Document: Emergency Rule, **Register Page Number:** 25 IR 3787
Source: August 1, 2002, Indiana Register, Volume 25, Number 11

TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #02-196(E)

DIGEST

Temporarily adds provisions to set out eligibility requirements for Medicaid for Employees with Disabilities (MED Works). Authority: IC 4-22-2-37.1(a); IC 12-15-41-15(b). Effective July 1, 2002.

SECTION 1. **(a) This document establishes the eligibility requirements for the two (2) optional Medicaid categories for Employees with Disabilities identified in 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI), and in accordance with the provisions of IC 12-15-41.**

(b) As used in this document, "applicant or recipient" means an individual whose Medicaid eligibility is being determined under one (1) of the above referenced Medicaid categories and in accordance with the requirements of this document.

(c) A person who is less than sixteen (16) years of age, or age sixty-five (65) or older is not eligible for Medicaid for Employees with Disabilities.

(d) A recipient must report any change in income, resources, employment status, or marital status within ten (10) days of the date of the change. An additional ten (10) days is allowed to provide any necessary verification.

(e) A disabled individual will be considered for eligibility under this document if the individual is ineligible for Medicaid under the Disability category for any of the following reasons:
(1) The individual's income exceeds the applicable standard specified in IAC 2-3-18 *[sic.]***.**
(2) The individual's resources exceed the limit in IC 12-15-3-1 or IC 12-15-3-2.
(3) The individual's gross earnings exceed the substantial gainful activity amount established by the Social Security Administration in 20 CFR 416.974.

(f) In addition to the requirements in this document, the requirements in the following rules apply to applicants and recipients of Medicaid for Employees with Disabilities:
(1) 405 IAC 2-1-2.
(2) 405 IAC 2-1-3.
(3) 405 IAC 2-2-4.
(4) 405 IAC 2-3-1.1.
(5) 405 IAC 2-3-2.
(6) 405 IAC 2-3-11.
(7) 405 IAC 2-3-12.
(8) 405 IAC 2-3-13.
(9) 405 IAC 2-3-14.
(10) 405 IAC 2-3-22.
(11) 405 IAC 2-4-1.
(12) 405 IAC 2-5-1.
(13) 405 IAC 2-8-1.
(14) 405 IAC 2-8-2.

SECTION 2. **(a) Countable income is gross monthly income less the deductions and exclusions required by federal or state statute or regulation and the deductions and exclusions in this SECTION.**

(b) The following are disregarded or deducted in determining net earned income:

(1) Up to ten dollars ($10) of earned income is disregarded if the income is either infrequent or irregular. Infrequent income is income received only once during the calendar quarter from a single source. Irregular income is income that could not reasonably be expected. If the total amount of infrequent or irregular earned income received in a month exceeds ten dollars ($10), this disregard cannot be applied.

(2) Expenses allowed by the Internal Revenue Service shall be deducted from gross income from self-employment to determine net self-employment earnings.

(3) Sixty-five dollars ($65) of earned income per month, plus impairment-related work expenses described in (4) below *[subdivision (4)]*, plus one-half (½) of remaining earned income is excluded.

(4) Impairment-related work expenses are expenses that are paid by the applicant or recipient for the purchase or rental of certain items and services that are necessary, due to the severity of his or her impairment, in order for the applicant or recipient to work. No deduction is allowed if the expense has been, could be, or will be paid by another source or if the applicant or recipient will be reimbursed by another source, including, but not limited to, Medicaid, Medicare, private health insurance, or another agency. Allowable impairment-related expenses are listed below:

(A) Payments for attendant care services in the following circumstances:

(i) Because of the applicant's or recipient's impairment, he or she needs assistance in traveling to and from work, or while at work needs assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating).

(ii) Because of the applicant's or recipient's impairment, assistance is needed at home with personal functions (e.g., dressing, administering medications) in preparation for going to and returning from work.

(iii) Payments made to a family member for attendant care services will be allowed only if the family member suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked in order to perform the services.

(iv) A family member is anyone who is related to the applicant or recipient by blood, marriage, or adoption, whether or not that person lives with the applicant or recipient.

(v) If only part of the payment to a person is for services that come under the provisions of items (i) and (ii), only the portion attributable to those services will be allowed.

(B) Payments for medical devices. If the impairment requires the applicant or recipient to utilize medical devices in order to work, the payments made for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment that can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators, and pacemakers.

