cost Comparison Budget (CCB) is approved; the Division of Aging has replaced CCBs with Service Plans). The area agency aging case manager can confirm the Service Plan approval date.

If a person who is approved for a waiver slot applies for Medicaid, is denied, and then reapplies, FSSA uses **the date of the current, active application** as the snapshot date rather than the earlier application date. This means that a waiver applicant can have more than one snapshot date, which is counter intuitive. The same result can occur if the waiver slot expires before Medicaid is approved. If the waiver slot expires and the Division of Aging issues a new slot, then the latter approval date will likely be treated as FSSA as the snapshot date. It is important to work with the area aging agency to keep the slot active until Medicaid is approved. For waiver applicants, it is very important to carefully assess the resources and to provide all

requested verifications in order to avoid the need to reapply, which could disrupt a Medicaid plan.

If a waiver spouse needs to spend down resources to be eligible for Medicaid, the result will be that the applicant will not be eligible for the month of application but plans to be eligible the month after application. It is imperative that the DFR consider eligibility not just for the month of application but also for the following month.

Example:

> Wilma seeks waiver services. She and her husband Fred have $200,000 of countable resources when she is approved for a waiver slot on April 3. She and her husband plan to spend down resources so that she will be eligible effective May 1. She applies for Medicaid on April 15 while they still have $200,000 of countable resources. Her snapshot date is April 15. If the DFR only considers eligibility for April and denies the application, then when she re-applies there will be a new snapshot date and a further spend down will be required. Wilma should provide verification of her resources on May 1 and explain that she is seeking eligibility for May 1 forward. The DFR will then determine eligibility for May.

When one is doing a spend down, it is recommended that one file the application around the 15th of the month or after so that one will be able to obtain verifications of the resources for the following month when verifications are submitted.

For a PACE applicant, the institutional status is established by the approval for the PACE program. The snapshot date is then the date of the approval for PACE or the date of Medicaid application, whichever is later, provided there was not a previous nursing home or hospital stay of thirty or more days. IHCPPM § 3380.15.00.

#### 4. The Total Countable Resources on the Snapshot Date are used to Compute the Community Spouse's Resource Allowance.

Once the "snapshot date" has been determined, then one must total the countable resources on the snapshot date. Countable resources in the name of either or both spouses are considered. But see below for real estate solely owned by the community spouse. Resources are either countable or exempt using the regular rules outlined in Subsection B above, with three exceptions. See also Subsection a, immediately below, for a possible fourth exception for community spouse retirement accounts.

- The equity value of any non-exempt real estate owned solely or jointly by the institutionalized spouse is counted, but **any real estate owned solely by the community spouse does not count**. IHCPPM §2635.10.10.05. Advantages can sometimes be gained by transferring property from joint ownership into the name of the community spouse.

  - The recent property tax assessed value or an estimate from a knowledgeable source, typically a realtor or appraiser, is used to determine value. IHCPPM § 2605.25.10.

- IHCPPM § 2605.25.10.10 contains a table to determine the value of life estate and remainder interests. The IHCPPM does not explain how to determine value for a joint life estate, such as a life estate owned by husband and wife. The DFR will typically use the table with the age of the youngest life estate owner. One can submit that the DFR should use the last-to-die remainder factor at www.irs.gov/retirement-plans/actuarial-tables using a 10% interest factor, since 10% is the rate the DFR uses for a single life.

• One vehicle of any value is exempt. IHCPPM §2635.10.10.05. There is no requirement that it be used for transportation by the applicant or a member of the household.

• Up to $2,000 of "separately identifiable funds or assets which have been set aside for burial can be excluded." IHCPPM §2635.10.10.05. This exemption applies to each spouse. This exemption refers to funds in a revocable account which are designated as being for burial. The $2,000 maximum is reduced by the face value of any life insurance exempt under IHCPPM §2615.25.05.15 and by the amount in any irrevocable funeral trust. The limit is $1,500 in non-spousal cases. IHCPPM § 2615.20.05. This exemption will not be used often, as one will typically set aside funds irrevocably for burial or funeral, in which case the $2,000 limit will not apply.

Once it is determined what resources count on the snapshot date and they are valued, one can calculate the presumptive community spousal share. The spousal share is one-half of the total countable resources, with a minimum in 2022 (often referred to as the "floor") of $27,480 and a maximum (often referred to as the "ceiling") of $137,400, as follows:

- If the total resources exceed $274,800, the community spouse's share is $137,400;

- If the total resources are greater than $54,960 but not greater than $274,800, the community spouse's share is one-half the resources;

- If the total resources are $54,960 or less, the community spouse's share is $27,480. (If the resources are less than $27,480, the community spouse can keep them all.)

These amounts are indexed to inflation and adjusted on January 1 of each year. The amounts were originally $12,000 and $60,000 in 1989; they are adjusted each January 1st using the Consumer Price Index, if this results in an increase. Even though the community spouse resource allowance is based upon the total resources on the snapshot date, the floor and ceiling amounts in effect at the time of application control.

Either spouse can request the DFR to assess the resources upon admission to the nursing home, even if an application for Medicaid is not being made then. IHCPPM §2635.10.10.05. The couple will then have an official determination of the value of their resources, so that they will know how much their resources must be reduced to become eligible. A sample assessment form is attached as Appendix J. The couple is not obligated to request such an assessment. Attorneys who work with clients in Medicaid pre-planning often find it useful, **if not better**, to complete

an assessment form themselves. If no assessment upon admission is requested, resources will then be assessed once a Medicaid application is made. If an assessment is done without an accompanying Medicaid application, then there is no right to a fair hearing to contest the DFR's assessment until a Medicaid application is actually made.

The amount as computed above can be increased by court order or by a fair hearing.

### a. Community Spouse Retirement Accounts

As explained in Section VIII(B)(4)(b), above, a qualified retirement account owned by an ineligible spouse is not counted as a resource. Based on this, once Indiana became an SSI state in 2014, the DFR did not count an IRA or other qualified retirement account owned by a community spouse as a countable resource at the snapshot date or at the eligibility date.

In January, 2020, with no advance notice, the DFR suddenly began counting a community spouse's retirement accounts. After the NAELA Chapter protested, the DFR suspended the change but stated that it still intended to proceed with this change in policy. It stated that it did not intend to promulgate a rule but instead intended to revise the IHCPPM in June, 2020 and begin counting community spouse accounts on July 1, 2020. The NAELA Chapter provided the DFR with its objections to this change and continued to assert that, even if a change can be made, the DFR must do it through a rule change for the reasons in Section III, below. The DFR agreed to review NAELA's response before proceeding. **The DFR then agreed not to change its policy until it goes through the rulewriting process.** The DFR may have agreed in part because it cannot adopt more restrictive eligibility rules during the COVID pandemic. The DFR has not yet published any notice of intent to promulgate a rule and has indicated that it is still considering the NAELA Chapter's objections to the counting of qualified retirement accounts owned by a community spouse.

Some states count community spouse retirement accounts in spousal cases, while some do not. The ones that count these accounts reason that because the community spouse is allowed to keep a resource allowance, the retirement account should go into the pot with the other assets, and the community spouse will still be allowed to keep a share as determined by the allowance. Other states either view the community spouse's accounts as protected due to the SSI rules or they recognize that the accounts should be looked at differently because the funds are specifically set aside for retirement and because there can be serious tax consequences if the account(s) must be liquidated suddenly.

The case law is split, with one case saying the community spouse's retirement accounts cannot be counted, two cases saying they do count, and two cases say it is up to the state to decide whether to count them.

- A Wisconsin appeals court decided a community spouse's IRA cannot be counted, because it is not countable under SSI, and the state must apply the SSI resource rules in spousal cases. *Keip v. Wis. Dep't of Health & Family Servs.*, 232 Wis. 2d 380, 606 N.W.2d 543 (Wisc. Ct. App. 1999).

• The 10th Circuit Court of Appeals decided that 42 U.S.C. § 1396r-5 is ambiguous and that it is the state's decision whether or not to count a community spouse's retirement account. *Houghton v. Reinertson*, 382 F.3d 1162 (10th Cir. 2004). An Arkansas appeals court agreed and ruled likewise. *Ark. Dep't of Human Servs. v. Pierce*, 2014 Ark. 251, 435 S.W.3d 469 (Ark. 2014).

• Ohio and New Jersey appeals courts decided that 42 U.S.C. § 1396r-5 requires that the community spouse's retirement account be counted. *Mistrick v. Div. of Med. Assistance & Health Servs.*, 154 N.J. 158, 712 A.2d 188 (N.J. 1998); *Martin v. State Dep't of Human Servs.*, 130 Ohio App. 3d 512, 720 N.E.2d 576 (Ohio Ct. App. 1998).

Each of these cases seeks to harmonize the language of 42 U.S.C. § 1396r-5. Although § 1396r-5(a)(1) says the section supercedes other sections, § 1396r-5(a)(3) says the section does not affect the determination of what constitutes a resource. That is, SSI methodology and standards apply. § 1396r-5(c)(5) says that "resources" do not include resources excluded under 42 U.S.C. § 1382(a) or (d). While community spouse retirement accounts are not specifically listed there, NAELA has asserted that the community spouse retirement accounts fall under § 1382b(a)(3)'s exemption of property essential for self support.

The DFR asserts that the SSI exemption for an ineligible spouse's retirement accounts does not apply because 20 CFR § 416.1202(a)(1), the SSI regulation containing the exemption for a non-eligible spouse, refers to a spouse "living with" a non-eligible spouse. The "living with" language is used because SSI rules do not count any resources of a spouse who is not living with the applicant spouse. When § 1396r-5 says to use SSI's resource methodology, it must be referring to the resource rules for spouses who live together; otherwise, none of the community spouse's resources would be counted. Thus, the phrase "living with" in 20 CFR § 416.1202(a)(1) does not show that it does not apply in the spousal impoverishment situation. *Keip* explained: "although it is true that the SSI rule which excludes an ineligible spouse's IRA as a countable asset applies only if the spouses are living together, that is because assets of the ineligible spouse are only deemed attributable to the eligible spouse if the couple is living together." 232 Wis. 2d at 395.

42 U.S.C. § 1396r-5 requires that none of the community spouse's income be counted. A qualified retirement account consists of income that was deposited into the account while working plus earnings on the account. A retirement account consists solely of income, so it is consistent with § 1396r-5 that it be fully exempt.

Even if FSSA at some time in the future begins counting retirement accounts owned by a community spouse, it cannot apply a new policy in cases where benefits have already been approved. Although *Houghton* allowed Colorado to count a community spouse's retirement accounts, it ruled that once the institutionalized spouse was found eligible, the state could not at annual review begin counting the accounts and make the institutionalized spouse ineligible.

For so long as a community spouse's retirement account is not counted, if a retirement account is transferred from the applicant spouse to the ineligible spouse, then it will no longer be a countable resource. One can file a legal separation action and seek an order to transfer a retirement account, such as an IRA, from the applicant spouse to the ineligible spouse. This is a

nontaxable transfer under 26 U.S.C. § 408(d)(6). A Qualified Domestic Relations Order (QDRO) is needed to transfer a qualified plan such as a 401(k), 403(b), or similar plan. A QDRO is not required for the transfer of an IRA, but one should talk to the IRA company to see what it will require for a transfer. The legal separation case can be dismissed once the transfer occurs.

**b. Usually, it Is Best to Keep Resources High for the Snapshot Date.**

There are various strategies couples can use to shelter resources. However, in most situations it is advisable to keep the amount of resources high at the date of the snapshot and then reduce the countable assets after the snapshot is taken. Since the community spouse's share depends upon how many resources the couple has when the snapshot is taken, the higher the countable resources on the snapshot date, the higher the community spouse's share. Although steps can be taken to shelter resources, most persons if given a choice prefer to have resources in a liquid form to use in whatever way desired. The community spouse's share of resources can be used however the community spouse desires. Most persons prefer to maximize the community spouse's share.

Examples:

Mr. Lincoln needs to enter a nursing home soon. Mr. and Mrs. Lincoln have $100,000 of countable resources. Mrs. Lincoln needs a new car, and she is interested in one she can purchase for $25,000. They owe $25,000 on their home mortgage. If she buys the car and pays off the mortgage before he enters the nursing home, the snapshot amount will be $50,000 and her share will be $27,480, the 2022 floor amount. If she waits until after Mr. Lincoln enters the nursing home to purchase the car and pay off the mortgage (or purchase funerals, purchase furniture, pay for home repairs, etc.), then the snapshot amount will be $100,000 and her share will be $50,000. The month after the car is purchased and the mortgage is paid, Mr. Lincoln will be eligible for Medicaid. By waiting until after Mr. Lincoln enters the nursing home to "spend down," Mrs. Lincoln's spousal share will be $50,000 rather than $27,480 and the spend down will result in eligibility.

Mr. Truman needs to enter a nursing home soon. He and his wife have $50,000 of countable resources and own their home. If Mr. Truman enters the nursing home now, his wife's share will be $27,480. If they were to take out a home equity loan of $50,000 before he entered the nursing home so that the countable resources are $100,000 on the snapshot date, Mrs. Truman's resource share would then be $50,000. Once Mr. Truman enters the nursing home, she could pay off the loan, the resources would be sufficiently reduced, and Mr. Truman could qualify for Medicaid the following month. Mrs. Truman could keep the remaining funds as her spousal share.

There are some exceptions to the general principle that one should keep resources high for the snapshot date. One exception to this advice is the situation in which the couple is able to reduce the countable resources to $29,480 (floor amount of $27,480 plus nursing home spouse's

maximum of $2,000) as of the first day of the month during which the spouse enters an institution. Then Medicaid can be obtained beginning with the first day of admission to the nursing home. At the other end of the scale, there is no benefit obtained from keeping resources worth more than twice the "ceiling" resource level, which is $137,400 in 2022. That is, if the couple has $274,800 or more, then the community spouse's resource share will be $137,400. Finally, if one anticipates being able to obtain a higher community spouse resource allowance through an administrative hearing or by a court order, then the community spouse's resource allowance will be dependent upon that process, not upon how many resources the couple has on the snapshot date.

### c. Increasing the Spousal Share By A "More Than Half Share" Administrative Hearing

Another way in which the spousal impoverishment rules are more favorable to applicants is that there are ways to obtain a higher spousal share than the amount listed by computing the one-half share. Even though the resource limit using the spousal impoverishment rules is much higher than the $3,000 resource limit for a married couple living in the community, the spousal share can potentially be increased by means of a successful administrative hearing or by a court order (described in the following subsection). The administrative hearing process provides a simple mechanism to raise the spousal share in some situations, but its use is limited to situations where the married couple has low income.

Federal law provides that either spouse can request a fair hearing to request a greater community spouse resource allowance. 42 U.S.C. §1396r-5(e)(2)(c) provides:

> If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

If the community spouse's income, including any interest or other income generated by the resources making up the spousal share, is less than her monthly income needs allowance (see Section IX(D)(3)(g), *below*), then the community spouse should be allowed to keep enough resources to generate the income needed to raise the income to the monthly needs allowance. DFR workers do not have the authority to apply this exception even though it involves a straightforward mathematical calculation. Instead, the law directs the Administrative Law Judges (ALJs) to make the determination. This important exception is commonly referred to as a "**more than half share**" appeal.

An important factor in determining whether the community spouse has sufficiently low income to qualify for a greater share is whether one considers only the community spouse's income, or whether one also considers the amount of the institutionalized spouse's income the community spouse will be allowed to keep as her spousal income allowance once Medicaid eligibility is established, as discussed below in Section IX(D)(3)(g). Before the enactment of the DRA in 2006, HHS gave states the option of counting the community spouse's income in either

way. The method of considering the potential allowance that the community spouse can receive after eligibility is approved is commonly referred to as the "income first" approach. The United States Supreme Court approved this approach in *Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 151 L. Ed. 2d 935, 122 S. Ct. 962 (2002). **In the DRA, Congress mandated that states utilize "income first" for persons entering a nursing home (or being approved for waiver services) on or after February 8, 2006. 42 U.S.C. §1396r-5(d)(6)**. Indiana did not use the "income first" position before the passage of the DRA, but it now applies this concept to institutionalized persons who became institutionalized on or after February 8, 2006.

Examples:

> Mrs. Carter entered a nursing home on April 1, 2022, while Mr. Carter remains at home. They have $100,000 countable resources as of her snapshot date. Suppose Mr. Carter has $1,200 of income. Using the formula as discussed in Section IX(D)(3)(g), *below*, suppose the DFR determines that his monthly income needs, including excess shelter expenses, are $2,500. Suppose also that the DFR determines that Mrs. Carter has income of $1,000 per month which can be allocated to her husband. With his and Mrs. Carter's income, he will still need another $300 per month of income to meet his needs. Suppose that the highest CD rate at her bank is 2%. At a 2% return, he would need to have $180,000 of assets to produce $300 of income (2% x $180,000 = $3,600 annual return; $3,600/12 = $300/mo income). Thus, an ALJ will find that Mr. Carter needs to keep all of the $100,000. Mrs. Carter will be eligible for Medicaid without needing to spend down resources to $52,000.
>
> Mr. and Mrs. Nixon (he in nursing home, she at home) have $100,000 countable resources as of the snapshot date. Using the formula as discussed in Section IX(D)(3)(g), *below*, suppose the DFR determines that her monthly income needs, including excess shelter expenses, are $2,200. Suppose also that she has income of $1,600 per month, and that Mr. Nixon has income of $1,000 per month. If Mr. Nixon entered the nursing home before February 8, 2006, the DFR will only consider Mrs. Nixon's income. The DFR will determine that she needs an additional $600 per month of income to meet her needs, and she should be allowed to keep enough assets to generate $600 per month of income. If Mr. Nixon entered the nursing home on or after February 8, 2006, the DFR will consider Mr. Nixon's income. Since he has sufficient income so that he can give her $600 per month once he is approved for Medicaid, the DFR will rule that she has no need to keep additional resources to generate additional income.

The result of the "income first" rule is that most married persons in a nursing home will not be able to utilize this approach. **It is much more of an option for waiver applicants**, because much less if any income of a married waiver applicant will be allocated to the community spouse. See Section IX(E)(1), below. One should be alert to this approach, since some couples, especially with a member on a waiver, will have low enough income to qualify using this. A benefit of this approach, where it applies, is that the community spouse does not need to convert resources into an exempt form, such as by purchasing an immediate annuity, but instead can keep resources in a liquid form.

An issue that can arise at a "more than half share" administrative hearing is the rate of return to use when computing the assets which the community spouse will need in order to generate sufficient income. Does one use this couple's rate of return or does one use some standard rate of return, such as the rate of return on long term certificates of deposit or on treasury notes? ALJs differ on this. If the couple is receiving a very low return, then one should be prepared to show the potential rate of return for a conservative investment, such as a long term CD at the couple's home bank. I.C. § 12-15-2-24(d) directs FSSA to adopt rules to determine how to calculate the amount of resources needed, but rules have not yet been proposed. If and when FSSA adopts rules, the rules may address the rate of return to use.

The process described above is the only basis for increasing the community spouse resource allowance above the presumptive share through a fair hearing. Although the calculation for a higher community spouse share is straightforward, this higher resource award can be obtained only through the fair hearing process. The federal statute specifically requires that a hearing concerning the determination of the community spouse resource allowance be held within thirty days of the request for the hearing. 42 U.S.C. §1396r-5(e)(2)(A). One may be able to dispense with the hearing. Because there are typically no facts at issue in a "more than half share" appeal, one may be able to enter into a stipulation of facts with the DFR, present the stipulation to the ALJ, and avoid the need for an in person hearing. It is useful to submit to the ALJ proposed findings such as the sample provided at Appendix K.

The community spouse's allowance is not limited to $137,400 in a fair hearing.

### d. Increasing the Spousal Share By Court Order

The other means of obtaining a larger share of resources for the community spouse than is provided by the formula described above is by a court order. Federal law provides that resources transferred to a spouse or family member pursuant to a court order of support are not counted. 42 U.S.C. §1396r-5(f)(3). Thus, a court order of support trumps the normal calculation of the community spouse's share. Where a guardianship exists, the probate court can be asked to enter an order setting aside a higher amount of resources for the community spouse. In the *Matter of Guardianship of Hall*, 694 N.E.2d 1168 (Ind. Ct. App. 1998), the Indiana Court of Appeals approved a distribution of guardianship assets to the community spouse based on the doctrine of necessaries.

Where a guardianship is not in place, can one spouse simply file an action for support against the other spouse, seeking an order concerning entitlement to and transfer of resources, relying on the common law duty of support? Arguably, a spouse can file an action for support relying on I.C. § 31-16-14-1. It refers to obtaining support "for the benefit of the dependent spouse and the dependent children in the custody of the dependent spouse." Although it refers to support for dependent children, it appears one can also use this Chapter when there is a "dependent spouse" but no dependent children. One needs to allege that "the other spouse has deserted the dependent spouse or dependent children without cause and without sufficient support." I.C. § 31-16-14-1(a)(1). The Chapter is directed at income support orders, not a division of assets, so it is not clear that a court would permit it to be used for the distribution of assets.

One may also be able to obtain an order to transfer resources for the support of the community spouse through a legal separation order under I.C. § 31-15-3. To obtain a legal separation, the court must find that conditions in or circumstances of the marriage make it currently intolerable for both parties to live together and that the marriage should be maintained. I.C. § 31-15-3-3. Once the transfer of resources is completed after an order of separation ordering the transfer of resources, then the separation can be dismissed.

In an unpublished decision issued April 25, 2011, the Indiana Court of Appeals agreed that a spouse can file a case relying on the common law doctrine of necessaries to divide income and resources, but it decided that an order was not appropriate in that case. It reversed a trial court's order granting a community spouse an increased resource and income allowance. *Roupp v. Roupp*, 2011 Ind. App. Unpub. LEXIS 545. The trial court ruled that $202,000 of the $222,000 should be awarded to the husband to meet his need for increased income to pay his assisted living costs. The trial court based the award on the amount of assets that would need to be amortized to produce the income the husband needed. FSSA intervened and appealed. Though the trial court's decision seemed logical, the Court reversed it. The Court agreed that the common law doctrine of necessaries could afford a cause of action to distribute marital assets in anticipation of a Medicaid application. It did not decide if a cause of action arises under the federal Medicaid statutory spousal impoverishment provisions. The Court decided that the trial court's decision did not follow the Indiana Supreme Court's dictates on the doctrine of necessaries in *Bartrom v. Adjustment Bureau, Inc.*, 618 N.E.2d 1 (Ind. 1993), where the Supreme Court rules that a financially superior spouse can be held secondarily liable for the necessary expenses of the financially inferior spouse. The Court of Appeals decided the husband could not rely on the doctrine of necessaries because he was the financially superior spouse and because his position relies upon speculation as to his future needs. The logic used in this decision seriously limits the possibility of relying on a court order. However, unpublished decisions cannot be relied on as precedent and cannot be cited in other cases. Ind. Appellate Rule 65(D).

It has not been determined if the DFR must be made a party to an action for division of the resources. It would seem that the DFR needs to be made a party to an action for a support order since the spouses will be claiming that the DFR will be bound by the order. On the other hand, the requirement in 42 U.S.C. § 1396r-5(f)(3) for the Medicaid agency to accept a court order says nothing about the Medicaid agency being a party.

The Attorney General's office in some cases took the position that a recipient cannot use a court order to increase the spousal share, but instead is limited to seeking an increase through the administrative hearing process. The federal statute appears to allow court orders as a separate means to increase the spousal share. *Roupp* did not address this argument because it ruled on other grounds.

FSSA may at some point promulgate rules to attempt to restrict the ability to obtain a court order which will be recognized by FSSA. I.C. § 12-15-2-24 refers to court orders in determining the community spouse's share as follows:

> (b)(3) An amount established by a court order or an administrative hearing if the community spouse's income is less than the minimum monthly needs allowance established under 42 U.S.C. 1396r-5(d)(3) and an increased amount is necessary

to increase the community spouse's income to the minimum monthly needs allowance.

...

(d) The office shall adopt rules under IC 4-22-2 to calculate the amount of resources necessary to provide income to the community spouse under subsection (b).

It is not clear if the phrase "if the spouse's income is less than ... " is also intended to modify "court order" such that a court order to award a higher resource amount will be honored only if more income is needed. If the phrase is intended to modify not only "administrative hearing" but also "court order," then that would be an effort to limit resource support orders to the same standard as "more than half share" administrative hearings, which are discussed in the section above. Because 42 U.S.C. § 1396r-5(f)(2)(A)(iv) provides that a court order for the transfer of resources from one spouse to the other is controlling when determining the community spouse allowance, it is questionable whether the legislature can limit what court orders will be recognized by Medicaid. Thus, it is more reasonable to construe this section to not limit a court's authority to issue a support order which will be controlling. It is also more reasonable to construe the section to limit FSSA's adoption of rules to administrative hearings.

One should be aware that when a court order is obtained, the DFR will typically not want to give it retroactive effect, but instead will only want to apply it beginning with the month after the decision is issued. To guard against this, one should ask the court to make its order effective no later than the first of the month in which one wants Medicaid to begin. One still may need to argue with Medicaid about the impact of the court order, but the court order should govern.

The community spouse's allowance is not limited to $137,400 in a court order.

### 5. The Resource Limit is the Community Spouse Resource Allowance Plus $2,000.

Once one has determined the community spouse resource allowance, then one can determine if the institutionalized spouse is resource eligible. The eligibility process is similar to that for other applicants, except that the resource limit for the couple depends on the community spouse's share. The resource limit (maximum) is then the community spouse's share plus $2,000 for the institutionalized spouse's share. The institutionalized spouse is in effect treated as a single person. If the couple's resources total less than this amount on the first day of a month, then the institutionalized spouse meets the resource test for that month.

Even though the institutionalized spouse's resource standard is based on the community spouse resource allowance plus $2,000 for institutionalized spouse's share, it is not necessary that the resources be divided so that the institutionalized spouse has no more than $2,000 of countable resources **at application**. In determining eligibility, resources held by either the institutionalized spouse, community spouse, or both, are considered. 42 U.S.C. § 1396r-5(c)(2). The test at application is simply whether the total countable resources are less than the resource

maximum. But see the following Section 6 for a discussion of whether this still applies when an institutionalized spouse who has previously been on Medicaid needs to reapply for Medicaid.

Examples:

Mr. and Mrs. Biden had countable resources of $60,000 on Mr. Biden's snapshot date, so Mrs. Biden's resource allowance is $30,000. Mr. Biden is eligible when their combined countable resources are less than $32,000 ($30,000 + $2,000) on the first day of a month.

Mr. and Mrs. Obama had countable resources of $40,000 when Mrs. Obama first enters a nursing home. Half of $40,000 is $20,000, which is less than the floor amount of $27,480. Mrs. Obama is eligible when their combined resources are less than $29,480 ($27,480 + $2,000) on the first day of a month. **A couple with countable resources of $29,480 or less will always meet the spousal impoverishment resource eligibility test.**

Mr. and Mrs. Kennedy had countable resources of $500,000 when Mrs. Kennedy entered a nursing home in July, 2012. Mrs. Kennedy wants to apply for Medicaid in 2022. Half of $500,000 is $250,000, which is more than the ceiling amount of $137,400. Note that the 2022 ceiling is used, even though the snapshot date was in 2012, because she is applying in 2022. Mrs. Kennedy is eligible when their combined resources are less than $139,400 ($137,400 + $2,000) on the first day of a month. **A couple with countable resources above $139,400 will never meet the resource eligibility test in the absence of a court or administrative order setting a higher community spouse share.**

If the limit would be met except for the equity value of non-exempt real estate owned solely or jointly by the institutionalized spouse, he or she is eligible if he or she agrees to offer the real estate for sale or rent. In other words, the "agree to sell or rent rule" applies to the Medicaid eligibility determination even though it is not used when the spousal share is calculated. IHCPPM §2635.10.10.10.

Example:

Mr. and Mrs. Clinton have countable resources of $100,000 on the snapshot date when Mr. Clinton enters a nursing home. The resources consist of a bank account of $20,000 and a vacation home jointly owned and worth $80,000. Mr. Clinton is eligible when their combined resources are less than $52,000 ($50,000 + $2,000) on the first day of a month. Because the value of the real estate places them above this limit, Mr. Clinton will satisfy the resource test if they agree to offer the vacation home for sale or rent. They can also reduce the amount of countable resources by transferring the vacation home into the name of Mrs. Clinton only. Once the vacation home is transferred into Mrs. Clinton's name, then the countable resources are only $20,000, well below $52,000.

Although the community spouse resource allowance is calculated at the time of admission, it does not come into effect until the institutionalized spouse becomes eligible for Medicaid. 42 U.S.C. §1396r-5(c)(2). This means that the community spouse resource allowance does not increase even if the resources increase in value after the institutionalized spouse enters the nursing home.

Example:

> Mr. and Mrs. Carter had $60,000 in countable resources when Mr. Carter entered a hospital for a forty day stay on April 15, 2000. Mr. Carter recovered, returned home, and went back to work. He again needs to enter a nursing home. Now Mr. and Mrs. Carter have $200,000 of countable resources. Because his snapshot date is April 15, 2000, resources must be reduced to $32,000 before he will be eligible. It does not matter that the resources have increased substantially since 2000 or that he is being treated much differently than a couple with identical assets with no prior institutionalization.

Once one shows upon application that the resource test has been met for a month, the amount of resources in subsequent months under consideration does not affect eligibility, because the community spouse's resources are no longer considered to be available. IHCPPM § 2635.10.10.10; 42 U.S.C. § 1396r-5(c)(4). Thus one should not be required to verify the amount of resources in the subsequent months, although the DFR typically requests verification of the resources in each of the months covered by the application. This is different than a non-spousal case, where resources need to be verified for each month being considered.

Examples:

> Sam, single, applies for Medicaid on May 7. Eligibility can potentially go back to February 1. Suppose his eligibility interview is held on May 15. The DFR will request verifications showing the resource totals on February 1, March 1, April 1, and May 1, since Sam must have less than $2,000 on the first of a month to meet the resource eligibility test for that month.
>
> Bill, married with a spouse at home, entered a nursing home in January and applied for Medicaid on May 7. Eligibility can potentially go back to February 1. Suppose the countable resources on the snapshot date were $70,000, so Bill is eligible when their combined resources are less than $37,000 ($35,000 + $2,000) on the first day of a month. If Bill shows that the total resources were less than $37,000 on February 1, then Bill will qualify for Medicaid for February forward, regardless of the amount of resources on the first day of the subsequent months. There should be no need for him to verify his resources for March, April, and May, since they will not affect his eligibility.

Once the snapshot is taken and the community spouse's share is established, then Medicaid eligibility can be obtained once the amount of resources are reduced to the community spouse's share plus two thousand dollars on the first day of a month. **There is no requirement that half of the resources be used to benefit the nursing home spouse**. So long as resources

are not improperly transferred to third parties, couples can reduce their assets in any way they desire. A common way to plan for Medicaid eligibility is to reduce countable resources by converting the resources into a form which does not count as a resource. To maximize the amount of resources which can be used to benefit the spouse at home, a couple can set aside one-half of the resources for the community spouse and then use the remaining resources to benefit the community spouse.

There are some very simple steps which can be taken to reduce assets. If the funerals are not already prepaid, then irrevocable funeral trusts for both husband and wife can be obtained. Burial spaces for immediate family members can also be purchased. See Section XIII(D)(4), *below.* Any debts can be paid, including any amount owing on the home. House repairs or improvements can be made. New furniture and clothes can be purchased, as these are exempt assets. Since the community spouse can have one vehicle of any value, he or she may wish to replace a car with a new vehicle.

Since real estate owned solely by the community spouse is not counted (IHCPPM §2635.10.10.05), non-exempt real estate can be sheltered by placing it into the name alone of the community spouse. Also, funds can be used to purchase real estate in the name of the community spouse.

Another way to reduce assets is to convert countable resources to income producing real estate. Since income producing real estate is not counted, rental real estate can be purchased in the name of the community spouse.

Since an irrevocable annuity is not an available resource, an annuity can be purchased in the name of the community spouse. The irrevocable annuity is not counted as a resource, and the community spouse can keep all of the income. Annuities are reviewed to ensure that they do not violate the transfer rules. See Section XIII(F)(3), *below*.

A promissory note is another potential tool, since a non-negotiable promissory note is not counted as a resource. IHCPPM § 2615.50.00. Promissory notes are reviewed to ensure that they do not violate the transfer rules. See Section XIII(F)(4), *below*.

*Hegadorn v. Dep't of Human Servs. Dir*., 503 Mich. 231, 931 N.W.2d 571 (Mich. 2019), held that an irrevocable "sole benefit trust" funded by the community spouse, which provided that the trustee would distribute principal to the spouse with the expectation that all the assets would be used during the spouse's lifetime, was not a countable resource for the applying spouse because the trust assets were available for use only by the non-applicant spouse. The Court reasoned that "the principal of an irrevocable trust generally will not be a resource available to either spouse according to 42 U.S.C. § 1396r-5(c), because such property is not held by either spouse." 931 N.W.2d at 581. Since it is held by a trustee and not by either spouse, it is not a countable resource in the eligibility determination. One should expect that FSSA would not be inclined to follow this reasoning, so that litigation would likely be needed to achieve the same result in Indiana.

In converting resources, one should consider the effect on the income calculations. If the community spouse has low income and can receive part of the nursing home spouse's income,

income from rental real estate or an annuity will reduce the income which can be transferred from the nursing home spouse to the community spouse.

Examples:

Mr. and Mrs. Grant have $50,000 when Mr. Grant enters a nursing home on May 9. Before the end of May, Mrs. Grant pays $5,000 on debts, purchases irrevocable funeral trusts for $10,000, and pays $8,000 to trade up to a new car. By June 1 their resources are reduced to $27,000. Mr. Grant is eligible for Medicaid on June 1, as Mr. Grant's resource limit is $29,480 (Mrs. Grant's spousal share of $27,480 plus $2,000).

Mr. and Mrs. Lee have $160,000 when Mr. Lee enters a nursing home on October 24. After institutionalization, Mrs. Lee immediately purchases real estate in her name for $80,000. The countable resources are now only $80,000, and Mr. Lee can qualify for Medicaid beginning in November. The same result could be reached by having Mrs. Lee use $80,000 to purchase a single premium immediate annuity. She also could loan $80,000 to a third party for a non-negotiable promissory note.

### 6. Once Eligibility Is Approved, Then the Resources must Be Divided Between the Spouses So That the Institutionalized Spouse Has No More than $2,000 in Countable Resources.

Once eligibility is established, then the community spouse's resource share must be placed in the sole name of the community spouse. IHCPPM § 2635.10.10.15; 42 U.S.C. §1396r-5(f)(1). The institutionalized spouse's countable resources must be reduced below $2,000. These transfers need not occur until after the institutionalized spouse is found eligible for Medicaid. The couple has ninety days after the eligibility determination to make any needed transfers. An extension can be granted if more time is needed. The notice approving the application for Medicaid will contain information about transferring resources to the community spouse. It will list an amount to be transferred from the institutionalized spouse to the community spouse; the amount listed is typically confusing. **The key is that sufficient resources must be transferred to the spouse at home so that the institutionalized spouse has no more than $2,000 of countable resources listed in his or her name ninety days after Medicaid eligibility is approved. Once ninety days have passed after eligibility is established, the institutionalized spouse will be treated like a single person, with a $2,000 resource limit.**

FSSA Policy has taken the position that a nursing home spouse only has one protected ninety day period during which to transfer resources, even if the spouse needs to reapply for Medicaid. Suppose Bob, a married nursing home resident, applies for Medicaid and is approved. Within ninety days of approval, Bob transfers resources to his spouse so that his resources are below $2,000. Suppose Bob then returns home, and he and his wife again commingle their assets. If Bob reenters a nursing home and again applies for Medicaid, FSSA's policy has been to require that Bob's resources be at or below $2,000 at application, rather than giving Bob and his spouse ninety days to divide the resources. The Indiana NAELA Chapter objected to this policy as being in conflict with 42 U.S.C. § 1396r-5. FSSA then asked CMS to review its policy.

CMS responded to FSSA that when an institutionalized spouse experiences a break in the institutionalization, goes off Medicaid and later re-enters a nursing home and applies for Medicaid, then that spouse will have a second protected ninety day period in which to transfer resources to the community spouse. CMS suggested the result may be different if the nursing home resident applies a second time for Medicaid without having had a break in the institutionalization, but it did not offer a definitive answer to that question since it was not asked by FSSA. FSSA has responded that it will follow CMS's guidance in cases where a resident has had a break in the institutionalization. FSSA will not grant a second protected period where there is no break in institutionalization.

Examples:

> Robert, married, enters a nursing home in 2010, has $100,000 in resources at his snapshot date, spends down below $52,000 (community spouse resource allowance of $50,000 + $2,000), is approved for Medicaid, and transfers resources to his wife during the ninety days after approval of his application. In 2012 he improves, returns home, and he and his wife again commingle their assets. In 2022, he returns to the nursing home and again applies for Medicaid. Once approved for Medicaid after having less than $52,000 in countable resources, he will have ninety days to transfer assets from his name to his wife.
>
> Mabeline, married, enters a nursing home, has $80,000 on her snapshot date, applies for Medicaid and is approved because total resources are below $42,000. Mabeline fails to transfer a life insurance policy with cash value of $3,000 to her wife. At recertification, Mabeline receives a termination notice because she has more than $2,000 in countable resources. Mabeline reapplies for Medicaid, she and her wife have total countable resources less than $42,000, but Mabeline still fails to transfer the life insurance policy to her wife. Arguably, Mabeline should be eligible for the initial month because total resources are below $42,000 and then ineligible for subsequent months because there is no protected period to transfer funds. IHCPPM § 2635.10.10.10; 42 U.S.C. § 1396r-5(c). FSSA is likely to deny eligibility even for the initial month, as it will likely require both that total resources be below $42,000 and that Mabeline's resources be below $2,000.

Once Medicaid eligibility is established, no resources of the community spouse are considered available to the institutionalized spouse. Thus, if the community spouse's resources increase in value **after** the institutionalized spouse is approved for Medicaid, the increased resources of the community spouse will not affect the eligibility of the institutionalized spouse. Also, any new resources which the community spouse obtains **after** the institutionalized spouse is on Medicaid will not affect the institutionalized spouse's Medicaid eligibility. For example, suppose the home is in the name of only the community spouse. It is exempt as long as she lives in it. The community spouse can sell the house once the institutionalized spouse is on Medicaid and keep all the proceeds without affecting the institutionalized spouse's Medicaid eligibility.

There is an important exception to the principle in the preceding paragraph. If the recipient spouse goes off Medicaid and later reapplies for Medicaid, then the application process starts over. Although the original snapshot date and amount is used, the resources of both

spouses, including any resources the community spouse obtained after eligibility was obtained the first time, are considered on the new application.

Example:

> Mr. and Mrs. Bush have countable resources of $70,000 on the snapshot date when Mr. Bush enters a nursing home, so Mrs. Bush's resource allowance is $35,000. Mr. Bush is eligible when their combined resources are less than $37,000 ($35,000 + $2,000) on the first day of a month. They reduce their countable resources below $37,000, and Mr. Bush is approved for Medicaid. Mrs. Bush then sells the family home for $150,000 and deposits the funds into an account in her name. Suppose Mr. Bush improves enough to return home, and he is terminated from Medicaid. If he later needs to re-enter the nursing home and apply again for Medicaid, the resources of both spouses, including the proceeds remaining from the sale of the home, will be considered, although the snapshot amount will continue to be $70,000.

If the institutionalized spouse receives resources more than ninety days after eligibility, the institutionalized spouse can transfer resources as needed to the community spouse so that the institutionalized spouse stays within the $2,000 resource limit. See Section XIII(D)(2), *below*, concerning whether a transfer between spouses triggers a transfer penalty.

Example:

> Mr. Trump, who has a community spouse, has been on Medicaid for a year when he receives an inheritance distribution of $40,000 on May 5. If Mr. Trump does nothing, then he will have excess resources on June 1, as he will have more than $2,000 of resources, and he will be ineligible for Medicaid for June forward. If Mr. Trump transfers the $40,000 to Mrs. Trump so that he has $2,000 or less of resources on June 1, he will continue to be eligible for Medicaid.

If as presented in subsection 1, *above*, one is able to convince FSSA or a court that the spousal impoverishment rules apply when both spouses are on the waiver, note that although one could argue that the initial eligibility resource limit is based on the snapshot amount (and note that each spouse may have differing snapshot amounts, because each spouse would have his or her own separate snapshot date), then ninety days after eligibility each spouse would be subject to a $2,000 resource limit. FSSA instead currently does not apply the spousal impoverishment rules when both spouses are on a waiver. FSSA compares both spouses' resources together to the married spouse at home resource limit of $3,000. If the position presented in this Manual were accepted, then ninety days after eligibility each spouse's resources would be considered separately and compared to the single person's resource limit of $2,000.

Medicaid will require that most of the liquid assets be transferred to the community spouse. Medicaid will not require that the homestead and income producing real estate be transferred to the community spouse, as those are exempt resources. Nonetheless, in most situations it will also be advisable to transfer ownership of real estate into the name alone of the community spouse.

With respect to the home and income producing real estate, whether it is owned solely or jointly will not affect Medicaid eligibility, as it is completely exempt in either case. In case the community spouse wants to sell the property some time after Medicaid eligibility is established and to prevent the property from passing to the institutionalized spouse if the community spouse dies first, such property should be solely in the name of the community spouse. Since the nursing home spouse could become incapable of executing a deed, this should be done sooner rather than later. The transfer of title to the community spouse can be done at any time without affecting Medicaid eligibility, as there is no penalty for transfers between spouses.

With respect to non-homestead real estate, there are sometimes advantages in not transferring title until after institutionalization occurs. If the real estate is producing income, it is exempt anyway and it does not matter how it is titled for Medicaid eligibility purposes. If it is not producing income, the real estate is counted as a resource if it is titled jointly or is in the name alone of the nursing home spouse, but is not counted if it is owned solely by the community spouse. IHCPPM §2635.10.10.10. Since one usually wants the snapshot amount to be high, it is often preferable if the nursing home spouse's name is on the property on the snapshot date. Then the property can be transferred to the community spouse after the snapshot date.

Example:

> Mr. and Mrs. Adams have $25,000 in savings and jointly own a $45,000 vacant lot producing no income. On April 24, Mr. Adams enters the nursing home. The snapshot total is $70,000 and Mrs. Adams' share is $35,000. On April 28, Mr. Adams deeds his share of the lot to Mrs. Adams. The lot is no longer counted, the countable resources now total $25,000, and Mr. Adams is eligible for Medicaid on May 1. If Mrs. Adams later rents the lot, she can keep all the income. If she sells it, she keeps all the proceeds.

Once sufficient assets are protected for the community spouse, one should consider what will happen to those assets if the community spouse dies first. Although one may expect that the nursing home spouse will die first, there are situations where the nursing home spouse has a longer life expectancy than the community spouse. In any event, one should plan for the possibility that the community spouse may die first. If the assets then pass to the nursing home spouse, those assets may need to be used on medical expenses and may not really benefit the nursing home spouse. The assets would not be available to benefit other heirs, such as the children.

When the nursing home spouse is on Medicaid, one should consider changing the community spouse's will and beneficiary designations on life insurance and the like so that the property will not pass back to the nursing home spouse. See Section XIII(C), *below*, however, which explains that a surviving institutionalized Medicaid recipient is subject to a transfer penalty for failing to take against the will and failing to claim the spousal allowance, if the will does not provide the minimum statutory share to the surviving spouse. Thus, one should provide a special needs trust by will for the benefit of the surviving institutionalized spouse in an amount that is at least equivalent to the minimum spousal share. See Appendix L, provided by Robert Fechtman, for sample language.

If the nursing home spouse does not have the capacity to execute a deed and there is no power of attorney, then one will need to attempt to persuade a probate judge to approve this type of transfer in a guardianship.

### 7. Spousal Refusal

A helpful provision addresses the potential problem that may occur if the community spouse refuses to cooperate in disposing of excess resources. Suppose, for example, that the community spouse's share is $35,000, but she has $40,000 of resources in her name and she refuses to dispose of the excess so that the institutionalized spouse will always be over the resource limit. 42 U.S.C. §1396r-5(c)(3) provides that the institutionalized spouse can become eligible for Medicaid by assigning his right to support from the spouse to the DFR. The institutionalized spouse can receive Medicaid, and the DFR can then sue the community spouse for support.

IHCPPM § 2434.00.00 provides that the assignment of medical rights is operational by law and the applicant does not even need to sign an assignment of rights. I.C. § 12-14-22-9 and 10 appear to give the DFR the right to seek such support even without an assignment. I.C. § 12-15-2-24(c) recognizes eligibility after assignment of support rights where the institutional spouse establishes that there is a right to support. It is not clear what is intended by requiring the spouse to establish that there is a right to support, since Indiana recognizes the obligation of spousal support. *Bartrom v. Adjustment Bureau*, 618 N.E.2d 1 (Ind. 1993).

In some states, the community spouse has intentionally refused to cooperate as a means of obtaining eligibility for the institutionalized spouse. “Spousal refusal” was commonly used in New York as a strategy to obtain eligibility. *See e.g.*, *In re Shah*, 95 N.Y.2d 148, 711 N.Y.S.2d 824 (N.Y.Ct.App. 2000) (guardian wife was permitted to transfer resources to herself and then execute a spousal refusal). A Connecticut court ruled that state’s Medicaid agency cannot deny eligibility where the institutional spouse assigned his rights to support to the agency. *Morenz v. Wilson-Coker*, 321 F.Supp.2d 398 (D.Conn. 2004). However, the community spouse can then be sued for support.

The last paragraph of IHCPPM § 2635.10.10.10 addresses spousal refusal as follows: “If the institutionalized spouse assigns to the State of Indiana his rights for support from the community spouse, the institutionalized spouse cannot be determined ineligible due to resources under this section.” Although arguably an assignment of support occurs in each case by operation of law, if one intends to rely on “spousal refusal,” then one should have the institutionalized spouse sign and submit an assignment of the right to support to the DFR. This provision provides that there should not be a denial for excess resources when there is an assignment of support. This is designed for situations when the community spouse refuses to cooperate but is not limited to that situation.

### 8. Undue Hardship

42 U.S.C. §1396r-5(c)(3)(c) provides that the institutionalized spouse shall not be ineligible because of resources deemed available where "the State determines that denial of eligibility would work an undue hardship." The Indiana IHCPPM does not include any provisions on

"undue hardship," but the federal law is binding. I.C. § 12-15-2-24(c)(2) provides for eligibility upon undue hardship, with no definition of "undue hardship."

## IX. Income Principles and Rules for the Aged, Blind, and Disabled

Income is defined broadly as the gain or benefit, earned or unearned, which is received or is available. IHCPPM § 2800.05.00. Despite this broad definition, not all income is counted, as discussed in Section A, below. Although most income is received regularly, some income may be received sporadically or only once.

Before June, 2014, there was no limit on how much income an applicant could have to qualify for Medicaid for the Aged, Blind, and Disabled. Instead, the only issue was how much of that person's income, if any, must be applied towards the medical expenses each month. That was referred to as the person's "spend down." If a person had a high enough income, it was even possible to be found eligible for Medicaid but Medicaid did not pay for any medical expenses. Effective June 1, 2014, there is now a limit on how much income one can have to qualify for non-institutional coverage, and the spend down system was eliminated.

Effective June 1, 2014, an "income cap" was put in place for nursing home coverage, for waiver services, and for the PACE program, with Miller Trusts then being required to obtain eligibility for those over the income cap.

The following subsections review the income principles for full Medicaid for the aged, blind, and disabled (MA A, MA B, and MA D). The income rules for MED Works and the Medicare buy-in programs are discussed in Sections X and XI, *below*. Be aware that HIP and the MED 2 and 3 categories use MAGI income, which is not discussed here.

### A. General Rules

The rules on income are listed in Chapter 2800 of the IHCPPM. Chapter 3400 of the IHCPPM has information on budgeting principles, such as how to handle income that fluctuates or is sporadic. Chapter 3400 also explains how to count self employment income, rental income, and in-kind income.

Income is categorized as earned or unearned. Earned income is payment for current work requiring personal involvement and effort. IHCPPM § 2810.00.00. It includes self employment as well as working for a third party and receiving wages, salary, or a commission. Although Social Security benefits and pensions are based on past work, they are classified as unearned income.

Some income is not counted at all. For example, SSI benefits are generally not counted. See Section D(3)(f), below. Other exemptions that occur less often are listed in IHCPPM Chapter 2800.

Chapter 3400 of the IHCPPM discusses how to determine income in various situations. For example, IHCPPM § 3420.05.05 explains what rental expenses are considered when determining net rental income. Most rental expenses allowed by the IRS are allowed, but depreciation and capital expenditures are not accepted expenses. Interest payments on a mortgage are allowed; payments on mortgage principal are not listed as allowable expenses.

Income which is received less than monthly is prorated over the period of time for which the payment is intended. For example, suppose one receives an annual annuity payment of $12,000. Since the payment is intended to be income for a year, the payment should be budgeted monthly as $1,000 per month income. IHCPPM § 3405.10.20. The income can be kept in a bank account and will not be counted towards the resource limit during the period for which the income was intended. IHCPPM § 2615.90.00. If income varies, one can request that it be averaged. IHCPPM § 3405.10.15.

The treatment of VA benefits can present issues because of the complexities of VA benefits and because VA notices often do not explain how the benefits are determined. IHCPPM § 2840.10.10 provides guidance on the Aid and Attendance Allowance and the Housebound Allowance, but issues can still arise.

VA benefits that are paid as compensation or as a pension benefit are unearned income. See Section (B), below, for the treatment of VA benefits that are based on unreimbursed medical expenses Any portion of the benefit which is allowed for a dependent is treated as the unearned income of the dependent. IHCPPM § 2840.10.00.

Only the interest payments on a promissory note are counted as income, even if the promissory note is non-negotiable and not counted as a resource. IHCPPM §2615.50.00. Similarly, IHCPPM § 3437.00.00 provides that only the interest payments on a land sale contract are countable as income. IHCPPM § 2875.10.10 also provides this. FSSA bases this on the SSI regulation at 20 CFR § 416.1103(f), which addresses proceeds of a loan as follows: "Money you borrow or money receive as repayment of a loan is not income. However, interest you receive on money you have lent is income." This regulation does not distinguish between negotiable and non-negotiable promissory notes.

The full payment of an annuity that has been annuitized is counted as income. This seems inconsistent with the treatment of promissory notes.

Interest earned on exempt resources is exempt. IHCPPM § 2850.00.00.

When a resource is sold or converted to another form, the proceeds remain a resource and are not countable as income. This is referred to as "conversion of a resource." IHCPPM § 2605.30.00. For example, when one withdraws funds from a bank account, the funds received are not income.

FSSA has fluctuated on its policy concerning the treatment of distributions from qualified retirement accounts, whether the distribution is counted as income or whether it is a conversion of a resource and not counted as income. In June, 2018, the DFR amended IHCPPM § 2615.15.00 to state that regular, periodic payments from qualified retirement accounts would

be treated as income rather than the conversion of resources. FSSA later reversed course and revised § 2615.15.00 effective for applications filed on or after May 1, 2019. The Section now says that "sporadic withdrawals" are a conversion of a resource and not income, while the payments on a retirement account annuitized to an irrevocable annuity are all counted as income. The Section does not address regular withdrawals from an annuity that can still be liquidated. Such payments should be counted as a conversion of a resource and not as income because the annuity holder has the option to withdraw more or less.

When income is being received for a business, such as a farm, the income should be placed into a separate account that is identified as a business account. For example, a farm account can be labeled as the "Old McDonald Farm Account." The funds in the account will not be counted as a resource. Income on the business will typically be averaged, so average income can then be distributed from the business account.

A lump sum is reviewed to determine if it is a recurring or a non-recurring payment. IHCPPM § 2880.00.00. A non-recurring payment is a one-time payment that is not expected to be received again.

•A recurring lump sum payment is counted as income and is pro rated. For example, if a recurring payment is received quarterly, it will be divided by three to obtain a monthly income. IHCPPM § 3405.10.20.

• A non-recurring lump sum payment is treated differently for recipients and new applicants.

• It is not counted as income for a recipient. IHCPPM § 2880.05.00 says that "an unanticipated non-recurring lump sum payment" is not counted. Eligibility for that month has already been awarded, so the payment is disregarded. Most non-recurring lump sum payments will be accepted as being unanticipated.

• For new applications, a lump sum received in a month prior to the month in which the application is processed is counted as income in the month received. IHCPPM § 2880.05.00; IHCPPM § 3435.00.00. For example, Jane applies for Medicaid in March, and her application is processed and authorized in April. If she received sweepstakes winnings in December, those winnings will be budgeted as income for December. If she received similar winnings in April or after, those winnings are not budgeted as income.

Indiana's Public Retirement System, known as IN PRS and formerly known as PERF, typically pays recipients a 13th check. Although this seems to occur regularly, it is dependent on the state legislature approving this from year to year. Because it is not certain that this will paid, the DFR has accepted the payment of a 13th check as an unanticipated non-recurring lump sum payment which is not countable as income. The DFR has stated that it will update the IHCPPM to specifically state this.

### B. Treatment of the VA Aid and Attendance and Housebound Allowances

The VA Aid and Attendance Allowance and the Housebound Allowance are considered to be reimbursement for unreimbursed medical expenses and are thus not countable as income by Medicaid. FSSA has implemented this exclusion by declaring that the VA aid and attendance allowance and the housebound allowance are not counted as income for the eligibility test. IHCPPM § 2840.10.10.

One must be able to show how much of a VA pension is actually paid due to unreimbursed medical expenses. FSSA workers often rely on a VA statement which labels a portion of the benefit as the "aid and attendance allowance." *Galletta v. Velez*, 2014 U.S. Dist. LEXIS 75248, 2014 WL 2468615 (D.N.J. June 3, 2014) explained that the test is whether the VA benefits were paid due to unreimbursed medical expenses, not what portion of the payment was labeled by the VA as the Aid and Attendance portion. See also *Summy v. Schweiker*, 688 F.2d 1233 (9th Cir. Or. 1982) (exempt for SSI); *Mitson v. Coler*, 670 F. Supp. 1568 (S.D. Fla. 1987); *Sherman v. Griepentrog*, 775 F. Supp. 1383 (D. Nev. 1991); *Peffers v. Bowman*, 599 F.Supp. 353 (D. Idaho 1984). If no VA benefits would have been paid except for the medical expenses, then none of the VA payment is countable income.

It is important to understand how the VA pension is computed. The VA provides a pension to eligible veterans and their surviving spouses called the "Non-Service Connected Pension" (NSCP). The NSCP is awarded based on the level of care needed.

- The "Base Pension" has no care requirements.

- The second level is "housebound," for a person substantially home-bound.

- The third level is for a person "in need of regular aid and attendance."

38 CFR § 3.351.

The NSCP benefits are means-tested, which results in the benefits being reduced by other income. 38 U.S.C. § 1521(d). The VA determines eligibility for and the amount of benefits as follows:

- The VA first determines an entitlement amount called the Maximum Annual Pension Rate (MAPR). The applicable MAPRs can be found at www.benefits.va.gov/pension/current_rates_veteran_pen.asp for veterans and at www.benefits.va.gov/pension/current_rates_survivor_pen.asp for widows. Some of the MAPRs for 2022 are:

| | Annual | Monthly |
|---|---|---|
| Veteran | $14,760 | $1,230 |
| Veteran housebound | 18,024 | 1,502 |
| Veteran aid & attendance | 24,612 | 2,051 |
| Widow | 9,900 | 825 |
| Widow housebound | 12,096 | 1,008 |
| Widow aid & attendance | 15,816 | 1,318 |

• The VA then compares the MAPR to the veteran's or widow's income. All payments from any source are included unless expressly excepted.

• Unreimbursed medical expenses, to the extent they exceed 5% of the MAPR, are then deducted from income to obtain net income, sometimes referred to as Income for VA Purposes (IVAP).

• If the IVAP is greater than the MAPR, no VA pension is awarded. If the IVAP is less than the MAPR, the VA grants a pension equal to the MAPR minus the IVAP.

Example:

Fred, a single veteran, resides in an assisted living facility which costs $3,000 per month. He meets the definition for aid and attendance. He has Social Security and pension income totaling $2,500 per month. He pays $300 per month for a Medicare supplement. If not for his medical expenses, he would not qualify for a VA pension, as his income exceeds $2,051, the veteran with aid & attendance MAPR. Once his medical expenses of $3,197 per month ($3,300 / month unreimbursed medical expenses - $103 (5% of 2,051), are subtracted, he has negative income. He is entitled to a VA pension of $2,051, all of which is payable due to his unreimbursed medical expenses. Therefore, none of the $2,051 is countable income for Medicaid in the eligibility test.

If the individual's income is above the MAPR, then one knows that without medical expenses, the individual would not receive any VA benefits, and therefore all of the VA benefit is based on medical expenses and not countable in the eligibility budget. IHCPPM §2840.10.10. If the individual's other income is below the MAPR, then FSSA will ask the applicant to show what portion of the benefit is paid based on medical expenses. To determine this, compare the VA benefits actually paid to the amount of VA benefits, if any, that would be received if there were no unreimbursed medical expenses. This amount is not countable as income in determining Medicaid eligibility. Review the initial VA benefits award letter, as an appendix details the amount of annual income and annual medical expenses considered. One can telephone the VA at 1-877-294-6380 and request a "Breakdown Letter," but it does not provide the detail contained in the initial award letter and does not show what portion of the benefit was based on medical expenses.

One will need to consider how to show FSSA what portion of the VA pension is non-countable. The VA "breakdown" letter does not contain sufficient information. The initial award letter shows how the benefits were computed and shows if all of the VA benefits were paid due to unreimbursed medical expenses. If the income other than the VA pension is under the Special Income Level (see Section (D)(1), below), but the income with the VA pension is over the Special Income Level, then one needs to decide whether one can convince FSSA that the VA pension is not countable or whether one will prepare and use a Miller Trust even though not truly needed.

Once Medicaid benefits are awarded, the award of Medicaid and the resulting change in unreimbursed medical expenses must be promptly reported to the VA, as this will often result in

a change in the VA benefit award, potentially reducing it to zero if Medicaid is covering all of the medical expenses. Once Medicaid benefits are obtained, an updated medical expense report should be provided to the VA. Even if one arguably does not need a Miller Trust because the Aid and Attendance Allowance is not countable income, one may still want to prepare a Miller Trust to hold the Aid and Attendance Allowance until the VA requests the return of an overpayment of VA benefits.

If in a nursing home, the veteran's or widow's pension will be reduced to $90 per month. The veteran or widow will be allowed to keep the $90 in addition to the $52 personal needs allowance. IHCPPM § 2840.10.10 provides that until the VA pension is reduced to $90, the recipient will be required to pay the VA pension, including any Aid and Attendance Allowance, to the nursing home as a part of the liability except to the extent the recipient establishes that there are non-Medicaid covered medical expenses which the Aid and Attendance Allowance is being used to pay.

### C. Rules for a Person Not in an Institution and Not Receiving Waiver, Money Follows the Person, or PACE Services

FSSA applies different rules if a person is institutionalized for thirty days or more or has been approved for a waiver, Money Follows the Person, or the PACE program. An institution is a Medicaid certified nursing home or a hospital. IHCPPM § 3455.15.00. This Section discusses the rules for a person at home in the community, who is not on a waiver, Money Follows the Person, or PACE.

#### 1. Countable Income Must be Less Than or Equal to the Income Standard

There is an income standard for Medicaid for the Aged, Blind, and Disabled. A person with countable income above the income standard is not eligible. A person with countable income at or below the standard passes the income test. See Sections D and E, below, for the rules for persons in an institution or receiving waiver services.

The income standard for Medicaid for the Aged, Blind, and Disabled is 100% of the federal poverty level (FPL), which in 2022 is $1,133 for a single person and $1,526 for a married couple. The income standard for a married couple is the same whether one or both spouses apply; the income of both spouses is counted, even if only one of them is applying for Medicaid. However, if a married couple is separated for non-medical reasons, then the spouse applying is treated as if single. IHCPPM § 3210.05.00.

The income standard is updated each year on March 1 or April 1, as the new FPL standards are typically published in January or February. Until the new income standard is in place, the annual Social Security cost of living increase is disregarded in determining eligibility. IHCPPM § 3455.05.05.10. Although the same policy should apply to other income cost-of-living increases, this Section only refers to disregarding Social Security cost-of-living increases.

### 2. Determining Countable Income

"Countable income" is used to determine eligibility for Medicaid for the Aged, Blind, and Disabled. An applicant household's **countable** income is the income after any exemptions and deductions. This section does not review every exemption and rule but instead reviews the general process for considering income.

The eligibility budget looks like this:

**Countable Income**

| Gross unearned income<br>minus<br>Standard disregard of $20<br>minus<br>Allocation to dependent child or essential person<br>equals<br>**Countable Unearned Income** | Gross earned income<br>minus<br>Any unused part of Standard disregard and Any unused Allocation to dependent child or essential person that was not deducted from unearned income<br>minus<br>Earned income disregard of $65<br>That Result is Divided by 2 to Obtain the **Countable Earned Income** |
|---|---|
| **Total Countable Income Equals Countable Unearned Plus Countable Earned Income** | |

Here is an explanation of the items used in this budget.

**Standard Disregard:** The first $20 of income is disregarded. Even if both spouses are applying for Medicaid, the married couple only receives one disregard.

**Allocation to Dependent Child:** One receives a deduction from income if he or she has a dependent child (under age 18, or between 18 and 21 and attending school) in the home with income less than $421 per month. This deduction takes into account the applicant's support of the child. The deduction is $421 minus the dependent child's income. IHCPPM §3455.05.10. If the dependent child has income above $421 per month, there is no deduction and the child's income is not counted. If the dependent child's income is less than $421, then there is a deduction equal to $421 minus the dependent child's income. This allocation is available for each dependent child in the household.

**Allocation to Essential Person:** There is a similar deduction for an "essential person" in the household with income less than $421 per month. An essential person is someone other than a spouse living in the home providing services that would otherwise need to be paid for. An "essential person" need not be a relative. IHCPPM §3455.05.15. If the essential person has income above $421/mo., there is no deduction and the essential person's income is not counted. If the essential person's income is less than $421, then there is a deduction of $421 minus the essential person's income. This deduction accounts in a small way for the applicant's support of the essential person.

**Unused Part of Standard Disregard or of Allocation:** If the unearned income is less than the deductions which can be subtracted from the unearned income, then any deduction(s) remaining after reducing the countable unearned income to zero is deducted from the earned income.

**Earned Income Disregard:** A deduction from gross earnings takes into account work expenses, such as taxes, and provides an incentive to work. The first $65 of gross earnings are disregarded, and then one-half of the amount remaining is disregarded. If there is an unused part of the standard disregard or of an allocation which can be deducted, then those amounts are deducted from gross earnings before the earned income disregard is considered.

There are some other deductions which apply in rare situations and are discussed in detail in Chapter 2800 of the IHCPPM. The eligibility budgeting procedure is explained in detail at IHCPPM §3455.05.30. The net income after deductions is the "countable income." It is helpful to consider some examples.

Examples:

Bill, single, receives Social Security of $1,150 per month. The standard disregard of $20 is deducted from his income, so his countable income is $1,130, which is less than the single person income standard of $1,133. He passes the income test.

Mary, single, has a pension of $1,400 per month. Her nephew lives with to help care for her, as she cannot live by herself. He has no income. She passes the income test, because her countable income of $959 is less than the single person income standard of $1,133.

| | |
|---|---|
| $1,400 | Gross Income |
| - 20 | Standard Disregard |
| - 421 | Allocation to Essential Person |
| $ 959 | Countable Income |

Sally and Sam are married. Sally, disabled, receives $300 per month Social Security Disability benefits. Sam works and grosses $3,000 per month. They have a son, age 6, with no income. Sally also has a daughter, age 12, from a previous marriage living with her for whom she receives $200 per month in child support. Sally applies for Medicaid disability benefits. Even though Sam is not seeking Medicaid, his income is also considered since they are married and living together. Their countable income is:

| | |
|---|---|
| $300 | Her Unearned Income |
| - 20 | Standard Disregard |
| - 421 | Allocation to son |
| - 221 | Allocation to daughter ($421 - $200) |
| $-362 | She has 0 countable unearned income and $362 of unused deductions which can be deducted from Sam's earnings |
| | |
| $3,000 | Sam's gross earned income |
| - 362 | Unused deductions from unearned income |
| - 65 | $65 Earned income disregard |
| $2,573 | |
| ÷ 2 | Remaining earned income disregard |
| $1,286.50 | Countable earned income |

Sally and Sam's total countable income is $1,286.50, which is less than the couple's income standard of $1,526. Sally passes the income test despite their substantial gross income.

