GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Indiana, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2024

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Version: 1.0 (March 2024)

This project is funded by the National Institutes of Health, National Institute of Aging, R01 AG030153.

Please cite as "Gateway to Global Aging Data (2024). *Gateway Policy Explorer: Indiana, USA, Long-Term Care In-Kind Benefit Plan Details, 1992-2024*, Version: 1.0 (March 2024), University of Southern California, Los Angeles. https://doi.org/10.25553/gpe.ltc.kb.u18"

Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Indiana, USA

In-Kind Benefits

Plan details 1992-2024 * †

Public long-term care (LTC) benefits in Indiana are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Indiana, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, Indiana's Medicaid LTC system has been subject to two major policy reforms: the implementation of a new eligibility track that increased income eligibility limits for aged, blind, and disabled adults in 2003, and a subsequent expansion of eligibility for the same population in 2014.

Key Dates

First law: 1965

Major changes since 1992: 2003, 2014

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* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

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Chapter 1: Policy enacted 1992-2002

Overview

Long-term care (LTC) benefits in Indiana are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Indiana is administered at the state level by the Indiana Family and Social Services Administration (IFSSA), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Indiana are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Aged & Disabled program).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Aged & Disabled program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the Aged & Disabled program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and Aged & Disabled beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

During this policy period, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023c)

Indiana Law for Medicaid

- Indiana Code, Title 12 - Human Services, Article 15 - Medicaid (IGA, 2023)
- Indiana Administrative Code, Title 405 - Office of the Secretary of Family and Social Services (IGA, 2024)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Indiana Medicaid spending on beneficiaries in fiscal year 1992 was 63.85%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (63.85% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Indiana Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Indiana.

Eligibility for Medicaid in Indiana for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States

  Indiana is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $1,500 for an individual and $2,250 for a couple.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be an Indiana resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be an Indiana resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023b) for additional information.
  - Other requirements
    - In Indiana, aged, blind, and disabled individuals must submit a separate (although duplicative) Indiana state application to apply for Medicaid coverage even after being determined eligible by the Social Security Administration (SSA). Additionally, disabled individuals applying under this track are subjected to stricter disability criteria than under the Social Security Disability Income (SSDI) program.[4]
    - The applicant must be at least age 65, blind, or disabled.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to be equal to or less than the medically needy income limit. As a 209(b) state, Indiana must allow aged, blind, and disabled applicants to spend down their income to become eligible for Medicaid. In 1992, this was $422 for an individual and $633 for a couple. Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Asset requirements: Resources may not exceed $1,500 for an individual and 2,250 for a couple. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]
    - Asset transfer: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Aged & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or under age 65 and disabled (Melemed, 1994; CICOA, 2009; CMS, 2023).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE)
- Traumatic Brain Injury Program —from 2000

Benefit

Home care benefit

Home Health Services

Home Health provides (IGA, 2003a; IGA, 2023, Ch. 5):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care

Nursing Facility Care does not provide home care.

Aged & Disabled

The Aged & Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (Melemed, 1994; CICOA, 2009; CMS, 2023):

- Personal care services
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Under the Aged & Disabled program, the above services may also be provided in an adult family care home or assisted living facility.

Semi-residential care

Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care.

Aged & Disabled

The Aged & Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (Melemed, 1994; CICOA, 2009; CMS, 2023).

Residential care

Home Health Services, Aged & Disabled

These programs do not provide residential care.

Nursing Facility Care

Indiana Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (IGA, 2009; IGA, 2023, Ch. 5). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Indiana Medicaid provides additional benefits related to LTC (IGA, 2003a):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Aged & Disabled

The Aged & Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (Melemed, 1994; CICOA, 2009):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Durable medical equipment and supplies: Additional equipment and supplies that are necessary to address participant functional limitations
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Transportation: Additional coverage of non-medical transportation to community services and activities
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Environmental modifications: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant
- Transition services: Non-reoccurring expenses for people who are in the process of transitioning from a nursing facility to a community setting (e.g., moving expenses, housing deposits)

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Indiana Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans have more limited provider networks.

Home Health Services

Skilled nursing services must be provided by a licensed registered nurse or practical nurse under the supervision of a licensed registered nurse. Home health aide services, such as personal care, assistance with medications, or ambulation, are provided by home health aides, but must be under the supervision of a licensed registered nurse (IHCP, 2001b; IGA, 2003a; IFSSA, 2023a).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (Melemed, 1994; IGA, 2006b; IFSSA, 2023b).

Aged & Disabled

The provision of care for program services will vary by authorized service (Melemed, 1994; CICOA, 2009; CMS, 2023).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary, prior authorized, and only provided to beneficiaries who are medically confined to the home (IHCP, 2001b; IGA, 2003a). Indiana's definition of "medically confined" does not mean an individual jeopardizes continued receipt of services if they leave their home, even on a very limited basis.

Nursing Facility Care

Applicants must be evaluated using the E-Screen and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant requires long-term assistance with a skilled medical need or with three or more activities of daily living (ADLs) due to a medical condition (Melemed, 1994; Rosato et. al., 2005; IFSSA, 2017).

Aged & Disabled

Applicants must meet an NFLOC, which is defined using the same criteria as described above under nursing facility care (Melemed, 1994; CICOA, 2009; CMS, 2023).

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

Home Health Services

A physician must review the plan of care and recertify the order for services every 60 days (IHCP, 2001b; IGA, 2003a).

Nursing Facility Care

Nursing facility residents must have a level of care reassessment when there is a significant change in medical condition, when those with long-term care approval's medical status has improved but does not wish to leave the facility, and when those whose short-term approval is coming to an end and they have medical needs to support continued stay (Melemed, 1994; IGA, 2006a; IFSSA, 2023b).

Aged & Disabled

Program participants must be reassessed at least every 12 months or more often as needed (Melemed, 1994; CICOA, 2009; CMS, 2023).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the three largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Aged & Disabled

The individual must be at least age 65, or under age 65 and physically disabled (Melemed, 1994; CICOA, 2009; CMS, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the three largest programs.

Home Health Services

Home health services must be medically necessary, prior authorized, and only provided to beneficiaries who are medically confined to the home (IHCP, 2001b; IGA, 2003a). Applicants who, because of illness or injury, are unable to leave home without the assistance of another person or of an assistive device, such as a wheelchair or walker, or for whom leaving the home is contrary to medical advice, are considered to be medically confined to home. Indiana's definition of "medically confined" does not mean an individual jeopardizes continued receipt of services if they leave their home, even on a very limited basis. When prior authorization requests are reviewed, factors such as rehabilitation potential, complexity of needs, and caregiver availability are considered; however, there is no specific criteria among the considerations that definitively equates to eligibility.

The amount of authorized home health services hours are determined based on the aforementioned factors detailed above for prior authorization requests. Guidelines are also used to help allot service hours. See Box 6 for the guidelines that are used to determine the appropriate number of hours reimbursable for general categories of home health care services. However, these are guidelines only and do not override medical decisions based on individual case review (IFSSA, 2007). While guidelines are not mentioned in state codes for this policy period (chapter), they were likely used during this time and are referenced here for additional context.

Nursing Facility Care

Applicants must be evaluated using the E-Screen and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant requires long-term assistance with a skilled medical need or with three or more activities of daily living (ADLs) due to a medical condition (Melemed, 1994; Rosato et. al., 2005; IFSSA, 2017).

In order to meet an NFLOC, one or more conditions must exist from Section 1 (Box 2), or 3 or more conditions must exist from Section 2A (Box 3).

Aged & Disabled

The applicant must meet an NFLOC, which is defined using the same criteria as described above under nursing facility care (Melemed, 1994; CICOA, 2009; CMS, 2023).

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary, prior authorized, and only provided to beneficiaries who are medically confined to the home (IHCP, 2001b; IGA, 2003a). Services must be ordered by the beneficiary's physician and performed in accordance with a written plan of care. Prior authorization requests submitted by the providing home health agency to the Indiana Family and Social Services Administration (IFSSA) must include the information listed in Box 1. When prior authorization requests are reviewed, factors such as rehabilitation potential, complexity of needs, and caregiver availability are considered; however, there is no specific criteria among the considerations that definitively equates to eligibility.