(C) Payments for prosthetic devices. If the impairment requires the applicant or recipient to utilize a prosthetic device in order to work, the payments made for that device may be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs, and other parts of the body.

(D) Payments for work-related equipment. If the impairment requires the applicant or recipient to utilize special equipment in order to do his or her job, the payments made for that equipment may be deducted.

(E) Payments for residential modifications. If the impairment requires the applicant or recipient to make modifications to his or her place of residence, the location of the workplace will determine if the cost of these modifications will be deducted. If the applicant or recipient is employed away from home, only the cost of changes made outside of the home to permit the applicant or recipient to get to his or her means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of the home will not be deducted if the person works away from home. If the applicant or recipient works at home, the costs of modifying the inside of the home in order to create a working space to accommodate his or her impairment will be deducted to the extent that the changes pertain specifically to the space in which he or she works. Examples of such changes are the enlargement of a doorway leading into the workspace or modification of the workspace to accommodate problems in dexterity. However, if the

applicant or recipient is self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(F) Payments for transportation costs in the following circumstances are allowed:

(i) The impairment requires that in order for the applicant or recipient to get to work, a vehicle that has structural or operational modifications is required. The modifications must be critical to the applicant's or recipient's operation or use of the vehicle and directly related to his or her impairment. The costs of the modifications will be deducted, but not the cost of the vehicle. A mileage allowance for the trip to and from work will be allowed in the same amount as allowed by the Supplemental Security Income program for this purpose.

(ii) The impairment requires the applicant or recipient to use driver assistance, taxicabs, or other hired vehicles in order to work. Amounts paid to the driver and, if the applicant's or recipient's own vehicle is used, a mileage allowance will be deducted, for the trip to and from work.

(iii) The impairment prevents the applicant or recipient from taking available public transportation to and from work, and he or she must drive his or her (unmodified) vehicle to work. A mileage allowance for the trip to and from work will be deducted if verification is obtained through the applicant's or recipient's physician or other sources that the need to drive is caused by the impairment, and not due to the unavailability of public transportation.

(G) All other impairment-related expenses allowed by the Supplemental Security Income program.

(c) Funds from a grant, scholarship, or fellowship that are designated for tuition and mandatory books and fees at an educational institution or for vocational rehabilitation or technical training purposes shall be deducted from the total of such funds except as prohibited by federal regulations.

(d) Tax refunds are excluded from income.

(e) Home energy assistance is disregarded.

(f) Up to twenty dollars ($20) of unearned income is disregarded if the income is either infrequent or irregular. Infrequent income is income received only once during the calendar quarter from a single source. Irregular income is income that could not reasonably be expected. If the total amount of infrequent or irregular unearned income received in a month exceeds twenty dollars ($20), this disregard cannot be applied.

(g) A general income disregard of fifteen dollars and fifty cents ($15.50) is deducted per month.

(h) Payments made to foster parents or licensed child caring institutions from county funds or reimbursed under Title IV-B of the Social Security Act on behalf of an applicant or recipient who is a ward of the county department are excluded.

(i) Income of the spouse of the applicant or recipient is excluded.

(j) Income of the parents of the applicant or recipient is excluded.

SECTION 3. **(a) An applicant's or recipient's income eligibility shall be determined by the following procedures:**

(1) Determine the applicant's or recipient's unearned income which is not excluded by state or federal statute or regulation.

(2) Subtract the general income disregard specified in SECTION 2 of this document. The resulting amount is countable unearned income.

(3) Determine the earned income of the applicant or recipient.

(4) Subtract any remaining general income disregard.

(5) Subtract the earned income disregard(s) specified in SECTION 2 of this document. The resulting amount is countable earned income.

(6) Combine countable unearned and countable earned income.

(7) Subtract the monthly income standard that is equal to three hundred fifty percent (350%) of the Federal

Poverty Guideline for a family size of one (1) , divided by twelve (12) and rounded up to the next whole dollar.

(8) If the resulting amount in *[subdivision]* (7) is zero dollars ($0) or less than zero dollars ($0), the applicant or recipient is eligible for Medicaid for Employees with Disabilities. If the resulting amount is greater than zero dollars ($0), the applicant or recipient is not eligible.

(b) The income standard referenced in *[subsection]* (a)(7) shall be increased annually beginning the second month following the month in which the federal poverty guidelines are published in the Federal Register.