### D. Rules for a Person in a Nursing Home or Medical Institution

The IHCPPM refers to two budgets for a person who is in a nursing hospital or hospital for thirty or more days: an eligibility budget and a post-eligibility budget. IHCPPM §3455.05.30 and §3455.15.00. The eligibility budget is used to determine initial eligibility. A separate "post-eligibility" budget is completed to compute the "liability," which is the amount of income that must be paid to the nursing home each month.

When both spouses of a married couple reside in a nursing home, their incomes are considered separately. Eligibility is considered separately, and a separate liability is computed for each spouse. Note this is different than the treatment of resources, as if both spouses are in a nursing home, the combined resources are compared to the couple's standard of $3,000.

#### 1. The Eligibility Test: Income Must be Less Than or Equal to the Special Income Level

The community Medicaid income limit of 100% FPL may work for Medicaid in the community, but it is clearly inadequate for nursing home care and for at-home long term care, both of which are very expensive. To address nursing home and waiver applicants and recipients, FSSA has chosen an option available under federal law to provide Medicaid to this group at higher income amounts. This coverage option is at 42 U.S.C. § 1396a(a)(10)(A)(ii)(V), which allows states to cover persons who:

> (V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose

> income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

This Section references the income standard in 42 U.S.C. § 1396b(f)(4)(C), which provides:

> (C) ... but only if the income of such individual ... does not exceed 300 percent of the supplemental security income benefit rate established by section 1382 (b)(1) of this title,

These sections taken together provide that persons who are in an institution for at least thirty days can qualify but only if the income is not more than 300% of the SSI benefit rate, which is $841 in 2022. Thus, this category contains an income limit of $2,523 in 2022 (300% of $841). FSSA calls this income limit the **Special Income Level (SIL)**. It is also sometimes referred to as an "income cap."

The eligibility test applies to a person who resides in an institution. IHCPPM § 3455.14.00. There is no requirement that the person be in a Medicaid certified facility or Medicaid certified bed. A person not in a certified facility or bed can potentially be approved for Medicaid, but Medicaid will not pay for the nursing home per diem costs if not in a certified bed. Medicaid will pay other medical expenses.

A thirty day institutionalization is required for eligibility using the Special Income Level. The CMS State Medicaid Manual Interim Manual § 3570 states that eligibility is not effective until the individual has been in a medical institutionalization for thirty days. The thirty days begins at 12:00 a.m. on the day of admission. § 3570 states that once an individual has been in an institution for thirty days, then eligibility begins with the first day of the thirty day period and ends when the individual is discharged. Although § 3570 states that eligibility begins with the first day of institutionalization, FSSA begins eligibility on the first day of the calendar month in which the institutionalization began.

For this eligibility test, only the income of the Medicaid applicant or recipient is counted. Even if married, the spouse's income is not counted.

**Gross income** is counted. This is often different than the amount of income actually received. With Social Security benefits, often a Medicare Part B premium, sometimes a Part D premium, and sometimes even taxes, are deducted from monthly benefits. Medicaid counts the **gross** Social Security benefit **before any deductions**. Similarly, taxes or insurance may be deducted from pension benefits. Medicaid counts the gross pension benefit **before any deductions**. For rental income, where the rental expenses can be deducted, net rather than gross rental income will be counted. See IHCPPM § 3420.05.05 for allowable rental expenses. Although an institutionalized person will rarely be working, gross earnings are counted with no employment disregard, but for a self employed person, only net self employment income is counted. IHCPPM § 3410.15.00 lists allowable self employment expenses.

One should be aware that income received regularly but less often than monthly is averaged and counted. For example, farm income or periodic annuity payments is averaged and counted.

Payments from a long term care insurance policy should not be counted as income if the applicant / recipient uses the payments to pay medical expenses. IHCPPM § 2840.45.05.05 provides that indemnity health insurance payments are counted as unearned income **unless** the individual uses the payments to pay medical expenses. One can notify FSSA that long term insurance payments are being used and will be used to pay the nursing home bill. The payments then do not count as income.

Income that is being withheld involuntarily due to a garnishment or levy is still counted as if it were received. The IHCPPM does not specifically address how to treat a reduction in Social Security benefits as a result of a garnishment for child support, but FSSA's policy is to not allow a deduction in this instance. *Indiana FSSA v. Patterson*, 119 N.E.3d (Ind. Ct. App. 2019), transfer denied 127 N.E.2d 229 (Ind. 2019), cert. denied Dec. 16, 2019, deferred to FSSA's position that it is not required to grant a deduction when Social Security benefits are being garnished for a child support order. But see *Mulder v. S.D. Dep't of Soc. Servs.*, 2004 S.D. 10, 675 N.W.2d 212 (S.D. 2004), where the court held that court ordered alimony payments must be deducted when computing the liability.

There are some situations where income being withheld is not counted. IHCPPM § 2805.25.00 provides that taxes involuntarily withheld from unearned income are an allowable deduction from income. Taxes being levied from income, such as from the Social Security check, are not to be counted as income. Social Security or pension benefits that are being recouped to recover an overpayment are not counted as income. IHCPPM §§ 2840.05.00 and 2840.20.05.

### 2. Using a Miller Trust (Qualified Income Trust) to Meet the Eligibility Test

Although $2,523 is a higher income limit than 100% of FPL, which is $1,133 for a single person, it is still not an adequate income limit for nursing home care, as a person with income above the limit does not have sufficient income to pay privately for nursing home care. The harsh effects of this artificially low income limit can be avoided if at least the amount of income above the SIL is placed into an income trust. This trust is referred to as a Qualified Income Trust (QIT). It is commonly referred to as a "Miller Trust" because it was first allowed in *Miller v. Ibarra*, 746 F. Supp. 19 (D. Col. 1990). This was later recognized and allowed by federal law at 42 U.S.C. §1396p(d)(4)(B).

Any income placed into a Miller Trust is not counted in the eligibility test. IHCPPM § 3325.05.00. Thus, to pass the eligibility test, any institutionalized person with gross monthly income (not otherwise excludable) above $2,523 must have a Miller Trust in place and be depositing at least enough income so that the remaining income not placed into the trust is less than the SIL.

#### a. The Trust Document

42 U.S.C. §1396p(d)(4)(B) only lists two requirements for the trust, in subsections (i) and (ii), as follows:

> (i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),
>
> (ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter;

First, the federal statute provides that the trust can only be composed of income; **the trust cannot be used to shelter resources**. CMS State Medicaid Manual § 3259.7(C) provides that the recipient can first receive the income and then transfer it, or some portion of the income, into the trust account, or the income can be deposited directly into the trust account by the payor. The recipient cannot **irrevocably** transfer the right to receive the income to the trust, as that would be treated as a transfer subject to a penalty.

Second, the federal statute provides that the trust must provide that the state will receive all amounts remaining in the trust at the death of the recipient, up to the amount the state has paid under Medicaid for the recipient. This is not limited to Medicaid benefits received after the establishment of the trust. Instead, it also must include repayment for any benefits received before establishment of the trust. Although FSSA will approve trusts that provide for payment to the State of Indiana for Medicaid benefits received in Indiana, the trust should provide for payment to any state in which the individual has received Medicaid, in case the person may receive Medicaid in more than one state.

The trust should be irrevocable. If it is a revocable trust, then any funds in the trust will count as a resource. Funds in the trust will not count as a resource if the trust is irrevocable. IHCPPM § 3320.10.00; CMS State Medicaid Manual § 3259.7(C)(1). FSSA's Instructions at www.in.gov/fssa/ompp/files/QualifyingIncomeTrustMillertrustinstructions.pdf on establishing a trust say that a Miller Trust must be irrevocable, but that is not technically accurate. However, even though one can argue that a Miller Trust can be revocable, there is no reason to set it up as revocable.

Deposits only need to be made into the trust for months when the individual is receiving Medicaid while in an institution or while receiving waiver services and while receiving income above the SIL. If the recipient goes off Medicaid, leaves the nursing home, or stops receiving waiver services, or if the income drops below the SIL, then deposits no longer need to be made into the trust. If the individual then later reenters a nursing home and needs Medicaid, a new Miller Trust will not be needed. The existing Miller Trust can be used.

The federal statute does not limit how the funds deposited into the trust can be spent. The CMS State Medicaid Manual allows the funds to be used broadly. It states:

> For example, funds placed in the trust can be used to pay the administrative fees of the trust, income tax owed by the trust, attorney's fees which the trust is obligated to pay (in proportion to whatever part of the trust benefits the individual), food or clothing for the individual, or mortgage payments for the individual's home.

CMS State Medicaid Manual § 3259.7(C)(3). The CMS State Medicaid Manual's very broad language appears to allow funds in the trust to be used for anything that is for the benefit of the recipient. However, the CMS State Medicaid Manual then proceeds to address whether payments from the trust will be treated as income to the recipient. CMS State Medicaid Manual § 3259.7(C)(4) states that payments from the trust that are for medical care are not treated as income to the recipient, but payments that are used or could be used for food, clothing, or shelter will be treated as income. (The SSI rules no longer treat payment for clothing as in-kind income, so payments used for clothing should not be treated as income.) If treated as income, then the recipient would fail the eligibility test and would not be eligible for Medicaid. This appears to mean that funds in the trust can be used for the recipient so long as they are not used for food or shelter. However, if FSSA does the post eligibility budgeting properly, as discussed below, then the funds deposited into the trust account will be needed to pay the liability and there will usually not be funds in the trust to pay for anything else.

A third party can establish the trust for the recipient. 42 U.S.C. §1396p(d)(4)(B) refers to "A trust established in a State for the benefit of an individual ... ." It does not state that the trust must be established by the individual or someone with legal authority to act for the individual. IHCPPM § 3320.10.00 uses similar language. A recipient or applicant with capacity should sign the trust as the settlor. But if the recipient or applicant does not have a guardian and does not have a power of attorney with authority to establish a Miller trust, then a third party can sign as settlor of the trust. An Authorized Representative or anyone with access to the recipient's income if the applicant is incapacitated can sign as settlor.

When drafting a power of attorney for an individual who has or may at some time have income above the SIL, one should include language in the document giving the attorney-in-fact the authority to establish a Miller Trust if needed. I.C. § 30-5-5-15 gives authority to establish a revocable trust that terminates at death, but it does not specifically give authority to establish an irrevocable trust. Although FSSA and most banks have not questioned the authority of an attorney-in-fact acting under general powers to establish a Miller Trust, one should include specific language in the power of attorney to avoid any question of authority to establish the trust. For example, one could include in the power of attorney: "General authority with respect to estate transactions, and including the authority to create, amend, and appoint trustees for a trust described under 42 U.S.C. Section 1396p(d)(4)(B), often referred to as a Qualified Income Trust or a 'Miller Trust,' to enable me to seek and obtain Medicaid benefits."

Attached at Appendix M is a sample Miller Trust form which can be used when a beneficiary is establishing his own trust. FSSA has posted a fill-in-the-blank template on its website at www.in.gov/fssa/ompp/files/Qualified_Income_Trust_Miller_Trust_template.pdf. Appendix N. The form has spaces for the beneficiary (also referred to as "primary beneficiary"), settlor, sources of income being placed into the trust, trustee, successor trustee, and distributee(s). The "distributees" are the persons who will receive the funds if there are more funds in the trust than what FSSA has paid out under Medicaid. There will rarely be funds left over for distributees. An alternative fill-in-the-blank form used by the Senior Law Project for pro se purposes is based on the FSSA form with some changes in language. Appendix O. At Appendix P are Instructions which the Senior Law Project gives clients with the pro se form. The definitions of the terms are included in the document. The sources of income are omitted due to a concern that this could

result in errors. Instead this form simply refers to "pension, Social Security, or any other income" of the beneficiary.

A person who has income under the SIL but who is having difficulty spending all of the income can establish a Miller Trust so that she will not accumulate resources above the resource limit. Although the Miller Trust is not designed for this situation, the language in the federal statute does not prohibit this. FSSA has confirmed it will not object to this.

### b. Setting up the Trust Account

The trustee must set up a financial account for the trust. The trustee will take the completed trust document to a bank or other financial institution to open the "[Primary Beneficiary] Qualified Income Trust" account. This should where possible be set up at the same financial institution where the recipient's income is deposited. Although this typically will be a checking account, it may be possible to set the account up as a savings account if the necessary transactions can be made from a savings account.

The financial institution should use the recipient's Social Security number as the identification number for the account. It should not ask for a separate EIN for the trust. See Internal Revenue Manual 21.7.13.5.8.3, www.irs.gov/irm/part21/irm_21-007-013r, which says the Social Security number of the beneficiary is to be used. There is no reason to use the trustee's Social Security number. One should always use the applicant/recipient's Social Security number.

If a new account is needed, the financial institution will likely require a small deposit (for example, $10 to $20) as initial funding and will likely require that some minimum balance must be maintained in the account.

Sometimes the nursing home manages the resident's funds. Some nursing homes contract with an entity such as Resident Funds Management Systems to manage the funds. FSSA has stated that such a system can be used to manage a Miller trust account so long as it accounts for the funds separately and follows all other rules for a Miller trust.

### c. Deposits to the Trust

**Deposits to the trust can only be made from the recipient's income**. Nothing else, such as excess resources or payments that are not income, can be deposited into the account.

There are choices on how much income is deposited into the Trust. **At a minimum the amount of gross income above the SIL must be deposited into the Trust to qualify for Medicaid**. Any amount of income at or above the minimum can be deposited. The typical choices include:

- Deposit only the gross income above the SIL into the Trust account. One should be able to arrange with the bank to automatically transfer the excess income from a non-trust account to the Trust account each month. The risk here is that if one miscalculates, or if the income is higher than what one thought, or if the income changes, the individual may be ineligible for Medicaid because too little is being

deposited. One should at least round up to a higher amount, such as by rounding up to the nearest $10, to be certain that the minimum is being deposited.

- Another option is to deposit all the income into the Trust account. One can arrange with the payor(s) of the income to directly deposit the income to the Trust account or all of the income can be transferred to the Trust account after being received in the non-trust account.

- If one receives income from multiple sources, one could arrange for income from one or more of the sources, but not all, to be deposited into the Trust account, so long as the amount being deposited is equal to or greater than the amount by which the total income exceeds the SIL.

- One could arrange for the amount set by FSSA as the liability to be deposited into the Trust account.

Example:

Mabel is in a nursing home receiving Medicaid. She receives gross Social Security benefits of $1,900 per month and a gross pension of $800 per month which are direct deposited into her bank account. Her gross income is $2,700, which is $177 above the 2022 SIL of $2,523. For 2022, she must deposit at least $177 per month ($2,700 - $2,523) into a QIT account to be eligible for Medicaid. She can sign a QIT, name a trustee, and the trustee can establish a separate QIT account. She can then arrange to have the bank automatically transfer $177 into her QIT account each month after the income is received.

In the alternative, Mabel could arrange to have all of her income deposited or transferred into the QIT account. The bank may be willing to convert her non-trust account into a QIT account. It may require the opening of a new QIT account. She could receive all income into her non-trust account and then transfer it into the QIT account, or she may be able to arrange to have the Social Security Administration and the pension payor directly deposit her income into the QIT account.

As a third alternative, she could arrange to have either her Social Security or her pension deposited into the QIT account.

She could arrange to have her liability amount deposited into the Trust account. If she has no other deductions, her liability will be $2,648 ($2,700 - $52). She can deposit $2,648 into the Trust account and pay her full monthly liability from the Trust account. The $52 remaining in her non-trust account can be used for her personal needs.

**She must deposit at least $177 per month into the QIT account for each month to be eligible for Medicaid**. It is best to deposit more than the bare minimum into the Trust account, as if she miscalculates and places too little into

the Trust account, she could receive a Medicaid termination notice. Note that the minimum amount that needs to be deposited may change in January, 2023 or if Mabel's income changes before then.

It is a matter of personal preference as to how much to deposit into the trust. Some persons will not want to deposit anything more than required into the trust. However, since transferring too little into the Trust can result in ineligibility, it is better to deposit more than the least required deposit. Some persons may find it simpler to have all income deposited into the trust. The amount deposited will not affect the amount owed to the nursing home. If only the excess income is deposited into the trust, then that income will be used to pay a portion of the liability. If all of the income is placed into the trust, then the recipient's personal needs allowance will need to be transferred from the trust to the resident. The only time where it may make a substantive difference is if the recipient dies early in the month and the full liability is not owed to the nursing home. If all of the income has been placed into the trust, then whatever is in the trust must be paid to the state. If only the excess has been placed into the trust, then the funds left in the non-trust account may pass to heirs if FSSA does not recover on the non-trust account through estate recovery.

### d. When Deposits Must be Made

There is no requirement that the income be transferred to the trust within a certain amount of time after receipt. **The only time requirement is that the deposit must be made before the end of the month in which the income is received.**

This requirement of deposit in the month received creates problems when a client is seeking retroactive eligibility and was not aware a Miller Trust was required. Suppose Maude enters a nursing home in April, believes her income is below the SIL, applies for Medicaid in June, and seeks retroactive coverage beginning in April. Suppose when Maude gets her income verifications, she learns her gross income is actually above the SIL, so she establishes a Miller Trust in July and begins making deposits. Can she make retroactive deposits for April, May, and June? Although one can argue that she should be able to do this, FSSA will deny eligibility for April, May, and June because she did not make deposits in those months. This may be subject to challenge. **It is critical to determine the gross income as soon as possible to determine whether a Miller Trust is needed.**

### e. Administration After Death

Any funds remaining in the trust at death must be paid to the state up to the amount paid by the Medicaid program. In most cases, that will be all of the funds remaining in the trust. This can be accomplished by the trustee by obtaining a check payable to the Treasurer, State of Indiana and mailing it to Estate Recovery Unit, Family and Social Services Administration, 402 W Washington St., Rm. W374 MS 07, Indianapolis IN 46204-2776. If there is a question whether Medicaid may have paid less than what remains in the trust, then one should request the Estate Recovery Unit to report on how much Medicaid paid.

If the funds are owed to the State, then one needs the permission of the Estate Recovery Unit to do anything other than to pay the State. For example, if the recipient died before paying

the last month's liability payment, one would need the State's permission to pay the liability. Although at times the Unit has allowed this, it appears that its current policy is not to allow this.

### 3. Deductions Allowed in Computing the Liability

**Beginning in April, 2020, FSSA stopped processing any changes in liabilities that resulted in an increase in the liability because that was considered to be a reduction in benefits that could not be implemented during the pandemic. Beginning March 1, 2021 FSSA began implementing liability increases after CMS clarified this is allowed.**

Once an applicant or recipient passes the eligibility test, the next step is to compute the monthly "liability" which is owed to the nursing home. The liability is calculated based on the gross income, regardless of whether any income is deposited into a Miller trust account. It is first necessary to determine what deductions apply. The various deductions are listed at § 3455.15.10.

#### a. Personal Needs Allowance (PNA)

One is allowed to keep $52 of income each month as a Personal Needs Allowance (PNA) which can be used for personal needs such as clothes, entertainment, and other personal items not covered by Medicaid.

Veterans and widows of veterans who receive a reduced VA benefit of $90 are allowed to keep the $90 as their PNA, in addition to the standard $52 PNA. IHCPPM § 2840.10.10.

SSI recipients only receive $30 per month of SSI benefits when in a nursing home. I.C. § 12-15-7-6 requires FSSA to pay SSI recipients $22 per month so they will have $52 to keep as a PNA. FSSA refers to the $22 payments as Supplemental Assistance for Personal Needs (SAPN), which it discusses in Chapter 5000 of the IHCPPM.

#### b. Health Insurance Premiums

If the applicant/ recipient has private health insurance, then the premium is deducted from the income. He or she is allowed to use enough income to keep private insurance in effect. This is done to give the recipient an incentive to retain private health insurance, since Medicaid is always the payer of last resort.

An applicant/recipient who has a less common type of health insurance policy, such as a dental policy marketed through some nursing homes, will likely be required to provide a copy of the policy and provide verification that the policy was actually purchased by the applicant. For more common types of policies, such as a Medicare supplement policy, one should only need to provide verification of the premium, such as by a billing statement. The IHCPPM does not address whether the premium for a long term care insurance policy can be deducted. It should be deductible if the policy limits the benefits to paying for medical care.

An applicant who is paying a Medicare Part B premium, typically through deduction from Social Security benefits, will be granted a deduction for the Part B premium in the initial liability calculation until the state begins paying the Part B premiums. For most persons receiving

Medicare, the Part B premium is deducted from the Social Security benefits by the SSA. When an applicant is first approved for Medicaid in a nursing home, the Part B premium is treated the same as the cost of a private health insurance policy, and it is deducted when computing the liability. Once Medicaid is approved, the State of Indiana begins paying the Part B premium to Social Security, and within about sixty days Social Security stops deducting the premium from the Social Security check. Medicaid will then notify the recipient that it is increasing the liability by the amount of the Part B premium, since it is no longer being deducted from the Social Security benefits. This typically occurs two to three months after initial approval. Inform your clients this will occur, as many recipients are confused by the increase in their liability when it appears that their income has not changed.

Medicare recipients who qualify for Medicaid will receive Medicare Part D (prescription drug plan) at no cost if the recipient has a drug plan with a premium of $29.65 or less. A recipient with a drug plan costing more than $29.65 per month is responsible for paying the cost above $29.65. That amount can be deducted in computing the Medicaid liability. Upon initial application, any amount of a Part D plan premium above $29.65 should be deducted. Although one can argue that the full Part D premium should be deducted until the Extra Help is processed, FSSA will assume at application that Extra Help will be granted and will only deduct the amount of the premium, if any, that is above the benchmark.

**Should a recipient retain her health insurance after Medicaid eligibility is approved?** Medicaid makes it possible to keep one's health insurance, since there is a deduction for the premiums. There are pros and cons to keeping the health insurance. If one drops the insurance and later stops receiving Medicaid, it may be difficult to regain health insurance. One may have a health care provider who will not accept Medicaid but who will accept the health insurance. On the other hand, it may be bothersome to pay the monthly premiums; one may also need to file claims. It is generally not advisable to cancel the health insurance unless it appears that the resident will not ever be going off Medicaid and Medicaid will continue to meet all medical needs. Federal law provides that in some situations a Medicaid recipient can suspend a Medicare supplement insurance policy and still have a right to reinstate it. If a recipient with a Medicare supplement policy issued or sold after November 5, 1991 notifies the insurance company within 90 days after becoming entitled to Medicaid, the insurance company will suspend the policy for up to two years. If the recipient goes off Medicaid within two years, then the company must at the insured's request automatically reinstate the policy so long as the company is notified within 90 days after Medicaid ends. 42 U.S.C. §1395ss(q)(5).

### c. Medical Expenses Not Subject to Payment by a Third Party

Medical expenses which are not subject to payment by a third party and are not covered by Medicaid are deducted from income. IHCPPM §3455.15.10. Medicaid does not cover every medical procedure. Since a recipient is limited to keeping $52 as a Personal Needs Allowance, this deduction is needed so that a nursing home resident can pay for needed medical care that is not covered by Medicaid. If the recipient declines a Medicare Part D drug plan, then the

prescription drug costs which the recipient will owe can be deducted. Any prescriptions not covered by the Medicare drug plan should be allowed as a deduction if the prescription is not covered by Medicaid. IHCPPM § 3455.15.10.

The DFR will not allow a deduction for a payment made to hold one's bed while in the hospital or on a therapeutic leave.

Example:

> Mr. Todd is in a nursing home and needs a medically necessary procedure costing $600 which Medicaid for some reason will not cover. Medicaid should deduct what he pays for the procedure in computing his liability, thus freeing up funds to pay for the procedure. Suppose his liability is $800. If he provides FSSA with a copy of the $600 medical bill, his liability will be reduced to $200 for one month, at which time he can pay the bill.

Not only current medical expenses, but also past medical expenses incurred before Medicaid eligibility can be deducted. See Section 5, below, on "Deviating the Liability for Old Medical Bills."

### d. Guardianship Fees

Court-ordered guardianship fees, not to exceed $35 per month, are deductible expenses. Fees include guardian's services and expenses as well as attorney fees. This amount is clearly inadequate. There have been state legislative efforts to increase this amount, but to date no legislation has been enacted.

### e. Income Tax Payments

Medicaid will not allow a recipient an ongoing deduction from income for income taxes, even if income taxes are being deducted from the recipient's pension check or other income. However, Medicaid will allow a one time deduction per year for the amount of federal, state, and local taxes on the recipient's unearned income which are owed and paid. See IHCPPM 3455.15.10. This is allowable in the month after the recipient provides verification of payment of the tax liability. For example, if a recipient verifies in April that she owes $500 of federal income taxes, her liability will be lowered by $500 in May. For a married couple filing a joint return with one spouse on Medicaid in a nursing home, DFR will typically allow one-half of the tax payment as a deduction.

There is some question as to whether the income tax deduction from liability can be spread over more than one month, if the income taxes paid are more than the monthly liability. For example, a recipient pays $2,000 in income taxes but has a $1,000 liability. The FSSA's position is that the deduction cannot be spread over more than one month. This is consistent with 405 IAC 2-1.1-7(b)(6), which states "Subtract an amount for federal, state, and local taxes owed and paid by the applicant or member. This deduction is limited to one (1) calendar month per year."

This language is not consistent with the language in Indiana's State Plan, which is the document that the FSSA submits to and has approved by the federal Centers for Medicaid and Medicare Services (CMS). It is located at www.indianamedicaid.com. Instead of referring to income tax recoupment as a deduction from liability, it frames it as an addition to the Personal Needs Allowance. It also does not use the term "one time" and instead refers to the "amount owed and paid for taxes." See Supplement 12 of Attachment 2.6A at provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_2/2.6a_s12.pdf. One can argue that the language of the State Plan controls, as it is the plan approved by CMS and does not include the one-month limitation.

Be aware that there are means to reduce or eliminate tax liability. One may be able to itemize payments to a nursing home as a medical expense on the federal tax return. For state income taxes, one can often use the Human Services Tax Deduction to reduce the state and local tax liability of a Medicaid recipient to zero. For more information on this deduction, see the instructions in the individual income tax booklet.

### f. Temporary SSI Payments

Although SSI benefits normally drop to $30 per month when a person is institutionalized, SSA allows an SSI recipient who is expected to return home within ninety days to keep the full SSI benefits for those ninety days. The recipient must notify SSA of the institutionalization and provide medical verification that the stay is expected to be less than 90 days. Those SSI payments are exempt for purposes of Medicaid and need not be paid to the nursing home. IHCPPM § 3455.15.05. This is designed to allow an SSI recipient to be able to maintain the home during a short nursing home stay.

### g. Spousal Allocation for an Institutionalized Spouse with a Community Spouse

#### (1). Income of the Community Spouse

None of the income of the community spouse can be budgeted for the resident. 42 U.S.C. §1396r-5(b)(1). There is no limit on the community spouse's income. For example, a community spouse who is working gets to keep all of those earnings.

Determining who should receive income, where there is an option, can be used in planning. It may be possible in some situations to convert property to income payable to the community spouse. For example, an irrevocable annuity can be established with income to the community spouse. Or, where both spouses are entitled to income, it may be possible to persuade the payer to issue checks only in the name of the community spouse. The "name on the check" rule in the following section then provides that all of the income belongs to the community spouse and none of it can be attributed to the resident spouse.

#### (2). Attribution of Income

One must determine to which spouse income belongs. 42 U.S.C. §1396r-5(b)(2) provides that for income not from a trust, if the instrument specifies the ownership of income, then that

controls. If the instrument does not establish ownership, then the "name on the check" rule governs. That is, the income is attributed to the spouse whose name is on the check. If income is payable to both spouses, then it is attributed one-half to each. IHCPPM §2805.15.05.05 does not refer to the instrument but instead looks only to the "name on the check." "Consider income paid in the name of one individual to be the income of that individual."

Example:

> Harold and Dorothy, married, own rental real estate. Harold is in a nursing home, and Dorothy is at home. If the tenant pays rent to "Harold and Dorothy," then one-half of the income is counted for each. If the tenant pays the rent only to Dorothy, then all the income will be counted as Dorothy's income.

The presumptions in the statute can be defeated by a preponderance of the evidence. 42 U.S.C. §1396r-5(b)(2)(D). For example, if the provisions of a written instrument show that income is owned other than the way the name appears on the check, then one can use the fair hearing procedure to challenge the "name on the check" presumption.

For income from a trust, the specific terms of the trust will be reviewed to determine ownership of the income. If the trust does not provide, then the name on the check will control. 42 U.S.C. § 1396r-5(b)(2)(B).

Using the "name on the check" rule, if an institutionalized spouse owns an IRA which is annuitized and directs that the income be paid to the community spouse, then the income should be treated as being the income of the community spouse. In *Hotmer v. Ind. FSSA*, 150 N.E.3d 705 (Ind. Ct. App. 2020), rehearing denied Aug. 24, 2020, Mr. Hotmer purchased two irrevocable annuities, not in qualified retirement accounts, which provided for the monthly payments to be paid to Mrs. Hotmer. FSSA denied Mr. Hotmer's application for nursing home Medicaid eligibility because it counted the income as belonging to Mr. Hotmer, which placed his income above the Special Income Level. Upon appeal, the Administrative Law Judge reversed based on the name on the check rule because the payments were payable to Mrs. Hotmer and thus not Mr. Hotmer's income. FSSA appealed the decision and on agency review FSSA reversed and ruled that Mr. Hotmer owned the income because he owned the annuities. The Court of Appeals ruled that the income had been transferred to Mrs. Hotmer and per 42 U.S.C. § 1396r-5 was to be counted as Mrs. Hotmer's income. See also a discussion of the application of the "name on the check" rule with income payable to the community spouse in *Fixing the Leak: Avoiding IRA Liquidation in Crisis Medicaid Planning* by Dale Krause and Scott Engstrom, 16 NAELA Journal 35, 51-53 (2020) and *Commentary on Fixing the Leak: Avoiding IRA Liquidation in Crisis Medicaid Planning* by Ron Landsman and David English, 16 NAELA Journal 131, 133-136 (2020).

### (3). Community Spouse Allocation

A community spouse may qualify for an allocation from the institutionalized spouse's income. As explained in Section VIII(E)(1), *above*, 42 U.S.C. § 1396r-5(h) defines a "community spouse" as the spouse of an "institutionalized spouse." A spouse not in a medical institution or in

a nursing home qualifies as a community spouse. A spouse on a waiver whose spouse is in a nursing home is a community spouse and can qualify for an allocation.

Once the nursing home spouse is found eligible for Medicaid, a formula is used to determine how much income the community spouse needs. First, it is assumed the community spouse needs the spousal income standard, which is $2,178 ($2,289 effective July 1, 2022) per month. This is 150% of the federal poverty guidelines for a household of two.

Next, one considers the community spouse's shelter expenses (rent or mortgage payment, taxes and insurance, and utility charges) to determine if the community spouse needs an excess shelter allowance in addition to the spousal income standard. An excess shelter allowance is granted for the amount, if any, by which the community spouse's total shelter expenses exceed $653 ($687 effective July 1, 2022), which is 30% of the spousal income standard of $2,178 ($2,289). In determining the utility charges, the community spouse can submit the actual utility charges or can use a monthly standard utility allowance. Although actual utility expenses can be used if higher than the standard, it is simplest to use the applicable utility allowance rather than obtaining and averaging all the actual expenses. The standard allowance is $447 if there is a primary heating or cooling expense, $266 if there is no heating or cooling expense (such as if heating and cooling are provided by a landlord) but the spouse is responsible for at least two utility expenses, $59 if the spouse has one utility expense other than heating or cooling or telephone, and $32 if the only utility expense is the telephone. IHCPPM §3455.15.10.10. The utility allowances listed in this paragraph are effective May 1, 2022. The allowances are typically updated on May 1 each year.

There is no reduction in the standard income allocation of $2,178 ($2,289) if the shelter expenses are less than $653 ($687) per month.

The community spouse income and shelter standards are revised each year on July 1, based on the federal poverty guidelines issued in January or February, if those guidelines result in an increase.

The spousal income standard of $2,178 ($2,289 effective July 1, 2022) is then added to the excess shelter allowance, if any, to determine the spousal maintenance standard. This is the amount of income which it is determined that the community spouse needs. The total spousal maintenance standard using this calculation cannot exceed $3,435. This amount is indexed for inflation and increases January 1 each year, if the consumer price index has increased.

The spousal maintenance standard is then subtracted from the community spouse's **gross income** to determine the community spouse income allocation. Gross income before deductions for taxes or health insurance premiums is counted. If working, gross earnings are used. There is no deduction for work expenses or taxes, which creates a disadvantage for community spouses who are working. See below for the possibility of arguing that work expenses are extraordinary expenses which should be considered.

The community spouse income allocation is then allowed as a deduction in computing the nursing home spouse's monthly liability.

Examples:

Mr. Red in nursing home has Social Security and pension monthly income of $2,000. Mrs. Red at home has Social Security monthly income of $1,500, and her shelter expenses, including utilities, total $1,000 per month. She is entitled to an excess shelter allowance of $347 ($1,000 - $653), so that the amount of income she will be considered to need will be $2,525 ($2,178 + 347). Mr. Red can thus transfer $1,025 of his income to her so that her income will total $2,525.

Mr. Blue in nursing home has total monthly income of $2,000. Mrs. Blue lives at home on a Medicaid waiver but still qualifies as a community spouse. She has monthly income of $1,500. She pays rent of $600 per month. Heat is provided, but she is responsible for paying the electric bill, which includes air conditioning. She can use the $447 utility allowance, so her total shelter expenses will be considered to be $1,047 per month. Her excess shelter expenses are $394 ($1,047 - $653), so her monthly maintenance standard is $2,572 ($2,178 + $394). Although Mr. Blue can transfer $1,072 ($2,572 - $1,500) monthly to her from his income, he should only transfer $1,023 to her, which is enough income to raise her income to $2,523 per month. Raising her income to more than $2,523 per month would create the need for a Miller Trust, as discussed above, and then she would have a waiver liability, unless she has deductions that eliminate her liability.

Mr. Pink in nursing home has monthly income of $2,000. Mrs. Pink lives in the same apartment complex as Mrs. Blue and pays the same amount of rent ($600). Mrs. Pink still works. She grosses $1,500 per month before taxes are deducted. She also drives 40 miles a day to and from work. Her work expenses are not considered. She qualifies for the same allocation as Mrs. Blue, $1,023, even though her net income is less.

Mrs. Orange in the nursing home has monthly income of $2,000. Mr. Orange works and grosses $4,000 per month. His income is already more than the maximum standard of $3,435. He will not qualify for an allocation. None of his income is considered available to Mrs. Orange.

The spousal allocation is allowed only to the extent the income is made available to the spouse at home. In the example above, if Mr. Red does not transfer the $1,025 to his wife or use it for her benefit, then it will not be deducted from his income, and his "liability" to the nursing home will include the $1,025.

**(4). Increasing the Spousal Allocation by an Administrative Hearing**

Either spouse can request a fair hearing to argue that the community spouse should be allowed more income. The standard to meet is that there be "exceptional circumstances resulting in significant financial duress." 42 U.S.C. §1396r-5(e)(2)(B); IHCPPM §4205.10.05. The IHCPPM states that exceptional circumstances are those where the community spouse has expenses beyond what is recognized in establishing the maintenance standard. Nowhere is there

an explanation of what is included in the standard. I.C. § 12-15-2-25(d) directs FSSA to adopt rules governing this, but FSSA has not yet done this. The IHCPPM gives an example of a medical expense which the community spouse could not be expected to pay out of the standard as being an exceptional circumstance. The Missouri Court of Appeals found that the husband's medical expenses of $675 per month created financial duress for the community spouse so that the husband was entitled to a higher allocation. *Plumb v. Mo. Dep't of Soc. Servs.*, 246 S.W.3d 475 (Mo. Ct. App. 2007). A New York court refused to find that college expenses for a child of the couple could be considered. The court stated that this provision was instead designed to alleviate true financial hardship that is thrust upon the community spouse by circumstances over which he or she has no control, such as extraordinary medical expenses, or the need to preserve the homestead or an income-producing asset. *Schachner v. Perales*, 85 N.Y.2d 316 (N.Y.Ct.App. 1995).

It may not be sufficient to show that the community spouse does not have sufficient income to meet her expenses. A New York court denied an appeal and emphasized that it is not the goal to maintain the community spouse at her previous standard of living.

> Plainly stated, the spousal impoverishment provisions are not meant to enable the community spouse "to maintain [his or her] prior life-style and have the public subsidize it" — i.e., Medicaid dollars would have to make up for any monies diverted from the institutionalized spouse's medical care to the community spouse *(Matter of Gomprecht v Gomprecht*, 86 NY2d 47, 52, 652 N.E.2d 936, 629 N.Y.S.2d 190 [1995] [Family Court may not make an award in an amount greater than MMMNA to community spouse absent showing of exceptional circumstances within meaning of Social Services Law § 366-c]). Instead, "the narrow purpose of the legislation providing for the [MMMNA was] to protect the community spouse from financial disaster when the primary income-providing spouse [became] institutionalized" (*Schachner*, 85 NY2d at 323). Congress established the MMMNA at an amount it deemed sufficient to achieve this narrow purpose. Thus, the spousal impoverishment provisions do not guarantee a community spouse the same standard of living — even if reasonable rather than lavish by some lights — that he or she enjoyed before the institutionalized spouse entered a nursing home. Congress itself has decided what is a reasonable basic living allowance for the community spouse: the MMMNA. The tradeoff for a married couple, of course, is that the institutionalized spouse's costly nursing home care is heavily subsidized by the taxpayer, as happened here (see p 2, *supra*).

*Matter of Balzarini v Suffolk Co. Dept. of Soc. Servs.,* 16 N.Y.3d 135, 143-144(N.Y. Ct. App. 2010).

Although one needs to show "exceptional circumstances" rather than exceptional expenses, it is helpful to focus on those expenses which are "exceptional" and ask for an increased allotment to meet the "exceptional" expense(s). For example, if the community spouse has medical expenses of $500 per month, one should document those expenses and ask for an increased allotment of $500 to meet those expenses. There is nothing that limits the type of expenses which can be considered, so long as one can in good faith argue that they truly are "exceptional" and cannot be paid within the regular allocation. If the community spouse is

working, then one can submit that the income taxes and other work expenses are "exceptional" expenses, though there is no guarantee this will be accepted. It can be helpful to present a budget with verification of all expenses, but the main focus should remain on the exceptional expenses. Once the administrative law judge approves an increased allocation, that allocation should continue until the spouse's circumstances change. IHCPPM §4205.10.05.

The spousal allocation pursuant to a fair hearing is allowed to exceed $3,435. 42 U.S.C. §1396r-5(d)(3)(c) and §1396r-5(e)(2)(B). See also IHCPPM §3455.15.10.10 which does not explicitly state this but which appears to implicitly recognize this.

**(5). Increasing the Spousal Allocation by Court Order**

If a court has ordered the resident to pay support to the community spouse that is greater than the amount calculated using the statutory formula, then the federal statute appears to require that the court order controls. 42 U.S.C. §1396r-5(d)(5). In the above example, if Mr. Red were ordered to pay $1,400 per month to Mrs. Red and he pays it, then it would appear that amount must be deducted from his income. See Section VIII(E)(4)(c), *above,* for a brief discussion about obtaining a court order. A spouse can file an action for support relying on I.C. § 31-16-14-1. One needs to allege that "the other spouse has deserted the dependent spouse or dependent children without cause and without sufficient support." I.C. § 31-16-14-1(a)(1). If there is a guardianship over the recipient, a support order can be sought in the guardianship case.

I.C. § 12-15-2-25(c) provides that a court order can be issued if "a higher allowance is needed due to exceptional circumstances resulting in significant financial duress." This is the standard to be applied in administrative hearings. It is not clear if this provision is intended to limit the recognition of court orders or if it is simply describing an instance in which a state court order of support would be appropriate. Since the federal law does not limit the recognition of court orders to court orders that follow this standard, it would not appear that a state legislature can limit the recognition of otherwise valid support orders. I.C. § 12-15-2-25(d) directs FSSA to adopt rules setting forth the manner in which it will determine the existence of exceptional circumstances resulting in significant financial duress. FSSA has not yet promulgated any regulations concerning exceptional circumstances or on limiting the recognition of court orders. If one believes that one can meet this standard, it may be useful to ask the court to make a finding that a higher allowance is needed due to exceptional circumstances resulting in significant financial duress.

Neither 42 U.S.C. §1396r-5(d)(5) nor any Indiana statute requires that FSSA or the DFR be named as a party in the support case or be given notice of the proceedings. FSSA has in some cases later sought to intervene in the court case and requested that the support order be vacated. FSSA is currently appealing a trial court decision not allowing it to intervene and set aside a support order. *Ind. FSSA v. Clarence E Weber et al.*, No. 21A-GU-02680 (Ind .Ct. App. filed Dec. 2, 2021).

One may wish to give FSSA notice of a hearing before a support order is entered to try to avoid the possibility that FSSA will later seek to intervene. IHCPPM § 3455.15.10.10 requires that eligibility workers submit support orders to the Policy Answer Line for review.

The spousal allocation pursuant to a court order is allowed to exceed $3,435. 42 U.S.C. §1396r-5(d)(5). See also IHCPPM §3455.15.10.10 which does not explicitly state this but which appears to implicitly recognize this.

Other state's courts have taken varying positions on support orders. Following is a non-exhaustive review of how some other states have treated court orders. There are decisions in other states not covered here.

• Michigan. The Michigan Court of Appeals rejected the Michigan state Medicaid agency's appeal of a probate court's order in a guardianship case that the institutionalized spouse transfer all of his income to the community spouse. The Court rejected the agency's argument that the federal law preempts a state court's authority to enter support orders. The Court remanded the case to the probate court to reconsider the support order, stating that the community spouse is not guaranteed to maintain a particular standard of living, and that the court should consider the needs of the institutionalized spouse. *Vansach v. HHS (In re Estate of Vansach)*, 922 N.W.2d 136 (Mich. Ct. App. 2018).

• Connecticut. Similar to Michigan, the Connecticut Supreme Court ruled that a probate court's support order was binding on the Medicaid agency. The court emphasized that Connecticut law required that the Medicaid agency be given notice of the request for a spousal support order, and the state agency failed to take advantage of the opportunity to appear and object to the support order. *Valliere v. Comm'r of Soc. Servs.*, 178 A.3d 346 (Conn. Sup. Ct. 2018).

• New Jersey. A New Jersey Court ruled that if a recipient or spouse unsuccessfully challenges the income allocation through the fair hearing process, that person cannot then seek a court order of support. *M.E.F. v. A.B.F.*, 393 N.J. Super. 543, 925 A.2d 12 (N.J. App. Div. 2007). Another New Jersey Court refused to enforce a court order of support that was issued by a family court in a non-contested proceeding, without notice to the Division, because the order was designed to circumvent the regulations governing the community spouse monthly income allowance under federal law, and the order transgressed the permissible limits of Medicaid planning. *R.S. v. Div. of Med. Assistance & Hlth. Servs.,* 434 N.J. Super. 250, 83 A.3d 868 (N.J. App. Div. 2014).

• Tennessee. In 2000, *Blumberg v. Tenn. Dept. Of Human Servs.*, 2000 Tenn. App. LEXIS 709, 2000 WL 1586454 (Tenn. Ct. App. 2000), ruled that the administrative hearing process and court orders of support are alternative processes, and no notice to the state Medicaid agency was required. The Court stated that the state agency could have attempted to intervene, but it did not. In 2012, Tennessee Courts of Appeal declined to follow *Blumberg*. *Crisel v. Crisel*, 2012 Tenn. App. LEXIS 109, 2012 WL 565914 (Tenn. Ct. App. 2012), ruled that the state Medicaid agency was entitled to notice of the petition for support and that the trial court was required to find exceptional circumstances before awarding increased support, probably because Tennessee had a state statute requiring courts to apply the standards used to determine Medicaid eligibility.

• Mississippi. *Alford v. Miss. Div. Of Medicaid*, 30 So. 3d 1212 (Miss. 2010), U.S. Sup. Ct. cert. denied, held that a court could not consider entering a support order unless administrative remedies were first exhausted.

### h. Family Allocation for an Institutionalized Spouse With a Community Spouse

MCCA provides a family allocation for children under the age of 21, dependent children, dependent parents, or dependent siblings of either spouse **who live with** the community spouse. See IHCPPM §3455.15.10.15; 42 U.S.C. § 1396r-5(d)(1)(C).

The allocation for each family member is computed by subtracting that member's income from $2,178 ($2,289 effective July 1, 2022) and then dividing the result by three. Unlike the spousal allocation deduction, the recipient can take the deduction even if the amount is not given to the family member.

To be considered "dependent," the child over age 21, parent, or sibling must be claimed as a tax dependent by the community spouse. It is not uncommon that the community spouse, although able to remain in the community, may be in poor health. Suppose the community spouse is in such poor health that an adult child has moved in with the community spouse to care for her. It is also not uncommon that an unemployed adult child lives with the community spouse. If the adult child is claimed on taxes as a dependent, then that child can potentially qualify for a family allocation if the child has income below the spousal income standard of $2,178. Generally, an adult child can be claimed as a dependent if the child has lived with the parent for more than half the year and the parent has provided more than half of the child's support.

The question then arises as to whether the child must already have been claimed on a tax return as a dependent, or is it sufficient that the child will be claimed. For example, suppose a child gave up a job and moves in with the community spouse in January, 2022 to care for the community spouse. Suppose the nursing home spouse is approved for Medicaid in July, 2022. The child will not be claimed as a dependent until the tax return for 2022 is filed in 2023, but suppose it is clear that the child will be claimed for tax purposes once the tax return is filed. Although FSSA took the position that the child does not qualify until a tax return has been filed, the Marion Superior Court, Room No. IV, in Case No. 49D04-1509-PL-031937, ruled that evidence showing the child will be claimed is sufficient to qualify the child for the family allocation. The Judge relied in part on language in the CMS State Medicaid Manual § 3710.1 that a child "who may be claimed as dependents" qualifies as a dependent for the allocation.

There is no allocation for minor children or dependents who do not live with a community spouse. No deduction is allowed for a single person to support a dependent child. For example, there is no allocation for a minor child who lives with a former spouse or with another family member. This difference in treatment is arguably contrary to federal law at 42 CFR § 435.733(c)(3) and to the requirements of equal protection.

Example:

Suppose two minor children, Bob and Jan, live with their mother Mrs. Smith, a community spouse. Bob has no income and Jan has $600 of monthly income. Bob will receive an allocation of $726 ($2,178/3), while Jan will receive an allocation of $526 ((2,178-600)/3). Note, in comparing Bob's and Jan's allocations, that there is not a dollar for dollar deduction for income.

Suppose their mother dies and Bob and Jan move in with their aunt Claire. They do not qualify for a family allocation because they do not live with a community spouse.

Suppose Frank gave up his job and moved in with his father, a community spouse, to help him remain at home. Frank has no income and is supported by his father's income. Frank qualifies as a tax dependent of his father and can qualify for a family allocation of $726 ($2,178/3).

There is no provision for increasing a family allocation by court order or by a fair hearing. However, unusual financial needs of a minor child or a dependent could be an "exceptional circumstance" which would justify raising the community spouse's allocation through an administrative appeal. Or these facts might support asking a trial court to issue a support order to help meet the needs of the family members living with the spouse.

The family allocation can make a significant difference in the liability. FSSA typically does not ask sufficient questions to identify when the liability may apply and family members typically are not aware of this deduction. Advocates should be aware of this allocation and identify when it applies.

### 4. Computation of the Liability (IHCPPM §3455.15.00 *et seq.*)

The liability is computed using the **post-eligibility budget**. Any remaining income after the allowed deductions are subtracted from the gross income is to be paid to the nursing home as the "liability" amount. Medicaid then covers the remaining nursing home cost and other medical expenses.

The liability is computed and applied beginning the first full month that an applicant is in a nursing home. If the applicant entered a facility after the first day of a calendar month, then if eligible for Medicaid there will be no liability for the first partial month, with the liability beginning for the first full month in the facility. Arguably, there should also be no liability for the first month if the applicant enters on the first day of the month, as the resident was not in the facility the entire month. If the resident moves out of a facility, there will still be a liability for the month of move-out. IHCPPM §3455.15.00.

Example:

Fred entered a nursing home from home on September 5, 2021 and is later found eligible for Medicaid. He will have a 0 liability for September. His liability will

begin in October, 2021. Suppose Fred moves back home on February 4, 2022. He will still have a liability for February, 2022. For February he will owe the liability or the private pay cost for the four days he was there, whichever is less.

If both spouses are in a nursing home, a separate liability is computed for each spouse based on that spouse's income and deductions. Each spouse is allowed to keep a $52 Personal Needs Allowance.

With a very few exceptions, gross income rather than "countable income" is used in computing the post-eligibility budget. Even when a Miller trust is required, once the applicant/recipient establishes and properly funds the Miller trust, then the post-eligibility budget is computed using all of the income, even that deposited into the Miller trust account.

The liability is computed as follows:

Total Countable Income
- Personal Needs Allowance of $52 (plus $90 for some veterans)
- Health Insurance Premiums
- Medical Expenses Not Subject to Payment by a Third Party
- Guardianship Fees (maximum of $35)
- Income Taxes (One time per year)
- Temporary SSI Payments
- Spousal Allocation
- Family Allocation

**= Patient Liability**
**Spousal Allocation Calculation**
Rent / Mortgage
+ Utilities (use actual or standard allowance)
+ Property Taxes / Property insurance
= Shelter Expenses
- Shelter Standard of $653
= Excess Shelter Allowance
+ Spousal Maintenance Standard of $2,178
= Spousal Maintenance Standard (Cannot be more than $3,435)
- Spouse's Total Gross Income
= Spousal Allowance

**Family Allocation Calculation (for each family member eligible for allowance)**

Income standard of $2,178
- Family Member's Income
= Difference
Divide "Difference" by 3 = Family Allowance

Examples:

Brad, unmarried, is in a nursing home and applies for Medicaid. He receives gross Social Security of $800 and a pension of $300. His daughter lives in his house. She pays $200 per month rent to Brad, and in addition, she pays the utilities, taxes and insurance on the house, which together average about $400 per month. Brad pays $100 monthly for supplemental health insurance, $5 per month for life insurance, $20 per month for a telephone in his room, and $40 per month to his brother, who is his guardian, pursuant to a court order, for his brother's fees and attorney fees. His total income is $800 + $300 + $200 net rent = $1,300. He can deduct his health insurance premium, guardian fees up to $35, and personal needs allowance of $52. $1,300 (income) - $100 (health insurance) - $35 (guardian fees) - $52 (PNA) = $1,113. His monthly liability is $1,113. He cannot deduct what he pays for life insurance or his telephone. He is expected to pay that out of his personal needs allowance.

Fred has Social Security income of $2,000/mo. and a pension of $900/mo. His total gross income of $2,900 is more than the SIL of $2,523, so he needs a Miller trust and must deposit at least $377 into the trust monthly. Suppose he decides to just deposit the excess income of $377 into the trust account each month. The liability will be based on his gross income of $2,900, so it will be $2,848 ($2,900 - PNA of $52) if he is not entitled to any other deductions. His trustee will pay $377 from the trust on the liability, and Fred will pay the rest of the liability from the non-trust account. If Fred chose to have all of his income deposited into the Miller trust account, the trustee will pay the liability from the trust account and transfer $52 to Fred each month. Fred might choose to transfer the $2,848 liability into the trust account each month, and then one check for the liability could be written by the trustee from the trust account to pay the liability.

Mrs. Brown is in a nursing home and has $2,400 per month total income. Mr. Brown still lives in their home. He has income of $1,600 and pays a mortgage of $700 per month, which includes taxes and insurance. They have a 16 year old son at home who does odd jobs and earns $150 per month. She has a supplemental health insurance policy she wants to maintain with a premium costing $150 per month. She is under a guardianship, and the attorney for the guardian is owed fees of $800.

First, one computes the community spouse allocation and the family allocation.

Mr. Brown's excess shelter expenses are $700 mortgage payment (property taxes and insurance are included) + $447 standard utility allowance - $653 shelter standard = $494.

His spousal income needs are the income standard of $2,178 + excess shelter expenses of $494 for a total of $2,672. Subtracting

his income of $1,600, he is entitled to community spouse allocation of $1,072.

The family allocation for the son is ($2,178- $150)/3 = $676.

Now one can compute Mrs. Brown's liability:

| | |
|---|---|
| Gross Income | $ 2,400 |
| Minus guardianship fee | - 35 |
| Minus health insurance premium | - 150 |
| Minus PNA | - 52 |
| Minus Comm. spouse allocation | - 1,072 |
| Minus Family allocation | - 676 |
| Liability | $ 449 |

Suppose Mrs. Brown in the example above has monthly income of $2,800. If she establishes a Miller trust and deposits at least $277 per month into the trust, she will be eligible for Medicaid. The $277 transferred into the Miller trust could then be transferred to Mr. Brown as part of his spousal allocation. If Mrs. Brown transferred her entire income into the trust, then from the trust the trustee would pay the guardian fee at $35 per month and the health insurance premium. The trustee would transfer the spousal and family allocations of $1,714 ($1,038 + $676) to Mr. Brown, and he would transfer $52 to Mrs. Brown for her personal needs.

### 5. Deviating the Liability For Old Medical Bills

As explained above, medical expenses not subject to payment by a third party can be deducted in calculating the liability. This is commonly referred to as "deviating the liability." This is explained in IHCPPM §3455.15.10. This includes not only current medical expenses but also old past due medical bills incurred before the recipient became eligible for Medicaid. A nursing home bill for a month not covered by Medicaid can be used. The end result is that Medicaid can be used to pay most old nursing home bills at private pay rates.

This process cannot be used for an unpaid liability bill during a Medicaid covered period. It also cannot be used for medical expenses that were not paid as a result of a transfer penalty. IHCPPM § 3455.15.10; 405 IAC 2-3-1.1(f). Also, Medicaid will not allow a deviation to pay for a nursing home bed hold payment for days not covered by Medicaid when the recipient is in a hospital or on a therapeutic leave.

Examples:

Mrs. Smith, a widow, with monthly Social Security benefits of $1,052 enters a nursing home and applies for Medicaid. Medicaid denies payment for March due to excess resources and approves her effective April 1 with a monthly liability of $1,000. She still owes $4,000 to the nursing home for March. Mrs. Smith can present the $4,000 nursing home bill to the DFR. The $4,000 will be deducted as a

medical expense. Her liability will be "deviated" to 0 for four months so she can pay the nursing home bill. After four months, her liability will return to $1,000.

Mr. Daniels applied for Medicaid. While his application was pending, he used his income to pay credit card and other bills and did not pay anything to the nursing home. In May he was approved for Medicaid retroactive to January 1 with a liability of $2,000 per month. He now owes $10,000 to the nursing home for unpaid liability payments. He cannot use deviation of liability to pay any part of the $10,000, since Medicaid determined this was his portion to pay for months he was approved for Medicaid.

Ms. James is ineligible for Medicaid to pay for her nursing home care for two months due to a transfer of assets that resulted in a transfer penalty. She then becomes eligible for Medicaid, and she still owes the nursing home bill for the two months she was subject to a transfer penalty. Even though she has unpaid medical expenses not covered by Medicaid, she cannot use her nursing home costs for those two months to obtain a reduction in her liability.

In some situations FSSA may allow a deviation for the medical bill of the recipient's spouse. It will likely be necessary to show that the recipient is being billed by the provider for the expense. Medicaid Policy has indicated that a deviation will be allowed in some situations, such as where the spouse is deceased and her estate was not sufficient to pay the debt or where the recipient had agreed to be responsible for the bill.

In 2021, the FSSA added this language to 3455.15.10 about the documentation needed for a deviation to be allowed:

The DFR will allow a deduction for an incurred medical expense not covered by Medicaid and not subject to payment by Medicare or other insurance, if an actual provider-generated bill, or copy of such a bill, is submitted to the worker. This bill must indicate the date and type of service that was provided and must clearly show the amount that the recipient owes after any third party has paid. If the recipient has third party insurance that does not show as a player [sic, should be payor] on the bill, the recipient or provider must submit either an EOB documenting denial of payment or some other documentation of why the insurance was not billed or did not pay. No other documentation is acceptable.

### 6. Special Budgeting Situations

The IHCPPM discusses how the budgeting is to be applied in some situations where the result may not be obvious.

- **Transfer Penalty Period**. IHCPPM §3455.15.00. A post-eligibility budget is not completed, so no liability is computed. If a nursing home resident subject to a transfer penalty passes the eligibility budget, then Medicaid will pay all medical expenses not covered by other insurance **except for the nursing home per diem**. If the resident's income is above the SIL, the resident must have a Miller Trust to

qualify for Medicaid in order for the transfer penalty period to start. The resident needs to continue to make monthly deposits into the Miller trust for Medicaid eligibility to continue during the penalty period. The same process should apply to waiver applicants.

- **Liability Exceeds Nursing Home's Private Pay Rate**. IHCPPM §3455.15.15. The resident pays the full private pay rate. Medicaid pays nothing to the nursing home, but will pay other medical expenses. One would need to have a very high income for this to occur.

- **Liability Exceeds Nursing Home's Medicaid Rate but is Less than Nursing Home's Private Pay Rate**. IHCPPM §3455.15.15.05. The resident must pay the liability, which the facility must accept as full payment. Medicaid pays nothing to the nursing home, but will pay other medical expenses.

- **Medicare or other Insurance Pays For All or Part of Month.** IHCPPM § 3455.15.20. The post-eligibility budget is still used and a liability is computed. If the nursing home charges are less than the liability, then the resident just pays the nursing home's charges.

Examples:

Brad has total income of $2,052 per month. He has been in a nursing home for about three months, and his Medicare covered stay ended April 25. His Medicare and his Medicare supplement covered all of the nursing home's charges through April 25. Its daily rate is $200, so he owes $1,000 for April 26 through 30. His liability is $1,800 ($2,052 - $52 PNA - $200 Medicare supplement premium). Since the nursing home bill is less than his liability, he pays $1,000 rather than $1,800 to the nursing home for April.

Bart has total income of $3,000 per month. He made gifts which subject him to a transfer penalty period of 6 months. Bart must establish a Miller Trust and make deposits into the trust of at least $477 per month ($3,000 - $2,523) in order to qualify for Medicaid and start the penalty period. If he establishes the Miller Trust and is approved for Medicaid, no liability will be computed. Medicaid will not pay the nursing home per diem charges during the penalty period. Other medical expenses not covered by insurance will be covered by Medicaid. He must continue to make monthly deposits into the trust throughout the penalty period for Medicaid to remain in place.

### E. Rules for Waiver Services, Money Follows the Person, and PACE Recipients

Indiana applies the institutional eligibility rules, including spousal impoverishment protections, to persons on a waiver. It is also used for recipients of Money Follows the Person (MFP) or PACE services. I.C. § 12-10-11.5-4 provides that the income standard is 300% of the

SSI level, or $2,523 in 2022. The eligibility test for waiver services, MFP, and PACE is the same eligibility test used for nursing home residents.

### 1. Eligibility and Post-Eligibility

A waiver, MFP, or PACE applicant must first pass the eligibility test using an eligibility budget. The countable income must be at or below the SIL ($2,523 in 2022). If the applicant does not pass the SIL test, either by having income at or below the SIL or by having a Miller trust in place, then the applicant is not eligible for Medicaid.

Once a waiver or MFP applicant passes the eligibility test, a post-eligibility budget is computed. The budget is computed the same as for a nursing home resident, as explained in Section IX(D)(3), *above*, **except that the personal needs allowance is $2,523**, the same as the SIL, rather than $52. The reasoning is that a waiver or MFP recipient has much greater personal needs than does a nursing home resident. The net result of the post-eligibility budget after subtracting deductions for a waiver or MFP recipients is labeled as a "waiver liability."

FSSA will not establish a liability for a PACE recipient. In 2021, the FSSA amended IHCPPM §§ 3380.00.00 and 3380.20.00 to state that PACE participants will not have a liability. The PACE participant will still need to pass the eligibility test, so Miller Trust deposits will be needed if income is above the SIL. (A PACE recipient can remain on PACE after needing to enter a nursing home. The IHCPPM seems to say that a PACE recipient entering a nursing home will not have a liability, even though that seems inconsistent with other residents.)

The result of the personal needs allowance being set at $2,523 is that every applicant or recipient with income under the SIL will qualify with no waiver liability. Persons who need a Miller Trust will typically have a waiver liability.

For a married person with a Miller trust, the spouse may be entitled to a community spouse income allocation, using the same formula as used for the community spouse of a nursing home resident. As explained above in Section VIII(E)(1), a "community spouse" is a spouse who is not in a medical institution (hospital) or a nursing home.

The community spouse is allowed to count all of the shelter expenses in determining the shelter expense deduction. IHCPPM § 3320.10.00 provides that there is no penalty for transferring funds from a Miller trust to the spouse, so the waiver recipient can actually transfer more to the non-waiver spouse than the amount determined by the allocation.

<u>Examples:</u>

> Sam is at home on a waiver. He has total income of $1,900 per month. He passes the eligibility test because his income is less than the SIL of $2,523. Because his income is less than his personal needs allowance of $2,523, he has no waiver liability.
>
> Judy, who left a nursing home on the MFP program, has gross income of $2,550. As her income is $27 above the SIL of $2,523, she must have a Miller Trust and

she must deposit at least $27 per month into the Trust in order to pass the eligibility test. If she is not entitled to any other deductions, such as for a health insurance premium, she will have a waiver liability of $27. If she transfers the minimum of $27 into her trust account, then those funds will be available to pay the waiver liability. If Judy transfers all of her income into the trust, then her trustee will transfer $2,523 monthly into Judy's non-trust account as her personal needs allowance.

If a waiver recipient is in an assisted living facility or an adult family care home, the facility can collect up to $841 per month from the recipient for room and board. The Division of Aging allows facilities to charge more than $841 per month where the resident receives extra services, such as cable or internet, or where the resident's unit is larger than the minimum size required, so long as the resident has the choice to select a base unit with base services with a room and board charge of $841. The resident must be allowed to keep at least $52.

Examples:

Wanda lives in an assisted living facility on a waiver. She has income of $1,200 per month. She has no waiver liability since her income is less than the SIL. The facility charges her $841 for room and board. Medicaid covers the remainder of its cost.

Cindy lives in an adult family care home on a waiver. She has SSI of $841 per month. The home can only charge her $789 for room and board. She will then have $52 to meet her personal needs.

If both spouses are waiver recipients, there is not a couple standard which is applied. Instead, their incomes are considered separately. If one spouse has income below $2,523 and one spouse has income above $2,523, then the spouse with income above $2,523 must establish a Miller trust.

### 2. The Waiver Liability Process

In September, 2018 FSSA removed language from the IHCPPM stating that the income spend down process used through May, 2014 continued to be used for waiver recipients with a Miller Trust and a waiver liability. The system is administered similar to the previous spend down process, but with no provision for non-claim expenses to be submitted directly to DFR to be applied to the liability. The DFR will need to adjust or "deviate" the liability if there are expenses that are not covered by Medicaid.

Once a waiver or MFP recipient qualifies for Medicaid with a "waiver liability," the expenses Medicaid will cover is determined on a month by month basis.

The process works somewhat like a private health insurance system with a deductible. Recipients have access to Medicaid covered services from the beginning of the month. After a Medicaid provider provides services, the provider files a claim with Gainwell Technologies, a contractor for Medicaid. If the recipient has Medicare or other health insurance, the provider must

first bill Medicare or other insurance before filing the remaining amount of the bill with Medicaid. Once the claim is submitted to Medicaid, the waiver liability amount is applied to claims in the order received for the month in which services were provided. The waiver liability amount is deducted much like an insurance deductible. Once sufficient claims are submitted for a month to meet the liability, any remaining claims for that month are covered by Medicaid.

On the second business day of each month Medicaid sends the recipient a Medicaid HCBS Waiver Liability Summary Notice which shows the claims which were processed in the previous month to meet the waiver liability. A sample Summary Notice is at Appendix R. The notice informs the recipient which providers the recipient is expected to pay. The Notice lists information for each month for which claims were processed that satisfy all or part of the waiver liability amount. Once the waiver liability is met for a month, any additional claims filed for that month are not listed. Only those claims counted towards the waiver liability are listed. Although one would expect these notices to be easy to read, they are often confusing. For example, on the Notice in Appendix R, every claim listed has some amount listed as a "future credit," which seems incorrect. The drug copays incurred later in the month after the liability was met should be future credits, to be credited towards the following month's liability, but it is not clear why the future credit amount is often different than the amount of the copay. The Notice can be appealed.