Nursing Facility Care

Applicants must be evaluated using the E-Screen and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant requires long-term assistance with a skilled medical need or with three or more activities of daily living (ADLs) due to a medical condition (Melemed, 1994; Rosato et. al., 2005; IFSSA, 2017).

The E-Screen has three sections:

1. Severe Medical Conditions
2. Substantial Conditions
    - (a) Medical Conditions Including ADLs
    - (b) Mental Health Conditions
3. Daily Personal Care Needs
    - (a) Informal Supports
    - (b) Instrumental Activities of Daily Living (IADLs)

The assessment consists of a list of conditions or dependency levels that the assessor will check if they apply to the applicant. While Sections 2B, 3A, and 3B are included in the assessment, they are not used to determine eligibility for nursing facility care or the Aged & Disabled program. See Box 2 for more information on Section 1 and Box 3 for Section 2A. To view the full assessment form, see IFSSA (2017).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 4 for more information on the PASRR, and Box 5 for the MDS.

Aged & Disabled

The Aged & Disabled program also uses the E-Screen, and the same process is followed as described above under nursing facility care (Melemed, 1994; CICOA, 2009; CMS, 2023).

Evaluators

Evaluators vary by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (IHCP, 2001b; IGA, 2003a; IFSSA, 2007; IFSSA, 2023a).

Nursing Facility Care

Level of care evaluations may be conducted by hospital, nursing facility, or local Area Agency on Aging (AAA) staff, depending on the applicant's point of entry. A physician provides the certification for nursing facility services (Melemed, 1994; IFSSA, 2007; IFSSA, 2023b).

Aged & Disabled

Initial level of care evaluations are completed by an Aging and Disability Resource Center (ADRC) Options Counselor and determinations are rendered by the care manager supervisor, unless the participant has been in a nursing facility for at least ninety days. In that instance, if a participant has already received a long term level of care designation for a nursing facility stay, then that determination will serve as the initial evaluation. All initial level of care approvals are reviewed and verified by the operating Department of Aging (DA) staff prior to service implementation. Reevaluations are completed by care managers and are approved or denied by AAA management staff or DA staff (Melemed, 1994; CICOA, 2009; CMS, 2023).

Benefit limitations

Can you mix LTC benefits?

All Indiana Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Indiana enforces Estate Recovery. The acceptance of Medicaid in Indiana creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 65 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (IGA, 2003b; IGA, 2023, Ch. 9). From 1993, the age was reduced from 65 to 55 years of age.

Home Health Services

Available Indiana state documents do not detail policy on copayments or related charges for these programs during this policy period, but they are subject to federal maximum allowable cost standards that are very limited. Current (2024) sources indicate that individuals eligible under aged, blind, or disabled eligibility tracks have no cost-sharing obligations for home health services (IFSSA, 2024b).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 1992, the PNA was $30 per month. Since 1992, the PNA has increased three times. See Table 3 for the years and associated PNA increases (IFSSA, 1998; LTC Ombudsman, 2001; IFSSA, 2002; IFSSA, 2024a, p. 8).

Aged & Disabled

There are no copayments or similar charges imposed on program participants (Melemed, 1994; CICOA, 2009; CMS, 2023).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2003-2013

Policy change in 2003

In 2003, Indiana implemented eligibility track 2a (Institutional Rules), expanding Medicaid income limits up to 300% of the Supplemental Security Income (SSI) amount for certain applicants (IGA, 2003d).[7] During this period, this income limit only applied to individuals applying for home and community-based services (HCBS) programs (e.g., Aged & Disabled program), and did not extend to the institutionalized population.

Other policy changes during this period:

- (2006) Indiana extended track eligibility track 2a to beneficiaries residing in nursing facilities through a Medicaid state plan amendment (IHCP, 2006).[8]
- (2007) Indiana extended spousal impoverishment rules to the HCBS population, including those enrolled in the Aged & Disabled program (IGCPD, 2007).[9]
- (2009) Following the Deficit Reduction Act of 2005 (DRA), Indiana implemented the home equity limit. From 2009, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (IFSSA, 2024a, Ch. 3000). From 2011, this figure increases annually with inflation. Prior to the DRA, Medicaid disregarded the full value of any primary residence.
- (2011) Indiana implemented a face-to-face encounter requirement for home health service authorization as mandated by the federal government (IFSSA, 2023a). A face-to-face encounter is a meeting between the practitioner and the beneficiary related to the primary reason the beneficiary requires home health services.
- (2012) Indiana incrementally increased the look back period for all asset transfers up to 60 months, where it currently (2024) remains (IFSSA, 2012).

Overview

Long-term care (LTC) benefits in Indiana are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Indiana is administered at the state level by the Indiana Family and Social Services Administration (IFSSA), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Indiana are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Aged & Disabled program).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Aged & Disabled program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). Those applying for the Aged & Disabled program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available. However, from 2013, there has been no waiting list for the Aged & Disabled program.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and Aged & Disabled beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023c)

Indiana Law for Medicaid

- Indiana Code, Title 12 - Human Services, Article 15 - Medicaid (IGA, 2023)
- Indiana Administrative Code, Title 405 - Office of the Secretary of Family and Social Services (IGA, 2024)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Indiana Medicaid spending on beneficiaries in fiscal year 2003 was 63.48%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (63.48% in 2003), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Indiana Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Indiana.

Eligibility for Medicaid in Indiana for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States
  Indiana is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2003, the monthly federal benefit amount was $552 for an individual and $829 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $1,500 for an individual and $2,250 for a couple.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[10]
    - Home equity limit: From 2009, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (IFSSA, 2024a, Ch. 3000). From 2011, this figure increases annually with inflation.[11] See Table 4 for annual home equity limits.
  - Citizenship/immigration requirements: The applicant must be an Indiana resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2023b) for additional information.
  - Other requirements

    - In Indiana, aged, blind, and disabled individuals must submit a separate (although duplicative) state application to apply for Medicaid coverage even after determination by the Social Security Administration (SSA). Additionally, disabled individuals applying under this track are subjected to stricter disability criteria than under the Social Security Disability Income (SSDI) program.[4]
    - The applicant must be at least age 65, blind, or disabled.

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2003, this was $1,656 for an individual. Eligibility for this track is generally determined as a household of one (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized (or from 2007, enrolled in the Aged & Disabled program) and has a spouse residing in the community.[12]
  - Asset requirements: Resources may not exceed $1,500 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $2,250 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized (or from 2007, enrolled in the Aged & Disabled program) and has a spouse residing in the community.[13]
    - Asset transfer & Home equity limit: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    - The applicant must be enrolled in a federally approved HCBS program (e.g., Aged & Disabled program). From 2006, this track also included individuals residing in nursing facilities.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to be equal to or less than the medically needy income limit. As a 209(b) state, Indiana must allow aged, blind, and disabled applicants to spend down their income to become eligible for Medicaid. In 2003, this was $552 for an individual and $829 for a couple. Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized (or from 2007, enrolled in the Aged & Disabled program) and has a spouse residing in the community.[12]
  - Asset requirements: Resources may not exceed $1,500 for an individual and 2,250 for a couple. Additional asset disregards exist if a person is institutionalized (or from 2007, enrolled in the Aged & Disabled program) and has a spouse residing in the community.[13]
    - Asset transfer & Home equity limit: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Program (BCCP): From 2009, provides Medicaid coverage including long-term care for certain women with breast or cervical cancer (IDoH, 2009).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Aged & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or under age 65 and disabled (Melemed, 1994; CICOA, 2009; CMS, 2023).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE)
- Traumatic Brain Injury Program
- Program for All-Inclusive Care for the Elderly (PACE) —from 2009

Benefit

Home care benefit

Home Health Services

Home Health provides (IGA, 2003a; IGA, 2023, Ch. 5):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care

Nursing Facility Care does not provide home care.

Aged & Disabled

The Aged & Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (Melemed, 1994; CICOA, 2009; CMS, 2023):

- Personal care services
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Under the Aged & Disabled program, the above services may also be provided in an adult family care home or assisted living facility.

Semi-residential care

Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care.

Aged & Disabled

The Aged & Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (Melemed, 1994; CICOA, 2009; CMS, 2023).

Residential care

Home Health Services, Aged & Disabled

These programs do not provide residential care.