(c) The following procedures are used to determine the amount of income to be paid to an institution for an applicant or recipient who has been determined eligible under subsection (a) of this SECTION and who is residing in a Title XIX certified health care facility:

(1) Determine the applicant's or recipient's total income which is not excluded by federal statute. Total income includes amounts deducted in the eligibility determination under subsection (a).

(2) Subtract the minimum personal needs allowance specified in IC 12-15-7-2.

(3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant's or recipient's legal guardian, not to exceed thirty-five dollars ($35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney fees for which the guardian is liable.

(4) Subtract the amount of health insurance premiums.

(5) Subtract an amount for expenses incurred for necessary medical or remedial care recognized by state law but not covered under the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.

(6) The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced.

SECTION 4. **(a) An applicant or recipient is ineligible for Medicaid for Employees with Disabilities for any month in which the total equity value of all nonexempt personal property owned by the applicant and his or her spouse exceeds the applicable limitation for a single individual or married couple as prescribed by the Supplemental Security Income program.**

(b) The resources of the applicant's or recipient's parents are excluded.

(c) In addition to that property required to be excluded by federal statute or regulation, the following property is exempt from consideration:

(1) All household goods and personal effects.

(2) Personal property required by an individual's employer while the individual is employed.

(3) The equity value of personal property used to produce food for home consumption or used in the production of income.

(4) The value of life insurance with a total face value of ten thousand dollars ($10,000) or less if provision has been made for payment of the applicant's or recipient's funeral expenses from the proceeds of such insurance. However, the ten thousand dollar ($10,000) limitation shall be reduced by any amount in an irrevocable burial trust or irrevocable prepaid funeral agreement.

(5) For a period of no more than nine (9) months from the date of receipt, the proceeds or any interest earned on the proceeds of casualty insurance received as a result of damage, destruction, loss, or theft of exempt real or personal property if the applicant or recipient demonstrates that the proceeds are being used to repair or replace the damaged, destroyed, lost, or stolen exempt property.

(6) One (1) motor vehicle according to the following provisions:

(A) One (1) motor vehicle is excluded, regardless of value, if, for the applicant or recipient or other member of his or her household, the motor vehicle is:

(i) necessary for employment;

(ii) necessary for the medical treatment of a specific or regular medical problem; or

(iii) modified for operation by or transportation of a handicapped person.

(B) If no motor vehicle is excluded under clause (A), four thousand five hundred dollars ($4,500) of the current market value of one (1) motor vehicle is excluded.

(7) Burial spaces.

(8) Subject to the requirements in subsection (d), the home which is the principal place of residence of:

(A) the applicant or recipient;

(B) the spouse of the applicant or recipient;

(C) the parent of the applicant or recipient who is under age eighteen (18);

(D) the applicant's or recipient's biological or adoptive child under eighteen (18) years of age; or

(E) the applicant's or recipient's blind or disabled biological or adoptive child eighteen (18) years of age or older.

(9) Income producing real property if the income is greater than the expenses of ownership.

(10) Up to twenty thousand dollars ($20,000), as approved by the central office of the family and social services administration, for an independence and self-sufficiency account defined in IC 12-15-41-2(3). A resource disregard for this purpose will be approved if the applicant or recipient submits a plan in writing to the local office of family and children caseworker that describes specifically the goods and or services that he or she intends to purchase that will increase, maintain, or retain his or her employability or independence. The items must be reasonable in terms of the applicant's or recipient's ability to achieve a stated goal which is focused on the individual's employability by removing barriers. Items for personal recreational use will not be approved. A request to save money without specifying goods or services to be purchased within an achievable period of time will not be approved. An approved account will be reviewed by the local office of family and children caseworker at each annual redetermination. If the terms of the original approved account have not been met, the recipient will be required to submit an updated request to the caseworker within thirty (30) days of receiving written notification from the caseworker that such an update is required. If the recipient fails to submit the update, the disregard will be disapproved and resource eligibility will be redetermined without it. The caseworker will forward updates to the central office for approval. At any time during the period of eligibility under the Medicaid for Employees with Disabilities program, the recipient may submit an update requesting an adjustment in the approved amount. Approval will not be given for any services that are available to the recipient under Medicaid or any other publicly funded program.

(11) Retirement accounts held by the applicant or recipient or his or her spouse are exempt. This includes Individual Retirement Accounts, Keogh Plans, 401(k), 403(b), and 457 plans, and any employer-related retirement account.