Almost all Medicaid providers are required to provide services to recipients regardless of whether waiver liability has been met for a month. Once the recipient is notified by Medicaid which providers the recipient must pay the waiver liability amount to, then the provider may bill the recipient. There is an exception to this process for pharmacies which do "point of service" billing for prescription drugs. These pharmacies can obtain instant processing of claims. These pharmacies can obtain up to date information on how much is required for a recipient to meet the waiver liability and can require the recipient to pay the waiver liability amount before releasing the prescription drugs. For other providers that do not use point of service billing, if the recipient fails to pay the waiver liability to the provider after receiving the monthly Summary Notice, then the provider can refuse to provide future services so long as the provider is applying a policy that applies equally to Medicaid and non-Medicaid patients. For example, suppose a doctor has a policy that no patient will be seen if the patient owes money to the doctor. If Medicaid mails a notice to the recipient on May 2 informing the recipient that he owes the doctor $30 for services provided in April, then the doctor can refuse to serve the patient until the $30 bill is paid.

If a recipient has medical expenses which cannot be filed by a provider as a claim, the recipient needs to submit the expense(s) to the DFR and request that the liability be adjusted. This could include medical services provided by a non-medical provider, "old bills" for medical services received before the recipient was eligible for Medicaid, or mileage for transportation to medical appointments. IHCPPM § 3325.10.00 specifically provides that one cannot obtain a deduction for home care such as companions, attendants, or homemakers, which are not included in the waiver care plan. Instead, FSSA's position is that if more hours are needed, then approval for those hours should be requested through the waiver plan.

IHCPPM Chapter 3300 on Waivers does not specifically address the treatment of the VA Aid and Attendance Allowance. The Aid and Attendance Allowance, or any VA benefits paid based on unreimbursed medical expenses, are not counted in the eligibility budget. IHCPPM § 2840.10.10. Once the waiver is approved and Medicaid begins paying Medicaid covered medical

services, the unreimbursed medical expenses may decrease or be eliminated completely, which must be reported to the VA. This often will result in a reduction or termination of the VA benefits. But suppose the waiver covered services are not adequate to meet the recipient's needs and the recipient desires to continue paying additional caregivers with the VA benefits. The recipient should be able to do so. The DFR should not include the VA Aid and Attendance Allowance as income and should not require it to be paid through a liability. If the VA benefits are needed to be able to pay for care in addition to the care available through the Medicaid waiver, one should be able to use the VA benefits for this purpose.

Examples:

Sally's income is $300 above the SIL, and she has no deductions for her post-eligibility budget. Suppose she is being billed by a hospital for a $5,000 bill incurred before she was eligible for Medicaid. She should submit the old hospital bill to the DFR and request that her liability be lowered to 0 until the $5,000 bill is extinguished. The DFR should lower her liability to 0 for 16 months and to $100 in the 17th month. FSSA can request verification that the bill remains unpaid for the deduction in liability to continue. Hopefully Sally will pay the hospital bill at the rate of $300 per month so that it will be extinguished. Even if she does not pay the back bill, she should still receive the deduction for the 17 months.

Chris, who has a $100 waiver liability, goes to a dentist who does not accept Medicaid. The dentist bills Chris $1,000 for an upper plate. Chris submits this expense to the DFR and requests that his liability be adjusted. His liability should be reduced to 0 for ten months, which will allow him to pay the dentist's bill.

Maude, a widow of a veteran, receives Social Security and a pension totaling $2,300 per month, along with a VA Aid and Attendance Allowance of $1,244 per month. She is using the Aid and Attendance Allowance to pay for additional home care beyond that provided by the waiver. The Allowance should not be counted as income. She has no waiver liability.

## X. Financial Eligibility for Working Individuals with Disabilities (MED Works)

As explained above in Section V(J), the Medicaid Buy-In Program for Working Individuals with Disabilities, referred to as MED Works, allows working individuals with disabilities to buy Medicaid coverage. This program has its own resource and income guidelines. It is a very useful program for disabled persons who are working, even part time.

The minimum amount of earnings required is low, at least $65 per month (405 IAC § 2-9-5(a)), or at least $290 per month when applying based on a medical improvement (405 IAC § 2-9-5(b); IHCPPM § 3047.00.00).

The resource limit is $2,000 for a single individual and $3,000 for a married couple. The regular Medicaid rules are generally used for assessing resources, except that retirement accounts held by either the applicant/recipient or the spouse are specifically exempted. 405 IAC 2-9-

4(c)(11); IHCPPM §2615.15.00. Another important benefit of the program is that a working disabled person is allowed to have an Independence and Self-Sufficiency Account in which resources up to $20,000 can be disregarded so the worker can save money to purchase goods or services needed to increase or maintain employability or independence. I.C. § 12-15-41-2(3). This Account needs to be approved by the Central Office of FSSA. See IHCPPM § 2626.00.00 for more information.

The income rules also are substantially more liberal than those for regular Medicaid benefits. Two income tests are used. The first income test (eligibility budget) determines eligibility for coverage under MED Works. If married, only the income of the applicant is counted; the spouse's income is exempt in the eligibility test. Then, the net countable income of the applicant is determined, using the same eligibility budgeting process used above in Section IX(C) except that any impairment related work expenses are deducted. Note that less than one-half of earned income is counted. If the net countable income is less than 350% of poverty, or $3,964, then the person passes the eligibility test. This means that a person with gross annual earnings as high as $95,000 (slightly less than one-half of gross earnings are counted) could potentially qualify. See IHCPPM § 3455.06.00 for the eligibility budgeting procedure.

Once the person passes the eligibility test, a separate calculation is made to determine if the applicant is required to pay a monthly premium. Monthly premiums are on a sliding scale and are listed at IHCPPM § 3010.20.20. The premium is determined based on the person's gross income, not net countable income. If married, the gross income of the spouse is also included, even though it is not counted in the eligibility budget. Premiums range from $48 to $187 per month for a single person and from $65 to $254 per month for a married recipient. See IHCPPM § 3010.20.20 for a table listing premiums. When a MED Works recipient is subject to post-eligibility budgeting in a Medicaid certified facility, there is no premium charged, because a liability is applicable.

## XI. Financial Eligibility for Medicare Savings Programs

As explained above in Section V(K), a Medicare beneficiary may still qualify for Medicaid under one of four special categories designed for Medicare beneficiaries even if she does not qualify for full Medicaid under the aged, blind, or disabled categories. These categories have more liberal financial eligibility guidelines than regular Medicaid but with more limited benefits.

Persons who apply to the Social Security Administration for Medicare Part D Extra Help will automatically have their applications transmitted to the DFR for processing for eligibility for QMB, SLMB, or QI, unless an applicant chooses to opt out. IHCPPM § 2050.00.00 *et seq*.

An added benefit to qualifying for QMB, SLMB, or QI is that the person automatically is eligible for "extra help" for Medicare Part D prescription drug coverage. This means that the person will avoid paying the premium and deductibles for Part D coverage and will only pay a small deductible for each prescription covered under the plan.

**A person who qualifies for Medicaid for the Aged, Blind, and Disabled but whose income is too high for QMB, SLMB, or QI will still have his or her Medicare Part B premium paid by the state, as this is a benefit of receiving Medicaid for the Aged, Blind, and Disabled.** For example, a nursing home resident or waiver recipient may still qualify for Medicaid A, B, or D even though the income is above the limits for any of the buy-in programs listed below. That person still receives "buy in" of the Part B premiums.

When a person with Medicare applies for Medicaid coverage with the goal of obtaining Medicaid for the Aged, Blind, and Disabled, the DFR often sends a notice saying the applicant is or is not eligible for one of the buy-in programs. This is typically included on a Form 619M "Eligibility Notice of Action," commonly known as a "manual notice," although it is completed by computer. See Appendix S for a sample "manual notice." This can be very confusing for applicants, so one should alert the applicant that such a notice may be received, but that denial for a "buy in" program does not mean the applicant will be denied for Medicaid A, B, or D.

### A. Qualified Medicare Beneficiaries (QMBs)

The first category, "Qualified Medicare Beneficiary" (QMB), acts like a basic Medicare supplemental insurance policy. For persons eligible, Medicaid will pay any Medicare deductibles or coinsurance. This includes the hospital deductible, nursing home copayment, Part B $233 deductible, and Part B 20% copayment. The nursing home copayments are covered even if the recipient is not in a Medicaid certified bed. Doctors, suppliers, and other providers cannot bill a recipient for covered medical services, equipment, and supplies. In addition, Medicaid will pay (also known as "buy in") the Part B (and Part A, where applicable) Medicare premium. Thus, the Part B premium is not deducted from the person's Social Security benefits.

QMB has its own financial eligibility criteria. The Medicare Improvements for Patients and Providers Act of 2008 provided that the Medicare buy-in programs must use the standard resource limit that is used for the Medicare Part D Low Income Subsidy. Thus, the resource limits in 2022 are $8,400 for an individual and $12,600 for a couple. IHCPPM § 3005.25.00.

Although federal law only requires a minimum income limit of 100% of the poverty guidelines, Indiana has chosen to set the countable income limits at 150% of the poverty guidelines: $1,699 for one person and $2,289 for a married couple. FSSA increased the percentage of poverty income limit in June, 2014 to assist some persons who lost spend down eligibility. The income limits normally increase each year on March 1 or April 1. January 1 Social Security cost of living increases cannot be considered until after the income limits have been updated that year. IHCPPM § 3455.05.05.10.

QMB does not provide retroactive coverage; instead coverage begins the month after the eligibility decision is made. IHCPPM § 2035.65.00. For example, suppose an applicant applies in April, and FSSA processes the application in May and determines the applicant is eligible for QMB. Coverage begins June 1.

Unlike other Medicaid services, a QMB recipient does not need to receive Medicare covered services from a Medicaid provider. Providers who are not Medicaid providers must

accept whatever Medicaid pays and cannot collect anything further from the recipient. 42 U.S.C. § 1396a(n)(3)(b). The Medicare Summary Notices now sent quarterly to beneficiaries who have QMB state that the maximum the recipient can be billed is zero. Page one of the Notice should show that it includes claims covered by QMB. Justice in Aging's website at www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing has CMS Documents, model letters, and other materials related to this issue.

A Medicare recipient who is a recipient of Medicaid for the Aged, Blind, and Disabled who also meets the QMB requirements should have both MA A, B, or D **and** QMB. IHCPPM § 1610.30.00 states that one can be eligible simultaneously for QMB and any other full coverage category of Medicaid (such as Medicaid for the Aged, Blind, and Disabled.) Such a recipient can go to a Medicare provider who does not accept Medicaid for Medicare covered services. This gives these recipients more flexibility concerning choice of provider.

For persons who have few medical expenses not covered by Medicare or who wish to use a non-Medicaid provider for Medicare covered services, QMB is an excellent program. QMB is not as useful for persons, such as persons in long term care, who have substantial medical expenses not covered by Medicare. But there still can be benefits for a nursing home resident to have QMB coverage. If one already receives QMB benefits before entering a nursing home for a Medicare covered stay, then Medicaid - QMB will cover the Medicare copayment for days 21 through 100 of the Medicare covered stay. Also, as explained above, QMB coverage gives a person the option of using non-Medicaid providers for Medicare covered services.

### B. Specified Low Income Beneficiaries (SLMBs)

A second more limited category was added effective January 1, 1993. This category is known as Specified Low Income Beneficiary (SLMB). The only coverage under this category is that Indiana pays the Medicare Part B premium so that it is not deducted from the person's Social Security benefits. The recipient then receives an increase in net benefits. Medicaid will not pay any portion of the person's medical expenses.

The resource limits are the same as for QMB.

Although federal law only requires a minimum income limit of 120% of the poverty guidelines, Indiana has chosen to set the countable income limits at 170% of the poverty guidelines: $1,926 for one person and $2,594 for a married couple. These standards also typically change each year on March 1 or April 1. January 1 Social Security cost of living increases cannot be considered until after the income limits have been updated that year. IHCPPM § 3455.05.05.10.

A difference from QMB is that three months of retroactive coverage can be granted.

Although limited, this category is at least useful in giving an increase in the net monthly income to those who qualify. Also, a SLMB recipient qualifies for full "Extra Help" for Medicare Part D.

IHCPPM § 1610.35.00 states that a person can be simultaneously eligible for SLMB and any other full coverage category of Medicaid. This is not important, since a recipient of a full coverage category of Medicaid will have "buy in" of the Medicare Part B premium regardless of eligibility for SLMB.

### C. Qualified Individuals (QIs)

A third category, known as Qualified Individual (QI), was added effective January 1, 1998. Congress initially only approved the QI benefit for five years. Each time the category approached expiration, Congress extended it, but only temporarily. Congress has now permanently extended the program. 42 U.S.C. 1396a(a)(10)(E)(iv). QI is identical to SLMB except with a higher income limit; the only benefit is that Medicaid pays the Medicare Part B premium. The reason that SLMB was not simply expanded to the QI income limit is the QI program is not set up as an entitlement program. Congress appropriates a set amount of money to each state for QI benefits; if and when those annual funds are exhausted, the state can stop providing QI benefits. To monitor this, Indiana keeps separate track of the QIs. To date, Indiana's allotment has been adequate to cover everyone in Indiana who applies.

Although federal law only requires a minimum income limit of 135% of the poverty guidelines, Indiana has chosen to set the countable income limits at 185% of the poverty guidelines: $2,096 for one person and $2,823 for a married couple. These standards also typically change each year on March 1 or April 1. January 1 Social Security cost of living increases cannot be considered until after the income limits have been updated that year. IHCPPM § 3455.05.05.10.

The resource limits are the same as for QMB and SLMB.

Like SLMB, a person can receive coverage for three months before the month of application. As with QMB and SLMB, a QI recipient qualifies for full "Extra Help" for Medicare Part D.

IHCPPM § 1610.45.00 provides that a person cannot simultaneously be eligible for QI and another category of Medicaid. This does not matter, since a recipient of a full coverage category of Medicaid has "buy in" of the Medicare Part B premium regardless of eligibility for QI (or QMB or SLMB).

### D. Qualified Disabled Worker (QDWs)

Federal law allows a person who continues to be disabled or blind but who no longer is eligible for Social Security Disability benefits or widow's or widower's insurance benefits due to excess earnings to purchase Medicare Part A coverage. 42 U.S.C. §1396i-2a. Under the Medicaid QDW category, Medicaid pays the cost of the Medicare Part A premium rather than the Part B premium. The cost of the Part A premium is substantially higher than that of the Part B premium, so this is an important benefit for those persons who fit into this category. QDW covers persons

with income below 200% of the federal poverty guidelines. The countable income limits are thus $2,265 for a single person and $3,052 for a couple.

The resource limits are the same as for QMB, SLMB, and QI.

## XII. How Medicaid Works with Medicare Part D

Medicare recipients are able to obtain Part D, also known as Prescription Drug Coverage. Medicare contracts with private companies to provide this benefit, so there are multiple plans (Prescription Drug Plans (PDPs)) with various options in every state. Plans do not necessarily offer the same prescriptions, as plans can establish their own formularies, within limits set by Medicare. Premiums and other costs vary from plan to plan. There are opportunities to sign up for Medicare managed care plans (Medicare Advantage) that may include prescription drug coverage.

Most Medicare beneficiaries who enroll in Part D pay a monthly premium set by the private company offering the plan. The premiums are not designed to pay the entire cost of the benefit; instead the premiums are only designed to cover 24.5% of the cost, with the federal government subsidizing the remaining 75.5% of the premium cost. 70 Fed.Reg. 4306 (Jan. 28, 2005).

Because prescription drug coverage is offered through various plans offered by private companies, there are many different plans in each state. There are several stand alone plans available in 2022 to choose from in Indiana. The Medicare law establishes a standard Medicare D plan established by the law. 42 U.S.C. § 1395w-102. Plans can offer either the standard benefit or an alternative benefit structure that is actuarially as good as or better than the standard benefit and that does not increase the standard deductible or the catastrophic threshold. Under the standard plan, there is a deductible, which is $480 per month. The "doughnut hole" has finally been closed. So, after meeting the deductible, the patient pays at most 25% of the cost of the drug. After the patient's out-of-pocket costs reach $7,050, the patient pays the higher of $3.95 for generic drugs, $9.85 for brand drugs, or a 5% copayment, whichever is higher.

There is also prescription drug coverage available through Medicare Advantage plans.

The premiums vary dramatically by plan. The benchmark for Indiana is $29.65 for 2022. Plans with higher premiums typically eliminate the deductible and provide some coverage in the coverage gap (doughnut hole).

The copayments, the amount one pays for prescriptions after the deductible has been met, also vary from plan to plan. In some plans, one pays the same copayment, a set amount, or coinsurance, a percentage of the cost, for any prescription. In other plans, there are different "tiers" with different costs. For example, one may pay less for generic drugs than brand names. Some brand names might have a lower copayment than other brand names. In many plans one's share of the cost can increase when the prescription drug costs reach a certain limit.

Each Medicare drug plan has a formulary. Plans cover both generic and brand-name prescription drugs. The drug list may not include specific drugs, but a similar drug that is safe and effective should be available in most cases (according to Medicare). Medicare requires drug plans to cover all, or substantially all, of the drugs in six specific categories. These categories are the antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS categories. All Medicare drug plans must cover all anti-retroviral drugs. This includes single chemical entities as well as combination products.

Medicaid recipients who have Medicare must obtain their prescriptions through a Medicare Drug Plan, but the recipient pays lower costs by virtue of being a Medicaid recipient.

### A. Dual Eligibles (Eligible for Medicare and Medicaid with Prescription Drug Coverage) Qualify for Full Extra Help with Auto Enrollment If Not Already in a Plan.

A "dual eligible" refers to a Medicare beneficiary who also has Medicaid with prescription drug coverage, which is Medicaid for the Aged, Blind, or Disabled. A person who only has Medicaid - QMB, SLMB, or QI coverage is not considered to be a "dual eligible," as these categories of Medicaid coverage do not cover prescription drugs, but persons in these categories still qualify for Full Extra Help. See Section B, *below*.

A "dual eligible" automatically qualifies for " full extra help," which reduces the Part D costs. A dual eligible has no Part D deductible and is not responsible for paying a monthly Part D premium if enrolled in a Part D plan with a premium at or below the "benchmark", which is $29.65 for 2022. Appendix T shows what plans are available for no premium for persons qualifying for "full extra help." A dual eligible enrolled in a Part D plan costing more than the benchmark is responsible for paying the amount of the premium that is above the benchmark. The only cost sharing required of dual eligibles are copayments of $1.35 for generics and $4.00 for brand name drugs for those with income less than or equal to 100% of the federal poverty guidelines and $3.95 for generics and $9.85 for brand name drugs for those with income above 100% of the federal poverty guidelines. Nursing home residents and waiver services recipients are not required to pay any copayments.

#### 1. Auto Enrollment into a Part D Plan for Those Not Already Enrolled in a Part D Plan

FSSA on about the 20th of each month electronically notifies the Center for Medicare and Medicaid Services (CMS), the agency which administers Medicare, of all Indiana persons who are eligible for Medicaid for that month. CMS then identifies Medicare recipients who are not already receiving full extra help. If CMS determines that a dual eligible is not enrolled in a Part D plan (see below for an exception involving persons in a qualified retiree plan), CMS will automatically enroll that person into a Part D plan that costs less than or equal to the benchmark premium. In 2022, there are six plans in Indiana with premiums below the benchmark that qualify for auto enrollment. See Appendix T. **The enrollment is retroactive back to the beginning date of Medicaid eligibility.**

For persons who do not have a Part D plan for one or more months that they were found eligible for Medicaid, CMS should automatically enroll them into the LINET (Limited Income Newly Eligible Transition) program administered by Humana. Individuals should also be able to receive immediate need coverage at the point-of-sale at the pharmacy even if they are not already enrolled into a Part D plan. This allows for a smoother transition as CMS autoenrolls them into standard Medicare prescription drug plans. This program also allows reimbursement for months in the retroactive coverage period. LINET can be reached at 1-800-783-1307. Its fax number is 1-877-210-5592. For example, suppose on May 23, CMS is notified that a Medicare recipient who has no Part D plan has been awarded Medicaid which was effective February 1. CMS will randomly auto enroll that person into one of the Part D plans with a premium at or below the benchmark, with coverage to be effective July 1. LINET will provide coverage for February 1 through June 30. The individual can change prospective plans but cannot change the LINET coverage for the retroactive period. For more information on LINET, see www.humana.com/provider/pharmacy-resources/medicare-limited-income-net-program.

Some persons may already have prescription drug coverage under another plan and may not want to be enrolled into a Part D plan. In that case, the individual can telephone 1-800-MEDICARE to decline the auto enrollment. Unless joining the Part D plan will cause the person to lose other insurance coverage, the Part D plan will typically be less expensive.

Normally Medicare recipients can only switch prescription drug plans during the open enrollment period from October 15 through December 7. However, a dual eligible is allowed to switch prescription drug plans at any time. Thus, if one is not pleased with the plan into which one is automatically enrolled, one can enroll in another plan. That enrollment is effective the beginning of the next month. The CMS letter notifying the person of the auto enrollment will include a list of all other plans in Indiana qualifying for a zero premium.

### 2. New Medicaid Recipient Is Already Enrolled in a Medicare Part D Plan.

Section 1 above discusses the situation in which a new Medicaid recipient with Medicare coverage is not already enrolled in a Part D plan. If a new Medicaid recipient is already enrolled in a Part D plan, then CMS has no need to auto enroll the recipient into a plan. Instead, the recipient will be notified by CMS that he or she is now eligible for full extra help. If there is retroactive Medicaid coverage, then the recipient should receive a refund from the prescription drug plan for premiums paid and for amounts paid for prescriptions that are more than the copayments owed.

If the recipient is enrolled in a Part D plan with a premium costing more than the benchmark, the recipient is responsible for paying that part of the premium which is above the benchmark. The recipient should consider switching to one of the plans shown in Appendix T with no premium. Before switching, the recipient should check to make sure the no premium plan will cover all of the recipient's medications. A Medicaid recipient can switch prescription drug plans and does not need to wait until the annual open enrollment period to switch plans.

### 3. New Medicaid Recipient Is Already Enrolled in a Qualifying Retiree Plan.

As explained in Subsection 1, *above*, normally CMS will auto enroll a dual eligible person into a Medicare Part D plan if that person is not already enrolled in a plan. There is an exception for persons enrolled in a qualifying employer or union plan. These plans receive a subsidy from the federal government because they have coverage equivalent to or better than the standard Part D plan. The government provides a subsidy so these plans do not drop their prescription drug coverage. If CMS' records show that a new Medicaid recipient is already enrolled in a qualifying employer or union plan, then CMS will not auto enroll the recipient into a Part D plan, but instead will send the recipient a notice explaining that the recipient can enroll in a Part D plan and explaining the potential benefits of doing so, but also cautioning the recipient to first discuss the consequences with the qualifying plan. Some qualifying plans provide that if the retiree opts into a Part D plan, then the retiree **and the retiree's dependents** lose not only their prescription drug coverage but also all other health insurance coverage. Therefore, some retirees will want to keep their qualifying plan even though the retiree's costs would be less under a Part D plan.

## B. Persons with Medicare Who Qualify for Medicaid QMB, SLMB, Or QI Also Qualify for Full Extra Help with Facilitated Enrollment.

QMB, SLMB, and QI recipients automatically qualify for Full Extra Help for their Medicare Part D plans.

If a person applies directly with the SSA for Extra Help, SSA will forward the application to FSSA to consider eligibility for QMB, SLMB, or QI. The applicant will not be asked to sign a separate Medicaid application, and an eligibility interview will not be scheduled.

Medicare recipients who are approved for QMB, SLMB, or QI and who are not already enrolled in a Part D plan or a qualifying retiree plan are enrolled prospectively into a Medicare Part D plan **but are not enrolled for retroactive coverage**. CMS refers to this enrollment as "facilitated enrollment" rather than "auto enrollment" because the recipient has the opportunity to choose a different plan before the enrollment takes effect. CMS sends a notice explaining that the recipient will be enrolled into X plan effective on Y date, but that the recipient can choose a different plan before that date, or the recipient can choose to opt out of the enrollment. The recipient qualifies for full extra help with copayments of $3.95 for generics and $9.85 for brand name drugs (in 2022).

## C. Troubleshooting and More Information

SHIP, the Senior Health Insurance Information Plan of the Indiana Department of Insurance, and the Area Aging Agencies assist persons to become eligible for the low income subsidy and to resolve problems with enrollment. A client with problems with enrollment in a

Part D plan can be referred to the client's Area Aging Agency. The local area aging agency can be reached at 1-800-986-3505.

For more information on the auto enrollment and facilitated enrollment processes, see www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/AutoandFacilitatedEnrollmentofLowIncomeBeneficiaries.html. Advocacy web sites, such as www.medicareadvocacy.org and www.kff.org/medicare, have information on the low income subsidy.

## XIII. Transfer Penalties

**As explained above in Section VII(G)(2), current recipients cannot have their Medicaid benefits terminated or reduced during the current Public Health Emergency. Thus, transfer penalties are not currently being imposed on recipients. Transfer penalties are being imposed on new applicants.**

In 2007, the U.S. Government Accountability Office determined that relatively few people transfer assets to become eligible for Medicaid. "Medicaid Long-Term Care: Few Transferred Assets before Applying for Nursing Home Coverage; Impact of Deficit Reduction Act on Eligibility is Uncertain," GAO-07-280 (March, 2007). Nonetheless, federal and Indiana law provide penalties for various "transfers." The general framework of the penalty is that transactions for a certain past period, referred to as the "look back" period, are reviewed, and certain transfers for less than adequate compensation that are determined to be penalizable transfers result in the assessment of a penalty period, which is a period of time that Medicaid will not pay for nursing home care or for waiver services. Since some transactions that one would not commonly view as a transfer can be subject to a penalty, but yet not every transfer results in a penalty, it is important to fully understand the transfer penalty rules. Even if one does not expect to need Medicaid, one should be aware that certain transactions can cause complications if a client unexpectedly were to need long term care.

Before July 1, 1988, transfer penalties varied from state to state. Effective July 1, 1988, Congress enacted federal transfer penalty rules at 42 U.S.C. §1396p(c) which every state must use. This section was rewritten by the Omnibus Reconciliation Act of 1993 (OBRA 93).

The federal agency did not promulgate any regulations interpreting the statutory penalty provisions in OBRA 93. Instead, CMS published explanatory materials in Section 3258 of the State Medicaid Manual, available online at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. Select Publication 45, the State Medicaid Manual, and then choose Section 3258. Indiana has promulgated regulations at 405 IAC 2-3-1.1 implementing the OBRA 93 provisions.

The federal law on transfer penalties was again substantially rewritten by the Deficit Reduction Act of 2005, Pub. Law 109-171 (DRA). The DRA lengthened the look back period to five years, changed the beginning date of penalties, and provided for partial month penalties. Although the DRA said it applied to transfers made on or after February 8, 2006, the Act was not self implementing. FSSA eventually implemented it for all transfers occurring on or after

November 1, 2009. CMS has not promulgated regulations implementing the DRA; instead it mailed "guidance" to the State Medicaid Directors. See "Enclosure on New Medicaid Transfer of Asset Rules under the DRA 2005," downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/TOAEnclosure.pdf.

Because the transfer penalty rules are federally mandated, one might expect the rules to be the same from state to state. Because federal regulations interpreting this section have not been promulgated and because resource rules can vary from state to state, some aspects of the rule are applied differently in different states. CMS has given states some options in implementation in Section 3258 of the State Medicaid Manual.

Indiana's implementation of the transfer penalties are discussed at length at IHCPPM §2640.10.

There are several issues to consider when determining whether a transaction may result in a transfer penalty, including:

- Was this transaction within the look back period? That is, was it recent enough that it will be considered?
- Was this transaction a "transfer of assets" that may result in a penalty?
- If the transaction is considered to be a "transfer of assets," was it a transfer which is exempt from a penalty?
- If it is not an exempt transfer, what was the "uncompensated value," if any, of the transfer?
- If it was not an exempt transfer and there was an uncompensated value, how long is the penalty period and when does it run?

### A. Penalties Only Apply to Nursing Home Per Diem and Waiver Services.

A transfer of assets that results in a penalty period, as discussed below, does not make a person ineligible for Medicaid. Instead, it makes that person ineligible for Medicaid payment for certain services. 42 U.S.C. §1396p(c) provides that a transfer penalty only makes a person ineligible for nursing home services, and, at the option of the state, waiver services. Indiana applies the penalty not only to nursing home services but also to all waiver services.

42 U.S.C. §1396p(c) also gives states the option to deny payment for some services, such as home health care, to "noninstitutionalized persons" under a transfer penalty. FSSA has not chosen this option. Note that a person receiving waiver services is actually defined as an "institutionalized person" for transfer penalty purposes, since the waiver is an alternative to nursing home care, so waiver recipients are subject to transfer penalties.

An applicant is not denied Medicaid during a penalty period, but Medicaid will not pay for that person's nursing home care or for waiver services. Since Medicaid includes most supplies and even therapy in its per diem payment, these ancillary items are not covered by Medicaid during a penalty period. A recipient under a penalty still receives Medicaid to pay physicians, hospitals, pharmacists, and other providers for other Medicaid covered services. An applicant subject to a transfer penalty receives a notice that the application has been approved but that Medicaid will not cover nursing home per diem expenses or waiver services during the penalty period. Expenses other than the nursing home per diem and waiver services are covered by Medicaid. No liability is set during a penalty period, so all Medicaid covered expenses except for the nursing home per diem and waiver services are covered.

Although one would also expect PACE and MFP services to not be covered during a penalty period, since they considered to be a type of "institutional care," they are not listed as being non-covered during a penalty period. IHCPPM § 2640.10.05; 42 U.S.C. § 1396p(c)(1)(C).

### B. The Look Back Period

The "look back" period is a time period during which the DFR considers transfers and whether they will result in a penalty period. Transfers made before the look back period do not affect eligibility. One needs to know what date one looks back from and how long one looks back. How long one looks back was changed by Indiana's implementation of the DRA for transfers made on or after November 1, 2009. Before November 1, 2009, the look back period was 36 months, except that it was five years for some transfers involving trusts. Effective November 1, 2009, the look back period was extended to five years, but the longer look back period was only applied to transfers made on or after November 1, 2009. **The look back period for all applications is now five years.**

First, one needs to determine what date to look back from. IHCPPM § 2640.10.10 refers to this as the "baseline date." The baseline date is the **first** date on which one is both in a nursing home (or at home receiving or approved for waiver services) and has applied for Medicaid. IHCPPM § 2640.10.10. The CMS State Medicaid Manual provides at §3258.4(c) that each individual has only one baseline date, regardless of the number of institutionalizations and applications for Medicaid, which is the **first** date upon which the individual has both applied for Medicaid and is institutionalized. In some situations, the way the baseline date is computed may be significant.

Examples:

> Mr. Helms gave away a large amount of money in January, 2016. He later enters a nursing home. On February 14, 2022 he applies for Medicaid and requests coverage beginning November, 2021. Because the look back period is five years before his **application** on February 14, 2022, the transfer in January, 2016 will not be considered, even though it was made less than five years before some of the months for which he is seeking coverage, since the transfer was more than five years before application.

Mr. Hatch gifted a large amount of money in January, 2010. He later enters a nursing home. On December15, 2014 he applies for Medicaid while in a nursing home. The transfer is within five years of his application date, so it is considered. Once he has applied and the look back period is established, he cannot reapply and establish a new look back period. Suppose he files a new application in May, 2021. His baseline date remains December 15, 2014, so the transfer in January, 2010 is still within his look back period, even though the transfer was made more than five years before his application in May, 2022.

One should be aware that although one can apply for Medicaid in the community after making a transfer without being subject to a penalty, the look back date will be set once the person enters a nursing home. In the example above, if Mr. Hatch applied for Medicaid after making the transfer in January, 2010 and then later enters a nursing home, his baseline date will be the date that he enters the nursing home.

Once the look back period is established, any transfers made after the look back date are also considered, as the review period extends indefinitely into the future. IHCPPM § 2640.10.10.

One also needs to be aware of the forward effect of a transfer. A transfer today will be considered on any application filed within the next five years.

### C. What Transactions Are "Transfers of Assets"?

To apply the penalty provisions, one must first consider whether there has been a "transfer of an asset." Is the property interest involved in a transaction covered by the penalty provisions, and does the transaction involve a "transfer"? If the answer is "no," then there cannot be a penalty assessed as a result of the transaction. If the answer is "yes," that does not mean there will be a penalty; it simply means that one needs to proceed with the analysis (see the series of questions at the beginning of Section XIII, above) to determine if a penalty will be assessed.

OBRA 93 applies penalties to disposing of "assets" rather than just "resources." For the most part, the DRA does not change which transfers are subject to penalty. The federal statute defines **"assets"** to include **any income and resources of the individual and spouse**, including any income or resources either of them is entitled to but does not receive because of action by the individual or spouse. 42 U.S.C. §1396p(h)(1). See also 405 IAC 2-3-1.1(a)(1) and IHCPPM § 2640.10.05. The federal statute further defines "income" and "resources" by cross referencing the SSI definitions and exclusions, except that the SSI exclusion of the home is disregarded. §1396p(h)(2) and (5). Thus the federal statute provides that there should not be any penalty for transferring any resource, other than the home, which is excluded for SSI. For example, since one vehicle of any value that is used for transportation is exempt under the SSI rules, there should be no penalty for transferring it. Indiana does not specifically refer to the SSI definitions and exclusions in its regulation, but as will be seen below, Indiana has relied on the SSI rules in revising its transfer penalty regulation.

Some transactions that one may not typically consider to be transfers meet the transfer definition. A landowner's act of renting real estate is a transfer. 405 IAC 2-3-1.1(d)(1)(E). Since

the lessee is receiving an interest in the property, the landlord has transferred an interest in the property. The transfer of the right to receive income or income or a stream of income, including rental income from real estate, is treated as a transfer. 405 IAC 2-3-1.1(d)(1)(D). Purchasing an annuity is a transfer because one is paying money to a company for the annuity contract.

A transfer includes **any total or partial divestiture of control or access**, including disposing of a part interest while retaining a part interest and limiting or relinquishing one's right to liquidate or sell an asset. 405 IAC 2-3-1.1(d)(1). Transferring an asset to joint ownership is considered to be a transfer if the transferor gives up some control or access to the property. Transferring real estate into joint tenancy with rights of survivorship or transferring a remainder interest while retaining a life estate is a transfer, because the transferor no longer has the right by himself to control or transfer the entire property. Adding a name to a bank account is not a transfer so long as the transferor retains access to all of the funds. However, any action which reduces or eliminates a person's ownership or control of jointly held property is considered a transfer. For example, the removal of funds from a joint bank account by the joint account holder is considered a transfer, the same as if the funds had been withdrawn by the owner and gifted to the third party. A transfer occurs when the owner loses control over the property.

There must be a true loss of control for there to be a transfer. In *Pfeffer v. Ariz. Health Care Cost Containment Sys. Admin*., 2011 U.S. Dist. LEXIS 113072 (D. Az. 2011), the Court upheld the agency's decision that funds transferred to a family member who then held and used the funds for the benefit of the transferor had not actually been gifted. The Court applied 42 U.S.C. § 1396p(d)(6), which states that a trust includes any legal instrument or device that is similar to a trust. The Court treated the funds as if they were being held in trust for the transferor. Funds held for the benefit of a transferor may not be treated as having been transferred. But they are then a countable resource.

**Transfers by either spouse are also considered**. Since the resources of both spouses are considered upon application for Medicaid by either spouse, a transfer by the non-applicant spouse potentially affects the eligibility of the applicant spouse. §1396p(c)(1)(A). It is not clear if transfers made by a spouse who later dies will affect the eligibility of the surviving spouse. Because a transfer by an applicant's spouse is attributed to the applicant, *Hallam v. Mo. Dep't of Soc. Servs.*, 564 S.W.3d 703 (Mo. Ct. App. 2018), upheld a transfer penalty where the property, including farmland, was transferred to the spouse and upon the spouse's death, her property was transferred to her trust and then distributed to her children pursuant to the terms of her trust. The Court concluded that the disposition of assets for transfer penalties is not limited to *inter vivos* transfers, but also includes transfers at death. The Court distinguished this from a testamentary trust, which is exempt by 42 U.S.C. § 1396p(d)(2)(A) from the transfer of asset penalty rules.

A transfer by a community spouse after the institutionalized spouse has qualified for Medicaid may not result in a penalty because it may qualify for an exemption. See Subsection D(7), *below*.

Since the definition of assets includes any income or resources that the applicant or spouse is entitled to but does not receive because of action by the individual or spouse, disclaiming an interest in an estate is a transfer, because it is an action which results in the person not receiving a resource. The failure of a spouse to elect against a will and to claim the spousal allowance is also

defined by FSSA as a transfer. 405 IAC 2-3-1.1(a)(1); 2-3-1.1(j). This expansion of the definition of a transfer appears to go beyond the definition in 42 U.S.C. §1396p(e)(1), which refers to assets "which the individual or such individual's spouse is entitled to but does not receive because of action ...." The federal statute appears to only apply to actions taken to avoid receiving an asset, not the failure to take an action needed to receive an asset. Despite this difference, a similar provision in Wisconsin was approved by the Wisconsin Supreme Court. *Tannler v. Wisconsin Dept. of Health and Social Services*, 564 N.W.2d 735 (Wisc. 1997).

In response to comments presented by elder law attorneys during the regulatory process, FSSA placed some limits on penalties being assessed as the result of a failure to take action. 405 IAC 2-3-1.1(j). First, there is no penalty if the surviving spouse, or that person's guardian or attorney-in-fact, is unaware of the right to make a claim. If the DFR notifies the spouse of the right to make a claim, then the spouse will be presumed to know his or her rights. Second, there is no penalty if the spouse is incapable of acting and there is no other person with authority to act for the spouse. Third, there is no penalty if the deceased spouse has made "other equivalent arrangements" to provide for the surviving spouse. 405 IAC 2-3-1.1(j)(4) states:

> In the case of a surviving spouse who fails to take a statutory share of a deceased spouse's estate, no penalty will be imposed if the deceased spouse has made other equivalent arrangements to provide for a spouse's needs. "Other equivalent arrangements" includes, but is not limited to, a trust established for the benefit of the surviving spouse.

Thus, a testamentary spousal trust set up to supplement Medicaid is allowed. There is no provision that the trust must contain a clause that any funds remaining in the trust after the death of the surviving spouse must be paid back to Medicaid. The trust must at least contain the elective spousal share plus spousal allowance, but the spouse may want leave it all in trust. A sample will clause establishing a supplemental needs trust for the spouse is at Appendix L. Finally, there will be no penalty if the expenses of collecting the share are greater than the value of the assets.

FSSA has periodically questioned some spousal testamentary supplemental needs trusts, although it is not clear on what basis. To date, these trusts have been upheld on appeal, as they are allowed by FSSA's own rule. If "other equivalent arrangements" have been made, it may be useful to have the surviving spouse make a claim and have it denied by the probate court, provided the probate court agrees the arrangements are equivalent.

### D. Exempt Transfers

The federal statute sets forth various exemptions from transfer penalties. These are situations where the transaction itself is treated as a transfer, but the transaction fits one of the exemptions so that there is no penalty.

#### 1. Adequate Compensation

There is no transfer penalty if the asset was transferred, or intended to be transferred, for adequate compensation. 42 U.S.C. §1396p(c)(2)(C); 405 IAC 2-3-1.1(k)(7)(A). If the person truly

intended to dispose of the asset for adequate compensation, the DFR cannot second guess whether he or she should have been able to sell it for more money. In a case in which the Court of Appeals reversed FSSA's assessment of a transfer penalty, the Court described "fair value," or adequate compensation, as follows:

> Fair market value is the price at which property would change hands between a willing buyer and seller where neither is under any compulsion to consummate the sale. *Southtown Props., Inc. v. City of Fort Wayne*, 840 N.E.2d 393, 400 (Ind. Ct. App. 2006), trans. denied. Anything affecting the sale value on the date of the taking is a proper matter for consideration in attempting to arrive at a fair market value. *Id.* Generally, all facts which an ordinarily prudent man would take into account before forming a judgment as to the market value of property he contemplates purchasing are relevant and material. *Id.*

*Brown v. Ind. FSSA*, 45 N.E.3d 1233, 1238-1239 (Ind. Ct. App. 2015). Even though the home was sold to a granddaughter for less than the tax value, there was substantial evidence showing it was sold at fair value because there was no evidence either buyer or seller were under any compulsion to complete the sale, and there was evidence the sale price was reduced because the sewer system needed to be replaced.

Even if adequate compensation was arguably received, some transfers may be questioned. In *Moore v. State*, 74 N.E.3d 1173 (Ill. Ct. App. 2017), an applicant used $15,000 to purchase a single-premium whole life insurance policy. The policy was written so that it only had a small cash value. Despite the applicant's argument that the policy was purchased for fair market value, the Court found it to be a transfer for less than fair market value because "[t]he apparent purpose of Buckley's purchase of the insurance policy, of which she would receive none of the proceeds, was to shelter assets from Medicaid while ensuring Moore received the benefits of her assets."

### 2. To Spouse

There is no penalty for transfers to one's spouse or to a trust for the "sole benefit" of the spouse. 42 U.S.C. §1396p(c)(2)(B)(i); 405 IAC 2-3-1.1(k)(2). This exemption can be very useful, as sometimes there will be a difference in how the assets are counted for purposes of Medicaid depending on how they are titled between the husband and wife. This exemption explains that there is no penalty for any transfers between spouses. To be for the "sole benefit" of the spouse, no one but the spouse can benefit from the trust. The trust cannot provide that the funds will pass to anyone else. CMS State Medicaid Manual §3257(B)(6).

Some states have argued that in a spousal case, unlimited transfers to a community spouse cannot be made because 42 U.S.C. § 1396r-5(f)(1) states that an institutionalized spouse may transfer an amount equal to the community spouse resource allowance to the community spouse. Courts that have reviewed this have discussed the seeming conflict between 42 U.S.C. §1396p(c)(2)(B)(i), which allows unlimited transfers from one spouse to another, and 42 U.S.C. § 1396r-5(f)(1), which appears in a spousal case to only allow a transfer to a community spouse that is equal to the community spouse resource allowance. Two federal circuit courts that have reviewed this make a distinction between transfers made before and after eligibility is established. *Morris v. Oklahoma Dep't of Human Servs.*, 685 F.3d 925 10th Cir. 2012) and *Hughes v.*

*McCarthy*, 734 F.3d 473 (6th Cir. 2013) ruled that unlimited transfers to the community spouse are allowed before eligibility is established, but once eligibility is established, then transfers are limited to the community spouse resource allowance. Both *Morris* and *Hughes* allowed the purchase of an annuity by the community spouse over the state agency's objections when it was done before eligibility.

*Fagan v. Bremby*, 244 F. Supp. 3d 280 (D.Conn. 2017) applied *Morris* and *Hughes* in determining that the institutionalized spouse was subject to a transfer penalty for making a transfer after initial eligibility. After Mr. Fagan, in a nursing home, was approved for Medicaid and the resources were divided with his wife, he received a net personal injury settlement of about $1 million. After his benefits were discontinued, he transferred the settlement proceeds to his wife and she purchased an immediate annuity. The Court ruled that a transfer of assets penalty could properly be assessed by the state agency because the transfer was made after initial eligibility was established.

FSSA has not assessed penalties for any transfers made between spouses, even for transfers made after eligibility has been established, even if the transfers give the community spouse more than the community spouse resource allowance.

### 3. To Disabled Son or Daughter (IHCPPM § 2640.10.15)

There is also no penalty for a transfer to one's disabled child, or to a trust for the "sole benefit" of a disabled child. 42 U.S.C. §1396p(c)(2)(B)(iii); 405 IAC 2-3-1.1(k)(4). To be disabled, the child must meet SSI disability criteria, although the child need not be receiving SSI.

There is no limit on the age of the child, so one should be able to use this exemption for transfer to a disabled son or daughter over the age of 65, provided verification of the disability can be provided.

There is no explanation of what is required for a trust to be for the "sole benefit" of a disabled child. The statute does not require that there be a payback clause to the state, as is required for a d(4)(A) trust, as discussed in Section VIII(B)(9)(d), *above.* Does naming a remainder beneficiary mean that it is no longer for the "sole benefit" of the disabled person? Note that if the state is listed as a remainder beneficiary, then arguably that is not for the sole benefit of the child. There is no definitive answer to what is required for a trust to be a "sole benefit" trust. IHCPPM § 2640.10.15 does not include the "sole benefit" language, so FSSA may not review this.

This does not appear to exempt from penalty a transfer to a disabled stepchild of the applicant/recipient, even if the transfer is made by the spouse who is the parent of the child.

### 4. To a Trust for a Disabled Person Under Age 65

There is no penalty for any transfer to a trust established solely for the benefit of a disabled person under age 65. **No relationship is required, so the trust could be for the benefit of a person who is not related to the grantor**. 42 U.S.C. §1396p(c)(2)(B)(iv); 405 IAC 2-3-1.1(k)(5). This exemption is not addressed in the IHCPPM. See the discussion in the immediately

preceding section about the "sole benefit" requirement.

There is no penalty for transfers to a (d)(4)(A) trust discussed in Section VIII(B)(9)(d), *above,* as this is a trust established for a disabled person under age 65.

Transfers to a "pooled trust" for a person under age 65 are also exempt from penalty**.**

There is not a specific exemption from penalty for transfer to a pooled trust after age 65. **To date, Indiana has not applied a penalty for a transfer to a pooled trust by a person over age 65.** Some states have assessed penalties for transfers into a "pooled trust" by a person over age 65. Several courts have ruled that although a pooled trust is exempt as a resource, a transfer into the pooled trust by an applicant or recipient over age 65 is not exempt from penalty, because 42 U.S.C. §1396p(c)(2)(B)(iv) refers to a transfer by a person under age 65. *Ctr. For Special Needs Trust Admin., Inc. v. Olson*, 676 F.3d 688 (8th Cir. 2012); *Me. Pooled Disability Tr. v. Hamilton*, 927 F.3d 52 (1st Cir. 2019); *Cox v. Iowa Dep't of Human Servs.*, 920 N.W.2d 545 (Ia. 2018)*; Pooled Advocate Trust v. S.D. Dep't of Soc. Servs.*, 813 N.W.2d 130 (S. Dak. 2012); *Hutson v. Mosier*, 54 Kan. App. 2d 679, 401 P.3d 673 (Kan. Ct. App. 2017).

Even though a transfer into a pooled trust is not automatically exempt from penalty, that does not mean a penalty should be assessed, as the recipient may be able to show that there will be adequate compensation for the transfer in the benefits that will be received from the use of the trust funds. Although *Hutson* ruled that a person over age 65 was not exempt from penalty for a transfer to a pooled trust, the Court also ruled that it was a question of fact whether fair value was received for the transfer into the trust, or to what extent the transfer into the pooled trust was for less than fair value. *Pfoser v. Harpstead*, 953 N.W.2d 507 (Minn. 2021), ruled that Pfoser showed that his equitable interest in the pooled trust was approximately equal to the $28,000 transferred into the account. The Court concluded the agency's fears about transfers were overstated.

> Pooled special-needs trusts are unlikely to be used to hide great wealth while creating eligibility for Medical Assistance because of the inherent limitations of these trusts: pooled special-needs trusts are available only to disabled persons, the person must give up control of the funds; and any unused funds will revert to the State. As a result, those who are likely to benefit through the use of pooled special-needs trusts are those who, like Pfoser, are disabled and have only modest assets that they wish to use for basic care not covered by Medical Assistance.

953 N.W.2d at 521 (citations omitted).

### 5. Household Goods and Personal Effects

IHCPPM § 2640.10.16 provides for the exemption from penalty of all transfers of household goods and personal effects. As these assets are exempt and do not affect eligibility, there is no penalty for transfers. The Section also provides that the following items can be transferred without penalty:

- One wedding ring (purchased by one spouse for the other) of the applicant/ recipient and spouse.

- One engagement ring (purchased by one spouse for the other) of the applicant/recipient and spouse.

- Medical equipment required due to the applicant's/recipient's physical condition, which are not used extensively or primarily by others.

IHCPPM § 2615.30.00 defines household goods as "items of personal property customarily found in the home and used in connection with the maintenance and occupancy of the home." Personal effects are "those items of personal property which are worn or carried by an individual." This exemption is not intended to cover items that are not being used. Apparently, the DFR does not consider multiple wedding or engagement rings to be personal effects.

### 6. The Home

There is a special rule for the transfer of the home. The home is the principal residence of the applicant, the spouse, the parent, or a minor or disabled child.

As with any asset, there is no penalty if the home is transferred to a spouse or to a disabled child. In addition, there is no penalty if the home is transferred to:

- A child under age 21, blind, or disabled;

- A child **who was residing in the home** for at least two years **immediately** before the person becomes institutionalized and who provided care which allowed the person to live at home rather than in an institution. This does not allow transfer to a child who came to the parent's home every day but did not reside there. It does not apply to grandchildren, step-children, or other relatives.

- A sibling with an equity interest in the home who resided in the home for at least one year before the person becomes institutionalized. The language of the statute does not seem to require that the equity interest have existed for at least a year. Suppose two sisters have resided together in a home for several years, but only one sister owns the property, and she needs to enter a nursing home. Suppose she transfers a small percentage interest in the home to her sister. Can she now convey her remaining interest in the property to the sister at home with no penalty, since the at home sister now has an equity interest in the property? It appears from the language one can argue this can be done, though FSSA may object.

IHCPPM §2640.10.15.05; 42 U.S.C. §1396p(c)(2)(A); 405 IAC 2-3-1.1(k)(1).

### 7. Gifts of $1,200 or Less Per Year To a Family Member or Nonprofit Organization

Because partial month penalties are applied and because all gifts after November 1, 2009 within the look back period are added together to compute one penalty period, advocates were very concerned that small, innocuous gifts could be added together to create a penalty period. The legislature adopted I.C. § 12-15-2-23 to address this by providing that certain small gifts are to be disregarded. I.C. § 12-15-2-23(b) provides that "the office shall not consider in total one thousand two hundred dollars ($1,200) per year of contributions made by the individual to a: (1) family member; or (2) nonprofit organization; as an improper transfer." This exemption is provided at IHCPPM § 2640.10.15.10. The DFR refers to this as the "**de minimis transfer allowance**."

The exemption is applied to all gifts made in a calendar year, not per person. For example, if one gives $1,000 to a son and $1,000 to a daughter in 2022, $1,200 of the total $2,000 of gifts is exempt from penalty. A "family member" is defined by FSSA as including a person related by blood, adoption, or existing marriage.

FSSA added the word "directly" to IHCPPM § 2640.10.15.10 to emphasize that the gift must be made directly from the applicant/recipient to the giftee.

FSSA states that the exemption only applies to gifts by the applicant; the exemption is not applied to gifts by the applicant's spouse. IHCPPM § 2640.10.15.10. This is arguably contrary to the statute. If both spouses are applying, then each spouse is entitled to the $1,200 exemption, but the spouses should make their gifts separately. The applicant wife can gift up to $1,200, and the applicant husband can gift up to $1,200.

The DFR will require documentation that the exemption applies. For family members, a signed written statement listing the name, birth date, and relationship of the family member should be filed. For a nonprofit organization, verification of 501(c)(3) status is needed. The receipt or letter which the organization provides to acknowledge the gift will be sufficient. IHCPPM § 2640.10.15.10.

### 8. Exclusively for a Purpose Other Than To Qualify for Medicaid

The federal law provides that no transfer penalty should be imposed if the applicant is able to satisfactorily show that the assets were transferred **exclusively** for a purpose other than to qualify for Medicaid. 42 U.S.C. §1396p(c)(2)(C)(ii). One should consider this exception as a way to soften the harshness of the five year look back. If one assisted a family member at a time when the need for long term care was not contemplated and then the gifter suffered unexpected health problems leading to a need for long term care, a strong argument can be made that the gifts were made exclusively for reasons other than to qualify for Medicaid. Some advocates have reported success when they can show a pattern of assisting a family member, while FSSA seems less willing to accept a lump sum gift. The key is providing facts to show that reducing assets to qualify for Medicaid was not a factor in making the gift.

FSSA's rule adds to the federal statute by requiring that the transfer must not have been made to escape estate recovery or a lien. 405 IAC 2-3-1.1(k)(7) now provides: "In order to

establish that a transfer was made exclusively for purposes other than qualifying for medical assistance, the applicant or recipient must submit sufficient evidence to show that the transfer was made exclusively for reasons not related to Medicaid eligibility, estate recovery, or lien." This change is discussed in IHCPPM § 2640.10.30 as follows:

> An allegation by the individual that the property transfer was done to avoid Medicaid estate recovery will not be accepted as a satisfactory showing that the property was transferred exclusively for a purpose other than to become eligible for Medicaid. Clearly, an individual who makes this claim has the intention of becoming eligible for Medicaid, or estate recovery would not even be an issue. Furthermore, a simple statement made by or on behalf of a recipient who has transferred property, that the transfer did not affect eligibility and is therefore allowable, does not constitute a satisfactory showing. The individual may be trying to protect all future eligibility. Again the avoidance of estate recovery may be the intent and will not suffice.

The federal statute does not place any emphasis on whether the person was attempting to avoid a lien or estate recovery. Instead, CMS State Medicaid Manual § 3258.10(C)(2) provides for a case by case determination, as follows:

> In some instances, the individual may argue that the asset was not transferred to obtain Medicaid because the individual is already eligible for Medicaid. This may, in fact, be a valid argument. However, the validity of the argument must be determined on a case-by-case basis, based on the individual's specific circumstances. For example, while the individual may now be eligible for Medicaid, the asset in question (e.g., a home) might be counted as a resource in the future, thus compromising the individual's future eligibility. In such a situation, the argument that the individual was already eligible for Medicaid does not suffice.

Based on this, it appears that if the asset transferred does not currently affect eligibility and it is unlikely to affect eligibility in the future, then transferring it should not result in a penalty. It appears that Indiana's policy conflicts with the federal statute. One can argue that this exemption should continue to allow the transfer of income producing real estate in most cases. Even if one is successful with this position, remember that there can still be a penalty for transferring the income, so if one transfers income producing real estate in reliance on this exemption, the income from the property should be preserved.

This exception should exempt a penalty for charitable transfers that are part of a pattern of giving. For example, if a person has always contributed to a church, that shows that the gifts were made solely for reasons other than to qualify for Medicaid. The DFR has typically not questioned routine contributions. If one makes a large contribution to charity shortly before applying for Medicaid, one should not expect this exception to apply. In 2009, the legislature added I.C. § 12-15-2-23(c), which provides that the DFR **may** disregard contributions that follow a pattern that existed for at least three years. At FSSA's request, the 2011 legislature, over the objections of advocates for the elderly, deleted this Section effective July 1, 2011. Section 123, P.L. 229-2011. FSSA stated that it was not its intent to penalize such gifts, but it claimed the Section was ambiguous.

It would be a monumental task for workers to review every charitable gift made during the five years before applying. The $1,200 per year exemption in Subsection 6, above, will exempt some gifts to charity, but many persons routinely give more than that. FSSA does not typically penalize legitimate gifts to charity that have been made as part of a pattern. For example, tithes to one's church, even if more than $1,200, have not been penalized. But making the same amount of gifts to one's child will likely be penalized.

This exception also protects the transfer of resources by a community spouse after the institutionalized spouse has obtained Medicaid. Because the resources of the community spouse are no longer considered after the institutionalized spouse obtains Medicaid, it should be simple to show that a transfer was made exclusively for a purpose other than to qualify for Medicaid, at least if the institutionalized spouse is expected to remain institutionalized. However, the transfer by the community spouse would potentially affect the community spouse's eligibility for Medicaid.

When a transfer has been made for less than fair value, FSSA will presume that the transfer was made to obtain Medicaid eligibility. The burden is on the applicant to rebut the presumption by presenting convincing evidence that the property was transferred exclusively for a purpose other than to qualify for Medicaid.

### 9. Assets Protected by Partnership Long Term Care Insurance Policy

Section VIII(D), *above*, explains that persons who purchase a qualified long term care insurance policy, referred to as a Partnership Policy, can have either some or all of one's assets not considered when applying for Medicaid. To preserve the usefulness of this incentive to purchase a qualified policy, the transfer rules provide that any asset disregarded through the use of a qualified long-term care insurance policy, along with any income generated by that asset, may be transferred without penalty. 405 IAC 2-3-1.1(k)(6).

### 10. Undue Hardship

"Undue hardship" is another reason listed in the federal statute not to impose a transfer penalty. §1396p(c)(2)(D). Indiana did not implement this exemption until November 1, 2009, even though it has been in the federal law since 1988. OBRA 93 amended the section to provide that HHS is to specify procedures and criteria for states to use. Section 3258.10.C.5 of the CMS State Medicaid Manual provides that "undue hardship exists when application of the transfer of assets provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life. Undue hardship does not exist when application of the transfer of assets provisions merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him/her at risk of serious deprivation." This is the only criteria that HHS has specified. The Section also provides that a state must give notice to recipients that an undue hardship exemption exists, provide a timely process for determining whether an undue hardship exemption will be granted, and provide for an appeal from an adverse determination.

The "undue hardship" provisions in the CMS State Medicaid Manual have now been given the force of law by the DRA. Section 6011(d) of the DRA requires the state to provide a hardship waiver process as follows:

> d) Availability of Hardship Waivers- Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))–
>
> (1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual–
> (A) of medical care such that the individual's health or life would be endangered; or
> (B) of food, clothing, shelter, or other necessities of life; and
> (2) which provides for–
> (A) notice to recipients that an undue hardship exception exists;
> (B) a timely process for determining whether an undue hardship waiver will be granted; and
> (C) a process under which an adverse determination can be appealed.

Although the requirement to implement this process seems to be an effort to soften the harsh results of the DRA's penalty provisions, it actually adds nothing beyond requiring states to do what they should already have been doing.

405 IAC 2-3-24 implements a hardship exemption, as follows:

> (e) In order to qualify for a hardship exception, the recipient shall supply written documentation proving that the application of transfer of asset rules will deprive the applicant of:
> (1) medical care such that the applicant's health would be endangered; or
> (2) food, clothing, shelter, or other necessities of life.
>
> (f) An undue hardship shall not exist when:
> (1) the imposition of the transfer of assets provisions:
> (A) merely cause the applicant inconvenience; or
> (B) such imposition might restrict the applicant's lifestyle but not put the applicant at risk of serious deprivation;
> (2) an individual is required to the sell an asset in an arms length transaction, which would result in a sale of the asset that is less than the current fair market value;
> (3) the undoing of a transfer causes:
> (A) adverse tax consequences; or
> (B) penalties, interest, or other contract damages;
> however where such penalties, interest, and contract damages are incurred in a contract between members of the same family (including step- and half- family members) the penalties, interest, and damages shall be considered transfers for inadequate consideration;
> (4) applicant claims that:

(A) imposition of the transfer penalty will result in the dissolution of a marriage; or

(B) the only way to avoid the transfer penalty is to dissolve the marriage;

(5) the undoing of a transfer will cause hardship to an individual who is not the applicant.

This list shall not be exclusive, and the decision to deny an undue hardship exception shall not be limited to situations described in this subsection.

As can be seen, this regulation limits situations in which a hardship exemption will be approved. IHCPPM § 2640.10.40 explains the hardship exemption in similar terms:

> The penalty will be removed or modified under a hardship exception if documentation substantiates that the recipient's health is endangered as result of the penalty or that the recipient will be deprived of food, clothing, shelter, or other necessities of life.

Whether one can qualify for an undue hardship depends on the facts of the case. FSSA has granted hardship exemptions. For example, if an applicant is in a nursing home, cannot receive Medicaid due to a transfer penalty, does not have means to pay the bill, and cannot get the transferred assets back, will that be sufficient? Certainly a nursing home which is not getting paid will want to discharge the resident, and that may endanger the resident. Having the nursing home prepare a letter that it intends to discharge the resident will support the hardship claim. 410 IAC 16.2-3.1-12 is a regulation of the Indiana State Department of Health which establishes procedures that a nursing home must follow before transferring or discharging a resident. The facility is required to do adequate discharge planning; the facility should not be able to simply dump a resident. Therefore a nursing home may end up being forced to keep a resident who cannot pay. So there is a question of whether that resident's life is really endangered. One should not expect that one will be able to gift away assets and then automatically claim hardship because of an inability to pay during a transfer penalty. But in cases where transfers were made for legitimate reasons, not to qualify for Medicaid, and now the recipient could be discharged from a facility, then a hardship claim should be approved.

*Brenckman v. Dep't of Human Servs*., 222 A.3d 38 (Pa. Commw. Ct. 2019), denied a hardship exception where the resident continued to receive care in the nursing home. The facts were bad, as the son whom the court described as a "purported" power-of-attorney used $159,000 of his mother's assets to pay his own living expenses. Despite a bill of more than $100,000 owed to the nursing home, the mother continued to be cared for by the nursing home. The Court ruled that there was not undue hardship because the mother continued to receive care and because even if the nursing home decided to transfer her, it must under health department regulations transfer her to a facility that can provide the care she needs. 222 A.3d at 47. The Court did not consider the hardship to the facility of not being paid and that no other facility would accept a transfer when there was no source of payment.

Another addition by the DRA to the hardship waiver process is that now the nursing home can file the application for a hardship waiver, with the consent of the resident or the resident's personal representative. 42 U.S.C. §1396p(c)(2). 405 IAC 2-3-24(c)(3); IHCPPM § 2640.10.40.

Indiana's rule provides that one cannot both appeal the imposition of a transfer penalty and also seek a hardship exception, since FSSA will treat the filing of a hardship request as an admission that the transfer penalty was properly applied. 405 IAC 2-3-24(a). This choice of remedies requirement appears to violate federal regulations protecting the right to appeal any determination.

To request an undue hardship exception to a transfer penalty, one should complete and submit State Form 45167, Request for Hardship Exception - Transfer of Property, available at www.in.gov/fssa/ompp/medicaid-estate-recovery/office-of-medicaid-policy-and-planning. The form states that by submitting the request, the recipient "agree[s] that there is no dispute about the factual situation that resulted in the transfer penalty and have not filed an appeal." The form states that a decision on the request will be issued by OMPP within 45 days.

### 11. Assets Returned in Whole or in Part

There will not be a penalty if all assets transferred for less than fair value have been returned. §1396p(c)(2)(C)(iii). IHCPPM § 2640.10.35.15 provides that the penalty period is to be reduced proportionately when only part of the assets are returned. Proportional reduction for partial returns is protected by I.C. § 12-15-2-23.5(c)(2). So long as the grantee is willing to return the property, this clause can be used as a last resort if one cannot convince the DFR that a transfer should not result in a penalty. If there is an explicit agreement to return the transferred assets if needed, then one runs the risk that the DFR may treat the assets as if they were never transferred.

When assets are returned, the DFR will vacate any transfer penalty. It will then treat the assets as if they were never transferred. It will determine eligibility by considering the resources. IHCPPM §2640.10.35.15.

How to treat partial returns can be problematic under the DRA. As shown below, for transfers after November 1, 2009, the penalty period does not start until the applicant is otherwise eligible for Medicaid. If the partially returned assets are treated as if they were not transferred, then that would affect the decision of when the applicant was otherwise eligible for Medicaid, which could then change the start date of the penalty period. In other words, a partial return might not result in any reduction in the penalty period. See the October 28, 2010 letter from the CMS Boston Regional Office, available at www.sharinglaw.net/elder/CT%20Commissioner%20Letter.pdf for a discussion of the problems in changing the start date of the penalty period. The CMS Regional Office concluded: "A State is allowed to adjust the original penalty period in response to a partial return of assets, but is not allowed to adjust the individual's eligibility, thereby nullifying the original penalty period and beginning a new, later penalty period." But see *Aplin v. McCrossen*, 2014 U.S. Dist. LEXIS 119682 (W.D.N.Y. Aug. 25, 2014), which upheld New York's decision to recalculate a new penalty start date after a partial return of assets.