Nursing Facility Care

Indiana Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (IGA, 2009; IGA, 2023, Ch. 5). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Indiana Medicaid provides additional benefits related to LTC (IGA, 2003a):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services

- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Aged & Disabled

The Aged & Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (Melemed, 1994; CICOA, 2009):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Durable medical equipment and supplies: Additional equipment and supplies that are necessary to address participant functional limitations
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Transportation: Additional coverage of non-medical transportation to community services and activities
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Environmental modifications: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant
- Transition services: Non-reoccurring expenses for people who are in the process of transitioning from a nursing facility to a community setting (e.g., moving expenses, housing deposits)

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Indiana Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans have more limited provider networks.

Home Health Services

Skilled nursing services must be provided by a licensed registered nurse or practical nurse under the supervision of a licensed registered nurse. Home health aide services, such as personal care, assistance with medications, or ambulation, are provided by home health aides, but must be under the supervision of a licensed registered nurse (IHCP, 2001b; IGA, 2003a; IFSSA, 2023a).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (Melemed, 1994; IGA, 2006b; IFSSA, 2023b).

Aged & Disabled

The provision of care for program services will vary by authorized service (Melemed, 1994; CICOA, 2009; CMS, 2023).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary, prior authorized, and only provided to beneficiaries who are medically confined to the home (IHCP, 2001b; IGA, 2003a). Indiana's definition of "medically confined" does not mean an individual jeopardizes continued receipt of services if they leave their home, even on a very limited basis.

Nursing Facility Care

Applicants must be evaluated using the E-Screen and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant requires long-term assistance with a skilled medical need or with three or more activities of daily living (ADLs) due to a medical condition (Melemed, 1994; Rosato et. al., 2005; IFSSA, 2017).

Aged & Disabled

Applicants must meet an NFLOC, which is defined using the same criteria as described above under nursing facility care (Melemed, 1994; CICOA, 2009; CMS, 2023).

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

Home Health Services

A physician must review the plan of care and recertify the order for services every 60 days (IHCP, 2001b; IGA, 2003a). From 2011, the face-to-face encounter must occur no more than 90 days before or 30 days after the start of services, but recertification is not required (IFSSA, 2023a).

Nursing Facility Care

Nursing facility residents must have a level of care reassessment when there is a significant change in medical condition, when those with long-term care approval's medical status has improved but does not wish to leave the facility, and when those whose short-term approval is coming to an end and they have medical needs to support continued stay (Melemed, 1994; IGA, 2006a; IFSSA, 2023b).

Aged & Disabled

Program participants must be reassessed at least every 12 months or more often as needed (Melemed, 1994; CICOA, 2009; CMS, 2023).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the three largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Aged & Disabled

The individual must be at least age 65, or under age 65 and physically disabled (Melemed, 1994; CICOA, 2009; CMS, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the three largest programs.

Home Health Services

Home health services must be medically necessary, prior authorized, and only provided to beneficiaries who are medically confined to the home (IHCP, 2001b; IGA, 2003a). Applicants who, because of illness or injury, are unable to leave home without the assistance

of another person or of an assistive device, such as a wheelchair or walker, or for whom leaving the home is contrary to medical advice, are considered to be medically confined to home. Indiana's definition of "medically confined" does not mean an individual jeopardizes continued receipt of services if they leave their home, even on a very limited basis. When prior authorization requests are reviewed, factors such as rehabilitation potential, complexity of needs, and caregiver availability are considered; however, there is no specific criteria among the considerations that definitively equates to eligibility.

The amount of authorized home health services hours are determined based on the aforementioned factors detailed above for prior authorization requests. Guidelines are also used to help allot service hours. See Box 6 for the guidelines that are used to determine the appropriate number of hours reimbursable for general categories of home health care services. However, these are guidelines only and do not override medical decisions based on individual case review (IFSSA, 2007).

Nursing Facility Care

Applicants must be evaluated using the E-Screen and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant requires long-term assistance with a skilled medical need or with three or more activities of daily living (ADLs) due to a medical condition (Rosato et. al., 2005; IFSSA, 2017).

In order to meet an NFLOC, one or more conditions must exist from Section 1 (Box 2), or 3 or more conditions must exist from Section 2A (Box 3).

Aged & Disabled

The applicant must meet an NFLOC, which is defined using the same criteria as described above under nursing facility care (Melemed, 1994; CICOA, 2009; CMS, 2023).

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary, prior authorized, and only provided to beneficiaries who are medically confined to the home (IHCP, 2001b; IGA, 2003a). Services must be ordered by the beneficiary's physician and performed in accordance with a written plan of care. Prior authorization requests submitted by the providing home health agency to the Indiana Family and Social Services Administration (IFSSA) must include the information listed in Box 1. When prior authorization requests are reviewed, factors such as rehabilitation potential, complexity of needs, and caregiver availability are considered; however, there is no specific criteria among the considerations that definitively equates to eligibility.

From 2011, a face-to face encounter is required for the initial certification of medical necessity of home health services, and must occur no more than 90 days before or 30 days after the start of services. Face-to-face is not required for recertifications. A face-to-face encounter is a meeting between the practitioner and the beneficiary related to the primary reason the beneficiary requires home health services.

Nursing Facility Care

Applicants must be evaluated using the E-Screen and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant requires long-term assistance with a skilled medical need or with three or more activities of daily living (ADLs) due to a medical condition (Melemed, 1994; Rosato et. al., 2005; IFSSA, 2017).

The E-Screen has three sections:

1. Severe Medical Conditions
2. Substantial Conditions
    - (a) Medical Conditions Including ADLs
    - (b) Mental Health Conditions
3. Daily Personal Care Needs
    - (a) Informal Supports
    - (b) Instrumental Activities of Daily Living (IADLs)

The assessment consists of a list of conditions or dependency levels that the assessor will check if they apply to the applicant. While Sections 2B, 3A, and 3B are included in the assessment, they are not used to determine eligibility for nursing facility care or

the Aged & Disabled program. See Box 2 for more information on Section 1 and Box 3 for Section 2A. To view the full assessment form, see IFSSA (2017).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 4 for more information on the PASRR, and Box 5 for the MDS.

Aged & Disabled

The Aged & Disabled program also uses the E-Screen, and the same process is followed as described above under nursing facility care (Melemed, 1994; CICOA, 2009; CMS, 2023).

Evaluators

Evaluators vary by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (IHCP, 2001b; IGA, 2003a; IFSSA, 2007; IFSSA, 2023a).

Nursing Facility Care

Level of care evaluations may be conducted by hospital, nursing facility, or local Area Agency on Aging (AAA) staff, depending on the applicant's point of entry. A physician provides the certification for nursing facility services (Melemed, 1994; IFSSA, 2007; IFSSA, 2023b).

Aged & Disabled

Initial level of care evaluations are completed by an Aging and Disability Resource Center (ADRC) Options Counselor and determinations are rendered by the care manager supervisor, unless the participant has been in a nursing facility for at least ninety days. In that instance, if a participant has already received a long term level of care designation for a nursing facility stay, then that determination will serve as the initial evaluation. All initial level of care approvals are reviewed and verified by the operating Department of Aging (DA) staff prior to service implementation. Reevaluations are completed by care managers and are approved or denied by AAA management staff or DA staff (Melemed, 1994; CICOA, 2009; CMS, 2023).

Benefit limitations

Can you mix LTC benefits?

All Indiana Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Indiana enforces Estate Recovery. The acceptance of Medicaid in Indiana creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (IGA, 2003b; IGA, 2023, Ch. 9).

Home Health Services

Available Indiana state documents do not detail policy on copayments or related charges for these programs during this policy period, but they are subject to federal maximum allowable cost standards that are very limited. Current (2024) sources indicate that individuals eligible under aged, blind, or disabled eligibility tracks have no cost-sharing obligations for home health services (IFSSA, 2024b).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2003, the PNA was $52 per month (IFSSA, 2002).