(d) The home exempted by subsection (c)(8) is exempt until such time as it is verified that none of the persons listed in subsection (c)(8) intends to reside there. The home is the shelter in which the person resides, the land on which the shelter is located, and related outbuildings.

(e) As a condition of eligibility for Medicaid for Employees with Disabilities, an applicant or recipient and his or her spouse must sign an agreement to offer for sale or for rent all nonexempt real property that he or she or his or her spouse own.

(f) If nonexempt real property is not offered for sale or for rent at current market value within thirty (30) days of written notification of medical assistance or within thirty (30) days after the agreement referenced in subsection (e) is signed, whichever is later, the recipient shall be ineligible.

SECTION 5. **(a) In order for an individual to be eligible for Medicaid for Employees with Disabilities, the individual must be engaged in a substantial and reasonable work effort. This means that the person must be either employed or self-employed, with the intent of such work activity being ongoing. Employment must be verifiable by pay stubs or other verification from an employer documenting that the income is subject to income tax and FICA withholding. Self-employment must be verified by the individual's income tax return or, in the case of a new business for which a tax return has not yet been filed, the personal business records of the individual.**

(b) In order for a recipient of Medicaid for Employees with Disabilities to remain eligible when the definition of medically improved disability in SECTION 7 *[of this document]* **is met, the recipient must be employed as defined in** *[subsection]* **(a) and must have monthly earnings as calculated under 405 IAC 2-5-1 that are equal to or greater than the federal minimum wage times forty (40), unless the provisions in** *[subsection]* **(c) are met.**

(c) A recipient who is involuntarily not working can remain eligible for the Medicaid for Employees with Disabilities program for up to twelve (12) months if he or she meets all other program requirements and is either:

(1) on temporary medical leave from his or her employment as defined in *[subsection]* **(d); or**

(2) maintains a connection to the workforce by participating in at least one (1) of the following activities below:

(A) Enrollment in a vocational rehabilitation program.

(B) Enrollment or registration with the department of workforce development.

(C) Participation in a transition from school to work program.

(D) Participation with an approved provider of employment services.

(d) As used in this SECTION, "temporary medical leave" means a leave from the place of employment due to health reasons when the employer is keeping a position open for the individual to return. If the employer is no longer holding a position open, the recipient must maintain a connection to the workforce as defined in subdivision *[subsection]* **(c)(2) in order for coverage to continue under Medicaid for Employees with Disabilities.**

(e) In order to remain eligible upon becoming unemployed, the recipient or his or her authorized representative must submit a written request for continued coverage to the local office of family and children no later than sixty (60) days after termination of employment. Attached to this written request must be verification that the recipient meets the requirements in subsection (c). On a quarterly basis thereafter, as long as the recipient continues to be unemployed and wishes coverage to continue, verification of his or her medical leave or workforce connection status must be provided to the local office of family and children. The quarterly verification must consist of a statement from the agency or service provider that documents the recipient's continued participation in an activity that constitutes connection to the workforce, or from the recipient's employer stating he or she remains on a temporary involuntary medical leave.

(f) A recipient who voluntarily terminates his or her employment for any reason is not eligible for Medicaid for Employees with Disabilities. Eligibility for the other Medicaid categories will be pursued.

(g) A recipient who fails to submit the initial request for coverage continuation within the required sixty (60) day period or who fails to submit the quarterly verification report is no longer eligible for Medicaid for Employees with Disabilities. Eligibility for other Medicaid categories will be pursued.

SECTION 6. **(a) In order to qualify for Medicaid for Employees with Disabilities, an applicant must meet the definition of disability in IC 12-14-15-1(2). If not for earned income, the applicant or recipient would medically qualify for Medicaid under the traditional disability category according to statute.**

(b) The determination of disability is made by the Medicaid medical review team (MMRT) based upon the principles found in 405 IAC 2-2-3, except that the determination of whether an impairment is substantial enough to meet the definition of disability is made without considering work activity, earnings, and substantial gainful activity (SGA). If not for the fact that the applicant or recipient is working, the condition would otherwise be substantial enough to prevent the person from participating in gainful activity.

(c) A redetermination of disability is required annually of each recipient at the time the county office does its complete redetermination of all factors of eligibility. A redetermination of disability may be required more frequently or may be waived at the discretion of the MMRT based upon the condition of the recipient.