Are assets being returned when the grantee pays expenses of the grantor? If a person makes a gift to his son, has a penalty period assessed, and the son pays the nursing home bill, are payments to the nursing home a return of assets that shortens the penalty period? At least one Administrative Law Judge has ruled this is a return of assets, but the DFR may dispute this. It is preferable to have the grantee first return the funds to the grantor, and have the grantor pay the expense. *Anderson v. State ex rel. Dep't of Health*, 430 P.3d 1162 (Wy. 2018), ruled that the sons' payment of attorney fees for the grantor to challenge a transfer penalty was a partial return of assets that should have resulted in a reduction of the transfer penalty.

### 12. Federal Tax Refund Within 12 Months of Receipt

Federal tax refunds are not a countable resource for the first 12 months after receipt. Consequently, they can be transferred during that 12 month exempt period without penalty. See CMCS Informational Bulletin, issued February 2, 2011, at www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/02-01-2011-Tax-Disregard.pdf. As the COVID stimulus payments were tax refunds, there was no penalty for their transfer.

### 13. 529 Plans

405 IAC 2-3-25 provides that money deposited into a 529 plan is not countable as a resource, and funds withdrawn from the plan will not be treated as a penalizable transfer so long as the withdrawn funds are used for eligible educational expenses.

FSSA has clarified that this result does not depend on the ownership of the account, so long as federal and state laws, rules, and regulations are followed. Suppose a grandparent contributes funds to a 529 plan for the benefit of a grandchild, and either the grandchild or the grandchild's parent is the owner of the plan. So long as the funds are not withdrawn and used for expenses that are not eligible education expenses, depositing funds into a 529 plan for the grandchild is not a penalizable transfer.

### 14. Theft of Funds

If the applicant or recipient claims that funds have been stolen or misused, this will not be treated as a transfer subject to a penalty provided that the applicant is actively pursuing the perpetrator. IHCPPM § 2605.45.00 provides that the applicant must file a police report, actively pursue charges, remove the attorney-in-fact or authorized representative as a representative, and report to Adult Protective Services if appropriate. Although IHCPPM § 2605.45.00 limits this to theft by an attorney-in-fact or authorized representative, the same policy should apply to theft by others. For example, if a scammer convinces a victim to give money to the scammer, and if the applicant reports and pursues the scammer, no penalty should be assessed.

## E. Computation of Penalty Periods

Since July 1, 1988, federal law has provided a formula for determining the length of any transfer penalty period. The penalty period is a period of months for which Medicaid will not cover the cost of nursing home care or waiver services.

The DRA made radical changes in how the penalty period is computed and when it runs, effective for transfers made on or after November 1, 2009.

One must first determine the amount of uncompensated value. For many transfers, this is straightforward. If no consideration was received, then the amount is the value of the assets. If some, but not adequate, consideration was received, then the difference between the fair market value and the amount of consideration is used. For example, if one sells a $50,000 home to one's son for $10,000 and no other consideration, the amount transferred is $40,000. The value of services can be counted as consideration, but IHCPPM §2640.10.20.20 requires that there have been an agreement in place when the services were provided that compensation would be paid in return for the services.

Neither OBRA 93 nor the DRA changed the underlying formula used to determine the penalty period, although there are dramatic differences on how the formula is applied. The formula is:

**(Uncompensated Value of Transfer(s)) ÷ (Average Monthly Cost of Nursing Home at time of Application) = Months of Penalty**

### 1. The Penalty Period Does Not Begin Until The Applicant is Eligible for Medicaid and Would Be Receiving Institutional Level of Care.

#### a. Start Date for a New Applicant

The penalty period does not begin to run until the person is eligible for Medicaid and Medicaid would be covering nursing home level of care (either in a nursing home or at home receiving waiver services) based on an approved Medicaid application except for the penalty period. 42 U.S.C. §1396p(c)(1)(D)(ii) provides that the penalty period begins on the following date:

> (ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (c) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

IHCPPM § 2640.10.35 explains that the penalty period begins on the later of the date on which the individual would be otherwise eligible for nursing home care or waiver services under

Medicaid based on an approved application for Medicaid but for the imposition of the penalty period, or the first day of a month during which assets have been transferred for less than fair market value. If a penalty period is already in place, then the penalty period will begin after the previous penalty period ends. The penalty period will not run until the transferor needs nursing home level of care and has exhausted his resources. The rationale is that if the assets had not been transferred, then they could have covered nursing home costs after the other assets are exhausted.

Example:

> Mabel, a widow, gifted $30,000 to her children in November, 2017. She enters a nursing home in April, 2022 and applies for Medicaid. Suppose she is otherwise eligible for Medicaid in May, 2022, as her resources are less than $2,000 on May 1, 2022. The penalty period begins on May 1, 2022, as that is the date on which she is eligible for nursing home services under Medicaid based on an approved application for Medicaid, but for the transfer penalty.

Must one actually be receiving institutional level of care services for the penalty period to begin? For example, if a person passes pre-admission screening for nursing home admission but cannot gain admission to a nursing home because the nursing homes all know they will not get paid due to the transfer penalty, or if a person passes pre-admission screening but family members or friends provide care at home, can the penalty period begin because the person has had an approved application for nursing home level of care? Relying on CMS Guidance, FSSA provides that the individual **must** be receiving institutional level of care to start the penalty period.

FSSA requires that a Medicaid application must actually be filed and approved. The federal statute refers to "an approved application for such care." It appears that the federal statute may be referring to the nursing home pre-admission screening or the waiver assessment rather than the application for Medicaid. But FSSA requires that a Medicaid application be approved for a penalty period to begin.

Must an applicant be in a Medicaid certified bed for a penalty period to begin? Not all nursing homes are certified as Medicaid providers, and even nursing homes which are certified often do not have all beds certified as Medicaid beds. As a practical matter, the DFR does not ask at application if the applicant is in a certified bed, so the DFR will not typically know if the applicant is in a bed that is certified for Medicaid. Even if it knew, that should not matter, as the definition of the start date only requires that the applicant be receiving institutional level of care; it does not appear to require that the care be provided in a certified bed. This is consistent with IHCPPM § 3455.14.00, which provides that the Special Income Level test applies "for individuals who either reside in an institution or are (would be) eligible to receive home and community based services under a waiver."

Can one apply and start the penalty period, even though the applicant's stay is initially covered completely by insurance? Nothing in the language provides that the penalty period should not begin. For example, suppose that Steven made a gift within the look back period that will result in a two month penalty. Steven enters the nursing home, and Medicare and a Medicare supplement is expected to cover the full cost of his care for 100 days. If he is Medicaid eligible,

he can apply for Medicaid, be approved for Medicaid subject to a two month penalty period, and the penalty period will expire before his Medicare covered period ends.

For a waiver recipient, CMS State Medicaid Director Letter 18-004, issued April 17, 2018, clarifies that the start date for the penalty is the point at which a state has "determined that the applicant meets the financial and nonfinancial requirements for Medicaid eligibility and the level-of-care criteria for the 1915(c) waiver; developed for the individual a person-centered service plan; and identified an available waiver slot for the individual's placement." www.medicaid.gov/federal-policy-guidance/downloads/smd18004.pdf?msclkid=34d49461bead11ec8a9dd7c9f17ab88a. For states with a wait list for waiver slots, this means that a person on a waiting list cannot start a penalty period until a slot becomes available. This is not currently an issue in Indiana since we do not have a waiting list for waiver slots.

**b. Start Date for A Recipient Who Makes a Transfer**

**As explained above in Section VII(G)(2), current recipients cannot have their Medicaid benefits terminated or reduced during the current Public Health Emergency. Thus, transfer penalties are not currently being imposed on recipients and cannot be imposed until the current national health emergency ends. FSSA cannot retroactively assess penalties after the emergency ends, but it can implement any remaining penalty after the end of the emergency.**

The DRA defines the penalty start date as **the later of** a) the date on which the person is otherwise eligible for long term care services based on an approved application; or b) the first day of the month during which assets have been transferred for less than fair market value. Suppose Mildred enters a nursing home and is approved for Medicaid. Suppose also that she has a home she is selling. Suppose Mildred sells the home on June 15, and after paying off the mortgage she nets $15,000, which she immediately gifts to her daughter. She reports this gift to the DFR on June 23. Since Mildred is already on Medicaid, the later date is June 1, the first day of the month of the transfer. So the penalty period once calculated will begin to run on June 1. But the DFR cannot terminate Mildred's full Medicaid coverage until August 1, since the DFR must provide notice at least ten days before the beginning of the month. It appears that Mildred may be able to avoid a penalty period.

There have been cases in which OMPP has pulled back payments from a nursing home after paying its claim. In the situation above with Mildred, OMPP may recover its payments back from the nursing home, even after having paid the nursing home's claims for June and July. It may be relying on 405 IAC 1-1.4-9, which allows OMPP to recover payment to a provider when the service reimbursed was provided to a person who was not eligible for Medicaid at the time of the provision of the service. It is not clear if this provision gives OMPP authority to recoup payment from the provider, which will then seek payment from the resident.

**2. All Transfers are Added Together and One Penalty Period is Calculated**.

All of the transfers are added together and one penalty period is calculated. IHCPPM § 2640.10.35.05; § 2640.10.35.10. This makes sense, since in most cases the penalty period will not

start immediately after transfer, but only after the applicant is institutionalized and eligible for Medicaid.

It is not clear if all transfers will still be added together if a penalty period has already been assessed. Consider the following scenario. Maude enters a nursing home on May 15, 2018 and is approved for Medicaid effective May 1, 2018 subject to a 13 day penalty for a gift she made on March 1, 2018. Suppose Maude owns a home worth $50,000 which she leases out. Suppose also that on May 7, 2022 she deeds the house to her daughter. Based on 42 U.S.C. §1396p(c) and the IHCPPM, one should add together the two gifts and compute one penalty based on a gift of $52,000. The penalty should start on May 1, 2018. It would then expire well before May, 2021 when the house was transferred. Medicaid could pursue an overpayment claim but could not stop paying for Maude's nursing home care. This is a very favorable result for Maude, but it is inconsistent with the purpose of the transfer penalty statute. One should expect that the state will take the position that the transfers cannot be added together because a penalty was already assessed for the first transfer.

### 3. The Divisor Used to Calculate the Penalty Period Is the Cost of Nursing Home Care at the Time of the Application.

The monthly cost of nursing home care to plug into the formula is the average cost of private pay nursing homes in the state, which is now determined to be $6,873 for applications filed on or after July 1, 2022. One rate is used for the entire state. FSSA revises the average nursing home cost each year effective July 1.

IHCPPM § 2640.10.35.05 provides that **the facility rate to be used is the rate as of the date of application, not the date of transfer**. Historical facility rates back to November 1, 1998 are listed in IHCPPM § 3006.00.00.

Examples:

Melania has made transfers that will result in a penalty period. She is in a nursing and has spent down her resources so that she will be otherwise eligible for Medicaid effective July 1, 2022. If she applies for Medicaid on June 20, 2021, the divisor of $6,873 will be used to calculate her penalty period. If she files her application on July 1, 2022 or later, then the updated divisor which will go into effect for applications filed on or after July 1, 2022 will be used. As the average nursing home cost continues to rise, a shorter penalty period will result if she waits until after July 1, 2022 to file her application.

George applied for Medicaid in August, 2010 and was approved. In May, 2022 he sells his home and makes a gift. Rather than using the nursing home rate in effect in May, 2022, the IHCPPM provides that FSSA is to use the nursing home rate of $4,826 in effect in August, 2010, when he first applied for Medicaid, to determine the penalty period for the May, 2022 transfer. If George voluntarily withdraws from Medicaid after making his gift in May, 2022 and then files a new application, will the FSSA use the much higher divisor in effect as of the date of his current application? It would appear it should, though the IHCPPM does not address this.

It seems illogical to use the divisor that was in effect when the original application was filed. In the example above, George will need to pay for care at 2022 rates, not 2010 rates, during his penalty period. FSSA's position seems to follow 42 U.S.C. § 1396p(c)(1)(E)(i)(II), which refers to the nursing home rate at the time of application. Congress was likely not contemplating transfers by recipients. Although FSSA may not always be consistent, one should plan as if it will use the nursing home rate for the date of the original application. Some advocates have withdrawn from Medicaid and then reapplied to be able to use the current divisor. That requires the processing of a new application.

One can question whether Indiana is properly computing the private pay rate. Indiana reduced the rate by $1 from July 1, 2020 until July 1, 2021, though few people would believe that nursing home costs decreased. 42 U.S.C. §1396p(c)(1)(E) states that one divides the amount of assets transferred by "the average monthly cost to a private patient of nursing facility services ...." CMS State Medicaid Manual 3258.1(A)(6) defines nursing facility services as "services as described in the State Medicaid Plan as nursing facility services." Indiana includes several things in its definition of nursing facility services that are typically billed out separately to private pay residents. 405 IAC 5-31-4 defines what is included within "per diem services" for purposes of Medicaid, including several items that are typically billed separately to private pay residents. It is unlikely that Medicaid has made any effort to include any of these items in its calculation of private pay costs, even though that is required. If the average private pay rate is the average per diem charged by nursing homes without considering these ancillary costs, then the average cost figure used is too low.

### 4. There is no maximum penalty period.

OBRA 93 provides that there is no maximum penalty period for transfers made after August 10, 1993. One cannot avoid the effect of the lack of a maximum by reapplying more than five years after the transfer, so that the transfer is not within the look back period, as that would evade the intent of the statute. The federal transmittal deals with this by stating that one does not get a new look back date when one reapplies, but instead the look back date is still determined based on the first time that the person is institutionalized and has applied for Medicaid. IHCPPM § 2640.10.10 defines the "baseline date" in this manner. To avoid this potential problem, **one who will definitely face a penalty of more than the look back period should not apply until the look back period has passed.**

Examples:

> Sally gives away $1 million in January, 2017 and applies for Medicaid in April, 2022. The transfer is within the look back period of five years, so she will suffer a lengthy penalty period of 145.5 months ($1 million/$6,873), or more than 12 years. Even if she reapplies more than five years after the transfer, she will be subject to the transfer penalty since she applied for Medicaid and set her baseline date.
>
> Jon gives away $1 million in January, 2016, and then in February, 2022 he first applies for Medicaid. The transfer is not within the 5 year look back period, and he is not subject to any penalty period. Note the difference from Sally's result.

### 5. Once it Starts, the Penalty Period Continues Even if the Applicant Leaves the Nursing Home or Stops Receiving Waiver Services.

Once a penalty period begins, is it necessary for the person to remain in the nursing home or continue to receive waiver services and continue to be eligible for Medicaid? When one looks at the rationale for the penalty period, as described above, one would expect that it would be necessary for the person to need to remain in a nursing home and continue to be eligible for Medicaid in order for the penalty period to continue to run. But if one examines the structure of the statutory language, this is not required. 42 U.S.C. §1396p(c)(1)(A) provides that the penalty period begins on the date specified in subsection (D) and continues for the number of months specified in subsection (E). Once the beginning date is fixed, there is no provision to toll the running of the penalty period. It is FSSA's policy that a penalty period once begun runs continuously until the end date regardless of the individual's circumstances.

Examples:

In March, 2018, Stella was in good health and gave her daughter her last $30,000 to help her daughter pay off her debts. Stella then has a stroke and enters a nursing home in May, 2022. She applies for Medicaid and argues the transfer should be exempt. However, the DFR finds this to be a violative transfer and assesses a penalty period. Because Stella has no means to pay the nursing home bill, her daughter agrees to take Stella into her home and care for her. The penalty period begins in May, 2022 and continues even after Stella returns home.

On May 4, 2022, Julio gives $50,000 to his children. He then enters a nursing home on May 10, 2022 and applies for Medicaid. He has his home listed for sale, but has no other remaining countable resources. In July, 2022 he sells his home for $60,000. Julio is found eligible for Medicaid for June and July, except that Medicaid will not cover his nursing home per diem for a penalty period beginning June 1. He is ineligible for Medicaid in August, 2022 because of the proceeds of the sale. He intends to use the proceeds of the sale to private pay during the penalty period. The penalty period continues to run even after Julio becomes ineligible for Medicaid due to his resources.

### 6. Partial Month Penalties Are Applied Rather Than Rounding Down the Penalty Period.

The DRA provides that penalty periods cannot be rounded down. Instead, fractional periods of ineligibility must be used. IHCPPM § 2640.10.35.05 explains the DFR's method for calculating partial month penalty periods. It calculates the penalty as a number of months and days. The uncompensated value of all gifts made are added together and divided by the appropriate nursing home rate, $6,873 if the application is filed on or after July 1, 2021 and before July 1, 2022. The result is rounded up at the second decimal place (hundredths). Since there are 30.42 days in an average month (365 ÷ 12 = 30.42), the fractional part of the penalty period is multiplied by 30.42 and rounded up to determine the number of days of ineligibility.

Example:

On December 15, 2018 Dorothy gave $10,000 to each of her two sons. In January, 2019, she gave $10,000 to her daughter. In May, 2022 she applies for Medicaid while in a nursing home. The transfers, if not exempt from penalty, are added together to compute one penalty period. The $30,000 total she gifted divided by $6,873 equals 4.365, which is rounded up to 4.37. The fractional part of .37 multiplied times 30.42 equals 11.26, which is rounded up to 13. The penalty period is 4 months and 13 days.

The effect of the first month of the penalty can be lessened by entering a facility late in the month. The partial month penalty at the end of the penalty period may not be much of a penalty since a liability is not computed until the month after the last month of the penalty period. IHCPPM § 2640.10.35.20.

Example:

Fred, single, enters a nursing home on April 28, 2022 and applies for Medicaid. The DFR determines that he was otherwise eligible for Medicaid on April 1, 2022 but that he made a penalizable transfer with $7,000 of uncompensated value during the look back period. The penalty period is one month and three days. ($7,000 / $6,873 = 1.018; round to 1.02; .02 x 30.42 = .61, which is rounded up to 1 day). The penalty period is April through May 1. Medicaid will not cover his nursing home costs for April or for May 1. No liability is computed until June, so Medicaid will pay the full cost of nursing home care for May 2 through 31. Although on paper the penalty period is one month and one day, in reality only four days (April 28 - May 1) are not covered. Fred must pay for three days in April and one day in May at the private pay rate, but he does not owe a liability for May.

**7. Penalty Periods Are Apportioned Between Spouses if Both Spouse Are Institutionalized.**

OBRA 93 provides that penalty periods shall be apportioned between spouses when one spouse suffers a transfer penalty and the other spouse then becomes otherwise eligible for Medicaid. §1396p(c)(4); 405 IAC 2-3-1.1(m). The spouses should not each incur a full penalty period based on the same transfer. CMS State Medicaid Manual 3258.5(J)(emphasis added) gives the following guidance:

J. Transfer By a Spouse That Results in Penalty Period for the Individual.--When a spouse transfers an asset that results in a penalty for the individual, the penalty period must, in certain instances, be apportioned between the spouses. You must apportion the penalty when:

- The spouse is eligible for Medicaid;

• A penalty could, under normal circumstances, be assessed against the spouse, i.e., the spouse is institutionalized, or the State has elected to impose penalties on noninstitutionalized individuals; and

• Some portion of the penalty against the individual remains at the time the above conditions are met.

When these conditions are met, you must apportion any existing penalty period between the spouses. **You may use any reasonable methodology you wish to determine how the penalty is apportioned. However, the methodology you use must provide that the total penalty imposed on both spouses does not exceed the length of the penalty originally imposed on the individual.**

EXAMPLE: Mr. Able enters a nursing facility and applies for Medicaid. Mrs. Able transfers an asset that results in a 36 month penalty against Mr. Able. Twelve months into the penalty period, Mrs. Able enters a nursing facility and becomes eligible for Medicaid. The penalty period against Mr. Able still has 24 months to run. Because Mrs. Able is now in a nursing facility, and a portion of the original penalty period remains, you must apportion the remaining 24 months of penalty between Mr. and Mrs. Able. You may apportion the remaining penalty period in any way you wish, provided that the total remaining penalty period assessed against both spouses does not exceed 24 months. When, for some reason, one spouse is no longer subject to a penalty (e.g., the spouse no longer receives nursing facility services, or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.

In the above example, assume the 24 month penalty period was apportioned equally between Mr. and Mrs. Able. After six months, Mr. Able leaves the nursing facility, but Mrs. Able remains. Because Mr. Able is no longer subject to the penalty, the remaining total penalty (12 months) must be imposed on Mrs. Able. If Mr. Able returns to the nursing facility before the end of the 12 month period, the remaining penalty is again apportioned between the two spouses.

Neither the Indiana regulation nor the IHCPPM gives DFR staff any guidance on how to apportion penalty periods. Should one simply divide by 2 times $6,873, or should one divide the gifts between the spouses and then compute penalty periods, or does one compute one penalty period and then divide it between the spouses? There can be a different result. Since the federal guidance refers to apportioning penalty periods, the more conservative approach is to assume that FSSA will compute one penalty period and apportion it. Not every penalty period is apportioned just because the spouses are married. The penalty period is only apportioned when both spouses are otherwise eligible and subject to a penalty. A common example is where one spouse enters, is subject to a transfer penalty, and then the other spouse also enters the nursing home.

Example:

> Mr. and/or Mrs. Jones made a gift to their children, and then Mr. Jones entered a nursing home. FSSA determines based on the size of the gift that he is subject to a penalty period of 8 months and 6 days. Suppose after two months, Mrs. Jones also entered the nursing home. It would be unfair for them each to be subject to the remaining six months and 6 days penalty period. Instead, it would be more logical to apportion it between them so that they are each subject to three months and three days of penalty which will run concurrently. Many workers have been willing to compute one common penalty period by dividing by 2 times $6,873, or $13,746. This may result in a different length of penalty, but with partial months of penalties being applied, the results will be similar.

## F. Rules Concerning Transfers Involving Specific Types of Property

### 1. Funeral Trusts and Burial Spaces for Family Members

*Indiana FSSA v. Culley*, 769 N.E.2d 680 (Ind.App. 2002) held that there is no penalty for purchasing funeral trusts for one's children and their spouses. The Court relied on the definition of "immediate family" in the SSI regulations at 20 CFR § 416.1231(a)(4). There, "immediate family" is defined as "an individual's minor and adult children, including adopted children and step-children; an individual's brothers, sisters, parents, adoptive parents, and the spouses of those individuals. Neither dependency nor living-in-the-same-household is a factor in determining whether a person is an immediate family member." Applying *Culley*, for many years FSSA agreed that purchasing a funeral trust for any of these persons would not result in a transfer penalty.

Despite the broad language of *Culley*, the SSI regulation at 20 CFR § 416.1231 only exempts "burial spaces" purchased for immediate family members. Section 416.1231(a)(2) defines "burial spaces" as including:

> burial plots, grave sites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

SSA POMS § SI 01130.400 makes it clear that a burial container includes a casket, urn, niche, or other repository.

In 2017, FSSA narrowed the language in IHCPPM § 2640.10.25.40 to only allow an exemption for the purchase of **burial plots or spaces** for immediate members. After objections from the Indiana NAELA Chapter that FSSA needed to promulgate a rule to restrict its policy, FSSA agreed that it would revert back to its prior policy until it promulgated a rule. FSSA

ultimately added 405 IAC 2-4-2 effective July 11, 2021 to define burial expenses and burial spaces and to provide that the purchase of burial spaces and expenses for the member, the spouse, or immediate family members will be an exempt resource. Although this rule has been finalized, **FSSA acknowledges that due to pandemic provisions prohibiting it from adopting more restrictive provisions until the Public Health Emergency (PHE) has ended, FSSA is still applying *Culley* until the first day of the month following the calendar quarter in which the PHE ends.**

The DFR is now (at least in some cases) requiring that a funeral or burial trust for a family member contain the language referred to in I.C. § 12-15-2-17(f) that any excess funds be payable to the purchaser's estate or to the state for Medicaid benefits paid for the purchaser. For example, if a parent purchases a funeral or burial trust for a child, the trust needs to provide that if there are any funds left after paying the child's expenses, those funds will be payable to the state for Medicaid received by the parent. The DFR will possibly review this on redetermination for old funeral trusts.

### 2. Trusts

OBRA 93 contains detailed provisions for trusts established after August 10, 1993. §1396p(d); IHCPPM §2615.75.10. The general concept of the rules is that assets placed in a trust are either considered as an available resource or are considered to have been transferred. Assets are considered as an available resource if there are **any** circumstances under which payment could be made to the individual. If there are **no** circumstances under which the individual could benefit, then the assets are treated as transferred when the trust was established.

Thus, for a revocable trust, placing funds into a revocable trust is not a transfer, because the assets are still available. Payments to a third party from a revocable trust which are not for the benefit of the individual are treated as transfers when they are paid to the third party. §1396p(d)(3)(A).

For an irrevocable trust, those portions of an irrevocable trust which can under some circumstances, no matter how remote, be used to benefit the individual are not treated as a transfer unless and until they are transferred to a third party. Those portions of an irrevocable trust which cannot ever be used to benefit the individual will be considered to have been transferred when the trust was established, or if later, the date upon which payment to the individual was foreclosed. §1396p(d)(3)(B).

Because a transfer by an applicant's spouse is attributed to the applicant, *Hallam v. Mo. Dep't of Soc. Servs.*, 564 S.W.3d 703 (Mo. Ct. App. 2018), upheld a transfer penalty where the property, including farmland, was transferred to the spouse and upon the spouse's death, her property was transferred to her trust and then distributed to her children pursuant to the terms of her trust. The Court concluded that the disposition of assets for transfer penalties is not limited to *inter vivos* transfers, but also includes transfers at death. The Court distinguished this from a testamentary trust, which is exempt by 42 U.S.C. § 1396p(d)(2)(A) from the transfer of asset penalty rules. See Section XIII(C), above, concerning the rules applying to spousal testamentary trusts.

### 3. Annuities

The rules on annuities became much more complex with requirements added by the DRA. Normally, an asset may be a countable resource, or it may have been transferred so one needs to consider if there is a transfer penalty. The DRA introduced the possibility that an annuity may be countable as a resource and yet also be subject to a transfer penalty.

Before proceeding to the rules, it is useful to consider what is an "annuity." Annuities are defined in 405 IAC 2-3-1.2(a) as follows: "'annuity' means a policy, certificate, contract, or other arrangement between two (2) or more parties whereby one (1) party pays a lump sum of money or other valuable consideration to the other party in return for the right to receive payments in the future and shall include any similar financial instrument, as may be specified by the Secretary of Health and Human Services." Although instruments labeled as annuities meet this definition, loan agreements and other arrangements not typically thought of as being annuities also appear to meet this definition. Although this would appear to include promissory notes, the more specific rules on promissory notes discussed in the next Section govern promissory notes.

#### a. Annuities Subject to the DRA: Purchased or Non-Routine Changes Made On or After November 1, 2009

FSSA applies the Deficit Reduction Act's (DRA) provisions on annuities in 42 U.S.C. § 1396p(c)(1)(F) and (G) and § 1396p(e) to annuities purchased on or after November 1, 2009. IHCPPM § 2640.10.25.10. The DRA rules also apply to annuities purchased before November 1, 2009, for which "non-routine" activity occurs on or after November 1, 2009, including additions to principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract, change in ownership, or other non-routine actions. Any of these actions subjects the whole annuity to the DRA rules. Routine transactions like an address change do not result in an annuity being pulled under the new rules. *Id.*

CMS has not promulgated regulations on the annuity provisions, but on July 27, 2006 at downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/TOAEnclosure.pdf, pp. 9-16, it issued guidance to states.

#### b. The Requirement to Name the State as a Remainder Beneficiary For Annuities Subject to the DRA Rules

The DRA added 42 U.S.C. § 1396p(c)(1)(F), which requires the State to be named as the remainder beneficiary in the first position (or in the second position after the community spouse or minor or disabled child) or the purchase will be considered to be the transfer of an asset for less than fair market value.

Because purchasing an annuity without naming the State as a remainder beneficiary is treated as the disposal of an asset for less than fair market value, a purchase of an annuity without naming the State that was made before the look back period does not result in any penalty. There should not be any requirement to change the beneficiary to name the State as a remainder beneficiary. The DFR should not be examining purchases of annuities that occurred

outside of the look back period. Because 42 U.S.C. § 1396p(c)(1)(F) refers to the purchase of the annuity, changing the beneficiary within the look back period should not change this result. Even if the State is not listed as a remainder beneficiary, it can potentially still seek recovery from a remainder beneficiary after the death of a beneficiary, as I.C. § 12-15-9-0.5(a)(4) states that any sums due to a person after the death of a Medicaid recipient under an annuity purchased after May 1, 2005 with the assets of the recipient are a part of the "estate" for purposes of a Medicaid claim.

This section initially only required that the state be named as beneficiary for Medicaid received by the annuitant, but it was amended by the Tax Relief and Health Care Act of 2006 to change "annuitant" to "institutionalized individual." This change was designed to require a non-recipient spouse to name the state as beneficiary for payment of the recipient institutionalized spouse's Medicaid. FSSA explains this requirement at IHCPPM § 2640.10.25.10 by stating that "the State is entitled to receive the total amount of medical assistance paid on behalf of the applicant for medical assistance." The state needs to be named as beneficiary (or in second position after the community spouse or a minor or disabled child) to receive the amount of Medicaid paid for either spouse.

*Hutcherson v. Ariz. Health Care Cost Containment Sys. Admin.*, 667 F.3d 1066 (9th Cir. 2012) ruled that the state was entitled to reimbursement from the community spouse's annuity for the institutionalized spouse's Medicaid benefits. Where the community spouse died before the institutionalized spouse, the Court ruled that the state was not only entitled to reimbursement for those expenses incurred by the institutionalized spouse before the community spouse died, but it was also entitled to reimbursement for continuing benefits received by the institutionalized spouse after the community spouse's death. Taking a contrary position, *Hughes v. McCarthy*, 734 F.3d 473 (6th Cir. 2013) ruled that since 42 U.S.C. § 1396p(c)(2)(B)(i) permits an unlimited transfer of assets to another for the sole benefit of the individual's spouse, an annuity purchased for the sole benefit of the community spouse did not need to name the state as a remainder beneficiary. However, in *Singleton v. Ky.*, 843 F.3d 238 (6th Cir. Ky. 2016), the Sixth Circuit ruled that the federal law requiring the state to be named as beneficiary for Medicaid received by the "institutionalized individual" controlled even though Kentucky's regulation only required that the state be named as beneficiary for Medicaid received by the annuitant. Thus, even though Kentucky did not amend its state regulation when the federal law was amended, the federal law still controlled.

The question then arises as to whether the state must be named as a remainder beneficiary before one liquidates an annuity. If an annuity has not yet been annuitized, it seems that it ought not to matter if the State is named as a remainder beneficiary. Note that unlike 42 U.S.C. § 1396p(e), § 1396p(c)(1)(F) does not contain the phrase "regardless of whether the annuity is irrevocable or is treated as an asset." This suggests that the requirement to name a remainder beneficiary may not apply while an annuity is treated as an asset. Nonetheless, the question arises as to whether the State must first be named as a remainder beneficiary before an annuity is liquidated. It should not be necessary to change the beneficiary before liquidation, and several DFR Regional Managers have confirmed this is not necessary.

Although the DFR sometimes requires that the state be named as a beneficiary even on those annuities purchased before November 1, 2009, IHCPPM § 2640.10.25.10 appears to only

require that annuities purchased on or after November 1, 2009 list the state as a remainder beneficiary.

Not properly listing the State as a remainder beneficiary will result in the entire purchase price of the annuity being treated as if it had been improperly transferred. If a penalty is assessed, it should be removed once the required beneficiary designation has been made.

In addition to requiring at 42 U.S.C. § 1396p(e)(1) that annuities owned by the applicant and spouse be disclosed when one applies for Medicaid, the federal statute and the state regulation state that the application or recertification packet must contain a statement signed by the applicant stating that the State becomes a remainder beneficiary on these annuities by virtue of providing Medicaid. Further, the State shall notify the annuity company of the State's right as a preferred remainder beneficiary. 42 U.S.C. § 1396p(e)(1) and (2); 405 IAC § 2-1-2(i). Paragraph 27 of the Notice Regarding Rights & Responsibilities, available in English and Spanish at www.in.gov/fssa/dfr/forms-documents-and-tools/forms, informs an applicant that the State will become a preferred remainder beneficiary for the total amount of Medicaid paid.

Although 405 IAC 2-1-2(i)(2) says that "the state will notify the issuer of the annuity of its right as a preferred remainder beneficiary," it does not appear FSSA currently does this. It is questionable how issuers would respond if the State submits such a notice, since the statement will not be a part of the annuity contract. IHCPPM § 2640.10.25.10 does not address this provision. Note that I.C. § 12-15-9-0.5(a)(4) already includes sums payable under an annuity contract as being part of a Medicaid recipient's estate after death. This Section is an effort to improve estate recovery by trying to make certain that benefits will automatically be paid to the State after death.

If receiving Medicaid is enough to automatically make the State the remainder beneficiary, then it would seem unnecessary that the applicant and spouse must list the State as a remainder beneficiary. However, that is the requirement, and the failure to name the State as a remainder beneficiary will result in the full value of the annuity being subject to a transfer penalty.

See the last paragraph of the next Section for a discussion of whether the state must be named as a remainder beneficiary for annuities described in that Section.

### c. Annuities That Are Not an Asset for Purposes of a Transfer Penalty

42 U.S.C. §1396p(c)(1)(G) exempts certain retirement annuities and actuarially sound non-retirement annuities from the definition of "assets" in determining if there has been a transfer. That is, the purchase of one of these annuities will not result in a transfer penalty (but see the further discussion below in this subsection on whether the State must be named as a remainder beneficiary). Be aware that an annuity which is not an asset for purposes of a transfer penalty may still be a countable resource. In its Guidance, CMS emphasizes that subsection (G) applies only to annuities purchased by or on behalf of a person applying for Medicaid for long

term care services. It does not apply to annuities purchased by a non-recipient spouse. downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/TOAEnclosure.pdf, p. 14. FSSA says the same thing in IHCPPM § 2640.10.25.10.

Any of the following qualified retirement annuities purchased by a person applying for Medicaid for nursing home or other long term care will not be treated as a transfer:

1. The annuity is considered either:

- An individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or
- A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408(q) of the IRC).

OR

2. The annuity is purchased with proceeds from one of the following:

- A traditional IRA (IRC Sec. 408a); or
- Certain accounts or trusts treated as traditional IRAs (IRC Sec. 408 §(c)); or
- A simplified retirement account (IRC Sec. 408 §(p)); or
- A simplified employee pension (IRC Sec. 408 §(k)); or
- A Roth IRA (IRC Sec. 408A).

42 U.S.C. § 1396p(c)(1)(G)(i); CMS' Guidance at pp. 14-15; and IHCPPM § 2640.10.25.10. The logic for this exclusion appears to be that the requirements for these accounts, such as required minimum distributions, are sufficient protection.

42 U.S.C. § 1396p(c)(1)(G)(ii) provides that an annuity purchased by a person applying for Medicaid for nursing home or other long term care will not be treated as a transfer if it:

- is irrevocable and nonassignable;
- is actuarially sound, with payback within life expectancy per the table in IHCPPM § 2640.10.25.10; and
- provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

The federal statute requires that an annuity be actuarially sound but does not set a minimum period during which an annuity must make payments. Is there a point at which an annuity is so short that it is either not an "annuity" or is not "actuarially sound"? For example, if an annuity pays off within six months, is that an actuarially sound annuity? The Third Circuit Court of Appeals reversed a Pennsylvania federal district court ruling that annuities that paid off in 12, 14, and 18 months were too short and subject to penalty where the life expectancies of the annuitants ranged from six to ten years. The Third Circuit declared that "Congress did not require any minimum term for an annuity to qualify under the safe harbor." *Zahner v. Sec'y Pa. Dep't of Human Servs.*, 802 F.3d 497, 505 (3d Cir. 2015). The Court stated that an annuity that paid out in two days, two hours, or two seconds may be a sham, but it was unwilling to say that

an annuity paying out in 12 months was a sham, even where there was a negative return after fees were considered.

The next question is whether §1396p(c)(1)(G)'s exemptions mean that annuities that fall under this Section do not need to meet the §1396p(c)(1)(F) requirement to name the state as a remainder beneficiary. CMS states in guidance that the safe harbor provision does not eliminate the need to name the state as remainder beneficiary. See p. 14 of downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/TOAEnclosure.pdf. IHCPPM § 2640.10.25.10 does not clearly address this. *Cook v. Glover*, 295 Ga. 495, 761 S.E.2d 267 (Ga. 2014), deferred to CMS' interpretation and ruled that the Georgia Medicaid agency could assess a transfer penalty for not naming the state as a remainder beneficiary even though the annuity fit one of the exemptions. FSSA does not clearly address this in IHCPPM §2640.10.25.10, and it has not been consistent in its treatment of this. Based on the CMS Guidance, one should name the State as remainder beneficiary even for annuities which fit the safe harbor of §1396p(c)(1)(G).

### d. Assessing Transfer Penalties

Even if the State is named as a beneficiary, one must still determine if there has been a transfer of an asset that will result in a penalty for annuities purchased by the community spouse and for annuities purchased by the applicant that do not fall into the safe harbor discussed in the preceding subsection.

IHCPPM §2640.10.25.10 provides instructions for determining if there is an uncompensated transfer for the purchase of an annuity. In order for the entire purchase price of the annuity not to be counted as uncompensated value for the transfer, the annuity must meet two criteria. First, it must be purchased from an insurance company, another commercial company that regularly sells annuities, or from a charitable organization. Thus, private annuities are penalized. Second, the annuity must provide for substantially equal monthly payments that do not increase by more than 5% per year. There cannot be a "balloon payment." If the annuity does not meet both of these criteria, then the entire purchase price is treated as uncompensated value. If the annuity meets these two criteria, then there is uncompensated value only to the extent that the annuity does not return the purchase price within the purchaser's life expectancy, as determined by the life expectancy tables at the end of IHCPPM § 2640.10.25.10.

Example:

> Mrs. Luck, a community spouse, age 90, purchases an immediate annuity for $100,000. The annuity provides for 11 annual payments of $10,000. The State is listed as the remainder beneficiary. The Life Expectancy Table shows her life expectancy as 4.78 years. Since only $40,000 will be paid back within her life expectancy, Mr. Luck will be subject to a transfer penalty based on $60,000 of uncompensated value. If the annuity paid back at least $100,000 within 4.78 years, then it would not be subject to a transfer penalty. However, if the State is not listed as a remainder beneficiary, then a transfer penalty based on $100,000 will be assessed.

In determining whether an annuity purchased by an applicant is actuarially sound, 42 U.S.C. § 1396p(c)(1)(G)(ii)(II) requires that life expectancy be determined in accordance with

actuarial publications of the Office of the Chief Actuary of the Social Security Administration. CMS in its guidance directs that the table at www.socialsecurity.gov/OACT/STATS/table4c6.html be used. That table has slightly different numbers than the numbers in the table in IHCPPM § 2640.10.25.10.

Compare the results for non-retirement annuities purchased by an applicant or by the applicant's spouse. An irrevocable, non-assignable, actuarially sound annuity with approximately equal payments is not considered to be a "transfer of asset" when purchased by the applicant. The same annuity when purchased by a community spouse is considered to be a transfer of an asset, but so long as it is an irrevocable, non-assignable, actuarially sound annuity, and purchased from a commercial entity, it will not result in a penalty because it is considered to be a transfer for adequate value. The result is the same. The only possible difference is that it appears the purchase of a private annuity by an applicant that is irrevocable, non-assignable, and actuarially sound annuity is protected, while a "private annuity" purchased by a community spouse is not protected.

#### e. Summary of Annuity Transfer Penalty Rules

The annuity rules as set forth in 42 U.S.C. § 1396p(c) are difficult to interpret. Read together, they appear to provide the following:

- Any interest in an annuity owned by the applicant or spouse must be disclosed.

- If the annuity was purchased on or after November 1, 2009 or if "non-routine" changes were made on or after November 1, 2009, and within the look back period, then the state needs to be named as beneficiary (or in second position after the community spouse or a minor or disabled child) to receive the amount of Medicaid paid for either spouse. Failure to do so results in the entire purchase price being subject to a transfer penalty.

- There is a safe harbor for the applicant/recipient such that the purchase of an annuity on or after November 1, 2009 will not be penalized if the annuity is a protected retirement annuity or is irrevocable, non-assignable, actuarially sound with no deferred or balloon payment. However the state must still be listed as a remainder beneficiary.

- Although the safe harbor does not apply to the purchase of an annuity by a community spouse, such annuity will not be penalized if it is irrevocable, non-assignable, actuarially sound, pays out in substantially equal payments, and is purchased from a commercial entity.

### 4. Promissory Notes (Including Land Sale Contracts)

42 U.S.C. §1396p(c)(1)(I) provides that a promissory note that meets the following requirements is not an "asset" for purposes of the transfer of assets penalty:

- The note must have a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

• The note must provide for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

• The note must prohibit the cancellation of the balance upon the death of the lender.

This gives a safe harbor for promissory notes that meet the three terms listed. Lending funds in return for a promissory note that meets those three terms is thus exempt from the imposition of any transfer penalty. Although not clearly stated, this Section suggests that a promissory note that does not meet these requirements will subject the lender to a transfer of assets penalty. IHCPPM § 2640.10.25.30 so provides. The value considered to be an improper transfer is the outstanding balance owed on the contract as of the date of application for Medicaid or the date of long term care admission, whichever is later.

IHCPPM § 2615.55.15 applies the three requirements in 42 U.S.C. §1396p(c)(1)(I) for promissory notes to land sale contracts. If these criteria are not met, the land sale contract will be treated as a penalizable transfer of resources. The amount that will be considered to be the uncompensated value will be the outstanding balance due as of the date of the individual's application for Medicaid or as of the date of long term care admission, whichever is later.

Although the statute refers to a specific actuarial publication, FSSA uses the life expectancy table at IHCPPM § 2640.10.25.10, which is slightly different than the table specified in the statute.

The requirement for actuarial soundness does not address whether there is a minimum period for payment. IHCPPM § 2640.10.25.30 only requires that the loan be repaid with the person's life expectancy; it does not set a minimum period for payment. 405 IAC 2-3-12 likewise provides that the repayment term cannot exceed the member's life expectancy. The Indiana Chapter of NAELA filed comments objecting to this provision, since many land sale contracts are for 15 or 30 years, which may exceed life expectancy. But FSSA requires a land sale contract not extend beyond the seller's life expectancy.

Although the section does not explicitly address the amount to be repaid, the promissory note should provide for payment back of at least the amount loaned plus some reasonable rate of return. In determining an appropriate interest rate to use in a promissory note, using the IRS Applicable Federal Rate, which can be found at resources.evans-legal.com/?p=2591, should be acceptable. Use the short term rate if the term is less than three years, the mid-term rate if the term is less than nine years, or the long term rate if longer than nine years.

*Frantz v. Lake*, 2014 WL 4204875, 2014 U.S. Dist. LEXIS 116916 (W.D. Okla. 2014) ruled that a non-negotiable promissory note that complied with 42 U.S.C. §1396p(c)(1)(I) was neither an available resource nor a trust-like device and was not subject to a transfer penalty.

Promissory notes are allowed by Medicaid, within limits, as a means to shelter resources. It is critical that the obligor understand the obligation to pay, be able to pay, and actually pay precisely as provided by the terms of the note. A sample promissory note is at Appendix H.

### 5. Property Used in a Trade or Business

Because SSI has a broad exemption for property used in a trade or business and because the federal statute cross references the SSI rules on resources, Indiana includes an exemption for real property used in a trade or business that is actively managed or operated by the applicant or recipient. 405 IAC 2-3-1.1(d)(6); IHCPPM § 2640.10.15.05(2). The Indiana rule does not mention personal property used in a trade or business, though personal property is also covered by the SSI rule and should be exempt from penalty if transferred.

It is useful to review the SSI rules on trade or business property. The SSI statute at 42 U.S.C. §1382b(a)(3) (emphasis added) excludes:

> other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Commissioner of Social Security, **except that the Commissioner of Social Security shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee.**

Thus, any property used in a trade or business is excluded for SSI and therefore also should not be subject to a transfer penalty if transferred. Social Security Ruling 64-40 sets forth a four part test for determining whether a person is involved in a trade or business. In that ruling the issue was whether the income would count for Social Security purposes, but SSI uses the same test. The four part test is:

> In this regard it has been concluded that a reasonable basis exists for a finding that a particular activity constitutes a trade or business if the following factors have been substantially met:
>
> > 1. The activity was initiated and conducted in good faith with the intention of making a profit or producing income.
> >
> > 2. The activity has been regularly carried on, i.e., there has been a continuity of operations, a constant repetition of transactions, or a regularity of activities.
> >
> > 3. The activity was engaged in as a regular occupation or calling.
> >
> > 4. The individual held himself out to others as being engaged in the selling of goods or services.

SSR 64-40, at www.ssa.gov/OP_Home/rulings/oasi/47/SSR64-40-oasi-47.html. The same test is included in the SSI POMS, which is the Social Security Administration's equivalent of Indiana's IHCPPM. Section SI 01130.501(c)(4)) of the POMS SSI Chapter refers to Section RS 01802.002, which lists the same four factors in its subsection (A). The POMS Manual also

instructs that the income tax return is to be reviewed. The applicant should file a Schedule F or Schedule C reporting the assets as an active business.

405 IAC 2-3-1.1(d)(6) says that before property can be excluded as "trade or business" property, it must be "actively managed or operated by the applicant or recipient." In reviewing property essential to self-support for purposes of SSI, 20 CFR § 416.1220 refers to the definition of "trade or business" contained in 20 CFR §404.1066. That section states "You can carry on a trade or business as an individual or as a member of partnership." That section does not contain the active management or operation requirement which is included in subsection (d)(6). Instead it appears to allow a partner to be managing or operating the trade or business. Thus, the "active management" requirement may be more restrictive than the SSI definition. Note though that the four factors above do require a certain level of involvement. The IHCPPM gives no guidance to DFR staff, as §2640.10.15.05(2) simply repeats the language from the regulation with no further explanation.

Applying these rules to specific situations, a farmer who is actively farming his land clearly meets the definition of carrying on a trade or business. What if the farmer has retired and has turned over the daily farming to a relative or has rented the farmland to a neighbor to farm? So long as the farmer is involved in the decision making, that should meet the "active management" test. Renting out the farm for cash rent would likely not be considered active management while a crop share lease may involve active management. Another example that could fit this exemption is rental real estate. A person who rents out one's former homestead will not meet this test. But if the person had been actively engaged in renting out real estate as an income producing activity, that should qualify as business property which can be transferred with no penalty, so long as the person is still involved in "active management."

### 6. Transfer of Non-Income Producing Real Estate

A transfer of a partial interest in real estate without receiving adequate consideration results in a transfer for uncompensated value. If real estate is transferred into joint ownership, then the amount transferred depends on the portion of the full interest which has been transferred.

Examples:

> Mary owns the fee simple interest in her home. She transfers her home to herself and her daughter as joint tenants with rights of survivorship for no consideration. She has transferred one-half of the value of her home, as her daughter now has a one-half interest in the home.
>
> Sam owns the fee simple interest in his home. He transfers his home to himself and his three children as joint tenants with rights of survivorship for no consideration. He has transferred three-fourths of the value of his home, as he now has only a one-fourth interest in his home.

The transfer of the remainder interest in real estate while retaining a life estate will be valued using the life estate table in the IHCPPM, which is located at § 2605.25.10.10. The amount

transferred is determined by multiplying the value assigned to the real estate by the fair market value of the property as a whole.

### 7. Transfer of Income Producing Real Estate Not Used in a Trade or Business

Indiana applies a penalty for transferring the property itself by utilizing the SSI $6,000/6% rule to income producing real estate not used in a trade or business. For income producing real estate, SSI has a rule known as the $6,000/6% rule. Only the first $6,000 of equity of income producing real estate is exempt for SSI, and then only if it is producing at least 6% rate of income. 20 CFR § 416.1222. For transfer purposes, the DFR counts the value of the income producing real estate, after allowing for a one time exemption of $6,000. Even though Indiana counts all except the first $6,000 of the equity value of income producing real estate which is transferred, it also includes income that would have been received during the transferor's lifetime when determining the total amount of the assets transferred. 405 IAC 2-3-1.1(h); IHCPPM §2640.10.25.25. Some examples show how this works.

Examples:

> Maggie, age 80, owns a rental property with equity value of $100,000 that currently produces net rental income of $10,000 per year. In March, 2022 she gifts fee simple title in the property to her daughter. If she has not previously transferred rental property, the first $6,000 is exempt, and the remaining $94,000 of value is counted as the value of the transfer. To this is added the income which could have been earned during the remainder of Maggie's life. Her life expectancy is 9.68 years according to the table in the IHCPPM, so the income transferred is $96,800 (9.68 x $10,000). The total considered transferred is $190,800 ($94,000 + $96,800).
>
> Brad, age 55, is in a serious accident and is totally disabled. He owns a rental property with equity value of $60,000 that earns net rental income of $4,000 per year. In August, 2022 he gifts the property to his son. If he has not previously transferred rental property, the first $6,000 is exempt, and the remaining $54,000 of value is counted as the value of the transfer. To this is added the income which could have been earned during the remainder of his life. His life expectancy is 25.5 years according to the table in the IHCPPM, so the income transferred is $102,000 (25.5 x $4,000). The total considered transferred is $157,000 ($54,000 + $102,00).

As can be seen from these examples, adding future income to the equity value creates illogical results that dramatically over value the amount of the real estate which has been transferred. The value of potential future rents is used to determine the fair market value of rental property, so FSSA is overvaluing what is being transferred. The Elder Law Section of the Indiana State Bar Association, along with others, objected to counting both the value of the property itself and of the income it may generate, since this over values the property. Despite the logic of these objections, the regulation was finally adopted. Indiana's rule is subject to challenge in court.

### 8. Purchase of a Life Estate If Purchaser Resides in the Property for a Year

One tactic that some persons have used in the past to shelter funds is to purchase a life estate in real estate owned by a family member. This was an effective technique because there is no estate claim against life estate interests. The DRA added 42 U.S.C. §1396p(c)(1)(J), which provides that

> For purposes of this paragraph with respect to a transfer of assets, the term `assets' includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

The intent of this provision appears to be to penalize the purchase of a life estate, even if purchased for fair value, if the purchaser does not live in the property for one year. Conversely, the provision provides a safe harbor for the purchase of a life estate if the purchaser lives in the home for one year after purchase. For example, if Dad moves in with Son, purchases a life estate in Son's home at the value according to the life estate table and lives there at least a year, there will be no penalty for Dad's purchase of the life estate.

FSSA applies this to the purchase of a life estate in another person's home. IHCPPM § 2640.10.25.05. The Section explains that there is no proportional reduction for one who lives there only a portion of a year. There will be a full transfer penalty even if the person resided in the home for eleven months. If an applicant applies while still living in another's home but less than a year after the purchase of a life estate, a transfer penalty will be assessed.

This provision does not address the purchase of a life estate in property that is not the home of the seller. This type of transaction is guided by general principles.

### 9. Rental of Real Estate (Applicant/Recipient or Spouse as Lessor)

Renting out real estate for less than fair market value is treated as a transfer with uncompensated value. 405 IAC 2-3-1.1(I); IHCPPM §2640.10.25.25. The uncompensated value of the transfer is determined by multiplying the persons's life expectancy (using the table at IHCPPM § 2640.10.25.10) by the difference between the fair market rental value and the amount of rent accepted. Note that the life expectancy is used even if the lease is not for a lifetime.

Example

> Sam, age 65, leases his former home to his son for $100 per month pursuant to a one year lease. The DFR determines that the fair market value is $500 per month. The uncompensated value is $400 ($500 - $100) per month times his life expectancy of 17.89 years, times 12 months per year, for a total uncompensated value of $85,872.

There is no discount to account for the present value of money, although there is also no factor to account for the potential increase in rent that may occur over time. The regulation also does not

speak to what happens if property is rented at fair market value or a different amount after a lease terminates. Potentially this will be treated the same as if some or all of the assets are returned, with a resulting reduction in a penalty period. See Section (D)(11), above.

Example

> Suppose Richard, age 65, on July 1,2017 allows his son to stay in a rental house he owns, which has a fair monthly rental value of $500, for $100 per month. As shown above, Richard has made a transfer for uncompensated value of $85,872. Suppose Richard then entered a nursing home on April 1, 2022 and agrees to begin charging his son fair market rent. Logically, Richard should not be subject to a transfer penalty. Since he only received the reduced rent for four years, the uncompensated value ought to be recalculated. One can say that the reduced rental value which the son might have received after April 1, 2022 has instead been given back to Richard.

### G. Summary List of Transfers That Can Be Made Without Penalty

The previous Sections discuss several types of transfers which can sometimes or always be made without penalty. Following is a summary list, with a reference to the Section above where these are discussed. See the Section listed for further explanation and detail.

• Any income or resource, other than the home, that is excluded by SSI. C.

• Transfer to spouse. D.2.

• Transfer to a disabled child. D.3.

• Transfer to a trust for the sole benefit of a disabled person under age 65. D.4.

• Certain individual and pooled special needs trusts. D.4.

• Household Goods and Personal Effects. D.5.

• Certain transfers of the home. D.6.

• Gifts of $1,200 or less per year to family member or nonprofit corporation. D.7.

• Transfer was exclusively for purpose other than qualifying for Medicaid. D.8.

• Assets are Disregarded Due to Partnership Long Term Care Insurance Policy. D.9.

• “Undue hardship”. D.10.

• Assets are returned. D.11.

• Federal Tax Refund **or stimulus payments** Within 12 Months of Receipt. D.12.

• 529 Plans. D.13.

• Theft of Funds. D.14.

• Purchase of funeral trusts for self or immediate family. F.1.

• Retirement Annuities. F.2.

• Actuarially sound irrevocable annuities. F.3

• Monies loaned in exchange for promissory note. F.4.

• Property Used in a Trade or Business. F.5.

• First $6,000 of income producing real estate. F.7.

• Purchase of Life Estate in Another's Home if Purchaser Resides in Property for a Year. F.8.

• Funds deposited into a 529 plan or withdrawn from a 529 plan and used for education expenses. F.10.

### H. Transfer Planning Is More Difficult, but Not Totally Foreclosed Under the DRA Rules.

Transfer planning is often important, as the client may have family members or others who depend on the client for support. The client may have other legitimate reasons for wanting to transfer assets, such as the desire to keep a farm or the home "in the family." Any client who makes gifts must do so in good faith. One cannot simply give assets to a family member or friend to hold. If the transferor has the right to get the assets back, the assets have not actually been gifted and are countable as a resource. Although this section will discuss some of the ways assets can be transferred as part of a Medicaid plan, it may not be in the person's best interests to transfer assets. The person may be better off keeping the assets for his or her own benefit. This section will briefly discuss some options available in transfer planning if transfers are appropriate and desired.

#### 1. Where Possible, Use Transfers Which Do Not Result in Any Penalty Period.

Many transfers of property can be made without resulting in a penalty period. See the list above in Section G. If the transaction is exempt from a penalty, then the penalty computation is not an issue.

If children or other family members are providing services, it is important to enter into a written agreement for payment of services. Paying for services after they have been provided

where there was no contract for payment is problematic, because IHCPPM § 2640.10.20.20 requires that an agreement for payment be in place when the services were provided. Although one can attempt to establish the existence of an oral agreement to provide services, one may have difficulty convincing the DFR that there really was an agreement. Having a written agreement and records will avoid this problem. For further information and sample client informational letter and agreements, see the forms by Keith Huffman in ICLEF's 2009 Elder Law Institute. See also IRS Publication 926, Household Employer's Tax Guide, available at www.irs.gov/pub/irs-pdf/p926.pdf. Advocates report using pay rates of $15 to $20 per hour for caregivers. One should also consult a tax advisor as needed. Properly handling the tax consequences will not only avoid problems with the IRS but will also help document that the transaction was done in good faith.

The DFR will question a service agreement that pays a lump sum for future services. *Austin v. Indiana FSSA*, 947 N.E.2d 979 (Ind. Ct. App. 2011) upheld the DFR's assessment of a transfer penalty where a lump sum was paid for future services. The Court explained it was a factual decision, and though it upheld DFR's decision, the Court did not say a lump sum contract can never be used. The Court stated:

> We are not prepared to say, categorically, that contracts such as the Agreement here could never be considered a fair market value exchange for a Medicaid applicant's assets. The IHCPPM does permit consideration in exchange for a transfer of assets to take the form of services, if it "is based on the market value of such services and the frequency and duration of the services." App. p. 188. We also happen to agree generally with the approach apparently taken by the *Reed* [*v. Mo. Dep't of Social Services, Family Support Div.*, 193 S.W.3d 839 (Mo. Ct. App. 2006)] and *Brewton v. St. Dep't of Health & Hosps.*, 956 So. 2d 15 (La. Ct. App. 2007)] courts; namely, that fair market value in this context question presents largely a question of fact, or at most a mixed question of law and fact, which can and possibly should include an examination of whether a care provider under a personal services contract is or has been actually providing valuable services to a nursing home resident that substantially exceed the services provided by the nursing home. Here, the FSSA considered the evidence and concluded, essentially, that the Agreement was not worth what Austin paid for it, and imposed a transfer penalty for that reason. We defer to the FSSA's finding and will not reweigh the evidence on this point; we do not rule out the possibility that under a different set of facts, a similar agreement would **not** give rise to a transfer penalty.

In *Thomas v. Florida Dept. of Children and Families*, 707 So.2d 954 (Florida Dist. Ct. of Appeals, 1998), the Court upheld as valid a contract in which the daughter agreed to supervise her mother's health care and to provide personal services in exchange for $67,725. The Court simply stated that the only evidence presented in the administrative proceedings showed that the contract was for fair value. Reaching the opposite decision was *E.S. v. Div. of Med. Assistance & Health Servs.*, 990 A.2d 701 (N.J. App. Div. 2010), where the appellate court upheld the Medicaid agency's rejection of a lump sum payment for future payments. See also *Joyner v. N.C. HHS*, 715 S.E.2d 498 (N.C. App. 2011), where the Court concluded that there are too many

contingencies in a future services contract and thus as a practical matter it could not conclude there was fair market value consideration for the future services to be provided.

Even though theoretically one should be able to write a valid contract for future services which will be provided in return for a lump sum present payment, the DFR will scrutinize the agreement closely and almost certainly reject it. Because courts tend to defer to administrative agency decisions, DFR decisions can be difficult to overturn. DFR is much more likely to approve an agreement which pays for services as they are provided.

Payment of fees to an attorney-in-fact under a power of attorney that does not prohibit payment of fees is not a transfer. IC 30-5-4-5 allows an attorney-in-fact to claim compensation for the prior twelve months, unless the power of attorney prohibits a fee for services.

### 2. One Can Transfer Resources Even Though a Transfer Penalty Will Be Incurred, So Long as Sufficient Exempt Assets Are Retained or Sufficient Income is Generated to Withstand Any Penalty Period.

Under the rules in place before the DRA, one could make transfers which resulted in a penalty, so long as sufficient resources were retained to withstand any penalty period. This could be done by determining that Medicaid would not be needed during the look back period, or by determining that there were sufficient resources to privately pay for services during the penalty period. This is more difficult to accomplish now that the DRA has been implemented, because the penalty period does not begin to run until the applicant is otherwise eligible for Medicaid, but it can still be accomplished through the use of exempt assets.

One can still make gifts of any size if Medicaid will not be needed within five years after the gift(s). Some clients will have sufficient assets or long term care insurance such that they will be confident that Medicaid will not be needed within five years. Even then, **it is important that a Medicaid application not be filed while gifts are within the look back period, as that could result in an unexpected penalty, unless one is aware of the penalty period and has a means to pay for care during the penalty period.**

It is possible to make gifts so long as one retains sufficient exempt resources that one can then utilize to pay privately during the penalty period. In order for the penalty period to begin running, the applicant needs to be in a facility and eligible for Medicaid. One can be eligible for Medicaid while retaining exempt resources. So the principle is that one needs to retain sufficient exempt resources to pay the private pay cost during any penalty period. An example will show how this might work.

Example:

> Suppose Dorothy now needs to enter a nursing home. Suppose she has $100,000 in countable resources, and her home, to which she will not be able to return, is worth $60,000. Suppose also that she has a child Larry who is dependent on her for support, but he does not meet the Social Security definition of disability. She explains that she wants to gift as much as she can to her other son, Dale, as he will use that to support Larry. Suppose also that the monthly total cost of nursing

home care for her will be $7,000, and that she has $4,000 per month income from her Social Security and pension benefits. If Dorothy were to gift $99,000 to Dale, she could then apply for Medicaid and become eligible, provided that she agrees to offer her home for sale or rent. She would be found eligible for Medicaid subject to a penalty period of 14.41 months ($99,000 ÷ $6,873 = 14.41), assuming there are no other penalizable transfers. To pay privately during this penalty period, she would need an additional $43,230 (14.41 times her monthly shortfall of $3,000) to supplement her income. If she is able to sell the house for $60,000, she would then have sufficient funds to pay privately during her penalty period.

If her nursing home costs increase or if she does not realize as much as expected from the sale, she could have insufficient funds. Hopefully Dale will make up any shortfall from the gift, but he would not be legally obligated to do so. One could gift less so that there would be a shorter penalty period, but Dorothy would still need to reduce countable resources enough to become Medicaid eligible, such as by purchasing a funeral trust. If Dorothy had no real estate but $160,000 in countable resources, she could accomplish the same thing by first going out and purchasing a $60,000 rental property. As explained above in Section F(4), it should not affect the running of the penalty period if Dorothy sells her home and then becomes ineligible for Medicaid.

The same result can be achieved by purchasing an irrevocable annuity or lending funds in return for a non-negotiable promissory note to generate enough income to pay for the length of the penalty period. An irrevocable, non-assignable annuity or a non-negotiable promissory note does not count as a resource. Thus, one can purchase an annuity that will pay out sufficient income to pay the difference between the client's income and the total cost of nursing home care. A rough formula which can be used to approximately determine how much can be gifted (assuming no other gifts already exist which create a penalty) is:

"Total" is total amount of assets available for gifting and purchase of the annuity
"Amount Needed" is additional monthly income needed to meet monthly expenses

$$\text{Amount to be Gifted} = \frac{\$6{,}873 \text{ times the Total}}{\text{Amount Needed} + \$6{,}873}$$

Applying this formula to an example, suppose Mildred has $200,000 in total assets available for gifting and purchase of an annuity. Suppose also she will need additional income of $5,000 per month during any penalty period to supplement her regular income so that she can pay all of her expenses, including her nursing home bill. The rough amount she can gift using this formula is (($6,873 x $200,000)/($5,000 + $6,873) = 1,374,600,000/ 11,873 = $115,775. If she gifts that amount, she would be subject to a penalty period of 16.85 months. If she used the remaining funds of $84,224 to purchase a 17 month annuity, the annuity would produce $4,954 per month if it only returned principal, so that it would produce almost enough to pay the amount needed during the 16.85 month portion of the penalty period, if the cost did not rise. Remember that the formula is only a rough calculation. One should adjust the result as needed to work for the individual situation.

Annuities are available to meet these situations, though one may not be able to find a company willing to sell an annuity for less than 13 months. Dale Krause of Krause Financial Services markets Medicaid annuities nationwide. More information is available from him at phone 1-866-605-7437 or see www.medicaidannuity.com for further contact information for his office. One can either request an annuity for a specific period and amount, or one can complete a form available from his office listing the assets, income, and nursing home expenses, and his office will do the calculation. Annuities are also available from other companies.

One can accomplish the same thing by use of a non-negotiable promissory note that meets the terms listed in 42 U.S.C. §1396p(c)(1)(I). See Section XIII(F)(4), *above*. A promissory note can be done for a shorter term than annuity companies may be willing to use for an annuity. Be certain that the party to a promissory note can be depended upon to make the payments and understands the payments that are required by the note.

Some factors to consider when deciding whether to use an annuity or a promissory note include:

- Is there a third party who can be depended upon to make the payments under a promissory note? If not, an annuity, which has payments being made by a commercial entity, should be used.

- What is the cost of obtaining the annuity?

- Is there a concern about whether the payments will be counted as income? If a community spouse is using an annuity or promissory note to shelter assets, any income received by the community spouse will affect the calculation of how much, if any, of the recipient spouse's income will be allocated to the community spouse. All of the income of an annuity counts as income, while only the interest of a promissory note is counted.