Aged & Disabled

There are no copayments or similar charges imposed on program participants (CICOA, 2009; CMS, 2023).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2014-2024

Policy change in 2014

In 2014, Indiana transitioned from a 209(b) state to a 1634 state. This meant that rather than making their own state determinations of Medicaid eligibility for individuals receiving Supplemental Security Income (SSI), they now automatically provided Medicaid coverage to SSI recipients determined eligible by the Social Security Administration (SSA). The 1634 transition replaced eligibility track 1b (209(b) states) with eligibility track 1a (Supplemental Security Income recipients). During this transition, Indiana also made the following changes:

- Discontinued eligibility track 3a (Medically Needy aged, blind, and disabled adults), so this population could no longer spend down their income to become eligible for Medicaid. If an individual has monthly income above this threshold, they can set up a Qualified Income Trust to meet this standard.
- Implemented eligibility track 2b (Federal Poverty Level aged and disabled), which provides Medicaid coverage to adults at least age 65 or older and disabled adults up to 100% of the federal poverty level (FPL) (IFSSA, 2014).
- Increased asset limits for the aged, blind, and disabled populations. The asset limit of $1,500 for a single person increased to $2,000, and the asset limit of $2,250 for a married couple (when both are receiving Medicaid) increased to $3,000 (Harvey, 2014).

Other policy changes during this period:

- (2015) Indiana received approval for and implemented Healthy Indiana Plan 2.0, a Medicaid plan that provided Medicaid expansion under the ACA. Medicaid expansion implements eligibility track 2c (ACA expansion adults), a track providing coverage to adults aged 19-64 with incomes up to 138% of the FPL. In Indiana, this eligibility track requires participants to make monthly contributions similar to a Health Savings Account (HSA).
- (2015) Indiana implemented Hoosier Care Connect, which transitioned aged, blind, and disabled beneficiaries to managed care. Individuals receiving state plan home care services (e.g., home health services), would now receive these through their managed care plan. However, there was no substantive change to home and community-based services (HCBS) programs or other long-term care (LTC), as individuals enrolled in these programs and residents of nursing facilities were not covered by the new plan.
- (2016) Indiana implemented the InterRAI-HC assessment tool into the nursing facility level of care determination process. However, the InterRAI-HC was added to help capture additional information on the applicant to inform care planning and serve as a supplement, while the E-Screen remained the primary level of care determination tool (IFSSA, 2017).
- (2020) The Consumer-Directed Personal Assistance benefit was added to the Aged & Disabled program.
- (2023) Indiana's home health services policy changed eligibility requirements for authorization and updated service authorization processes (IFSSA, 2023a). These policies are detailed in the *Minimum Level of Dependence*, *Evaluation of Dependence*, and *Definition of Dependence* sections of this policy period (chapter).
- (2023) The caregiver training benefit was added to the Aged & Disabled program (CMS, 2023).

Overview

Long-term care (LTC) benefits in Indiana are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Indiana is administered at the state level by the Indiana Family and Social Services Administration (IFSSA), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Indiana are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Aged & Disabled program).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Aged & Disabled program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC). There is no waitlist for the Aged & Disabled program.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and Aged & Disabled beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive

assessment prior to admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023c)

Indiana Law for Medicaid

- Indiana Code, Title 12 - Human Services, Article 15 - Medicaid (IGA, 2023)
- Indiana Administrative Code, Title 405 - Office of the Secretary of Family and Social Services (IGA, 2024)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Indiana Medicaid spending on beneficiaries in fiscal year 2014 was 66.92%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (66.92% in 2014), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.[14]

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Indiana Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Indiana.

Eligibility for Medicaid in Indiana for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2014, the monthly federal benefit amount was $721 for an individual and $1,082 for a couple (SSA, 2023a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989 (for SSI).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[15]

        - Home equity limit: The equity interest in the individual's home may not exceed $543,000, or else they will be ineligible for LTC services (IFSSA, 2024a, Ch. 3000). This figure increases annually with inflation.[11] See Table 4 for annual home equity limits.
    - Citizenship/immigration requirements: The applicant must be an Indiana resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2023b) for additional information.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[16]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
    - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2014, this was $2,163 for an individual. Eligibility for this track is generally determined as a household of one (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Aged & Disabled program and has a spouse residing in the community.[17] If an individual has monthly income above this threshold, they can set up a Qualified Income Trust to meet this standard.
    - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized or enrolled in the Aged & Disabled program and has a spouse residing in the community.[18]
        - Asset transfer & Home equity limit: Same as eligibility track 1b.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
    - Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., Aged & Disabled program)
- 2b. Federal Poverty Level (FPL) aged and disabled
    - Income requirements: Monthly income may not exceed 100% of the federal poverty level (FPL). In 2014, this was $973 for an individual and $1,311 for a couple. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Aged & Disabled program and has a spouse residing in the community.[17]
    - Asset requirements: Same asset requirements as eligibility track 1b. Additional asset disregards exist if a person is institutionalized or enrolled in the Aged & Disabled program and has a spouse residing in the community.[18]
        - Asset transfer & Home equity limit: Same as eligibility track 1b.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[16]
- 2c. Affordable Care Act (ACA) expansion adults (from 2015)
    - Income requirements: Monthly income may not exceed 138% of the FPL. In 2015, this was $1,354 for an individual and $1,832 for a household of two. See Table 2 for historical income limits.
    - Asset requirements: There is no asset test for this population.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
    - Other requirements
        - Applicants must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.
        - Applicants may be required to contribute to a savings account similar to an HSA. See Box 7 for more information.
        - In order to receive LTC benefits, applicants must be determined medically frail.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Program (BCCP): Provides Medicaid coverage including long-term care for certain women with breast or cervical cancer (IDoH, 2009).

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Aged & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or under age 65 and disabled (CICOA, 2009; CMS, 2023).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE)
- Traumatic Brain Injury Program
- Program for All-Inclusive Care for the Elderly (PACE)
- End Stage Renal Disease Program —from 2015

Benefit

Home care benefit

Home Health Services

Home Health provides (IGA, 2003a; IGA, 2023, Ch. 5):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care

Nursing Facility Care does not provide home care.

Aged & Disabled

The Aged & Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (Melemed, 1994; CICOA, 2009; CMS, 2023):

- Personal care services —from 2020, these may be consumer-directed
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Under the Aged & Disabled program, the above services may also be provided in an adult family care home or assisted living facility.

Semi-residential care

Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care.

Aged & Disabled

The Aged & Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (Melemed, 1994; CICOA, 2009; CMS, 2023).

Residential care

Home Health Services, Aged & Disabled

These programs do not provide residential care.

Nursing Facility Care

Indiana Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (IGA, 2009; IGA, 2023, Ch. 5). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing

- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Indiana Medicaid provides additional benefits related to LTC (IGA, 2023, Ch. 5):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Aged & Disabled

The Aged & Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (CMS, 2023):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Durable medical equipment and supplies: Additional equipment and supplies that are necessary to address participant functional limitations
- Transportation: Additional coverage of non-medical transportation to community services and activities
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Environmental modifications: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant
- Transition services: Non-reoccurring expenses for people who are in the process of transitioning from a nursing facility to a community setting (e.g., moving expenses, housing deposits)
- Caregiver training: Instruction provided to a participant or caregiver to teach a variety of skills necessary for independent living, such as the use of specialized or adaptive equipment and assistance with ADLs —from 2023

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Indiana Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans have more limited provider networks.

Home Health Services

Skilled nursing services must be provided by a licensed registered nurse or practical nurse under the supervision of a licensed registered nurse. Home health aide services, such as personal care, assistance with medications, or ambulation, are provided by home health aides, but must be under the supervision of a licensed registered nurse (IHCP, 2001b; IGA, 2003a; IFSSA, 2023a).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (Melemed, 1994; IGA, 2006b; IFSSA, 2023b).

Aged & Disabled

The provision of care for program services will vary by authorized service (Melemed, 1994; CICOA, 2009; CMS, 2023).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary, prior authorized, and only provided to beneficiaries who are medically confined to the home (IHCP, 2001b; IGA, 2003a). Indiana's definition of "medically confined" does not mean an individual jeopardizes continued receipt of services if they leave their home, even on a very limited basis. Individuals eligible for Medicaid under eligibility track 2c must be determined medically frail in order to receive this benefit. See Box 8 for conditions that may qualify an individual as medically frail (CMS, 2018).

In 2023, Indiana's home health services policy changed eligibility requirements for authorization (IFSSA, 2023a). Prior authorization is satisfied if at least one indicator from each of the following two categories is present: (1) Member, and (2) Caregiver. See Box 9 for the list of indicators.

Nursing Facility Care

Applicants must be evaluated using the E-Screen and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant requires long-term assistance with a skilled medical need or with three or more activities of daily living (ADLs) due to a medical condition (IFSSA, 2017).