SECTION 7. **(a) In order to qualify for the Medicaid For Employees with Disabilities program after improvement of a medical condition, a recipient must meet the requirements in this SECTION.**

(b) The person must be a recipient of Medicaid under the Medicaid For Employees with Disabilities group described in SECTION 6 of this document who no longer qualifies for coverage under that category due to a medical improvement in his/her condition. The improvement of the condition must be verifiable by acceptable clinical standards; however, the disease, illness, or process must be of a type that, due to the nature and course of the illness, will continue to be a disabling impairment. A condition that has been resolved or a person who is

completely recovered does not medically qualify for this program.

(c) The determination of whether a recipient meets the medical eligibility requirements for this category will be made at the time of the regularly scheduled annual redetermination for Medicaid by the county office. Determination of medical eligibility under this SECTION is made by the Medicaid medical review team (MMRT).

SECTION 8. **(a) To be eligible for Medicaid for Employees with Disabilities, an individual must pay monthly premiums in accordance with the requirements specified in this SECTION, unless the gross income of the individual and the individual's spouse is less than one hundred fifty percent (150%) of the federal poverty level. The amount of the premium is based on the gross income of the recipient and the recipient's spouse as a percentage of the federal poverty level for the applicable family size as determined in subsection (b) or (c). The amount of the premium will be adjusted by the premium amount of other creditable private health insurance as defined in 42 U.S.C. §300gg-91 that covers the applicant or recipient and is paid by the applicant or recipient, or his or her spouse or parent. The amount of the premium is calculated as described in the following table:**

Income as a Percent of the Federal Poverty Level	**Amount of Premium**	
Less than 150%–No Premium is Required	**Individual**	**Married Couple**
150% to 175%	**$ 48**	**$ 65**
More than 175% to 200%	**$ 69**	**$ 93**
More than 200% to 250%	**$ 107**	**$ 145**
More than 250% to 300%	**$ 134**	**$ 182**
More than 300% to 350%	**$ 161**	**$ 218**
More than 350%	**$ 187**	**$ 254**

(b) The individual premium amount is used when the individual, regardless of age, is not married or not living with his or her spouse. When the individual premium amount is used, only the individual's income is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of one (1).

(c) The married couple premium amount is used when the individual is legally married and living with his or her spouse. When the couple premium amount is used, the income of both spouses is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of two (2).

(d) When an applicant is determined eligible, the applicant will be conditionally approved pending payment of the premium. The first month for which a premium is required is the month following the month in which an applicant is approved as conditional. After the premium is received, coverage will be retroactive to the first day of the third month prior to the month of application if all eligibility requirements were met in the prior months.

(e) The individual must pay the first premium in order to receive coverage. If payment is not received by the due date specified in the second premium notice, the Medicaid application will be denied. A payment of less than the full amount due will be considered nonpayment.

(f) If any premium after the first premium is not paid by the due date, coverage will continue for a maximum of sixty (60) days before being discontinued. When an individual or couple have been discontinued from the program due to nonpayment of premiums, an application must be filed in order to be considered for eligibility. To be reenrolled based on an application filed after such a discontinuance, the individual must pay all past due premiums in addition to premiums owed for the current application. Past due premiums remain the obligation of the individual as a condition of eligibility for two (2) years after the date of discontinuance.

(g) When both spouses are recipients of Medicaid for Employees with Disabilities, the enrollment and continued eligibility of the couple is based on the payment of the married couple premium amount. Failure to

pay the required premium amount in accordance with this SECTION will result in the discontinuance of Medicaid coverage for both spouses.

(h) When a recipient reports a change in income or marital status as required by SECTION 1(d) of this document, and the change results in a lower premium, the new premium amount will be effective the first month following the date in which verification of the change is received.

(i) When a recipient who is eligible for Medicaid in the blind or disabled categories obtains employment, the change must be reported within ten (10) days as required by 470 IAC 2.1-1-2. An additional ten (10) days is allowed to provide verification of the employment. If the recipient is eligible for Medicaid for Employees with Disabilities, eligibility begins the first month following the date on which verification is received, subject to the timely notice requirements in 42 CFR 431.211.

SECTION 9. **SECTIONS 1 through 8 of this document expire July 10, 2002.**

LSA Document #02-196(E)
Filed with Secretary of State: June 28, 2002, 10:19 a.m.