## XIV. Liens Against the Recipient's Real Estate

**FSSA is not currently filing a lien in those cases where it can, but FSSA has at times stated that it plans to begin utilizing liens. It is unknown when or if this will be implemented. This Section discusses FSSA's authority to seek a lien.**

Federal law sets limits on a state's right to request a recipient to repay it for the Medicaid assistance received. Section XV, *below*, discusses the state's right to file a claim against a recipient's estate. In addition, federal law gives states the option to place a lien against a recipient's real estate when the recipient is expected to be permanently institutionalized. 42 U.S.C. §1396p(a). The 2002 Indiana legislature gave OMPP the authority to file liens beginning January 1, 2003. I.C. § 12-15-8.5; 405 IAC 2-10. Liens are administered at the state level after referral from the county. If a permanently institutionalized recipient sells real estate to which a lien has attached, FSSA can then obtain repayment from the sale proceeds. If the recipient does not sell the property during his or her lifetime, the lien gives added protection to FSSA's claim against the estate.

OMPP can file a lien only after it determines that a Medicaid recipient who resides in a nursing home, intermediate care facility for the developmentally disabled (ICF/IDD), or a hospital cannot reasonably be expected to be discharged and return home. I.C. § 12-15-8.5-2. If OMPP determines that the recipient will be unable to return home to live, then OMPP **may** file a lien against the recipient's interest in **any** real estate. OMPP cannot obtain a lien if any one of the following persons is living in the recipient's home:

- the recipient's spouse;
- the recipient's child under age 21;
- the recipient's child who is disabled as defined by SSI;
- the recipient's parent; or
- the recipient's sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least twelve (12) months before the recipient was admitted to the medical institution

I.C. § 12-15-8.5-3. If any of these persons resides in the home, OMPP cannot obtain a lien even on other real estate owned by the recipient.

Before it obtains a lien, OMPP must provide notice to the recipient and the recipient's authorized representative, if there is one, of OMPP's intent to obtain a lien and of the recipient's right to request an administrative hearing to challenge the filing of a lien. A lien cannot be filed until at least thirty days after the notice is given, or if the recipient requests a hearing, until after the appeal is completed. I.C. § 12-15-8.5-4. At the hearing the recipient can challenge the determination that he or she cannot reasonably be expected to return home, or the recipient can show that one of the persons listed above is living in the home.

Once the time for appeal has elapsed, or once the hearing process has been completed and an appeal decision is issued in favor of OMPP, OMPP can then file a lien with the county recorder or recorders where the property is located. The notice of lien must contain the legal description of the real estate; OMPP cannot file a general lien attaching all real estate located in the county. I.C. § 12-15-8.5-5. The lien will be for all expenditures made by Medicaid for the recipient. I.C. § 12-15-8.5-2. Thus, the amount of the lien will change over time. One cannot determine the amount of the lien by reviewing the lien itself; one needs to obtain that information from OMPP. If the Medicaid recipient returns home to live, then OMPP must release the lien within ten business days of being notified that the recipient has returned home. I.C. § 12-15-8.5-9.

Even once a lien is filed, it is subordinate to loans obtained from a financial institution for operating capital for a farm, business, or other income producing real estate. I.C. § 12-15-8.5-2(c). The original legislation in 2002 protected more loans, but in 2003 the legislature removed protection for loans for payment of taxes, insurance, maintenance, and repairs and for medical and education expenses.

If the property is sold, OMPP must release its lien at the closing, and the lien then attaches to the sale proceeds. I.C. § 12-15-8.5-9(c). The state will receive payment from the proceeds, but no more than the amount paid by Medicaid for the recipient.

OMPP can file suit to foreclose on its lien when the recipient sells the property or when the recipient dies. The deadline for filing a foreclosure suit is two years after the recipient dies. I.C. § 12-15-8.5-7. However, OMPP cannot enforce its lien against the recipient's home so long as either of the following persons lives there:

> • the recipient's child of any age if the child lived in the home for at least two years before the recipient was admitted to the medical institution, provided care to the recipient that delayed the recipient's admission to the medical institution, and has lived continuously in the home since the recipient's admission to the institution.
>
> • the recipient's sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least one year before the recipient was admitted to the medical institution.

I.C. § 12-15-8.5-8. In these last two instances, OMPP can file to enforce its lien once the person listed is no longer living in the home. However, the lien will not last more than two years after the recipient dies. The exemptions from enforcement of the lien are broader than the exemptions from enforcement of a claim against the estate, as discussed in the next section. The fact that OMPP cannot enforce its lien does not mean that OMPP cannot assert a claim against the estate, although one could argue that was the intent.

The owner of property has a remedy when FSSA delays in seeking foreclosure. If the owner of property subject to a lien gives notice to FSSA to file for foreclosure and no foreclosure action is filed within sixty days, the lien is then void. This is limited to situations where a foreclosure action can be filed, i.e., where the property has been sold or the recipient has died. I.C. § 12-15-8.5-12.

An Ohio appellate court upheld the state's filing of a lien on real estate after the recipient died. *Wiesenmayer v. Vaspory*, 135 N.E.3d 1237 (Ohio Ct. App. 2019). In response to the argument that a lien could not be filed after the death of the intestate decedent because the property passed to the heirs upon death, the Court responded "The definition of "estate" established by R.C. 5162.21(A)(1), however, supersedes the common law definition and embraces property that would otherwise have transferred automatically at the moment of Edwards's death to any survivors, heirs and assigns." 135 N.E.3d at 1242. Ohio's lien and claim statutes appear to be similar to Indiana's statutes. The authors of this Manual are not aware of Indiana ever seeking to file a lien after a recipient's death.

It is important to remember that liens and claims are separate means by which state Medicaid can seek reimbursement. The fact that FSSA has not filed a lien against real estate that potentially is subject to a lien does not mean the property is exempt from an estate claim.

## XV. Claims Against the Estate

Medicaid is the only public benefits program that provides for estate recovery for benefits that were correctly paid under the program. The federal Medicaid statute requires states to have an estate recovery program. In contrast, even though Medicare is substantially subsidized by the federal government, there is no estate recovery for Medicare payments. In November, 2020 thirty one organizations, including NAELA, sent a letter to the Medicaid and CHIP Payment and Access Commission (MACPAC),explaining why Medicaid estate recovery should ultimately be eliminated.
naela.informz.net/NAELA/data/images/AdvocacyPubPolicy/MACPACEstateRecoveryLetterNov2020.pdf The letter presented the following points:

- States have objected to Medicaid estate recovery because it places an undue burden on poor families.

- Medicaid estate recovery prevents families from escaping poverty.

- Medicaid estate recovery likely exacerbates the racial wealth gap.

- The financial benefit to states remains relatively minimal.

- Estate recovery of capitated payments rates is particularly unjust, because recovery may far exceed the expense of services actually received by the beneficiary.

MACPAC responded in March, 2021 by issuing a report to Congress that recommended making positive changes to estate recovery, including 1) making estate recovery optional for state Medicaid programs; 2) allowing state managed care arrangements to pursue estate recovery based on cost of care instead of capitated payment amounts, and; 3) setting minimum standards for hardship waivers across states.
www.macpac.gov/publication/medicaid-estate-recovery-improving-policy-and-promoting-equity
NAELA, Justice in Aging, and other groups released an issue brief "Medicaid Estate Claims: Perpetuating Poverty & Inequality for a Minimal Return" at
justiceinaging.org/wp-content/uploads/2021/04/Medicaid-Estate-Claims.pdf submitting that estate recovery should be eliminated.

The Stop Unfair Medicaid Recoveries Act, H.R. 6698, has been introduced in Congress to amend the Medicaid statute to repeal the requirement that states establish a Medicaid estate recovery program.

### A. Laws, Regulations, and Policy Manuals Governing Medicaid Estate Recovery

42 U.S.C. §1396p(b) is the federal statute that requires states to have an estate recovery program. It requires states to assert claims against a recipient's probate estate and gives states the option to assert claims against various types of non-probate transfers.

I.C. § 12-15-9 is the Indiana statute establishing Indiana's Medicaid estate recovery program.

The following sections in Indiana's probate code and other statutes are of interest for Medicaid estate recovery:

• I.C. § 12-14-17 contains limits for funeral and cemetery expenses.

• I.C. § 29-1-7-7(d) - When an estate is administered, notice must always be given to the Estate Recovery Program if the decedent was age 55 or older and died on or after June 30, 2018.

• I.C. § 29-1-7-15.1(b) provides a "five month rule" for when the sale of real estate to pay creditors can be compelled in an estate administration.

• I.C. § 29-1-10-21 lists the personal representative's authority to act.

• I.C. § 29-1-14-1(a) - Claims of the state or a subdivision of the state, which includes Medicaid claims, are not subject to the claims deadlines.

• I.C. § 29-1-14-9(a)(2) - "Reasonable funeral expenses, expenses of a tombstone, and expenses incurred in the disposition of the decedent's body" of a Medicaid recipient shall not exceed the limits provided in I.C. § 12-14-17.

• I.C. § 29-1-17-2(f) - A decree of final distribution in a supervised estate is conclusive. If no Medicaid claim is filed, this can be used to prevent the state from later attempting to assert a claim.

• I.C. § 32-17-13 provides for liability of nonprobate transferees. This Chapter is referenced by I.C. § 12-15-9-0.6(a).

Indiana's regulations concerning Medicaid estate recovery are at 405 IAC 2-8.

The federal policy manual provisions on Medicaid estate recovery are located in § 3810 of the CMS (Center for Medicare and Medicaid Services) State Medicaid Manual. The Manual is available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.

Chapter 4700 of IHCPPM contains FSSA's policy on estate recovery.

### B. The Extent of a Medicaid Claim Against the Estate

When a recipient dies, the state can assert a preferred claim for any medical coverage paid under Medicaid after the recipient reached age 55. I.C. § 12-15-9-1; 42 U.S.C. §1396p(b)(1)(B). For Medicaid provided before October 1, 1993, no claim can be enforced

unless the recipient was 65 years or older when the benefits were received. The result of this is:

• A person born before October 1, 1928 is subject to estate recovery for all Medicaid provided after age 65.

• A person born between October 1, 1928 and September 30, 1938 is subject to estate recovery for all Medicaid provided on or after October 1, 1993.

• A person born on or after October 1, 1938 is subject to estate recovery for all Medicaid provided after age 55.

Examples:

Fred Flintstone dies in August, 2020, at age 72 after being on Medicaid for many years. He was born on February 10, 1948. Indiana can assert a claim for all medical claims paid under Medicaid after Fred turned age 55 on February 10, 2002.

Barney Rubble dies in August, 2020, at age 88 after being on Medicaid for many years. He was born on March 15, 1932. On October 1, 1993 Barney was age 62. Indiana cannot claim for any medical claims paid under Medicaid before October 1, 1993, because he was then under age 65. It can claim for any medical claims paid under Medicaid on or after October 1, 1993, because he was then over age 55.

An overpayment of Medicaid benefits to a recipient of any age is subject to estate recovery. I.C. § 12-15-2-19; IHCPPM § 4620.35.00.

Although most Medicaid claims are filed against recipients of Medicaid for the Aged, Blind, and Disabled, estate recovery applies to recipients of any Medicaid category. Thus, a recipient of HIP 2.0 is subject to an estate claim for any assistance received after age 55. The recovery is for the "capitation rate" FSSA pays the medical plan. But see *Exec. Office of Health & Human Servs. v. Trocki*, 100 Mass. App. Ct. 117, 174 N.E.3d 322 (2021), which held that based on language in the CMS State Medicaid Manual, in order for the state to recover capitation payments from an estate, it must provide separate notice in advance of enrollment that the payments made will be recovered against the estate

No claim will be asserted for the amount of the Medicare premiums which Medicaid pays for a recipient. IHCPPM § 4705.00.00.

42 U.S.C. § 1396p(b)(1)(B)(ii) states there should be no recovery for any benefits paid under Medicaid - QMB (Qualified Medicare Beneficiaries). Section 1396p(b)(1)(B)(ii) states (emphasis added):

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

...

(ii) at the option of the State, any items or services under the State plan **(but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title).**

42 U.S.C. § 1396a(a)(10)(E) refers to Medicare cost sharing for Qualified Medicare Beneficiaries. "Medicare cost-sharing" is defined in 42 U.S.C. § 1396d(p)(3) to include not only premiums but also Medicare copayments and deductibles.

Although this language seems clear that there should be no estate recovery against benefits paid under Medicaid - QMB, § 3810(A)(3) of the CMS State Medicaid Manual provides that a state has the option not to recover from the estate of a person who only receives Medicaid - QMB. Based on the statute, it appears estate recovery should be prohibited, not optional. Further, § 3810(A)(3) of the CMS State Medicaid Manual provides that the state must recover benefits paid under QMB for a person who receives both QMB and full Medicaid. This seems to contradict the statute's clear language with respect to Medicaid's payment of copayments and deductibles for Medicare covered services, which is covered by QMB. (But could the state claim it paid under full Medicaid rather than under QMB?) There is a good claim that there should be no recovery against any benefits paid under QMB.

For persons who have coverage under both QMB and Medicaid for the Aged, Blind, and Disabled, there should arguably be no recovery for those claims paid under QMB. For example, suppose a nursing home resident with Medicaid for the Aged also has QMB coverage. One can argue there should be no recovery for claims paid under QMB for the copays and deductibles for Medicare covered services. FSSA and CMS do not appear to agree with this.

A trial court has no discretion to reduce the amount of a valid claim. *In the Matter of Estate of Cripe*, 660 N.E.2d 1062 (Ind. Ct. App. 1996). But the state can compromise a claim. For example, if an estate is opened and a valid claim is filed, but the estate contains an asset that cannot be easily liquidated, the state can agree to take less than its full claim. See IHCPPM § 4725.05.00. I.C. § 4-6-2-11 requires the Attorney General and the Governor to approve the compromise of a claim.

### C. What Property is Not Subject to Medicaid Estate Recovery?

There are some statutory exceptions from enforcement of the state's claim. 42 U.S.C. § 13960(b)(2) provides that if there is a surviving spouse, there can be no recovery until after the surviving spouse's death. There also can be no recovery until there is no child under age 21 and no child who is blind or disabled. Indiana's statute is worded somewhat differently, as it says no claim can be enforced against real estate or personal property while needed for the support of the surviving spouse, dependent children under age 21, or a dependent who is non-supportive

because of blindness or other disability. I.C. § 12-15-9-2(1) and (2). Although this seems to require some showing that the survivor needs the property of the decedent, FSSA does not require any such showing. 405 IAC 2-8-1(c) and (d) and IHCPPM §4710.00.00 follow the language of the federal statute and do not require any showing that the survivor needs the property of the decedent for the survivor's support. Although the federal statute and the FSSA regulation limit the exemption to disabled children, I.C. § 12-15-9-2 refers to "a dependent who is nonsupporting because of blindness or other disability." The Indiana statute appears to include any disabled dependent, even if not the decedent's child.

Even though the exception for the spouse and for minor and disabled children (and possibly other disabled dependents) appears to allow delayed recovery after the death of the spouse or dependent, FSSA does not make a delayed recovery. If the recipient is survived by a spouse or a minor or disabled child, Indiana will not enforce a claim.

A Medicaid claim cannot be enforced against the deceased's "personal effects, ornaments, or keepsakes." I.C. § 12-15-9-2(3).

A claim cannot be asserted against assets which were disregarded under the Indiana Long Term Care Insurance Program, also known as the "Partnership Plan." 405 IAC 2-8-1(e)(2); IHCPPM § 4710.00.00.

Funeral expenses can be paid out of the recipient's estate ahead of a Medicaid claim. Although I.C. § 12-15-9-1 refers to only a small exempt amount for funerals of $350, the Probate Code at I.C. § 29-1-14-9(a)(2), through cross reference to I.C. § 12-14-17, provides for a larger funeral exemption, $1,750 for funeral expenses in I.C. § 12-14-17-4 and $400 for cemetery expenses in I.C. § 12-14-17-5. FSSA will allow $2,150 without regard to the breakdown between funeral and cemetery expenses. However, I.C. § 12-14-17-4 and 5 appear not to allow for any payment for funeral expenses if the recipient had a pre-paid funeral plan, no matter how small, even if that plan was not intended to cover the full cost of the funeral.

In 2005, the Indiana legislature amended I.C. § 12-15-9-1 to allow recovery in some instances from the estate of a surviving spouse of a Medicaid recipient who died after the recipient. This was rescinded effective July 1, 2012, so there is no longer any claim on the surviving spouse of a Medicaid recipient. As explained above, the statute allows delayed recovery of property the surviving spouse received from the recipient spouse upon the recipient's death, but Indiana does not pursue this delayed recovery.

See the discussion below of non-probate transfers for an explanation of which non-probate transfers are not subject to recovery.

### D. When Will Indiana Not Recover Due to Undue Hardship?

405 IAC 2-8-2 and IHCPPM §4725.10.00 set forth a procedure and criteria for waiving enforcement of the state's claim in the case of undue hardship. More details have been added to IHCPPM §4725.10.00, so review this Section. Notice of the hardship procedure should be sent

along with the claim. State Form 48259, Application for Hardship Waiver, used to apply for a waiver is available at forms.in.gov/Download.aspx?id=9413. One can also e-mail a request for hardship to EstateRecovery@fssa.in.gov.

Undue hardship exists if enforcing the state's claim will cause a beneficiary to become eligible or remain eligible for public assistance, if it will result in the complete loss of an income-producing asset when the beneficiary has no other source of income, or if other compelling circumstances exist as determined on a case-by case basis.

If the beneficiary claims that enforcement of the state's claim will result in public assistance eligibility, OMPP will determine eligibility for assistance with and without the asset. If the beneficiary claims the only income comes from the property in the estate, OMPP will determine if the income is less than the federal poverty level. IHCPPM §4725.10.00.

CMS State Medicaid Manual §3810(c) also states that homesteads of modest value, which it defines as homes worth less than fifty per cent of the average price of homes in the county, should be given special consideration as undue hardship. Indiana's regulation does not include this provision. Although Estate Recovery staff has from time to time stated it will not pursue real estate worth less than $40,000, the state will sometimes open an estate even though the home is of modest value. One may be able to argue that Indiana is also required to grant undue hardship protection when the asset is a homestead of modest value.

OMPP makes the final determination on the waiver application. Its decision is appealable through the regular administrative appeal process.

### E. Non-Probate Transfers that are Subject to Medicaid Estate Recovery

Until 2002, Indiana only asserted claims against the probate estate. The 2002 Indiana legislature expanded the definition of estate to include some non-probate transfers.

I.C. § 12-15-9-0.5 includes property conveyed through a "nonprobate transfer," as defined in I.C. § 32-17-13-1, as being within the recipient's "estate." The expanded definition of non-probate transfers does not apply to any assets that were transferred out of the probate estate before May 1, 2002 or that the DFR had determined were exempt or unavailable before May 1, 2002. I.C. § 12-15-9-0.8. Does this mean that property that was determined exempt before May 1, 2002 but not transferred by a nonprobate transfer until after May 1, 2002 is exempt from estate recovery? For example, suppose Hillary lived at home on May 1, 2002, was a Medicaid recipient, and consequently her home was determined to be an exempt asset. If she executes a transfer on death deed on August 15, 2018, is the house exempt from estate recovery? The literal language of the statute seems to say "yes," though FSSA would undoubtedly contest this literal reading.

I.C. § 32-17-13-1(a)(2) defines a nonprobate transfer as a transfer by a transferor who immediately before death had the power, acting alone, to prevent transfer of the property by revocation or withdrawal and to use the property for the recipient's own benefit or to discharge

claims against the transferor's probate estate. I.C. § 32-17-13-1(e) specifically provides that a transfer on death transfer is a nonprobate transfer.

I.C. § 32-17-13-1(b)(1) states that the following transfers at death are not nonprobate transfers:

(1) a survivorship interest in a tenancy by the entireties real estate;
(2) a life insurance policy or annuity;
(3) the death proceeds of a life insurance policy or annuity;
(4) an individual retirement account or a similar account or plan; or
(5) benefits under an employee benefit plan.

Payment under a life insurance policy to a named beneficiary is not a nonprobate transfer.

Although this Section provides that an annuity or the death proceeds of an annuity is not a "nonprobate transfer," I.C. § 12-15-9-0.5(a)(4) states that any sums due to a person after the death of a Medicaid recipient under the terms of an annuity contract purchased after May 1, 2005 with the assets of the Medicaid recipient is a part of the "estate" for purposes of a Medicaid claim. I.C. § 12-15-9-7 provides that a person receiving beneficiary payments from an annuity contract of a deceased Medicaid recipient is liable to the state for Medicaid benefits paid. See also Section XIII(F)(3)(b), above, concerning the requirement after November 1, 2019 to name the state as a remainderman for some annuities owned by a Medicaid recipient or a recipient's spouse.

Although Medicaid has a claim against the beneficiary of an annuity, other creditors will likely not have a claim against the state of Indiana, when it is named as a beneficiary, for claims against the estate. The Iowa Court of Appeals ruled in *In re Estate of Jordan*, 927 N.W.2d 209 (Ia. Ct. App. 2019) that where Iowa was named as the beneficiary of an annuity for a Medicaid recipient who died, the annuity was not subject to a claim against the estate for the funeral home's expense. Iowa was the sole owner of the annuity and it was not a probate asset. The result would likely be the same in Indiana since an annuity does not meet the definition of a nonprobate asset in I.C. § 32-17-13-1(b)(1).

Although not specifically listed, a remainder interest in real estate is not a nonprobate transfer, as a remainder interest vests once created, and a life estate owner cannot prevent the property from passing to the remainder owner upon the death of the life estate owner.

Joint financial accounts with a survivorship interest are included in the definition, provided that the recipient had full access to the funds before death. Property held in a revocable trust where the grantor has full authority to revoke the trust or withdraw all of the funds is included in the definition. If the revocable trust provides that a third party's agreement is needed to revoke or withdraw assets, then it would not be included. An irrevocable trust is not included.

Although real estate owned as a joint tenant with rights of survivorship (JTWROS) could be considered to fall within the general definition of a nonprobate transfer, there is a specific

provision addressing JTWROS real estate. I.C. § 12-15-9-0.5(a)(2) provides that the definition of estate includes any interest in JTWROS real estate owned by the recipient if the joint tenancy was created after June 30,2002. The expanded estate definition does not apply to joint survivorship tenancies created before July 1, 2002. The claim extends to the recipient's interest at the time of death. Although the statute refers to the recipient's interest at the time of death, the statute actually intends to extend the claim to the interest the recipient held immediately before death.

Example:

> In 2006, Maude, a widow, transferred her home to herself and her two children as joint tenants with rights of survivorship. In 2015, she entered a nursing home, applied for Medicaid, and was approved. The transfer of the home into joint ownership in 2006 was outside the five year look back period, so there was no transfer penalty. After Maude entered the nursing home, the home was rented out, so it was exempt. When Maude died, her one-third interest transferred to her two children. Suppose the house was worth $150,000 when she died. Indiana can pursue a claim against her two children for the $50,000 value of Maude's interest that transferred to them up to the amount of Medicaid claims paid for her.

### F. The Mechanics of Medicaid Estate Recovery

For many years, each county contracted with a local attorney to represent it in estate recovery matters. Beginning in mid-2006, estate recovery was centralized. It is now handled by an estate recovery office. The Estate Recovery program has now been made a part of the Medicaid Eligibility department, which manages Medicaid policy and the Policy Answer Line. Ali Bippen is Manager of both Eligibility and Estate Recovery. In fiscal year 2019 the Office recovered approximate $13,198,000, down from an apparent high of $19,077,000 in fiscal year 2017.

Payments are to be mailed to Estate Recovery Program, Family and Social Services Administration, 402 W Washington St., Rm. W374 MS 07, Indianapolis IN 46204. One can e-mail EstateRecovery@fssa.in.gov or telephone 1-877-267-0013 for inquiries. The Estate Recovery website at www.in.gov/fssa/ompp/4874.htm has general information.

The state can open an estate when it believes there is property it can collect against, with the Attorney General's office filing to open the estate. The Estate Recovery Office gets a monthly list of deceased recipients and reviews a data base to check for heirs and assets. It searches death records and commercial databases to obtain asset information, and it monitors probate filings.

The office files claims in estates when it is notified of the opening of an estate, regardless of the value of the estate. The office also reviews estate openings on on-line dockets. County offices have been instructed to notify the office if they receive a notice of administration of an estate or if they learn of the opening of an estate.

Effective July 1, 2018, when a supervised or unsupervised estate is administered, notice must always be given to the Estate Recovery Program if the decedent was 55 years of age or older at the time of death. I.C. § 29-1-7-7(d). Notice should be given to Medicaid Estate Recovery Program, Indiana Family and Social Services Administration, 402 W. Washington Street, W374 MS 07, Indianapolis, IN 46204. (This is also the address where payments, payable to "Treasurer, State of Indiana," are to be mailed.)

There is no time limit for FSSA, as a governmental entity, to file a claim or to open an estate. I.C. § 29-1-14-1(a). The only limitation is the general ten year residual statute of limitations. I.C. § 34-11-1-2. But see Section A, below, on the five month rule concerning the sale of real estate. If FSSA does not file a claim after being given notice, then the estate can be made supervised and closed under I.C. § 29-1-17-2 with a final report and account and decree of distribution. If there is no appeal, the decree is final and should prevent the state from filing a later claim.

Compromise of the state's claim is addressed in IHCPPM § 4725.05.00. A claim can be compromised when it is in the state's best interest, such as if the claim is disputed or the asset is not easily liquidated. Any compromise must be approved in writing by the Attorney General and the Governor. I.C. § 4-6-2-11.

Questions can arise as to the obligation to notify the state of assets, particularly where no estate is opened. Ethics Opinion No. 2 of 2003 from the Ethics Committee of the Indiana State Bar Association, cdn.ymaws.com/www.inbar.org/resource/resmgr/Ethics_Opinions/2003_(2).pdf addresses several scenarios. It concludes that an attorney assisting with an Application for Consent to Transfer a bank account has no obligation to notify the state of the transfer.

### 1. The Five Month Rule for Real Estate

Although there is no time limit for the state to present a claim, there is a time limit on opening an estate where the state is seeking to compel the sale of real property **passing by an estate**. I.C. § 29-1-7-15.1(b) appears to say that real estate is not to be sold if an estate is not opened within five months of death. Nonetheless, the Indiana Court of Appeals ruled 2-1 in *St. of Indiana ex rel. FSSA v. Estate of Roy*, 963 N.E.2d 78 (Ind.Ct.App. 2012), transfer denied, that I.C. § 29-1-7-15.1(b) does not limit a probate court's authority to order that real estate be sold to pay debts, claims, and expenses of an estate, even when the estate is not opened within five months after death. The legislature responded to this in 2013 by adding I.C. § 29-1-10-21, which provides:

> (a) All authority to act with respect to an estate administered under IC 29-1-7 and IC 29-1-7.5 is vested exclusively in the personal representative.
>
> (b) If this article prohibits an action by the personal representative, the prohibition restricts the personal representative, regardless of court order, unless:
>
> (1) a majority in interest of the distributees expressly consent to the proposed action; or

(2) the statute imposing the restriction expressly permits a court to approve the prohibited action.

The personal representative cannot sell the real estate unless the majority in interest of the distributees consent to the sale. I.C. § 29-1-10-21. If the estate was opened after five months and the personal representative sells the real estate, then effective July 1, 2018, the proceeds of the sale are not subject to the state's claim. I.C. § 29-1-7-15.2.

Prior to July 1, 2018, there was a question about whether the state could compel the sale of real estate where the petition to open an estate was filed within five months of death but letters were not issued until after five months. The 2018 Indiana legislature addressed this. I.C. § 29-1-7-15.1(b) now provides that real estate can be sold to satisfy a claim if the petition for probate or for appointment of an administrator is filed within five months after death and letters are issued within seven months of death. I.C. § 29-1-7-15.1(c) provides that the failure to issue letters is not fatal if the clerk's failure to issue letters within seven months is not the result of the petitioner's failure to comply with the Probate Code, the trial rules, or the local rules.

If there is real estate passing by an estate and it is still within five months of death with no estate having yet been opened, one needs to decide whether to contact the Attorney General's Office to try to reach a resolution or to wait and see if the Attorney General opens an estate. If the Estate Recovery Unit has sent a notice to the family but not yet opened an estate, then it is likely the state will open an estate. Contacting the state will help avoid the possibility that the state will file to open the estate and then an heir wishes to file to be appointed as personal representative. If the Estate Recovery Unit has not sent a notice, one will want to consider whether it is possible the State will not act within its time limits. One's decision on how to proceed may depend on the value of the property, the potential size of the state's claim, and the urgency for the heirs to proceed.

### 2. The Estate Recovery Unit's Use of Small Estate Affidavits

The Estate Recovery unit will sometimes send a small estates affidavit or demand letter to family members requesting that any remaining funds of the recipient be paid to the State. Unless an estate is opened, there is no obligation to respond to such requests. The small estates affidavit is not a tool which creditors can use to demand funds. I.C. § 29-1-8-1 provides that third parties can pay a "distributee," but it does not provide for payments to creditors.

### 3. Nursing Home Accounts

Some nursing home residents keep their personal funds in a trust account held by the nursing home. 410 IAC 16.2-3.1-6(h) requires a nursing home to transfer funds remaining in a trust account within thirty days of a resident's death. Many nursing homes routinely forward the personal needs account of a Medicaid resident to FSSA. In 2007, FSSA issued a Bulletin notifying nursing homes to in most circumstances transfer funds remaining in a deceased Medicaid recipient's resident trust account to OMPP as repayment of the Medicaid claim. See Bulletin BT200726 (Oct. 4, 2007), provider.indianamedicaid.com/ihcp/Bulletins/BT200726.pdf. Although FSSA is not currently requiring nursing homes to transmit the funds of deceased Medicaid recipients to FSSA, many nursing homes continue to do so.

### 4. Recovery Against Non-Probate Transfers

**Note: Because Medicaid recovery against nonprobate transfers is accomplished by the same process used by any creditor to make claims against non-probate transfers, the discussion below applies not just to Medicaid recovery but to recovery by any creditor. The only difference is that OMPP is not subject to the time limits if the nonprobate assets were not disclosed to the DFR.**

I.C. § 12-15-9-0.6(a) provides that the state can enforce its Medicaid claim against nonprobate estates by using the procedure set forth in I.C. § 32-17-3. This statute provides a means for creditors to recover from the transferee(s), not the property. I.C. § 32-17-13-2 provides that a transferee of a nonprobate transfer is subject to liability to a decedent's probate estate for allowed claims to the extent the probate estate is not sufficient to satisfy the claims. The transferee's liability is limited to the value of property received or controlled by the transferee. Once an estate is opened and a claim is allowed, the creditor must make a written demand on the personal representative of the estate to commence a proceeding against the nonprobate transferee. The personal representative can then sue the nonprobate transferee seeking payment to the estate. But the personal representative is not obligated to pursue the claim. The representative incurs no liability for declining in good faith to pursue the claim. I.C. § 32-17-13-7(g). If the personal representative does not sue the nonprobate transferee, then the creditor can sue the nonprobate transferee in the name of the estate at the creditor's expense. I.C. § 32-17-13-7(f).

The statute sets time limits on creditors, including OMPP, to file its claim and to proceed against nonprobate transferees. Because of alleged ambiguities in the statute concerning the time limits, the 2018 Indiana legislature enacted Pub. Law 163-2018 (Senate Enrolled Act 247) to specify time limits for each of the steps needed to pursue a claim. These changes were effective July 1, 2018. The 2019 legislature amended I.C. § 32-17-13-7 to explain how the changes apply to a person who died before June 30, 2018. The discussion below applies to persons who die on or after June 30, 2018.

**The time limits do not apply to assets that were not reported to the DFR.** I.C. § 12-15-9-0.6(c). For non-disclosed assets, there appears to be no time limit for OMPP to pursue its claim. Note that this section does not require that the non-probate transfer have been disclosed; it only refers to the reporting of the asset. If the asset was disclosed but the recipient failed to disclose the non-probate transfer, it appears the time limits still apply. For example, if a recipient after obtaining eligibility executed a transfer on death deed for the home but did not report the transfer on death deed to the DFR, it appears the time limits still apply. The state is not jeopardized because the DFR was still aware of the ownership of the home. But if the recipient owned real estate that was not reported to the DFR, then the time limits do not apply to the state. One may want to report the non-probate transfer to Medicaid to avoid any potential argument by Medicaid that the non-probate transfer had to have been reported before the time limits apply to the state.

**The five month time limit for opening an estate in order to compel the sale of real estate, discussed above in Section VI(A), does not apply to real estate that is part of a nonprobate transfer**, such as real estate in a revocable trust or that passes at death by a transfer

on death deed. IC 32-17-13 does not subject the property received by a nonprobate transferee to sale; instead it provides for liability by the nonprobate transferee to the probate estate for allowed claims up to the value of nonprobate transfers received. As seen below, a separate five month time limit applies.

I.C. § 32-17-13-7(h) states that the process for proceeding against nonprobate transferees does not affect or prevent an action to enforce a valid lien. Thus, if FSSA has filed a valid lien against real estate, FSSA can proceed to enforce its lien against the property even if the property passed at death by a nonprobate transfer.

I.C. § 32-17-13 sets the following time limits for recovery from nonprobate transfers:

**Five Month Time Limit for Filing the Claim and Delivering Notice to Nonprobate Transferees:** I.C. § 32-17-13-7(d) requires the claimant (creditor) to file a claim in the estate **and** deliver a copy to each nonprobate transferee **not later than five months after death**.

**Seven Month (or not later than 30 days after allowance of the claim) Time Limit for Demanding the Personal Representative Proceed Against the Nonprobate Transferee(s):** I.C. § 32-17-13-7(d)(3) requires the claimant (creditor) to within seven months of death deliver a written demand to the personal representative and to each known nonprobate transferee for the personal representative to proceed against the nonprobate transferee(s). I.C. § 32-17-13-7(e) specifies what information the written demand must include. I.C. § 32-17-13-7(j) provides that the demand can be filed concurrently with filing the claim in the estate, but the demand shall be filed no later that seven months after death or thirty days after the final allowance of the claim, whichever occurs last.

**If claim is not allowed or disallowed** within the deadlines provided in I.C. § 29-1-14-10, claimant must petition to set the claim for trial **within thirty days** after the deadlines for the allowance or the disallowance of the claim. I.C. § 32-17-13-7(f).

**Nine Month (or Potentially Longer) Time Limit for Creditor to Sue the Nonprobate Transferees if Personal Representative Does Not Proceed:** I.C. § 32-17-13-7(g) provides that a creditor may sue the nonprobate transferee(s) in the name of the estate if the personal representative declines or fails to sue the transferee(s) within thirty days after receiving a written demand to proceed. I.C. § 32-17-13-6 clarifies that this may be a separate lawsuit against the nonprobate transferee(s). I.C. § 32-17-13-8(a) provides that the creditor must sue within nine months of death or it can be filed after final allowance of the claim within the earlier of 1) thirty days after the personal representative files notice of no intent to commence a proceeding; or 2) ninety days after final allowance of the claim if the personal representative does not commence a proceeding and does not file a notice of the intent not to pursue the claim.

If a personal representative files suit and recovers from a nonprobate transferee, then what is recovered is added to the estate and distributed through the estate.

If a claimant files a timely suit, the claimant who files the lawsuit gets to keep all proceeds recovered. The claimant does not need to forward the proceeds to the personal representative to distribute among all claimants. If other claimants intervene in the lawsuit, then the proceeds will be distributed among the claimants participating in the lawsuit according to the priorities of their claims. I.C. § 32-17-13-10.

## XVI. Assignment of Right to Medical Support and Liens Against Personal Injury and Insurance Claims

IC 12-15-2-16.5 provides that an individual who applies for or receives Medicaid is considered to have automatically assigned to the state the right to medical support and other third party payments for medical care for the duration of enrollment in the Medicaid program by the individual or the individual's dependent.

I.C. § 12-15-8 gives the DFR a lien against personal injury claims and insurance claims to the extent Medicaid has paid the person's medical expenses. I.C. § 12-15-8-3 states the requirements for the Office to perfect the claim. *Division of Family and Children v. Tyree*, (1989) Ind., 540 N.E.2d 18. The United States Supreme Court ruled that the lien only applies to the portion of an award or settlement that represents medical costs; the lien does not attach to that part of the award or settlement that represents other damages, such as pain and suffering and lost wages. *Arkansas HHS v. Ahlborn*, 547 U.S. 268 (2006). On January 10, 2022, the U.S. Supreme Court heard oral argument in *Gallardo v. Marstiller*, Docket No. 20-1263, on the issue of whether Florida can recover reimbursement for Medicaid's payment of Gallardo's past medical expenses by taking funds from the portion of her tort recovery that compensates for future medical expenses. In *Giraldo v. Agency for Health Care Admin.*, 248 So. 3d 53, 248 So. 3d 53 (Fla. 2018), the Florida Supreme Court ruled that a Medicaid lien only reaches the past medical expenses portion of a Medicaid recipient's tort recovery and does not attach to the portion of the award intended for future medical expenses.

In two cases, the Indiana Court of Appeals decided that Indiana's lien reduction statute at I.C. § 34-51-2-19, which provides for a proportionate reduction in a subrogation claim or other lien where there is less than full recovery, applies to Medicaid liens. *In re Guardianship of Wade*, 711 N.E.2d 851 (Ind. Ct. App. 1999)(Medicaid lien reduced where claim settled for policy limit, which was substantially less than total damages); *Pedraza v. Grande*, 712 N.E.2d 1007 (Ind. Ct. App. 1999)(Medicaid lien reduced where settled for discounted amount due to difficulty establishing liability). In *FSSA v. Schluttenhofer*, 768 N.E.2d 885 (Ind. 2002), the Indiana Supreme Court held each claim to which FSSA asserts subrogation rights must be evaluated independently of others that might arise from an injury. Because the medical insurer paid the policy limits for medical expenses, there was no reduction of that claim and FSSA could collect on all of those proceeds under its lien, even though its lien against other settlement amounts was reduced.

One cannot avoid Medicaid's lien against a personal injury claim by establishing a special needs trust (see Section VIII(B)(9)(d), above), as Medicaid's lien must be satisfied before the trust is established, even though the trust contains a clause providing that Medicaid will be paid after the recipient's death from any assets remaining in the trust. *Sullivan v. County of Suffolk*, 174 F.3d 282 (2d Cir. 1999). The Minnesota Supreme Court held that the Minnesota Medicaid agency could not enforce the Minnesota lien statute against a Minnesota personal injury award. It reasoned that because the recipient had assigned to state Medicaid its rights to damages for reimbursement for medical expenses, only the state could pursue such a claim. The recipient could only sue for pain and suffering and other damages, so the state could not enforce a lien against the resulting damages award. *Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. Sup. Ct. 2002).

Once OMPP recovers on a lien, it is responsible for paying its share of the litigation expenses, including witness fees and deposition expenses. I.C. § 12-15-8-7. OMPP will allow attorney's fees at the rate of 25% if there was no litigation and 33 1/3 % if there was litigation. I.C. § 12-15-8-8.

## XVII. Developing a Medicaid Plan

This section will review some of the overall concepts in Medicaid planning. Medicaid planning requires knowing the rules concerning Medicaid, obtaining full information concerning your client and what your client wants to accomplish, and then developing a plan which meets the client's needs as closely as possible. Always consider the tax (income, gift, estate) implications of any action taken. Tax implications will not be discussed here.

Some states have found that Medicaid planning is the practice of law. The Ohio Supreme Court approved a consent decree enjoining a non-attorney from "[r]endering advice or providing a strategy for the appropriate way to reduce resources in order to achieve Medicaid, including rendering advice or providing strategy for spending down and arranging assets and income to meet Medicaid eligibility requirements." *Toledo Bar Ass'n v. Abreu*, 147 Ohio St. 3d 35 (Ohio 2016) Similarly, the Committee on the Unauthorized Practice of Law appointed by the New Jersey Supreme Court ruled that "non-lawyers [can] ... assist applicants and beneficiaries with Medicaid applications and represent persons in hearings. While non-lawyer Medicaid advisors may provide these limited services, the Committee finds that it is the unauthorized practice of law when non-lawyers provide advice in matters that require the professional judgment of a lawyer. Hence, only a lawyer may provide legal advice on issues such as strategies for Medicaid eligibility, including provisions of wills and powers of attorney; on the need for guardianships and the authority to transfer assets; on nursing home laws; on transfers of property; on the impact of marriage and divorce; and on estate administration and the elective share. Opinion 53, issued May 16, 2016, judiciary.state.nj.us/notices/2016/n160518c.pdf.

It is crucial to identify who the client is and what the client wants to accomplish. It is very common for the attorney to be contacted by a family member other than the Medicaid applicant/recipient. The attorney must carefully identify who is the client and be certain to communicate that to all involved. The attorney's duties and responsibilities depend on whether

the client is the individual seeking Medicaid or whether the client is the family member who wants to insure that his or her expectation in receiving certain property is protected.

Once the client has been identified, identify what the client wants to accomplish. Some clients want to maximize Medicaid eligibility, while other clients may want to maximize the funds that are available to pay for home care. Others simply want to know the rules so that no problems develop. In developing a plan to establish Medicaid eligibility, it is important to remember Medicaid's potential preferred claim against the estate, if the client has an estate which the client wishes to protect for heirs. It is also helpful to learn how aggressive the client wishes to be. Most clients do not want to use any plan which is unusual or questionable and may be subject to challenge by the DFR, but some clients want to be as aggressive as possible, even if an administrative hearing or litigation is required.

When developing a plan, several options may be available. Often there are relatively simple steps which can be taken. Generally the simplest plan which works is the best. There are some complex financial instruments or mechanisms which one may be able to use, but it is also important that the client understand the plan so that the client can properly implement the plan.

In choosing a strategy, one must have full and accurate information about assets, transfers which already have been made, other health insurance, the expected length of stay in the nursing home, and the special needs of a spouse, child, or other family member. If the client has substantial assets, review whether those assets and the income they produce will be adequate to meet the client’s needs and whether there is any need to plan for Medicaid.

If any asset is omitted or misvalued, Medicaid eligibility may be lost. Also, in a spousal impoverishment situation, one must carefully identify the snapshot date. Carefully inquire whether there have been any earlier hospital or nursing home stay(s) of more than thirty days beginning on or after September 30, 1989.

Determine whether Medicare, private insurance, or a long term health care insurance policy will cover any portion of needed long term care. For instance, if Medicare and a Medicare supplement policy is expected to cover 100 days of care in a nursing home, that will give some additional time to implement a plan for a client who first contacts you after admission to a nursing home. However, one must be careful not to assume that every client with Medicare will be eligible for 100 days of coverage, since Medicare has restrictive coverage criteria and many clients with Medicare do not qualify for Medicare coverage of nursing home stays.

Consider whether the facility and the room in which the client resides or wishes to reside is certified for Medicaid. Obtaining Medicaid may require that the client move to another room or even another facility. Though most facilities accept Medicaid, many facilities do not accept Medicaid for every bed.

Also be aware that Medicaid will not pay for a private room unless there is a medical need for a private room. However, Medicaid will allow the family to pay the difference in rates between a private and a semi-private room so that the client can remain in a private room, so long as that room is certified for Medicaid.

Consider if the client is able to execute the plan. If transfers are part of the plan, then one should consider whether the title holder has the capacity to make the desired transfer(s). If not, is a power of attorney in place which authorizes the transfers? One should pay close attention to the limits on gifting in the power of attorney statute, which presumes that an attorney in fact cannot transfer more than the annual federal gift exclusion to himself or herself or to anyone he or she has a duty to support. I.C. § 30-5-5-9(2). The gifting presumption can be expressly modified, so as a part of the planning process, the attorney should consider whether broader gifting powers are needed. If an adequate power of attorney is not in place, a guardianship and court approval for certain transfers may be needed, which will increase the complexity and cost of the plan and may create some uncertainty, since court approval for transfers will be needed. I.C. § 29-3-9-4.5 provides that a guardian may make gifts and exercise other estate planning, with the court's approval. The court shall consider various factors, including the person's eligibility for governmental benefits, with the goal of trying to determine what decision the person would have made if he or she still had capacity.

The 2021 Act rewriting health care advance directives, SEA 204, Pub. Law 50-251, includes the decision to apply for Medicaid as a health care decision (I.C. § 16-36-7-10, effective July 1, 2021), while I.C. § 16-36-7-36(a)(6), effective July 1, 2021, authorizes a health care representative to apply for Medicaid for the principal unless this authority is expressly limited by the appointment document. For appointments of a health care representative under the new law, one should consider whether this authority should be limited. This may be especially important when the timing of an application is critical, so that one may not want to give authority to a representative who may file an application for Medicaid at an inappropriate time.

It is helpful to determine what, if any, ongoing role the attorney will have once a plan has been developed. The plan should address how or when the client should update the plan.

## XVIII. Appeals and Litigation

Applicants and recipients can appeal negative decisions concerning their benefits. Administrative Law Judges (ALJs) are assigned to hear administrative appeals. ALJs who hear Medicaid appeals now belong to the Office of Administrative Law Proceedings (OALP), established by I.C. § 4-15-10.5. The DFR appeals office, previously known as the Hearings and Appeals Office, has not moved, but it is now a part of OALP. A newly hired ALJ must be a licensed attorney. Non-attorney ALJs in place before May 1, 2019 can continue.

You may contact the FSSA OALP by mail, fax, or e-mail:

Mail: Office of Administrative Law Proceedings – FSSA Hearings
402 W. Washington St., Rm E034
Indianapolis, IN 46204

Fax: 317-232-4412
Phone: 317-234-3488 or 1-866-259-3573
Email: fssa.appeals@oalp.in.gov

See www.in.gov/oalp/resources-for-fssa-appeals for general information from OALP about FSSA appeals. A set of forms related to Medicaid appeals follows in the Appendices.

### A. Fair Hearings

**COVID - 19: All administrative hearings are being conducted by telephone during the public health emergency. Hearing packets are mailed in advance to the appellant and/or advocate. Hearings will likely continue to be heard by telephone unless one requests an in-person hearing.**

The concept of a "fair" hearing is based on due process principles under the landmark case of *Goldberg v. Kelly,* 397 U.S. 254 (1970) and the 14th Amendment of the U.S. Constitution. The due process requirements are delineated in the federal regulations at 42 CFR § 431.200 et seq., which specifically refer to *Goldberg v. Kelly* at 42 CFR § 431.205(d). Essential to the procedural rights of the Medicaid applicant or recipient are the rights to notice of adverse actions, to appeal adverse actions, to an evidentiary hearing, to view the DFR case file and all documents and records to be used by the DFR at a hearing, to bring witnesses, to establish all pertinent facts, to present argument, and to question and rebut evidence.

#### 1. Notification of Adverse Actions

**Most adverse actions cannot be applied to recipients during the COVID Public Health Emergency. See Section VII(G)(2), above.**

Administrative appeals may be taken from any action or proposed action that is adverse to the applicant or recipient. Proposed actions to deny, suspend or discontinue assistance are communicated to the applicant/recipient by a computer generated notice. See Appendix U for a sample Notice of Action with appeal information.

The notice must adequately inform the person of the action to be taken. The notice must state what action the DFR intends to take, the reasons for the action, the specific federal or state regulations supporting the action, and how to request a fair hearing. 42 CFR § 431.210. *Featherston v. Stanton*, 626 F.2d 591 (7th Cir. 1980) requires that a "reasoned basis" for the decision be given; mere conclusions without a meaningful explanation frustrate the ability to receive a fair hearing and render a notice invalid. See also *Vargas v. Trainor*, 508 F. 2d 485 (7th Cir. 1974), *cert. den*., 420 U.S. 1008 (1975) (notice inadequate when it advised person to contact caseworker for reasons); *Banks v. Trainor*, 525 F.2d 837 (7th Cir. 1975), *cert. den*. 424 U.S. 978 (1976) (detailed notice listing income and deductions required for denial of food stamps); *Dilda v. Quern*, 612 F.2d 1055 (7th Cir. 1980), *cert. den*., 447 U.S. 935 (1980) (AFDC denial notice must include copy of the worksheet showing budget calculations).

The Indiana Supreme Court ruled in *Perdue v. Gargano*, 964 N.E.2d 825 (Ind. 2012) that FSSA's failure to use denial notices that specifically list what documents were allegedly missing violates due process. As a result, FSSA must give specific notice in "failure to cooperate" denials of what the applicant/recipient failed to do.

Notices have improved in their explanation of what is regarded as a "failure to cooperate." For instance, an adequate notice stated, "Failure to cooperate in verifying income" along with a statement that "The following information was not verified: Jane Smith, proof of unearned income: retirement/pension." A review of the denial or termination notice should provide this type of specific reasons for the action. If the notice does not provide specific information, contact the Document Center for clarification.

A defective notice is an appealable issue. Objections to the notice should be raised at the fair hearing to be preserved on appeal. Be aware that the remedy for an inadequate notice is remand to the DFR to issue an adequate notice. This will delay matters and may not result in much benefit. Thus one may decide to waive an inadequate notice.

A notice of appeal rights is listed on DFR notices. As a result of a lawsuit challenging the adequacy of notices in disability determinations, the Medical Review Team (MRT) sends a separate notice, in addition to the notice generated by the DFR, containing a detailed explanation for the disability denial. IHCPPM §2412.45.00.

A recipient is normally entitled to receive ten (10) days notice before any adverse action. The notice must be mailed at least ten days before the effective date of the action. 42 CFR § 431.211. IHCPPM §2232.00.00 defines "timely" to mean that "the notice is mailed at least 13 days before the date the action is effective." The proposed date of action will be the first day of a month. It appears that FSSA begins counting on the day the notice is mailed. For example, if the notice was mailed on April 18 with an effective date of May 1, DFR counts April 18 through April 30 as a 13 day notice. If the recipient does not receive ten days notice, the notice is subject to attack. Such a notice is arguably invalid, and the DFR may be required to issue a new notice.

There are limited exceptions to the ten-day requirement. Notice may be mailed not later than the effective date of action if the DFR has factual information confirming the recipient's death, the recipient signs a voluntary withdrawal from Medicaid, the recipient is in an institution where the recipient is ineligible for Medicaid, or the recipient's whereabouts are unknown and the Post Office has no forwarding address.

Effective March 31, 2021, Medicaid benefits are not being terminated or reduced until the public health emergency. If a termination notice was sent early in the pandemic but then benefits continued due to the pandemic, it is not clear if the DFR will send a new notice explaining that benefits end at the end of the month when the emergency ends. A new notice should be required.

### 2. Requesting a Fair Hearing

#### a. What Can Be Appealed

An applicant or recipient can appeal any adverse action. 42 CFR § 431.220; 405 IAC 1.1-1-3(a). The only exception is that the DFR need not grant a hearing if the **sole issue** is a federal or state law requiring an automatic change. 42 CFR § 431.220(b). Even then, a hearing must be granted if the person seeks to challenge the way in which the new law is being applied to that

person's situation. An adverse action can include the failure to take action, such as the timely processing of an application. 42 CFR § 431.220(a)(1). Notices include appeal rights and directions on how to file an appeal.

### b. Who Can Appeal

Only those persons whose "rights, duties, obligations, privileges, or other legal relations" are alleged to have been adversely affected by any agency action. 405 IAC 1.1-1-2. That includes the applicant or recipient or any household member whose rights are affected. Thus, a community spouse has standing to appeal a decision that affects that spouse's resource share or income allowance. 405 IAC 1.1-1-2 further provides that the adversely affected person's attorney at law may request an appeal.

A health care provider does not have standing on its own behalf to file an appeal of an eligibility decision. The provider needs to file on behalf of the applicant or recipient.

If someone other than the applicant or recipient, you should show how the person filing the appeal has standing to file the appeal.

### c. How to Appeal

A fair hearing can be requested by any clear, written expression by the applicant, recipient, or representative requesting review or appeal. Reasons for the hearing request need not be included. In fact, listing a reason may foreclose other reasons not listed on the request.

Agency notices include information on how to file an appeal. Formerly, an appeals form was included with notices, but this is no longer the case. An appeals form can be printed from www.in.gov/fssa/dfr/files/Administrative_Appeal_And_Hearing_Request_SF53932.pdf. See Appendix V. One can use FSSA's appeal form or prepare a letter requesting an appeal. One should clearly state the date of the notice and what is being appealed, or attach a copy of the notice being appealed.

The hearing request can be mailed, faxed or hand-delivered. The appeal request should be sent to the FSSA Document Center, P. O. Box 1810, Marion, Indiana 46952 or fax number (800) 403-0864. One can also hand-deliver an appeal request to the county DFR office during business hours (before 4:30 p.m. local time). Some advocates continue to send appeals notices to both the state OALP - FSSA Hearings office and the Document Center. There is no negative consequence to this practice, but it is not necessary.

> **NOTE:** Appeals concerning a **prior authorization** matter, a **level of care** decision, or **Healthy Indiana Plan** (HIP) are treated differently and should be sent, faxed, or emailed with a pdf document directly to the OALP - FSSA Hearings office (contact information listed above). These types of appeals are not handled through the Document Center, although if it receives such an appeal request, the Document Center should forward it to the state OALP - FSSA Hearings.

To insure that the attorney receives notice of the hearing, the attorney should file an appearance (this can be done by letter or an appearance form) with the OALP - FSSA Hearings. The letter should contain the name of the client and the Medicaid case number. A separate appeal number will be created for the appeal. If known, include both the appeal number and the Medicaid case number on all correspondence. Include a copy of the Authorized Representative form. If a hearing has already been scheduled, filing an appearance should trigger a new notice of scheduling for the same date. Filing can be accomplished by mail, fax, or e-mail to the OALP - FSSA Hearings office. Consistent with normal rules of procedure, copies of documents filed with the OALP - FSSA Hearings should also be sent to the Document Center.

Because of the importance in preserving an appeal, whatever method is chosen should include a means to verify the date that the appeal was sent. While it is possible to check online at the Case Status page to see that an appeals request has been received, there is a time delay between when a document is received and when it is logged into the system. Allow 48 hours for the document to be logged into the system.

OALP - FSSA Hearings will issue a notice titled "Appeal Received–Notice to Appellant." See Appendix W. This notice confirms the appeals request and contains important information including the date sent, the type of appeal, how to withdraw the appeal, information on informally resolving the matter with the local DFR, request for notice if a representative will be involved, and the requirement for notice of change of address. This notice will be sent by OALP - FSSA Hearings to the person who requested the appeals hearing. This notice is not sent to anyone else.

### d. Time Limit to Appeal

Appeals must be filed within 33 calendar days of the effective date of the action being appealed, or 33 calendar days from the date of the notice, whichever is later. If the 33rd day is a Saturday, Sunday, state holiday, or day the DFR office is closed, then the deadline is extended until the end of the next business day. 405 IAC 1.1-1-3.

For an applicant whose application is denied, the 33 days run from the date of the computer notice. For recipients, the effective date is listed on the computer notice form. It will typically be the first day of a following month.

"Filing" means that the appeal request must be **received** by the close of the business day on the 33rd day. The business day closes at 4:30 p.m. local time where the appeal is received. *Id*. Mailing, even by certified mail, return receipt requested, is not sufficient if not actually received by the deadline. If the applicant/recipient is close to the appeal deadline, the appeal request can be hand delivered to the local DFR or faxed to the Document Center at 1-800-403-8064. Note that if faxed to the Document Center, the request must still be received by 4:30 p.m. EDT on the 33rd day.

### e. Expedited Appeals

Federal regulation 42 CFR § 431.224 provides that DFR must establish and maintain an expedited fair hearing process for individuals who request an expedited fair hearing if the state agency determines that the time allowed under 42 CFR § 431.244(f)(1) could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. Notice must be provided "expeditiously as possible" as to whether the request is granted or denied.

Indiana has not implemented this provision yet, nor does it offer any notice in the notice of appeal rights that an expedited hearing may be requested.

When an urgent situation arises, asking for an expedited hearing should be considered. The time between requesting a fair hearing and the actual hearing is fairly prompt and usually within the time frames required by 42 CFR § 431.244(f). In the past, DFR has suffered delays in processing appeals. If such delays are experienced in the future, requesting an expedited fair hearing would be an additional tool for advocates.

### f. Other Considerations

When an appeal is requested, it is also appropriate to indicate if an interpreter is needed or if an accommodation is needed regarding the location of the hearing. This type of request should be directed to the state OALP - FSSA Hearings Office with a copy to the Document Center.

The OALP - FSSA Hearings office does not arrange for the interpreter, but it will note the request. It is FSSA's responsibility to arrange for an interpreter. Language Line (800) 523-1786 is one source of telephonic interpretive services available. Verify in advance of the hearing that an interpreter will be present or available. This is especially important if the needed language for interpretation is not a common language in the community.

## 3. Prior Authorization and HIP Hearings

Most DFR hearings follow the same format. Prior Authorization (PA) and HIP appeals present significant differences in their processing. They differ as to the parties involved, the potential issues, and the location of the hearings. In the case of HIP appeals, there is also a preliminary grievance process that must be utilized before requesting a fair hearing. Attach a copy of the grievance denial to the appeal request. Anticipating the difference in these hearings can allow for effective advocacy.

### a. Prior Authorization

Like private health insurers, Indiana Medicaid requires that prior authorization (or approval) be obtained before it will pay for certain medications or services. Specifically, prior authorization is defined in 405 I.A.C. 5-2-20.

Sources for information about Medicaid Prior Authorization are found at 405 IAC 5-3 and 407 IAC and in the Indiana Health Coverage Programs Provider Reference Module: www.in.gov/medicaid/files/prior%20authorization.pdf. There are additional regulations as to specific services and drugs.

A denial of prior authorization will be sent to the medical provider, who is responsible for requesting the prior authorization. The provider or the patient may appeal.

Generally, the issue on a prior authorization appeal will be "medical necessity." An appeal can arise on the denial of an initial request or after the patient has been receiving a benefit which is later terminated or reduced.

At the fair hearing, the state will be represented by the private contractor. Pre-pandemic, the hearings were scheduled at the state OALP - FSSA Hearings Office in Indianapolis. Due to the insufficient information on the hearing notices, it may be difficult to identify who represents the private contractor and how to contact this person prior to the hearing. Contact the state OALP - FSSA Hearings Office to obtain the name of the representative and contact information.

An appeal may be resolved through negotiation with the representative. Often this may be accomplished by providing additional documentation to support the prior approval. The medical provider should be helpful in this regard. This is a significant stage where an advocate for the Medicaid recipient can be effective in resolving the denial without the need for a hearing. However, requesting the appeal can be the leverage to reach a resolution.

### b. Healthy Indiana Plan (HIP)

Participants in the Healthy Indiana Plan (HIP) are assigned to a private managed care insurer, referred to as a "Managed Care Entity" (MCE), which makes decisions about eligibility and coverage. Recipients under Medicaid for the Disabled and Medicaid for the Aged programs are not assigned to MCEs.

Issues on appeal may include whether the individual is "medically frail" (IHCPPM § 3515.05.00 *et seq.*), fast track eligibility (IHCPPM § 3525.05.00), presumptive eligibility (IHCPPM § 3525.05.10), or POWER Account issues (IHCPPM 3540 *et seq.).*

The MCE's own grievance process must be exhausted before appealing an adverse decision to the state. The state is not directly involved in the private grievance process. Advocates report frustrations with the MCE grievance process, in part due to the lack of transparency. Understanding the MCE's process for decision making is important in being able to challenge whether the determination was correct.

Subsequent fair hearing appeals include representatives from both the state and the MCE. Obtaining cooperation from the MCE can be challenging, especially in obtaining the hearing packet in advance. Consideration should be given to utilizing formal discovery procedures if the MCE is not cooperative in providing information promptly.

### 4. Continuation of Benefits Pending the Fair Hearing Decision

In cases where a recipient receives a notice, the recipient must be given a period of at least ten days within which to file a request for a fair hearing and retain benefits at the current level. If the recipient files an appeal before the effective date of the action, the proposed action cannot be implemented. 42 CFR § 431.230. The Consent Decree in *Daugherty v. Roob*, Cause No. 06-CV-00878-SEB-WTL, 2009 U.S.Dist. 27777 (S.D. Ind. 2009), provides that if the day before the effective date is not a business day, then the recipient has until the close of business on the next FSSA business day to file the appeal and still receive continuing benefits.

For example, if a notice stated that action would be taken effective March 1, 2021, a Sunday, then a recipient who filed an appeal before the close of the business day on Monday, March 2, 2021, is entitled to receive continuing benefits.

The appeal request need not request that benefits be continued. If the appeal is filed before the effective date, the DFR must continue the benefits. This continuation of benefits will last until a fair hearing decision is issued. If the recipient wins the fair hearing, benefits will continue unaffected. If the recipient loses the fair hearing, benefits will be adjusted to the proposed level pending further proceedings, if any. The DFR can attempt to recoup any overpayment but must first send a notice of overpayment.

One should monitor that benefits have been continued since the process is not computer automated and requires human intervention. The Consent Decree in *Daugherty*, *supra*, provides that FSSA must provide continuing benefits when appeals are timely filed. It is recognized that there may be a short delay in restoring benefits if the appeal is filed close to the effective date of the action.

Even if a recipient does not request a fair hearing in time to preserve continuing benefits, the recipient still has thirty three (33) days from the effective date of the action within which to request a fair hearing, but benefits will not continue pending the hearing decision.

### 5. Use of Discovery

The appellant and representative have the right to examine the entire case file, including any documents or records which the DFR will use at the hearing. 42 CFR § 431.242(a). DFR staff should be willing to discuss the case and explain the basis for DFR actions.

With paperless files, it is no longer possible to sit down at the local office and review the physical file. A request for the file and/or the hearing packet should be made in writing to the Document Center as soon as practical. With a telephone hearing, one should not need to request the hearing packet, as it should be provided without request. If other documents in FSSA's records need to be reviewed, they can be requested. See Appendix X for a sample request for the record. Follow up with telephone calls to the Document Center as appropriate. Avoid asking for the hearings and appeals section since that may result in the call being transferred to the state OALP - FSSA Hearings Office. Ask for the "Hearings Work Group" to talk directly with someone at the Regional Call Center about a pending hearing.

The DFR will provide the hearing packet on the day of an in-person hearing unless requested in advance. **For telephone hearings during the current public health emergency, packets are mailed in advance.** Make a written request to the appeals section for the region for the hearing packet as soon as the appeal is filed. Continue to follow up on the request. If the hearing packet fails to appear until the day of the hearing, one can request a continuance. If the hearing goes forward, place an objection on the record to the late delivery of the packet as a violation of due process. Preserve the issue for appeal. If the DFR fails to correct this problem, litigation may be necessary to guarantee due process rights.

The hearing packet provided by the DFR may not be the entire file, particularly if the person has been a recipient for more than a year. It is difficult to know if the packet contains the entire record. It will usually include any documents provided by the applicant/recipient. So, it may not be necessary to submit those documents as applicant/recipient exhibits, but until it is possible to confirm the contents of the packet, it is advisable to bring all exhibits to the hearing.

If formal discovery is needed, all forms of discovery provided by the trial rules, such as a Request for Production of Documents, are available. Trial Rule 28(F). Send the request to the legal department. In the event the DFR office does not comply with discovery, apply to the ALJ for an order to the local DFR office compelling discovery. This constitutes the necessary exhaustion of administrative remedies. See *State v. Frye*, 315 N.E.2d 399 (Ind. Ct. App. 1974), which concerned enforcement of a discovery request in an administrative agency case.

If application to the ALJ does not work, discovery can be compelled by making application to a court of general jurisdiction in the county where discovery is being sought, or where the hearing is being held. Trial Rule 28(F). This is accomplished by filing a complaint and serving the summons on the DFR seeking an order compelling discovery as the requested relief. Costs and attorney fees should be recoverable under Trial Rule 37(B)(2).

Subpoenas may be obtained from the OALP - FSSA Hearings by calling (317) 232-4411 or (317) 232-4405 with the name and address of the witness. The OALP - FSSA Hearings prepares the subpoena, presents it to an ALJ for signature, and then forwards the subpoena to counsel for service. Counsel should fill in the proof of service information and return a copy of the subpoena to state OALP - FSSA Hearings.

If a particular DFR worker's physical presence is needed as a witness, it will be necessary to subpoena the worker to the hearing since the DFR staff involved in processing the case typically do not appear at a hearing, either in person or by telephone.

### 6. Conduct of the Fair Hearing

Fair hearings are presided over by an ALJ, who is a member of the OALP. The ALJ must not have previously been involved in the case. 405 IAC 1.1-1-4; 42 CFR § 431.240. The fair hearing is an informal hearing at which the parties are provided an opportunity to explain the facts and circumstances relevant to the contested action.