Aged & Disabled

Applicants must meet an NFLOC, which is defined using the same criteria as described above under nursing facility care (CICOA, 2009; CMS, 2023).

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

Home Health Services

The face-to-face encounter must occur no more than 90 days before or 30 days after the start of services. Recertification for services is required every 60 days, but face-to-face is not required (IFSSA, 2023a).

Nursing Facility Care

Nursing facility residents must have a level of care reassessment when there is a significant change in medical condition, when those with long-term care approval's medical status has improved but does not wish to leave the facility, and when those whose short-term approval is coming to an end and they have medical needs to support continued stay (IGA, 2006a; IFSSA, 2023b).

Aged & Disabled

Program participants must be reassessed at least every 12 months or more often as needed (CICOA, 2009; CMS, 2023).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the three largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Aged & Disabled

The individual must be at least age 65, or under age 65 and physically disabled (Melemed, 1994; CICOA, 2009; CMS, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the three largest programs.

Home Health Services

Home health services must be medically necessary, prior authorized, and only provided to beneficiaries who are medically confined to the home (IHCP, 2001b; IGA, 2003a). Applicants who, because of illness or injury, are unable to leave home without the assistance of another person or of an assistive device, such as a wheelchair or walker, or for whom leaving the home is contrary to medical advice, are considered to be medically confined to home. Indiana's definition of "medically confined" does not mean an individual jeopardizes continued receipt of services if they leave their home, even on a very limited basis. When prior authorization requests are reviewed, factors such as rehabilitation potential, complexity of needs, and caregiver availability are considered; however, there is no specific criteria among the considerations that definitively equates to eligibility. Individuals eligible for Medicaid under eligibility track 2c must be determined medically frail in order to receive this benefit. See Box 8 for conditions that may qualify an individual as medically frail.

The amount of authorized home health services hours are determined based on the aforementioned factors detailed above for prior authorization requests. Guidelines are also used to help allot service hours. See Box 6 for the guidelines that are used to determine the appropriate number of hours reimbursable for general categories of home health care services. However, these are guidelines only and do not override medical decisions based on individual case review (IFSSA, 2007).

From 2023, Indiana's home health services policy changed eligibility requirements for authorization (IFSSA, 2023a). Prior authorization is satisfied if at least one indicator from each of the following two categories is present: (1) Member, and (2) Caregiver. See Box 9 for a list of indicators. The aforementioned hourly guidelines continued to be used to determine service hours.

Nursing Facility Care

Applicants must be evaluated using the E-Screen and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant requires long-term assistance with a skilled medical need or with three or more activities of daily living (ADLs) due to a medical condition (IFSSA, 2017).

In order to meet an NFLOC, one or more conditions must exist from Section 1 (Box 2), or 3 or more conditions must exist from Section 2A (Box 3).

Aged & Disabled

The applicant must meet an NFLOC, which is defined using the same criteria as described above under nursing facility care (CICOA, 2009; CMS, 2023).

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home health services must be medically necessary, prior authorized, and only provided to beneficiaries who are medically confined to the home (IHCP, 2001b; IGA, 2003a). Services must be ordered by the beneficiary's physician and performed in accordance with a written plan of care. Prior authorization requests submitted by the providing home health agency to the Indiana Family and Social Services Administration (IFSSA) must include the information listed in Box 1. When prior authorization requests are reviewed, factors such as rehabilitation potential, complexity of needs, and caregiver availability are considered; however, there is no specific criteria among the considerations that definitively equates to eligibility. Individuals eligible for Medicaid under eligibility track 2c must be determined medically frail in order to receive this benefit. See Box 8 for conditions that may qualify an individual as medically frail (CMS, 2018).

A face-to face encounter is required for the initial certification of medical necessity of home health services, and must occur no more than 90 days before or 30 days after the start of services. Face-to-face is not required for recertifications. A face-to-face

encounter is a meeting between the practitioner and the beneficiary related to the primary reason the beneficiary requires home health services.

From 2023, Indiana's home health services policy changed eligibility requirements for authorization (IFSSA, 2023a). Prior authorization is satisfied if at least one indicator from each of the following two categories is present: (1) Member, and (2) Caregiver. See Box 9 for a list of indicators.

Nursing Facility Care

Applicants must be evaluated using the E-Screen and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant requires long-term assistance with a skilled medical need or with three or more activities of daily living (ADLs) due to a medical condition (Rosato et. al., 2005; IFSSA, 2017).

The E-Screen has three sections:

1. Severe Medical Conditions
2. Substantial Conditions
    - (a) Medical Conditions Including ADLs
    - (b) Mental Health Conditions
3. Daily Personal Care Needs
    - (a) Informal Supports
    - (b) Instrumental Activities of Daily Living (IADLs)

The assessment consists of a list of conditions or dependency levels that the assessor will check if they apply to the applicant. While Sections 2B, 3A, and 3B are included in the assessment, they are not used to determine eligibility for nursing facility care or the Aged & Disabled program. See Box 2 for more information on Section 1 and Box 3 for Section 2A. To view the full assessment form, see IFSSA (2017).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 4 for more information on the PASRR, and Box 5 for the MDS.

Aged & Disabled

The Aged & Disabled program also uses the E-Screen, and the same process is followed as described above under nursing facility care (CICOA, 2009; CMS, 2023).

Evaluators

Evaluators vary by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (IHCP, 2001b; IGA, 2003a; IFSSA, 2007; IFSSA, 2023a).

Nursing Facility Care

Level of care evaluations may be conducted by hospital, nursing facility, or local Area Agency on Aging (AAA) staff, depending on the applicant's point of entry. A physician provides the certification for nursing facility services (Melemed, 1994; IFSSA, 2007; IFSSA, 2023b).

Aged & Disabled

Initial level of care evaluations are completed by an Aging and Disability Resource Center (ADRC) Options Counselor and determinations are rendered by the care manager supervisor, unless the participant has been in a nursing facility for at least ninety days. In that instance, if a participant has already received a long term level of care designation for a nursing facility stay, then that determination will serve as the initial evaluation. All initial level of care approvals are reviewed and verified by the operating Department of Aging (DA) staff prior to service implementation. Reevaluations are completed by care managers and are approved or denied by AAA management staff or DA staff (Melemed, 1994; CICOA, 2009; CMS, 2023).

Benefit limitations

Can you mix LTC benefits?

All Indiana Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Indiana enforces Estate Recovery. The acceptance of Medicaid in Indiana creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (IGA, 2003b; IGA, 2023, Ch. 9).

Home Health Services

Beneficiaries have no cost-sharing obligations under Indiana Medicaid for home health services (IFSSA, 2024b). Individuals eligible for Medicaid through the Healthy Indiana Plan may be required to pay copayments or make contributions to a POWER savings account. See Box 7 for more information.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2014, the PNA was $52 per month (IFSSA, 2002).

Aged & Disabled

There are no copayments or similar charges imposed on program participants (CICOA, 2009; CMS, 2023).

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Indiana Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	63.85%
1993	63.21
1994	63.49
1995	63.03
1996	62.57
1997	61.58
1998	61.41
1999	61.01
2000	61.74
2001	62.04
2002	62.04
2003	63.48
2004	64.53
2005	62.78
2006	62.98
2007	62.61
2008	62.69
2009	73.72
2010	75.69
2011	71.75
2012	66.96
2013	67.16
2014	66.92
2015	66.52
2016	66.60
2017	66.74
2018	65.59
2019	65.96
2020	70.49
2021	72.03
2022	72.50
2023 [1]	70.63
2024	65.99

Source: U.S. DHHS (2023)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period. [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Historical Indiana Medicaid Income Limits & Spousal Impoverishment Standards

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	100% FPL (Individual)	100% FPL (Couple)	138% FPL (Individual)	138% FPL (Couple)
1992	$422.00	$633.00						
1993	434.00	652.00						
1994	446.00	669.00						
1995	458.00	687.00						
1996	470.00	705.00						
1997	484.00	726.00						
1998	494.00	741.00						
1999	500.00	751.00						
2000	513.00	769.00						
2001	531.00	796.00						
2002	545.00	817.00						
2003	552.00	829.00	$1,656.00	$2,487.00				
2004	564.00	846.00	1,692.00	2,538.00				
2005	579.00	869.00	1,737.00	2,607.00				
2006	603.00	904.00	1,809.00	2,712.00				
2007	623.00	934.00	1,869.00	2,802.00				
2008	637.00	956.00	1,911.00	2,868.00				
2009	674.00	1,011.00	2,022.00	3,033.00				
2010	674.00	1,011.00	2,022.00	3,033.00				
2011	674.00	1,011.00	2,022.00	3,033.00				
2012	698.00	1,048.00	2,094.00	3,144.00				
2013	710.00	1,066.00	2,130.00	3,198.00				
2014	721.00	1,082.00	2,163.00	3,246.00	$973.00	$1,311.00		
2015	733.00	1,100.00	2,199.00	3,300.00	981.00	1,328.00	$1,354.00	$1,832.00
2016	733.00	1,100.00	2,199.00	3,300.00	990.00	1,335.00	1,367.00	1,843.00
2017	735.00	1,103.00	2,205.00	3,309.00	1,005.00	1,354.00	1,387.00	1,868.00
2018	750.00	1,125.00	2,250.00	3,375.00	1,012.00	1,372.00	1,397.00	1,893.00
2019	771.00	1,157.00	2,313.00	3,471.00	1,041.00	1,410.00	$1,437.00	$1,945.00
2020	783.00	1,175.00	2,349.00	3,525.00	1,064.00	1,437.00	1,468.00	1,983.00
2021	794.00	1,191.00	2,382.00	3,573.00	1,074.00	1,452.00	1,482.00	2,004.00
2022	841.00	1,261.00	2,523.00	3,783.00	1,133.00	1,526.00	1,564.00	2,106.00
2023	914.00	1,371.00	2,742.00	4,113.00	1,215.00	1,643.00	1,677.00	2,268.00

Source: SSA (2023b)

Notes: SSI and federal poverty level (FPL) amounts for individuals and couples are monthly. While Indiana was a 209(b) state until 2014, they still covered the SSI population at the income limit of track 1a (SSI recipients). Income limits at 300% of the SSI amount, 100% of the FPL, and 138% of the FPL begin in 2003, 2014, and 2015, respectively, corresponding to Indiana's implementation of each eligibility track.

Box 1: Required Items to Include in Home Health Prior Authorization Requests

The following information must be submitted with the written prior authorization request form:

1. The name, address, age, and Medicaid number of the patient.
2. The name, address, telephone number, provider number, and original signature, or a copy of the original signature (signature stamps are also acceptable) of the provider.
3. Diagnosis and related information (ICD-9-CM code).
4. Services or supplies requested with appropriate CPT, HCPCS, or ADA code.
5. Name of suggested provider of services or supplies.
6. Date of onset of medical problems.
7. Plan of treatment.
8. Treatment goals.
9. Rehabilitation potential (where indicated).
10. Prognosis (where indicated).
11. Description of previous services or supplies provided, length of such services, or when supply or modality was last provided.
12. Statement whether durable medical equipment will be purchased, rented, or repaired and the duration of need.
13. Statement of any other pertinent clinical information that the provider deems necessary to justify medical necessity.
14. Additional information may be required as needed for clarification, including, but not limited to, the following:
    - X-rays.
    - Photographs.
    - Other services being received.

Source: IGA (2003a)

Box 2: Indiana E-Screen: Section 1 - Severe Medical Conditions

Section 1: Severe Medical Conditions

The focus of this section is on the need for nursing facility care as determined by unstable complex medical conditions.

1. Direct assistance from others is needed with any of the following conditions at least 5 days per week:
    - A. Treatment of extensive (stage 3 or 4) Decubitus Ulcers (Note: Describe size and stage)
    - B. A Comatose condition
    - C. Management of severe pain requiring frequent injections
2. Direct assistance from others is required with any of the following prescribed medical equipment or interventions at least 3 days per week:
    - A. Ventilator / Respirator
    - B. Suctioning
    - C. Tube feeding / Gastronomy care
    - D. Central venous access or I.V.
3. Direct assistance from others is required for special routines or prescribed treatments that must be followed at least 5 days per week:
    - A. Tracheostomy
    - B. Acute rehabilitation condition requiring physical therapy, occupational therapy, and/or speech therapy —general strengthening exercise programs are excluded
    - C. Administration of continuous oxygen for a new or recent condition when the individual's overall condition requires the significant involvement of skilled nursing personnel
4. Direct assistance from others is required to administer physician prescribed medicine (excluding vitamins) by intramuscular, intravenous, or subcutaneous injection more than 1 time per day, other than insulin injections for an individual whose diabetes is under control
5. Medical observation and physician assessment due to a changing, unstable physical condition is required more often than every 30 days (Note: Assessor must document the specifics)
6. Direct assistance from others is required for the safe management of an uncontrolled Grand Mal seizure disorder (i.e., at least weekly seizure activity)

Source: IFSSA (2017)

Notes: While the referenced source was published in 2017, Appendix J. (E-Screen form) is dated 2001, demonstrating that it has been in use from at least 2001.

Box 3: Indiana E-Screen: Section 2A - Substantial Medical Conditions Including Activities of Daily Living (ADLs)

1. The person has experienced a sigificant deterioration in overall condition of health in the last six months.
2. The person requires daily recording of the kind and amounts of fluids and solids intake and output.
3. The person requires direct assistance with the administration of oxygen (either continuous or as needed) for a chronic or stable condition.
4. The person requires supervision and direct assistance on a daily basis to ensure that physician prescribed medications are taken correctly.
5. The person requires 24 hours a day supervision and/or direct assistance to maintain safety due to confusion and/or disorientation that is not related to or a result of mental illness.
6. The person requires direct assistance with turning or repositioning every 2-4 hours to prevent skin breakdown per medical plan of care.
7. The person requires passive range of motion exercise on a daily basis per medical plan of care.
8. To maintain a stable medical condition, the person requires monitoring of the health care plan on a 24 hour a day, seven day a week basis by a licensed nurse.
9. The person is unable to eat without direct assistance. This does not include meal preparation.
10. The person is unable to transfer from a bed or chair without direct assistance.
11. The person is unable to change clothes without direct assistance. This does not include needing help with tying their shoes or grooming. If the individual is able to perform this activity with adaptive equipment (i.e., velcro closures or stocking pullers), do not check.
12. The person is unable to bathe without direct assistance. This does not include needing help with washing back, feet, or grooming.
13. The person is unable to manage bowel and/or bladder function without direct assistance. If able to self catheterize or self apply and change an incontinency product, do not check.
14. The person is unable to ambulate or use a wheelchair without direct assistance. This includes the individual who is currently experiencing frequent falls despite the use of an assistance device (e.g., cane or walker). If they are able to safely ambulate with an assistive device, or appropriately self propel a wheelchair, do not check.

Source: IFSSA (2017)
Notes: While the referenced source was published in 2017, Appendix J. (E-Screen form) is dated 2001, demonstrating that it has been in use from at least 2001.

Box 4: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 5: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

Box 6: Home Health Services - Hourly Guidelines

The amount of authorized home health services hours are determined based off the individual's severity and complexity of their medical condition(s), and many factors are taken into account including the beneficiary's complexity of need, rehabilitation potential, and caregiver availability. The following guidelines are used to determine the appropriate number of hours reimbursable for general categories of home health care services. However, these are guidelines only and do not override medical decisions based on individual case review.

- 3-7 hours per day: Persons who require primarily heavy physical care with some skilled nursing monitoring to avoid deterioration, may receive three to seven hours of home health care per day. These members are generally stable but with chronic conditions such as congenital anomalies, neuromuscular disorders, central nervous system disorders or other disorders that severely disrupt the capacity to care for one's self.
- 8 hours per day: Members who require extensive care and daily monitoring of their medical/physical conditions, but who do not possess the same degree of potential to deteriorate quickly into life-threatening situations as do members requiring 24-hour monitoring, may receive up to eight hours of home health care daily. An additional hour or two may be allowed for transportation to and from work in situations where the caregivers work full-time outside the home.
- Up to 12 hours per day: Members requiring 24-hour monitoring may be authorized for up to 12 hours a day of skilled nursing or home health aide services to prevent deterioration in life sustaining systems. Examples of these conditions include but are not limited to severe respiratory conditions or tracheostomy care.
- Up to 16 hours per day: Special situations may occur where home health hours may be approved for up to 16 hours per day of skilled care on an ongoing basis, although each individual situation must be evaluated with a prior authorization request.