The parties are the person appealing (appellant) and, for most cases, the DFR office. There are a few types of cases, such as prior approval denials, where an entity other than the DFR made the decision and will act as the party. 42 CFR § 431.243. The appellant has a right to be represented by a lawyer, paralegal, or even a lay representative. The DFR can be represented by an attorney, but typically is represented by a designated appeals representative who is not an attorney.

### a. Notice of Hearing

Currently hearings are held by telephone unless other arrangements are made. Pre-pandemic, most hearings were held in person at the local county office, with the DFR representative appearing by telephone. The ACLU of Indiana filed a class action case in Marion County challenging the adequacy of telephonic hearings in disability appeals. The Indiana Court of Appeals allowed the use of telephone hearings in *Terrell v. Murphy*, 938 N.E.2d 823 (Ind. Ct. App. 2010), *trans. denied*.

If a telephone hearing will not be sufficient, a request for a special location for the hearing should be made to OALP - FSSA Hearings with a copy sent to the Document Center.

A Notice of Hearing will be issued by OALP - FSSA Hearings ten days to two weeks before the hearing. It will list the date, time, and location of the hearing. For a telephone hearing, it will provide instructions on how to call in to participate in the hearing.

### b. Continuances

Continuances can be requested, but good cause needs to be shown as described in the Notice of Hearing. Reasonable requests for a continuance are generally honored. Although a written request for a continuance is required, because of the short advance notice of hearings, it is advisable to also contact the OALP at 317-234-3488 to obtain a continuance and then follow up with a confirming letter. The Document Center should also be notified. A sample request for a continuance is at Appendix Y.

### c. Meet and Discuss

The Notice of Hearing directs the parties to meet and discuss the issues and prepare any stipulations possible in a pre-hearing conference. This can be done informally by telephone. It will be difficult, if not impossible, to arrange an in-person meeting with the DFR appeals representative, who typically works out of a regional call center. An advocate may request a pre-hearing conference by contacting the Document Center.

Be aware that DFR staff may contact a claimant directly for a pre-hearing conference without notice to counsel. Claimants should be advised to ask that the DFR telephone the claimant's attorney. Claimants may not understand that the call they receive is actually a pre-hearing conference call. The pre-hearing conference call may be attempted within a few days after the appeals request is received. Some advocates list only the advocate's telephone number on the Medicaid application to insure that the advocate is contacted directly.

Claimants can be susceptible to pressure to dismiss their appeals. They may be led to incorrectly believe that the problem has been resolved or that there is no basis for their appeal. The DFR staff is prohibited from exerting pressure on Medicaid applicants/recipients to withdraw an appeals request. IHCPPM § 4205.50.10.

Formal written stipulations can be prepared to submit to the ALJ, if a worker or the regional manager will agree to stipulations, but it is sufficient if the parties are prepared to orally explain to the ALJ what agreements have been reached and what issues remain unresolved. If stipulations are prepared and filed with the OALP - FSSA Hearings, the ALJ has the discretion to dispense with the hearing. This can be useful for a "more than half share" hearing.

### d. Exhibits

The parties are to exchange hearing exhibits at least seven days before the hearing. See www.in.gov/oalp/resources-for-fssa-appeals. The DFR's exhibits will be contained in a hearing packet. The appellant should mail, fax, or email his or her exhibits to the OALP - FSSA Hearings as well as file them with the Document Center. If e-mailing exhibits to OALP, one should use secure email so that confidential or sensitive information will be protected. One may be able to redact some information, such as a portion of account numbers. If there are concerns about filing confidential information by e-mail, then it can be submitted to OALP by fax or mail.

The DFR's exhibits will be labeled in the lower right-hand corner alphabetically (e.g., Exhibit A, page 1.) The appellant's exhibits are to be labeled in the lower right corner using numbers (e.g., Exhibit 1, page 1.)

OALP directs that exhibits be exchanged a week before the hearing. Ideally, it is helpful to have FSSA's exhibits at the time of the pre-hearing conference.

FSSA's exhibits, or "hearing packet," will not be a copy of the entire file. It will consist of selective documents, computer screens, and "running" notes. FSSA may not be aware of what issue the appellant intends to pursue, so the packet may not contain all of the FSSA records that apply to the issue the appellant wants to pursue. It may be critical to recognize omissions and either supply them independently, seek to obtain the needed documents from the DFR, or take testimony from the DFR representative to establish missing information. Do not rely upon the DFR to provide all relevant information.

If you do not receive FSSA's exhibits with sufficient time to prepare for the hearing, this is grounds for the hearing to be continued.

### e. Hearing Format

Although the hearing is informal, the hearing follows a set format. Every hearing is recorded. After the ALJ explains the appellant's rights, a party may request the opportunity to make a short opening statement. This opportunity should be used to give a short summary of the issues and appellant's position. The ALJ will have the exhibits that are submitted in advance of the hearing, but the ALJ is not permitted to review the exhibits in advance of the hearing. An

opening statement can explain the purpose of the hearing to the ALJ and allow the ALJ to focus on the pertinent issues.

The DFR is always asked to present its evidence first, through testimony and documents, and the appellant has the right to cross examine any witnesses. The appellant's case is then presented through testimony and documents. The appellant can compel witness attendance through a subpoena issued by the ALJ. 405 IAC 1.1-1-4(c). Finally, each party can make a closing statement. The ALJ will usually take the case under advisement. A written decision is always issued.

The Indiana rules of evidence do not apply. Instead, 405 IAC 1.1-1-5(b) provides that "irrelevant, immaterial or unduly repetitious evidence" shall be excluded. Hearsay is usually admissible, although it can be objectionable if the circumstances do not suggest that the statement is trustworthy. 42 CFR § 431.242 and *Goldberg v. Kelly*, 397 U.S. 254 (1970) refer to the appellant's right to confront and cross examine opposing witnesses. There is an unresolved issue of the extent to which those rights should limit the ability of the ALJ to admit hearsay. Raising an objection on the record to explain why the particular evidence should be excluded preserves the issue on appeal. Likewise, if the ALJ refuses to admit certain evidence, it is appropriate to make an offer of proof to preserve the issue on the record.

### f. *De Novo* Hearing

The fair hearing is a *de novo* hearing. A *de novo* hearing is defined in 42 CFR § 431.201 as "a hearing that starts over from the beginning." Further, an evidentiary hearing means "a hearing conducted so that evidence may be presented." 42 CFR § 431.201. A *de novo* hearing is also referenced at 42 CFR § 431.244 (e). Indiana's own statutory provision, I.C. § 12-15-28-4, allows both the claimant and the county office to introduce additional evidence at the hearing. Parties have the right to present evidence, but the ALJ can exclude irrelevant, immaterial, or unduly repetitious evidence. 405 IAC 1.1-1-5.

The burden of persuasion and the burden of proof is addressed in I.C. § 4-21.5-3-14(c), which applies to Medicaid hearings by I.C. § 12-15-28-2. I.C. § 4-21.5-3-14(c) provides "At each stage of the proceeding, the agency or other person requesting that an agency take action or asserting an affirmative defense specified by law has the burden of persuasion and the burden of going forward with the proof of the request or affirmative defense." Thus, the DFR has the burden when it attempts to terminate or reduce a recipient's benefits, but a new applicant has the burden to show that all eligibility requirements have been met by the applicant.

Although *Curtis v. Roob*, 891 N.E.2d 577 (Ind. Ct. App. 2008) found that the hearing must allow new evidence, *Curtis v. Murphy,* 930 N.E.2d 1228 (Ind. Ct. App. 2010), *trans. denied*, found it did not violate due process for FSSA to prohibit disability appellants from offering evidence concerning diagnoses not included in their initial applications. To date, FSSA has not applied this policy to other appeals to limit the evidence which can be presented.

What evidence can be presented and considered will depend on the issue and to some extent on the discretion of the ALJ. Some ALJs do not want to consider evidence not previously

submitted to the agency, while other ALJs are more open to new evidence. If admissible evidence is rejected, the party offering it can make an offer of proof. 405 IAC 1.1-1-5(c). For example, if the issue is whether the DFR correctly denied an application for failure to verify a bank account balance, one likely will not be allowed to present a bank statement that was not previously filed with the DFR.

### g. Preparation for the Hearing

Preparation for the hearing should be conducted in the same manner as for any other trial or hearing. Develop a theory of the case explaining why the client should win the case, determine what facts must be proven, and decide what evidence will be used to prove those facts. Although there are other remaining steps in the appeal process, this is normally the only place at which evidence can be presented. It is extremely important that all relevant evidence be presented at the hearing.

**Documents**. While the DFR representative will normally place relevant case file documents into evidence, it is important to be sure that crucial documents are not omitted. Notices received by the claimant may look different than the copy of the computer screen typically submitted by the county. The claimant's notices are usually easier to read than the printed computer screen submitted by the DFR. So, it can be helpful to provide the claimant's notice even when the DFR's version has been accepted into evidence. While the ALJ may be adept at interpreting the DFR computer screens, a judge on judicial review may appreciate seeing the actual document received by the claimant.

There are times when information has been sought but not received prior to the hearing. For instance, there may be a delay in the receipt of medical records necessary to the issue of disability or a delay in obtaining information about a life insurance policy. The claimant may ask the ALJ orally at the hearing for an extension of time in which to submit the delayed documents. This leaves the hearing record open.

Usually, a request to leave the record open should be limited to thirty (30) days or less. Documents not received by the ALJ before the extension of time expires will be excluded from the record. Keep in mind that requesting additional time will delay the receipt of the ALJ's decision. Consider the need for the information in support of the case before requesting an extension of time. If the extension of time is granted, submit the documents promptly and indicate that nothing further will be submitted so that the ALJ can then decide the case without waiting for the expiration of the extension of time.

Where an exhibit comparing or organizing numbers or dates could be helpful to an understanding of the case, prepare an exhibit. For instance, where there are financial issues, it is often persuasive to prepare written calculations consistent with the case position rather than giving oral explanation alone. Seeing a concise written explanation or summary involving numbers is easier to understand than testimony or pages of individual receipts.

**Witness Preparation.** Witness preparation is necessary, particularly since some ALJs may question witnesses more aggressively than either of the parties. Preparation is also important to focus immediately on the issue. It is helpful if the client-witness clearly understands the legal theory involved and can avoid irrelevant testimony. It can be tempting for witnesses to vent frustrations with the DFR. This can be counter-productive and should only be indulged cautiously.

**Opening Statement**. A clear, concise opening statement can immediately focus the ALJ on the issues and the relief sought. Prior to the hearing, the ALJ will have little information about the case other than the request for appeal. The ALJ will have the exhibits, but the ALJ is not permitted to review them until the hearing. Likewise, the ALJ should not have an *ex parte* conversation with either of the parties at any time. There may be confusion about the issue(s) on appeal. An opening statement can clarify the issue(s).

Likewise, a closing statement at the close of the hearing can summarize the evidence and legal arguments. A clear request for the relief desired should be included.

If the issue is one of fact, then the hearing is the claimant's best opportunity to win the case, as it is difficult to overturn factual findings. If the claimant is challenging a DFR regulation or a provision in the manual, it is highly unlikely the ALJ will rule for the claimant. Even in those cases it is important to develop a record of relevant, sympathetic, and supportive facts which can be relied upon in later stages of the appeal.

**Avoid Waiver of Arguments.** Any arguments not presented to the ALJ are waived and cannot be raised at later stages of the appeal process. It is important to raise any issue that affects the case. Do not depend on the ALJ to intuit the legal basis for the claimant's position. Be specific. If time and circumstances permit, submit a memorandum stating the legal position for granting the appeal. This may be especially useful for cases that raise unusual or new issues that the ALJ may not have considered prior to this case.

**Preserve the record.** Always be mindful of how to preserve issues and evidence in the record for an appeal. While the hearing is informal, objections to evidence, for instance, should be raised to preserve the issue on appeal. If confronted with a "surprise," ask for time to submit a legal memorandum or ask to continue the hearing. If a matter is addressed in negotiations immediately prior to the start of the hearing, be sure to memorialize the matter on the record. Make sure that critical issues are reflected in the record. If one anticipates that judicial review may be needed, attempt to personalize the appellant on the record, as the court will only have a paper record to review.

After the hearing when the record is closed, it is generally too late to preserve a forgotten or ignored matter for the record. However, it may be worth the effort to submit a request for consideration of additional or supplemental evidence or argument immediately after the hearing along with an explanation for failure to present it at the hearing. Be sure to provide a copy to FSSA to allow for a response.

Because the hearing process is informal, do not be limited in thinking that the procedures prevent action that might be permissible, for example, in a trial court setting. The worst that will happen is that the ALJ will decline to consider the post-hearing submission.

### 7. The Fair Hearing Decision

The fair hearing process must be expeditious. The fair hearing decision must be issued within ninety (90) days after the request for a fair hearing was made. 42 CFR § 431.244(f). The state must issue its final agency notice within the same ninety days beginning with the request for a fair hearing. To allow time for a written decision to issue and for the next level of review to occur, the fair hearing should take place within about sixty (60) days of the appeals request. Currently hearings are being scheduled promptly after the request for hearing is filed.

The fair hearing decision must set forth findings of facts on the disputed issues, reach a definitive decision, give the reasoning and facts used to reach the decision, and state the effective date of the decision. 405 IAC 1.1-1-6(b) and (c). The findings must be specific enough to inform the parties of the bases for the ultimate findings and to allow reviewing courts the opportunity to meaningfully review the decision. Unlike a trial court setting, counsel will not be asked to submit proposed findings.

The findings cannot simply relate each witness' testimony without stating what the ALJ determined to be the facts. *Moore v. Indiana FSSA*, 682 N.E.2d 545 (Ind. Ct. App. 1997); *Glaser v. IDPW*, 512 N.E.2d 1128 (Ind. Ct. App. 1987). *Pack v. Indiana FSSA*, 935 N.E.2d 1218 (Ind. Ct. App. 2010). "[W]hile there is no requirement that the ALJ cite each and every piece of evidence presented, the ALJ's 'decision must demonstrate a **rational connection** between the basic facts found by the ALJ and the ALJ's ultimate decision' and must 'relate the facts to the law.' 405 IAC 1.1-1-6(c) (emphasis added)." *Indiana FSSA v. Pickett*, 903 N.E.2d 171, 176-177 (Ind. Ct. App. 2009).

The hearing decision must be sent to DFR and the appellant. 42 CFR § 431.244. The appellant must be advised of the procedure to obtain further review. 42 CFR § 431.245.

The fair hearing decision constitutes the decision of the DFR and may result in any of the following determinations: (1) the action of the DFR can be sustained in all respects; (2) the action of the DFR can be reversed in all respects; ( 3) the action of the DFR can be modified; or (4) the DFR is in error, but the error does not affect eligibility or amount of payment, e.g. violations of client rights.

### 8. Post Decision Enforcement

Implementation of a favorable decision may not be automatic since it requires a human being to complete the necessary casework in the computer system. Requesting implementation may prompt the system to act more quickly than waiting for the natural course of things. It is important to follow up as new DFR notices are received to make sure that the correct action has been taken, i.e. to identify all the months of coverage and to correctly calculate the spousal allocation and nursing home liability.

Where there are providers who have not been paid, it can be helpful to provide notice of the favorable decision to the provider, who can then follow up on its claim to Medicaid. Outstanding claims otherwise eligible for coverage should be paid by Medicaid.

Although normally Medicaid only pays providers and does not reimburse recipients for out of pocket expenses, 42 CFR § 431.246 requires state agencies to make "corrective payments" after an agency decision is reversed on appeal. *Schott v. Olszewski*, 401 F.3d 682 (6th. Cir. 2005) ruled that a Medicaid applicant was entitled to full and direct reimbursement for medical services she received and paid for during the three months prior to the initial filing of her Medicaid application. A request for reimbursement should first be sought from the provider whose claim should be paid by Medicaid. However, it may be necessary to contact FSSA for reimbursement.

### 9. Delays in the Administrative Process

Although the hearing process is generally proceeding promptly now, there have been periods where administrative appeals were backlogged and delayed. Once the Public Health Emergency ends, there will likely be lots of adverse action notices issued, so the appeals volume will likely increase dramatically. When the administrative appeals process is delayed beyond the ninety (90) day limit in 42 CFR § 431.244(f), the remedies include:

a. Complain to the OALP - FSSA Hearings Office.

b. File an individual action in court to require the DFR to act. This could take the form of a mandamus action or a declaratory judgment. Rules 2 and 3, Rules of Procedure for Original Actions; Trial Rule 57, Indiana Rules of Trial Procedure.

c. File a petition for judicial review under I.C. § 4-21.5-5.

The legal remedies to force the process to work when it does not work are not particularly effective in saving time or frustration. For instance, an informal complaint to the agency may not produce the desired result when the system is simply overloaded. However, if special or compelling circumstances require immediate action, this would justify extraordinary measures.

Potentially, court action for a mandamus, Orig. Act. R. 2 and 3, or declaratory judgment, T.R. 57, can be done quickly (i.e. by stipulation), the court's involvement can set deadlines and can force accountability by the agency. Involving the agency's legal staff may motivate agency action. Publicity may also enter into speeding the process.

If a petition for judicial review is filed, the failure to exhaust administrative remedies is likely to be raised by the agency. Be prepared to show that the remedies were inadequate. It will also be important to have a sufficient basis in the record to support a ruling by the court on the merits of the case. Otherwise, the trial court will merely remand the case to the agency for further action.

A favorable court ruling still must be implemented by the DFR . Class action litigation may be the most effective way in the legal system to address systemic problems at the DFR. [**Note**: Federal regulations prohibit legal services providers, such as Indiana Legal Services, Inc., funded by the Legal Services Corporation, from participating in class action litigation on behalf of their clients. 45 CFR § 1617.3.]

The delay in issuing final decisions on Medicaid disability cases pursuant to 42 CFR § 431.244(f) was addressed by *Gomolisky v. Davis*, 716 N.E.2d 970 (Ind. Ct. App. 1999), brought by the ACLU of Indiana. The finding in *Gomolisky* confirmed the state's obligation to comply with the 90-day rule in 42 CFR § 431.244(f) on Medicaid appeals. A subsequent case, *Murray v. Roob,* cause number 49D12-0505-PL-16671 (filed 2005), was brought by the ACLU of Indiana in Marion County. It was settled with an agreement that FSSA would comply with the 90-day rule for decisions in disability appeals by March 31, 2007 and that FSSA would hire additional ALJs to catch up its backlog. Contempt proceedings were filed, and a second consent decree was entered requiring FSSA to meet specific compliance standards. As a result, the timeliness of Medicaid hearings improved. Practitioners should continue to be alert to timeliness issues since budgetary or staffing constraints could again affect FSSA's ability to process cases in compliance with the 90-day rule.

Lastly, the usefulness of the political system should not be ignored in compelling circumstances. Media attention and involvement of political representatives can highlight a particular problem to the extent that FSSA must take action. Representatives and senators have staff members to address constituent concerns. Not every circumstance may be suitable for this approach. That said, it is a powerful tool to bring issues to public light.

### 10. Cost Considerations

Generally, if there is a need for Medicaid planning, there should be sufficient resources to pay the legal fees associated with the application process and potential appeals. A fair hearing can be anticipated as necessary in those situations where an ALJ order is required, such as a request for more than a one-half share in a spousal allocation case. Other appeals in this area of the law arise due to disputes over processing information and application of the law. New rules or statutes may require litigation to clarify how they should be applied.

Unfortunately, it may be necessary to request a fair hearing to correct a processing mistake. Contacting the regional e-mail mailbox and regional manager may allow FSSA to quickly correct errors. When the simple fix does not work, consider the following:

#### a. Filing a New Application

As a practical matter, some issues will not merit appeal due to the cost of an appeal versus the benefit of winning an appeal. In those situations involving an application issue, it may be simplest to file a new application. Appeals will take additional time, especially if FSSA is out of compliance with its statutory 90-day limit for final agency action on an appeal. It is also possible to both request an appeal and file a new application.

Filing a new application may affect the intended start date for eligibility. When there is a lengthy delay in receiving an adverse decision on an application, there is a risk of incurring charges for a nursing home resident that will not be covered by Medicaid because the charges are outside of the preceding three-month coverage period. In those situations, an appeal may be necessary to avoid gaps in coverage. This assumes that there is a legal basis for the appeal and that the applicant will be eligible for the months in question.

#### b. Fee Agreements

Practitioners should anticipate that there will be some situations that can only be resolved by an appeal. Some practitioners build in the cost of a potential fair hearing as part of the application process. Others may exclude the cost of an appeal from the initial application process and require additional fees for handling an appeal. Providing clients with a clear statement of services and fees should be part of a fee agreement. Setting aside some funds within the $2,000 resource allowance might be a way to provide for legal fees should an appeal be needed. This may also be a way of keeping funds available for recertification or other future legal expenses.

#### c. Other Factors

When the practitioner has already gathered and organized the documentation for an application, preparing the evidence for an appeals hearing may require little additional work. However, when agreeing to handle an appeal after the initial application has been handled by someone else, the time and effort needed to prepare the appeal could be significant depending on the circumstances.

The cost of handling the appeal goes up once a case reaches judicial review. The administrative process requires no filing fees. Judicial review will require a filing fee and costs for the preparation of the transcript of the fair hearing, unless such fees and costs can by waived due to the indigency of the appellant. Briefing and oral argument will be part of the process, necessitating direct attorney involvement and a court hearing.

### B. Agency Review

The appellant may request an administrative review if dissatisfied with the fair hearing decision. The review is conducted by a designee of the DFR . If the applicant or recipient wins at the fair hearing stage, the DFR, the Medical Review Team, or a Medicaid contractor can request agency review. 405 IAC 1.1-1-1 defines a “party” to an appeal as including OMPP, a county office of DFR, or a contractor acting for OMPP. 405 IAC 1.1-2-1(a) allows any party dissatisfied with the ALJ decision to request agency review. The Indiana Court of Appeals decided in *Gomolisky v. Davis*, 716 N.E.2d 970 (Ind.App. 1999), that nothing prohibits FSSA from reviewing ALJ decisions which are favorable to applicants and recipients, but it must complete agency review within ninety days from the original request for a hearing.

A request for agency review must be made in writing and must be **received** by the OALP within ten days following the receipt of the appeal decision by the appellant. 405 IAC 1.1-2-1(a).

The appeal should be mailed, delivered or faxed to OALP - FSSA Appeals Agency Review, Attn: Ultimate Agency Designee, 402 W. Washington St. Room E-034, Indianapolis, Indiana 46204-2379, fax number (317) 232-4412. A letter requesting review is sufficient. The reasons for appeal need not be included, but for efficiency, the letter can include the basis for appeal and the rationale for why the ALJ decision should be reversed.

If the case has already passed or is about to pass the 90th day, a notice will be sent on Medicaid cases that states that a sixty day continuance will automatically be granted for purpose of review unless the party asking for review notifies OALP - FSSA Hearings that a continuance is **not** desired. The party's notice must be given within five days of receipt of the Agency Review notice. If the five-day notice is given, a Notice of Final Agency Action will then be issued.

Oral argument is not available at this stage. A memorandum of law can be filed within twenty (20) days of the date when the ALJ decision was received. No transcript of the ALJ hearing is prepared routinely for the administrative review, but the audio recording from the hearing is available for review at the OALP - FSSA Hearings office. Arrangements also can be made to obtain a copy of the audio recording. Particularly when counsel was not present at the ALJ hearing, listening to the hearing is helpful in preparing the memorandum of law.

Take advantage of the opportunity to file a memorandum. Besides containing the legal argument, it should include a persuasive statement of facts which personalizes the client and explains why relief is important to the client. All legal arguments should be included in order to preserve them for judicial review. The memorandum can take the form of a letter if the issue is relatively simple, or it can be in the traditional form of a memorandum of law. No particular format is required. In cases where the record is extensive, attach key exhibits to the memorandum for easy reference. A copy of the memorandum should also be sent or faxed to the Document Center.

Additional evidence is not permitted. 405 IAC 1.1-2-1(c). If new evidence becomes available subsequently, an applicant should make a new Medicaid application even if an appeal is still pending. The DFR should be notified. As at any stage, it may be possible to negotiate a solution based on the new evidence and dismiss the appeal.

A written, though typically brief, standard decision will be issued. A sample decision is at Appendix Z. The decision should conform to 405 IAC 1.1-2-2(b). Further appeal rights should be noted in the decision.

### C. Judicial Review

Judicial review of decisions of the DFR is provided by I.C. § 4-21.5-5. Before filing a judicial review action, an attorney should carefully review that statute, as failure to comply with the statute can be fatal to meeting jurisdictional requirements. The petition must be filed within thirty (30) days after the decision on state agency review is served. I.C. § 4-21.5-5-5.

In assessing the merits of a case for judicial review, be aware of the limits of judicial review. First, only issues raised during the agency proceedings can be presented. (See I.C. § 4-21.5-5-10 for limited exceptions to this principle.) That is why it is useful to anticipate the possibility of judicial review as early as the ALJ hearing. Next, the court cannot *de novo* review facts, but instead only reviews the record to see if there was "substantial evidence" to support the findings made by the ALJ. I.C. § 4-21.5-5-11. As to questions of law, the court can and should independently make its own decision. The scope of review is very similar to that of an appellate court reviewing the decision of a trial court.

### 1. Venue

The petition must be filed in Circuit or Superior Court. I.C. § 4-21.5-5-6 lists the options for proper venue. It is most common to file it in the county in which the case originated. Since Marion County is the location of FSSA's principal office, Marion County is also a proper venue option.

Consideration should be given to the venue that offers the best likelihood of a favorable outcome. Judicial review actions are atypical of what most trial courts handle. Some courts may relish the idea of an out of the ordinary type of case. Also true is that Medicaid regulations and procedures may be new territory for some trial courts. Consider whether the local court may be more sympathetic to the client or to obtaining Medicaid to pay local providers.

### 2. Parties

The proper defendant is the Indiana Family and Social Services Administration (FSSA). The local DFR office need not be listed as a defendant. I.C. § 4-21.5-5-8 states that each party to the agency proceedings must be served, and 405 IAC 1.1-1-1(b) provides that OMPP or the local DFR office is a party. However, the local DFR office is a subdivision of FSSA, and it need not be listed. The Indiana Attorney General must also be served with notice of the law suit. The Attorney General usually represents FSSA in judicial review proceedings and will enter an appearance following service of process.

### 3. Summons

A summons must be issued both to the Secretary (Dan Rusyniak, M.D., as of April 2022), Indiana Family and Social Services Administration, Room W-461, 402 West Washington Street, Indianapolis, Indiana 46204, and to the Indiana Attorney General (Todd Rokita, as of April, 2022), Indiana Government Center South, 302 West Washington Street, Fifth Floor, Indianapolis, Indiana 46204.

### 4. Petition Contents

The requirements for the petition are contained in I.C. § 4-21.5-5-7. They include:

- The name and mailing address of the petitioner;

- The name and mailing address of the agency whose action is at issue: Indiana FSSA, 402 West Washington Street, Indianapolis, Indiana 46201;

- Identification of the agency action at issue, together with a copy, summary, or brief description of the agency action. This will be the Medicaid denial or termination of benefits. Attach the Notice of Final Agency Decision. Including the ALJ decision allows for a clearer understanding of the agency action;

- Identification of persons who were parties in any proceedings that led to the agency action;

- Specific facts to demonstrate that the petitioner is entitled to obtain judicial review under section 2 of this chapter. These must be facts that are contained in the record of the administrative proceedings;

- Specific facts to demonstrate that the petitioner has been prejudiced by one (1) or more of the grounds described in section 14 of this chapter; and

- A request for relief, specifying the type and extent of relief requested. A typical request would be for Medicaid benefits under a specific Medicaid program, such as Medicaid for the Aged.

A sample petition is at Appendix AA.

List each and every reason the agency action is erroneous. The petition should include sufficient factual detail to give notice of the legal basis for the judicial review.

**The petition must be verified**. I.C. § 4-21.5-5-7. Failure to verify is jurisdictional and can result in dismissal of the petition. Although case law suggests the attorney can verify the petition, to avoid risking dismissal the attorney should always have the client verify the petition, or if the client is unable, a family member. See *IDPW v. Chair Lance Service, Inc*., 523 N.E.2d 1373 (Ind. 1988) (permissible for attorney for corporation to verify petition for judicial review).

When filing for judicial review, one should consider whether there is a basis to join a claim under 42 U.S.C. §1983 claim. A §1983 claim may provide additional relief, including injunctive and declaratory relief and attorney fees, that is not provided by judicial review alone. In some cases involving violation of rights by a private contractor, monetary damages may even be available in some cases. See Section D, *below*, for a further discussion of §1983 claims.

### 5. Record

Even though FSSA prepares the record, I.C. § 4-21.5-5-13 places responsibility on the petitioner to file the record within thirty (30) days of filing the petition, or within the time as extended by the court. The record consists of the documents that are part of the appeals file, including evidence received at the evidentiary hearing, the ALJ decision, the hearing transcript, and Agency Review documents.

FSSA usually does not complete the record within thirty days. At the initiation of the judicial review case, a notice to produce directing the DFR to produce the record should be served on the DFR. Either at the beginning of the case or prior to the expiration of the 30-day deadline, file a motion to extend time to file the record (and order) until after the record is received from the DFR. A sample Request for Record is at Appendix BB, and a sample Motion to Extend Time is at Appendix CC.

Because **filing the record is a jurisdictional requirement**, the record must be filed within 30 days or an extension of time must be obtained. *Teaching Our Posterity Success, Inc. v. Ind. Dep't of Educ.,* 20 N.E.3d 149 (Ind. 2014). This decision refers to the "bright line approach." *Id. at 155*. The bright line of the 30-day deadline is absolute. Otherwise, the case will be dismissed either at the request of the DFR or potentially on the Court's own motion.

The trial court cannot grant an extension for filing the record after the time for filing has passed. *Indiana FSSA v. Meyer*, 927 N.E.2d 367 (Ind. 2010). It is important to calendar this deadline and to take action if the record is not received in sufficient time to meet the deadline.

If the DFR fails to produce the record within a reasonable time, even if there is an open-ended extension of time, the attorney should file a motion to compel. It is helpful to stay in contact with opposing counsel to gauge when an order may be needed to prompt completion of the record, including a confirming letter that can be attached to a Motion to Compel. Limited state resources may delay preparation of record, particularly transcription of the hearing. A court order elevates the priority of an individual record. Appendix DD contains a sample Motion to Compel and Order to Compel.

Once the DFR prepares the record, it will give notice that the record is ready and the cost of the record. The fee for the record must be paid before the record is released. However, if the client is indigent, the fee can be waived. I.C. § 4-21.5-5-13(d). If a waiver of the filing fee is requested of the court, waiver of the fee for the record also should be requested at the same time. The order should specifically waive the fee for the record. The order can be presented to the OALP - FSSA Hearings Office in lieu of paying the fee.

After the attorney receives the record, it is important to review the record. The entire appeals documentary record is included as part of the record, not just the transcript of the ALJ hearing. Although the ALJ will certify that the record is accurate and complete before it is released, it is possible that errors occurred and were not corrected. If a significant problem is discovered, take action to have the record corrected. Check the record to make sure that it contains the hearing exhibits and that the entire hearing was captured in the written transcript. Also, check the transcript for errors and omissions. Occasionally, portions of the recorded hearing may be lost or inadvertently omitted. Circumstances may require a new hearing if no record was made of the hearing.

If an error is discovered before filing, contact OALP - FSSA Hearings with a request for correction. If the error is discovered after filing, it will be necessary to file a motion to correct or supplement the record. Consult with the opposing counsel to reach a solution, if necessary.

The original record must be filed with the court. Little preparation of the record is required for filing, but it can be helpful to the trial court to prepare a table of contents and attach it to the front of the record. The pages of the record will already be numbered. With the advent of electronic filing, the record should be scanned as part of the e-filing process. It seems likely that, at some point in the future, FSSA will provide an electronic version of the record rather than a hard copy.

A Notice of Filing should also be prepared to file with the original record as proof of filing. Samples of both a table of contents and the Notice of Filing are included at Appendix EE.

With e-filing, some of the former challenges of utilizing the record are solved. Having a copy of the record is essential for page references for brief writing and for easy reference during oral argument. A hole-punched, hard copy that can be placed in a binder keeps the record in good order and allows easy access for those who like to work from a hard copy. For those who like to search the record electronically, a scanned copy will be helpful, especially for records that are lengthy.

### 6. Brief

Once the record is filed, the attorney should prepare a brief in support of the judicial review petition. Since the procedure is similar to an appeal, the attorney should use the same principles used in appellate advocacy to prepare the brief and prepare for oral argument. Because the procedure and timing for filing briefs is not specified in the statute or in the trial rules, it is helpful to file a motion to request a briefing schedule. See Appendix FF for a sample Motion for Briefing Schedule. Opposing counsel should be consulted both as a courtesy and as a way of avoiding unnecessary continuances.

The brief should contain a clear statement of the facts. The record may contain many documents, some of which will not be meaningful to the court without an explanation of the facts. The facts should endeavor to put the case in human terms. Where facts are in dispute, the court is bound by the findings of fact made by the ALJ unless there is not sufficient evidence in the record to support the findings. *Brown v. Ind. FSSA,* 45 N.E.3d 1233, 1235-1236 (Ind. Ct. App. 2015). The court should not re-try the facts. *Id.*

The brief should provide a thorough explanation of the applicable law and how it applies in the case. The court is not bound by FSSA's interpretation of the law, although it will look to FSSA for its expertise in the area. *Id.* Medicaid law consists of federal statutes, regulations, and case law, and similarly, state statutes, regulations, and case law. Few issues will be entirely new, but the issues may be new to the particular court hearing the case. It is important to present an understandable argument to the court. Assume that the court may not be familiar with Medicaid law.

Use the record to make appropriate citations to the administrative proceedings. Given the often large number of documents and pages in a record, it will assist the court to have page citations to relevant matters. Likewise, it is helpful to attach legal authority to the brief, particularly if such authority is unfamiliar to the court or not easily located using traditional electronic research. For instance, while a link to the IHCPPM can be included in the brief,

reproducing the specific section in the text or attaching that section in an appendix makes it easy for court to read it in the context of the brief.

### 7. Oral Argument

One may request oral argument as part of the request for a briefing schedule. Some courts will automatically set the case for oral argument. If feasible, the petitioner, or a family representative, should attend oral argument, so that the judge sees the real person who is affected by the decision.

Courts will typically allow each side to present argument for thirty (30) minutes. Check with the court to verify that this is the case or if it is necessary to request an appropriate amount of time. Expect to answer questions posed by the court. Petitioner goes first. The court should permit rebuttal, as well. It is possible for the parties to agree to waive oral argument, but weigh carefully giving up the opportunity to address the court in person. The likelihood is that the court may have questions about Medicaid law that can be addressed at oral argument.

It is useful to have a tabbed copy of the record available to answer factual questions posed by the court. Because the oral argument may be held many months after the ALJ hearing, knowledge of the facts can begin to fade with the passage of time. Intimate knowledge of the record can be persuasive especially when opposing counsel is not familiar with the record. The Attorney General's office, which represents FSSA on judicial review, is seldom involved in the case until the judicial review stage. Consequently, the deputy attorney general will not have participated in the fair hearing and may not be familiar with the evidence to the same degree as the attorney for the applicant/recipient.

In terms of presentation, treat the oral argument as an appellate argument. Focus on the most important part of the case, but also pay close attention to the questions posed by the court and what the court views as most important. Help the court understand the issues. Ask for specific relief that the court is capable of granting.

Most courts will not be familiar with Medicaid law. Be prepared to give a short, clear explanation of relevant Medicaid laws and regulations as background to the particular case. Do not assume that the trial court will understand terms of art or acronyms used in Medicaid practice, such as "spousal allocation" or "MA D." Even if explained in the brief, the court may not have internalized the specialized language.

### 8. Findings of Fact and Conclusions of Law

Indiana Trial Rule 52 (A)(2) requires a trial court to make specific findings of fact and conclusions of law, so it is not necessary to request findings. At the conclusion of oral argument, the trial court will usually request that the parties submit proposed orders and provide a deadline for the submission. It can be useful to prepare the proposed order prior to oral argument, especially as preparation for the argument. It may be necessary to adjust a proposed order after oral argument, but the exercise of preparing the order can focus the oral presentation.

If an appeal is taken from the trial court, an appellate court will examine the trial court's basis for its decision. Even if the applicant/recipient prevails, the DFR may appeal. So, there is considerable incentive to prepare a proposed order with findings of fact based on evidence in the record and with conclusions of law supported by the findings of fact. The trial court may ignore the proposed orders and craft its own, or it may incorporate portions of the proposed orders or sign one party's order. The opportunity to influence the court's order should be maximized by writing a persuasive proposed order.

### 9. Judgment

The trial court may affirm the agency action below or it may set aside the agency action pursuant to I.C. § 4-21.5-5-15 and either (1) remand the case to the agency for further proceedings; or (2) compel agency action that has been unreasonably delayed or unlawfully withheld. The trial court cannot specify that a specific decision be made on remand. *Ind. Fam. & Soc. Servs. Admin. v. Jones*, 691 N.E.2d 1354, 1358 (Ind. Ct. App. 1998) (holding that the trial court's authority on review is limited to remand for further proceedings and that it may not dictate or specify a particular procedure to be utilized upon remand; however, the agency must proceed in accordance with applicable law on remand). However, when remanding a case to FSSA, the court may direct that the agency take actions pursuant to I.C. § 4-21.5-5-12 (b) to conduct further fact finding or to prepare an adequate record. In *Brown v. Ind. FSSA*, 71 N.E.3d 50 (Ind. Ct. App. 2017), the Court of Appeals directed the trial court to remand the case to FSSA for a rehearing on the issue of medical necessity.

The trial court may remand the case to FSSA with directions to implement its order as to the issues on appeal. For favorable eligibility decisions, FSSA will still determine if the applicant otherwise meets eligibility for each month of potential eligibility. Given the passage of time required for judicial review, one should continue to maintain documentation to satisfy ongoing verification requirements from the date of denial**.**

## D. Litigation under 42 U.S.C. § 1983

If there is a claim that the actions of the state agency or its private contractors violated federal law or the U.S. Constitution, a lawsuit can be filed under 42 U.S.C. §1983. The courts are not always receptive to § 1983 claims, as *Gonzaga University v. Doe*, 536 U.S. 273 (2002), limits when a private cause of action is allowed. A court must decide whether Congress intended to create a private right of action for a particular class of plaintiffs. This intent (or lack thereof) is manifested by the presence (or absence) of statutory language granting private rights to an identifiable class. As a result there are court decisions as to the availability of a private right of action under specific Medicaid sections. The need to show a private right of action was recognized by the Indiana Supreme Court in *Murphy v. Fisher*, 932 N.E.2d 1235, (Ind. 2010), but it did not reach the issue in that case. The decision upheld the finding below that the State had conceded that the recipient plaintiffs had a private right of action in a lawsuit challenging Medicaid's transportation provider payment rates.

A § 1983 claim is typically used to obtain prospective injunctive relief. Neither FSSA nor the DFR nor a county DFR can be sued for damages under § 1983, because they are not

considered persons who can be sued under § 1983. *Ind. FSSA v. Anderson*, 155 N.E.3d 621 (Ind. Ct. App. 2020). One also cannot obtain damages from a state official sued in her official capacity. *Id.* In most cases, a § 1983 claim will only be available if there is an ongoing violation of federal law. For example, if a client continues to be ineligible due to a provision that is contrary to federal law, one can seek declaratory and injunctive relief under § 1983.

One may be able to pursue a damages claim against state contractors, which provide staffing for various functions in the Medicaid program. For example, in *Novak v. Ind. FSSA*, Cause No. 1:10-CV-0677-RLY-DML, the U. S. District Court for the Southern District of Indiana refused to dismiss a damages claim against state contractor IBM, ruling that it was acting "under the color of state law" but did not have immunity from a claim for damages. Entry Addressing Defendants' Motions to Dismiss, March 30, 2011.

A §1983 claim can be filed in federal or state court. Exhaustion of administrative remedies is not required if one is challenging an agency policy or practice. *King ex rel. Jacob v. Sec'y, Ind. FSSA*, 774 N.E.2d 1008, 1011 (Ind. Ct. App. 2002). A failure to timely file for judicial review did not bar King's §1983 claim.

A § 1983 claim can also be joined with a petition for judicial review filed in state court. *Stevens v. Indiana Dept. of Family and Children*, 566 N.E.2d 544 (Ind. Ct. App. 1991) held that a §1983 claim for class action injunctive and declaration relief could be joined with a petition for judicial review. Or a 1983 claim can be filed in federal court seeking prospective relief and a judicial review case can be filed in state court to preserve the opportunity to receive retroactive relief. *Felder v. Casey*, 487 U.S. 131 (1988) held that a state's tort claims notice law cannot be used to dismiss a §1983 claim brought in state court because the Supremacy Clause imposes on states a duty to proceed in such a manner that all substantive rights of parties under controlling federal law are protected.

A §1983 claim may provide additional relief, such as injunctive relief, not provided by judicial review. A §1983 claim will also potentially support a claim for attorney's fees because 42 U.S.C. §1988 provides for attorney's fees in §1983 cases. *Magnant v. Lane*, 582 N.E.2d 461 (Ind. Ct. App. 1991), held that a successful claimant was entitled to attorney's fees for a §1983 claim joined with a judicial review claim.

The presence of a § 1983 claim in a judicial review case may allow for the use of discovery to obtain information from FSSA, such as policy and data information. Since a petition for judicial review is based on the existing record, no discovery is normally permitted on a judicial review claim. Adding the §1983 claim may open the door to additional evidence and an evidentiary hearing on that claim.

If a §1983 claim is included, the judicial petition must name appropriate defendants, as FSSA and the DFR are not "persons" for purposes of §1983. The Director of OMPP and DFR or other appropriate individuals or the private contractor can be added as defendants. Since exhaustion of administrative remedies is not required for §1983 claims, a §1983 suit can be filed without first exhausting all of the procedures listed above. However, it may still be desirable to exhaust the administrative procedures and then join the §1983 action to a petition for judicial review.

If an applicant/recipient lacks capacity to bring his/her own claim, the third party who files for the applicant/recipient must have standing to bring the lawsuit. *Bria Health Servs. LLC v. Eagleson*, 950 F.3d 378 (7th Cir. 2020), ruled that consultants who provided financial services did not have standing to sue the state Medicaid director seeking more timely payment of claims, even though they did have signed authorizations to act as authorized representatives. The Court noted that the recipients would likely not benefit from the lawsuit. Being an authorized representative by itself did not give standing to the consultants. The Court emphasized that its decision does not mean that a third party can never sue for a recipient, as guardians, next friends, and associations can have representational standing.

> None of this means, of course, that third parties may not bring claims on behalf of Medicaid beneficiaries. If a state does not comply with its Medicaid obligations and vulnerable populations do not receive timely notice of eligibility determinations or do not receive services, they may be entitled to remedies in court. Given the severe medical conditions that many of these people face, it may be difficult for them to assert their own rights. But there are established processes for bringing claims on behalf of others that—unlike the system read into the regulation by the consultants—contain safeguards and ensure that the interests of vulnerable individuals are represented. If a beneficiary lacks capacity, a guardian or next friend may sue on her behalf. These consultant-plaintiffs, however, do not have standing.

950 F.3d at 386.

# Appendices

# Division of Family Resources

## Indiana Family & Social Services Administration

Region 1 (Lake): DFR.region1@fssa.IN.gov

Region 2 (St. Joseph): DFR.region2@fssa.IN.gov

Region 3 (Allen): DFR.region3@fssa.IN.gov

Region 4 (Grant): DFR.region4@fssa.IN.gov

Region 5 (Marion): DFR.region5@fssa.IN.gov

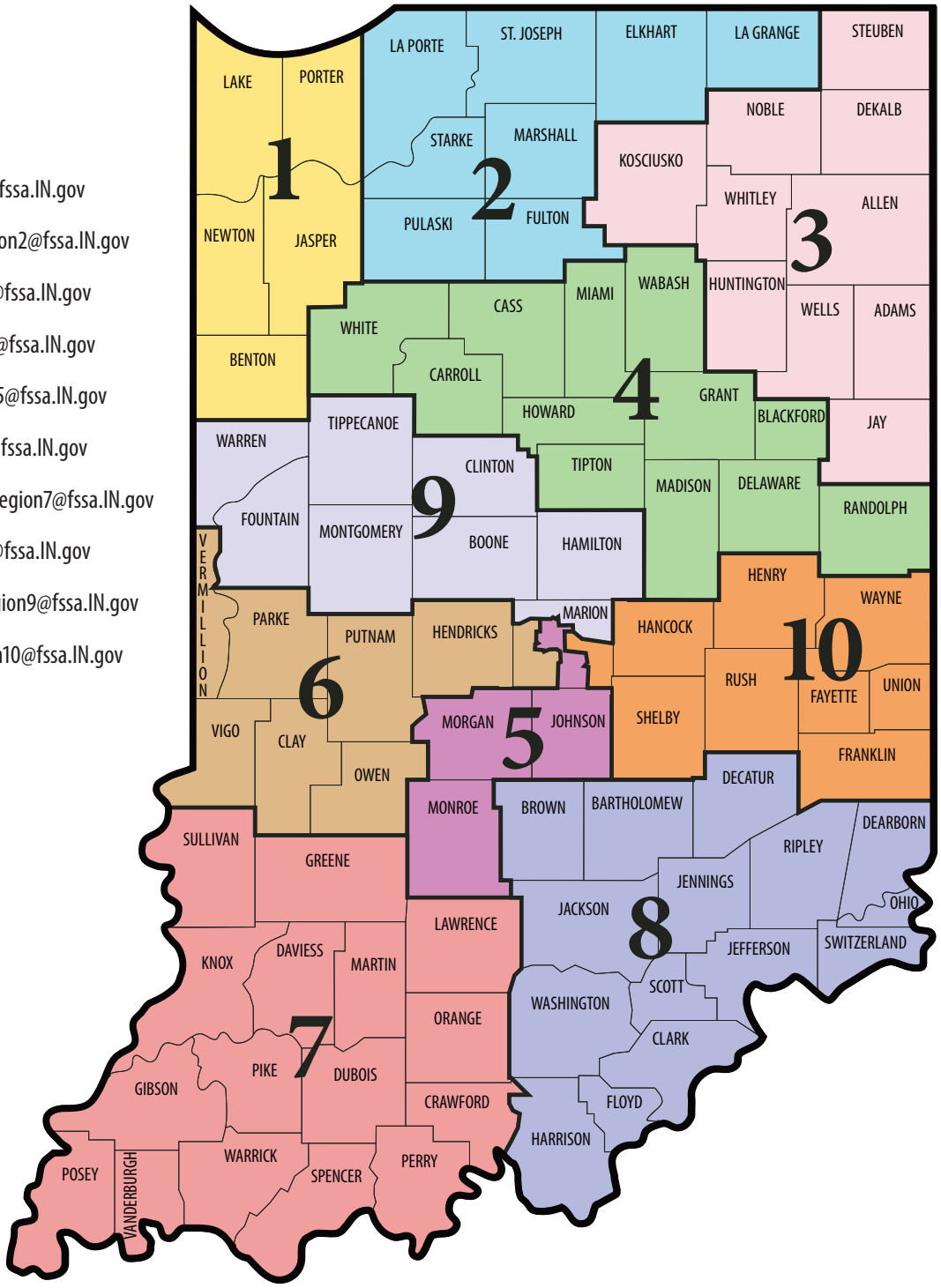
Region 6 (Vigo): DFR.region6@fssa.IN.gov

Region 7 (Vanderburgh): DFR.region7@fssa.IN.gov

Region 8 (Clark): DFR.region8@fssa.IN.gov

Region9 (Tippecanoe): DFR.region9@fssa.IN.gov

Region 10 (Wayne): DFR.region10@fssa.IN.gov




**Inquiries sent to a DFR Region email address will receive a response within three to five business days.**

Find a complete list of offices and contact information beginning on the next page.

## Regional Managers

| STATE REGION | REGIONAL MANAGER | EMAIL ADDRESS |
|---|---|---|
| Region 1 | Tamara Rollins | DFR.region1@fssa.IN.gov |
| Region 2 | Letitia Johnson | DFR.region2@fssa.IN.gov |
| Region 3 | Kim Yann | DFR.region3@fssa.IN.gov |
| Region 4 | Stacey Young | DFR.region4@fssa.IN.gov |
| Region 5 | Tim Bolton | DFR.region5@fssa.IN.gov |
| Region 6 | Felecia Vaccaro | DFR.region6@fssa.IN.gov |
| Region 7 | Donna Martin | DFR.region7@fssa.IN.gov |
| Region 8 | Denise Harter | DFR.region8@fssa.IN.gov |
| Region 9 | Penny Yoho | DFR.region9@fssa.IN.gov |
| Region 10 | Mary Stenger | DFR.region10@fssa.IN.gov |

*DFRAZAE01*

# AUTHORIZED REPRESENTATIVE FOR HEALTH COVERAGE

State Form 55366 (R2 / 12-14) / DFR 2123HC

**Section 1**

If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed. Be sure to select the function(s) that the representative is being authorized to do. You can select more than one representative and choose the same or different functions. The representative may be an individual or an organization. Complete ONE form per authorized representative. Both you and your representative must sign and date this form.

**Section 2**

Name of Representative (*Please print clearly*)

Check association with applicant/recipient. Please select ONE *(1)*.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Attorney | ☐ | Eligibility Assistance Company | ☐ | Friend | ☐ | Family |
| ☐ | Institution of Residence | ☐ | Waiver Case Manager | ☐ | Other (*Specify*): _____ | | |

Mailing Address (*number and street, city, state, and ZIP code*)

| | | SELECT THE FUNCTION(S) THE AUTHORIZED REPRESENTATIVE WILL DO: |
|---|---|---|
| **FUNCTION** | **FUNCTION DESCRIPTION** | **HEALTH COVERAGE** |
| **APPLY** | • Sign application and be interviewed.<br>• Provide all required proof of information necessary to determine eligibility for benefits.<br>• Receive the Notice of the application decision.<br>• Speak on applicant's behalf at a hearing if the application decision is appealed. | **Apply** ☐ |
| **ONGOING** | • Report changes.<br>• Attend periodic redeterminations.<br>• Receive the appointment notices and any redetermination mail-in forms.<br>**NOTE:** Do not check this function if the representative will not continue to act on recipient's behalf after the application decision is made. | **Ongoing** ☐ |

**In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. I agree to maintain or be legally bound to maintain the confidentiality of any information regarding the applicant/recipient provided by the Division of Family Resources.**

| Signature | Date (*mm/dd/yyyy*) | Telephone ((###) ###-####) |
|---|---|---|
| | | |

**Section 3**

**I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above. (If applicant/recipient is medically incapable to sign authorization, provide medical documentation.) I understand that I am responsible for the information anyone acting as my authorized representative gives, including any information that may be incorrect. I also understand that if at any time I wish to stop the person(s) I chose from being my authorized representative, it is my responsibility to contact the Division of Family Resources.**

| Applicant/Recipient Name | Applicant/Recipient Signature | Date (*mm/dd/yyyy*) |
|---|---|---|
| | | |

| Case Number (*Optional*) | Applicant/Recipient Date of Birth (*mm/dd/yyyy*) | Applicant/Reciipient Social Security Number |
|---|---|---|
| | | XXX-XX- |

**EXHIBIT C**

**CHECKLIST OF DOCUMENTS YOU WILL NEED FOR _____'S MEDICAID CASE [SINGLE'S CASE]**

**PLEASE NOTE: In order for Medicaid to pay the per diem cost of care in a nursing home, the Medicaid applicant must be in a MEDICAID-CERTIFIED BED.**

If you purchased an immediate annuity or annuitized an annuity within the last five years or if you have made withdrawals (other than minimum required distributions from an IRA annuity) or if there has been other significant activity on the annuity, then you MUST change the beneficiary designation to read: "The State of Indiana in an amount not to exceed the amount expended for medical assistance for the institutionalized individual under Subchapter XIX, Chapter 7, of Title 42 of the United States Code." If the annuity company asks, the State of Indiana EIN is: 356000158. See below for further information on annuities.

## Your targeted date of eligibility is _____ 1, 2022.

1. **Birth certificate and photo ID card (such as driver's license).** If there is no birth certificate, then provide **one other proof** of date of birth, such as passport, baptismal record, insurance policies, Social Security record which states date of birth, health care record (from doctor or other health care provider). You also may request a birth certificate by telephone, mail, or online at https://www.vitalchek.com/birth-certificates

2. **Copy of death certificate or divorce decree**, if applicable or any other credible evidence of the event.

3. **Copies of Social Security, Medicare, health care insurance supplement, Medicare Advantage Plan, and Medicare Part D (prescription drug plan) cards**. Please copy both the front and back of your health care supplement and Part D cards. Replacement Social Security cards can be obtained at the mysocialsecurity portal at socialsecurity.gov/myaccount

4. **Health Insurance:** Verification of the amount of monthly health care insurance premium. The premium stub is an ideal proof. If you do not have a premium stub, please request a letter from the company. A notation on a bank statement is NOT sufficient. Please include premium information for Medicare Part D (prescription drug benefits). If you have a Medicare advantage plan, Medicaid requires you to have a statement from the company showing which part of the premium is attributable to Part C and which is attributable to Part D.

5. **Legal Documents:** Copy of power of attorney and copy of trust (if applicable). If there is a guardianship in place, we will need the "Letters of Guardianship." If the power of attorney requires a letter of incapacity, please get this statement from your doctor.

6. **Proof of 2022 Social Security income**. You will need the "Your New Monthly Benefits Amount" letter for 2022 showing the gross monthly benefit, deduction for the Medicare Part B premium, and the net deposit. **A notation on the bank statement is not sufficient proof.** *You

can also get the proper form by setting up an online account by following the prompts under "Get your benefit verification letter online" section of the SSA website at www.ssa.gov.

7. **Proof of Veterans benefits**: the check or letter of notification (if within 12 months) or call 1-800-827-1000. If you receive a non-service connected pension from the VA, please request a letter which gives a breakdown of what part of the pension is for aid and attendance or is awarded due to unreimbursed medical expenses. Medicaid is now requiring this information. You can also contact the VA at 1-877-294-6380 which is the National VA Pension Line. Please call at a time when you can afford to be on hold for a half hour or more.

8. **Proof of Railroad Retirement benefits**: the check or letter of notification (if within 12 months) or call 1-877-772-5772.

9. **Proof of pension income**: the check stub or a statement from the company showing gross and net income. **A notation on a bank statement is not sufficient proof.**

10. **Income from rental of property** along with the expenses of ownership (real estate tax, real estate insurance, utilities, routine maintenance, interest on mortgage payments). We will need a copy of your tax return showing income received from farming or rental properties in the past year.

11. **Fair Market Rental Value:** Medicaid will request proof that your real estate is earning a fair market income. You should not have to pay for an appraisal. Instead, please request that a realtor (or perhaps a farm bureau, if the property is agricultural) give you a free fair market analysis of the income your property should be receiving.

12. **Earnings**: name of employer, pay stubs covering the last 3 months or one pay stub with year-to-date totals.

13. **Proof of any other income received**.

14. **Proof of date of admission to the nursing home**. (The nursing home can typically give you an admission face sheet.)

15. **Proof of any long term care (nursing home) insurance**. We will need information regarding the policy term (length of coverage) and how much the policy will pay, if applicable. The policy information face sheet typically provides this information. If the Medicaid applicant is already receiving payments for services, we will need copies of the last three check stubs and proof that the medical service provider (e.g., nursing home or home care agency) is receiving the payments. If the policy is an Indiana Partnership policy, we will need the service summary report showing the benefits paid out and the asset disregard.

16. **Prepaid funeral arrangement and deed to burial plot.** In order for the funeral to be exempt, the amount paid must be linked to a statement of funeral goods and services. In other words, if you pay $10,000.00, you must have a statement from the funeral home that shows you have

purchased $10,000.00 worth of goods and services. For prepaid funerals, we need the following:

- A copy of the Statement of Goods and Services
- Proof of the irrevocable nature of the agreement. If the funeral plan is being purchased within the month before our targeted date for Medicaid, the funeral paperwork should also contain a statement similar to the following: "IRREVOCABILITY: Indiana law requires that pre-need funeral agreements be made irrevocable after 30 days. By initialing here (_____) the pre-need funeral agreement will be made irrevocable immediately."
- A statement within the funeral paperwork that indicates that if there are excess funds in the trust at the time of the individual's death, that the excess amount will be paid to the individual's estate or to Medicaid office (or State of Indiana or Division of Family Resources). **THIS IS A CRITICAL COMPONENT OF THE PROOF WE NEED TO SATISFY THE MEDICAID REQUIREMENTS.**

17. **Verification of life insurance policies**:

- Written verification from the company of the cash surrender value of the policy.
- Copy of the face sheet which shows the issue date of the policy and the face amount of the policy.
- Since you are cash surrendering the policy, please copy the cash surrender check and accompanying paperwork
- Since you are changing ownership on a policy, we will proof of the ownership change, including date of change and new owner name.
- For policies that have only a death benefit, you will need a statement from the company indicating there is no cash surrender value for the policy.

18. **Bank statements** showing the balance in any and all accounts owned (checking, savings, C.D.s, Christmas Club, etc.) covering the following dates: _____

- We also need proof of closing of any account and proof of disposition of the proceeds (e.g., deposited into checking account, etc.). **This applies to any account closed within the last five years.**
- If you have written large checks or have large deposits in the material you provide to us, as requested above, please provide copies of those checks (if not included in the bank statement) and explanations of large deposits.
- We need all numbered pages of any bank statement, even if those pages are blank or contain only reconciliation information.

19. **Verification of ownership and value of any stocks or bonds** (including U.S. Savings Bonds) covering the following dates: _____. We also need proof of closing of any account and proof of disposition of the proceeds (e.g., deposited into checking account, etc.). **This applies to any account closed within the last five years.**

20. **Cryptocurrency such as Bitcoin or Litecoin:** Proof of current market value for the following dates: _____ All virtual currencies which are listed

on the exchange should be determined using that exchange. If the virtual currency is not held on an exchange, utilize "Coinbase" at https: www.coinbase.com to determine the value.

21. **Special Requirements for annuities, depending on date of purchase and activity on annuities:**
    a.) For any annuity purchased prior to November 1, 2009, Medicaid is requiring either a statement from the company that says there has been no activity on the annuity such as change of ownership, withdrawals, or deposits for the last five years OR you will need to produce all statements of activity on the annuity for the last five years.
    b.) If there *has* been activity on the annuity such as change of ownership, withdrawals, or deposits over the past five years, you will need to change the beneficiary to the state of Indiana as specifically detailed on page one of this checklist.
    c.) If the annuity was purchased on or after November 1, 2009, you will need to change the beneficiary to the state of Indiana as specifically detailed on page one of this checklist.

22. **Property deeds for all real estate**, including the home, if there is a home. Please also provide the real estate tax notice which shows the assessed value of the real estate.

23. **The registration or title** as well as verification of the current market value of any non-motorized recreational vehicle, camper trailer, boat, etc. owned by applicant.

24. **The registration or title** to all vehicles owned by the Medicaid applicant. We can assist you in getting values so long as we know the make, model, and approximate number of miles on the vehicle. However, if the vehicle is older than 1992, you will need a written statement by a licensed dealer of the value.

25. **A listing of the contents of any safety deposit box rented by the Medicaid applicant**.

26. **Copy of the last federal income tax return filed on behalf of the Medicaid applicant.**

27. **Proof of gifts made in the last five years**. (Copies of checks are ideal proof.)

**EXHIBIT D**

**CHECKLIST OF DOCUMENTS YOU WILL NEED**
**FOR _____'S MEDICAID [MARRIED COUPLE; ONE IN NURSING HOME]**

If you purchased or annuitized an annuity on or after November 1, 2009 *OR* if there has been activity on the annuity such as change of ownership, withdrawals (other than minimum required distributions), or deposits ) in the last five years, then, if you are keeping the annuity, you MUST change the beneficiary designation to read: "The State of Indiana in an amount not to exceed the amount expended for medical assistance for the institutionalized individual under Subchapter XIX, Chapter 7, of Title 42 of the United States Code." The non-Medicaid spouse should still be named the primary beneficiary if the annuity is owned by the Medicaid spouse with the state in the contingent position. If the annuity company asks, the State of Indiana EIN is: 356000158. See below for further information on annuities.

**PLEASE NOTE: In order for Medicaid to pay the per diem cost of care in a nursing home, the Medicaid applicant must be in a MEDICAID-CERTIFIED BED. Please check with the nursing home to ensure that this is the case.**

## Your two key dates are: _____& _____

1. **Birth certificate for both spouses and photo ID for both spouses**. If there is no birth certificate, then provide **two proofs** of date of birth, such as passport, baptismal record, insurance policies, driver's license or i.d. card, Social Security record which states date of birth, health care record (from doctor or other health care provider). You also may request a birth certificate by telephone, mail, or online at https://www.vitalchek.com/birth-certificates.

2. **Record of marriage**, such as certificate or license. You also may request a marriage certificate by telephone, mail, or online at https://www.vitalchek.com/marriage-records.

3. **Copies of Social Security, Medicare, health care insurance supplement, Medicare Advantage Plan, and Medicare Part D (prescription drug plan) cards for both spouses**. Please copy both the front and back of your advantage plan OR health care supplement and Part D cards. Replacement Social Security cards can be obtained at the mysocialsecurity portal at socialsecurity.gov/myaccount

4. **Legal Documents:** Copy of power of attorney and copy of trust for the Medicaid applicant spouse. If there is a guardianship in place, we will need the "Letters of Guardianship." If the power of attorney requires a letter of incapacity, please get this statement from your doctor.

5. **If there has been a prior 30 consecutive day stay in a facility (hospital, rehab, nursing home or any of those facilities combined), then we will need proof of date of admission to the hospital and proof of dates of admission to and discharge from the nursing home**. (The nursing home can typically give you an admission face sheet with the "qualifying hospital stay.")

OR **Proof of date of admission to the hospital and also proof of date of admission to the nursing home**. (The nursing home can typically give you an admission face sheet with the "qualifying hospital stay.")

6. **Health Insurance:** Verification of the amount of monthly health care insurance premium paid for each spouse. The premium stub is an ideal proof. If one premium is paid for both spouses, please ask the company to give you a specific breakdown of the premium that is attributable to the Medicaid applicant spouse. If you do not have a premium stub, please request a letter from the company. A notation on a bank statement is NOT sufficient. Please include premium information for Medicare Part D (prescription drug benefits). If your spouse has an advantage plan, Medicaid requires you to have a statement from the company showing which part of the premium is attributable to Part C and which is attributable to Part D.

7. **Proof of 2022 Social Security income for both spouses.** You will need the "Your New Monthly Benefits Amount" letter for 2022 (sent in early December to most beneficiaries) showing the gross monthly benefit, deduction for the Medicare Part B premium, and the net deposit. **A notation on the bank statement is not sufficient proof.** *You can also get the proper form by setting up an online account by following the prompts under "Get your benefit verification letter online" section of the SSA website at www.ssa.gov.

8. **Proof of Veterans benefits**: the check or letter of notification (if within 12 months) or call 1-800-827-1000. If you receive a non-service connected pension from the VA, please request a letter which gives a breakdown of what part of the pension is for aid and attendance or is awarded due to unreimbursed medical expenses. Medicaid is now requiring this information. You can also contact the VA at 1-877-294-6380 which is the National VA Pension Line. Please call at a time when you can afford to be on hold for a half hour or more.

9. **Proof of Railroad Retirement benefits**: the check or letter of notification (if within 12 months) or call 1-877-772-5772.

10. **Proof of Pension Income for both spouses:** the check stub or a statement from the company showing gross and net income. **A notation on a bank statement is not sufficient proof.**

11. **Income from rental of property** along with the expenses of ownership (real estate tax, real estate insurance, utilities, routine maintenance, interest on mortgage payments). We will need a copy of your tax return showing income received from farming or rental properties in the past year.

12. **Fair Market Rental Value:** Medicaid will request proof that your real estate is earning a fair market income. You should not have to pay for an appraisal. Instead, please request that a realtor (or perhaps a farm bureau, if the property is agricultural) give you a free fair market analysis of the income your property should be receiving.

13. **Earnings**: name of employer, pay stubs covering the last 3 months, verification of work expenses.
14. **Proof of any other income received**.