Source: IFSSA (2007)

Table 3: Indiana Changes to the Personal Needs Allowance (PNA)

Year	PNA
1998	$35
1999	50
2002	52

Source: IFSSA (1998); LTC Ombudsman (2001); IFSSA (2002); IFSSA (2024a)

Table 4: Annual Home Equity Limits

Year	Limit
2009	$500,000
2010	500,000
2011	506,000
2012	525,000
2013	536,000
2014	543,000
2015	552,000
2016	552,000
2017	560,000
2018	572,000
2019	585,000
2020	595,000
2021	603,000
2022	636,000
2023	688,000
2024	713,000

Source: IFSSA (2024a)

Box 7: Indiana Healthy Indiana Plan 2.0 - Additional Requirements

The Healthy Indiana Plan (HIP), authorized under a section 1115(a) demonstration, provides authority for the state to offer a new plan that provides health care coverage for adults and an account similar to a health savings account called a Personal Wellness and Responsibility (POWER) Account. Under this approval, Indiana has been granted the authority to change premium and copayment amounts without submitting an amendment to CMS.

POWER Accounts

Under HIP, beneficiaries who consistently make required monthly contributions to their POWER Account will maintain access to an enhanced benefit plan, known as HIP Plus, which will include enhanced benefits such as dental, vision, and chiropractic coverage. Beneficiaries with income at or below 100% of the federal poverty level (FPL) who do not make monthly POWER Account contributions will be defaulted to a more limited benefit plan meeting alternative benefit plan requirements (known as HIP Basic). Individuals above 100% of the FPL who do not make monthly contributions would be disenrolled and subject to 6-month non-eligibility period. The HIP Basic plan will require copayments for all services in amounts that would be permitted in the state plan rather than the monthly POWER Account contributions required to participate in the HIP Plus plan. All beneficiaries will have the opportunity to have their POWER Account contributions reduced in subsequent years for completion of preventive services and through successfully managing their POWER Accounts.

Other User Charges

Individuals covered under the demonstration, regardless of income, who make POWER account contributions shall be enrolled in HIP Plus. Those enrolled in HIP Plus will not be subject to cost sharing, with the exception of an $8 copayment for nonemergency use of emergency department services. Beneficiaries enrolled in HIP Plus who are identified as tobacco users will have a tobacco user surcharge equal to a 50% increase in individual contribution amount. Adults with incomes at or below 100% of the FPL who do not choose to make contributions will be enrolled in HIP Basic and will be subject to copayments at levels permitted under federal Medicaid rules.

Source: CMS (2018)

Box 8: Eligibility track 2c (ACA expansion adults) Medically Frail Requirements

In order to receive long-term care (LTC) services under this eligibility track, individuals must be determined medically frail. There are several conditions that may qualify an individual as medically frail, however, having a condition on this list does not guarantee they will be considered frail. Severity of the condition may also be evaluated.

Medical

- Cancer: includes all cancers subject to the 150 point limit
- Aplastic anemia
- Cerebral vascular accidents
- Transplant or transplant wait list for heart, lung, liver, kidney or bone marrow
- HIV, AIDS
- Blood clotting disorders, frequent blood transfusions
- Lipid storage diseases: Tay Sach's disease, Nieman Pick disease, Fabry's disease
- Primary immune deficiencies: DiGeorge syndrome, combined immune deficiency, Wiskott-Aldrich syndrome, T-cell deficiency
- Muscular dystrophy
- Primary pulmonary hypertension
- Amyotrophic lateral sclerosis
- Cirrhosis
- Chronic hepatitis B or hepatitis C
- Cystic fibrosis
- Diabetes mellitus with: ketoacidosis, hypersmolar coma, renal complications, retinopathy, peripheral vascular complications, or coronary artery disease
- Renal failure / end stage renal disease
- CMV retinitis
- Tuberculosis
- Paraplegia or quadriplegia

Mental Health

- Alcohol and substance abuse
- Mental illness including major depression, schizophrenia, bipolar disorder or post-traumatic stress disorder

Activities of Daily Living

- Need assistance in an activity of daily living
  - 24 hour supervision and/or direct assistance to maintain safety due to confusion and/or disorientation
  - Turning or repositioning every 2 to 4 hours to prevent skin breakdown per medical plan of care
  - 24 hour monitoring of a health care plan by a license-nurse
  - Eating
  - Transferring from bed or chair
  - Dressing
  - Bathing
  - Using the toilet
  - Walking or using a wheelchair

Source: CMS (2018); IFSSA (2024c)

Box 9: Home Health Services: Eligibility Indicators

At least one indicator from each of the following two categories must be present for a beneficiary to be eligible for home health services:

1. Member
    - The member is at risk of respiratory failure, severe deterioration or hospitalization without constant monitoring.
    - The member requires total care - monitoring 24 hours per day.
    - The member desires to stay in the home, rather than in a long-term care (LTC) facility.
    - The medical condition of the member has deteriorated, creating the need for more intense short-term care (practitioner's statement required).
2. Caregiver
    - The member does not have a primary caregiver or access to other care.
    - The caregiver is employed and absent from the home or is unable to provide the necessary care.
    - The caregiver has additional child-care responsibilities, disallowing the time needed to care for the member (three or more children under 6 years of age, or four or more children under the age of 10).
    - The caregiver has additional children with special needs to care for (one or more children with special healthcare needs requiring extensive medical and physical care).
    - A caregiver is experiencing a major illness or injury, with expectation of recovery.
    - There is a temporary but significant change in the availability of a caregiver - for example, military service.
    - There is a significant permanent change in a caregiver's status - for example, death or divorce with loss of one caregiver.

Source: IFSSA (2023a)

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1634 State: States known as "1634" states are states that have completed a "1634 agreement" with the Social Security Administration. This agreement determines eligibility for a specific state's Medicaid program for Supplemental Security Income (SSI) recipients, known as categorical eligibility. The agreements are only with states that use SSI criteria to determine Medicaid eligibility, in contrast to "209(b)" states that have their own criteria and do not automatically provide Medicaid coverage to SSI recipients.

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary. In Indiana, this service is referred to as "Adult day services."

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably is the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Aged & Disabled program: Indiana's main 1915(c) program that provides home and community-based services to participants who, but for the provision of such services, would require nursing facility level of care.

Aging and Disability Resource Center (ADRC): One-stop resource centers for information about programs and services available to older adults, people with disabilities, or their caregivers in Indiana. Staff at Indiana ADRCs conduct evaluations for the Aged & Disabled program.

Area Agency on Aging (AAA): Indiana's Area Agencies on Aging provide case management, information and referrals to various services for persons who are aging or developmentally disabled. They also may conduct evaluations for nursing home care or the Aged & Disabled program.

Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE): CHOICE is a state-funded long-term care program provided to olders adults in Indiana. CHOICE applicants must be at least 60 years of age or have a disability. Applicants must

also be found to be at risk of losing their independence, usually indicated by difficulties with activities of daily living, such as bathing, dressing, walking, transferring or medications set-ups. CHOICE funds may not be used if other funding such as Medicare or Medicaid is available to meet the individual's needs.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Consumer-Directed Personal Assistance Services (CDPAS): Personal care services provided by an aide that is hired and managed by the recipient. In Indiana, this service is referred to as "participant directed home care."

Deficit Reduction Act of 2005 (DRA): Federal legislation that established Self-Directed Personal Assistance, the Section 1915(i) State Plan Option, and home equity limits.

Eligibility Screen (E-Screen): The Indiana state assessment tool used to determine eligibility for the Aged & Disabled program and nursing facility care.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that generally automatically results in Medicaid coverage for individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with low income and assets.

Eligibility Track 1b. 209(b) States: The Social Security Act provides states the authority to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program. States that elect this option are called 209(b) states. Because eligibility for SSI does not guarantee Medicaid eligibility in a 209(b) state, these states do not cover the mandatory SSI Beneficiaries group. Instead, 209(b) states impose more restrictive criteria through the mandatory 209(b) group. A person receiving SSI can still be eligible for Medicaid in the mandatory 209(b) group, but that person must also meet the more restrictive eligibility requirements imposed by the state.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits up to 100 percent of the federal poverty level for individuals that are at least age 65, blind, or disabled.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. Indiana does not limit recovery to the federally required minimum services and seeks recovery of payments for all medical assistance received.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the

average per capita income for each State relative to the national average. The minimum FMAP is 50 percent. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50 percent with exceptions for some administrative activities such as training and compensation of skilled professionals (75 percent) and preadmission screening and resident review (75 percent).

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed.

Health Savings Account (HSA): A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses.

Healthy Indiana Plan 2.0: The Healthy Indiana Plan is a Medicaid health-insurance program for qualified adults. The plan covers Hoosiers ages 19 to 64 whose family incomes are less than approximately 138 percent of the federal poverty level and who aren't eligible for Medicare or another Medicaid category.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Hoosier Care Connect: Hoosier Care Connect is a Medicaid health care program for individuals who are aged 65 years and older, blind, or disabled and who are also not eligible for Medicare.

Indiana Department of Aging: The Department of Aging is a department within the IFSSA that administers long-term care Medicaid programs for older adults in Indiana.

Indiana Family and Social Services Administration (IFFSA): The IFSSA is Indiana's single state agency that administers the state Medicaid program.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Intermediate Care Facility (ICF): A long term care facility that provides nursing and supportive care to residents on a non-continuous skilled nursing care basis, under a physician's direction. An ICF is typically regarded as a lower-level nursing care facility when compared to a skilled nursing facility (SNF), but its residents require more care and attention than those in a residential care facility for elderly or an adult residential care facility.

Managed Care Organization (MCO): Health plans that administer Medicaid services and contract with providers to deliver services. MCOs receive a capitated per member per month fee from the state and reimburse providers for services enrollees receive.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit

package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically frail: Medically frail refers to a federally required designation of members who have disabling mental disorders, including serious mental illness, chronic substance use disorders, serious or complex medical conditions, physical, intellectual or developmental disabilities that significantly impair the ability to perform one or more activities of daily living, or a disability determination based on Social Security Administration criteria.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy Income Limit (MNIL): The income standard that a Medicaid applicant must spend-down to meet if they are seeking Medicaid eligibility through eligibility track 3a (medically needy aged, blind, and disabled). Typically, this standard is very low.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is a optional pathway.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care, and more.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility. In Indiana, this service is two separate services referred to as "Attendant Care" and "Home and Community Assistance Service" under the Aged & Disabled program.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

Private duty nursing: Private duty nursing services consist of individual and continuous care (in contrast to part-time or intermittent care) provided by licensed nurses within the scope of the State's Nurse Practice Act.

Program of All-inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults still living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. However, enrollment in PACE programs is typically capped at a relatively low number of participants.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Qualified Income Trust: A Qualified Income Trust (QIT), or Miller Trust, is an irrevocable trust that allows individuals with excess income to qualify for Medicaid benefits. Each month, the beneficiary's excess income is deposited in the QIT, and a designated trustee can use these funds for limited purposes that include the beneficiary's monthly personal needs allowance, residential care facility costs, community spouse allocations, and any other care-related expenses. When the beneficiary passes away, any remaining funds in the account are claimed by the State. From 2014, Indiana beneficiaries applying for or receiving (1) institutional (nursing home) Medicaid or (2) home and community-based services with incomes greater than the Medicaid eligibility limit, cannot be eligible unless their income (part or all) goes into a QIT, where it can be disregarded in the eligibility determination.

Section 1115 Demonstration : Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

Skilled Nursing Facility (SNF): A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

Social Security Disability Insurance (SSDI): Social Security Disability Insurance is a payroll tax-funded federal insurance program of the United States government. It is managed by the Social Security Administration and designed to provide monthly benefits to people who have a medically determinable disability that restricts their ability to be employed.

State Supplemental Payment (SSP): Small supplement to recipients of federal Supplemental Security Income (SSI) and some non-SSI recipients who are low-income persons with disabilities and older adults with limited resources to pay their living expenses. In Indiana, state supplements are provided to all adult Medicaid or SSI recipients who, because of age, blindness, or disability, are unable to reside in their own home and need care in a residential facility. Children under age 18 are not eligible for optional supplementation.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a

PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See SSA (2011) for more information.

2. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application (IGA, 2003b).

3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).

4. Individuals who are disabled, as defined by a physical or mental impairment, disease, or loss that is verifiable by a physician, that appears reasonably certain to result in death or to last for a continuous period of at least 12 months without significant improvement, and that substantially impairs the individual's ability to perform labor or services or to engage in a useful occupation. Unlike in states that provide Medicaid coverage to all SSI recipients, Indiana performs their own medical review to determine eligibility for disabled individuals receiving federal benefits. For more information on the disability determination process and to view the determination form, see DFR (2011).

5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the minimum MMNA in Indiana was $985.00 per month, and the maximum was $1,718. This standard increases annually with inflation (U.S. Senate, 1996).

6. Spousal considerations for assets: The community spouse is also able to keep 50% of the couple's countable assets with a minimum of $13,740 and a maximum of $68,700 in 1992. This is referred to as the Community Spouse Resource Allowance (CSRA). Countable assets/property are real and personal property that are counted to determine eligibility (U.S. Senate, 1996).

7. Our team has not yet verified the exact year that Indiana officially implemented eligibility track 2a (Institutional Rules). Conflicting sources indicate varying years of implementation, and we have chosen to use the year where the Indiana Code reflected this policy change (2003). See IGA (2003), NCSL (2004), and Frick et. al. (2022) for sources indicating different years of policy implementation, ranging from 2003-2006. Other sources, while not explicitly stating the implementation year, reference the existence of this track in years prior to the aforementioned sources. See Bruen et. al. (2001) and Tilly et. al. (2001) to see the track referenced in the year 2001, and Stone (2002) for a conflicting source that states this track did not exist in the year 2002.

8. Stone (2011) and KFF (2010) indicate that eligibility track 2a did not exist for institutionalized beneficiaries in 2009, however, Indiana's state plan amendment was approved in 2006. For this reason, we have marked the policy change as 2006.

9. Spousal impoverishment laws did not always include individuals in the Aged & Disabled program. Upon implementation of eligibility track 2a, most sources state that spousal impoverishment protections did not apply to this group. However, some sources state that spousal impoverishment and eligibility track 2a existed for this population as early as 2001 (Bruen et. al., 2001). Because we have chosen 2003 as our implementation year for track 2a, we have chosen the first year in which we see spousal impoverishment included for the Aged & Disabled program population after this year. We first see this in 2007 (IGCPD, 2007). However, this policy change may have been implemented at an earlier time.

10. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. As of 2012, Indiana incrementally increased the look back period for all assets up to 60 months, where it currently (2024) remains (trusts continued to remain at 60 months throughout this period).

11. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.

12. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2003, the minimum MMNA in Indiana was $1,493 per month, and the maximum was $2,267. This standard increases annually with inflation (ILSA, 2004).

13. Spousal considerations for assets: The community spouse is also able to keep 50% of the couple's countable assets with a minimum of $18,132 and a maximum of $90,660 in 2003. This is referred to as the Community Spouse Resource Allowance (CSRA). Countable assets/property are real and personal property that are counted to determine eligibility (ILSA, 2004).
14. The Affordable Care Act (ACA) provides 100% matching funds for newly eligible adults with incomes up to 138% of the Federal Poverty Level between 2014-2016, gradually declining to 90% in 2020 where it remains indefinitely (ASPE, 2014). However, Indiana did not implement the ACA until 2015, which is when the enhanced FMAP would begin.
15. The look back period is 60 months prior to the date of application for all assets.
16. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023d) for more information on these requirements.
17. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or enrolled in the Aged & Disabled program and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2014, the minimum MMNA in Indiana was $1,939 per month, and the maximum was $2,931. This standard increases annually with inflation (IFSSA, 2024).
18. Spousal considerations for assets: The community spouse is also able to keep 50% of the couple's countable assets with a minimum of $23,448 and a maximum of $117,240 in 2014. This is referred to as the Community Spouse Resource Allowance (CSRA). Countable assets/property are real and personal property that are counted to determine eligibility (IFSSA, 2024).

Version information

Current Version: 1.0 (March 2024)

Version History

- 1.0 (March 2024): First version.