15. **Proof of any long term care (nursing home) insurance**. We will need information regarding the policy term (length of coverage) and how much the policy will pay. The policy information face sheet typically provides this information. If the Medicaid applicant is already receiving payments for services, we will need copies of the last three check stubs and proof that the medical service provider (e.g., nursing home or home care agency) is receiving the payments.

16. **Prepaid funeral arrangement and deed to burial plot for both spouses.** In order for the funeral to be exempt, the amount paid must be linked to a statement of funeral goods and services. In other words, if you pay $10,000.00, you must have a statement from the funeral home that shows you have purchased $10,000.00 worth of goods and services. For prepaid funerals, we need the following:
    - A copy of the Statement of Goods and Services
    - Proof of the irrevocable nature of the agreement. If the funeral plan is being purchased within the month before our targeted date for Medicaid, the funeral paperwork should also contain a statement similar to the following: "IRREVOCABILITY: Indiana law requires that pre-need funeral agreements be made irrevocable after 30 days. By initialing here (_____) the pre-need funeral agreement will be made irrevocable immediately."
    - A statement within the funeral paperwork that indicates that if there are excess funds in the trust at the time of the individual's death, that the excess amount will be paid to the individual's estate or to Medicaid office (or State of Indiana or Division of Family Resources). **THIS IS A CRITICAL COMPONENT OF THE PROOF WE NEED TO SATISFY THE MEDICAID REQUIREMENTS.**

17. **Verification of both spouses' life insurance policies for the following dates:**
    - Written verification from the company of the cash surrender value of the policy.
    - Copy of the face sheet which shows the issue date of the policy and the face amount of the policy.
    - Since you are cash surrendering the policy, please copy the cash surrender check and accompanying paperwork
    - If you are keeping the policy owned by your spouse, you must change ownership of the policy to your name. Your spouse will still be the insured, and you will still be the beneficiary. We will proof of the ownership change, including date of change.
    - For policies that have only a death benefit, you will need a statement from the company indicating there is no cash surrender value for the policy.

18. **Bank statements showing the balance in any and all accounts owned - checking, savings, Certificates of Deposit (C.D.s), Christmas Club, etc.) - for the following two dates:**
    - If a date (the targeted date for Medicaid eligibility) has not yet occurred, then submit these verifications when they are available.

- We also need proof of closing of any account and proof of disposition of the proceeds (e.g., deposited into checking account, etc.)

- If you have written large checks or have large deposits in the material you provide to us, as requested above, please provide copies of those checks (if not included in the bank statement) and explanations of large deposits.
- We need all numbered pages of any bank statement, even if those pages are blank or contain only reconciliation information.

19. **Nursing home trust (personal needs or RFMS - Resident Funds Management Services) account** covering from opening through _____. I recommend that you do ***not*** open a trust account if at all possible. These accounts are countable assets for purposes of Medicaid eligibility.

20. **Cryptocurrency such as Bitcoin or Litecoin:** Proof of current market value for the following two dates: _____. All virtual currencies which are listed on the exchange should be determined using that exchange. If the virtual currency is not held on an exchange, utilize "Coinbase" at https: www.coinbase.com to determine the value.

21. **Verification of ownership and value of any stocks or bonds (including U.S. Savings Bonds) for the following dates:** _____
We also need proof of closing of any account and proof of disposition of the proceeds (e.g., deposited into checking account, etc.)

22. **Special Requirements for annuities, depending on date of purchase and activity on annuities:**
    a.) For any annuity purchased prior to November 1, 2009, Medicaid is requiring either a statement from the company that says there has been no activity on the annuity such as change of ownership, withdrawals, or deposits for the last five years OR you will need to produce all statements of activity on the annuity for the last five years.
    b.) If there *has* been activity on the annuity such as change of ownership, withdrawals, or deposits over the past five years, you will need to change the beneficiary to the state of Indiana as specifically detailed on page one of this checklist.
    c.) If the annuity was purchased on or after November 1, 2009, you will need to change the beneficiary to the state of Indiana as specifically detailed on page one of this checklist.

23. **The registration or title** as well as verification of the current market value of any non-motorized recreational vehicle, camper trailer, boat, etc. owned jointly or individually by applicant or spouse.

24. **The registration or title** to all vehicles owned by the Medicaid applicant or spouse. We can assist you in getting values so long as we know the make, model, and approximate number of miles on the vehicle. If the vehicle is older than 1992, you will need to obtain a written statement of value from a licensed auto dealer.

25. **Property deeds for all real estate, including the home, owned by either spouse or by both jointly. Please also provide the real estate tax notice which shows the assessed value of the real estate.**

26. A **listing of the contents of any safety deposit box** rented by the resident.

27. **Copy of the last federal income tax return** filed on behalf of the Medicaid applicant.

28. **Shelter expenses:**
    - Proof of your rent OR your monthly mortgage payment.
    - If you live in an assisted living facility, the facility will need to provide us with a breakdown of the payment (e.g., which portion is for room & board, which portion for meals, etc.) Medicaid will factor only the room & board payment into your "shelter allowance" calculation.
    - Copy of your real estate taxes for your home
    - Copy of the premium bill for your homeowners or renters insurance
    - Condo or neighborhood association fees (if applicable)
    - One recent heating bill and electric bill**.**

29. **List and proof of gifts made in the last five years.** (Copies of checks are ideal proof.)

Flanner Buchanan
CREMATION · BURIAL

(317) 387-7000
FlannerBuchanan.com

Date: , 2018

To: Indiana Family and Social Services Administration

Re:

CERTIFICATION AS TO INDIANA CODE 12-15-2-17 (f)

Flanner Buchanan (Funeral Home) hereby certifies that the sum of $ .00 was paid by to National Guardian Life on September 9, 2015 under the attached Exhibit A which is incorporated herein.

That such sum has been applied to the cost of funeral and/or interment of for (Donee).

The funeral home hereby certifies to the Indiana Family and Social Services Administration that in the event that the funeral and/or cost for Donee when rendered, after the Donee's demise is less than such sum paid for such Donee, the excess sum paid shall be refunded to the IFSSA to reimburse Medicaid as required under Indiana Code 12-15-2-17 (f).

Appropriate notation has been made with regard to the insurance funeral contracts to enforce such obligation of the funeral home to the IFSSA.

A copy or electronic reproduction hereof shall be effective as an original.

Dates this th day of 2018.

Flanner Buchanan

By: VPSOP.
Vice President of Funeral Operations

Broad Ripple
(317) 475-4475

Carmel
(317) 848-2929

Decatur Township
(317) 856-2627

Geist
(317) 454-7078

Market Street
(317) 387-7000

Speedway
(317) 387-7020

Zionsville
(317) 873-3366

Floral Park
(317) 241-9311

Hamilton Memorial Park
(317) 896-9770

Memorial Park
(317) 898-4462

Oaklawn Memorial Gardens
(317) 849-3616

Washington Park East
(317) 899-7115

Washington Park North
(317) 251-5959

# NGL Funeral Expense Trust -- Irrevocable Assignment of Proceeds

Insured: _____ Policy Number: _____

In exchange for entering into a contract for the costs of funeral merchandise and services (attached) of the funeral for the Insured named above and upon the signed acceptance of the Funeral Provider listed below, the Trustee of the NGL Funeral Expense Trust (Live Oak Bank), "Trustee," hereby irrevocably assigns the payment of proceeds to the Funeral Provider named below effective immediately.

It is understood that by irrevocably assigning the payment of proceeds to the Funeral Provider:

- The Trustee is directed to pay an amount not to exceed the death benefit of the insurance policy to the Funeral Provider, or any other funeral home as their interest may appear, upon receipt of proof that funeral merchandise and services have been provided.

- The insurance policy proceeds that exceed the cost of the approved goods and services for the Insured's funeral, burial or cremation shall be paid to the State, if required by the applicable State's Medicaid recovery program. If payment to the State is not required, or if excess proceeds exist after payment to the State, all such excess proceeds shall be paid to the Estate of the Insured. This supersedes any Beneficiary named on the insurance policy application.

- It is understood and agreed that this irrevocable assignment in no way inhibits the Insured from hereafter selecting another Funeral Provider to perform funeral services and provide funeral merchandise in connection with the funeral of the Insured. The Insurer is not a party to this assignment and the sole responsibility of the Insurer is to pay the death benefit proceeds pursuant to the terms of the insurance policy as directed by this assignment.

On behalf of the Funeral Provider, I hereby accept this assignment in accordance with the terms set forth above.

Name of Funeral Provider _____

Address _____

_____

Signature of Funeral Provider Date

By: _____

Administrator or Trustee Date

# TRUST FOR THE SOLE BENEFIT OF

# *BFN

**TRUST FOR THE SOLE BENEFIT OF**

***BFN**

THIS AGREEMENT is entered into this _____ day of _____, 2021, by and between *GNTR, of * County, Indiana ("Grantor") and Robert W. Fechtman, of Marion County, Indiana ("Trustee"), for *BFN ("*Ben"), who is disabled. Whenever the term "Trustee" is used in this document, it shall apply equally to any "Successor Trustee" "Co-Trustees" or remaining "Co-Trustee". Whenever used herein, the term "Grantor" will have the same meaning as the term "Settlor" as defined in the Indiana Code section 30-4-1-2, or its successor section.

WITNESSETH THAT:

WHEREAS, the Grantor wishes the Trustee to utilize the limited funds available to protect *Ben's legal rights, and to provide supplemental items and incidental services for him without replacing any forms of private or public assistance to which he would otherwise be entitled; and

WHEREAS, the Grantor wishes the corpus and any undistributed income of the trust remaining at the death of *Ben to be distributed pursuant to the terms of ArticleV herein; and

WHEREAS, the Trustee has agreed to hold and administer such property as may be received hereunder, upon the terms and conditions hereinafter set forth.

NOW THEREFORE, in consideration of the promise and mutual covenants herein contained and other valuable consideration, the parties do hereby agree as follows:

## ARTICLE I.

## Trust Purpose

The purpose of this Trust is to utilize the limited funds available to the Trustee for *Ben, to protect *Ben's legal rights, and to provide supplemental items and incidental services for him,

after utilizing available assistance from governmental and private agencies and when such assistance or benefits are incomplete or insufficient, and not to replace such assistance or benefits or to render *Ben ineligible for any assistance or benefits to which he would otherwise be entitled or eligible.

## ARTICLE II.

## Trust Funding

The Grantor has delivered to the Trustee, the property described in Schedule A. Such property and any other property that may be received by the Trustee as additions to this Trust shall be held and disposed of by the Trustee on the terms stated in this Agreement.

## ARTICLE III.

## Irrevocability

The Trust created by this Agreement shall be irrevocable, except that the Trust may be amended or revoked, in whole or in part, by an order of a court of competent jurisdiction, for the sole purpose of allowing the Trust to continue to accomplish its stated purpose, in the event that a change in the law, policy, interpretation of the law or other circumstance will frustrate such purpose.

## ARTICLE IV.

## Administrative of Trust During *Ben's Life

**A. Personal Decisions.**

Any decisions with respect to matters that are personal to *Ben, such as the selection of physicians, or other health care and rehabilitation professionals, or facilities, living arrangements for *Ben and similar matters shall be made by *Ben or *Ben's guardian.

**B. Distribution of Income and Principal.**

Except as limited herein, the Trustee may spend or indefinitely retain the income and principal of this Trust, subject to the mandatory distribution upon termination of this Trust. Any net income not so disbursed shall be added to the principal of the Trust. The Trustee, in determining whether to make any distribution to or for the benefit of *Ben, shall consider the advisability of making such distribution in light of the amount to which he may be entitled from any insurance program or governmental agency, including but not limited to TRICARE benefits, Medicaid (medical assistance), or Supplemental Security Income (SSI) benefits. The Trustee shall not supplant services, assistance and medical care available to *Ben from any such source, unless the Trustee, in the Trustee's sole discretion, determines that the benefits to *Ben of the services, assistance, and medical care available through such programs are outweighed by the burdens imposed on *Ben by the programs, and that *Ben's long-term interest will best be served by other means. The Trustee may employ legal counsel to assist in this determination, and shall be held harmless for actions or inactions done in reasonable reliance on the report or opinion of such counsel.

In the event the Trustee is requested to release any part of the trust estate to *Ben, or *Ben's guardian, to pay for expenses that are otherwise paid for by public assistance programs for which *Ben is eligible, or to petition the Court, or any administrative agency, for the release of any part of the trust estate for such purpose, then the Trustee is authorized to deny such request. The Trustee is further authorized, in the Trustee's sole, absolute, complete and unfettered discretion, to take whatever administrative or judicial steps the Trustee deems necessary to continue *Ben's public assistance program eligibility. However, the Trustee is not required to maintain such eligibility, if it is not in *Ben's best interest to do so. The Trustee's

discretion to determine the use of the Trust funds should not be replaced by any other party's, including any court, administrative agency or other person, except as provided for otherwise herein. The Trustee's discretion should not be tested by any other person's standard of reasonableness, but should be based solely on what is reasonable for *Ben given his special circumstances.

The Trustee is authorized to rely on the advice of any person authorized under Paragraph A of this Article, or of legal counsel, in making expenditures under this provision. The Trustee may, for example, employ legal counsel to determine whether the proposed expenditure is for services that are ordinarily paid for by Medicaid or other insurance or public benefit programs to which *Ben may otherwise be entitled. The Trustee shall be held harmless against and in respect of any and all losses, liabilities, judgments, damages and expenses arising out of the Trustee's reliance on such person's advice.

**C. Accounting.**

The Trustee shall render an annual statement of accounts to *Ben or *Ben's legal guardian.

## ARTICLE V.

## Death of *Ben

Upon *Ben's death, the Trustee shall, as soon as practicable, terminate the Trust and distribute and convey the entire remaining balance of the Trust as follows:

A. The Trustee shall pay to the State of Indiana (and such other state as may provide Medicaid assistance to *Ben), such amount of the trust estate as is legally required to meet the requirements of 42 U.S.C. §1396p(d)(4)(A) or the corresponding provision of any successor Medicaid laws.

B. The Trustee shall then pay Ten and 00/100 Dollars ($10.00) to *GNTR (*or someone else, like a parent or grandparent, if the Grantor is also the Beneficiary) and the remainder of the trust estate to *Ben's heirs at law.

## ARTICLE VI.

## Spendthrift Provision

No interest under this instrument shall be transferable, attachable, or assignable by any beneficiary, or be subject during his life to the claims of his creditors. If any attempt should be made by any creditor of the beneficiary to reach any rights, benefits, or interests of the beneficiary, the Trustee may apply the income or principal to which the beneficiary would otherwise be entitled, for his support and maintenance, or the support and maintenance of those dependent upon the beneficiary in such manner as the Trustee in the Trustee's sole discretion shall determine.

## ARTICLE VII.

## Administration of Trust

**A. Governing Law.**

This instrument and the dispositions hereunder shall be construed and regulated and their validity and effect shall be determined by the laws of Indiana.

**B. Method of Payment.**

The Trustee may make payments to or on behalf of the beneficiary in any one or more of the following ways:

1. To any person or organization furnishing care, support, maintenance, or education for such beneficiary; or

2. By making expenditures directly on behalf of the beneficiary.

The Trustee shall not be required to see to the application of any funds so paid, and the receipt by such payee shall be full acquittance to the Trustee. The decision of the Trustee as to direct payments or application of funds shall be conclusive and binding upon all parties in interest.

**C. Waiver of Bond.**

The Trustee shall not be required to give any bond as Trustee, nor to obtain the order of approval of any court in the exercise of any power of discretion hereunder, although the Trustee may do so at the Trustee's discretion.

**D. Compensation.**

The Trustee shall be entitled to reasonable compensation for services in administering and distributing the Trust and to reimbursement for expenses. The Trustee shall also be entitled to reasonable additional compensation for extraordinary services rendered; provided, however, that the Trustee shall give notice to *Ben or his guardian, before such additional compensation for extraordinary services is remitted to the Trustee.

**E. Charges to Trust.**

All reasonable expenses in establishing, maintaining, administering, and defending this Trust, including but not limited to reasonable attorneys fees, accounting fees, Trustee fees, taxes, and costs, shall be a proper charge to the Trust. This shall also include any guardian's fees and guardian's attorney's fees as authorized by a court, pursuant to any guardianship proceedings.

## ARTICLE VIII.

## Trustee Powers

The Trustee and any Successor Trustee, shall have all powers enumerated under the Indiana Code and any other power that may be granted by law, to be exercised without the necessity of court approval, as the Trustee, in the Trustee's sole discretion, determines to be in the best interest of the beneficiary.

The Trustee may petition a court of competent jurisdiction for instructions and guidance in the administration of this Trust.

Said Trustee powers are to be construed in the broadest possible manner and shall include the following, and shall pertain to both principal and income, but shall in no way be limited thereto:

**A. Power to Sell.**

To sell, assign, exchange, convey or otherwise transfer any part or all of the property held under the terms hereof at such times and upon such terms and conditions as the Trustee may deem prudent and for the best interest of the Trust, and to receive and receipt for the proceeds of any such sale, assignment, conveyance, or other transfer.

**B. Power to Invest.**

To invest and reinvest any and all funds coming into the Trustee's possession for investment in such securities or property, real or personal, as the Trustee may in the Trustee's absolute and uncontrolled discretion deem proper and suitable, including corporate stocks of all classes.

**C. Power to Invest in Non-Income Producing Property.**

To invest in non-income producing, depreciating assets if, in the Trustee's discretion, such investment appears prudent and is in the best interest of *Ben.

**D. Power to Conserve Trust Estate.**

To take any action with respect to conserving or realizing upon the value of any property of the Trust, and with respect to foreclosures, reorganizations, or other changes affecting the property of the Trust; to collect, pay, contest, compromise, or abandon demands of or against the Trust, wherever situated; and to execute contracts, notes, conveyances, and other instruments, including instruments containing covenants and warranties binding upon and creating a charge against the Trust.

**E. Power to Take All Actions Necessary.**

To exercise all the above powers and to do such other acts which in the Trustee's sole judgment are needful or desirable for the proper and advantageous control, management and investment or reinvestment of the property held in trust hereunder to the same extent and with the same effect as might legally be done by an individual in absolute ownership and control of said property.

## ARTICLE IX.

## Succession of Trustees

**A. Replacement of Trustee**

*Ben, *Ben's guardian, or any interested party on *Ben's behalf, may petition the Court to replace the Trustee.

**B. Resignation of Trustee**

Any Trustee may resign at any time by giving written notice, specifying the effective date of the resignation, to *Ben, *Ben's guardian and to the Court.

**C. Successor Trustee**

In the event that Robert W. Fechtman resigns as Trustee, or is removed, then the Court shall designate a Successor Trustee.

IN WITNESS WHEREOF, the parties have executed this Trust Agreement on the day and year first written above.

_____

*GNTR,
Grantor

_____

Robert W. Fechtman,
Trustee

**TRUST FOR THE SOLE BENEFIT OF**

***BFN**

**SCHEDULE A**

| DATE | DESCRIPTION | VALUE |
|---|---|---|

**APPENDIX H**

## NON-NEGOTIABLE PROMISSORY NOTE AND SECURITY AGREEMENT

In consideration of a loan from _____ ("the Lender") in the amount of $_____, the undersigned, _____ ("the Borrower"), promises to pay only to _____ the total sum of $_____, including interest at the rate of _____, according to the following schedule for repayment that is feasible: in equal monthly installments as follows: the sum of $_____ shall be paid on _____, _____, and on the _____ day of each month thereafter until _____, _____ when the last monthly installment shall be paid. Upon the death of the Lender, the payments shall be paid to _____.

The Borrower shall **not** have the right or privilege to prepay note.

The Borrower shall **not** have the right to make any deferral payments or to make any balloon payments pursuant to this note.

The cancellation of the balance of this note upon or after the death of the Lender is **prohibited**. The Lender, the Lender's heirs, and the personal representative of the Lender's estate are **prohibited** from canceling the unpaid balance of this note upon or after the death of the Lender.

The Borrower expressly intends to repay this note by pledging personal property. The Borrower hereby pledges and grants to Lender a security in all of the Borrower's personal property, including the Borrower's accounts and deposits at any financial institution.

This promissory note is **non-negotiable**, and it **cannot** be sold or transferred under any circumstance.

Dated this _____ day of _____, _____.

_____
Borrower

_____
Approved by Lender

RECEIVED SEP 4 1998

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

"People helping people help themselves"

Frank O'Bannon, Governor
State of Indiana

*Office of General Counsel*
402 W. WASHINGTON STREET, ROOM W451
INDIANAPOLIS, IN 46204-2744

Venita J. Moore, Acting Secretary

September 2, 1998

William J. Holwager
Holwager, Byers and Caughey
1818 Main Street
Beech Grove, IN 46107

Re: Farm Corporations

Dear Bill:

You requested a determination regarding the treatment of farm corporations for Medicaid eligibility purposes. Your question concerned a situation in which a family places farm property and related assets into a closely held corporation, so that the family members are shareholders in the corporation, rather than holding title to the property. As you noted in your letter, income-producing real property, including farm property, is exempt from consideration in determining Medicaid eligibility; however, stock is a countable resource.

I have discussed your question with Medicaid policy staff. While each case must be evaluated individually, because there may be unique facts that affect Medicaid eligibility, there are certain principles that will be applied in determining how shares in a closely held farm corporation are counted for purposes of Medicaid eligibility. Shares in such a corporation are exempt if the corporate assets would be exempt if they were not owned by a corporation. Examples of assets that are exempt for Medicaid eligibility purposes are income-producing real property (ICES manual §2620.15.20), income-producing personal property (ICES manual §2615.35.15), and business bank accounts (ICES manual §2615.10.05.05). If the corporation holds non-exempt assets, the corporate stock, or at least a portion of it, could be considered a countable resource, depending on the specific facts of the case.

Placing non-exempt assets into a farm corporation could subject a Medicaid applicant or recipient to a transfer penalty if there are restrictions on the sale of the stock. Placing non-exempt, liquid assets into a corporation, and taking shares of stock in return, would be considered a transfer under 405 IAC 2-3-1.1(b)(1)(B) if the individual relinquishes or limits the right to liquidate or sell the asset. Whether a

penalty is assessed, and the length of the penalty, depend on the facts of a given case. In some cases, there may not be a penalty because the individual receives earnings that compensate for the transfer .

I apologize for the delay in responding to your question. This is a complex issue, and it has taken some time to reach a solution that does not unnecessarily penalize farm owners, while still maintaining program integrity. If you have any questions, please feel free to call me at (317) 232-1282, or (812) 265-2027, ext. 311.

Sincerely,

Donna Stolz Sembroski

Donna Stolz Sembroski
Staff Attorney

cc: Cindy Stamper, Division of Family and Children

County:
Medicaid Case No.:

# RESOURCE ASSESSMENT FOR MEDICAL ASSISTANCE TO THE AGED, BLIND, AND DISABLED

**Resource Assessment Date:**

| Community spouse<br>Name:<br>Address: | Institutionalized spouse<br>Name:<br>Facility:<br>**Admission Date:** |
|---|---|

| Resource Description | Policy or Account No. | Comm. Spouse Owned | Inst. Spouse Owned | Other joint owner | Means of documenta-tion | Countable value |
|---|---|---|---|---|---|---|
| | | | | | Exhibit 1 | $ |
| | | | | | Exhibit | |
| | | | | | Exhibit | |
| | | | | | Exhibit | |
| | | | | | Exhibit | |
| | | | | | Exhibit | |
| | | | | | Exhibit | |
| Total Combined Countable Resources | | | | | | 0.00 |
| **Spousal Share** | | | | | | **0.00** |
| Spousal Share + Institutionalized Spouse Resource Limit | | | | | | **2,000.00** |

RE: John Doe
CASE NUMBER: 1000000000
ISSUE: Denial of Medicaid Assistance to the Aged

## PROPOSED FINDINGS OF FACT AND DECISION

The Administrative Law Judge now makes the following Findings of Fact:

l. That John Doe was approved for a Waiver Service Plan on March 1, 2022. He did not have a prior period of continuous institutionalization of at least thirty days. The Appellant's spouse, Jane Doe, resides in the community.

2. That an application for Medical Assistance to the Aged for the appellant was filed with FSSA on March 2, 2022, seeking assistance effective March 1, 2022.

3. That on April 15, 2022, FSSA denied this application due to resources exceeding the limit. The Appellant was mailed the notice of denial on April 15, 2022.

4. That a request for a hearing was received at the FSSA Document Center on April 21, 2022, from Claire E. Lewis, attorney.

5. All parties waived their rights to an oral hearing. The Appellant is represented in this cause by Claire E. Lewis.

6. That pursuant to Public Law l00-360, the Medicare Catastrophic Coverage Act (MCCA) of l988, Section l924 was added to the Social Security Act which mandates the use of special income and resource criteria in determining eligibility for certain institutionalized individuals. The special resource criteria pertains to individuals who are legally married to community spouses and who begin continuous periods of institutionalization in a hospital or health facility on or after September 30, l989.

7. That the Appellant meets the requirements for special income and resource criteria considerations. These special criteria require the calculation of a couple's combined countable resources as of the date of the institutionalized individual's admission to an institution.

8. That the DFR and the Appellant stipulate to the accuracy of the resource assessment which shows the combined countable resources of the Appellant and the community spouse on the first day of the first continuous period of institutionalization on or after September 30, 1989 (March 2, 2022) to have been $95,000.00.

9. That according to §2635.10.10.05 of the Indiana Health Coverage Program Policy Manual (IHCPPM), the community spouse's share of these resources is half of the couple's combined countable resources or $47,500.00.

l0. That according to §3005.15.00 of the IHCPPM, "The community spousal resource limit is the greatest of the following amounts effective January 1, 2022:

a. the state standard of $27,480;
b. the spousal share, up to a maximum of $137,400;
c. any amount of resources ordered by a court against the institutionalized spouse for the support of the community spouse; or
d. the amount established by an Administrative Law Judge as the result of an appeal.

11. That the community spouse's resource standard was established by FSSA as $47,500.00.

l2. That according to §2635.10.10.10 of the Integrated Policy Manual for Public Assistance Programs, the "total value of the couple's non-exempt resources, including real property owned by the institutionalized spouse, is compared to their combined resource standards (the community spouse standard plus the standard for a single individual). If countable resources are equal to or less than the standard, the institutionalized spouse is eligible for assistance for that month, which is the initial month of special resource eligibility for the institutionalized spouse. For subsequent months during the continuous period of institutionalization, resources owned solely by the community spouse are exempt."

l3. That there was no dispute that the couple's combined resources as of March 2, 2022, were $95,000.00. This amount minus the community spouse resource standard of $47,500.00 exceeds the $2,000.00 institutionalized spouse resource standard.

l4. That according to 42 USC l396r-5(e)(2)(c), "If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance."

l5. That the community spouse has no monthly income other than Social Security and interest income from investments. Once Mr. Doe is approved for Medicaid, she will not be allocated any of his income, as his income is less than the Special Income Level of $2,523.

16. That the Appellant used the highest annual rate of return payable on a 60 month term certificate of deposit at Bank of Indiana at which appellant and community spouse do much of their banking to demonstrate that even if the couple earned this high interest rate on all of the investments, the investments owned by the couple would not produce income sufficient to bring the community spouse up to the spousal income standard set by Medicaid.

17. That by investing all of the appellant's assets as of March 2, 2022 ($95,000.00) at the highest interest rate (2.0%) paid on a long term certificate of deposit, the appellant would then be generating a monthly interest income of $158.33 ($95,000.00 x 2.0% = $1,900 annual interest ÷ 12 = $158.33 per month interest income).

18. That the spousal income standard is $2,178 and the shelter standard is $653, according to §3010.20.10 of the IHCPPM.

19. The parties agree that the community spouse has no monthly excess shelter expenses, so that her monthly income maintenance allowance is $2,178.

20. That the community spouse's total monthly income of $1,500.00 (Social Security income) plus $158.33 (projected hypothetical monthly interest income using an interest rate of 2.0% on all investments owned as of March 1, 2022) = $1,658.33 total monthly income.

21. That the community spouse's resources standard of $47,500.00 invested at an annual rate of 2.0% would not be sufficient to meet the income standard for the community spouse.

22. That the community spouse's resource allowance of $47,500.00, when considered in relation to the amount of income generated by the resource standard is inadequate to raise the community spouse's income to the monthly maintenance allowance. Therefore, a different community spouse resource allowance must be substituted.

23. That the Administrative Law Judge establishes the community spouse resource standard to be $95,000.00.

24. That the Appellant's remaining resources are less than $2,000, therefore, the appellant is resource eligible for Medical Assistance effective March 1, 2022.

25. That the Appellant has 90 days from receipt of this decision to transfer resources to the community spouse. (Integrated Policy Manual for Public Assistance Programs, §2635.10.10.15.)

26. That the County has 30 days from the date of this decision to generate a new notice of eligibility.

**APPENDIX L**

**ARTICLE**

**Disposition of Residuary Estate**

In the event that my spouse, *S, does not survive me by thirty (30) days, then I devise and bequeath all my residuary estate, being all property, real and personal, tangible and intangible, wherever situated, in which I may have any interest at the time of my death not otherwise effectively disposed of to my children, *C1 and *C2, in equal shares, per stirpes.

In the event that my spouse, *S, survives me by thirty (30) days, then I devise and bequeath *[one-half (1/2) of my residuary estate to my children, *C1 and *C2, in equal shares, per stirpes.

I devise and bequeath the remainder of]* my residuary estate to *TE as Trustee, in trust for my spouse. Such property shall be administered in accordance with the following terms and conditions:

**A. Payments of Net Income and Principal.**

The Trustee may, after taking into consideration all other forms of income and property of my spouse from any source, pay to or for the benefit of my spouse, at any time and from time to time, so much of the net income of the trust estate and so much of the principal of such trust estate as the Trustee, in the Trustee's sole discretion, deems advisable to meet *his/her needs for reasonable comfort and welfare and to protect *his/her legal rights. These expenditures may be made even to the point of exhaustion of the Trust assets as the Trustee may determine. However, in making any such distributions, the Trustee shall consider the effect of such distributions on any public benefit which *S may be eligible to receive, and shall make such distributions in a manner that will supplement and not reduce such benefits. Any net income not so distributed shall be incorporated into the principal of the trust estate.

**B. Distribution Upon *S's Death.**

Upon *S's death, the Trustee shall pay the expenses of my spouse's funeral and expenses of wrapping up *his/her affairs as the Trustee, in the Trustee's sole and absolute discretion, deems necessary, taking into account my spouse's probate assets and all other sources of payment. The Trustee shall then, as soon as practicable, terminate the Trust and distribute the remaining trust assets to my children, *C1 and *C2, in equal shares, per stirpes.

**C. Spendthrift Clause.**

No interest under the Trust created in this Will shall be transferable or assignable by any beneficiary, or be subject during a beneficiary's life to the claims of *his/her creditors, including alimony claims. If any attempt should be made by any creditor of a beneficiary to reach any rights, benefits or interests of a beneficiary, the Trustee may apply the income or principal to which the beneficiary would otherwise be entitled, as the Trustee, in the Trustee's sole discretion, shall determine.

**D. Payments.**

During the administration of the Trust, the Trustee may pay, transfer, or assign income or principal in any one or more of the following ways: (1) directly to a beneficiary; (2) to the guardian of the person or of the property of a beneficiary during the incapacity of a beneficiary; or, (3) by expending such income or principal directly to a provider of goods or services for the reasonable comfort, welfare and protection of the legal rights of a beneficiary.

**E. Governing Law.**

This instrument and the dispositions hereunder shall be construed and regulated and their validity and effect shall be determined by the laws of the State of Indiana.

**F. Failure of Trust Purpose.**

If the Trustee determines, after consultation with legal counsel, that because of a change in the law the existence of this Trust or any benefits provided hereunder will disqualify *S from any necessary payments (as determined by the Trustee), benefits or services from any government program so as to frustrate the purpose of this Trust to be a supplemental source of assistance to *S, and an amendment to the Trust would, in the opinion of legal counsel, enable the purpose of the Trust to be substantially carried out, then the Trustee may amend the Trust. If, in the opinion of counsel, the trust purpose cannot be substantially carried out by amending the Trust, then the Trustee may prematurely terminate this Trust and distribute the assets pursuant to Paragraph B of this 0.

In the event the spendthrift provisions of this Trust, as they apply to *S, are not enforced by order or determination of a Court, then the Trustee may prematurely terminate this Trust and distribute the assets pursuant to Paragraph B of this 0. If the existence of this Trust or any benefits provided hereunder as determined by order of a Court should disqualify *S from necessary payments, benefits or services from government programs, the Trustee shall consult with legal counsel and any other appropriate professionals or organizations concerning the continued existence of the Trust, and then may, in the Trustee's sole and absolute discretion, terminate this Trust and distribute all of the assets pursuant to Paragraph B of this 0.

**G. Trustee's Compensation.**

Any Trustee shall be entitled to reasonable compensation for services in administering and distributing the trust property and to reimbursement for expenses.

**H. Succession of Trustee.**

In the event that *TE is unable or unwilling to serve as Trustee, then * is designated as Successor Trustee.

## ARTICLE

## Powers of the Trustee

The Trustee and any Successor Trustee shall have all powers enumerated under the Indiana Code and any other power that may be granted by law, to be exercised without the necessity of court approval as the Trustee, in the Trustee's sole discretion, determines to be in the best interests of the beneficiaries. Said powers are to be construed in the broadest possible manner and shall include the following, and shall pertain to both principal and income, but shall in no way be limited thereto:

**A. Retain Property.**

To retain any property received from my estate without liability for loss due to lack of diversification or non-productivity.

**B. Investments.**

To invest and reinvest the trust estate in any kind of real or personal property without regard to any law restricting investment by a Trustee and without regard to current income.

**C. Sale of Trust Assets.**

To sell any trust property, for cash or on credit, at public or private sales; to exchange any trust property for other property; and to determine the prices and terms of sales and exchanges.

**D. Actions with Regard to Trust Assets.**

To take any action with respect to conserving or realizing upon the value of any trust property, and with respect to foreclosures, reorganizations, or other changes affecting the trust property; to collect, pay, contest, compromise, or abandon demands of or against the trust estate, wherever situated; and to execute contracts, notes, conveyances, and other instruments, including instruments containing covenants and warranties binding upon and creating a charge against the trust estate.

**APPENDIX M**

# QUALIFIED INCOME TRUST
# FOR
# FIELD(SETTLOR (Caps))

THIS TRUST AGREEMENT is made on FIELD(Month) FIELD(day), 2022, between FIELD( Settlor) as the **SETTLOR** and FIELD(Trustee) as the **TRUSTEE**.

## ARTICLE ONE
## NAME OF TRUST

THIS TRUST shall for convenience be known as the **FIELD(SETTLOR (Caps)) QUALIFIED INCOME TRUST** and it shall be sufficient that it be referred to as such in any instrument of transfer, deed, assignment, bequest or devise.

## ARTICLE TWO
## PURPOSE OF THIS TRUST

The **SETTLOR's** intention in maintaining this Trust is to create a trust described under 42 U.S.C. Section 1396p(d)(4)(B) to enable the **SETTLOR** to seek and obtain Medicaid benefits despite having available income in excess of the Special Income Level (hereinafter referred to as the SIL) ($2,382 in 2022) established by the Indiana Family & Social Services Administration (hereinafter referred to as the FSSA). This Trust will be composed only of pension, Social Security, and any other income to the Settlor, as provided by Article 4, together with any accumulated income in this Trust.

## ARTICLE THREE
## IRREVOCABLE TRUST

This Trust is irrevocable except that:

A. Settlor may amend this Agreement to name new, successor or additional trustees.

B. Any Trustee may amend this Agreement to name one or more replacement or successor trustees to himself or herself.

C. The Settlor or the Trustee may amend this Agreement in accordance with requests of FSSA or to comply with rules, regulations and/or law as may be existing from time to time.

## ARTICLE FOUR
## ADDITIONS TO PRINCIPAL

For any month during which the **SETTLOR** receives Medicaid benefits that are subject to the SIL, **SETTLOR** hereby covenants and agrees to deliver or cause to be delivered to the **TRUSTEE** at a minimum the **SETTLOR's** monthly income which exceeds the SIL ($2,523 in 2022). No property other than part or all of the **SETTLOR's** income (and the earnings thereon) shall be used to fund this Trust.

## ARTICLE FIVE
## APPOINTMENT OF TRUSTEE

5.1. APPOINTMENT. The **SETTLOR** hereby nominates and appoints FIELD(Trustee) as **TRUSTEE** of this Trust.

5.2. RESIGNATION. Any **TRUSTEE** hereunder (whether originally designated herein or appointed as successor) shall have the right to resign at any time by giving thirty (30) days notice to that effect to the current income SETTLOR (or beneficiaries) of the Trust and the Successor Trustee named in 5.03 below.

5.3. APPOINTMENT OF SUCCESSOR. A. Upon the death, resignation or incapacity of FIELD(Trustee), FIELD(Successor Trustee) shall serve as the Successor **TRUSTEE**. Upon the death, resignation or incapacity of FIELD(Successor Trustee) to serve as **TRUSTEE**, then the SETTLOR or the SETTLOR's guardian or attorney in fact shall appoint a Successor **TRUSTEE** and shall notify such trustee of such appointment. Such Successor **TRUSTEE** must be an individual or a trust company or bank able to act as such.

B. Any Successor **TRUSTEE** hereunder shall possess and exercise all powers and authority herein conferred on the original **TRUSTEE**. If Co-Trustees are named, either Co-Trustee may act independent of the other Co-Trustee. No Successor **TRUSTEE** shall be personally liable for any act or omission of any predecessor. With the approval of the **SETTLOR**, if living and competent to act, otherwise a Court of competent jurisdiction or the **SETTLOR**, a Successor **TRUSTEE** may accept the account rendered and the property received as a full and complete discharge to a predecessor **TRUSTEE** without incurring any liability for so doing.

5.4. COMPENSATION. Every **TRUSTEE** shall be entitled to receive compensation for services rendered hereunder commensurate with the time and expertise required. Further, every **TRUSTEE** shall be reimbursed for all reasonable expenses incurred in the management and protection of the Trust Estate.

5.5. ACCOUNTING. The **TRUSTEE** shall render to the **SETTLOR** statements of account or receipts and disbursements as **TRUSTEE** upon request of the **SETTLOR**.

## ARTICLE SIX
## TRUST ADMINISTRATION DURING SETTLOR'S LIFETIME

The TRUSTEE shall make distributions from the trust in amounts and for the purposes necessary to maintain eligibility of the SETTLOR for Medicaid benefits. The TRUSTEE shall not make any distribution which jeopardizes the Settlor’s eligibility for Medicaid benefits. The TRUSTEE may pay the following items from the trust:

A. Amounts needed to pay the SETTLOR's share of the costs (currently described as income spend down or liability) for any services covered by Medicaid, to the extent those costs are not covered by Medicaid or by other sources.

B. Spousal and family allocation, if any.

C. The amount of any exemptions or deductions which are allowed by Medicaid in Post Eligibility budgeting, including but not limited to, health insurance premiums, medical expenses not subject to payment by a third party and not covered by Medicaid, and court-ordered guardianship fees.

D. Incurred medical expenses of the primary beneficiary as defined by the Medicaid program.

E. Amounts reasonably necessary to establish and maintain the existence of this Trust, including but not limited to bank fees, Trustee fees and commissions, and reasonable attorneys' fees.

F. Payments to or on behalf of the SETTLOR that will not result in the loss or reduction of benefits available to the SETTLOR from the medical assistance program.

G. A monthly personal needs allowance for the SETTLOR, if all of the SETTLOR's income, or more than the amount by which the SETTLOR's total income exceeds the personal needs allowance, is deposited into the Trust.

Any excess income may be distributed to or on behalf of the SETTLOR (or the SETTLOR'S spouse, if married) only to the extent allowed under the Indiana Administrative Rules, the Indiana Program Policy Manual, other state law or policy, federal law, or the CMS State Medicaid Manual governing Medicaid assistance and Qualified Income Trusts. In no event shall the amounts distributed exceed such amount determined by the state of Indiana as required or allowed to be disbursed and not cause the SETTLOR's Medicaid qualification to thereby be jeopardized.

If the SETTLOR delivers income to the TRUSTEE for a month for which the SETTLOR is not approved for and does not receive Medicaid services subject to the SIL, then the TRUSTEE shall pay such income directly to the SETTLOR or the SETTLOR's representative.

If any money remains after the monthly distributions and deductions from the Trust, such funds shall be retained and be added to the principal of the Trust.

No part of the principal or undistributed income of the Trust shall be considered available to nor be distributed to the SETTLOR except as provided above.

## ARTICLE SEVEN
## TERMINATION OF TRUST

7.1. DISTRIBUTION UPON DEATH OF SETTLOR. This Trust shall terminate upon the death of the **SETTLOR** and any portion of the Trust estate remaining after payment of the amounts described in Section 7.02 below shall be distributed to beneficiaries designated by the **SETTLOR** by will, trust, or other document. If no such designation has been made, then any remaining portion shall be distributed to **SETTLOR's** heirs under Indiana's law of intestate succession. In disposing of any Trust property subject to a designation by a will, the **TRUSTEE** may rely upon an instrument admitted to probate in any jurisdiction as the will of the **SETTLOR** or may assume that the **SETTLOR** died intestate without making any designation if the **TRUSTEE** has no notice of a will or other document making a designation within three months after his or her death.

7.2. REPAYMENT TO THE STATE FOR MEDICAID PROVIDED. Upon the death of the **SETTLOR**, the **TRUSTEE** shall distribute and deliver to the state of Indiana, and/or to any other state in which Medicaid benefits were received, all amounts remaining in the Trust up to an amount as certified by its appropriate agency equal to the total medical assistance paid on behalf of the **SETTLOR** under Medicaid.

## ARTICLE EIGHT
## TRUST ADMINISTRATION

8.1. PROTECTION FROM CLAIMS OF CREDITORS. A. The **TRUSTEE** is herein vested with full and complete title to all property and the estate embraced within the Trust hereof, both as to principal and income therefrom, subject only to the execution of the Trust herein.

B. The **SETTLOR** shall not have the power to sell, assign, transfer, encumber or in any other manner anticipate or dispose of his or her interest in the Trust Estate or the income produced thereby. No disposition, charge or encumbrance of either the income or principal of any of the Trust or any part thereof by the **SETTLOR** shall be of any validity or legal effect or be in any wise regarded by the **TRUSTEE**.

C. If any creditor of the **SETTLOR** asserts a claim against the **SETTLOR's** interest in the trust estate, the **TRUSTEE** shall object to such claim and shall notify FSSA of the assertion of any such claim.

D. This provision shall not bar any remedy sought by either the state of Indiana, or any other state or county, for the purpose of obtaining amounts payable thereto in accordance with this Trust Agreement.

## ARTICLE NINE
## TRUSTEE POWERS

9.1. POWERS OF TRUSTEE. The **TRUSTEE** shall have all the powers with respect to the **SETTLOR's** trust estate given a trustee with respect to trust property under Ind. Code 30-4-3-3 and given to all unsupervised personal representatives with respect to estate property under Ind. Code 29-1-7.5-3. Where these powers are similar to each other, the broadest of these powers or discretions shall control.

9.2. CONTRACT PROTECTION. The **TRUSTEE** shall have the power to protect the **TRUSTEE** from personal liability in any contract entered into on behalf of the trust.

9.3. CHANGE LOCATION OF TRUST. The **TRUSTEE** shall have the power to transfer the situs or location of the trust to any place.

9.4. PROTECTING SETTLOR'S ELIGIBILITY FOR PUBLIC BENEFITS. The **TRUSTEE** is authorized, as it may in its discretion deem appropriate, to take whatever administrative or judicial steps which may be necessary to continue the **SETTLOR's** eligibility for any public assistance programs, including obtaining instructions from a court of competent jurisdiction and obtaining a ruling that the Trust principal is not available to the **SETTLOR** for such eligibility purposes. All costs

incurred by the **TRUSTEE** in relation to these matters, including reasonable attorney's fees, shall be a proper charge to the Trust unless payment of such costs or fees would result in rendering the **SETTLOR** ineligible for any public benefits to which he would otherwise be entitled.

## ARTICLE TEN
## MISCELLANEOUS

10.1. Whenever Trustee or Trustees is used herein, the same shall be deemed to include any singular Trustee or Successor Trustee or Trustees. Any reference in this Trust to the FSSA shall include any successor public agency or program which becomes vested with the responsibility for providing publicly supported nursing home care to eligible Indiana residents or the residents of the State in which the **SETTLOR** resides.

10.2. To the same effect as if it were the original, anyone may rely upon a copy of this instrument certified by the **TRUSTEE** to be a true and accurate copy of the original.

10.3. No one dealing with the **TRUSTEE** need inquire concerning the validity of anything it purports to do nor need see to the application of the monies paid or any property transferred by it upon the order of the Trustee.

10.4. This Agreement and the Trusts hereby created shall be governed by and construed in all respects in accordance with the laws of the state of Indiana, except that if the **SETTLOR** moves to another state to reside there on a continuing basis, then it shall be governed by the laws of the new state of residence.

IN WITNESS WHEREOF, the **SETTLOR** and **TRUSTEE** have signed this Trust Agreement on FIELD(Month) FIELD(day), 2022.

**SETTLOR:**

_____
FIELD(Settlor)

**TRUSTEE:**

_____
FIELD(Trustee)

We certify that the above instrument was on the date thereof signed and sealed by FIELD( Settlor) as **SETTLOR** and by FIELD(Trustee) as **TRUSTEE** in our presence and that we, in the **Settlor's** and **Trustee's** presence and in the presence of each other, have signed our names as witnesses.

| | |
|---|---|
| _____ | _____ |
| Witness | Witness |
| _____ | _____ |
| _____ | _____ |
| Witness' Address | Witness' Address |

THIS INSTRUMENT PREPARED BY: Dennis K. Frick, Attorney at Law (#7910-48), Indiana Legal Services, Inc., 151 N. Delaware Street, Suite 1800, Indianapolis, Indiana 46204-2534 [(317) 631-9410 x 2254].

_____QUALIFIED INCOME TRUST (MILLER TRUST)
[Name of Beneficiary]

_____ [name of settlor] hereby creates a trust, to be known as _____ [name of primary beneficiary] Qualified Income Trust and to be governed by the terms set out below:

The primary beneficiary of the trust is _____ [name of primary beneficiary]. The purpose of this trust is to assure eligibility of the primary beneficiary for medical assistance program benefits.

The property to be placed in the trust is the income received by the primary beneficiary from the following source(s):

1. _____
2. _____
3. _____

No property other than the primary beneficiary's income may be placed in the trust. The trust may receive any or all of the primary beneficiary's income, but the entire amount of the income allocated to the trust from each income source shall be deposited directly in the trust account or deposited in the trust account in the same month the income is received by the primary beneficiary.

The Trustee shall make distributions from the trust in amounts and for the purposes necessary to maintain eligibility of the primary beneficiary for medical assistance program benefits, notwithstanding any other provisions of this document. Among the requirements of the medical assistance program at the time of establishment of this trust, which the Trustee shall meet as long as and to the extent required, is the requirement that the trustee make payments from the trust in the following priority, no later than the last day of the month after the income is received by the trust:

1. A monthly personal needs allowance for the primary beneficiary, if the primary beneficiary is depositing his/her entire income into the trust;
2. A sum to the spouse of the primary beneficiary, if any, sufficient to provide but not exceed the minimum monthly maintenance needs allowance for the spouse as provided by Title XIX of the Social Security Act;
3. Incurred medical expenses of the primary beneficiary as defined by the Medicaid program;
4. The cost of medical assistance provided to the primary beneficiary;
5. Payments to or on behalf of the primary beneficiary that will not result in the loss or reduction of benefits available to the beneficiary from the medical assistance program.

_____ (name of initial trustee) shall serve as Trustee of this trust. In the event the Trustee resigns, becomes legally incapacitated or dies while holding office, _____ (name of successor trustee) shall serve as successor trustee. Any Trustee may, while serving as Trustee, appoint one or more successor trustees. If there is no named trustee eligible or willing to serve as Trustee, any interested person may apply to the primary beneficiary of the trust in order to be appointed Trustee. No bond shall be required for any Trustee. The Trustee shall have all powers given to a trustee by the Indiana Trust Code, Ind. Code § 30-4.

The Trust's assets, income and distributions shall not be subject to anticipation, assignment, pledge, sale or transfer in any manner, nor shall the primary beneficiary have the power to anticipate or encumber such interest nor shall such interest, while in the possession of the Trustee, be liable for, or subject to the debts, contracts, obligations, liabilities or torts of the primary beneficiary.

This trust is irrevocable. This trust shall terminate upon the death of the primary beneficiary. Upon the death o f the primary beneficiary, the Trustee shall distribute to the Indiana Family and

Social Services Administration or its successor agency any remaining trust property up to an amount equal to the total medical assistance paid on behalf of the primary beneficiary by the State of Indiana. The Trustee shall distribute any remaining trust property to _____ [name(s) of distributee(s)].

Signed the _____ day of _____20____.

_____ _____

Settlor Initial Trustee

**APPENDIX O**

_____QUALIFIED INCOME TRUST (MILLER TRUST)
[Name of Primary Beneficiary]

**Definitions**:

**Primary Beneficiary**: The Medicaid recipient/applicant who needs the trust due to having income above the Medicaid "Special Income Level" ($2,523 in 2022).

**Settlor**: The person who is setting up the Trust. (This can be the Medicaid recipient/applicant, an Authorized Representative, or anyone who manages the income of the Medicaid recipient/ applicant.)

**Trustee**: The person who manages the funds deposited into the Trust. There can also be a successor (back-up) Trustee appointed if the first initial Trustee cannot serve.

**Distributee(s)**: If there are funds in the Trust at the Medicaid recipient's death, those funds must be paid to the state to reimburse it for Medicaid benefits it paid. If at death there are more funds in the Trust than are owed to the state, then the Trustee will pay the remaining funds to the persons who are listed as "distributees" on the trust form.

**Special Income Level (SIL)**: The Special Income Level (SIL) is an income limit used for nursing home and some waiver services. If a Medicaid applicant/recipient has income above the SIL, the individual cannot qualify for Medicaid without a Qualified Income Trust. In 2022, the SIL is $2,523 per month.

_____ [name of Settlor] hereby creates a trust, to be known as the

_____ [name of Primary Beneficiary] Qualified Income Trust and to be governed by the terms set out below.

The Primary Beneficiary of the trust is _____ [name of Primary Beneficiary]. The purpose of this trust is to assure eligibility of the Primary Beneficiary for medical assistance program benefits.

For any month during which the Primary Beneficiary receives Medicaid services that are subject to the SIL, at a minimum the Primary Beneficiary's monthly income which exceeds the SIL will be placed into this trust. This Trust will be composed only of pension, Social Security, or any other income received by the Primary Beneficiary, together with any accumulated income in this Trust. No property other than income of the Primary Beneficiary shall be placed in the Trust.

_____ [name of initial Trustee] shall serve as Trustee of this Trust. If the Trustee resigns, becomes legally incapacitated or dies, _____[name of successor Trustee] shall serve as successor trustee. Any Trustee may, while serving as Trustee, appoint one or more successor trustees. If there is no named trustee eligible or willing to serve as Trustee, any interested person may apply to be appointed Trustee. No bond shall be required for any Trustee. The Trustee shall have all powers given to a trustee by the Indiana Trust Code, Ind. Code § 30-4.

The Trustee shall make distributions from the trust in amounts and for the purposes necessary to maintain eligibility of the Primary Beneficiary for Medicaid benefits. The Trustee shall not make any distribution which jeopardizes the Primary Beneficiary's eligibility for Medicaid benefits. The Trustee may pay the following items from the trust:

1. A monthly personal needs allowance for the Primary Beneficiary, if all of the Primary Beneficiary's income, or more than the amount by which the Primary Beneficiary's total income exceeds the personal needs allowance, is deposited into the Trust.

2. Amounts needed to pay the primary beneficiary's share of the costs (currently described as liability or income spend down) for any services covered by Medicaid, to the extent those costs are not covered by Medicaid or by other sources.

3. Spousal and family allocation, if any.

4. Incurred medical expenses of the primary beneficiary as defined by the Medicaid program.

5. Amounts reasonably necessary to establish and maintain the existence of this Trust, including the costs and expenses of managing and administering this Trust.

6. Payments to or on behalf of the primary beneficiary that will not result in the loss or reduction of benefits available to the primary beneficiary from the medical assistance program.

The Trust's assets, income and distributions shall not be subject to anticipation, assignment, pledge, sale or transfer in any manner, nor shall the primary beneficiary have the power to anticipate or encumber such interest nor shall such interest, while in the possession of the Trustee, be liable for, or subject to the debts, contracts, obligations, liabilities or torts of the primary beneficiary.

This Trust is irrevocable. This Trust shall terminate upon the death of the primary beneficiary. Upon the death of the primary beneficiary, the Trustee shall distribute to the Indiana Family and Social Services Administration or its successor agency any remaining trust property up to an amount equal to the total medical assistance paid on behalf of the primary beneficiary by the State of Indiana. The

Trustee shall distribute any remaining trust property to _____

_____ [name(s) of Distributee(s)].

Date Signed: _____

_____ _____

Settlor Initial Trustee

**APPENDIX P**

## Information on Establishing a Qualified Income (Miller) Trust

### What is a Miller Trust?

Changes were made to the Medicaid eligibility rules effective June 1, 2014 that make nursing home and "waiver" recipients subject to an income eligibility limit. A Miller Trust is a special type of trust known as a Qualified Income Trust ("QIT") that allows people who would otherwise be over Medicaid's income limit to be eligible for nursing home services, waiver services, or Money Follows the Person services. The term "Miller Trust" is a nickname for this type of trust. The more formal name for the trust is Qualified Income Trust ("QIT").

### Who Needs a Miller Trust?

A person who is in a nursing home with Medicaid benefits, who will be entering a nursing home and applying for Medicaid benefits, is receiving or applying for Medicaid Home and Community Based Services, also known as "waiver services," or is receiving or will receive Money Follows the Person services needs a QIT if that person's income is more than the income eligibility limit of $2,523 in 2022. This limit is referred to as the Special Income Level ("SIL"). The limit is subject to change each year on January 1. **A person whose individual income is at or below the SIL does not need a QIT.**

Because most persons with income above this limit cannot afford to privately pay for their care, federal law allows a person with income above the SIL to be eligible for Medicaid by using a QIT. Once a person agrees to place at least all monthly income above the SIL ($2,523 in 2022) into a QIT account, the person will not be disqualified from receiving Medicaid due to the income.

### What Income Is Counted?

Only the income of the Medicaid applicant or recipient is counted. If married, the spouse's income is not counted.

**Gross** income is counted. This is often different than the amount of income actually received. With Social Security benefits, often a Medicare Part B premium and sometimes a Part D premium is deducted from monthly benefits. Medicaid counts the **gross** Social Security benefit **before any premiums are deducted**. Similarly, taxes or insurance may be deducted from pension benefits. Medicaid counts the gross pension benefit **before any deductions**. VA Aid and Attendance benefits are not to be counted.

**How Do I Establish a Valid QIT?**

You can retain an attorney knowledgeable about Medicaid. Also, FSSA has a QIT form on its website at www.in.gov/fssa/files/Qualified_Income_Trust_Miller_Trust_template.pdf . Or you can complete the form QIT presented with this handout. It is similar to FSSA's form.

**Definitions of Terms Used in the QIT Form:**

**Primary Beneficiary**: The Medicaid recipient/applicant who needs the trust due to having income above the Medicaid "Special Income Level."

**Settlor**: The person who is setting up the Trust. (This can be the Medicaid recipient/applicant, an Authorized Representative, or anyone who manages the income of the Medicaid recipient/ applicant.)

**Trustee**: This person manages the funds deposited into the Trust. There can also be a successor (back-up) Trustee appointed if the first initial Trustee cannot serve.

**Distributee(s)**: If there are funds in the Trust at the Medicaid recipient's death, those funds must be paid to the state to reimburse it for Medicaid benefits it paid. If at death there are more funds in the Trust than are owed to the state, then the Trustee will pay the remaining funds to the persons who are listed as "distributees" on the trust form.

**Special Income Level (SIL)**: The Special Income Level (SIL) is a monthly income limit used for nursing home and some waiver services. If a Medicaid applicant / recipient has income above the SIL, the individual cannot qualify for Medicaid without a Qualified Income Trust. The SIL is $2,523 in 2022.

**Step 1**. Decide who will sign as the Settlor. Can the Medicaid applicant/recipient understand and sign the QIT form? If so, then his or her name should be inserted on the lines as the Settlor and as the Primary Beneficiary.

If the Medicaid applicant / recipient is not able to understand and sign the QIT form, then decide who will sign as the Settlor. Someone else can set up the trust for the benefit of the applicant / recipient. This could be a guardian, the attorney-in-fact under a Power of Attorney, the Authorized Representative for the Medicaid application, or anyone who has access to the person's income. The person who agrees to set up the QIT for the applicant / recipient can then be listed as the Settlor. The applicant / recipient is listed as the Primary Beneficiary.

**Step 2**. Decide who will serve as trustee to handle any funds placed into the trust account. One can list both an initial trustee and a successor trustee who can step in when the initial trustee can no longer serve.

**Step 3**. Once the blanks in the QIT form are completed, then the Settlor and the initial Trustee both need to sign and date the form. The person listed as trustee agrees to serve as trustee by signing the form.

**The Trustee Must Open a Trust Account Once the QIT Form is Signed.**

The Trustee must set up a financial account for the trust. Take the completed QIT Form to a bank or other financial institution to open the "[Primary Beneficiary] Qualified Income Trust" account. Set this up at the same financial institution where the recipient's income is deposited.

The financial institution must use the recipient's Social Security number as the ID number for the account. It should not ask you to get a separate EIN for the trust. The IRS rules say that the recipient's Social Security number must be used as the ID number for the trust.

If a new account is needed, the financial institution will likely require a small deposit (for example, $10 to $20) as initial funding. A small amount of the beneficiary's money or money from another person may be deposited to open a new account. The money that a bank requires as a deposit to open a new account is not counted as a resource or income to the beneficiary.

**What Must Be Deposited into the QIT Trust Account?**

Deposits to the trust can only be made from the recipient's income. Do not deposit anything else, such as excess assets, into the account.

There are choices on how much income is deposited into the Trust. In every month a nursing home or waiver recipient has income above the SIL, **at a minimum the amount of gross income above the SIL must be deposited into the Trust to qualify for Medicaid.**

- Deposit only the gross income above the SIL into the Trust account. It may be possible to arrange with the bank to automatically transfer the excess income from a non-trust account to the Trust account each month.

- Another option is to deposit all the income into the Trust account. One can arrange with the payor(s) of the income to directly deposit the income to the Trust account. Or all of the income can be transferred to the Trust account after being received in the non-trust account.

- If one receives income from multiple sources, one could arrange for income from one or more of the sources, but not all, to be deposited into the Trust account, so long as the amount being deposited is equal to or greater than the amount by which the total income exceeds the SIL.

EXAMPLE

Mabel is in a nursing home receiving Medicaid. She receives gross Social Security benefits of $1,600 per month and a gross pension of $1,000 per month which are direct deposited into her bank account. Her gross income is $2,700, which is $177 above the 2022 SIL. She must deposit at least $177 per month into a QIT account in 2022 to be eligible for Medicaid. She can sign a QIT, name a trustee, and the trustee can establish a separate QIT account. She can then arrange to have the bank automatically transfer $177 into her QIT account each month after the income is received.

In the alternative, Mabel could arrange to have all of her income deposited or transferred into the QIT account. The bank may be willing to convert her non-trust account into a QIT account, although it may require the opening of a new QIT account. She could receive all income into her non-trust account and then transfer it into the QIT account, or she may be able to arrange to have the Social Security Administration and the pension company directly deposit her income into the QIT account. As a third alternative, she could arrange to have either her Social Security or her pension deposited into the QIT account. She could also choose any other amount to deposit so long as it is at least $177. She could for example deposit $180 every month so that she is certain she is depositing enough.

**She must deposit at least $177 per month into the QIT account for each month in 2022 to be eligible for Medicaid.** Note that the minimum amount that needs to be deposited may change in future years or if Mabel's income changes before then.

**What Must Be Reported to FSSA Once the QIT Is Signed?**

Once the QIT form is signed and the trust account is opened, a copy of the trust and of the QIT account information must be provided to FSSA. The financial institution can provide a copy of the signature card or other document showing how the account is titled. You should also provide verification of the initial deposit. FSSA has also asked for proof that arrangements have been made to deposit income on a monthly basis to FSSA.

**How Can Information Be Reported to FSSA?**

When submitting information, FSSA requests that you use a Document Cover Sheet that is bar coded for your case. If you do not already have this Sheet, you can obtain it on-line at https://fssabenefits.in.gov/bp/#/. Log in or Register and enter the information requested, including your Medicaid case number. After you enter the requested information, the website will bring up your case, where you can click on "Print Bar coded Cover Sheet." You can then submit your Document Cover Sheet and verifications to FSSA by:

- Fax to 1-800-403-0864

- Mail to: Family and Social Services Administration
  P.O. Box 1810
  Marion, IN 46952

- Take the documents to a local FSSA Division of Family Resources office.

**How Does the Trustee Manage the Account?**

Once a QIT is in place, FSSA will calculate a "post eligibility" budget to determine your liability (the portion that the individual recipient owes). FSSA will use all of your income, including any income deposited into the QIT account, in this calculation. The QIT can be used to pay the liability or other deductions allowed by FSSA. If all the income is placed into the Trust, then the Trustee can transfer a Personal Needs Allowance to the recipient. This is $52 for a nursing home resident and $$2,523 in 2022 for a waiver services recipient.

EXAMPLES

Mabel, in a nursing home, has total income in 2022 of $3,000 per month. She transfers her excess income of $477 into her QIT account each month. She will owe a liability of $2,948 ($3,000 - her personal needs allowance of $52) to the nursing home each month. (Her liability could be less if she pays a health insurance premium or qualifies for another deduction.) Her trustee will pay $477 from the QIT account to the nursing home each month, and the rest of the liability will be paid from the non-trust account. The trustee will likely need to keep some minimum balance in the account to keep it open.

Mabel, with total income of $3,000 per month, arranges for all of her income to be deposited into her QIT account. Her trustee will transfer Mabel's personal needs allowance of $52 to Mabel and will pay the liability from the QIT account. In the alternative, she could transfer $2,948 to the trust account each month and then pay the full liability of $2,948 from the trust account. Mabel could also arrange to deposit $2,948 into the trust, which will then be used to pay the liability.

Harold, married, in a nursing home, has 2022 total income of $2,800 per month. He deposits $277 ($2,800 - $2,523 = $277; rounds up deposit to $280) into the trust. FSSA calculates his budget and determines that his wife is entitled to an income allocation of $1,000 and he owes a liability of $1,748 per month to the nursing home. The trustee can use the $280 deposited into the trust to pay either (a) the nursing home as part of the liability (the rest of the liability will be paid from the income he did not deposit into the trust) or (b) the wife as part of her income allocation (the rest of the income allocation will be paid from the income he did not deposit into the trust account).

Mildred is on the Aged & Disabled Waiver. She has 2022 gross income of $3,000 per month and pays $200 per month for a Medicare supplement policy. She deposits her excess income of $477 ($3,000 - $2,523) into the trust account. FSSA should set a liability or spend down of $277 per month ($3,000 income - $2,523 personal needs allowance - $200 health insurance premium). The trustee will pay the health insurance premium from the trust account. Medicaid will not pay the first $277 of claims that are submitted each month. The provider can bill Mildred for those amounts, which her trustee can pay from the trust account.

**What Happens if the Recipient Goes Off Medicaid?**

The Trust is irrevocable but the recipient only needs to make deposits for each month that he or she receives Medicaid and has income above the SIL. If the recipient leaves the nursing home and stops receiving Medicaid benefits, then deposits no longer need to be made into the trust account. If the trust account balance is zero, it can be closed. If the individual returns to a nursing home, the trust account can be reopened and deposits can resume. There will not be a need to sign a new QIT form.

**What Happens When the Recipient Dies?**

The trust says that at death all funds in the trust account are to be paid to the State of Indiana to reimburse it for Medicaid benefits received by the beneficiary. Funds are to be made payable to "Treasurer, State of Indiana" and mailed to Estate Recovery Unit, Office of Medicaid Policy and Planning, Family and Social Services Administration, 402 W Washington St., Rm. W374, MS 07, Indianapolis IN 46204-2776. An explanation should be included explaining that the checks are the funds remaining in a "Miller Trust" account. Although it is unlikely there will be more funds in the Trust than are owed to the state, if there are then the Trustee will pay the remaining funds to the person or persons listed as "distributees" on the trust form.

Prepared by Senior Law Project, 1200 Madison Ave., Suite 300, Indianapolis, IN 46225
Revised: April 20, 2022

## MEDICAID HCBS WAIVER LIABILITY SUMMARY NOTICE

DENNIS FRICK
151 N.DELAWARE ST SUITE 1800
INDIANA LEGAL SERVICES INC.
INDIANAPOLIS, IN 46204-0000

Mailing Date of Notice: 03/04/2019
Member Name: [redacted]
Medicaid ID Number: 10[redacted]

This is a summary of your medical bills that were processed from 02/01/2019 through 02/28/2019 for HCBS Waiver Liability. Some bills are not filed with Medicaid until after Medicare or other insurance has paid. This notice includes claims filed by your medical providers.

**THIS IS NOT A BILL**

Keep this notice and compare it to the bills sent by your medical providers.

Your medical providers may bill you for the amounts shown in the column marked "Amount Applied to HCBS Waiver Liability". Medicaid will not pay the amounts in this column.

### Medical Expenses Processed for your February, 2019 HCBS Waiver Liability

| Date of Service | Provider/ Service | Amount Charged | Paid by Other Insurance | Billed to Medicaid | Amount Applied to HCBS Waiver Liability | See Notes Section | Future Credit | Possible Refund |
|---|---|---|---|---|---|---|---|---|
| 11/28/18 | MIDWEST AMBULANCE SERVICE INC<br>8450 W WASHINGTON ST<br>INDIANAPOLIS, IN 46231<br><br>COPAY | $4,000.00 | | $4,000.00 | $106.31 | C, T, X | $2.00 | |
| 11/28/18 | MIDWEST AMBULANCE SERVICE INC<br>8450 W WASHINGTON ST<br>INDIANAPOLIS, IN 46231<br><br>COPAY | $4,000.00 | | $4,000.00 | $106.31 | C, T, X | $2.00 | |
| 02/01/19 | [redacted]<br>INDIANAPOLIS, IN 46227<br><br>ATTENDANT CARE SERVICE<br>(15M | $931.20 | | $931.20 | $931.20 | | $2.00 | |

APPENDIX R

## Medical Expenses Processed for your February, 2019 HCBS Waiver Liability

| Date of Service | Provider/ Service | Amount Charged | Paid by Other Insurance | Billed to Medicaid | Amount Applied to HCBS Waiver Liability | See Notes Section | Future Credit | Possible Refund |
|---|---|---|---|---|---|---|---|---|
| 02/05/19 | HOOK-SUPERX, L.L.C.<br>640 S STATE RD 135<br>GREENWOOD, IN 46142<br><br>COPAY | $3.00 | | | $3.00 | C, F | $2.00 | |
| 02/07/19 | STATELINE MEDICAL EQUIPMENT<br>1090 CHESTER BLVD<br>RICHMOND, IN 47374<br><br>DME/Medical Supply Dealer | $141.27 | $34.71 | | $8.86 | A | $2.00 | |
| 02/16/19 | [redacted]<br>INDIANAPOLIS, IN 46227<br><br>ATTENDANT CARE SERVICE /15M | $931.20 | | $931.20 | $804.32 | B | $2.00 | |
| 02/18/19 | HOOK-SUPERX, L.L.C.<br>640 S STATE RD 135<br>GREENWOOD, IN 46142<br><br>COPAY | $1.31 | | | $1.31 | C, F | $2.00 | |
| 02/18/19 | HOOK-SUPERX, L.L.C.<br>640 S STATE RD 135<br>GREENWOOD, IN 46142<br><br>COPAY | $3.00 | | | $3.00 | C, F | $2.00 | |
| 02/19/19 | HOOK-SUPERX, L.L.C.<br>640 S STATE RD 135<br>GREENWOOD, IN 46142<br><br>COPAY | $1.31 | | | $1.31 | C, F | $2.00 | |
| 02/20/19 | HOOK-SUPERX, L.L.C.<br>640 S STATE RD 135<br>GREENWOOD, IN 46142<br><br>COPAY | $3.00 | | | $3.00 | C, F | $2.00 | |

**Notes Section:**

A Our records show that Medicare and or other health insurance paid on this claim. Check your Medicare Summary Notice or other insurance explanation of benefits for details of what they paid, how much the other insurance allowed for this expense, and how much you can be billed after the other insurance has paid. Amounts paid by other insurance and any provider 'write-off' in excess of the allowed amount are not applied to your HCBS Waiver Liability obligation. Legal Authority: 405 IAC 2-3-10

**Notes Section:**

B Any amount of the provider's bill to Medicaid that is more than your HCBS Waiver Liability obligation will be paid by Medicaid in accordance with reimbursement rules.

C This co-payment amount is itemized on the Summary Notice as a separate line item and is part of the total medical expense for the service you received.

F The co-payment amount for this service is itemized on a separate line.

T An adjustment to a claim previously processed was made. This changed the amount applied to your HCBS Waiver Liability. This happened because the system made a claims payment correction. You may be due a refund if you paid the medical provider.

X The medical expense exceeded your HCBS Waiver Liability obligation and was carried forward to be applied to a future month.

**Summary of your HCBS Waiver Liability status for the months listed in this notice as of 03/04/2019.**

| Month/Year | HCBS Waiver Liability Amount | Status |
|---|---|---|
| February 2019 | $1,756.00 | HCBS Waiver Liability satisfied |

**Summary of your HCBS Waiver Liability status for the months listed in this notice as of 03/04/2019.**

| Month/Year | HCBS Waiver Liability Amount | Status |
|---|---|---|

**If you have any questions**

If you have any questions about your Medicaid eligibility or how your HCBS Waiver Liability amount is calculated, please contact a caseworker at the local Division of Family Resources office or contact the FSSA Call Center at 1-800-403-0864. If you have any questions about the claims information on this notice you may contact Member Services at: (317) 713-9627 or 1-800-457-4584.

Contact Medicare or your other insurance if you have questions about the amount they paid on your bill.

**If you disagree with the amount applied to HCBS Waiver Liability for claims on this notice**

You have the right to file an appeal within 30 days (plus 3 days for mailing) from the date of this notice. If you appeal, you will be notified by mail of the date, time and place for your fair hearing. At the hearing you may represent yourself, or you may have a friend, authorized representative, or an attorney represent you.

Follow these instructions to appeal:

1) Circle the item(s) you disagree with and explain in writing why you disagree.

2) Send this notice, or a copy, to MS04, Family and Social Services Administration, Hearings and Appeals, 402 W. Washington Street, Indianapolis, IN 46204

3) Sign your name here: _____

4) Phone Number: (_____)_____

*DFR21AE0100PHKMO4*

**ELIGIBILITY NOTICE OF ACTION**
**Medicaid / Hoosier Healthwise**
State Form 1110 (R14 / 4-16) FI 0619M

| Name of applicant / recipient (*last, first, middle*) | Case Number | Office Telephone Number |
|---|---|---|
| [redacted] | [redacted] | 1-800-403-0864 |

Address (*number and street, city, state, ZIP code*)
[redacted]

| Application date (*month, day, year*) | **Mailing date of Notice** (*month, day, year*) 4/11/2018 |
|---|---|
| ☐ Your application was approved<br>☐ Full Coverage ☐ Pregnancy coverage ☒ Medicare cost sharing only<br>☐ Full coverage except long term care ☐ Emergency care only<br>☐ Family Planning Services Only<br>Your health coverage is effective . | ☒ Your application was denied. |
| ☐ The following months were denied: | Reason(s) for denial<br>INCOME EXCEEDS PROGRAM ELIGIBILITY STANDARDS FOR MA J 01 (QMB) |

Supporting law(s) or regulations:

| | | |
|---|---|---|
| ☐ You have a spend-down of $ effective | $ effective | $ effective |
| ☐ You have a premium of $ effective | $ effective | $ effective |

☐ You are responsible for paying the following monthly amount (liability) to the facility where you reside:

$ effective $ effective $ effective

☐ You are eligible for the Medicare Savings Program effective _____.

☐ Medicaid will pay your Medicare Part A & B premiums, the Part A & B deductibles and coinsurance. This is called "QMB".

☐ Medicaid will pay your Medicare Part A and Part B Premiums.

☐ Effective your health coverage is ☐ Continued ☐ Discontinued ☐ Suspended

☐ Your spend-down is $ . ☐ Your patient liability is $ . ☐ Your premium is $ .

Reason(s) for the Action

☐ Because you filed a timely appeal of a proposed action to stop or reduce your benefits prior to the effective date of the proposed adverse action, your coverage is being maintained at the previous level until a decision is made on your appeal.
☐ The action was ordered by the Administrative Law Judge on your appeal. Appeal rights explained on this notice are for information only. Refer to your hearing decision for further Agency Review rights.
☐ Other:

Supporting law(s)or regulation(s) for adverse action:

Additional Information:

# $0 PREMIUM LIS QUALIFIED PLANS IN INDIANA FOR 2022

| MEDICARE PRESCRIPTION DRUG PLANS | | |
|---|---|---|
| **Organization** | **Plan Name** | **Contact Information** |
| Aetna Medicare | SilverScript Choice | 1-833-526-2445 |
| Cigna | Cigna Secure Rx | 1-800-735-1459 |
| Clear Spring Health | Clear Spring Health Value Rx | 1-877-317-6082 |
| Humana Insurance Company | Humana Basic Rx Plan | 1-800-706-0872 |
| United Healthcare | AARP Medicare Rx Saver Plus | 1-888-867-5564 |
| Wellcare | Wellcare Classic | 1-888-293-5151 |

| MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION DRUGS | | | | | | |
|---|---|---|---|---|---|---|
| **Covered Counties in Indiana** | **Company Name** | **Plan Name** | **Monthly Premium (Includes Part C + D)** | **Annual Drug Deductible** | **Gap Coverage** | **Contact Information** |
| La Porte, Lake, Porter | Aetna Medicare | Aetna Medicare Assure Premier - Local HMO D-SNP Dual-Eligible (H3192-008) | $0 | $0 | No | 1-833-859-6031 TTY Users should call: 711 |
| Delaware, Hamilton, Hendricks, Johnson, Madison, Marion, Monroe, Morgan | Aetna Medicare | Aetna Medicare Assure Premier - Local HMO-POS Dual-Eligible (H3192-009) | $0 | $0 | No | 1-833-859-6031 TTY Users should call: 711 |
| Bartholomew, Boone, Brown, Clay, Clinton, Delaware, Fountain, Hamilton, Hancock, Hendricks, Howard, Jackson, Jennings, Johnson, Lawrence, Madison, Marion, Miami, Monroe, Montgomery, Morgan, Owen, Parke, Putnam, Shelby, Tippecanoe, Tipton, Vermillion, Vigo, Warren, Wayne | Aetna Medicare | Aetna Medicare Premier - Local PPO (H5521-302) | $0 | $0 | YES | 1-833-859-6031 TTY Users should call: 711 |
| All Counties | Anthem Blue Cross and Blue Shield | Anthem MediBlue Access Preferred – Local PPO (H1607-015) | $0 | $0 | YES | 1-855-593-0907 TTY Users should call: 711 |
| All Counties | Anthem HealthKeepers | Anthem MediBlue Dual Advantage – Local HMO D-SNP Dual-Eligible (H3447-020) | $0 | $0 | No | 1-855-679-0541 TTY Users should call: 711 |
| All Counties | Anthem HealthKeepers | Anthem MediBlue Extra – Local HMO (H3447-024) | $0 | $0 | YES | 1-855-679-0538 TTY Users should call: 711 |

| Covered Counties in Indiana | Company Name | Plan Name | Monthly Premium with full LIS | Annual Deductible with full LIS | Gap Coverage | Contact Information |
|---|---|---|---|---|---|---|
| Boone, Gibson, Hamilton, Hancock, Hendricks, Howard, Madison, Montgomery, Posey, Putnam, Shelby, Vanderburgh, Warrick | Ascension Complete | Ascension Complete St. Vincent DSNP -Local HMO D-SNP Dual-Eligible (H7925-003) | $0 | $0 | No | 1-844-578-1929 TTY Users should call: 711 |
| Allen, Brown, Elkhart, Fayette, Hamilton, Hancock, Johnson, Marion, St. Joseph | CareSource | CareSource Dual Advantage -Local HMO D-SNP Dual-Eligible (H7076-015) | $0 | $0 | No | 1-844-607-2830 TTY Users should call: 711 |
| Bartholomew, Boone, Clark, Clinton, Decatur, Delaware, Floyd, Grant, Harrison, Hendricks, Henry, Howard, Kosciusko, La Porte, Madison, Marshall, Morgan, Rush, Shelby, Tipton, Vigo | CareSource | CareSource Dual Advantage -Local HMO D-SNP Dual-Eligible (H7076-016) | $0 | $0 | No | 1-844-607-2830 TTY Users should call: 711 |
| Marion | CommuniCare Advantage | CommuniCare Advantage CSNP – Local HMO C-SNP Chronic Condition (H3727-001-1) | $0 | $0 | No | 1-855-969-5869 TTY Users should call: 711 |
| Clark, Elkhart, Fayette, Floyd, Hamilton, Hancock, Harrison, Howard, Johnson, Lake, Marion | CommuniCare Advantage | CommuniCare Advantage ISNP – Local HMO I-SNP Institutional (H3727-002-1) | $0 | $0 | No | 1-855-969-5869 TTY Users should call: 711 |
| Fountain, Vermillion, Warren | Health Alliance Medicare | Simplete 2 -Local HMO (H1463-024) | $0 | $0 | YES | 1-877-634-3390 TTY Users should call: 711 |
| **All Counties Except:** Adams, Allen, Boone, Clark, DeKalb, Delaware, Floyd, Hamilton, Hancock, Harrison, Hendricks, Huntington, Kosciusko, Johnson, Madison, Marion, Morgan, Noble, Wells, Whitley | Humana | HumanaChoice –Local PPO (H5216-111) | $0 | $0 | No | 1-800-833-2364 TTY Users should call: 711 |
| Clark, Floyd, Harrison | Humana | HumanaChoice –Local PPO (H5216-188) | $0 | $0 | No | 1-800-833-2364 TTY Users should call: 711 |
| Benton, Blackford, Carroll, Cass, Clay, Crawford, Daviess, Dearborn, Decatur, Dubois, Fayette, Fountain, Franklin, Fulton, Grant, Greene, Henry, Jasper, Jay, Jefferson, Jennings, Knox, Lagrange, Lawrence, Martin, Miami, Newton, Ohio, Orange, Owen, Parke, Perry, Pike, Pulaski, Randolph, Ripley, Rush, Scott, Spencer, Starke, Steuben, Sullivan, Switzerland, Union, Vermillion, Vigo, Wabash, Warren, Washington, Wayne, White | Humana | Humana Value Plus –Local PPO (H5216-193) | $0 | $0 | No | 1-800-833-2364 TTY Users should call: 711 |

| Covered Counties in Indiana | Company Name | Plan Name | Monthly Premium with full LIS | Annual Deductible with full LIS | Gap Coverage | Contact Information |
|---|---|---|---|---|---|---|
| Benton, Blackford, Carroll, Cass, Clay, Crawford, Daviess, Dearborn, Decatur, Dubois, Elkhart, Fayette, Fountain, Franklin, Fulton, Gibson, Greene, Henry, Jasper, Jay, Jefferson, Jennings, Knox, Lawrence, Martin, Miami, Newton, Ohio, Orange, Owen, Parke, Perry, Pike, Posey, Pulaski, Randolph, Ripley, Rush, Scott, Spencer, Starke, Steuben, Sullivan, Switzerland, Union, Vanderburgh, Vermillion, Vigo, Warren, Warrick, Washington, Wayne, White | Humana | HumanaChoice SNP-DE –Local PPO D-SNP Dual-Eligible (H5525-048) | $0 | $0 | No | 1-800-833-2364 TTY Users should call: 711 |
| Adams, Allen, Bartholomew, Boone, Brown, Cass, Clinton, DeKalb, Delaware, Elkhart, Gibson, Grant, Hamilton, Hancock, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Johnson, Kosciusko, La Porte, Lagrange, Lake, Lawrence, Madison, Marion, Marshall, Miami, Monroe, Montgomery, Morgan, Noble, Porter, Posey, Putnam, Shelby, St. Joseph, Tippecanoe, Tipton, Vanderburgh, Wabash, Warrick, Wells, Whitley | Humana | Humana Gold Plus SNP-DE –Local HMO D-SNP Dual-Eligible (H5619-054) | $0 | $0 | No | 1-800-833-2364 TTY Users should call: 711 |
| Clark, Floyd, Harrison | Humana | Humana Gold Plus SNP-DE –Local HMO D-SNP Dual-Eligible (H5619-076) | $0 | $0 | No | 1-800-833-2364 TTY Users should call: 711 |
| Bartholomew, Boone, Brown, Cass, Clinton, Delaware, Hamilton, Hancock, Hendricks, Henry, Howard, Jackson, Johnson, Lawrence, Madison, Marion, Miami, Monroe, Montgomery, Morgan, Putnam, Shelby, Tippecanoe, Tipton | Humana | Humana Gold Plus – Local HMO (H5619-124) | $0 | $0 | No | 1-800-833-2364 TTY Users should call: 711 |
| Benton, Brown, Carroll, Cass, Clinton, Decatur, Fountain, Hamilton, Hancock, Hendricks, Henry, Howard, Jennings, Madison, Marion, Miami, Montgomery, Parke, Pike, Putnam, Randolph, Rush, Shelby, Tipton, Union, Warren, White | MDwise Medicare | Mdwise Medicare Inspire Plus – Local HMO (H7746-002) | $0 | $0 | YES | 1-833-958-4036 TTY Users should call: 711 |
| Benton, Brown, Carroll, Cass, Clinton, Decatur, Fountain, Hamilton, Hancock, Hendricks, Henry, Howard, Jennings, Madison, Marion, Miami, Montgomery, Parke, Pike, Putnam, Randolph, Rush, Shelby, Tipton, Union, Warren, White | MDwise Medicare | Mdwise Medicare Inspire Duals – Local HMO D-SNP Dual-Eligible (H7746-004) | $0 | $0 | No | 1-833-958-4036 TTY Users should call: 711 |
| All Counties | UnitedHealthcare | UnitedHealthcare Dual Complete – Local PPO D-SNP Dual-Eligible (H0271-005) | $0 | $0 | No | 1-888-834-3721 TTY Users should call: 711 |
| Allen, Boone, DeKalb, Delaware, Elkhart, Grant, Hamilton, Hancock, Hendricks, Henry, Howard, Huntington, Johnson, Kosciusko, La Porte, Lake, Madison, Marion, Marshall, Monroe, Montgomery, Morgan, Noble, Porter, Shelby, St. Joseph, Tippecanoe, Wabash, Wells | UnitedHealthcare | UnitedHealthcare Nursing Home Plan – Local PPO I-SNP Institutional (H0710-013) | $0 | $0 | No | 1-888-834-3721 TTY Users should call: 711 |
| Adams, Allen, Cass, DeKalb, Elkhart, Fulton, Grant, Huntington, Jay, Kosciusko, Lagrange, Marshall, Miami, Noble, St. Joseph, Steuben, Wabash, Wells, Whitley | UnitedHealthcare | AARP Medicare Advantage Choice Plan 1 – Local PPO (H2228-019) | $0 | $0 | YES | 1-800-555-5757 TTY Users should call: 711 |

| Covered Counties in Indiana | Company Name | Plan Name | Monthly Premium with full LIS | Annual Deductible with full LIS | Gap Coverage | Contact Information |
|---|---|---|---|---|---|---|
| Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Clinton, Decatur, Delaware, Fayette, Fountain, Hamilton, Hancock, Hendricks, Henry, Howard, Johnson, Lawrence, Madison, Marion, Monroe, Montgomery, Morgan, Orange, Putnam, Randolph, Rush, Shelby, Tippecanoe, Tipton, Union, Warren, Wayne, White | UnitedHealthcare | AARP Medicare Advantage Choice Plan 1 – Local PPO (H2228-021) | $0 | $0 | YES | 1-800-555-5757 TTY Users should call: 711 |
| Crawford, Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick | UnitedHealthcare | AARP Medicare Advantage Choice Plan 1 – Local PPO (H2228-022) | $0 | $0 | YES | 1-800-555-5757 TTY Users should call: 711 |
| Jasper, La Porte, Lake, Newton, Porter, Pulaski, Starke | UnitedHealthcare | AARP Medicare Advantage Choice Plan 1 – Local PPO (H2228-064) | $0 | $0 | YES | 1-800-555-5757 TTY Users should call: 711 |
| Clark, Dearborn, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Ohio, Ripley, Scott, Switzerland, Washington | UnitedHealthcare | AARP Medicare Advantage Choice – Local PPO (H2228-065) | $0 | $0 | YES | 1-800-555-5757 TTY Users should call: 711 |
| All Counties | WellCare by Allwell | Wellcare Dual Access – Local HMO D-SNP Dual-Eligible (H3499-005) | $0 | $0 | No | 1-866-277-6583 TTY Users should call: 711 |
| **All Counties Except:** Vermillion, Vigo | WellCare by Allwell | Wellcare Assist - Local HMO (H3499-008) | $0 | $0 | No | 1-866-277-6583 TTY Users should call: 711 |
| Allen, Lake, Marion | Zing Health | Zing Open Access IN - Local HMO-POS (H4624-015) | $0 | $0 | YES | 1-866-946-4458 TTY Users should call: 711 |
| Allen, Lake, Marion | Zing Health | Zing Complete Plus IN – Local HMO-POS D-SNP Dual-Eligible (H4624-016) | $0 | $0 | No | 1-866-946-4458 TTY Users should call: 711 |
| Marion | Zing Health | Zing Dual Platinum Plus – Local HMO-POS D-SNP Dual-Eligible (H4624-018) | $0 | $0 | No | 1-866-946-4458 TTY Users should call: 711 |

**If you join a Medicare drug plan that isn't listed above, you may have to pay a monthly premium.**
**Those eligible for Partial LIS will have a reduced premium and deductible, not $0.**

APPENDIX U

## Eligibility Notice for Health Coverage

Indiana Family and Social Services Administration
PO Box 1810
Marion, IN 46952
Phone/Fax: 1-800-403-0864

Payee Name :

Case Number : 601

AG Number :

Program : Health Coverage

Mailing Date : APRIL 07, 2021

115 N Girls School Rd
Indianapolis, IN 46214

**IMPORTANT NOTICE ABOUT YOUR BENEFITS**

Dear

Your application for Health Coverage dated MARCH 02, 2021 has been approved.

Your health coverage is effective MAY 01, 2021.

The following person(s) are eligible for health coverage:

You were also eligible for the following month(s):

| |
|---|
| APRIL 2021 |
| MARCH 2021 |

You are responsible for a liability payment for long term care services. If you are/were residing in a long term care facility, you are responsible for making the liability payment to that facility. If you are receiving home and community based services under a Medicaid waiver, you will be responsible for making the waiver liability payment to the appropriate medical providers.

Your ongoing liability amount will be $3303.00 beginning MAY 01, 2021.

Your liability amounts for the prior month(s) are:

| Months | Liability | Spend Down | Premium |
|---|---|---|---|
| APRIL 2021 | $3303.00 | $0.00 | $0.00 |

You were not eligible for the month(s) of:

| |
|---|
| FEBRUARY 2021 |
| JANUARY 2021 |
| DECEMBER 2020 |

Because:



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- VALUE OF RESOURCES EXCEEDS PROGRAM ELIGIBILITY STANDARD
- INCOME EXCEEDS PROGRAM ELIGIBILITY STANDARDS
- YOUR QUALIFIED INCOME TRUST (MILLER TRUST) IS NON-COMPLIANT WITH ONE OR MORE OF THE MEDICAID REQUIREMENTS.
- ASSISTANCE GROUP IS INELIGIBLE DUE TO TRANSFER OF RESOURCES

Legal Basis: IC 12-15-3-1 IC 12-15-2-3.5 42 USC 1396P(D)(4)(B) 7 CFR 273.8(i)

You are not eligible for the additional program that pays your Medicare cost sharing. However, your full Medicaid coverage will continue without change.

The resources, income and/or expenses of the following individuals were considered in determining your eligibility.

Your Health Coverage does not include payment for nursing facility services or home and community-based waiver services because we determined that property was transferred in order for you to become eligible for Health Coverage as follows:

| Individual | Date of Transfer | Amount |
|---|---|---|
| | FEBRUARY 26, 2021 | $4600.00 |

This penalty is in effect from MARCH 01, 2021 through MARCH 21, 2021 in accordance with Section 1917(c) of the Social Security Act.

If you disagree with this determination you have the right to appeal as explained at the end of this notice. The appeal would be about the merits of the determination. For example, you may disagree with the value of the property, what you received in return for the property, or the way the rules were applied to your circumstance.

If you believe that this restriction on your Health Coverage benefits will cause you a hardship, you can file for a hardship exception. In filing for a hardship exception, you agree that you have no dispute about the facts or interpretations of law that we used to apply the penalty. If you file an appeal on the merits, you cannot file for a hardship exception.

A hardship exception to the penalty must be requested within 30 days of the date of this notice if you choose not to file an appeal. In a hardship request you must substantiate that the transfer penalty will cause you to be deprived of food, clothing, shelter, or other necessities of life, or will deprive you of medical care such that your health is endangered.

A "Request for Hardship Exception-Transfer of Property" form can be obtained on the internet at www.in.gov/fssa/ompp, or by calling the Office of Medicaid Policy and Planning at 317/232-4966. A hardship exception can be requested by:
the applicant;
the applicant's personal representative; or
the facility in which the applicant currently resides if written consent is provided by the applicant or applicant's personal representative.

Please note that if the penalty has been imposed due to the purchase of an annuity or transaction involving an annuity, a hardship exception is not approvable.

**Financial Summary Table:**

| From Date: FEBRUARY 01, 2021 | To Date: FEBRUARY 28, 2021 | |
|---|---|---|
| **Description** | | **Amount** |
| INDIVIDUAL UNEARNED INCOME | : | $3652.15 |
| SPOUSE UNEARNED INCOME | :+ | $0.00 |

| | | |
|---|---|---|
| PARENTAL DEEMED INCOME | :+ | $0.00 |
| GENERAL INCOME DISREGARD | :- | $0.00 |
| INELIGIBLE CHILD ALLOCATION | :- | $0.00 |
| ELIGIBLE CHILD ALLOCATION | :- | $0.00 |
| ESSENTIAL PERSON ALLOCATION | :- | $0.00 |
| INDIV SELF-EMPL NET EARNINGS | : | $0.00 |
| SPOUSE SELF-EMPL NET EARNINGS | :+ | $0.00 |
| INDIV ADDITIONAL EARNED INCOME | :+ | $0.00 |
| SPOUSE ADDITIONAL EARNED INCOME | :+ | $0.00 |
| REMAIN GEN INCOME DISREGARD | :- | $0.00 |
| REMAIN ALLOCATION | :- | $0.00 |
| EARNED INCOME DISREGARD | :- | $0.00 |
| COUNTABLE EARNED INCOME | := | $0.00 |
| PLAN FOR SELF SUPPORT | :- | $0.00 |
| INCOME STANDARD | :- | $2382.00 |
| SURPLUS INCOME | := | $0.00 |
| MEDICAL EXPENSES | : | $0.00 |
| GROSS SPEND-DOWN | : | $0.00 |
| MEDICAL PREMIUMS | :- | $0.00 |
| NET SPEND-DOWN | := | $0.00 |

**Financial Breakdown Table:**
Financial details for the individuals used in the calculation above are as follows and financial assets for the individuals used in the total deemed income calculation is listed below. Deeming is the process of counting a portion of the income of certain individuals in the benefit calculation.

| From Date: FEBRUARY 01, 2021 | | To Date: FEBRUARY 28, 2021 | | |
|---|---|---|---|---|
| **Deemed Calculation (Yes/No)** | **Individual** | **Type** | **Amount** | **Additional Information** |
| No | | UNEARNED INCOME | $235.93 | Retirement/Pension |
| No | | UNEARNED INCOME | $1638.72 | Retirement/Pension |
| No | | UNEARNED INCOME | $1777.50 | Social Security |

**Financial Summary Table:**

| From Date: JANUARY 01, 2021 | To Date: JANUARY 31, 2021 | |
|---|---|---|
| **Description** | | **Amount** |
| INDIVIDUAL UNEARNED INCOME | : | $3627.65 |
| SPOUSE UNEARNED INCOME | :+ | $0.00 |
| PARENTAL DEEMED INCOME | :+ | $0.00 |

| | | |
|---|---|---|
| GENERAL INCOME DISREGARD | :- | $20.00 |
| INELIGIBLE CHILD ALLOCATION | :- | $0.00 |
| ELIGIBLE CHILD ALLOCATION | :- | $0.00 |
| ESSENTIAL PERSON ALLOCATION | :- | $0.00 |
| INDIV SELF-EMPL NET EARNINGS | : | $0.00 |
| SPOUSE SELF-EMPL NET EARNINGS | :+ | $0.00 |
| INDIV ADDITIONAL EARNED INCOME | :+ | $0.00 |
| SPOUSE ADDITIONAL EARNED INCOME | :+ | $0.00 |
| REMAIN GEN INCOME DISREGARD | :- | $0.00 |
| REMAIN ALLOCATION | :- | $0.00 |
| EARNED INCOME DISREGARD | :- | $0.00 |
| COUNTABLE EARNED INCOME | := | $0.00 |
| PLAN FOR SELF SUPPORT | :- | $0.00 |
| INCOME STANDARD | :- | $1064.00 |
| SURPLUS INCOME | := | $0.00 |
| MEDICAL EXPENSES | : | $0.00 |
| GROSS SPEND-DOWN | : | $0.00 |
| MEDICAL PREMIUMS | :- | $0.00 |
| NET SPEND-DOWN | := | $0.00 |

**Financial Breakdown Table:**
Financial details for the individuals used in the calculation above are as follows and financial assets for the individuals used in the total deemed income calculation is listed below. Deeming is the process of counting a portion of the income of certain individuals in the benefit calculation.

| From Date: JANUARY 01, 2021 | | To Date: JANUARY 31, 2021 | | |
|---|---|---|---|---|
| **Deemed Calculation (Yes/No)** | **Individual** | **Type** | **Amount** | **Additional Information** |
| No | ! | UNEARNED INCOME | $235.93 | Retirement/Pension |
| No | ! | UNEARNED INCOME | $1638.72 | Retirement/Pension |
| No | | UNEARNED INCOME | $1777.50 | Social Security |

**Financial Summary Table:**

| From Date: DECEMBER 01, 2020 | To Date: DECEMBER 31, 2020 | |
|---|---|---|
| **Description** | | **Amount** |
| INDIVIDUAL UNEARNED INCOME | : | $3630.25 |
| SPOUSE UNEARNED INCOME | :+ | $0.00 |
| PARENTAL DEEMED INCOME | :+ | $0.00 |
| GENERAL INCOME DISREGARD | :- | $20.00 |

| | | |
|---|---|---|
| INELIGIBLE CHILD ALLOCATION | :- | $0.00 |
| ELIGIBLE CHILD ALLOCATION | :- | $0.00 |
| ESSENTIAL PERSON ALLOCATION | :- | $0.00 |
| INDIV SELF-EMPL NET EARNINGS | : | $0.00 |
| SPOUSE SELF-EMPL NET EARNINGS | :+ | $0.00 |
| INDIV ADDITIONAL EARNED INCOME | :+ | $0.00 |
| SPOUSE ADDITIONAL EARNED INCOME | :+ | $0.00 |
| REMAIN GEN INCOME DISREGARD | :- | $0.00 |
| REMAIN ALLOCATION | :- | $0.00 |
| EARNED INCOME DISREGARD | :- | $0.00 |
| COUNTABLE EARNED INCOME | := | $0.00 |
| PLAN FOR SELF SUPPORT | :- | $0.00 |
| INCOME STANDARD | :- | $1064.00 |
| SURPLUS INCOME | := | $0.00 |
| MEDICAL EXPENSES | : | $0.00 |
| GROSS SPEND-DOWN | : | $0.00 |
| MEDICAL PREMIUMS | :- | $0.00 |
| NET SPEND-DOWN | := | $0.00 |

**Financial Breakdown Table:**
Financial details for the individuals used in the calculation above are as follows and financial assets for the individuals used in the total deemed income calculation is listed below. Deeming is the process of counting a portion of the income of certain individuals in the benefit calculation.

| From Date: DECEMBER 01, 2020 | | To Date: DECEMBER 31, 2020 | | |
|---|---|---|---|---|
| **Deemed Calculation (Yes/No)** | **Individual** | **Type** | **Amount** | **Additional Information** |
| No | | UNEARNED INCOME | $235.93 | Retirement/Pension |
| No | | UNEARNED INCOME | $1638.72 | Retirement/Pension |
| No | | UNEARNED INCOME | $1755.60 | Social Security |

**Resource Summary Table:**

| From Date: FEBRUARY 01, 2021 | To Date: FEBRUARY 28, 2021 | |
|---|---|---|
| **Resource Type** | **Amount** | **Deemed Group** |
| VEHICLE | $0.00 | $0.00 |
| LIQUID ASSETS | $8140.00 | $0.00 |
| REAL/PERSONAL PROPERTY | $0.00 | $0.00 |
| ANNUITY | $0.00 | $0.00 |



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| | | |
|---|---|---|
| LIFE INSURANCE | $0.00 | $0.00 |
| DEEMED RESOURCES | $0.00 | $0.00 |
| TOTAL NON-EXEMPT RESOURCE AMOUNT | $28077.24 | $0.00 |
| RESOURCE MAXIMUM | $2000.00 | $0.00 |

**Resource Breakdown Table:**
Resource assets for the individuals used in the calculation above are as follows and financial assets for the individuals used in the total deemed income calculation is listed below. Deeming is the process of counting a portion of the income of certain individuals in the benefit calculation.

| From Date: FEBRUARY 01, 2021 | | To Date: FEBRUARY 28, 2021 | | |
|---|---|---|---|---|
| **Deemed Calculation (Yes/No)** | **Individual** | **Type** | **Amount** | **Additional Information** |
| No | | Liquid Asset | $8140.00 | Checking Account |
| No | | Trust | $19937.24 | |

**Resource Summary Table:**

| From Date: JANUARY 01, 2021 | To Date: JANUARY 31, 2021 | |
|---|---|---|
| **Resource Type** | **Amount** | **Deemed Group** |
| VEHICLE | $0.00 | $0.00 |
| LIQUID ASSETS | $7255.95 | $0.00 |
| REAL/PERSONAL PROPERTY | $0.00 | $0.00 |
| ANNUITY | $0.00 | $0.00 |
| LIFE INSURANCE | $0.00 | $0.00 |
| DEEMED RESOURCES | $0.00 | $0.00 |
| TOTAL NON-EXEMPT RESOURCE AMOUNT | $31947.78 | $0.00 |
| RESOURCE MAXIMUM | $2000.00 | $0.00 |

**Resource Breakdown Table:**
Resource assets for the individuals used in the calculation above are as follows and financial assets for the individuals used in the total deemed income calculation is listed below. Deeming is the process of counting a portion of the income of certain individuals in the benefit calculation.

| From Date: JANUARY 01, 2021 | | To Date: JANUARY 31, 2021 | | |
|---|---|---|---|---|
| **Deemed Calculation (Yes/No)** | **Individual** | **Type** | **Amount** | **Additional Information** |
| No | | Liquid Asset | $7255.95 | Checking Account |
| No | | Trust | $24691.83 | |

**Resource Summary Table:**

| From Date: DECEMBER 01, 2020 | To Date: DECEMBER 31, 2020 |
|---|---|

| Resource Type | Amount | Deemed Group |
|---|---|---|
| VEHICLE | $0.00 | $0.00 |
| LIQUID ASSETS | $8056.00 | $0.00 |
| REAL/PERSONAL PROPERTY | $0.00 | $0.00 |
| ANNUITY | $0.00 | $0.00 |
| LIFE INSURANCE | $0.00 | $0.00 |
| DEEMED RESOURCES | $0.00 | $0.00 |
| TOTAL NON-EXEMPT RESOURCE AMOUNT | $32501.27 | $0.00 |
| RESOURCE MAXIMUM | $2000.00 | $0.00 |

**Resource Breakdown Table:**
Resource assets for the individuals used in the calculation above are as follows and financial assets for the individuals used in the total deemed income calculation is listed below. Deeming is the process of counting a portion of the income of certain individuals in the benefit calculation.

| From Date: DECEMBER 01, 2020 | | To Date: DECEMBER 31, 2020 | | |
|---|---|---|---|---|
| Deemed Calculation (Yes/No) | Individual | Type | Amount | Additional Information |
| No | | Liquid Asset | $8056.00 | Checking Account |
| No | | Trust | $24445.27 | |

Effective June 1, 2014, eligibility for the Aged, Blind, and Disabled categories of Medicaid will be based on income, resource, and disability requirements that are used by the Social Security Administration. If you receive Supplemental Security Income (SSI) you will automatically become eligible for Medicaid as long as you are receiving SSI. If you are not receiving SSI, individuals will have to meet new income and resource limits. The income limit for most people who live in the community will be 100 percent of the federal poverty level (approximately $973 for a single individual and $1,311 for a married couple) and the amount of countable resources (assets) that an individual may have is $2,000 and $3,000 for a married couple. Individuals, who are not receiving SSI or Social Security Disability Insurance (SSDI) and are less than 65 years of age, may be required to apply for Social Security benefits so a determination of disability or blindness can be made.

**LIMITATIONS ON COST SHARING FOR MEDICAID-COVERED SERVICES FOR ADULTS**

SSA 1916A(c); 42 CFR 447.56

**MEMBERS WHO ARE EXEMPT FROM COST SHARING**

Children under age 18, pregnant individuals, former foster children, Native Americans and Alaskan Natives who have ever received a service or referral from an Indian health care provider, members living in a Medicaid-approved institution, and those receiving hospice care are exempt from cost sharing.

**IF YOU ARE COVERED THROUGH MANAGED CARE IN HOOSIER CARE CONNECT**

Your health plan will stop charging you copayments and premiums if you hit your 5 percent limit and will send you a notice that you do not have cost sharing for the remainder of that calendar quarter. If you have questions or think your family has met your 5 percent cost-sharing limit for covered services, please contact your health plan.

**IF YOU ARE ON A HOME AND COMMUNITY BASED WAIVER OR RECEIVING MEDICARE**

Indiana Medicaid will stop charging you premiums and copayments if you hit your 5 percent limit and will send you a notice

that you do not have cost sharing for the remainder of that calendar quarter. This is separate from any Medicare cost sharing you may have. If you have questions or think your family has met your 5 percent cost-sharing limit for covered services, please contact Indiana Medicaid at 1-800-457-4584.

**HOW WE CALCULATE YOUR COST SHARING**

Cost sharing is tracked based on monthly Medicaid premiums as well as copayments for claims submitted by health care providers within each calendar quarter (three months).

| Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|
| January 1st to March 31st | April 1st to June 30th | July 1st to September 30th | October 1st to December 31st |

Total cost sharing by members in your household is limited to 5 percent of quarterly household income. 5 percent of your current income is $547.82.

Copayments for Medicaid-covered services are listed in the table below.

| Service | Amount | Service | Amount | Service | Amount |
|---|---|---|---|---|---|
| Transportation costing $10 or less | $0.50 | Transportation costing $10.01 - $50 | $1 | Transportation costing $50.01 or more | $2 |
| Prescription Drugs | $3 | | | | |

The decision referenced in this notice was based, in whole or in part, on information obtained from the consumer reporting agency listed below. The decision made was not based upon a numeric credit score. The consumer reporting agency did not make the decision referenced in this notice and is unable to provide you with the specific reasons why the decision was made.

Under the Fair Credit Reporting Act, you have the right to obtain a free copy of your consumer file from the consumer reporting agency, if you request it no later than 60 days after you receive this notice. In addition, if you find that any information contained in the file you receive is inaccurate or incomplete, you have the right to dispute the matter with the consumer reporting agency.

You may contact the AVS agency at the toll free number listed below or in writing at the listed address to obtain the applicable contact information for your consumer reporting agency handling your file. The consumer reporting agency will be providing you any additional information regarding your rights under Fair Credit Reporting Act

Softheon Inc,
Contact Number: 888-780-7764
PO Box 1628
Stony Brook, New York 11790

## IF YOU DISAGREE WITH OUR DECISION

You have the right to appeal. A fair hearing will be scheduled for you if we receive your appeal by a certain date. Please read all of this information carefully as it explains how to appeal and tells you the deadlines you must meet.

You will be notified in writing of the date, time and place for the hearing. An administrative law judge will hear your case and make a decision. You may speak for yourself at the hearing or bring someone else such as an attorney, friend or relative. If you want an attorney to speak for you at the hearing but cannot afford one, Indiana Legal Services may be able to help. Call the office serving your area at 1-844-243-8570. Their web site address is: www.indianajustice.org.

## YOUR BENEFITS CAN CONTINUE WITHOUT CHANGE

Your benefits can continue without change while your appeal is pending. This applies if you are currently receiving benefits. If you decide to appeal and want your benefits to continue without change, file your appeal right away.

The deadlines are different for each program as explained below. If you meet these deadlines, your benefits will continue without the change explained in this notice until a decision is made on your appeal. If the hearing decision is not in your favor, you will be required to repay these extra benefits you received. If you do not want your benefits to be continued, tell us that in your appeal request.

Please note that all of the deadlines explained below refer to the close of business, which is 4:30 PM local time where the appeal is received. If a deadline falls on a weekend or a holiday, we must receive your appeal by the next business day. You should expect a short interruption in coverage if we receive your appeal request near the deadline. Please note that if you mail your appeal, we will not look at the postmark to determine whether we can continue your benefits.

Additional Important Information for Health Coverage and Hoosier Healthwise:

If the post office returns mail that we sent to you about a change in your benefits and we cannot locate you, we may take action to stop or reduce your benefits. However, if you contact us before the effective date of the action your benefits will continue.

We are required to issue a notice that your benefits are being stopped or reduced at least thirteen (13) days in advance of the effective date. If we do not issue this advance notice to you, your benefits will be reinstated if you appeal within thirteen (13) days of the mailing date of the notice.

## TIME LIMIT TO APPEAL

The previous section tells you to appeal very quickly if you want your benefits to continue. You do have more time to appeal; however, we will take the action on your benefits as stated in this notice if you do not meet the rules and deadlines explained in the previous section.

We must receive your appeal by the program deadline(s) explained below. Please note that all of the deadlines explained below refer to the close of business, which is 4:30 PM local time where the appeal is received. If the deadline is on a weekend or holiday, we must receive your appeal by the next business day. Please note that if you mail your appeal, we will not consider the postmark.

Deadline for Health Coverage, Hoosier Healthwise

The appeal request must be received within:

Thirty-three (33) days from the effective date of the action; or
Thirty-three (33) days from the date of this notice, whichever is later.

**HOW TO FILE AN APPEAL**

You can mail, fax, or hand deliver your written appeal request.

To appeal, please send a signed letter with as much information as possible including your Name, Case Number, and Reason for the appeal, along with a copy of this entire notice to one of the following locations listed below. For your case, this information is provided below for your convenience.

Name: Case Number: 601(

Date of Notice: APRIL 07, 2021 County: 32

1. Mail your written appeal to:

FSSA Document Center
PO Box 1810
Marion, IN 46952

Or,

2. Fax your written appeal to FSSA Document Center: 1-800-403-0864

Or,

3. Take your written appeal to your local Office of the Division of Family Resources during regular business hours.

**FOR MORE INFORMATION ABOUT THE FAIR HEARING PROCESS**

If you have questions please call us at 1-800-403-0864. You can also read about the fair hearing process on our website at www.in.gov/fssa.

Local Office of Family Resources
HENDRICKS COUNTY DFR
2471 E. Main St.
Plainfield, IN 46168-9209
PHONE: 1-800-403-0864

# ADMINISTRATIVE APPEAL AND HEARING REQUEST

State Form 53932 (R /2-12) / H&A 1001

********THIS FORM MAY BE USED TO FILE A WRITTEN ADMINISTRATIVE APPEAL.********
**FOOD STAMP APPEALS MAY BE ALSO FILED VERBALLY BY CALLING 1-800-403-0864.**

Name: _____

Address: _____

_____

Phone number: _____

Relationship: _____
(*self, spouse, representative, relative*)

**Signature:** _____ **Date (*month, day, year)*:** _____

**Did you receive a written notice about the denial, termination or change of your benefits? ☐ YES ☐ NO**

Mailing date of the notice (*if known*) _____ Case number shown on the notice: _ _____

**List of names of persons you are appealing for, including yourself:**

_____ _____

_____ _____

_____ _____

| **What benefits are you appealing?** | **Benefit was:** | | |
|---|---|---|---|
| ☐ TANF | ☐ Denied | ☐ Terminated / Closed | ☐ Changed |
| ☐ Medicaid | ☐ Denied | ☐ Terminated / Closed | ☐ Changed |
| ☐ HIP (Healthy Indiana Plan) | ☐ Denied | ☐ Terminated / Closed | ☐ Changed |
| ☐ Food Stamp | ☐ Denied | ☐ Terminated / Closed | ☐ Changed |
| ☐ Child Care (CCDF) | ☐ Denied | ☐ Terminated / Closed | ☐ Changed |
| ☐ Other - Explain | ☐ Denied | ☐ Terminated / Closed | ☐ Changed |

**Mail or fax your request to the location listed below or you may deliver your request in person at the local Division of Family Resources office. If possible, please attach a copy of the notice you are appealing.**

**Mail or fax to:**

**FSSA Document Center**
**PO Box 1810**
**Marion, Indiana 46952**
**Fax: 1-800-403-0864**

[redacted]

Michael R. Pence, Governor
State of Indiana

***Hearings and Appeals***
MS04, 402 W. WASHINGTON STREET, ROOM E034
INDIANAPOLIS, IN 46204-2739
317-234-3488/Toll Free: 866-259-3573
Fax: 317-232-4412

## NOTICE - RECEIPT OF APPEAL

DATE: 8/3/2016

TO: **CRYSTAL FRANCIS//INDIANA LEGAL SERVICES//INDIANAPOLIS IN**

**Re:** [redacted]

This is to inform you that your appeal has been received. If you appealed as an authorized representative, attorney, or Power of Attorney, this notice is sent to you as that representative.

**IF YOU DECIDE YOU NO LONGER WANT OR NEED TO APPEAL, PLEASE COMPLETE AND SIGN THE ENCLOSED WITHDRAWAL FORM. YOU MAY DO THIS AT ANY POINT IN THE APPEAL PROCESS. MAIL OR FAX THE FORM TO THE ADDRESS OR FAX NUMBER GIVEN BELOW.**

**IF YOUR APPEAL IS ABOUT FOOD STAMPS, YOU MAY ALSO CALL THE TOLL-FREE NUMBER AT THE BOTTOM OF THIS NOTICE TO WITHDRAW IT.**

**It is also very important that you do the following:**

- Notify Hearings and Appeals if you have someone else to represent you in your appeal. This would include persons you have asked to do this such as an attorney, friend, family member or a service provider. This person will also be sent copies of the information and notices you are sent.

- Notify Hearings and Appeals if you move. The address given with the appeal will be used unless Hearings and Appeals is notified there is a new one.

This is the first notice you will be sent regarding your appeal. If you continue with the appeal, the next step will be scheduling your administrative hearing.

**YOU WILL BE SENT A HEARING SCHEDULING NOTICE. IT IS NOT NECESSARY TO CONTACT HEARINGS AND APPEALS TO HAVE THE HEARING SCHEDULED.**

Thank you for your cooperation in the appeal process.

MS04 Hearings and Appeals Section

402 W. Washington St. Room E-034

Indianapolis, Indiana 46204

FAX 317-232-4412

TOLL FREE 1-866-259-3573

Indianapolis Area 317-234-3488





DFR03AE0100KT75H9

## APPENDIX X

[date]

Document Center
Attn: Hearings Work Group
Family & Social Services Administration
P. O. Box 1810
Marion, IN 46952 Delivery by fax: (800) 403-0864

Re: John J. Jones, Case No. _____
Appeals Hearing

Dear Appeals Section:

I am an authorized representative in this matter. Please provide me with a copy of Mr. Jones' file, including the exhibits that will be presented at the hearing set for April 29, 2022. I require this information to prepare for the hearing. Please provide this information no later than April 20, 2022. If I do not have this information by that date, I will have to file a request for a continuance of the hearing.

My fax number is (317) 631-9775. My e-mail address is dennis.frick@ilsi.net.

Please have the representative who will be presenting the case for DFR call me for a pre-hearing conference at my telephone number, (317) 829-3075.

Yours truly,

Dennis Frick
Staff Attorney

cc: John J. Jones

## APPENDIX Y

[date]

Office of Administrative Law Proceedings – FSSA Hearings
402 W. Washington St., Rm. E-034
Indianapolis, IN 46204

RE: Betty Jo Smith
Case No.
Appearance
Request for Continuance

Dear Sir/Madam:

Please enter my appearance on behalf of Betty Jo Smith. It is my understanding that a Medicaid disability hearing is now set for May 8, 2022 at 8:30 a.m. I request a continuance of this hearing date. I will on vacation during the weeks of May 3, 2022 through May 14, 2022. I will be unavailable that hearing date and will need additional time to prepare adequately for Ms. Smith's hearing.

I have left a message at the FSSA Document Center regarding my request to continue the hearing. I have not received a response. I am available for a new hearing date on May 21st, May 25thth (afternoon only), May 28th (morning only), and May 29th.

Please let me know if my continuance is granted.

[ Further, I request that the hearing be held at Ms. Smith's home due to her severe medical condition. Ms. Smith is homebound and is unable to travel by normal means of transportation. Her presence at the hearing is necessary to present testimony and to assist her counsel.]

[ Further, I request that a deaf interpreter be provided at the hearing. Ms. Smith is hearing impaired and uses sign language to communicate with others.]

Yours truly,

Dennis Frick
Attorney at Law

cc: FSSA Document Center
Betty Jo Smith

Eric Holcomb, Governor
State of Indiana

***Hearings and Appeals***
MS04, 402 W. Washington Street, ROOM E034
Indianapolis, IN 46204-2739
317-234-3488
Toll Free: 866-259-3573
FAX: 317-232-4412

MAR 02 2017

**IN THE MATTER OF:**

**CASE NAME:** [redacted]
**CASE NUMBER:** [redacted] / [redacted]
**HEARING DECISION RELEASE DATE:** **January 20, 2017**

**NOTICE OF FINAL AGENCY ACTION**

The record of the administrative hearing and the Administrative Law Judge's Findings of Fact and Decision in the above identified case were reviewed by the Secretary of the Family and Social Services Administration or their designee, and the agency hereby issues the following final order:

The Decision of the Administrative Law Judge dated **January 20, 2017 is affirmed**

**This is the final action that the agency will be taking on this case. NO further consideration of this matter will be available through the Family and Social Services Administration.**

However, if you have been the appellant in this matter, and are dissatisfied with this final agency action, you may ask that a court review the matter. This is a process called judicial review. **If you choose to file a petition for judicial review, it must be filed within thirty-three (33) days after the date on this notice.** Since this involves filing a legal petition with the appropriate court, as well as other specific requirements, it is advisable (but not required) to have legal representation or help. However, FSSA **cannot** provide or pay for this representation, nor can the agency assist beyond the general information provided here. More detailed information on this process can be found in Indiana law at I.C.4-21.5-5.

cc: [redacted]
DENNIS FRICK, ATTORNEY
[redacted]
MADISON COUNTY DFR
GRANT SERVICE CENTER
OMPP POLICY
[redacted], ADMINISTRATIVE LAW JUDGE

CERT. MAIL # 7015 0640 0003 2680 9908
7015 0640 0003 2680 9915
7015 0640 0003 2680 9922



LT0550

## APPENDIX AA

| | | |
|---|---|---|
| STATE OF INDIANA | ) | IN THE VIGO COUNTY COURTS |
| | ) §§: | |
| COUNTY OF VIGO | ) | CAUSE NO. |
| JOHN DOE, | ) | |
| | ) | |
| Petitioner, | ) | |
| | ) | |
| vs. | ) | |
| | ) | |
| INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, | ) | |
| | ) | |
| | ) | |
| Respondent | ) | |

VERIFIED PETITION FOR JUDICIAL REVIEW

Petitioner John Doe, being duly sworn upon his oath and states that:

l. This action is brought pursuant to Ind. Code §4-2l.5-5-7 governing judicial review of an order or determination of an Indiana administrative agency.

2. John Doe resides at 2200 East Indiana Avenue, Terre Haute, Indiana 47805.

3. The Vigo County Division of Family Resources ("County Division") is located at 43L Meadows Shopping Center, Terre Haute, Indiana 46807.

4. The Indiana Family and Social Services Administration ("FSSA") is located at P. O. Box 7083, 402 West Washington, Indianapolis, Indiana 46204.

5. The Medicaid Program 42 U.S.C. §l396 et seq., is a federal and state financed program which furnishes medical assistance to low income persons and families.

6. On or about December 19, 2021, John Doe was sent a notice that his October 21, 2021 Medicaid application was denied for the reason that "limitations do not prohibit employment."

7. John Doe timely appealed this decision to an Administrative Law Judge (ALJ) for the FSSA. A hearing was held on March 13, 2022.

8. On March 19, 2022, the ALJ issued a decision in which he sustained the County Division's decision to deny John Doe benefits.

9. That ALJ decision is attached as Exhibit A.

l0. John Doe appealed that decision to be reviewed by the FSSA.

11. On April 20, 2022, the FSSA issued its Notice of Final Agency Action affirming the ALJ's decision.

l2. This final Notice is attached as Exhibit B.

l3. The decision of the FSSA is:

a. Arbitrary, capricious, an abuse of discretion, and otherwise not in accordance with law;
b. Contrary to constitutional right, power, privilege, or immunity;
c. In excess of statutory jurisdiction, authority, limitation, or of statutory right;
d. Without observance of procedure required by law; and
e. Unsupported by substantial evidence.

l4. Specifically, [provide details of basis for appeal]

THEREFORE, John Doe respectfully requests the Court to:

l. Find that the FSSA decision to deny him Medicaid was unlawful;
2. Remand the case to the FSSA for action consistent with Indiana law, Federal law, and the Constitution; and
3. Grant all other just and proper relief.

_____
ATTORNEY FOR PETITIONER

VERIFICATION

I hereby verify under the penalties for perjury, that the foregoing representations are true and accurate to the best of my knowledge and belief.

DATE: _____

_____
John Doe, Petitioner

**APPENDIX BB**

| | | |
|---|---|---|
| STATE OF INDIANA | ) | IN THE VIGO COUNTY COURTS |
| | ) §§: | |
| COUNTY OF VIGO | ) | CAUSE NO. |
| JOHN DOE, | ) | |
| | ) | |
| Petitioner, | ) | |
| | ) | |
| vs. | ) | |
| | ) | |
| INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION, | ) | |
| | ) | |
| Respondent. | ) | |

REQUEST FOR RECORD

Petitioner John Doe, by counsel, requests that, pursuant to I.C. § 4-21.5-5-13, the Indiana Family and Social Services Administration (FSSA) serve upon Petitioner's counsel at [address], for filing in this cause, certified copies of:

1. The Vigo County Division of Family Resources decision dated December 19, 2021 denying his Medicaid eligibility.

2. His appeal of this decision.

3. All documents offered or entered into evidence at the hearing held in this matter and a transcript of that hearing.

4. The decision of the Administrative Law Judge.

5. The decision of the Family and Social Services Administration affirming the Administrative Law Judge's decision.

6. Any and all other documents making up the Administrative Record in this cause.

_____
ATTORNEY FOR PETITIONER

## APPENDIX CC

| | | |
|---|---|---|
| STATE OF INDIANA | ) | IN THE VIGO COUNTY COURTS |
| | ) §§: | |
| COUNTY OF VIGO | ) | CAUSE NO. |

| | |
|---|---|
| JOHN DOE, | ) |
| Petitioner, | ) |
| | ) |
| vs. | ) |
| | ) |
| INDIANA FAMILY AND SOCIAL | ) |
| SERVICES ADMINISTRATION, | ) |
| Respondent. | ) |

MOTION FOR EXTENSION OF TIME FOR FILING TRANSCRIPT

Petitioner John Doe, by counsel, and pursuant to Ind. Code §4-2l-5.5-l3 moves this Court for an extension of time for filing of the transcript of the administrative proceedings in this cause. Petitioner alleges that:

l. On this date, he filed a Verified Petition for Judicial Review of a decision of the Indiana Family and Social Services Administration ("FSSA") and, unless time is extended, must file a transcript of the administrative proceedings within thirty (30) days.

2. He has on this date filed a Request for Transcript and Documents.

3. Based on past experience with FSSA, his counsel believes that the transcript of the administrative proceedings may not be completed by FSSA within thirty (30) days. In the event that it is not prepared and provided to Petitioner within thirty (30) days, good cause exists for an extension of time within which to file the transcript.

THEREFORE, Petitioner respectfully requests that this Court grant an extension of time within which to file the transcript of the administrative proceeding for a period of time not to exceed fifteen (l5) days following the date that the Indiana Family and Social Services Administration provides a certified copy of the transcript of the administrative proceedings to Petitioner's counsel, and for all other proper relief.

_____

ATTORNEY FOR PETITIONER

## APPENDIX DD

| | | |
|---|---|---|
| STATE OF INDIANA | ) | IN THE VIGO SUPERIOR COURT 1 |
| | ) | §§: |
| COUNTY OF VIGO | ) | CAUSE NO. |

| | |
|---|---|
| [name] | ) |
| Petitioner, | ) |
| vs. | ) |
| INDIANA FAMILY AND SOCIAL | ) |
| SERVICES ADMINISTRATION | ) |
| Respondent. | ) |

MOTION TO COMPEL

Petitioner, by counsel, moves for an order to compel Respondent Indiana Family and Social Services Administration (FSSA) to produce the administrative record in this matter, and states that:

l. Petitioner filed this action on [date] pursuant to Ind. Code §4-2l.5-5-7 governing judicial review of an order or determination of an Indiana administrative agency.

2. Petitioner applied for Medicaid benefits on [date] and was denied Medicaid benefits on [date].

3. Since the date that FSSA initially denied his application, Petitioner has diligently pursued his appeal and has met all of the time deadlines established to preserve his appeal.

4. Petitioner's case cannot be heard until the administrative record is filed and the issues briefed by the parties.

5. Petitioner has the burden of filing the administrative record with the Court pursuant to Ind. Code §4-21.5-5-13(a) within thirty (30) days after filing his petition for judicial review.

6. Petitioner requested the administrative record on [date] in accordance with Ind. Code §4-21.5-5-13(c). At the time of filing his petition, Petition also requested an extension of time for filing the record pursuant to Ind. Code §4-21.5-5-13(b), which was granted by this Court.

7. It has been over [# days/months] since the record was requested.

8. Petitioner sent a letter to Respondent's counsel on [date] again requesting the record and advising that a motion to compel would be filed. See attached Exhibit A.

9. Shortly afterwards, Petitioner's counsel and Respondent's counsel discussed the delay in the preparation of the record. At that time, counsel for Respondent indicated that FSSA was giving priority to preparing those records in which the petitioning party for judicial review had obtained a court order to compel the record's preparation. **[or otherwise provide a summary of the conversation]**

10. Without an order from this Court, it appears that there is an indefinite time before which FSSA will produce the administrative record, and that Petitioner's record is subject to being preempted by other cases at FSSA.

THEREFORE, Petitioner requests that the Court order Respondent FSSA to complete and forward the administrative record in this matter to Petitioner's counsel within ten (10) days.

_____
ATTORNEY FOR PETITIONER

**CERTIFICATE OF SERVICE**

| | | |
|---|---|---|
| STATE OF INDIANA | ) | IN THE VIGO SUPERIOR COURT 1 |
| | ) | §§: |
| COUNTY OF VIGO | ) | CAUSE NO. |

| | |
|---|---|
| [name] | ) |
| | ) |
| Petitioner, | ) |
| | ) |
| vs. | ) |
| | ) |
| INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION | ) |
| | ) |
| Respondent. | ) |

**ORDER TO COMPEL**

A Motion to Compel having been filed by Petitioner to require Respondent Indiana Family and Social Services Administration to produce the administrative record in this matter, and good cause appearing,

IT IS ORDERED that Respondent shall produce the administrative record in this matter and shall provide it to Petitioner within ten (10) days.

DATED: _____

_____
JUDGE
Vigo Superior Court 1

Distribute copies to:

**APPENDIX EE**

| | | |
|---|---|---|
| STATE OF INDIANA | ) | IN THE _____ COURT |
| | ) §§: | |
| COUNTY OF | ) | CAUSE NO. |
| XXX | | ) |
| Petitioner, | | ) |
| vs. | | ) |
| INDIANA FAMILY AND SOCIAL | | ) |
| SERVICES ADMINISTRATION, | | ) |
| Respondent. | | ) |

NOTICE OF FILING DOCUMENTARY RECORD

Petitioner, by counsel, hereby files the documentary record of the administrative proceedings in this cause.

_____
Dennis Frick, #7910-48
INDIANA LEGAL SERVICES, INC.
1200 Madison Ave., Suite 300
Indianapolis, Indiana 46225
(317) 829-3075
ATTORNEY FOR PETITIONER

**CERTIFICATE OF SERVICE**

I certify that a copy of the foregoing has been sent to the person(s) named below by first class U.S. mail, postage prepaid on _____:

Deputy Attorney General
Office of the Attorney General
Indiana Government Center, 5th Fl.
302 W. Washington St.
Indianapolis, IN 46204-2770

_____
Dennis Frick
Attorney at Law

TRANSCRIPT
[PETITIONER'S NAME]
Case No._____

CONTENTS PAGES

**APPENDIX FF**

| | | |
|---|---|---|
| STATE OF INDIANA | ) | IN THE VIGO SUPERIOR COURT |
| | ) §§: | |
| COUNTY OF VIGO | ) | CAUSE NO. |
| | | |
| JOHN DOE, | ) | |
| Petitioner, | ) | |
| vs. | ) | |
| INDIANA FAMILY AND SOCIAL | ) | |
| SERVICES ADMINISTRATION, | ) | |
| Respondent. | ) | |

MOTION FOR BRIEFING SCHEDULE

Petitioner JOHN DOE, by counsel, respectfully files his Motion for Briefing Schedule and states:

1. Inasmuch as this case is an appeal of an administrative action, this case can be decided on the basis of opposing memoranda of law.

2. The administrative record was filed in this matter on April 30, 2022.

3. Petitioner proposes the following briefing schedule:

   a. Petitioner's Memorandum of Law in this matter to be due within 45 days after the filing of the administrative record.

   b. Any Memorandum of Law Respondent wishes to file to be due 45 days after the filing of Petitioner's memorandum.

   c. Petitioner's Reply to Respondent's Memorandum be due within 20 days after the filing of the Respondent's memorandum.

   d. Oral argument be set on the parties' memoranda, allowing 1 hour for argument, 30 minutes per side.

THEREFORE, Petitioner respectfully requests this court to issue a briefing schedule in this case so that the matter can be disposed of and for all other proper relief.

_____
ATTORNEY FOR PETITIONER

**[CERTIFICATE OF SERVICE]**

| | | |
|---|---|---|
| STATE OF INDIANA | ) | IN THE VIGO COUNTY COURTS |
| | ) §§: | |
| COUNTY OF VIGO | ) | CAUSE NO. |
| JOHN DOE, | ) | |
| Petitioner, | ) | |
| | ) | |
| vs. | ) | |
| | ) | |
| INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION | ) | |
| Respondent. | ) | |

ORDER ON MOTION FOR BRIEFING SCHEDULE

Petitioner John Doe, by counsel, has filed his Motion for Briefing Schedule and the Court now finds good cause to grant it.

IT IS THEREFORE ORDERED that the following briefing schedule shall be complied with:

1. The Petitioner's Memorandum of Law in this matter is due on or before _____, 2022.

2. Any Memorandum of Law Respondent wishes to file shall be due 45 days after the filing of Petitioner's memorandum.

3. Petitioner's Reply to Respondent's Memorandum shall be due within 20 days after the filing of the Respondent's memorandum.

4. Oral argument shall be held on the _____ day of _____, 2022 at the hour of _____ M.

DATED: _____

_____
JUDGE
Vigo Superior Court

Distribute copies to: