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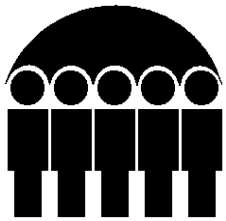
Employees' Manual
Title 8
Chapter F

## MEDICAID

# COVERAGE GROUPS



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# OVERVIEW

This chapter provides the Medicaid eligibility standards for FMAP-related and SSI-related coverage groups.

The first part of the chapter explains coverage groups for pregnant and postpartum women and for newborns, which apply to both FMAP-related and SSI-related people. The next section explains the coverage group for women who need treatment for breast or cervical cancer. FMAP-related or SSI-related policy does not apply to this coverage group.

The third section describes coverage groups for families and children that derive most of their eligibility requirements from the Family Medical Assistance Program (FMAP-related groups), followed by a similar section for coverage groups that are based on the general policies of the Supplemental Security Income program (SSI-related groups).

## Summary of Aid Types and Fund Codes

This chart includes aid types for the coverage groups discussed in this chapter. See 14-B-Appendix for a complete list of aid types, including those reflecting Refugee Resettlement funding for these coverage groups.

The medical aid type reflects the coverage group under which Medicaid eligibility is being granted. The case aid type reflects the type of cash assistance benefits the person receives or the type of medical facility in which the person resides. If the person does not receive cash assistance and does not live in a medical institution, the case aid type and the medical aid type are the same. This is also true if the person receives Medicaid and food stamps.

| Coverage Group Description | Medical Aid Type | Fund Code* | Facility Case Aid Type |
|---|---|---|---|
| Family Medical Assistance Program | 30-8 FMAP | A, C | |
| Transitional Medicaid | 37-0 TM | A, C | |
| Extended Medicaid due to receipt of support | 37-0 | A, C | |
| Child Medical Assistance Program | 37-2 CMAP | R | |

| Coverage Group Description | Medical Aid Type | Fund Code* | Facility Case Aid Type |
|---|---|---|---|
| Mothers and Children | 92-0 MAC | A, C | |
| Ineligible for FMAP due to residence in a medical institution | 30-8 FMAP | A, C | 37-7 People under 21 in PMIC or MHI<br>39-0 NF care<br>73-1 Skilled nursing care |
| SSI recipients in their own homes; recipients of mandatory supplements. | 14-0 Aged<br>64-0 Disabled | 1<br>1, 2 | |
| SSI recipients in medical institutions | 13-1<br>13-7<br>14-0<br>63-1<br>64-0<br>63-3<br>14-0<br>63-8<br>64-0 | 1<br>1<br>1<br>1, 2<br>1, 2<br>1, 2<br>1<br>1, 2<br>1, 2 | 13-1 Aged, NF<br>13-7 Aged, MHI<br>63-1 Disabled, NF<br>63-3 State resource center ICF/MR<br>63-8 Community-based ICF/MR |
| People eligible for SSI benefits but not receiving them | 14-3 Aged<br>64-3 Disabled | A<br>A, C | |
| Essential people | 14-2 Aged<br>64-2 Disabled | A<br>A, C | |
| People ineligible for SSI or SSA due to requirements that do not apply to Medicaid | 14-2 Aged<br>64-2 Disabled | A<br>A, C | |
| People ineligible for SSI or SSA due to Social Security COLAs (503 medical only) | 14-2 Aged<br>64-2 Disabled | A<br>A, C | |
| Ineligible for SSI or SSA due to Social Security benefits paid from parent's account | 14-2 Aged<br>64-2 Disabled | A<br>A, C | |

| Coverage Group Description | Medical Aid Type | Fund Code* | Facility Case Aid Type |
|---|---|---|---|
| People ineligible for SSI or SSA due to Social Security increase of October 1972 | 14-2 Aged<br>64-2 Disabled | A<br>A, C | |
| People ineligible for SSI due to substantial gainful activity (1619b) | 14-0 Aged<br>64-0 Disabled | 1<br>1, 2 | |
| People ineligible for SSI or SSA due to actuarial change for widowed persons | 14-2 Aged<br>64-2 Disabled | A<br>A, C | |
| Ineligible for SSI or SSA due to receipt of widow's social security benefits | 14-2 Aged<br>64-2 Disabled | A<br>A, C | |
| People ineligible for SSI due to residence in a medical institution | 13-0<br>13-8<br>63-0<br>63-2<br>63-7<br>73-1 | A<br>A<br>A, C<br>A, C<br>A, C<br>A, C | 13-0 Aged, NF<br>13-8 Aged, MHI<br>63-0 Disabled, NF<br>63-2 Hospital-school ICF/MR<br>63-7 Community-based ICF/MR<br>73-1 Skilled nursing care |
| People in medical institutions under 300% income level | 13-6<br>63-6<br>73-1<br>73-2<br>73-3<br>73-4<br>73-5 | A<br>A, C<br>A, C<br>A ,C<br>A, C<br>A, C<br>A | 13-6 Aged, NF<br>63-6 Disabled, NF<br>73-1 Skilled nursing care<br>73-2 Hospital-school ICF/MR<br>73-3 Community-based ICF/MR<br>73-4 Hospital<br>73-5 MHI |
| Qualified disabled and working people (QDWPs) | 90-2 Disabled<br>QMB Indicator = W | 9 | |

| Coverage Group Description | Medical Aid Type | Fund Code* | Facility Case Aid Type |
|---|---|---|---|
| Qualified Medicare beneficiaries | 90-0 Aged<br>90-2 Disabled<br>QMB Indicator = Q | 9<br>9 | |
| Specified low-income Medicare beneficiaries | 90-0 Aged<br>90-2 Disabled<br>QMB Indicator = L | 9<br>9 | |
| Expanded specified low-income Medicare beneficiaries | 90-0 Aged<br>90-2 Disabled<br>QMB Indicator = E | 9<br>9 | |
| Medically Needy | 37-E | A, C, P, S, R | |
| Medicaid for employed people with disabilities | 60-M | A, C, P | |

* A = Adult, Medicaid only
C = Child, Medicaid only
P = Conditionally eligible
R = CMAP
S = Considered person

1 = Adult, receives cash assistance
2 = Child, receives cash assistance
4 = Child, state funding only
9 = Limited benefits

## PREGNANT OR POSTPARTUM WOMEN AND NEWBORNS

Four conditions for Medicaid eligibility cross all coverage groups:

- Pregnant women can be presumed eligible for Medicaid prenatal services based on the determination of a qualified provider.
- Once a pregnant woman establishes Medicaid eligibility (except for Medically Needy), she remains eligible throughout the pregnancy without regard to income.
- A woman who is determined eligible for Medicaid for the month in which her pregnancy ends and who would not otherwise qualify for Medicaid once her pregnancy ends, remains eligible for Medicaid for the 60-day postpartum period without regard to income or resources.

- A child born to a Medicaid-eligible mother may receive Medicaid without an application through the child's first year of life if the mother continues to be eligible or would be eligible if she were pregnant.

## Presumptive Eligibility for Pregnant Women

**Legal reference:** 441 IAC 75.1(30)

A pregnant woman can file an application with a qualified provider to obtain Medicaid payment for ambulatory prenatal care services. If the pregnant woman requests eligibility only for ambulatory prenatal services, she will remain eligible through the end of the month following the month in which she is determined eligible for these services.

If the pregnant woman also formally applies for Medicaid at the same time, she will remain eligible for the period of time it takes DHS to process her Medicaid application. In either case, this is referred to as *presumptive eligibility*.

"Ambulatory" prenatal care includes all Medicaid-covered services except inpatient hospital care and services associated with the delivery of the baby or with a miscarriage or termination of pregnancy.

Since virtually any medical condition that affects the health of the mother could potentially affect the health of the unborn child, all ambulatory medical care is covered. Ambulatory prenatal care services received during the time the woman is presumptively eligible will be paid even if DHS does not approve the woman for Medicaid.

Inpatient hospital care and other charges associated with an inpatient stay are not covered. If the pregnant woman incurs bills from an inpatient hospital care (e.g., when the baby is born), these services are not paid unless the Department determines that the woman is Medicaid-eligible and approves her application for assistance.

The pregnant woman has until the last day of the month following the month of the presumptive eligibility determination to file a formal Medicaid application with DHS. If the woman files a Medicaid application, presumptive Medicaid eligibility continues until the Department approves or denies the Medicaid application.

If the woman does not file a Medicaid application by the end of the last day of the month following the month of the presumptive eligibility determination, presumptive eligibility ends on the last day of that month.

When the pregnancy of a presumptively eligible pregnant woman ends before she files a formal Medicaid application, she is not considered to have established Medicaid eligibility before the end of her pregnancy. Therefore, she is not eligible for the postpartum coverage group. If the pregnancy ended in a live birth, the baby is not eligible as the newborn child of a Medicaid-eligible mother.

A pregnant woman cannot be determined presumptively eligible more than once per pregnancy.

The IM worker is not directly involved in determining presumptive eligibility. However, when processing a Medicaid application for a woman who is presumptively eligible, it is important to make the IABC system entries (e.g., pending, denying, or approving the application) as soon as possible. These system entries affect when a woman's presumptive eligibility ends.

The following sections give more information on:

- Application processing
- Income guidelines
- Procedure after an eligibility decision has been made
- Notice requirements and appeal rights

### Application Processing

**Legal reference:** 441 IAC 75.1(30)

Form 470-2927, *Health Services Application*, is used to apply for presumptive eligibility. The pregnant woman files the form with a qualified provider. In Iowa, qualified providers are usually maternal and child health centers operated under the Department of Public Health. For requirements of qualified providers, see 8-M, **Qualified Providers for Presumptive Eligibility for Pregnant Women**.

If the applicant also requests Medicaid, the provider routes the white copy of the application within two working days to the county DHS office in the applicant's county of residence.

After determining that countable income does not exceed 200% of poverty, but before approving presumptive eligibility, the qualified provider must call Quality Assurance to obtain a state identification number, even if the provider has reason to believe that the pregnant woman already has a state identification number.

When contacted by the qualified provider, Quality Assurance completes the following steps in the order listed:

1. The Quality Assurance operator determines if a state identification number has previously been assigned to the pregnant woman.

2. If a state identification number has been previously assigned, the operator checks the social security number, name and date of birth given to check if the pregnant woman is currently receiving Medicaid.

3. If the pregnant woman is a current Medicaid recipient, the operator tells the qualified provider to deny presumptive eligibility, explains to the provider why the denial is being made, and takes no further action.

   If the pregnant woman is not a current Medicaid recipient, the operator checks the presumptive eligibility screen to determine if the woman has already been determined presumptively eligible during this pregnancy. The operator consults with the qualified provider to determine if this is a different pregnancy.

4. If the woman has previously been determined presumptively eligible within this pregnancy, the operator tells the qualified provider to deny presumptive eligibility and takes no further action.

5. If the woman already has a state identification number but is not a current recipient, the operator gives the number to the qualified provider, and proceeds to Step 6.

   If the woman does not have a state identification number, the operator assigns a number and gives the number to the qualified provider.

6. The operator obtains sufficient information from the provider so the claims can be paid. The operator enters this information on the presumptive eligibility screen and transmits it, via computer, to the Department's fiscal agent. There, the data updates the Recipient Eligibility Verification System (REVS).

7. Once the fiscal agent edits the information, the operator authorizes the provider to grant presumptive eligibility.

## Income Guidelines

**Legal reference:** 441 IAC 75.1(30)

Based on the information on the application, the qualified provider completes form 470-2629, *Presumptive Medicaid Income Calculation*, and compares the net countable income to 200% of poverty, which is the income limit under the Mothers and Children (MAC) coverage group.

Even though other household members are not entitled to Medicaid under presumptive eligibility, the income and needs of other household members are considered in determining the pregnant woman's presumptive eligibility. (In order for other household members to be approved for Medicaid, an application must be filed with DHS and eligibility determined.)

If the countable family income exceeds 200% of poverty, presumptive eligibility is denied. If the income is below the limit, the provider must call Quality Assurance at (800) 373-6306 or, if in Des Moines, 242-6306 before granting presumptive eligibility. See **Application Processing**.

## After an Eligibility Decision Has Been Made

**Legal reference:** 441 IAC 75.1(30)

The qualified provider issues form 470-2580, *Presumptive Medicaid Eligibility Notice of Decision*, to inform the pregnant woman of the decision on her application. If the woman is presumptively eligible, the notice also tells her that in order to continue Medicaid coverage beyond the presumptive period, she must file a Medicaid application with DHS by the last day of the month following the month of the presumptive eligibility determination.

Form 470-2580 also serves as proof of the pregnant woman's presumptive Medicaid eligibility status (instead of a *Medical Assistance Eligibility Card*). The form:

- Indicates the date on which the presumptive eligibility determination was made.
- Tells the provider to access the Recipient Eligibility Verification System (REVS) before providing service to make sure there has been no change in the woman's eligibility status since eligibility is granted on a daily basis.

The presumptive eligibility system "searches" the ABC system nightly to identify if:

- A Medicaid application has been filed. If an application has been filed, the system continues eligibility until the worker enters a Medicaid eligibility determination.
- A Medicaid application has been denied or approved. In either case, presumptive eligibility ends with the day of the approval or denial. If the application was approved, the woman is entitled to full Medicaid coverage.
- A Medicaid application has not been filed by the end of the last day of the month following the month of the presumptive eligibility determination. If no application is filed, presumptive eligibility ends on the last day of the month.

The presumptive eligibility system will automatically update its files to reflect what has been entered on the ABC system and will also update REVS.

1. Ms. P is determined presumptively eligible for Medicaid on July 25. She files an application for Medicaid on August 31 (the last day of the month following the month of the presumptive eligibility determination). Therefore, Ms. P continues to receive coverage for ambulatory medical care as a presumptively eligible pregnant woman until the Department makes a decision on her Medicaid application.

   July 25: Determined presumptively eligible.
   August 31: Last day of the month following the month of the presumptive eligibility determination. If Ms. P had not filed a Medicaid application, her presumptive eligibility would have ended on this date.

2. Same as Example 1, except that Ms. P was determined presumptively eligible for Medicaid on July 1. Ms. P still has until August 31 to file a Medicaid application.

   July 1: Determined presumptively eligible.
   August 31: Last day of the month following the month of the presumptive eligibility determination. If no application has been filed, Ms. P's presumptive eligibility ends.

3. Same as Example 2, except that Ms. P files her application for Medicaid on July 14. Ms. P reports on the application that she has $25,000 in bonds. The worker denies the Medicaid application on July 25 due to excess resources. Therefore, presumptive eligibility ends on July 25.

   July 1: Determined presumptively eligible.
   July 14: Medicaid application filed.
   July 25: Application denied. Presumptive eligibility ends.

### Notice Requirements and Appeal Rights

**Legal reference:** 441 IAC 75.1(30)"f"

Presumptive eligibility is granted on a daily basis and may be terminated on any given day, without notice, once it is determined that the pregnant woman is no longer presumptively eligible.

The adequate and timely notice requirements and appeal rights of the Medicaid program do not apply to a woman who is:

- Denied presumptive eligibility by a qualified provider.
- Determined to be presumptively eligible by a qualified provider but whose presumptive eligibility ends because she fails to file an application by the last day of the month following the month of the presumptive eligibility determination.
- Determined to be presumptively eligible by a qualified provider but whose presumptive eligibility ends due to the denial of a filed Medicaid application. Appeal rights apply to the Medicaid denial but not to the cancellation of the presumptive eligibility.

## Continuous Eligibility for Pregnant and Postpartum Women

**Legal reference:** 441 IAC 75.1(24) and 75.18(249A)

A pregnant woman who applies for Medicaid before the end of her pregnancy and subsequently establishes Medicaid eligibility remains continuously eligible for Medicaid throughout the pregnancy and postpartum period without regard to any changes in family income. The woman must continue to meet all other eligibility requirements (including resource limits) during the rest of her pregnancy. (See also **Postpartum Eligibility**.)

"Subsequently establishes Medicaid eligibility" means the woman was determined eligible as a pregnant woman under any coverage group other than Medically Needy. The determination may be made after the pregnancy ends, as long as it was made on an application filed before the end of the pregnancy.

When an increase in income makes a pregnant woman ineligible for Medicaid (except for Medically Needy), she is determined continuously eligible and placed in the MAC coverage group. If a pregnant woman is already eligible under MAC, she is not required to verify income changes and may be considered "continuously eligible."

A pregnant woman applying for Medicaid who meets all eligibility criteria (including income) for any month of the retroactive period is continuously eligible for Medicaid beginning with the first month of the retroactive period in which eligibility is established. The woman must meet the following retroactive Medicaid eligibility requirements:

- The woman would have been eligible in the retroactive period had she applied.
- The woman has verified that she incurred at least one bill for services that is or would have been payable under the Medicaid program for the retroactive month in which she would have been eligible had she applied. The bill can be paid or unpaid.
- The woman was pregnant in that retroactive month.

A pregnant woman whose retroactive eligibility is established continues to be eligible as long as an increase in income is the only factor that makes her currently ineligible. This policy **does not** apply to women who would have been eligible or potentially eligible only under Medically Needy in the retroactive period.

1. Mrs. K, aged 20 and verified as pregnant, receives Medicaid under CMAP. On August 15, she reports that her husband got a promotion and received a $500-per-month raise. The worker determines that the household's income now exceeds CMAP limits for a three-member household (Mr. K, Mrs. K, and one unborn child). The worker grants continuous eligibility to Mrs. K and places her in the MAC coverage group.

   Mrs. K remains eligible throughout her pregnancy, as long as she continues to meet all non-income criteria of the MAC program. If Mrs. K is eligible for and receiving Medicaid on the last day of her pregnancy, her eligibility continues through the 60-day postpartum period, regardless of any changes in either her family income or resources.

2. Ms. T, age 37, is six months pregnant when she applies for Medicaid August 5. The worker determines that Ms. T's countable income exceeds Medicaid limits for a two-member household under any program except Medically Needy with a spenddown.

Ms. T also requests Medicaid benefits for the retroactive months of May, June, and July. The worker determines that Ms. T was eligible for the month of June under the MAC coverage group. Ms. T verifies that she has bills for Medicaid-covered services for June.

Ms. T is granted continuous eligibility because (1) she would have been eligible in June as a pregnant woman had she applied, and (2) she has verified bills for covered Medicaid services in June, and (3) increased income is the only reason that Ms. T is currently ineligible. (Increased income created ineligibility for July.) Ms. T is placed in the MAC coverage group beginning with the month of June.

Eligibility continues throughout the pregnancy under the MAC coverage group, as long as Ms. T continues to meet all other eligibility criteria of the MAC program. If Ms. T is eligible for and receiving Medicaid on the last day of her pregnancy, she continues to be eligible through the 60-day postpartum period, without regard to any changes in her income or resources.

Ms. T is also potentially eligible for Medically Needy for the month of May if she had Medicaid-covered bills and if her excess income is the only reason that she is ineligible for another Medicaid coverage group during the month.

3. Ms. R is pregnant and receiving Medicaid under the CMAP coverage group. On July 15, Ms. R turns 21. The continuous eligibility provisions do not apply, since her ineligibility was not due to an increase in income. However, an automatic redetermination is completed to determine eligibility under the MAC coverage group.

4. Ms. P is four months pregnant when she files an application for Medicaid on September 5. Ms. P's income exceeds limits for all programs, but she has resources under $10,000. She is potentially eligible for the Medically Needy program with a large spenddown. Ms. P states that she wants eligibility examined for the retroactive period of June, July, and August, because she was not working and has unpaid medical bills.

   The worker determines that even though Ms. P's income in the months of the retroactive period was under the income limits of the MAC coverage group, her resources exceeded $10,000 in June, July, and August. Therefore, since Ms. P cannot establish initial eligibility and subsequent ineligibility due to increased income, Ms. P is not determined continuously eligible.

   The Medically Needy program is the only coverage group under which Ms. P is potentially eligible for ongoing assistance. Eligibility during the retroactive period does not exist.

5. Ms. Z's baby was born July 23. Ms. Z applies for Medicaid July 30 and requests retroactive eligibility for April, May and June. Ms. Z is over income for July. Ms. Z is eligible for the retroactive months. Ms. Z is not continuously eligible because she applied for Medicaid after the birth of the baby.

6. Household consists of:

   Mr. J, aged 36, employed
   Child A, aged 10, receives MAC
   Child B, aged 9, receives MAC

   Mr. J's pregnant girlfriend Ms. K, aged 30, moves into his home in August. Mr. J is the father of the unborn child. Ms. K requests retroactive Medicaid back to May.

   It is determined that in May, before living with Mr. J, the father of her unborn child, Ms. K would have been eligible for Medicaid as a pregnant woman. Ms. K is granted continuous eligibility, and Mr. J's income is not considered in her eligibility determination for ongoing assistance.

## Postpartum Eligibility

**Legal reference:** 441 IAC 75.1(24)

Medicaid continues to be available during the 60-day postpartum period to a woman who applies for Medicaid before her pregnancy ends and is determined Medicaid eligible for the month in which her pregnancy ended. The postpartum period begins with the last day of pregnancy and continues throughout the month in which the 60-day period ends.

An application is not required, unless the woman is a Medically Needy recipient. If a Medically Needy recipient's certification period expires during the postpartum eligibility period, she must file an application.

If a woman is determined eligible for Medicaid on the last day of her pregnancy but is not eligible under any coverage group once her pregnancy ends, she continues to be eligible for 60 days of postpartum coverage in the same coverage group under which she received Medicaid while pregnant.

During the postpartum period, the woman must meet **all** eligibility factors except income and resource criteria.

When the pregnancy terminates (for any reason), the woman is still entitled to postpartum coverage if she meets all other eligibility factors. Verify the date the pregnancy terminated to establish the first day of the 60-day period of postpartum eligibility.

Notify the previously pregnant woman when eligibility under this coverage group is established. Send a notice immediately after you are notified that the pregnancy has ended using reason code 819.

Issue timely notice before the end of the postpartum period using reason code 818.

1. The household consists of Mr. U, aged 40, who works full time, and Mrs. U, aged 32, who is pregnant. Mrs. U currently receives Medicaid under the MAC coverage group.

   On April 15, the baby is born. Mrs. U is eligible for postpartum coverage regardless of any changes that occur in her income or resources. After the postpartum period ends, a redetermination of Mrs. U's eligibility is completed. Countable resources now exceed $10,000.

   Since there is no other coverage group under which Medicaid eligibility can be established, Medicaid eligibility no longer exists for Mrs. U and is timely canceled effective July 1. Medicaid eligibility for the baby as a newborn does not exist beyond July 1, since Mrs. U would not be Medicaid-eligible if she were still pregnant due to excess resources.

2. The household consists of Mr. W, aged 29, who works full time, and Mrs. W, aged 26, who is pregnant. Mrs. W applies for Medicaid September 20. On September 27, the baby is born. The application is processed on September 29.

   Mrs. W is eligible for postpartum coverage if it is determined that she was Medicaid-eligible as a pregnant woman, even though her application was not approved by the last day of her pregnancy.

   If it is determined that Mrs. W was Medicaid-eligible as a pregnant woman, Mrs. W's postpartum period begins on September 27 and will end on November 25. However, Ms. W is eligible for Medicaid beginning September 1 and she remains Medicaid-eligible through November 30.

3. Ms. J, age 27, is pregnant and receives Medicaid under the MAC coverage group. The father of her unborn child does not live with her. On July 12, the baby is born.

   Ms. J is now the specified relative of a child. Therefore, Medicaid eligibility for Ms. J can continue after the postpartum period under the FMAP coverage group, if Ms. J chooses to "add" the baby to her household and she is otherwise eligible.

   If Ms. J does not choose to add the baby to her household, her Medicaid eligibility ends after the postpartum period, because she cannot establish eligibility in her own right. However, her child would be eligible as a newborn child of a Medicaid eligible mother, since Mrs. J would be eligible if she were still pregnant.

4. The household consists of Mr. F, age 29, who works full time, and Mrs. F, age 25, who is pregnant. Mrs. F is currently receiving Medicaid under the Medically Needy program for an October-November certification period. The baby is born October 15

   Mrs. F continues to remain eligible for Medicaid for November. She must reapply for Medically Needy if she wants to continue to receive postpartum eligibility for December, because her certification period has expired. She must meet the spenddown obligation for the new certification period, if applicable, before receiving Medicaid postpartum coverage for December.

5. Ms. R, age 19, is pregnant and currently receiving Medicaid under the CMAP coverage group. The baby is born December 13.

   Since her income does not exceed the CMAP limit for a one-member household, her Medicaid eligibility under CMAP continues after the birth of the baby. Therefore, Ms. R is not eligible for postpartum coverage, since postpartum coverage is available only to women who are not Medicaid-eligible under any other coverage group.

   Since Ms. R was eligible for and receiving Medicaid on the last day of her pregnancy, and since her Medicaid eligibility continues, Ms. R's child is eligible as the newborn child of a Medicaid-eligible mother.

## Newborn Children of Medicaid-Eligible Mothers

**Legal reference:** 42 CFR 435.117, 441 IAC 75.1(20)

Medicaid is available to newborn children if:

- The mother applies for Medicaid before the end of her pregnancy and establishes Medicaid eligibility under an SSI-related or FMAP-related coverage group for the month of the child's birth, and
- The baby lives with the mother.

The baby is eligible for Medicaid regardless of the requirements in effect for other coverage groups, including the mother's coverage group.

If the mother was **not** determined to be eligible for Medicaid for the month the child was born, she must file an application and establish Medicaid eligibility before coverage can begin for the child.

An application is not required to add the newborn child to an existing FMAP-related Medicaid case. Add the newborn to the Medicaid case no later than ten days after the birth is reported to the local office. **Note:** Do not add a newborn to the mother's case when the mother is an SSI recipient.

The newborn is not required to have a social security number. See 8-C, **SOCIAL SECURITY NUMBER**. Do not delay adding the newborn for Medicaid even if there is a delay in adding the child to the household for FIP.

1. Household composition:
   Mr. K, aged 30
   Mrs. K, aged 25, pregnant
   Child K, aged 2

   Mr. and Mrs. K have no income and receive Medicaid under FMAP. On January 20, the hospital informs the county office that Mrs. K gave birth to her baby on January 18. Policy requires that the baby be added to the eligible group.

   The day the birth of the child is reported becomes the application date. Add the baby to the existing Medicaid case immediately, effective January 1.

2. Ms. T, age 19, is pregnant and receives Medicaid under the CMAP coverage group. On March 2, she reports to the county office that her baby was born February 27. She also reports that she intends to give the baby up for adoption.

   The worker adds the baby to Ms. T's case as the newborn child of a Medicaid-eligible mother for the months of February and March. On March 11, Ms. T reports she relinquished custody of the child to an adoption agency on March 4. The worker removes the newborn from the Medicaid case effective April 1, because the baby no longer lives with the mother.

Accept reports of birth when made by a responsible member of the household or a hospital or other facility representative, published in the newspaper, or made by any other method deemed to be a valid authority.

Enter information for the newborn on the mother's case. Verify the newborn's birth date to establish the period of eligibility. The mother must provide verification (such as a birth certificate, a hospital record of birth, or a doctor's statement) by the first day of the second month after she was discharged from the hospital.

If the newborn's birth date is not verified, cancel the newborn's Medicaid with timely notice. Reopen Medicaid as a newborn retroactively if verification is received before the newborn's first birthday and if all other eligibility factors continue to be met.

1. Ms. R is pregnant and receives Medicaid under the MAC coverage group. On May 19, the billing clerk of the hospital calls Ms. R's worker and reports that Ms. R's child was born on May 18.

   Based on this report, a baby is added to Ms. R's case as the newborn child of a Medicaid-eligible mother. The worker also requests in writing that Ms. R verify the birth date of her child.

2. Ms. L reports to the county office on June 15 that her child was born on June 7. The worker adds the newborn to Ms. L's case effective June 1. Ms. L fails to provide verification of the newborn's birth date by August 1. The worker cancels the newborn's Medicaid effective September 1.

   On December 15, Ms. L provides verification of the child's birth date. The worker reopens the child's Medicaid eligibility as a newborn effective September 1. No application is required for the reinstatement.

Make system entries for the newborn on the mother's case. If the birth was reported by a person who did not know the name of the newborn, or the report did not include the name, add the newborn to the Medicaid case with a first name of "Baby" or "Baby Boy" or "Baby Girl." If the last name is also unknown, use the mother's last name. When the newborn's name becomes known, correct the first name and, if necessary, the last name.

Issue adequate notice when eligibility under this coverage group is established, using reason code 812.

The following sections give more information on:

- The duration of newborn coverage.
- The affect of the mother's loss of eligibility.
- Procedure when the child reaches age one.

### Duration of Coverage

**Legal reference:** 441 IAC 75.1(20)

Newborn coverage begins with the month of the birth and extends through the month of the first birthday, if the child lives with the mother and either:

- The mother remains eligible for Medicaid without needing to file a new application to continue her eligibility, or
- The mother would be eligible for Medicaid if she were still pregnant.

When a child is born and granted "newborn" status, the newborn is not counted in determining the mother's household size. This is because the newborn is automatically deemed Medicaid-eligible based on the mother's eligibility. Therefore, the mother cannot be granted Medicaid based on the consideration of the newborn. She must be Medicaid-eligible in her own right.

Do not include a baby with a newborn status when determining ongoing eligibility for the mother or other household members. If the newborn is receiving Medicaid as the newborn child of a Medicaid-eligible mother, enter a "Y" in the NWBN field of the child on TD03. This will prevent the newborn from being counted in the eligible group size in ABC system calculations.

1. Ms. B, aged 19, is on CMAP. She is also pregnant. She has no other children living with her. On May 2, Ms. B gives birth. The baby is added to Ms. B's case as the newborn child of a Medicaid-eligible mother. Ms. B must continue to be Medicaid-eligible without regard to the child.

   While Ms. B's household size when she was pregnant was two, her household size is now one, since the baby is receiving Medicaid as a newborn. The worker enters a "Y" in the NWBN field so the ABC system identifies Ms. B as a one-member household. If all eligibility factors are met, Ms. B remains eligible for CMAP, because she meets the CMAP age requirement.

   If Ms. B's income exceeds the limits for a one-member household, she may request to have the child added to her eligible group, increasing the household size to two. In order for the ABC system to identify this as a two-member eligible group, the child must have either an "N" in the NWBN field or this field must be blank.

   If Ms. B chooses not to add the child to the Medicaid eligible group, she loses CMAP eligibility. The worker explores eligibility under Medically Needy and determines whether Ms. B would be Medicaid-eligible if she were still pregnant to determine if the child's "newborn" status continues.

2. Same as Example 1, except Ms. B is 23 and was receiving Medicaid as a pregnant woman under MAC.

   Since Ms. B cannot establish Medicaid eligibility once she is no longer pregnant, Ms. B is not eligible for Medicaid once her postpartum period expires. (The baby remains in "newborn" status because Ms. B would be eligible if she were still pregnant.)

   However, if Ms. B wanted to continue her Medicaid, she could choose to "add" the baby to her household and have the baby's Medicaid eligibility determined. In that case, Ms. B's household size would be two.

   If Ms. B's income and resources are below the FMAP standards, Ms. B and her baby would be eligible under FMAP. If income and resource standards exceed FMAP limits, the child may be eligible under MAC and Ms. B may be eligible under Medically Needy.

"Newborn" status is lost if the mother and child are required to file a new application to reattain Medicaid eligibility. "Newborn" status is not lost if the mother and child can be reinstated.

"Newborn" status is not available to a newborn whose mother received Medicaid in another state at the time of the birth, then moved to Iowa and applied for Medicaid.

> Ms. G, aged 19, receives Medicaid as an SSI recipient. On December 10, she reports the birth of her child on December 2. The child is added to Ms. G's Medicaid case as the newborn child of a Medicaid-eligible mother, beginning with December.
>
> On January 3, Ms. G reports she is moving to Illinois. The worker cancels her assistance February 1. Ms. G applies for and receives Medicaid in Illinois for the month of February.
>
> On March 4, Ms. G returns to Iowa. Even though Ms. G has continuously received Medicaid, and her child is under one year of age, Ms. G must file an application and meet all program requirements if she wishes to receive Medicaid for the child. Her child is no longer eligible for the newborn coverage group.

Coverage of a newborn child under another coverage group in Iowa does not preclude the child from attaining or reattaining newborn eligibility within the one-year period.

> Ms. B, aged 24, is pregnant and receives Medicaid under MAC. She gives birth on April 5. The newborn child is added to Ms. B's case as the newborn child of a Medicaid-eligible mother. A "Y" is entered in the NWBN field on TD03 for the newborn. A "P" is entered in the NWBN field and the month in which the postpartum period expires is entered in the limit date field on TD03 for Ms. B.
>
> In June, since the postpartum period is expiring, the worker contacts Ms. B and determines that Ms. B wants to continue receiving Medicaid. Since Ms. B is not eligible for Medicaid in her own right, the worker requests any information needed to determine the eligibility of the baby.
>
> After replacing the "Y" and "P" codes with "N," the worker "adds" the baby to Ms. B's case beginning with July. The two-member eligible group is eligible under FMAP.
>
> In August, Ms. B reports a new job. Verification of the new income indicates the family is over the MAC income limits. Medicaid for both Ms. B and the baby is canceled. Since the baby is still under the age of one, and because Ms. B would be eligible if she were still pregnant, Medicaid for the baby is reopened as the newborn child of a Medicaid-eligible mother beginning with September.

The Automated Benefit Calculation system issues a tickler as a reminder when the child's first birthday approaches, so an automatic redetermination can be completed.

Issue adequate and timely notice when eligibility under this coverage group is lost. Use reason code 814. Redetermine eligibility.

## If the Mother Loses Eligibility

**Legal reference:** 441 IAC 75.1(20)

Newborn eligibility ends when the baby's mother loses her Medicaid eligibility and would not qualify for Medicaid even if she were still pregnant.

The child retains newborn status if:

- If the mother remains eligible for Medicaid, or
- The mother would be eligible for Medicaid if she were still pregnant.

"Remains eligible" means the mother receives Medicaid in all months of the newborn's first year of life without having to file an application to reestablish her eligibility.

In determining if the mother "would be eligible if she were still pregnant," ignore any increases in income. This is because if the mother were pregnant, an increase in income causing ineligibility in a coverage group would have resulted in the granting of continuous eligibility.

Complete a redetermination before the effective date of the mother's cancellation. To do this, determine if the mother would be eligible for Medicaid if she were still pregnant. Consider the newborn child as an unborn child. Ignore any changes in household income.

1. Ms. M, 20, received Medicaid under CMAP during her pregnancy. Her income did not exceed CMAP limits for a two-person household (Ms. M and the unborn child). However, now that her baby is receiving Medicaid as the newborn child of a Medicaid-eligible mother, the baby cannot be considered when determining Ms. M's eligibility.

   Ms. M's countable income exceeds CMAP limits for one person. The only program under which she can establish eligibility in her own right is Medically Needy with a spenddown. Since Medicaid had been paying Ms. M's medical bills, she cannot meet spenddown.

If Ms. M asks to add the child to her eligible group, newborn status is lost, and the child is required to meet all eligibility factors. Countable income must be within the FMAP limits for a household of two for Ms. M to establish eligibility under FMAP.

If Ms. M chooses not to include the child in her eligible group, the child remains eligible as a newborn, because Ms. M would be eligible if she were still pregnant.

2. Ms. P, aged 19 and pregnant, is eligible for Medicaid under MAC. When Ms. P reports the birth of the baby, the worker adds the newborn to the Medicaid case. During the automatic redetermination process before Ms. P's postpartum period expires, she is determined eligible for Medically Needy with a spenddown because of a reported increase in income.

   Newborn status continues for Ms. P's child, since Ms. P would be eligible if she were still pregnant. (Increases in income are disregarded for pregnant women.)

3. Ms. K and her two children, ages 6 years and 10 months, are on FMAP. Her infant is eligible as a newborn child of a Medicaid eligible mother. Ms. K is canceled effective November 1 for failing to return information requested by her worker. She returns the requested information on October 23 and is reinstated.

   The infant remains eligible as a newborn. Ms. K meets the criteria of remaining eligible for Medicaid because she did not need to file a new application to reestablish her eligibility.

4. Same as Example 3, except Ms. K fails to return the requested information by November 1. Since Ms. K must file a new application to reestablish Medicaid eligibility for November, she has not met the criteria of remaining eligible for Medicaid for the purposes of determining newborn status.

   The infant is no longer eligible as a newborn, because Ms. K did not remain eligible and because she would not be eligible if she were still pregnant, due to her failure to provide requested information.

5. The household consists of Ms. P, aged 24, who is not pregnant; Child A, age 2; and Child B, who is eligible as a newborn child of a Medicaid-eligible mother.

   Ms. P and Child A receive Medicaid under the FMAP coverage group. Ms. P is due for her annual review but fails to return the RRED form. Since pregnant women are not exempt from review requirements, Child B loses "newborn" status. An automatic redetermination to another coverage group is not done because cooperation with the review process is a requirement of all coverage groups.

If the mother would not be eligible for Medicaid if still pregnant, or if Medicaid has ended (for example, due to cancellation or the end of a certification period), newborn status ends. The child loses newborn status but an application is not required as part of the child's automatic redetermination process.

Reinstatements before an anticipated effective date of cancellation do not cause a break in the mother's continuous eligibility, so a new application is not required.

If the mother's ineligibility creates ineligibility for the newborn, send a notice. Enter reason code 816 on TD03.

## When the Child Reaches Age One

**Legal reference:** 441 IAC 75.1(20)

A child who has remained eligible because of newborn status during the first year must be found eligible for Medicaid under another coverage group to continue Medicaid eligibility past the first birthday.

Complete an automatic redetermination of eligibility under other coverage groups before the newborn's first birth date. An application is not required to determine eligibility under a Medicaid coverage group even when the newborn is the only person in the household on Medicaid. However, you may need additional information to determine under which coverage group the child is eligible.

If the child's first birthday falls on the first day of the month, eligibility ends on the last day of the previous month. If the child's first birthday falls on any day other than the first of the month, eligibility ends on the last day of the birth month.

If additional information is needed, request this information in writing in the month before the first birthday (if the birthday falls on the first day of the month) or in the month of the first birthday (if the birthday falls on any other day of the month). This allows enough time to complete the redetermination before newborn status is lost.

1. Ms. K, aged 17, receives Medicaid under CMAP. Her child is eligible for Medicaid as a newborn child of a Medicaid-eligible mother. This child turns one on June 4. In June, the worker completes an automatic redetermination and requests needed information, in writing. Eligibility continues, and Ms. K and her child become an FMAP eligible group effective July 1.

2. Same as Example 1, except Ms. K is not on Medicaid. An application is not required as part of the automatic redetermination process. However, information regarding the household circumstances must be verified. The worker requests this information in writing early in June, so the redetermination is complete by July 1.

If adding the newborn to the existing FMAP eligible group results in an adverse action for any household member, contact the household to find out if they would like to exclude the child voluntarily. See 8-C, **Eligible Group: Who Must Be in the FMAP Eligible Group: People Voluntarily Excluded from the Eligible Group**.

## BREAST OR CERVICAL CANCER TREATMENT

**Legal reference:** 441 IAC 75.1(40)"a"

Medicaid is available under the breast and cervical cancer treatment (BCCT) coverage group to women who meet the following eligibility requirements:

- Needs treatment for cancerous or precancerous condition of the breast or cervix;
- Either:
  - Screened and diagnosed or diagnosed through the Breast and Cervical Cancer Early Detection Program (BCCEDP), or
  - Funds from the Susan G. Komen Foundation have been used to cover some or all of the screening or diagnostic services; and
- Not eligible for Medicaid in one of the mandatory coverage groups.

The following sections explain:

- Responsibilities of the screening program
- Mandatory Medicaid coverage groups
- The BCCT eligibility period
- Responsibilities of the IM worker
- Responsibilities of the BCCT client
- Presumptive eligibility

## Responsibilities of the Screening Program

The Breast and Cervical Cancer Early Detention Program (BCCEDP) is responsible for determining that the woman:

- Is in need of treatment for cancerous or precancerous condition of the breast or cervix.
- Is at least 40 years of age but under age 65. (**Note:** There may be exceptions to the minimum age.)
- Meets income guidelines.
- Does not have creditable health insurance coverage, except when the woman:
  - Has exhausted her lifetime benefits for breast or cervical cancer treatment, or
  - Has an exclusion clause in her health insurance coverage for breast or cervical cancer treatment.

**Note:** "Creditable coverage" is defined in the Health Insurance Portability and Accountability Act (HIPAA). Most health insurance is considered creditable coverage, including insurance that has limits on benefits or high deductibles. For the purposes of this coverage group, the Indian Health Services available to Native American women is **not** creditable coverage.

### Proof of Eligibility

When a BCCEDP considers a woman eligible and the woman chooses to apply for Medicaid, the program will give the woman written verification that she meets the eligibility criteria for BCCT. The woman will be instructed to present the *Medicaid Treatment Option Eligibility Verification* form to the Department of Human Services (DHS) office. The form provides:

- Date of screening.
- Woman's name, date of birth, and diagnosis.
- Whether the woman does or does not have creditable health insurance coverage.
- Program name, address, and BCCEDP number.
- Signature of the program staff person completing the form.

**Referrals to DHS**

When a program refers a woman to DHS, the woman will usually complete a *Health Services Application*, form 470-2927 or 470-2927(S), at the program office. The program will attach to the application the proof of screening form. However, if you are aware that a woman is eligible but the *Medicaid Treatment Option Eligibility Verification* form is not attached to the application, either:

- Make a written request for the woman to obtain it and provide it to you, or
- Ask the woman to sign a release so you can request verification from the program.

## Mandatory Medicaid Coverage Groups

The woman must not be eligible for Medicaid under any of the mandatory Medicaid coverage groups. If the woman is eligible under a mandatory coverage group, establish Medicaid eligibility under the mandatory coverage group, even if the woman is eligible under the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA). The mandatory Medicaid coverage groups are:

- Family Medical Assistance Program (FMAP)
- People ineligible for FMAP due to the receipt of child or spousal support
- Transitional Medicaid
- Mothers and children (MAC)
- Postpartum eligibility
- Children receiving IV-E foster care or IV-E subsidized adoption
- Mandatory State Supplementary Assistance recipients
- Essential persons
- SSI recipients
- People ineligible for SSI (or SSA) due to:
  - Requirements that do not apply to Medicaid
  - The October 1972 social security COLA
  - Social security COLAs (also referred to as the 503 Group)
  - Receipt of widow's social security benefits
  - Reevaluation of childhood disability criteria
  - Actuarial change for widowed persons
  - Social security benefits paid from a parent's account

There are no income or resource tests for this group. Financial information needs to be collected only to the extent necessary to determine if the person is eligible for Medicaid under a mandatory coverage group. A woman is not eligible for Medicaid under a mandatory coverage group if:

- She has no children in the home under the age of 19.
- She is not pregnant.
- She is not disabled.

Ms. A has been diagnosed with breast cancer by a health care provider authorized by the BCCEDP and is in need of treatment. She applies for Medicaid and provides proof of diagnosis from the BCCEDP.

The worker determines that Ms. A is eligible for Medicaid under the FMAP coverage group. Her 16-year-old son lives with her and she meets all of the other FMAP eligibility criteria. Medicaid eligibility for Ms. A is established under FMAP.

## Eligibility Period

**Legal reference:** 441 IAC 75.1(40)"b" and 76.5(1)

BCCT eligibility can cover the retroactive period if the woman has met all relevant BCCPTA eligibility requirements, including having been screened and diagnosed.

1. Ms. A applies for Medicaid September 4. Her application form is accompanied by the proof of screening form showing that she was diagnosed with cervical cancer August 28. Residing with Ms. A is her 16-year-old son.

   After all verification is submitted, the IM worker determines that Ms. A would be eligible only for Medically Needy with a spenddown, so eligibility under the BCCT coverage group is established effective September 1.

   Ms. A requests retroactive coverage to cover her screening costs. If Ms. A would not have been eligible under any mandatory Medicaid coverage group in August, the worker can establish Medicaid eligibility for August under the BCCT coverage group because she was diagnosed in August.

   The IM worker cannot establish Medicaid eligibility for July under the BCCT coverage group since Ms. A had not been diagnosed in July. The worker explores eligibility for July (and June) under all other coverage groups.

2. Same as Example 1, except that Ms. A was diagnosed on September 4, the same day as the application date. The IM worker cannot establish Medicaid eligibility for any retroactive month under the BCCT coverage group. Ms. A had not been diagnosed in any of the months in the retroactive period.

Eligibility under this coverage group continues until the woman is:

- Covered under creditable insurance coverage; or
- No longer receiving treatment for breast or cervical cancer or a precancerous condition; or
- No longer under age 65. **Note:** If the woman turns 65 on the first day of the month during her eligibility period, her eligibility ends as of the last day of the previous month. If the woman turns 65 on any day other than the first of the month, eligibility ends on the last day of the birth month.

A woman is not limited to one period of eligibility. A new period of eligibility and coverage shall begin each time a woman is:

- Diagnosed under a Centers for Disease Control and Prevention BCCEDP;
- Found to need treatment for breast or cervical pre-cancer or cancer; and
- Meets all other eligibility criteria.

## Responsibilities of the Income Maintenance Worker

DHS income maintenance is responsible for determining that the applicant:

- Has supplied proof of BCCPTA eligibility, and
- Is not eligible for Medicaid under a mandatory coverage group.

Accept the statement regarding the absence of creditable health insurance coverage on the proof of diagnosis form unless you have reason to question it. If you have reason to believe that the applicant has creditable coverage, request a statement from the insurance company documenting the scope of coverage or that coverage has been dropped or exhausted. If you verify that the applicant does have creditable coverage, report this to the local BCCEDP.

The following sections address procedures for:

- Referring an applicant to a BCCEDP
- Application processing
- Determining the anticipated length of treatment
- Annual review
- Evaluating changes in the client's health insurance coverage
- Ending BCCT coverage when treatment ends
- Including BCCT in automatic redeterminations

## Referrals to a BCCEDP

Refer a woman to the Breast and Cervical Cancer Early Detection Program (BCCEDP) with caution. Only BCCEDP staff or trained designees can determine if a woman is eligible for the program and what services may be available to her.

Do not suggest a woman is eligible or will receive help from the BCCEDP. If you believe a woman may benefit from the BCCEDP, simply refer her by saying, *"There is a program I suggest you call. Their staff will know if you are eligible."* Call 1-800-369-2229 to determine the most convenient screening provider to which the woman could be referred.

Do **not** refer a woman who is applying for Medicaid to a BCCEDP if she has already:

- Been diagnosed with a cancerous or precancerous condition of the breast or cervix, or
- Started treatment for cancerous or precancerous condition of the breast or cervix.

If you verify that Susan G. Komen Foundation funds were used to pay for some or all of the screening and diagnostic services, E-mail the BCCT policy specialist. Include the following information:

- Applicant's name, state ID number, and case number.
- Applicant's phone number. (Indicate if only messages can be left at this number.)
- IM worker's name and worker number processing the application.
- Name of the health care provider making the cancer diagnosis (either the name of the clinic, if the provider is associated with a clinic, or the name of the practice, if different from the health care provider name).

If the woman is not sure whether funds of the Susan G. Komen Foundation were used to pay for some or all of the screening and diagnostic services, either:

- Ask the woman to provide verification from the provider of the screening or diagnostic services; or
- Have the woman sign a release of information so that you can contact the provider.

**Application Processing**

When an applicant meets the eligibility criteria for this coverage group, Medicaid eligibility is **not** established through the ABC system. Instead, contact Quality Assurance at (515) 281-6401 or 1-800-373-6306. Quality Assurance staff will need the following information:

- County and worker number of the IM worker handling the ongoing case
- The month in which eligibility under BCCT begins
- The eligible person's:
  - Last name, first name, and middle initial.
  - Mailing address.
  - County of residence
  - Date of birth.
  - Social security number.
  - State ID number, if one has been issued.

**Note:** If no state ID number has previously been issued to the person, Quality Assurance staff will issue a state ID number based on the information listed above.

Using this information, Quality Assurance staff will make entries on the Presumptive Medicaid Eligibility (PRSM) system that will generate a Medicaid Eligibility (SSNI) system file and will automatically send Medicaid cards.

A notice of decision will not be system-generated. Manually issue a notice of decision to the eligible person. For appropriate wording, use notice reason code 017. See 14-B-Appendix, **NOTICE CODES**.

**Determining Anticipated Length of Treatment**

Immediately following approval of Medicaid in the BCCT coverage group, determine the anticipated length of time treatment is expected to last.

Since the BCCEDP will not be treating the woman, they will not be able to state the length of treatment. During the eligibility interview, request that the woman provide proof of when the treatment will end. If she needs assistance, have her sign form 470-3951, *Authorization to Obtain or Release Health Care Information*. This allows you to contact the health care provider who will be treating the woman to determine when treatment will end.

When treatment will end is not a condition of **initial** Medicaid eligibility under the BCCT coverage group. Verification of when treatment will end is due by the end of the month following the month of decision.

If the woman fails to provide proof of when treatment will end or fails to sign and return the release, eligibility for Medicaid in this coverage group is lost. Complete an automatic redetermination, since the date treatment will end pertains only to information necessary for the BCCT coverage group.

If the woman is eligible for Medicaid in an optional coverage group other than Medically Needy with a spenddown, switch the woman's Medicaid eligibility to the optional coverage group. Contact Quality Assurance to cancel Medicaid under the BCCT coverage group.

Establish Medicaid eligibility under the optional coverage group by making the usual entries in the ABC system. No notice of decision canceling eligibility under the BCCT coverage group is necessary.

If the woman is only conditionally eligible under Medically Needy with a spenddown or is not eligible in any optional coverage group, complete and issue a timely notice of decision canceling Medicaid for failure to return requested information. Contact Quality Assurance to cancel Medicaid under BCCT.

In this situation, Medicaid received under the BCCT coverage group before the effective date of cancellation is not subject to recoupment.

Accept the statement of the medical professional providing the woman's treatment as to when treatment is expected to end. If treatment is expected to end at a time other than at the annual review, manually tickle the case for the first working day of the month in which treatment is expected to end.

**Annual Review**

At the annual review, determine whether the woman:

- Continues to be under age 65, and
- Continues to not have creditable health insurance coverage.

Also, at annual review, when a woman is categorically eligible for a mandatory coverage group but was over income or resource limits at time of approval or the last annual review, you must determine that the woman continues to be over income or resources. If you determine that the woman now is also financially eligible under a mandatory coverage group, open a case on ABC in the appropriate aid type.

1. Ms. K is diagnosed with breast cancer and applies for Medicaid in November 2001. Also living with Ms. K is her 16-year-old son. The worker determines that, due to family income, Ms. K would only be conditionally eligible for Medically Needy with a spenddown. Medicaid eligibility for Ms. K is established under BCCT effective November 1, 2001.

   As part of conducting the annual review during October 2002, the worker requests information about family income and household composition. The worker determines that the household composition is the same and the family income continues to make Ms. K still only conditionally eligible for Medically Needy with a spenddown.

   Since Ms. K is under age 65, continues to not have creditable health insurance coverage, and continues to receive treatment, eligibility under BCCT continues.

2. Mrs. R is diagnosed with cervical cancer and applies for Medicaid in September 2001. Also living with Mrs. R is her husband and two children, ages 18 and 22. The worker determined that due to family resources, Mrs. R would only be eligible for Medically Needy with zero spenddown. Medicaid eligibility for Mrs. R was established under BCCT effective September 1, 2001.

The worker conducts the annual review during August 2002. Since Mrs. R's youngest child has turned age 19, the worker simply confirms with Mrs. R that she does not have a child under the age of 19 living with her. No resource information is requested, since Mrs. R is no longer categorically eligible for a mandatory coverage group.

Since Mrs. R is under age 65, continues to not have creditable health insurance coverage, and continues to receive treatment, eligibility under BCCT continues.

People receiving Medicaid under the BCCT coverage group are not required to complete any "review form."

Workers and supervisors will be notified via E-mail from central office when a person receiving Medicaid under BCCT is due for an annual review. Two notifications will be given. The first will be at the end of the second month before the month in which the review should be completed. The second notification will be at the end of the month before the month in which the review should be completed.

When a woman receiving Medicaid under the BCCT coverage group moves, call Quality Assurance at (515) 281-6401 or 1-800-373-6306 with the new address along with the new county and worker number. This will ensure that the correct worker is contacted about the annual review.

When you receive an e-mail notification, schedule the required face-to-face interview in the same manner as any other Medicaid case needing an annual review.

Ms. A began receiving Medicaid under the BCCT coverage group July 2001. Ms. A's worker will be notified at the end of April 2002 and at the end of May 2002 that Ms. A is due for an annual review during June 2002.

When the woman attends the face-to-face interview, determine that she does not have creditable health insurance coverage. Document this in the case record.

If the woman turns 65 on the first day of the month, Medicaid eligibility under the BCCT coverage group ends as of the last day of the previous month. If the woman turns 65 on any other day of the month, Medicaid eligibility under the BCCT coverage group ends on the last day of the birth month. Complete an automatic redetermination.

When the annual review has been completed, contact Quality Assurance at 281-6401 or 1-800-373-6306 to report that an annual review has been completed. Quality Assurance staff will make the necessary entries. Medicaid can continue beyond the annual review month **only** if Quality Assurance is contacted.

> Ms. B began receiving Medicaid under the BCCT coverage group August 2001. In July 2002, Ms. B's worker conducts an annual review and determines that Ms. B remains eligible. Ms. B's Medicaid will not continue beyond July 2002 unless the worker contacts Quality Assurance.

No notice of decision needs to be issued if

- Eligibility under BCCT continues, or
- Eligibility under BCCT is ending and Medicaid eligibility is beginning under another coverage group, other than Medically Needy with a spenddown. **Note:** Contact Quality Assurance staff to close the BCCT case before opening an ABC case under the other coverage group.

If eligibility under BCCT is ending and either no other Medicaid eligibility exists or eligibility is beginning under Medically Needy with a spenddown, adequate and timely notice is required. Notices about BCCT eligibility must be issued manually.

When a person receiving Medicaid under BCCT fails to comply with the annual review process, timely notice is required. However, no contact with Quality Assurance is necessary since Medicaid under BCCT will automatically end on the last day of the month in which the review should be processed.

If the person subsequently complies with annual review requirement before the effective date of cancellation and is eligible for reinstatement, contact Quality Assurance when the review has been completed.

If the person indicates a desire to comply with the annual review requirements on or after the effective date of cancellation, a new application will be required. However, if treatment has continued, the person does not require a new proof of screening form.

**When a Change in Health Insurance Is Reported**

When a woman receiving Medicaid under the BCCT coverage group reports either a change in her health insurance coverage or that health insurance coverage has begun, determine if the insurance coverage is creditable coverage.

Consider a woman who has one of the following types of coverage to have creditable coverage and, therefore, ineligible for this coverage group:

- Medicare, Part A or Part B
- Medicaid
- A group health plan
- Armed forces insurance
- A state health risk pool
- A medical care program of the Indian Health Service or of a tribal organization
- Health benefits providing medical care directly, through insurance, or by reimbursement

If a woman appears to have creditable coverage but is not actually covered for treatment of breast or cervical cancer, consider that she meets the standard for eligibility under this group. This could occur in circumstances such as:

- A woman has creditable coverage but is in a period of exclusion (such as a pre-existing condition) for treatment of breast or cervical cancer.
- A woman exhausts her lifetime limit on all benefits under her plan or coverage, including treatment for breast or cervical cancer.
- A woman has coverage that is limited in scope, such as dental, vision, or long term care, or coverage only for a specified disease or illness.

**When Treatment Ends**

Request that the woman provide you verification from the provider who is treating her as to when her treatment is expected to end. She may sign form 470-3951, *Authorization to Obtain or Release Health Care Information*, allowing you to contact the provider. Verify if treatment has ended or will end, or if treatment will continue and for how long.

If treatment ended before the date previously given by the provider, complete an automatic redetermination for the month following the month in which treatment was expected to end. Do not establish recoupment for any Medicaid received in the BCCT coverage group in the months following the month in which treatment ended.

Ms. E begins receiving Medicaid under the BCCT coverage group in September. The provider treating Ms. E provides a statement, in September, saying that treatment will continue into the month of January. The worker tickles the case for the first working day in January.

Early in January, the worker sends a release to Ms. E, asking her to sign and return it. Ms. E complies, and the provider now states that Ms. E's treatment ended in December. Since Ms. E is no longer eligible under the BCCT coverage group, the worker completes an automatic redetermination. Medicaid for the month of January is not subject to recoupment since the worker acted on the best information available.

If treatment ended or will end at the time previously given by the provider, conduct an automatic redetermination for the month following the month in which treatment ended or will end.

Mrs. D begins receiving Medicaid under the BCCT coverage group in July. The provider treating Mrs. D provides a statement, in August, saying that treatment will continue into the month of November. The worker tickles the case for the first working day in November.

Early in November, the worker sends a release to Mrs. D asking her to sign and return it. Mrs. D complies, and the provider now states that Mrs. D's treatment did end in November. Since Mrs. D will no longer be eligible under the BCCT coverage group, the worker completes an automatic redetermination.

If treatment is expected to continue beyond the date previously given by the provider, manually tickle the case for the first working day of the month in which treatment is now expected to end.

> Mrs. F begins receiving Medicaid under the BCCT coverage group in August. The provider treating Mrs. F provides a statement, in September, saying treatment will continue into the month of February. The worker tickles the case for the first working day in February.
>
> Early in February, the worker sends a release to Mrs. F that she signs and returns. The provider now states that Mrs. F's treatment will continue into the month of April. The worker tickles the case for the first working day in April.

A woman must provide verification of when her treatment ends or is expected to end. She may cooperate in one of two ways:

- Provide a signed statement from the provider treating her, or
- Sign and return the release of information so you can contact the provider treating her.

If she fails to provide verification of when her treatment ends or is expected to end, she is ineligible for the Medicaid BCCT coverage group for failure to cooperate. Complete an automatic redetermination, since the information on when her treatment ends pertains only to the BCCT coverage group.

- If the woman is eligible for Medicaid in an optional coverage group other than Medically Needy with a spenddown, switch the woman's Medicaid eligibility to the optional coverage group.
- If the woman is only conditionally eligible under Medically Needy with a spenddown or is not eligible in any optional coverage group, issue a timely notice of decision canceling Medicaid for failure to return requested information.

In both situations above, contact Quality Assurance to cancel Medicaid under the BCCT coverage group. No notice of decision canceling eligibility under the BCCT coverage group is necessary since you are making a determination of eligibility under another coverage group. Medicaid received under the BCCT coverage group before the effective date of cancellation is not subject to recoupment.

**Including BCCT in an Automatic Redetermination**

Complete an automatic redetermination and examine Medicaid eligibility under the BCCT coverage group when a woman who was diagnosed under the BCCEDP and provided proof of BCCPTA eligibility is no longer eligible for Medicaid under a mandatory coverage group.

In this situation, verify that the woman is continuing to receive treatment for the breast or cervical cancer or a precancerous condition of the breast or cervix. If treatment is continuing and if the woman is not eligible in a mandatory coverage group, Medicaid eligibility for the woman should be established in the BCCT coverage group. Do not make an additional referral.

Neither DHS nor the BCCEDP requires a new eligibility determination. Eligibility in the BCCT group exists based on the initial screening and the fact that the woman's treatment is continuing.

Mrs. C applies for Medicaid in April. She provides proof of screening that shows she in need of treatment for breast cancer. However, the worker determines that Mrs. C is eligible for Medicaid under FMAP, because her 12-year-old son lives with her and she meets all other eligibility criteria.

In May, Mrs. C reports beginning income that results in her countable income exceeding the FMAP limit for two people. Since Mrs. C and her son have not received FMAP in at least three of the previous six months, they are not eligible for transitional Medicaid. Other than the BCCT group, the only other coverage group under which Mrs. C can establish eligibility is Medically Needy with a spenddown.

The worker asks Mrs. C to either provide verification that she is still under treatment for breast cancer or sign a release of information so that the worker can contact the provider. If Mrs. C is still under treatment, the worker establishes Medicaid eligibility under the BCCT coverage group.

If Mrs. C is no longer under treatment for the breast cancer, conditional eligibility should be established under Medically Needy.

## Additional Case Actions

The following case actions are handled differently for BCCT than for other coverage groups.

- Canceling eligibility under BCCT
- Establishing retroactive eligibility
- Replacing lost *Medical Assistance Eligibility Cards*
- Reimbursing medical transportation expense

### Canceling Eligibility Under BCCT

When eligibility under BCCT no longer exists, contact Quality Assurance at 281-6401 or 1-800-373-6306. Quality Assurance staff will need to know the last month of BCCT eligibility and will make the appropriate entries in the PRSM system. A notice of decision will not be generated.

Complete an automatic redetermination. If Medicaid eligibility exists under another coverage group other than Medically Needy with a spenddown, no notice to the client is necessary. After the BCCT case has been closed, open or reopen a case on the ABC system with an effective date of the month following the last month of eligibility under BCCT.

If no Medicaid eligibility exists, manually complete and issue a timely notice of decision canceling Medicaid eligibility under BCCT. If the person is only conditionally eligible under Medically Needy, complete and manually issue a timely notice of decision canceling Medicaid eligibility under BCCT and make the appropriate Medically Needy entries in the ABC system.

### Establishing Retroactive Medicaid Eligibility

Quality Assurance (QA) can make entries for retroactive coverage at the same time of initial approval. Quality Assurance staff will need to know the earliest retroactive month of **ongoing** BCCT eligibility.

If retroactive eligibility is determined after Quality Assurance has established ongoing BCCT eligibility, you must complete form 470-0397, *Request for Special Update*, and send it to Quality Assurance, regardless of the coverage groups under which retroactive eligibility exists.

If eligibility exists under BCCT for any of the retroactive months, use 37-3 as the aid type for BCCT. Do this regardless of whether retroactive eligibility was determined at the same time as ongoing BCCT eligibility or after ongoing BCCT eligibility was determined.

## Replacing Lost Medical Assistance Cards

Replacement of medical assistance cards must be done manually. Computer issued replacement cards cannot be generated on BCCT cases.

Some county DHS offices maintain supplies of:

- *Medical Assistance Eligibility Card (Fee for Service)*, form 470-1911
- *Medical Assistance Eligibility Card (Lock-In)*, form 470-3348
- *Medical Assistance Eligibility Card (Managed Care)*, form 470-2213

For offices maintaining supplies, complete the appropriate blank medical assistance card and give or mail the replacement to the recipient. Refer to Title 6, Appendix, for more information about the above forms.

For offices not maintaining supplies of blank medical assistance cards, eligibility for persons eligible for Medicaid under BCCT may be verified for providers in the same ways as any other Medicaid eligible person who has lost their medical assistance card.

## Reimbursing Medical Transportation Expenses

People eligible for Medicaid under BCCT are eligible for reimbursement of medical transportation expenses, according to the policies in place for any other Medicaid eligible person. See 8-M, **MEDICAL TRANSPORTATION**, for more information.

However, reimbursement must be issued using an ABC case with a medical aid type. For BCCT recipients with an ABC case for any other program in closed, active, or pending status, make sure the case has a medical aid type and follow the instructions in 14-B(7), **Medical Transportation**.

For BCCT recipients with no medical case in closed, active, or pending status:

- Pend medical assistance on a case on the ABC system. Suggested aid types are 30-8 or 92-0, although others will work. Do not use aid type 37-3.
- Once the pending entries have updated, follow the instructions in 14-B(7), **Medical Transportation**.
- Once the TD06 entries have updated, deny the pended medical assistance program on the ABC case using "000" in the MED RSN2 field, no notice of decision will be issued.

## Responsibilities of the Client

A woman who establishes Medicaid eligibility under the BCCT coverage group is required to report only when:

- Creditable health insurance coverage begins, or
- She changes her living or mailing address.

A woman who establishes Medicaid eligibility under the BCCT coverage group is asked but not required to report when her treatment ends. Rely on the statement of the medical professional providing the treatment as to when treatment is expected to end. However, if a woman reports that her treatment has ended, act on the report. For more information, see **Responsibilities of the Income Maintenance Worker: When Treatment Ends**.

A woman who establishes Medicaid eligibility under the BCCT coverage group is not required to report:

- Changes in family income
- Changes in family resources
- Changes in household composition
- Turning age 65 (it is the responsibility of DHS to track this and act on it)

## Presumptive Eligibility

**Legal reference:** 441 IAC 75.1(40)"c"

A presumptive eligibility provider can determine a woman to be presumptively eligible under the BCCT coverage group when she:

- Has been screened for breast or cervical cancer under the BCCEDP, and
- Is found to need treatment for breast or cervical cancer or a pre-cancerous condition.

There are no income or resource tests for presumptive eligibility. During the period of presumptive eligibility, a woman is entitled to full Medicaid coverage. Coverage is not limited to treatment of cancer or a pre-cancerous condition. Services provided during the presumptive eligibility period shall be paid, regardless of whether the woman is later found eligible for Medicaid.

IM workers are not directly involved in determining presumptive eligibility. However, when processing a Medicaid application for a woman who is presumptively eligible, it is important to make the ABC system entries (e.g., pending, denying, or approving the application) as soon as possible. These system entries determine when a woman's presumptive eligibility ends.

The following sections address:

- Application processing for presumptive determinations
- Evidence of presumptive eligibility
- The period of presumptive eligibility
- Notice requirements and appeal rights

### Application Processing

**Legal reference:** 441 IAC 75.1(41)

To apply for presumptive eligibility, a woman must file form 470-2927 or 470-2927(S), *Health Services Application,* with a BCCEDP screening provider. She can:

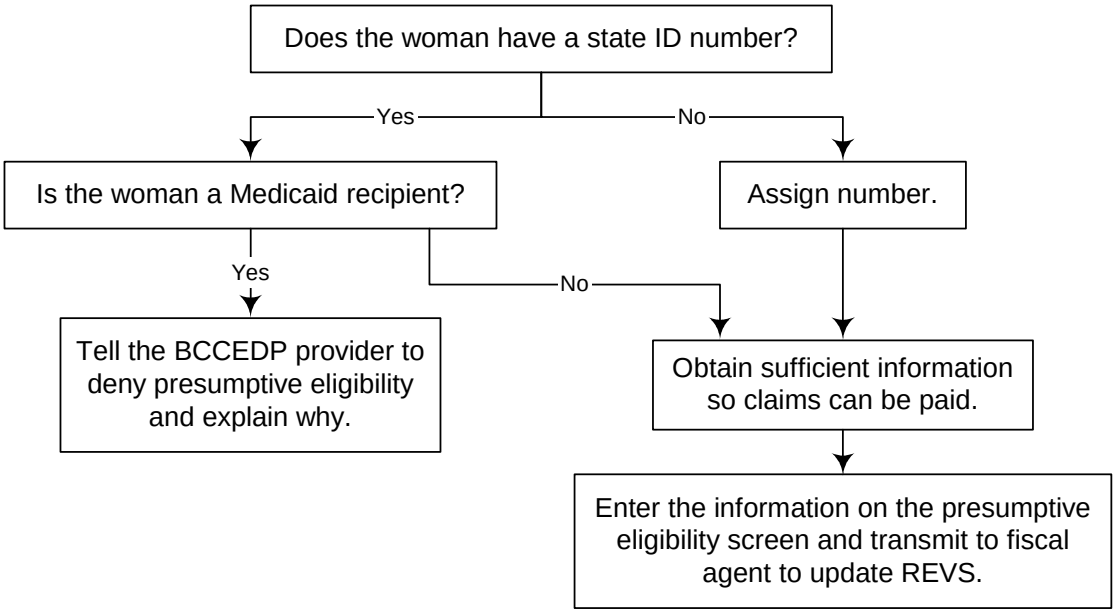
- Request eligibility for the presumptive period only, or
- Apply for ongoing Medicaid benefits.

In Iowa, BCCEDP providers are usually lead agencies for a county or a regional local breast and cervical cancer early detection program under a contract with the Iowa Department of Public Health. For requirements of BCCEDP providers, see 8-M, **Qualified Providers for Presumptive Eligibility for BCCT**.

If the applicant also requests Medicaid, the program routes a copy of the application within two working days to the DHS office for the applicant's county of residence along with verification of screening and the need for treatment.

The BCCEDP provider must call Quality Assurance to obtain a state identification number, even if the provider has reason to believe that the woman already has a state identification number. Quality Assurance will verify the applicant's Medicaid status before authorizing presumptive coverage.

When contacted by the BCCEDP provider, the Quality Assurance operator completes the following steps:



## Evidence of Presumptive Eligibility

**Legal reference:** 441 IAC 75.1(40)

The BCCEDP provider issues form 470-2580, *Presumptive Medicaid Eligibility Notice of Decision*, to inform the woman of the decision on her application.

If the woman is presumptively eligible, the notice also tells her that in order to continue Medicaid coverage beyond the presumptive period, she must file a Medicaid application with DHS by the last day of the month of the presumptive eligibility determination.

Form 470-2580 also serves as proof of the woman's presumptive Medicaid eligibility status instead of the *Medicaid Assistance Eligibility Card*. The form:

- Indicates the date on which the presumptive eligibility determination was made.
- Tells the health care provider to access the Recipient Eligibility Verification System (REVS) before providing service to make sure there has been no change in the woman's eligibility status, since eligibility is granted on a daily basis.

## Presumptive Eligibility Period

**Legal reference:** 441 IAC 75.1(40)"c"

Presumptive eligibility is granted on a daily basis and may be terminated on any given day, without notice, once it is determined that the woman is no longer presumptively eligible. Presumptive eligibility shall begin no earlier than the date the BCCEDP provider determines eligibility.

Presumptive eligibility shall end when:

- The woman fails to file an application for Medicaid by the last day of the month following the month of the presumptive eligibility determination.
- The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and a decision is made on the application.

A woman has until the last day of the month following the month of the presumptive eligibility determination to file a formal Medicaid application with DHS. If the woman files a Medicaid application, presumptive Medicaid eligibility continues until the Department approves or denies the Medicaid application.

1. A woman is determined presumptively eligible for Medicaid on July 31. She files an application for Medicaid on August 31 (the last day of the month following the month of the presumptive eligibility determination). Presumptive eligibility continues until the Department makes a decision on her Medicaid application.

2. A woman is determined presumptively eligible for Medicaid on July 1. She has not filed an application as of August 31. Her presumptive eligibility ends on August 31.

3. A woman is determined presumptively eligible for Medicaid on July 1. She files an application for Medicaid on July 31. On August 5, the IM worker denies the application, because the woman turned 65 years of age on August 1. Therefore, presumptive eligibility ends on August 5.

4. An alien woman is determined presumptively eligible for Medicaid on July 15 and files an application for Medicaid at the same time. On August 15, the IM worker denies the application because the woman does not meet citizen or qualified alien status. Therefore, presumptive eligibility ends on August 15.

The presumptive eligibility system "searches" the ABC system nightly to identify if:

- A Medicaid application has been filed. If an application has been filed, the system continues eligibility until the worker enters a Medicaid eligibility determination.
- A Medicaid application has been approved or denied. In either case, presumptive eligibility ends with the day of the approval or denial.
- A Medicaid application has not been filed by the end of the last day of the month following the month of presumptive eligibility determination. If no application is filed, presumptive eligibility ends on the last day of the month.

The presumptive eligibility system will automatically update its files to reflect what has been entered on the ABC system and will also update REVS.

### Notice Requirements and Appeal Rights

**Legal reference:** 441 IAC 76.1(40)

The adequate and timely notice requirements and appeals rights of the Medicaid program do not apply to a woman who is:

- Denied presumptive eligibility by a qualified provider.
- Determined to be presumptively eligible by a BCCEDP provider but whose presumptive eligibility ends because she fails to file an application by the last date of the month following the month of the presumptive eligibility determination.
- Determined to be presumptively eligible by a BCCEDP provider but whose presumptive eligibility ends due to the denial of a filed Medicaid application. Appeal rights apply to the Medicaid denial but not to the cancellation of the presumptive eligibility.

## FMAP-RELATED COVERAGE GROUPS

**Legal reference:** P.L. 104-193; 441 IAC 75.1(1)

The Family Medical Assistance Program (FMAP) is the basis of Medicaid eligibility policy for coverage groups for pregnant women, families, and children. People who are eligible for FMAP-related coverage groups include:

- Family Medical Assistance Program (FMAP) recipients.
- People who are ineligible for FMAP due to residence in a medical institution.
- People who are ineligible for FMAP due to the receipt of support.
- Transitional Medicaid recipients.
- Child Medical Assistance Program (CMAP) recipients.
- Mothers and children eligible under the MAC program.
- Residents of a medical institution eligible under the 300% group.
- Pregnant women and postpartum women. See **PREGNANT OR POSTPARTUM WOMEN AND NEWBORNS**.

- Newborn children of Medicaid-eligible mothers. See **Newborn Children of Medicaid-Eligible Mothers**.
- Medically Needy recipients. See 8-J, ***MEDICALLY NEEDY***.

The applicant has the right to choose the coverage group under which eligibility will be determined. **Exception:** Examine eligibility for the Medically Needy coverage group only when the household is over income or over resources for all other coverage groups.

Provide adequate information so the applicant can make an informed choice between coverage groups for which the applicant may be eligible.

> Ms. T, aged 18, lives with Mr. J, age 23. She is pregnant and has income from part-time employment. Mr. J is also employed part time and has acknowledged that he is the father of the unborn child. Since Ms. T is potentially eligible for either MAC or CMAP coverage groups, explain the program requirements and eligibility factors of each coverage group to Ms. T so she may make an informed choice.

Medicaid is available to children under age 21 who are placed in subsidized adoption or approved foster care living arrangements for whom the Department has financial responsibility. Medicaid is available to children under age 18 who are in or subsidized guardianship placement. See 8-H, ***FOSTER CARE AND SUBSIDIZED ADOPTION***, for information on determining eligibility for these children. Establish a case number with an FBU of 19 when determining eligibility.

## Family Medical Assistance Program (FMAP)

**Legal reference:** 441 IAC 75.1(14)

Medicaid may be available under the Family Medical Assistance Program (FMAP) to children and their parents or other specified relatives who meet financial and nonfinancial eligibility requirements.

Parents or other specified relatives must have a dependent child in their care in order to be eligible. However, it is not necessary for the dependent child to be included in the FMAP-eligible group.

1. Mr. S applies for Medicaid for himself. Also in the home is Mr. S's son who receives SSI. Mr. S's son receives Medicaid as an SSI recipient. Mr. S is categorically eligible for Medicaid under FMAP because he has a child in his care. Mr. S's FMAP eligible group will be a one-member group.

2. Mr. and Mrs. X apply for Medicaid for themselves. Also in the home is their common child. The common child has a $25,000 CD that is a countable resource in determining Medicaid eligibility for Mr. and Mrs. X. The X's decide to voluntarily exclude the common child. Mr. and Mrs. X are categorically eligible for Medicaid under FMAP because they have a child in their care. The X's eligible group will be a two-member group.

3. Ms. F applies for Medicaid for herself. Also in the home is Ms. F's daughter who receives Medicaid under an HCBS waiver. The child is considered institutionalized only for the child's eligibility. In determining Medicaid eligibility for Ms. F, the daughter shall be considered under Ms. F's care. Therefore, Ms. F is categorically eligible for Medicaid under FMAP. Ms. F's eligible group will be a one-member group.

To determine eligibility for this coverage group, use the policies and procedures in:

- 8-C, **NONFINANCIAL FMAP-RELATED ELIGIBILITY**.
- 8-D, **RESOURCE ELIGIBILITY OF CHILDREN**.
- 8-D, **FMAP-RELATED RESOURCE POLICIES**.
- 8-E, **INCOME POLICIES FOR FMAP-RELATED COVERAGE GROUPS**.

**Note:** Medicaid is not linked to FIP. Therefore, it is possible to be ineligible for FIP and still be eligible for Medicaid benefits or to be eligible for FIP and ineligible for Medicaid.

Do not consider this coverage group for:

- Children who do not live with a specified relative.
- Children who live with a specified relative who does not receive Medicaid under FMAP.
- Children over the age of 18 (unless they are attending school). See 8-C, **NONFINANCIAL FMAP-RELATED ELIGIBILITY: Age** and **School Attendance**.
- Adults who do not have a dependent child in their care.
- Adults who are not specified relatives.
- Pregnant women with no children other than the unborn child.

1. Ms. L applies for Medicaid for herself and her two-year-old son. She has no income or resources. Since Ms. L and her son meet the financial eligibility factors, both are eligible for Medicaid under the FMAP coverage group.

2. The household consists of Ms. T, age 25, and her six-year-old daughter, who receives $500 per month in child support. There is no other household income. Ms. T chooses to voluntarily exclude her daughter from the eligible group, thereby excluding her income.

   If all other eligibility factors are met, Ms. T is eligible for FMAP as a household of one because she has a dependent child in her care. Her daughter is not eligible for any other Medicaid coverage group because she was voluntarily excluded.

3. Mr. and Mrs. Z and their two children apply for Medicaid. Both Mr. and Mrs. Z are employed, but their countable income is less than the FMAP limit for a four-member household. The Z family is eligible for FMAP if all other eligibility factors are met.

4. Mr. P applies for FMAP for himself and his five-year-old neighbor, who is currently living with him. Neither Mr. P nor his neighbor child is eligible for FMAP, because Mr. P is not a specified relative of the child. If all other eligibility factors are met, the five-year-old is eligible for CMAP as a household of one.

5. Ms. N and her three children (ages 14, 15, and 16) apply for Medicaid. One of the children has social security benefits and veterans income from a deceased father totaling $700 per month. Ms. N has earnings each month of $300. The family income exceeds the FMAP income limit. The children are eligible for MAC. Ms. N is eligible for Medically Needy with a spenddown if all other factors of eligibility are met.

   Ms. N voluntarily chooses to exclude the child with social security and veterans payments from the Medicaid eligible group so she can get FMAP. The income of the three remaining members is less than the FMAP limit for a household size of three. Ms. N and two of her children are eligible for FMAP.

   The voluntarily excluded child is not eligible for Medicaid under any other coverage group and is not included in the household size. Do refer this child to the ***hawk-i*** program since he's voluntarily excluded due to income.

6. Household consists of:

   - Mrs. A, aged 20
   - Mr. A, aged 23, in the military
   - Child B, common child

   Mr. A is not in the home, but the couple is not estranged. No referral is made to CSRU.

   Eligibility under FMAP is examined for Mrs. A and Child B as a household of two. Income allotments from the service and any money Mr. A makes available to Mrs. A and Child B are considered in determining eligibility.

## People Who Are Ineligible for FMAP

Medicaid benefits are available to people who are ineligible for FMAP due to:

- Receipt of child or spousal support (extended Medicaid), or
- Increased income from employment (transitional Medicaid), or
- Being a resident in a medical institution.

### Ineligible Due to Receipt of Support (Extended Medicaid)

**Legal reference:** 441 IAC 75.1(21)

Medicaid continues to be available to people whose child or spousal support, minus the $50 exemption, exceeds the FMAP income limits. Recipients in this coverage group are eligible for up to four months of extended Medicaid coverage.

To qualify, the person must have received FMAP in three of the six months immediately before the month of cancellation. Do not consider any month in which the assistance is subject to recoupment in this three-month calculation.

1. Mrs. K and her three children are canceled from FMAP effective June 1 due to receipt of child support. The family is eligible for the four months of extended Medicaid if they received FMAP in three of the previous six months.

2. Mrs. B and her two children are canceled from FMAP effective February 1, 1999, due to increased child support. The family received FMAP in August and September of 1998 and in January 1999. Mrs. B and her two children are eligible for the four months of extended Medicaid.

Recipients may request cancellation of FMAP because they are receiving child support directly. However, grant extended Medicaid only if the child support, minus the $50 exemption, exceeds the FMAP income limit.

A family receiving Medicaid under FMAP starts receiving child support directly on March 22 but does not report this to their IM worker until April 25. The child support, minus the $50 exemption, is enough to cancel FMAP. Extended Medicaid begins April 1 since the receipt of child support was not timely reported.

Had the child support been reported timely, FMAP cancellation would not be effective until May 1, allowing a ten-day notice. Extended Medicaid would begin May 1.

Begin the four months of extended Medicaid with the month following the month the family became ineligible for FMAP due to receipt of support. During these four months, the family must continue to meet all FMAP eligibility requirements except income.

Ms. A and her two children become ineligible for FMAP effective August 1 due to child or spousal support. On September 10, Ms. A reports a permanent increase in household resources, which now total $8,100.

Effective October 1, Ms. A is determined conditionally eligible under Medically Needy. Since Ms. A is now ineligible for FMAP for an additional reason, the children cannot continue to receive Medicaid under this coverage group. Effective October 1, the children are determined eligible under the CMAP or MAC coverage group because resources are not used to determine the children's eligibility.

If FMAP is reinstated but later lost again due to the receipt of child support, begin a new four-month period if the family qualifies.

### Adding People to the Eligible Group

**Legal reference:** 441 IAC 75.1(21)

The extended Medicaid eligible group includes:

- Every person who was in the FMAP eligible group in the last month FMAP was received.
- Every person whose needs and income were included in determining the FMAP eligibility of the household when FMAP benefits were terminated.

Also add the following people to the eligible extended Medicaid group:

- People returning to the home whose needs and income would be taken into account in determining the FMAP eligibility if the household were applying in the current month.
- Dependent children returning to the home from foster care, if they would have been included if they were at home while the household was on FMAP.
- People who were not included in the FMAP eligible group because they were receiving SSI, if they have since lost SSI.
- People who were not included in the eligible group, such as a child in newborn status.

If an adult is a mandatory member of the eligible group and is not eligible for Medicaid (ineligible adult alien, sanctioned adult, etc.) other than a voluntarily excluded person, the adult remains a member of the eligible group as a "considered" person.

If new household members are not eligible to be included in the extended Medicaid group, do not consider the income and resources of the extended Medicaid group when determining eligibility for the new household members.

Determine the household size for the new member's eligible group by considering:

- The new household members.
- Any other household members who are required to be included with them and:
  - Who are not part of the extended Medicaid group, or
  - Whose income is not counted in determining the eligibility of the extended Medicaid group.

## Transitional Medicaid

**Legal reference:** P.L. 100-485, 441 IAC 75.1(31)

Transitional Medicaid is available to families who are **recipients** of FMAP (not CMAP) and who are no longer eligible due to:

- Increased earned income of a specified relative, or
- A combination of increased earned income and other factors that create ineligibility.

A "recipient" is a person who has been successfully approved on the system. Transitional Medicaid is not available to applicants.

1. The M family has been receiving Medicaid under FMAP for the past six months. They are canceled effective November 1 for failure to provide information. They reapply for Medicaid December 5. At the interview on December 7, Mrs. M reports beginning a job December 5.

   The worker processes the application December 27. The Ms are eligible for Medicaid under FMAP for December, but they are over income for January. Because they are considered recipients at the point they are successfully entered on the system, they are eligible for transitional Medicaid effective January 1.

2. Same as Example 1, except the worker processes the application January 2. The Ms have Medicaid eligibility under FMAP for December, but they are over income for January. Because they were recipients in December, they are eligible for transitional Medicaid.

3. Same as Example 1, except the family is over income for December and ongoing. There is no transitional Medicaid eligibility, because they are not recipients and they were canceled for failure to provide information.

"Family" consists of:

- The people living in the household whose needs and income were included in determining the FMAP eligibility when the FMAP benefits were terminated.
- Ineligible people who were included in the eligible group and whose income was counted in the FMAP eligibility determination.
- Children, parents, or needy specified relatives who begin to reside in the household during the transitional period.
- Children who lose newborn status.

The earned income must be the earnings of a specified relative of a dependent child. The specified relative must either:

- Be in the eligible group, or
- Have returned to the home and be a person whose income and needs must be considered in the eligibility determination.

1. Ms. T reports the return of the father of the children. Ms. T's income and the returning parent's income create ineligibility for FMAP. Therefore, the family (Ms. T, the returning parent, and children) is eligible for transitional Medicaid.

2. Mrs. O reports the return of her husband, the father of her children. Mrs. O is not employed. Mr. O's income makes the family ineligible for FMAP. Therefore, the family (Mrs. O, Mr. O, and children) is eligible for transitional Medicaid.

See 8-C, **Specified Relatives**, for a definition of specified relative.

Transitional Medicaid eligibility does not exist if the income creating ineligibility for FMAP belongs to a stepparent who:

- Is not a member of the FMAP eligible group, or
- Is in the eligible group but has not assumed the role of the caretaker.

Transitional Medicaid eligibility also does not exist if the FMAP-eligible group does not contain a child.

> Ms. Q receives Medicaid under FMAP for herself. Also in the home is Ms. Q's daughter who is voluntarily excluded. Ms. Q becomes ineligible for FMAP due to earned income. Ms. Q is not eligible for transitional Medicaid because her eligible group does not contain a child. Eligibility under other Medicaid coverage groups shall be explored.

In order to be eligible for transitional Medicaid, the family must have received FMAP in Iowa at least three of the previous six months. Do not consider any month in which Medicaid was received under FMAP incorrectly and the family should have received Medicaid under another coverage group.

If a needy specified relative is canceled from FMAP because the relative's income exceeds limits, the needy relative is not eligible for transitional Medicaid, because there is no child in the transitional Medicaid eligible group. The child will continue to receive CMAP.

> Mrs. Z, aged 50, is receiving FMAP for her two grandchildren, Sally, aged 17, and Jeff, aged 10. Mrs. Z is also included in the eligible group as a needy specified relative because she has no income to meet her needs.
>
> On August 5, Mrs. Z reports she began employment on August 1. The worker determines that Mrs. Z's increased income from employment is sufficient to meet her needs and prospectively creates FMAP ineligibility for Mrs. Z. Therefore, Mrs. Z is removed from the FMAP eligible group effective September 1.
>
> Mrs. Z is not eligible for transitional Medicaid coverage, because there would not be a child in the transitional Medicaid eligible group. The children remain eligible for CMAP.

Transitional Medicaid begins with the effective date of termination of FMAP. When ineligibility occurred in a prior month, the first month of transitional Medicaid is the first month that FMAP was erroneously granted, unless it is determined that FMAP was received through fraud, according to the transitional Medicaid definition of fraud. See **Determining Eligibility**, for more information on determining if fraud exists.

1. Mrs. M timely reports an increase in earned income October 23. Timely notice cannot be given for November 1. FMAP is canceled December 1. Transitional Medicaid begins December 1. There is no overpayment for November.

2. Mr. J and his two children are receiving FMAP. He starts work but fails to report this to his worker. Two months later, Mr. J reports his employment.

   When the worker receives the verification of his new job, it shows Mr. J and his children are not eligible for transitional Medicaid because, according to the transitional Medicaid definition of fraud, Mr. J fraudulently received FMAP. Eligibility for Mr. J and the children is explored under MAC and Medically Needy.

Transitional Medicaid coverage lasts for up to 12 months, divided into two six-month periods. To receive the entire 12 months of coverage, the eligible group must meet all eligibility criteria for each six-month period.

The following sections give more information on:

- Determining eligibility.
- Requirements after eligibility is established.
- Notices and reporting requirements.
- Income requirements.
- Good cause for failing to meet reporting or earnings requirement.
- Effective date of changes.
- Adding people to the eligible group.
- Review requirements.

**Determining Eligibility**

**Legal reference:** 441 IAC 75.1(31)

When the only change in circumstances being considered is an increase in earned income, the FMAP eligible group is eligible for transitional Medicaid if the increase in earned income creates ineligibility for FMAP and all other eligibility factors are met.

When other changes in circumstances are being considered at the same time as the increase in earned income, use the following steps to determine if the FMAP eligible group is eligible for transitional Medicaid.

1. Would the increase in earned income have resulted in FMAP ineligibility if the other changes in circumstances hadn't happened?
   - ♦ Yes. The FMAP eligible group is eligible for transitional Medicaid, if all other eligibility factors are met.
   - ♦ No. Go to question two below.
2. Would the other changes in circumstances have resulted in FMAP ineligibility if the earned income hadn't increased?
   - ♦ Yes. The FMAP eligible group is not eligible for transitional Medicaid. Explore eligibility under other coverage groups.
   - ♦ No. Go to question three below.
3. Does the increase in earned income combined with the other changes in circumstances result in FMAP ineligibility?
   - ♦ Yes. The FMAP eligible group is eligible for transitional Medicaid, if all other eligibility factors are met.
   - ♦ No. FMAP eligibility continues.

1. Mrs. K begins employment in the same month in which her child begins to receive Social Security benefits. The earned income alone is sufficient to create FMAP ineligibility. The household is eligible for transitional Medicaid.

2. Mrs. M is working, and her earnings increase. She has one child. In March, the child begins receiving Social Security benefits. Mrs. M's increase in earnings alone is not enough to create ineligibility. The increased unearned income is enough to create ineligibility.

   The household is not eligible for transitional Medicaid, since the unearned income alone is enough to result to ineligibility. An automatic redetermination is completed.

3. The household consists of Mrs. J and her two children. Mrs. J works and receives a raise on January 1. On January 10, she reports her increase in pay and that her daughter moved out of the household on January 7.

   First, ignoring the change in the household size, Mrs. J's increased earnings are compared to the FMAP limit for a three-person eligible group. The countable income exceeds limits. Therefore, Mrs. J and the remaining child are eligible for transitional Medicaid, if all other eligibility factors are met.

4. Mrs. E and her child receive Medicaid under FMAP. On January 10, Mrs. E reports that her child received her first Social Security check on January 3 and that Mrs. E began working on January 8.

   First, ignoring the beginning Social Security, Mrs. E's new earnings are compared to the FMAP limits for a two-person eligible group. The countable income does not exceed limits. Then, ignoring the new earnings, the new Social Security benefits are compared to the FMAP limits for a two-person eligible group. The countable income does not exceed limits.

   Finally, the combined new earnings and new Social Security benefits are compared to the FMAP limits for a two-person eligible group. The countable income does exceed limits. Mrs. E and her child are eligible for transitional Medicaid if all other eligibility factors are met.

5. Mrs. M and her child receive Medicaid under FMAP. In March, Mrs. M's earnings increase and her child begins receiving Social Security benefits. First, ignoring the Social Security income, Mrs. M's increased earnings are compared to FMAP limits for a two-person eligible group. The countable income does not exceed FMAP limits.

   Then, ignoring the increase in earnings, Mrs. M's earnings before the increase and the new Social Security income are compared to FMAP limits for a two-person eligible group. The countable income does exceed limits.

   Mrs. M and her child are not eligible for transitional Medicaid, since the increased earnings alone did not create FMAP ineligibility, and the other change in circumstances alone did create FMAP ineligibility.

6. The household consists of Ms. L and two children. Ms. L's "countable" earned income is $380 per month. The family receives FMAP.

   Ms. L receives an increase in earned income. Her "countable" earned income is now $420. At the same time, she reports an increase in earned income, she also reports that one of her children has moved out of the home.

   Step 1. Does the increase in earned income result in FMAP ineligibility if the other changes in circumstances had not happened? No ($420<$426). Go to step 2.

   Step 2. Does the loss of a household member result in FMAP ineligibility if the earned income had not increased? Yes ($380>$361).

   There is no transitional Medicaid eligibility, since the loss of a household member alone causes ineligibility for FMAP. FMAP is canceled for income exceeding the two-person FMAP limit, **not** due to the increased earned income.

A household is **not** eligible for transitional Medicaid if:

- The income of a stepparent who is not a member of the FMAP eligible group makes the household ineligible for FMAP.
- The income of a stepparent who is a member of the eligible group but has not assumed the role of caretaker (e.g., incapacitated) makes the household ineligible for FMAP.
- The household was ineligible for FMAP in any of the last six months before cancellation because of fraud. For the purposes of determining transitional Medicaid eligibility, a person is guilty of a fraudulent practice when the person:
  - Knowingly makes false statements concerning eligibility, or
  - Obtains Medicaid by misrepresentation or by failing, with fraudulent intent, to bring forth all of the facts required.

1. On April 15, Ms. M attends her annual face-to-face interview. She indicates on her review form that she does not have any income and confirms at the interview that the information is correct.

   On June 15, the IM worker receives an IEVS report indicating that Ms. M has unreported earned income. Ms. M provides an employer's statement verifying that she began employment in March.

   Had the earnings been reported, Ms. M would have been determined prospectively ineligible for FMAP as of April 1. April would have been the first month of the transitional Medicaid period.

   However, since Ms. M knowingly provided false information and was ineligible to receive FMAP for the months of April, May, and June, Ms. M is not entitled to receive transitional Medicaid coverage. FMAP ineligibility occurred on April 1, and an automatic redetermination is completed.

2. Same as Example 1, except that after Ms. M verifies her earnings, the worker determines that Ms. M would have remained eligible for FMAP. In July, Ms. M reports that she got a better job. Prospectively, Ms. M's new increased earnings create ineligibility for FMAP as of August 1.

   Ms. M's previous failure to report her earnings does not disqualify her from transitional Medicaid, since her failure to report did not result in FMAP ineligibility. Therefore, August is the first month of the transitional Medicaid period.

When ineligibility for FMAP has already been determined based on a change other than increased earned income, a subsequent increase in earned income in the same month as the change that caused ineligibility does not make the family eligible for transitional Medicaid.

> Mr. A and his two children receive Medicaid under FMAP. Mr. A receives Unemployment Compensation. On April 10, Mr. A reports that one of his children permanently moved out on April 5 to live with relatives.
>
> Countable income of Mr. A and the remaining child exceeds FMAP limits for a two-person eligible group. Effective May 1, eligibility for the child is established under MAC and conditional eligibility for Mr. A is established under Medically Needy. A notice of decision is issued April 12.
>
> On April 15, Mr. A reports that he will begin working April 20 and his first check will be received April 30. Although his earned income would exceed the FMAP limits for a two-person eligible group, eligibility has already been established under another coverage group for May based on the earlier reported change. Therefore, Mr. A and his child are not eligible for transitional Medicaid.

## Requirements After Eligibility Is Established

**Legal reference:** 441 IAC 75.1(21), 75.1(31)"h" and "i"(1)

During all 12 months of the transitional Medicaid period, the household must continue to cooperate with Quality Control, DIA, CSRU, Third-Party Liability, and the Health Insurance Premium Payment Unit.

If a person fails to cooperate, sanctions are applied.

During the initial six-month period, the eligible group must:

- Continue to include a specified relative whose income is used or an ineligible specified relative whose income is used, and
- Continue to include a child, as defined by FMAP policy, and
- Timely report any changes in the household composition, and
- Timely return a complete form 470-2663, *Transitional Medicaid Notice of Decision/Quarterly Income Report*.

The requirement of the eligible group continuing to include a child is met if:

- A child is absent, as described in 8-C, **Absence**, or
- The only child in the home is an SSI recipient, or
- The only child in the home is a "considered" person.

The requirement is not met if the only child in the home is the newborn child of a Medicaid-eligible mother or if the only child is voluntarily excluded.

A family receiving transitional Medicaid for the entire first six months is entitled to receive an additional six months of transitional Medicaid if the following eligibility factors are met:

- The eligible group must meet quarterly reporting requirements by timely returning two completed forms 470-2663, *Transitional Medicaid Notice of Decision/Quarterly Income Report*. See 8-G, **Requirements for a Complete Report**.
- The eligible group must continue to include either:
  - A specified relative whose income is used and who had earned income in each of the previous three months (unless good cause exists), or
  - An ineligible specified relative whose income is used and who had earned income in each of the previous three months (unless good cause exists).
- The eligible group must continue to include a child, as defined by FMAP.
- The eligible group must continue to meet income guidelines. (See **Income Requirements** later in this chapter on how to calculate.)

The amount of resources is not an eligibility factor for transitional Medicaid.

A family receiving transitional Medicaid is not required to report income changes except at review time. If you receive a report of change in income, take no action until the review. However, if an application is filed and eligibility is established under another coverage group, cancel the transitional Medicaid.

If the household fails to return the completed quarterly report timely, transitional Medicaid shall **not** be reinstated, unless good cause is determined to exist. This is true even when the report is returned complete before the effective date of cancellation. An automatic redetermination shall be completed to determine whether eligibility exists under any other coverage group.

**Notices and Reporting**

The ABC system automatically generates a *Notice of Decision* to a household that becomes eligible for transitional Medicaid. The notice indicates the months for which the family is eligible for transitional Medicaid and states the terms under which their eligibility may end.

If the initial notice is issued manually, use the same language as the system-generated notices to inform the family of their initial eligibility:

> "Your increased earnings qualify your family to receive Transitional Medical Assistance benefits through _____. You will continue to receive the same Medical Assistance coverage that you received as an FMAP participant. The transitional benefits shall be canceled if your family ceases to include a child who was included in the original eligible group.
>
> "After the date stated above, you may be eligible for an additional six months of Transitional Medical Assistance if the caretaker relative remains employed and your income is within guidelines. To receive the additional six months of coverage, you must also report your income when required to do so by the Department."

Because the family was previously notified of the conditions of eligibility and the consequences of failing to meet these conditions, timely notice requirements are met. Another timely notice does not have to be issued before transitional Medicaid is canceled. The system issues an adequate notice.

If, for any reason, the family was not issued the initial notice specifying the terms under which transitional Medicaid may be terminated, timely notice requirements have not been met. Therefore, a timely notice will be necessary before cancellation.

The ABC system also sends form 470-2663, *Transitional Medicaid Notice of Decision/Quarterly Income Report*, to the family in the third, sixth, and ninth months. If a form 470-2663 is manually issued, include a self-addressed postage-paid envelope for the recipient to use in returning the form.

The notice sent in the third month of the initial six-month period states:

> "You are currently receiving transitional Medicaid coverage through (*enter the date initial six-month period ends*). You may be eligible for an additional six months of coverage. Please complete each section of the attached report form for each month indicated below and return it by (*enter the Quarterly Report due date*) in order for an eligibility determination to be made.
>
> Failure to return the completed report with all appropriate verification by (*enter the twenty-first day of the fourth month*) will result in ineligibility for the additional six months of transitional coverage and cancellation of your transitional Medicaid benefits effective (*enter the first day of the seventh month*)."

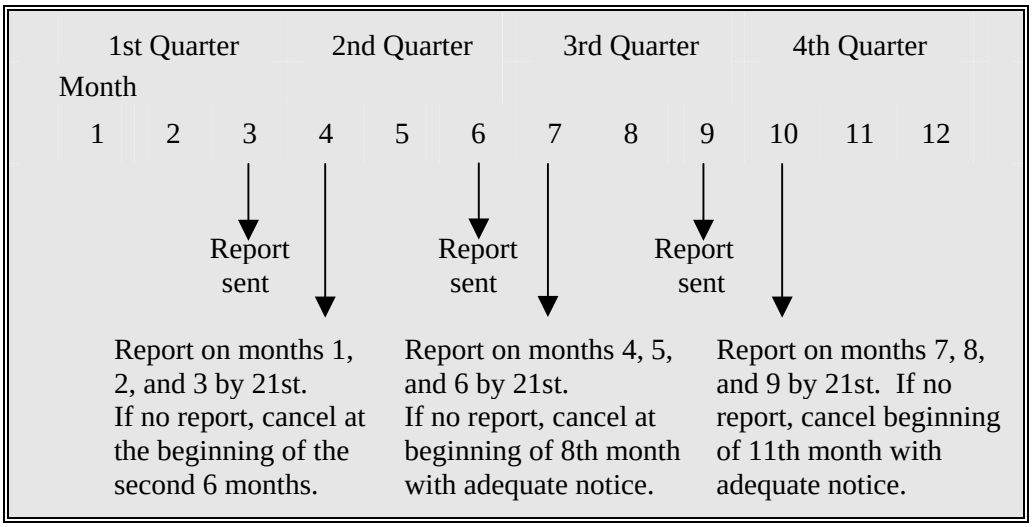
The notice sent in the sixth month of the initial six-month period states:

> "You are currently receiving transitional Medicaid coverage through (*date entered on the initial notice*). You may be eligible for an additional six months of coverage. Please complete each section of the attached report form for each month indicated below and return it by (*Quarterly Report due date*) in order for an eligibility determination to be made.
>
> Failure to return the completed report with all appropriate verification by (*twenty-first day of the seventh month*) will result in cancellation of your transitional Medicaid benefits effective (*first day of the eighth month*)."

The notice sent in the ninth month states:

> "You are currently receiving transitional Medicaid coverage. In order for benefits to continue, please complete each section of the attached form for each month indicated below and return it by (*Quarterly Report due date*). Failure to return the completed report with all appropriate verification by (*twenty-first day of the tenth month*) will result in cancellation of your transitional Medicaid benefits effective (*first day of the eleventh month*)."

Cancel the case if the family fails to return the requested report timely, unless the family has good cause. See **Good Cause for Failing to Meet Reporting or Earnings Requirements**. If the twenty-first of the month falls on a weekend or holiday, consider the quarterly report timely if it is returned by the next working day.




## Income Requirements

**Legal reference:** 441 IAC 75.1(31)"i"(2) and (3)

The amount of the family's income is not a factor in establishing continuing eligibility **for the first six months**.

During the **second six months**, cancel Medicaid if information on form 470-2663 indicates that the parent or other specified relative had no earnings in one or more of the previous three months, unless the person has good cause. See **Good Cause for Failing to Meet Reporting or Earnings Requirements**.

At review time, determine the family's average gross earned income during the immediately preceding three months. Subtract actual child-care expenses for the children in the eligible group that are necessary for the employment of the parent or other specified relative. Do not apply the FMAP child-care deduction limits.

Cancel Medicaid if countable income is more than 185% of the federal poverty level for a family of the same size. Consider only people in the transitional Medicaid group for this comparison. Do not divert income to meet the needs of ineligible people or for adult care expenses.

The ABC system calculates continuing transitional Medicaid eligibility when entries are made timely. However, if eligibility must be calculated manually, the formula to determine the average amount of countable earned income to compare to 185% of poverty is:

| |
|---|
| Total quarterly gross earned income of eligible group<br>- Total quarterly actual child care paid / 3 = Countable average monthly income to compare to 185% of poverty |

| **185% of Poverty** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Household Size | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| $1,436 | $1,926 | $2,416 | $2,907 | $3,397 | $3,887 | $4,377 | $4,868 |
| For each additional person, add $491. | | | | | | | |

Consider only earned income of people who are included in the transitional Medicaid eligible group according to FMAP policy. This includes people who are "considered" people.

Do not use the income of a stepparent who is not a part of the transitional Medicaid eligible group.

## Good Cause for Failing to Meet Reporting or Earnings Requirements

**Legal reference:** 441 IAC 75.1(31)"i"(1)

The household can establish good cause for not returning form 470-2663, *Transitional Medicaid Notice of Decision/Quarterly Income Report*, by the due date when the household verifies that at least one of the following conditions exists:

- There was a serious illness or death of the recipient or a member of the recipient's family.
- There was a family emergency or household disaster, such as a fire, flood, or tornado.
- There were other reasons beyond the recipient's control for not returning the report.
- The household did not receive the form for a reason that was not the recipient's fault. Lack of a forwarding address is considered to be the recipient's fault.

The household can establish good cause for not having earned income when the household verifies that the lack of earnings was due to:

- An involuntary loss of employment, **or**
- An illness, **or**
- Other circumstances that negatively affect the person's ability to work.

Allow good cause for the first month of a period of proration of a non-recurring lump sum when there was unearned income in the month. Unearned income is not used in calculating transitional Medicaid eligibility.

The household must verify good cause before the first day of the month after the report month.

If circumstances beyond the control of the household make it difficult for household members to get documentation, grant additional time. However, do not continue transitional Medicaid past the first day after the report month pending substantiation of a good cause claim.

If the household later provides information that establishes good cause, reinstate transitional Medicaid as of the first day of the month after the report month.

If the household fails to provide information that establishes good cause, cancel transitional Medicaid. Complete an automatic redetermination to establish eligibility under other coverage groups.

1. The A family is issued a quarterly report form at the end of September, due no later than October 21. On October 15, Mr. A returns a complete report, indicating that he had no earnings in one of the report months because of an injury sustained in a car accident.

   This meets the definition of good cause. Transitional Medicaid coverage continues as long as Mr. A provides documentation to substantiate his claim before the effective date of cancellation, November 1.

   The A's do not provide documentation by October 21. The worker issues a notice of decision canceling the transitional Medicaid coverage effective November 1 and completes an automatic redetermination.

   On October 28, Mr. A notifies the worker that he had been unable to obtain a statement to substantiate his claim because his doctor has been on vacation. Since Mr. A was unable to provide the necessary documentation due to circumstances beyond his control, the worker allows Mr. A additional time to provide the information.

   On November 2, Mr. A provides a statement verifying that his injuries prevented him from working. The worker reinstates transitional Medicaid coverage as of November 1.

2. Same as Example 1, except that Mr. A informs the worker on November 2 that he did not provide documentation to substantiate his claim of good cause because he forgot. Since the reason for not providing the information timely was not due to circumstances beyond Mr. A's control, good cause is not granted. Transitional Medicaid remains canceled as of November 1.

## Effective Date of Change

**Legal reference:** 441 IAC 75.1(31), 75.52(4), and 76.10(249A)

When a transitional Medicaid eligible group reports a change in circumstances, the effective day of the change depends on:

- The type of change,
- When, during the twelve-month period, the change occurred, and
- How the change was reported.

The following table assumes that the change is reported timely.

| Reported Change | When Occurred | How Reported | Effective Date |
|---|---|---|---|
| Child not in school or not expected to finish school by 19th birthday turns 18: | | | |
| ♦ On the first day of the month | During any month of the 12-month period | NA | Remove child from TM effective the first day of the birthday month. If child is the only child in the TM group, cancel TM effective the first day of the birthday month. |
| ♦ On a day other than the first day of the month | During any month of the 12-month period | NA | Remove child from TM effective the first day of the month following the birthday month. If child is the only child in the TM group, cancel TM effective the first day of the month following the birthday month |
| Child 18 and in school completes school | During any month of the 12-month period | NA | Remove child from TM effective the first day of the month after the month in which school was completed. |
| TM group no longer contains a child or no longer contains a specified relative | During any month of the 12-month period | On quarterly report | Cancel TM effective the first day of the month after the month of change. Adequate notice required. Timely notice not required. |
| | | Other than on the quarterly report | Cancel TM effective the first day of the month after a ten-day timely notice period. Timely and adequate notice required. |

| Reported Change | When Occurred | How Reported | Effective Date |
|---|---|---|---|
| Other TM eligible group composition changes | During any month of the 12-month period | On quarterly report | Remove people allowing for adequate notice only. Add people according to 8-G, **Adding a New Member to an Existing FMAP-Related Case**. |
| | | Other than on the quarterly report | Remove people allowing for adequate and timely notice. Add people according to 8-G, **Adding a New Member to an Existing FMAP-Related Case**. |
| Changes in income | In the first 3 months of TM | NA | The first day of the seventh month of TM |
| | In the second 3 months of TM | NA | The first day of the eighth month of TM |
| | In the third 3 months of TM | NA | The first day of the eleventh month of TM |
| | In the fourth 3 months of TM | NA | None |

When a change is not reported timely, redetermine eligibility for all months, beginning with the month following the month in which the change occurred. **Exception:** Any changes in income occurring during the first three months of transitional Medicaid are effective on the first day of the seventh month, whether reported timely or not.

## Adding People to the Eligible Group

**Legal reference:** 441 IAC 75.1(31)"b" "d," and "f"

The transitional Medicaid eligible group includes:

- Every person who was in the FMAP eligible group in the last month FMAP was received.
- Every person whose needs and income were included in determining the FMAP eligibility of the household when FMAP benefits were terminated.

Also add the following people to the eligible transitional Medicaid group:

- People returning to the home whose needs and income would be taken into account in determining the FMAP eligibility if the household were applying in the current month.
- Dependent children returning to the home from foster care, if they would have been included if they were at home while the household was on FMAP.
- People who were not included in the FMAP eligible group because they were receiving SSI, if they have since lost SSI.
- People who were not included in the eligible group, such as a child in newborn status.

Examine the earned income of people who have been added to the household at the time of the quarterly report.

1. Ms. M receives FMAP for herself and Child A. Child B receives SSI and is not included in the FMAP eligible group. Ms. M becomes employed and her earnings create FMAP ineligibility. Ms. M and Child A are placed on transitional Medicaid. Due to Ms. M's increased income, Child B also loses SSI eligibility.

   Since Child B would have been included in the FMAP eligible group except for the receipt of SSI, Child B is added to the transitional Medicaid group effective the first day of the month following the last month in which Child B received SSI.

2. Ms. A and her two children are receiving FMAP. Ms. A's earned income creates FMAP ineligibility, and Ms. A and her children begin receiving transitional Medicaid March 1. On May 7, Ms. A reports that one of her children has left the home and is residing with the father. The child is removed from the transitional Medicaid eligible group effective June 1.

   On July 28, Ms. A reports the child returns home. Because the child would be part of the FMAP group if applying in the current month, the child is added to the transitional Medicaid group effective July 1.

3. Mr. and Mrs. B and their three children begin receiving transitional Medicaid August 1. On January 20, Mrs. B gives birth. The baby may be added to the transitional Medicaid group effective January 1 or be eligible for Medicaid as the newborn child of a Medicaid-eligible mother effective January 1.

4. Mrs. C and her three children begin receiving transitional Medicaid May 1. In July, Mrs. C reports that the father of the children returned to the home. He has no income. Mr. C's needs and income would be considered in determining Medicaid eligibility if they were applying in the current month. Mr. C is added to the Transitional Medicaid group effective July 1.

5. Mr. and Mrs. D and their child begin receiving transitional Medicaid June 1. In September, Mrs. D reports and verifies she is pregnant with twins. The transitional Medicaid eligible group household size is increased. The unborn twins would be members of the FMAP-related eligible group if applying in the current month.

6. Ms. F and her two children begin receiving transitional Medicaid April 1. In May, Ms. F reports her third child returned to the home after a six-month foster care placement. The child is added to the transitional Medicaid group effective the first day of the month following the month in which the child left the foster care placement.

7. Mrs. G and her child begin receiving transitional Medicaid May 1. Also in the household is Mr. G, an SSI recipient, who is disabled. Mr. G loses SSI eligibility effective August 1 due to the receipt of social security disability payments. Mr. G is added to the transitional Medicaid group effective August 1.

8. Mr. L begins receiving transitional Medicaid for himself and his son, John, on July 1. Mr. L reports on October 5 that his 15-year-old son, Adam, moved in with the family October 2. Adam is added to transitional Medicaid group effective October 1.

9. Ms. K and her son, James, have received transitional Medicaid for three months (January - March). Ms. K reports to her worker on April 21 that her son, Ken, aged 15, returned to her home on April 14. Ken receives $500 per month Social Security.

   The worker adds Ken to the transitional Medicaid group April 1. The Social Security Ken receives does not affect transitional Medicaid eligbility, because it is unearned income.

10. Ms. Z and her children have received transitional Medicaid for five months (December - April) when Mr. Z, the children's father, returns to the home. Ms. Z reports to the worker on April 10 that Mr. Z returned home April 2. She also reports that Mr. Z is working. Mr Z is added to the transitional Medicaid group effective April 1.

    The worker will examine Mr. Z's income with Ms. Z's income on the next quarterly report received. The second quarterly report is sent in May to the Z family. Mr. Z reports his income for the fifth and six months.

If an adult is a mandatory member of the eligible group and is not eligible for Medicaid (ineligible adult alien, sanctioned adult, etc.) other than a voluntarily excluded person, the adult remains a member of the eligible group as a "considered" person.

If new household members are not eligible to be included in the transitional Medicaid group, do not consider the income and resources of the transitional Medicaid group when determining eligibility for the new household members.

Determine the household size for the new member's eligible group by considering:

- The new household members.
- Any other household members who are required to be included with them and:
    - Who are not part of the transitional Medicaid group, or
    - Whose income is not considered in determining the eligibility of the transitional Medicaid group.

**Review Requirements**

**Legal reference:** 441 IAC 76.7(249A)

Households receiving transitional Medicaid do not have any review or reporting requirements other than those explained in the section **Requirements After Eligibility Is Established**.

After transitional Medicaid households lose their eligibility under this coverage group and establish eligibility under another coverage group, they are again subject to review and reporting requirements as explained in 8-G, **ADDITIONAL FMAP-RELATED CASE MAINTENANCE**.

Determine when the household members attended the last face-to-face review. If 12 or more months have passed since the last face-to-face review, issue the household the *Review/Recertification Eligibility Document* (RRED). A face-to-face review is required for the adults on the case before the end of the second month following the month transitional Medicaid eligibility ends.

If 12 months have not passed since the last face-to-face review, hold the next face-to-face review for the adult's eligibility at the regular time.

## Ineligible for FMAP Due to Residence in a Medical Institution

**Legal reference:** 441 IAC 75.1(6)

Medicaid coverage is available to people living in licensed medical institutions who would be eligible for FMAP if they were not living in the institution.

When determining eligibility, examine the circumstances as if the person were living at home. Consider the needs, income, and resources of the family at home. Resources of all appropriate household members are counted in determining eligibility of children under this coverage group.

If the family at home would not be eligible for FMAP by including the institutionalized person, the institutionalized person must establish eligibility under another coverage group.

If the family at home would be eligible for FMAP by including the institutionalized person, establish a separate Medicaid case for the institutionalized person. Do not grant FMAP to the family at home based on this determination. The family must apply for FMAP and establish eligibility without the institutionalized person if they want to get FMAP benefits for themselves.

1. Mr. A, age 41, is in a nursing home. He cannot continue to be included in the FMAP eligible group with his family at home, since it has been verified that he will not be returning to the home within 12 months. Because the family at home would remain eligible for FMAP if Mr. A continued to be included in the eligible group, Mr. A is Medicaid-eligible under this coverage group.

   Even though Mr. A is included in the eligible group when determining his Medicaid eligibility, Mr. A is not included in the eligible group when determining the family's FMAP eligibility.

2. Mr. C applies for FMAP for himself and his two children. He is also applying for Medicaid for his wife who was critically injured in an auto accident and who currently is living in the local hospital. Mrs. C may be discharged from the hospital within 12 months, but she will be entering a nursing facility and will not return home.

   If Mr. C, Mrs. C, and the children would be eligible for FMAP as a four-member eligible group, Mrs. C is eligible for Medicaid under this coverage group. The FMAP eligibility determination for Mr. C and the children is based on a three-member eligible group.

## Child Medical Assistance Program (CMAP)

**Legal reference:** 42 CFR 435.222, 441 IAC 75.1(15) and 75.13(1)

Medicaid coverage under the Child Medical Assistance Program (CMAP) is available to people under age 21 who meet all FMAP eligibility requirements except:

- Age.
- Living with a specified relative who receives Medicaid under FMAP.
- Resource limits.

A person eligible under this coverage group continues to be eligible during the month the person turns 21, unless the twenty-first birthday falls on the first day of the month. A person born on the first is ineligible for the month of the twenty-first birthday.

Count unborn children in determining household size if the pregnancy has been verified. Count parents who are ineligible for Medicaid in the household size if they reside with the eligible group.

Disregard resources of all household members when determining eligibility under this coverage group.

See the following sections for more information on:

- CMAP income guidelines
- Eligibility for people living apart from parents or spouse
- Eligibility for people living in FMAP households
- Eligibility for people living with self-supporting parents
- Eligibility for people living with a spouse

## CMAP Income Guidelines

**Legal reference:** 441 IAC 75.1(15)"a"

Consider income according to FMAP policies. **Exception:** Do not use the income of any "man in the house" who is not married to a CMAP-eligible pregnant woman, except for any income he makes available to the woman. It does not matter if he is the legal or natural father of the unborn child.

Even though a 17-year-old living independently could not receive FMAP, CMAP eligibility is determined as though the person met the FMAP definition of a dependent child.

When determining whether income is countable for students under the age of 18, follow FMAP policies regarding earnings of a child in school. See 8-E, **Child's Earnings**.

Allow a pregnant woman under 21 to choose to receive Medicaid under either CMAP or MAC.

The household consists of Ms. K, age 19, and Mr. H, age 26. Mr. H is employed full time. Ms. K is pregnant and has earned income of $500 per month. Because Ms. K has no health insurance, she applies for Medicaid, and indicates Mr. H as the father of her unborn child.

The worker tells Ms. K that she is not eligible for CMAP in her own right because her income exceeds the FMAP limit for one person. Ms. K provides a physician's statement verifying her pregnancy. She is determined eligible for CMAP based on a two-person household (Ms. K and the unborn child). Mr. H's income is not considered because he is not married to Ms. K and states he makes no income available to her.

## People Living Apart From Parents or Spouse

**Legal reference:** 441 IAC 75.1(15)"a"(5)

A person under 21 who lives apart from parents or a spouse may be eligible for CMAP if the person's income does not exceed the limits for a FMAP family of one. This includes a person living with friends or under the care and control of someone who is not the parent or a specified relative.

If the person lives with a sibling who is under age 21, consider the siblings together in determining eligibility, unless one sibling is:

- Emancipated, due to marriage (except if the marriage is annulled) or due to court order.
- Voluntarily excluded. (Do not exclude unborn children.)
- Eligible as the newborn child of a Medicaid-eligible mother.
- An unmarried parent under age 21 who cares for a child regardless of the parent's school attendance. The siblings have a choice to be one eligible group or separate eligible groups.

In determining whether children are living independently from parents, see 8-C, **NONFINANCIAL FMAP-RELATED ELIGIBILITY: Eligible Group** and **Absence**.

1. Bob, aged 5, lives with a friend of his mother. As long as Bob's income is within the FMAP limits for one person, he is eligible for Medicaid under CMAP.

2. Kay, aged 19, and her sister, Sue, age 20, live with their aunt. As long as the income of Kay and Sue is within the FMAP limits for a two-person household, they are eligible for Medicaid under CMAP.

3. Joe, aged 5, and his sister, Jan, aged 16, live with a family friend. Jan is married but separated from her husband. As long Joe's and Jan's income is each within the FMAP limits for a one-person household, Joe and Jan are eligible for Medicaid under CMAP as separate eligible groups.

Iowa law requires that people who care for children who are unrelated to them be licensed for foster care. While this requirement does not affect eligibility for Medicaid, if you are aware of this situation, make a referral to the service unit to report the possibility of an unlicensed home.

## People Living in FMAP Households

**Legal reference:** 441 IAC 75.1(15)

People under age 21 who live in a family in which some members receive FMAP may be eligible for CMAP if their needs are not included in the FMAP eligible group. To be eligible under CMAP, income attributed to the CMAP group cannot exceed FMAP limits for a household of the same size as the CMAP group.

Parents, siblings, and other people who must be considered together according to FMAP policy must also be considered together for CMAP eligibility when they are not included in the FMAP eligible group.

Brothers or sisters (of whole or half blood, or adoptive) who are not in the FMAP eligible group must be considered together if they are under 21, unless the sibling is:

- Emancipated, due to marriage (except if the marriage is annulled) or due to court order.
- Voluntarily excluded. (Do not exclude unborn children.)
- Eligible as the newborn child of a Medicaid-eligible mother.
- An unmarried parent under age 21 who cares for a child regardless of the parent's school attendance.

When CMAP-eligible people live in an FMAP household, establish two cases with different aid types. The case number should be the same, but the FBUs must be different.

1. Ms. L and her 12-year-old son receive FMAP. Ms. L's 20-year-old son moves into the home. For purposes of determining CMAP eligibility, the 20-year-old son is considered as an eligible group of one. He is eligible for CMAP if his income does not exceed the FMAP standard for a one-person household.

2. Child A, age 20, applies for Medicaid. He lives with his self-supporting parents, Mr. and Mrs. B. Child A is eligible for Medicaid under CMAP if the income of Mr. and Mrs. B and Child A do not exceed the FMAP standard for a family of three.

3. Ms. Q and Child B receive transitional Medicaid. Child C, age 19, enters the home and applies for Medicaid. Child C will be a household of one under the CMAP coverage group if Child C's income does not exceed the FMAP income limits for a household of one. Since Ms. Q and Child B receive transitional Medicaid, no income of theirs will be diverted to the CMAP household.

## People Living With Self-Supporting Parents

**Legal reference:** 441 IAC 75.1(15)"a"(3)

People under age 21 who live with their parents may be eligible for CMAP if the parents do not want Medicaid. To be eligible, the total income of all family members, including parents, must not exceed the FMAP income limit for a family of the same size.

**Note:** The children are CMAP eligible because the parents have chosen not to receive FMAP. For children to receive FMAP, the specified relative must also receive FMAP.

Mr. and Mrs. K have four children, ages 22, 17, 12, and 5. Mr. and Mrs. K do not want Medicaid for themselves. The children under 21 are eligible for Medicaid under CMAP if the income of Mr. and Mrs. K and the three children under 21 does not exceed the FMAP standards for a family of five, regardless of household resources.

## People Living With a Spouse

**Legal reference:** 441 IAC 75.1(15)"a"(4)

A person under age 21 who lives with a spouse (who is not receiving FMAP) may be eligible under the CMAP coverage group. Married people under 21 do not have to have children to be eligible for Medicaid under this coverage group.

The total income of the person, the person's spouse, and any minor children (include unborn children of a verified pregnancy) must not exceed the FMAP income limit for a family of the same size.

When one spouse is under 21, and the other is 21 or older, the spouse who is 21 or older is included in the household to determine eligibility for the spouse under 21. However, when the spouse over 21 is receiving FMAP, the needs and income of the FMAP group are not used in the CMAP determination.

1. Household consists of:
   Mrs. D, 24 years old
   Mr. D, 19 years old, stepparent
   Child A, 5 years old, Mrs. D's child from a previous relationship

   All have requested Medicaid on an initial application. Determine FMAP eligibility for Mrs. D and Child A. Mr. D's income is counted but he's not included in the household size. Mr. D has gross earning of $456 per month. Mrs. D and Child A have no income.

| | | |
|---|---|---|
| $ | 456.00 | Gross income |
| – | 91.20 | 20% earned income deduction |
| $ | 364.80 | < than Mr. D's needs of $365 |

   There is no income from Mr. D to attribute to the FMAP group, so Mrs. D and Child A are FMAP-eligible as a household of two.

   Mr. D's income passes Test 1 and Test 2. For Test 3:

| | | |
|---|---|---|
| $ | 364.80 | Income after 20% subtracted |
| – | 182.40 | 50% work incentive deduction |
| $ | 182.40 | < $183 |

   Mr. D is CMAP-eligible as a household of one.

2. Same as Example 1, except that Mr. D's gross income is $456.25.

| | | |
|---|---|---|
| $ | 456.25 | Gross income |
| – | 91.25 | 20% earned income deduction |
| $ | 365.00 | Meets Mr. D's needs of $365 |

There is no income from Mr. D to attribute to the FMAP group, so Mrs. D and Child A are FMAP-eligible as a household of two.

Mr. D is not CMAP eligible because he does not pass Test 2, so eligibility is examined under Medically Needy.

| | | |
|---|---|---|
| $ | 365.00 | Income after 20% subtracted |
| - | 483.00 | MNIL for one person |
| $ | 0 | Mr. D is eligible for Medically Needy as a household of one with zero spenddown |

3. Same as Example 1, except Mr. D's gross income is $500.

| | | |
|---|---|---|
| $ | 500.00 | Gross income |
| – | 100.00 | 20% earned income deduction |
| $ | 400.00 | |
| – | 365.00 | Meets Mr. D's needs – not CMAP eligible |
| $ | 35.00 | |
| – | 17.50 | 50% work incentive deduction |
| $ | 17.50 | Applied toward the FMAP group as unearned income |

Mrs. D and Child A are FMAP-eligible as a household of two.

To determine Mr. D's eligibility under Medically Needy, use $365 plus the $17.50 that was not applied toward the FMAP group.

| | | |
|---|---|---|
| $ | 365.00 | Meets Mr. D's needs. |
| + | 17.50 | Income not deemed to eligible group |
| $ | 382.50 | < $483 MNIL for one person |

Mr. D is eligible for Medically Needy as a household of one with a zero spenddown.

## Mothers and Children (MAC) Program

**Legal reference:** 42 CFR 435.116, 441 IAC 75.1(28)

Medicaid is available through the mothers and children (MAC) coverage group to pregnant women and to children who have not reached age 19.

To be eligible, pregnant women and children must meet FMAP eligibility requirements except for:

- Living with a specified relative.
- School attendance.
- Countable resources and the resource limits. (See **MAC Resource Limit**.)
- Income limits. (See **MAC Income Limits**.) Do not allow the 50% work incentive deduction for applicants or recipients.

There are also specific requirements for:

- Pregnant women.
- Infants under one year of age.
- Children aged one through 18.
- Children who lose MAC eligibility because of an age change while inpatients in a medical institution.

The following sections give more information on:

- MAC eligibility requirements.
- MAC resource limit.
- MAC income limit and requirements.
- Composite MAC/medically needy households.
- Composite MAC/FMAP households.
- Continued MAC coverage of children receiving inpatient care.

**Eligibility Requirements**

**Legal reference:** 42 CFR 435.116, 441 IAC 75.1(28)"a," "d," "e," "i"

Pregnant women are eligible for the MAC coverage group if:

- The household's countable income does not exceed 200% of the federal poverty level (see **MAC Income Limits**) AND
- For pregnant women aged 19 or older, the household's resources do not exceed $10,000 (see **MAC Resource Limit**) AND
- The pregnancy has been medically verified. (See 8-C, **Verification of Pregnancy**.)

Treat a pregnant woman under age 19 as a child when determining resource eligibility. Disregard all household resources.

Pregnant women who are eligible under MAC do not have to cooperate in establishing paternity and obtaining support for their Medicaid-eligible born children. See 8-C, **Pregnant Women Who Are Exempt From Cooperation**.

If the mother, regardless of her age, is establishing eligibility as a pregnant woman, the father of the unborn must be a considered person in the eligible group if he is in the home, regardless of whether he is married to the mother. If the father is under the age of 19, he may be eligible to receive Medicaid as a member of the eligible group

Coverage can begin three months before the month of application, but no earlier than the first day of the month of conception.

Once eligibility for MAC is established, coverage continues throughout the woman's pregnancy, even if the household's income changes. However, the woman must continue to meet all other eligibility factors.

If a pregnant woman loses eligibility under another coverage group because of excess income, grant continuous eligibility and change the aid type to 92-0. (See **Continuous Eligibility for Pregnant and Postpartum Women**.)

When a woman receives Medicaid on her last day of pregnancy, coverage also continues for the 60-day postpartum period, even if there are changes in the household's income and resources. (See **Continuous Eligibility for Pregnant and Postpartum Women**.)

Ms. T, aged 24, is pregnant. She lives alone and has verified her pregnancy. She also verifies that her monthly income is less than 200% of the federal poverty level for two people (herself and the unborn child) and her resources are less than $10,000. Therefore, Ms. T is eligible for MAC coverage.

As long as Ms. T continues to meet all other eligibility factors throughout her pregnancy, she continues to be eligible under this coverage group, without regard to changes in household income. If Ms. T is eligible on the last day of her pregnancy, she continues to be eligible through the 60-day period following the end of the pregnancy, regardless of her income or resources.

If the pregnant woman wants Medicaid but does not want the unborn child included in the eligible group, she must have another basis of eligibility. Good documentation is essential when explaining to the client how this decision affects the household.

Ms. A, aged 24 and verified pregnant, applies for Medicaid for herself and her two-year-old child. She has countable income that exceeds the FMAP income limit for three people but does not exceed the MAC income limit at 133% of poverty for three people. Ms A and her child are approved for Medicaid under MAC.

Later, Ms. A reports that Mr. B has moved into her home. Mr. B is the father of the unborn child but is not the father of Ms. A's born child. Mr. B must be included in the eligible group. Mr. B has liquid resources with a countable value that exceeds $10,000.

Ms. A may choose to exclude the needs of her unborn child in order to prevent Mr. B's resources making her ineligible. Eligibility for the born child would continue under MAC if the original projected income amount did not exceed the limit for two people at 133% of poverty. Eligibility for Ms. A would be explored under Medically Needy as a two-member eligible group.

**Infants under one year of age** are eligible under MAC if household income does not exceed 200% of the federal poverty level. See **MAC Income Limits**.

Mr. and Mrs. D apply for Medicaid under the MAC coverage group for their son, Tim, aged 4 months. If the household's countable monthly income does not exceed 200% of the federal poverty level for a three-member household, Tim is eligible under the MAC coverage group as an infant, regardless of household resources.

If the countable monthly income exceeds 200% of the federal poverty level, examine eligibility under Medically Needy.

At the child's first birthday, determine if the child continues to be eligible under MAC. If the child's first birthday falls on the first day of the month, eligibility as an infant ends on the last day of the previous month. If the child's first birthday falls on any other day of the month, eligibility ends on the last day of the birth month.

**Children ages 1 through 18** are eligible under MAC if countable household income does not exceed 133% of the federal poverty level. See **MAC Income Limits**. If the child's nineteenth birthday falls on the first day of the month, eligibility ends on the last day of the previous month. If the child's nineteenth birthday falls on any day other than the first of the month, eligibility ends on the last day of the birth month.

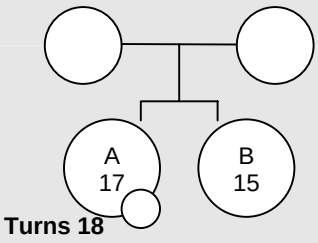
1. Mr. and Mrs. P apply for Medicaid for their daughter, Jennifer, whose birthday is October 11. Jennifer is eligible under the MAC coverage group. When Jennifer turns 19, her MAC eligibility will end effective November 1.

2. The same as Example 1, except that Jennifer's birthday is September 1. When Jennifer turns 19, her MAC eligibility will end effective September 1.

When a minor parent or minor pregnant woman turns 18 and is no longer considered a child based on FMAP rules, the income of the self-supporting parents and siblings is no longer counted, even though the 18-year-old is still a child under MAC.

Household consists of:

Mother, aged 45
Father, aged 47
Child A, aged 17 and pregnant
Child B, aged 15




The parents apply for Medicaid because Child A is pregnant. The worker explains two options of how to provide Medicaid to Child A:

**Option 1.** Child A can be an eligible group of two (Child A and the unborn). The parents' income will be diverted to meet their needs and the needs of Child B. Any income remaining after diversion will be considered when determining eligibility for Child A.

Child A would be eligible for Medicaid under MAC if her income plus any income of her self-supporting parents and sibling does not exceed 200% of poverty for a two-member eligible group

**Option 2.** Child A can be part of an eligible group that includes her parents and sibling. The FMAP, CMAP, or MAC eligible group size will be five (Child A, the unborn, Child B and the parents) unless Child B is voluntarily excluded.

Child A would be eligible for Medicaid under MAC if the income of the eligible group does not exceed 200% of poverty for a five-member eligible group. Child B would be eligible under MAC if the income of the eligible group does not exceed 133% of poverty for a five-member eligible group. Eligibility under Medically Needy should be explored for the parents and also for Child B, if income exceeds 133% of poverty.

When Child A turns 18:

- If she is receiving Medicaid under option 1, the income of her self-supporting parents will no longer be used in the eligibility determination beginning with the month following the month of her 18th birthday.
- If she is receiving Medicaid under option 2, beginning with the month following the month of her 18th birthday, Child A will be a two-member eligible group separate from the eligible group of her parents and sibling. The size of the eligible group for her parents and sibling will change from five to three.

**Remember:** If the 18th birthday falls on the first day of the month, the changes are effective with the month of the birthday.

## MAC Resource Limit

**Legal reference:** 441 IAC 75.1(28)"b"

When determining eligibility for children and pregnant women under age 19, disregard the resources of all household members. For pregnant women age 19 or older, resources must not exceed $10,000 per household, regardless of household size.

Do not consider the resources of a person in the household who is:

- Receiving FMAP.
- Receiving SSI.
- Voluntarily excluded from the eligible group. The excluded person is not eligible to receive Medicaid under any other coverage group.

Follow **FMAP-RELATED RESOURCE POLICIES** in 8-D. Count only liquid resources such as:

- Cash.
- Checking and savings accounts.
- Stocks and bonds.
- Certificates of deposit.
- Medicaid qualifying trusts.
- Mutual funds.

Exempt resources that meet the IRS definition of a retirement account, such as IRAs, 401Ks, Keogh plans, and IPERS. Annuities are also exempt, but if an applicant or recipient transfers money from a countable resource to an annuity, it may be considered a transfer of an asset. See 8-D, **TRANSFER OF ASSETS**.

1. Ms. D, aged 23, who is pregnant and lives alone, applies for Medicaid. She reports and verifies income that is within MAC limits and the following resources:

| | |
|---|---|
| $ 53 | Cash |
| 1,200 | Checking account |
| 1,000 | Savings account |
| 5,000 | Certificate of deposit |
| 8,700 | IRA |
| 4,000 | Car (equity value) |

The only resources that are considered in Ms. D's eligibility determination under MAC are the cash, the checking and savings accounts, and the CD. The IRA and the vehicle are exempt resources. If all other eligibility factors are met, Ms. D is eligible under MAC, since the combined value of all countable resources is less than $10,000.

2. Mr. E and Mrs. E apply for Medicaid. Mrs. E is 28 years old and pregnant. They report and verify income that is within MAC limits and the following resources:

| | |
|---|---|
| $ 102 | Cash |
| 2,106 | Joint checking account |
| 600 | Joint savings account |
| 4,700 | Value of Mr. E's mechanics tools, used in his employment |
| 3,500 | 1986 Honda motorcycle (equity value) |
| 14,350 | 1957 Thunderbird (equity value) |
| 2,500 | 1987 Chevrolet (equity value) |
| 2,000 | Joint certificates of deposit |

The only resources that are considered in the eligibility determination for Mrs. E are the cash, the checking and savings accounts, and the CD. Mr. E's tools of the trade and the vehicles are exempt resources. If all other eligibility factors are met, Mrs. E is eligible under MAC, since the combined total of all countable resources is less than $10,000.

3. Ms. L, who is pregnant, Child A (aged 9 years), and Child B (aged 12 years) apply for Medicaid. The household's income exceeds FMAP limits for four people, but is below 133% of the federal poverty level for a family of the same size.

However, MAC eligibility for Ms. L does not exist, because Child B has $15,000 in savings bonds that were left to him by his grandmother. As a result, the household's resources exceed the $10,000 limit in determining eligibility for Ms. L. Resources of all household members are disregarded in determining eligibility for Child A and Child B.

Ms. L voluntarily chooses to exclude Child B and, therefore, Child B's resources, from her eligibility determination. Ms. L is then eligible for MAC coverage, but Child B is not entitled to receive Medicaid benefits under any coverage group.

## MAC Income Limits

**Legal reference:** 441 IAC 75.1(28)"a"

When determining initial and ongoing eligibility for MAC, the income limits are:

- 200% of the federal poverty level for pregnant women and infants.
- 133% of the federal poverty level for children ages 1 through 18.

| Household Size | 133% of Poverty (Children 1 through 18) | 200% of Poverty (Pregnant women and infants) |
|---|---|---|
| 1 | $1,032 | $1,552 |
| 2 | $1,385 | $2,082 |
| 3 | $1,737 | $2,612 |
| 4 | $2,090 | $3,142 |
| 5 | $2,442 | $3,672 |
| 6 | $2,795 | $4,202 |
| 7 | $3,147 | $4,732 |
| 8 | $3,500 | $5,262 |
| For each additional person, add: | $353 | $530 |

Complete an automatic redetermination whenever the net countable income exceeds the established limits under the MAC coverage group.

When there are people on the same case who are Medicaid eligible or "considered" at 133% of poverty and 200% of poverty, the *Notice of Decision* will show only the 133% calculation. However, the system does do a calculation for 200% of poverty for eligibility purposes.

The following sections explain procedures for:

- MAC income requirements
- Determining countable income
- Receipt of a lump sum

## Income Requirements

**Legal reference:** 441 IAC 75.1(28)"a" and "e"

Consider the income of everyone in the household according to FMAP policy, except do not consider:

- Income of a child voluntarily excluded from the eligibility determination.
- Income of people who are receiving FMAP benefits when establishing MAC eligibility for people not in the FMAP eligible group.
- Any income that has been diverted to an FMAP eligible group.
- The FIP grant.

Exclude the needs, income, and resources of SSI recipients in the household when determining eligibility.

Exclude from the household size stepparents who have no children of their own and no common children. **Exception**: Incapacitated stepparents and those stepparents caring for a stepchild while the parent works are included in the household size. (See 8-C, **Who May Be in the FMAP Eligible Group**.)

Follow FMAP policy when establishing household size, including the following:

- Count one unborn child as if it were born and living with the mother when the pregnancy has been verified. If the existence of more than one unborn child has been verified, count the actual number of unborn children as if they were born and living with the mother.
- Apply Medicaid policies regarding voluntary exclusion of certain household members.

If the self-supporting parents' income creates ineligibility for the minor parent and the minor parent's child, the needs and income of the self-supporting parents may be voluntarily excluded. (**Note:** The self-supporting parents' income and needs cannot be voluntarily excluded when a minor pregnant woman has no born children living with her.)

By voluntarily excluding the needs and income of the self-supporting parents, the minor parent's needs are not included in the eligibility determination of the minor parent's child. However, the minor parent's income is used in the eligibility determination of the minor parent's child.

When the income of the minor parent and the minor parent's child exceeds FMAP income limits, determine eligibility under MAC and Medically Needy.

1. Child A (age 6) and Child B (age 14) live with Aunt V. Child A receives $600 per month from a trust fund established by a relative. Child B receives $800 per month from the same trust fund.

   This creates ineligibility for Child A and Child B under the MAC coverage group, because their combined unearned income exceeds 133% of the poverty level for a two-member household.

   Aunt V may voluntarily exclude either Child A or Child B from the eligibility determination in order to gain eligibility for the other child. The voluntarily excluded child cannot receive Medicaid under any other coverage group. If Aunt V chooses not to voluntarily exclude either child, examine Medically Needy eligibility for the entire household and make a referral to hawk-i.

2. Mr. and Mrs. D live with Child E (aged 17) and Child E's daughter, Child F (aged 2). Child E applies for Medicaid for herself and Child F.

   The income of Mr. and Mrs. D, her self-supporting parents, combined with Child E's own earned income, creates FMAP and MAC ineligibility for Child E and Child F.

   Child E may voluntarily exclude the income of her parents and, therefore, her own needs from the eligibility determination for Child F. Child F would be Medicaid-eligible under the MAC coverage group if the countable income of Child E and Child F (minus applicable deductions) exceeds the FMAP limit for one person but is less than 133% of poverty for one person.

   Since the self-supporting parents are responsible for Child E's needs, none of Child E's income can be diverted to meet her own needs. Child E is not eligible for Medicaid under any other coverage group.

## Determining Countable Income

**Legal reference:** 441 IAC 75.1(28)"a"(1), 75.57(4), 75.57(8)

When determining the amount of income to compare to the applicable poverty level, apply the following income deductions in the order listed. Follow FMAP policy when determining the amount allowed for each deduction.

1. 20% earned income deduction.
2. Child-care expenses that have been verified and are the responsibility of the client.
3. Court-ordered current or back child support for any people not living in the home.
4. Diversions for an ineligible or excluded person's needs, if applicable.

When considering the income of a stepparent in the home, apply the following income deductions in the order listed:

1. 20% earned income deduction.
2. Child-care expenses for the stepparent's ineligible dependents, including the common child, that have been verified and are the responsibility of the client.
3. Any verified amount paid for dependents not living in the home who are or could be claimed as dependents for federal income tax purposes.
4. Verified child support and alimony paid to a person not living in the home.
5. A diversion to meet the needs of the stepparent and the stepparent's ineligible dependents living in the home, including the common child, based on the FMAP schedule of living costs.

1. Ms. A applies for Medicaid for her one-month-old son. Her gross monthly earned income is $1,700. She has no child-care expenses. To determine MAC eligibility, consider Ms. A's income as follows:

| | |
|---|---|
| $ 1,700 | Gross monthly income |
| - 340 | 20% earned income deduction |
| $ 1,360 | Net earned income |

Ms. A's net earned income is less than 200% of the poverty level for a two-member household). Her son is eligible for MAC coverage.

2. Ms. B applies for Medicaid for her four-month-old daughter. Ms. B receives social security disability benefits of $775 per month. Her daughter receives social security benefits of $200 per month. The father of the infant pays $500 per month in child support. To determine eligibility for MAC coverage, consider income as follows.

| | |
|---|---|
| $ 775 | Ms. B's social security |
| + 200 | Child's social security |
| + 450 | Child support ($500 - $50 exemption) |
| $ 1,425 | Total unearned income |

Since the unearned income does not exceed 200% of the federal poverty level for a two-member household, the daughter is eligible for MAC.

3. The same as Example 2, except that Ms. B's daughter is 18 months old. To determine MAC eligibility for the child, the worker compares $1,425 to 133% of the federal poverty level for a two-member household.

Since the income exceeds 133% of poverty, the child is not eligible for MAC coverage. However, the worker examines the child's eligibility under Medically Needy and makes a referral to hawk-i.

4. Ms. T applies for Medicaid for her six-month-old son. The household's only income is $600 monthly in child support payments. Ms. T's child is eligible for MAC coverage, since the countable income of $550 ($600 minus $50 child support exemption) does not exceed 200% of the federal poverty level for a two-member household.

If the family income exceeds 133% of the federal poverty level for a two-member household when the child turns one year old, the worker will cancel MAC eligibility and examine eligibility under Medically Needy and make a referral to hawk-i.

5. Mrs. Z applies for Medicaid for her one-year-old daughter. Mr. Z, a stepparent, is also in the home. He has earnings of $1,700 per month. Mrs. Z has no income. In determining MAC eligibility, the worker considers the income as follows:

| | |
|---|---|
| $ 1,700 | Mr. Z's earned income |
| - 340 | 20% earned income deduction |
| - 365 | Diverted to meet needs of stepparent (FMAP Schedule of Living |
| $ 995 | Costs for one person) |

Since the countable income does not exceed 133% of federal poverty level for a two-member household, the child is eligible for MAC coverage.

**Receipt of Lump Sum**

Follow FMAP policy when considering a recurring lump sum (which may be earned or unearned income) or a nonrecurring lump sum (which is always unearned income). See 8-E.

If a pregnant woman receives a nonrecurring lump sum that creates ineligibility for more than one month, consider it as an increase in income. Grant continuous eligibility.

When prorating lump sums and using the prorated amount as income, do not count the lump sum as a resource.

1. Mr. and Mrs. A receive Medicaid for their three-year-old child under MAC. Their countable monthly income is $600. In May, Mr. A receives an inheritance of $900. The period of proration begins with the benefit month of July and is determined as follows:

| | |
|---|---|
| $ 600 | Countable monthly income |
| + 900 | Nonrecurring lump sum |
| $ 1,500 | Total countable income for the May budget month |

$1,500 divided by $849 (FMAP Standard of Need for a three-member household) = 1.76 months (the period of proration)

$849 is the countable income used to determine eligibility for the July benefit month, since the $600 countable income for May was used to determine the period of proration and cannot be used twice.

July is the first month of the proration period. MAC eligibility exists for July, since $849 does not exceed 133% of poverty for a household of three.

Since the lump sum by itself does not create ineligibility for more than one month, the worker determines if the remainder of the lump sum to be used in the August benefit month will create ineligibility when added to countable monthly income.

| | |
|---|---|
| $ 1,500 | Total countable income for the May budget month |
| - 849 | FMAP Standard of Need for a three-member household |
| $ 651 | Remainder of lump sum countable for August |
| + 600 | Countable monthly income |
| $ 1,251 | Total countable income for August |

Since the total countable income for August does not exceed 133% of poverty for a three-member household, the child remains eligible.

2. Ms. B, aged 25, is a pregnant woman receiving Medicaid under MAC. Her countable monthly income of $1,400 does not exceed 200% of poverty for a two-member household.

   In August, Ms. B receives a $5,000 nonrecurring lump sum. The period of proration is nine months (October through June). The lump sum, plus Ms. B's countable income of $1,400, exceeds the MAC income limits. Ms. B is granted continuous eligibility.

   Ms. B remains Medicaid-eligible for the reminder of her pregnancy, regardless of changes in household income. She gives birth to her baby the following December. The baby is granted newborn status beginning with the month of December.

   Ms. B's postpartum period expires effective March 1. The worker completes an automatic redetermination and Ms. B is conditionally eligible for Medically Needy with a spenddown. The baby remains in newborn status, because Ms. B would be eligible for Medicaid if she were pregnant.

| March | | April | |
|---|---|---|---|
| $ 1,400 | Countable income | $ 1,400 | Countable income |
| + 719 | Lump sum proration | + 719 | Lump sum proration |
| $ 2,119 | | $ 2,119 | |
| – 483 | MNIL for one person | – 483 | MNIL for one person |
| $ 1,636 | | $ 1,636 | |

| | | |
|---|---|---|
| $ | 1,636 | |
| + | 1,636 | |
| $ | 3,272 | Spenddown for March/April certification period |

   In April, Ms. B decides to take a leave of absence from her job for a few months, effective May 1. She will have no earnings for May or June. The worker completes an automatic redetermination.

| May | | June | |
|---|---|---|---|
| $ 719 | Lump sum proration | $ 648 | Lump sum remainder |
| – 483 | MNIL for one person | – 483 | MNIL for one person |
| $ 236 | | $ 165 | |

| | | |
|---|---|---|
| $ | 236 | |
| + | 165 | |
| $ | 401 | Spenddown for May/June certification period |

   Ms. B is conditionally eligible for Medically Needy with a spenddown. The baby remains in newborn status because Ms. B would be eligible for Medicaid if she were pregnant.

3. Household composition: Mr. and Mrs. C; Child A, aged 16; Child B, aged 12; and Child C, aged 6 months.

   The children receive Medicaid under MAC because the Cs' countable monthly income of $1,500 does not exceed 133% or 200% of poverty for a five-member household. In June, Mrs. C receives a $15,000 nonrecurring lump sum. The worker determines the period of proration as follows:

   | | |
   |---|---|
   | $15,000 | Nonrecurring lump sum |
   | + 1,500 | Countable monthly income |
   | $16,500 | Total countable income for the August benefit month |

   $16,500 divided by FMAP Standard of Need for a five-member household = 16 months of proration.

   The total countable income for the August benefit month is the FMAP Standard of Need for a five-member household ($1,092). August is the first month of the proration period. $1,092 does not exceed 133% or 200% of poverty for a household size of five.

   To determine the total countable monthly income for the September benefit month, the worker adds the countable portion of the lump sum ($1,092) to the countable monthly income ($1,500).

   Since the total monthly countable income ($2,592) exceeds 133% of poverty for a five-member household, Child A and Child B are determined potentially eligible for Medically Needy coverage for the September/October certification period and are referred to the Hawk I program.

   However, since the total countable income does not exceed 200% of poverty for a five-member household, Child C continues to be eligible for Medicaid under MAC.

4. Ms. E, aged 34, is pregnant (not verified) and is also the mother of Child F, aged 12. She receives FMAP benefits for herself and her child. They have no other income.

   In May, Ms. E receives a nonrecurring lump sum of $3,000 and reports this to her worker. Ms. E and her child are determined ineligible for FMAP for four months ($3,000 ÷ 719). There is a carryover of $124.

   The worker completes an automatic redetermination, during which Ms. E verifies her pregnancy. In examining MAC eligibility, the worker compares $719 to 200% of poverty for three persons for Ms. E, and 133% of poverty for three persons for Child F.

Ms. E and Child F remain on MAC for the period of the FMAP ineligibility, provided all MAC eligibility factors are met.

**Note:** Had Mrs. E's pregnancy been verified when the lump sum was prorated, the standard of need would have included the unborn child. The period of proration would have been reduced to three months with a $453 carryover, and Mrs. E would have been granted continuous eligibility.

## Composite MAC/Medically Needy Households

If a household with income above FMAP limits has some members who might be eligible for MAC coverage and some who would not, determine eligibility under both MAC and the Medically Needy coverage groups. Examine MAC eligibility before Medically Needy.

If some household members are eligible under each group, establish two separate cases. Examples of MAC/Medically Needy composite households include:

- Households with parents aged 19 or older and their children.
- Households with a pregnant woman who also has insured children over the age of one when family income is less than 200% of the federal poverty level but more than 133% of the federal poverty level.
- Households with infants and insured children when family income is less than 200% of the federal poverty level but more than 133% of the federal poverty level.

When determining eligibility, the household size is usually the same for each program, but may be different. Include the following in both eligible groups:

- People who are categorically eligible under MAC.
- People who are categorically eligible under Medically Needy.
- Any additional people who must be considered when determining household size.

Enter MAC-eligible people as considered people on Medically Needy spenddown cases. Do not enter them on zero-spenddown cases. See 8-C, ***NONFINANCIAL ELIGIBILITY***, and 8-J, ***MEDICALLY NEEDY***, for more information.

1. Household composition: Mrs. J, who is pregnant with one unborn child; Mr. J; Child A (age 13 months); and Child B (age 5).

   The household's net monthly countable income is $2,500. Since this amount exceeds 133% of the federal poverty level for a five-member household (including the unborn child), Child A and Child B are not eligible for Medicaid under the MAC program.

   However, since the income is below 200% of the federal poverty level for a five-member household, Mrs. J is eligible for Medicaid under the MAC coverage group. Eligibility under the Medically Needy program is examined for the other household members and the children are referred to the ***hawk-i*** program.

   Medical bills for Mrs. J that were incurred before the MAC eligibility date are used to meet spenddown of the Medically Needy household, if the household remains legally obligated for them.

2. Household composition: Mr. and Mrs. V, Child A (age 6 months), Child B (age 18 months), Child C (age 14 years).

   Mr. V has earned income of $2,000 per month. Mrs. V has earned income of $1,000 per month. Mrs. V verifies monthly child care of $200. Income is considered as follows when establishing eligibility under MAC for the children:

| Mr. V | | Mrs. V | |
|---|---|---|---|
| $ 2,000 | Gross monthly income | $ 1,500 | Gross monthly income |
| - 400 | 20% earned income ded. | - 300 | 20% earned income ded. |
| $ 1,600 | Countable earned income | $ 1,200 | |
| | | - 200 | Child care expense |
| | | $ 1,000 | Countable earned income |

   Since the couple's total countable earned income of $2,600 does not exceed 200% of the federal poverty level for a five-member household, Child A is eligible. Child B and Child C are over income for MAC because the countable income exceeds 133% of the federal poverty level for a five-member household.

   When establishing eligibility and the spenddown for Child B and Child C under Medically Needy, the worker uses the following calculations:

| Mr. V | | Mrs. V | |
|---|---|---|---|
| $ 2,000 | Gross monthly income | $ 1,500 | Gross monthly income |
| - 400 | 20% earned income ded. | - 300 | 20% earned income ded. |
| $ 1,600 | Countable earned income | $ 1,200 | |
| | | - 200 | Child care expense |
| | | $ 1,000 | Countable earned income |

| | |
|---|---|
| $ 2,600 | Total countable earned income |
| - 733 | MNIL for a five-member household |
| $ 1,867 | |
| x 2 | Months |
| $ 3,734 | Spenddown |

Medical bills for Child A that were incurred before the MAC eligibility date may be used to meet the spenddown of the Medically Needy household, if the household remains legally obligated for them.

The children are also referred to the ***hawk-i*** program.

## Composite MAC/FMAP Households

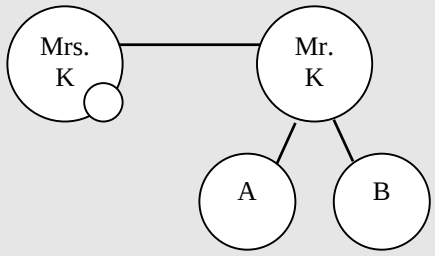
Do not consider the needs or income of people who are receiving FMAP benefits when establishing MAC eligibility for household members who are not included in the FMAP eligible group.

Do not consider any income that has been diverted to the FMAP eligible group in determining the countable income.

Do not count the FIP grant received in the eligibility determination for the MAC household. Generally, this occurs when there is a stepparent in the household whose income is considered in the FIP eligibility determination. Establish separate cases with different aid types.

1. Household composition:

   Mrs. K age 28, pregnant stepparent
   Mr. K
   Child A aged 9, Mr. K's child
   Child B aged 7, Mr. K's child




Mr. K is receiving unemployment of $350 per month and Mrs. K has gross monthly earnings of $600. The household wants Medicaid eligibility determined for everyone.

Step 1. The worker determines eligibility for the FMAP group:

| | |
|---|---|
| $ 600.00 | Gross earnings of Mrs. K |
| – 120.00 | 20% earned income deduction |
| - 365.00 | Diverted to meet the needs of Mrs. K (Schedule of Living Costs for one person) |
| $ 115.00 | |
| – 57.50 | 50% work incentive deduction |
| $ 57.50 | Mrs. K's net income |
| + 350.00 | Mr. K's unemployment |
| $ 407.50 | Compare to FMAP schedule of Basic Needs for three ($426) |

Therefore, Mr. K, Child A, and Child B are eligible for FMAP.

Step 2. The worker determines eligibility for Mrs. K:

| | |
|---|---|
| $ 600.00 | Gross earnings of Mrs. K |
| - 120.00 | 20% earned income deduction |
| $ 480.00 | |
| - 57.50 | Diverted to the FMAP-eligible group * |
| $ 422.50 | Compare to 200% of poverty for a two-person household ** |

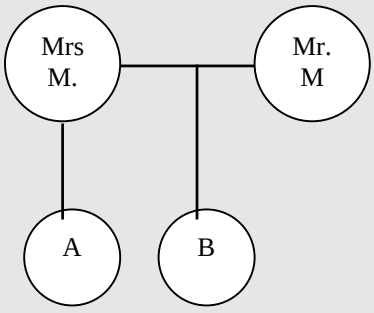
Since $422.50 does not exceed 200% of poverty for two, Mrs. K is eligible under MAC.

* Any income diverted to the FMAP eligible group is not considered when determining the countable income for other FMAP-related groups.

** FMAP-eligible people are not considered when determining eligibility for the MAC eligible group.

2. Household composition:

Mrs. M age 40, not pregnant
Mr. M
Child A age 18, not in school, Mrs. M's child from a previous relationship
Child B age 3, their common child




Mr. M has gross monthly earnings of $1,000.
Mrs. M and Child B have no income.
Child A has gross monthly earnings of $1,100.

Step 1. The worker determines eligibility for the FMAP group of Mrs. M, Mr. M, and Child B.

| | | |
|---|---|---|
| $ | 1,000.00 | Gross earnings of Mr. M |
| - | 200.00 | 20% earned income deduction |
| $ | 800.00 | |
| - | 400.00 | 50% work incentive deduction |
| $ | 400.00 | Compare to FMAP Schedule of Basic Needs for three ($426) |

Since the countable income of $400 does not exceed the FMAP limit, Mrs. M, Mr. M, and Child B are eligible for Medicaid under FMAP.

Step 2. The worker determines MAC eligibility for Child A:

| | | |
|---|---|---|
| $ | 1,100.00 | Gross earnings of Child A |
| - | 220.00 | 20% earned income deduction |
| $ | 880 | Compare to 133% of poverty level for a one-person household * |

Since $880 is less than 133% of federal poverty level for one, Child A is eligible for Medicaid under MAC.

* FMAP-eligible people are not considered when determining eligibility for the MAC eligible group.

## Continued MAC Coverage of Children Receiving Inpatient Care

**Legal reference:** 441 IAC 75.1(28)"j" and "k"

Infants and children who are currently eligible for MAC remain eligible when they are inpatients in a medical institution, even if they turn age one or 19, as long as they continue to meet the income requirements in effect before the age change. They remain eligible through the month the continuous inpatient stay ends.

Issue timely notice when an infant or child is losing MAC eligibility because of an age change and when it is not known if the child is an inpatient in a medical institution. Complete an automatic redetermination to establish Medically Needy eligibility and the amount of the spenddown. Include the following wording in the Medically Needy *Notice of Decision*:

"(*Name of child or infant*) may not need to meet this spenddown if this child is an inpatient in a medical institution. Contact your worker if this child is in a medical institution."

Do not consider the age change until the infant or child leaves the medical institution. All other eligibility factors continue to apply.

1. Carey is an infant who currently receives Medicaid under MAC. On September 10, Carey turns one year old. The worker completes an automatic redetermination and issues a notice of decision canceling MAC effective October 1, since the family's income exceeds 133% of poverty.

   The family informs the county office and verifies that Carey was admitted into the hospital August 30 and is expected to remain in the hospital until November 15.

   Although the household's income exceeds 133%, it remains less than 200% of the federal poverty level. Therefore, Carey remains Medicaid eligible under MAC through the end of November, because she meets all MAC eligibility factors for infants, except for age.

2. Sarah, age 18, is currently receiving Medicaid under MAC. In August, an automatic redetermination is completed because of her nineteenth birthday on August 22.

   The household verifies that Sarah is an inpatient in a medical institution and is expected to remain there until late November. She must continue to meet all MAC eligibility factors for children ages one through 18, except for age and resources.

   In September, the household reports increased resources that now exceed $10,000. Sarah continues to be Medicaid-eligible under MAC, since the resources of all household members are disregarded when determining eligibility for children.

3. Bobby is an infant currently receiving Medicaid under MAC. He will turn 1 on April 15. In March, the worker does an automatic redetermination and requests income information from the household to determine continuing eligibility under MAC at 133% of poverty.

   The household informs the worker that Bobby is currently in the hospital. Because Bobby is an inpatient in the hospital, he remains eligible for Medicaid if the household's income is within 200% of poverty.

   One of the family members receives a salary increase while Bobby is still hospitalized. The family's net countable income now exceeds 200% of poverty. Medicaid canceled effective the first of the next month allowing a 10-day notice.

## Medicaid/*hawk-i* Composite Families

This section is designed to provide guidance in situations where some family members have health care coverage through the ***hawk-i*** program and other family members receive or are applying for Medicaid.

See 8-B, **REFERRALS TO THE *hawk-i* PROGRAM**, for more information on making ***hawk-i*** referrals for applicant children who are ineligible for Medicaid or only conditionally eligible for Medically Needy with a spenddown.

See 8-G, **Referrals to the *hawk-i* Program**, for more information on making ***hawk-i*** referrals for recipient children who are ineligible for Medicaid or only conditionally eligible for Medically Needy with a spenddown.

When children in a family receive health care coverage through ***hawk-i*** and other family members apply for Medicaid, determine if the children on ***hawk-i*** are Medicaid eligible as part of the family's eligible group, according to Medicaid Household composition policy. See 8-C, **Eligible Group**, for more information.

If the children continue to be only conditionally eligible for Medically Needy with a spenddown and, therefore, remain eligible for ***hawk-i***, the ***hawk-i*** eligible children will be "considered persons" in the family's Medicaid eligible group.

Mrs. A applies for ***hawk-i*** for her two children. Family income exceeds 133% of poverty but does not exceed 200% of poverty. ***hawk-i*** coverage is approved for the children beginning October 1.

In January, Mrs. A is injured in an accident and applies for Medicaid. Family income still exceeds 133% of poverty, so the children would still only be conditionally eligible for Medically Needy with a spenddown. Therefore, they remain ***hawk-i*** eligible.

Mrs. A would also, only be conditionally eligible for Medically Needy with a spenddown. Her two ***hawk-I***-eligible children will be "considered persons" in her eligible group. Eligibility and spenddown for Mrs. A will be based on a three-member eligible group.

If the children are found to be Medicaid-eligible under coverage groups other than Medically Needy with a spenddown, the family can choose to leave the children on ***hawk-i*** until the ***hawk-i*** annual review or to have the children begin receiving Medicaid. If the family chooses to have the children receive ***hawk-i*** until the ***hawk-i*** annual review, the children receiving ***hawk-i*** are "considered persons" in the family's Medicaid eligible group.

If the family chooses to have the children begin receiving Medicaid, no action by the worker processing the Medicaid application is necessary in order for the ***hawk-i*** coverage to be canceled. The ***hawk-i*** computer system will be notified when the children are approved for Medicaid and ***hawk-i*** coverage will be canceled.

1. Ms. B applies for ***hawk-i*** for her son. Family income exceeds 133% of poverty for a two member eligible group. ***hawk-i*** eligibility is established for Ms. B's son effective May 1. In September, Ms. B applies for Medicaid because she is pregnant and verifies her pregnancy. Family income remains unchanged but is now below 133% of poverty for a three-member eligible group (Ms. B, her son, and the unborn).

   Ms. B chooses to have her son remain on ***hawk-i*** until the ***hawk-i*** annual review. While Ms. B's son remains on ***hawk-i***, he is a considered person in her eligible group. The size of Ms. B's eligible group is three (Ms. B, the unborn and her son as a considered person).

2. Mr. and Mrs. C apply for ***hawk-i*** for their three children. Family income exceeds 133% of poverty for a five-member eligible group. ***hawk-i*** eligibility is established for the three children effective June 1.

   In October, Mr. and Mrs. C apply for Medicaid. During the Medicaid eligibility determination process, the worker determines that family income is now less than the FMAP limit for a five member eligible group. If the Cs choose to have their children remain on ***hawk-i*** until the ***hawk-i*** annual review, the children would be considered persons in the Medicaid eligible group and the Medicaid eligible group size will be five.

   **Note:** The Cs could decide to have only one or two of their children begin receiving Medicaid and let the others stay on ***hawk-i***.

## People in a Medical Institution Within the 300% Income Limit

**Legal reference:** 441 IAC 75.1(7)

Medicaid is available to a child under age 21 who meets **all** the following conditions:

- Has received care in a medical institution for 30 consecutive days.
- Meets the level of care requirements for the institution, as determined by the Iowa Foundation for Medical Care.
- Meets the FMAP eligibility requirements except for age, income, and resources.
- Has gross countable monthly income that does not exceed 300% of the SSI benefit standard for one.

Children who are eligible under another coverage group (except Medically Needy) are not eligible under this coverage group.

Disregard the resources of all household members in determining eligibility of people under age 21 in this coverage group. See **SSI-RELATED COVERAGE GROUPS: People in Medical Institutions: 300% Income Level** for more information on determining eligibility.

# SSI-RELATED COVERAGE GROUPS

People who are aged, blind, or disabled may be eligible for Medicaid. Eligibility for these people is determined by following the general policies of the Supplemental Security Income (SSI) program. Thus they are referred to as "SSI-related" coverage groups.

This section explains the various SSI-related coverage groups under which a person may be eligible. Use the Supplemental Security Income program policies contained in Title 8 for these coverage groups unless a different policy is listed in the Employees' Manual.

People who are eligible under SSI-related coverage groups include:

- SSI recipients.
- "Essential" people from assistance programs before SSI began.
- People who are eligible for SSI benefits but do not receiving them.
- State Supplementary Assistance (SSA) recipients.
- People ineligible for SSI because of requirements that do not apply to Medicaid.
- People who are ineligible for SSI or SSA because of social security cost of living adjustments occurring after July 1, 1977, called the "503 medical-only" group.
- Blind or disabled people who received SSI or SSA after their eighteenth birthday for a condition which began before age 22 but who became ineligible for SSI or SSA due to social security benefits from a parent's account.
- People who would be eligible for SSI except for the October 1972 increase in social security benefits.
- Blind or disabled people who become ineligible for SSI due to "substantial gainful activity" (1619b people).
- Widowed people who became ineligible for SSI or SSA because of a January 1984 actuarial change and who applied for Medicaid before July 1, 1988.
- Widowed people who become ineligible for SSI or SSA because they receive social security and are not entitled to Medicare Part A.
- Children who are ineligible for SSI due to revision of the childhood disability criteria on August 22, 1996.

- People who would be eligible for SSI or SSA if they were not in a medical institution.
- People in medical institutions who are eligible because their incomes are within 300% of the SSI standard (300% group).
- People who were in a medical institution in December 1973.
- People in Medicare savings programs.
  - Qualified disabled and working people.
  - Qualified Medicare beneficiaries.
  - Specified low-income Medicare beneficiaries.
  - Expanded specified low-income beneficiaries.
  - Home health specified low-income beneficiaries.
- Medically needy people. See 8-J, ***MEDICALLY NEEDY***.
- People eligible for waiver services. See 8-N, ***HOME AND COMMUNITY-BASED WAIVERS***, for additional information.
- Postpartum women. See **Postpartum Eligibility**.
- Newborn children of Medicaid-eligible mothers. See **Newborn Children of Medicaid-Eligible Mothers**.

## SSI Recipients

**Legal reference:** 441 IAC 75.1(4), 42 CFR 435.120

SSI recipients, including people receiving SSI payments based on presumptive disability, are eligible for Medicaid unless the recipient:

- Does not cooperate with third-party liability. See 8-C, **Cooperation With Third-Party Liability Unit**.
- Does not cooperate in establishing paternity or support for a child under 18. See 8-C, **COOPERATION WITH SUPPORT RECOVERY**.
- Has a trust that makes the person ineligible for Medicaid. See 8-D, **TRUSTS**.
- Does not meet residency requirements.
- Is in a medical facility with a community spouse and the attributed resources make the recipient ineligible for Medicaid. See 8-D, **ATTRIBUTION OF RESOURCES**.

**Note:** An SSI recipient who transferred assets to attain or maintain Medicaid eligibility may not be eligible for payment of certain types of services. See 8-D, **TRANSFER OF ASSETS**.

Establish eligibility under another coverage group or terminate Medicaid when you receive an SDX or notice from the Social Security Administration that the SSI recipient is no longer eligible for benefits. See 8-B, **PROCEDURES FOR SSI APPLICANTS OR POTENTIAL SSI ELIGIBLES**, for information on how to process applications involving SSI recipients, persons who will be applying for SSI benefits, or persons who are waiting for a decision from the Social Security Administration.

## Essential Persons

**Legal reference:** 441 IAC 75.1(8), 42 CFR 435.131

Medicaid is available to people who were living with a recipient of Old Age Assistance, Aid to the Blind or Aid to the Disabled in December 1973 and whose needs were included in the grant. These people are called "essential persons."

Eligibility ends when:

- The essential person no longer lives with the aged, blind or disabled recipient; or
- The aged, blind or disabled recipient becomes ineligible for SSI.

"Essential persons" are different from "dependent persons" because essential persons were included in the state assistance grant in December 1973 (the last month of state benefits before the federal SSI program began).

In addition, the aged, blind, or disabled person receives a special increment in the SSI check for the needs of the essential person, paid totally by SSI, while the qualified person in a dependent person case receives State Supplementary Assistance, funded totally by the state. Federal financial participation is available for the medical costs of the essential person.

## People Eligible for SSI Benefits But Not Receiving Them

**Legal reference:** 42 CFR 435.210, 441 IAC 75.1(17)

Medicaid is available to people who would be eligible for SSI cash benefits but who are not receiving them. This usually occurs when a person has declined or chosen not to apply for SSI benefits.

Do not grant eligibility under this coverage group for people who have applied for SSI before applying for Medicaid or within five working days after applying for Medicaid. Wait for the SSI determination, unless the person withdraws the SSI application. See 8-B, **Concurrent Medicaid and Social Security Disability Determinations**.

Establish if a person would be eligible for SSI cash benefits by determining if the person:

- Is aged, blind, or disabled.
- Has assets that are less than the applicable SSI resource limits.
- Has countable income that is less than the applicable (individual or couple) SSI income limit.

## SSA Recipients and Dependent Relatives

**Legal reference:** 441 IAC 75.1(4) and (9), 42 CFR 435.232

Medicaid is available to aged, blind, and disabled applicants and recipients of State Supplementary Assistance payments, and to the dependent relative of a person who is receiving State Supplementary Assistance for the relative, unless:

- The SSA recipient or dependent has a trust that makes the person ineligible for Medicaid. See 8-D, **TRUSTS**.
- The SSA recipient does not cooperate with the Third Party Liability Unit. See 8-C, **Cooperation With Third-Party Liability Unit**.
- The SSA recipient does not cooperate in establishing paternity or support for a child under 18. See 8-C, **COOPERATION WITH SUPPORT RECOVERY**.

A State Supplementary Assistance recipient who has transferred assets is not eligible for Medicaid payment of certain services. See 8-D, **TRANSFER OF ASSETS**.

While there is federal financial participation (FFP) in the cost of medical care for the State Supplementary Assistance recipient, there is no FFP in the cost of medical care for the dependent person who is not aged, blind, or disabled. Because of this, it is important to enter the "state-only" fund code on the ABC system for dependent persons. See 14-B-Appendix for fund codes.

**Note:** Resources continue to be a Medicaid eligibility factor for children or adults who are eligible as an SSA recipient or dependent relative.

# People Ineligible for SSI (or SSA)

Several coverage groups provide Medicaid to people who are ineligible for SSI or State Supplementary Assistance benefits due to specific circumstances. The following sections explain coverage requirements for people who are ineligible due to:

- Requirements that do not apply to Medicaid.
- Receipt of a social security cost-of-living adjustment.
- Receipt by a disabled adult of social security benefits from a parent's account.
- Receipt of the 20% social security increase of October 1972.
- Substantial gainful activity.
- The January 1984 actuarial change in determining widow's or widower's benefits.
- Receipt of widow's or survivor's social security benefits.
- Reevaluation of childhood disability under Public Law 104-193.

## Due to Requirements That Do Not Apply to Medicaid

**Legal reference:** 441 IAC 75.1(3), 42 CFR 435.122

Medicaid is available to people who would be eligible for SSI except that they do not meet an SSI requirement that is specifically prohibited in the Medicaid program. The client must meet all other Medicaid eligibility requirements.

For example, for a person living in a public medical institution to be eligible for SSI, Medicaid must be paying at least 50% of the cost of care. Since Medicaid does not pay 50% of the cost of care for everyone, some people lose SSI. If these people meet all other eligibility factors, Medicaid eligibility continues under this coverage group.

Count the resources of applicable household members when determining eligibility of either children or adults in this coverage group.

Exception: Persons between age 21 and 65 who live in a mental health institute or facility for psychiatric care are not eligible under this coverage group. They may however, be eligible for limited Medicaid benefits under the qualified Medicare beneficiary coverage group. See **Qualified Medicare Beneficiaries (QMBs)**.

> Tom, age 12, an SSI recipient, moves into an ICF/MR. His parents are paying the cost of the ICF/MR from a trust fund established just for this care. Tom is canceled from SSI, since Medicaid does not pay at least 50% of the cost of care. Tom continues to be eligible for Medicaid in the ICF/MR under the SSI coverage group.

**Due to Social Security COLAs (503 Medical Only)**

**Legal reference:** 42 CFR 435.135, 441 IAC 75.1(13)

Medicaid is available to social security recipients who meet all the following conditions:

- They were eligible for and received social security and SSI or SSA benefits concurrently at some time since April 1977, **and**
- They later lost eligibility for SSI or SSA benefits (for any reason), **and**
- They would now be eligible for SSI or SSA if all social security cost-of-living adjustments (COLAs) since they were last concurrently eligible were deducted from income. This includes any COLA income received by the parent, spouse, or children since the applicant was canceled from SSI or SSA when that income is considered through deeming.

This provision applies to any social security cost-of-living increase occurring after July 1, 1977. Two categories of people are affected:

- Those who lose SSI or SSA directly because of a social security COLA.
- Those who become ineligible for SSI or SSA for another reason, and are then ineligible only for SSI or SSA only because of social security COLAs.

  For example, a person who became ineligible for SSI or SSA because resources exceeded limits may reapply when resources are under limits. The person may now be ineligible for SSI or SSA because of COLAs. If the person was simultaneously eligible for social security and SSI or SSA at some time since April 1977, examine eligibility for 503 coverage.

In either circumstance, the person can be eligible for Medicaid under the 503 group if there was concurrent eligibility and the person's current income without COLAs is within current eligibility limits.

To qualify for Medicaid under this coverage group, a person must continue to meet all other SSI standards. If resources or income from other sources exceed SSI limits, Medicaid eligibility under this coverage group ceases. However, a person who loses eligibility under this coverage group may later become eligible when income or resources are again within limits.

1. Mrs. W was an SSI recipient in 1994. She also received social security benefits. Her social security benefits increased due to a COLA in January 1995 and her SSI was canceled. She was put on the 503 program but then failed to return a review form.

   In 1996, Mrs. W applies for Medicaid. Since she was concurrently eligible for SSI and social security benefits in December 1994, Mrs. W may attain Medicaid eligibility under the 503 group if her current income is below SSI limits after disregarding social security COLAs since she was last concurrently eligible for SSI and social security.

2. Mr. W applied for both SSI and social security benefits when he became disabled. He began receiving SSI benefits in March. On July 20, he receives his first monthly social security disability benefit of $600.

   Even though Mr. W received both an SSI check and a social security check in July, he was not concurrently eligible, because his social security income was over SSI limits and he was not concurrently "eligible" for SSI and social security benefits. Mr. W cannot attain Medicaid eligibility under the 503 group, even if at some point disregarding his social security COLAs brings him under the income limits for SSI.

You will receive a 503 alert notice when a client loses SSI eligibility because of a COLA. These 503 notices are sent to alert you to potential 503 Medicaid eligibility only. Receiving a 503 alert notice does not guarantee that eligibility exists.

Social Security also sends notice when SSI and State Supplementary Assistance cases are canceled for other reasons. These recipients may also be eligible for Medicaid under the 503 coverage group.

Alert notices are not sent for persons who lose state-administered SSA (such as in-home health-related care or RCF) eligibility due to COLAs. Review SSA cases when there is a social security COLA to determine qualification for this coverage group.

If you receive a 503 notice for a client who is a former SSI recipient and you determine the client is eligible for 503 coverage, send a letter explaining that you now have responsibility for Medicaid eligibility determination. Also send form 470-2051, *10-Day Report of Change*. An example of a letter you might send is:

Although you are no longer eligible for a monthly SSI payment, you continue to be eligible for all the medical and health services available under Medicaid. You will continue to receive a monthly Medical Assistance Eligibility Card. Any future cost-of-living increase will also be disregarded in determining your eligibility for Medicaid.

Your local Human Services office is now responsible for determining your continuing eligibility for Medicaid, rather than the district office of the Social Security Administration.

You should report any changes in your circumstances (income, property, address, etc.) to your local Human Service office at the address given below. If you have any further questions, please contact us at the following address.

To examine 503 eligibility:

1. Determine if the person had concurrent eligibility for both social security and SSI or SSA at some time since April 1977.

2. Determine that the person meets all other SSI standards. For example, if resources or income from other sources exceeds SSI limits, the person is not eligible for Medicaid under the 503 group.

3. Ask the applicant to verify the social security income of any ineligible spouses, parents, or dependents when SSI is canceled. Contact the Social Security Administration if the applicant cannot provide verification.

4. Find the amount of the person's social security entitlement when SSI or SSA was canceled. Multiple that entitlement by the percent of increase in the COLA for each year since cancellation using the table that follows. Add the result to the immediately preceding entitlement. Use that total to calculate the next increase, if any.

| | | | |
|---|---|---|---|
| July 1977 | 5.9% | January 1991 | 5.4% |
| July 1978 | 6.5% | January 1992 | 3.7% |
| July 1979 | 9.9% | January 1993 | 3.0% |
| July 1980 | 14.3% | January 1994 | 2.6% |
| July 1981 | 11.2% | January 1995 | 2.8% |
| July 1982 | 7.4% | January 1996 | 2.6% |
| 1983 | 0 | January 1997 | 2.9% |
| January 1984 | 3.5% | January 1998 | 2.1% |
| January 1985 | 3.5% | January 1999 | 1.3% |
| January 1986 | 3.1% | January 2000 | 2.5% * |
| January 1987 | 1.3% | January 2001 | 3.5% |
| January 1988 | 4.2% | January 2002 | 2.6% |
| January 1989 | 4.0% | January 2003 | 1.4% |
| January 1990 | 4.7% | January 2004 | 2.1% |

* The 2000 amount was adjusted for a CPI error.

Before July 1982, the Social Security Administration rounded COLA benefits to the nearest dime (for example, $179.555 became $179.60). Since July 1982, Social Security has dropped benefits to the nearest dime (so $179.555 becomes $179.50).

If there were no increases other than COLAs, your calculation should be equal to the current social security income. If the calculation is off less than $2 from the current actual gross social security benefit, the difference is likely due to rounding. Consider the figures equal.

Due to an error or another factor, the social security entitlement may have decreased. If this is the case, confirm it with the Social Security office.

If there are benefit increases other than COLAs, count those as income in determining current SSI or SSA eligibility. Verify this income from the client's records or the Social Security office.

Current gross social security is $580.00. Cancellation was in March 1978. Gross social security income was then $178.30.

| Date of COLA | % of COLA | Result Before Rounding | Entitlement |
|---|---|---|---|
| 7-78 | 6.5 | 189.8895 | $189.90 |
| 7-79 | 9.9 | 208.7001 | $208.70 |
| 7-80 | 14.3 | 238.5441 | $238.50 |
| 7-81 | 11.2 | 265.212 | $265.20 |
| 7-82 | 7.4 | 284.8248 | $284.80 |
| 1-84 | 3.5 | 294.768 | $294.70 |
| 1-85 | 3.5 | 305.0145 | $305.00 |
| 1-86 | 3.1 | 314.455 | $314.40 |
| 1-87 | 1.3 | 318.4872 | $318.40 |
| 1-88 | 4.2 | 331.7728 | $331.70 |
| 1-89 | 4.0 | 344.968 | $344.90 |
| 1-90 | 4.7 | 361.1103 | $361.10 |
| 1-91 | 5.4 | 380.5994 | $380.50 |
| 1-92 | 3.7 | 394.5785 | $394.50 |
| 1-93 | 3.0 | 406.335 | $406.30 |
| 1-94 | 2.6 | 416.8638 | $416.80 |
| 1-95 | 2.8 | 428.4704 | $428.40 |
| 1-96 | 2.6 | 439.5384 | $439.50 |
| 1-97 | 2.9 | 452.2455 | $452.20 |
| 1-98 | 2.1 | 461.6962 | $461.60 |
| 1-99 | 1.3 | 467.6008 | $467.60 |
| 1-00 | 2.5 | 479.29 | $479.20 |
| 1-01 | 3.5 | 495.972 | $495.90 |
| 1-02 | 2.6 | 508.7934 | $508.70 |
| 1-03 | 1.4 | 515.9165 | $515.90 |
| 1-04 | 2.1 | 526.7339 | $526.70 |

These calculations show that if there were no other increase, the current gross social security income should be $526.70. Since the actual amount is $580.00, the conclusion is that there is an increase in social security other than the COLAs.

5. Determine countable income. Add any other current income to the figure calculated in Step 4. Do not deduct overpayments from the gross social security entitlement. Allow all disregards of income as provided by SSI or SSA.

   Compare this countable income to the current income limits for SSI or for the current SSA living arrangement. If countable income is below limits for SSI or SSA, the person is eligible under the 503 coverage group.

**1. Single Person with Unearned Income**

Mrs. Z, a single person living independently, applies for the 503 coverage group. She was canceled from SSI in September 1986. Her gross social security benefit in September 1986 was $360.40 and her gross is now $589.00. She also has VA benefits of $57 monthly, for a total income of $646.

The worker determines that there was an increase in social security other than COLAs. The Social Security Administration verifies this amount to be $40 monthly.

To calculate income eligibility for SSI:

| | | |
|---|---|---|
| $ | 360.40 | Social security at time of SSI cancellation |
| + | 40.00 | Non-COLA social security income |
| + | 57.00 | Veterans income |
| $ | 457.40 | |
| - | 20.00 | General income exclusion |
| $ | 437.40 | Countable income to compare to $564, the need standard for her current situation. Since countable income is less than need, she is eligible for Medicaid. |

**2. Single Person with Earned Income**

Miss Y, who is over 65, had $394.90 gross social security income in March 1995 when she was canceled from SSI. She continues living independently, and now has $482.00 social security income and $500 monthly gross earned income.

The worker determines that the social security income includes more than the cost of living increases. Social Security verifies that there is $40 per month attributable to a non-COLA increase.

The calculation of income eligibility is as follows:

| | | |
|---|---|---|
| $ | 394.90 | Social security in March 1995 |
| + | 40.00 | Non-COLA increase |
| $ | 434.90 | |
| + | 217.50 | Countable earned income ($500 - 65 ÷ 2) |
| $ | 652.40 | |
| - | 20.00 | General income exclusion |
| $ | 632.40 | Countable income |

Miss Y's countable income is over the SSI income limit of $564.00 for a single person in her own home. She is not eligible for Medicaid under the 503 coverage group. However, she may be eligible under another coverage group when her total social security income and earnings are considered (such as Medically Needy).

**3. State Supplementary Assistance**

Mr. W was canceled from RCF State Supplementary Assistance beginning January 1997. His gross social security income in December 1996 was $725.00. He is still in an RCF. His current gross social security is $789.00. The state supplementary assistance per diem rate that has been established for the RCF that Mr. W lives in is currently $21.32 per day.

The worker has determined that Mr. W's social security increases were all attributable to COLAs. The calculation of income eligibility for 503 Medicaid is as follows:

| | | |
|---|---|---|
| $21.32 per diem in the RCF X 31 = | $ | 660.92 |
| Personal need | + | 81.00 |
| Need standard | $ | 741.92 |

The countable income is $725.00, the social security income before cancellation. Since the countable income is less than the need standard, Mr. W meets the income requirement for the 503 coverage group. (Eligibility for the 503 coverage group enables Mr. W to qualify for Medicaid only. Mr. W will still not qualify for State Supplementary Assistance.)

**4. Eligible Couple**

Mr. and Mrs. B both received social security income and SSI in December 1990 and were canceled from SSI in January 1991. Mr. B's gross social security in December 1990 was $333 and Mrs. B's gross social security income was $165.

Mr. B's current gross social security is $441 and Mrs. B now has gross social security of $218. Mr. B started to receive a veterans pension in 1994, which is now $150 per month. The worker has determined that there were no social security increases other than COLAs.

Income computation:

| | |
|---|---|
| $ 333 | Mr. B's social security in 1/91 |
| + 165 | Mrs. B's social security in 1/91 |
| $ 498 | |
| + 150 | Veterans benefits |
| $ 648 | |
| - 20 | General income exclusion |
| $ 628 | Net countable income |

Mr. and Mrs. B are eligible for Medicaid under the 503 coverage group, since their countable income of $628 is less than their need standard of $846.

## Due to Social Security Benefits Paid From Parent's Account

**Legal reference:** Public Law 99-643, 441 IAC 75.1(25)

Medicaid is available to people who are at least 18 who meet all of the following conditions:

- They received SSI or SSA after their eighteenth birthday because of a disability or blindness that began before age 22.
- They were canceled from SSI or SSA effective July 1, 1987, or later because they became entitled to social security benefits from a parent's account, or they received an increase in those benefits.
- They would continue to be eligible for SSI or SSA if not for the social security benefits or increased benefits from the parent's account.

Social security benefits from a parent's account are available for disabled adult children whose disability began before the age of 22, including people who are blind.

When the parent begins receiving social security benefits (upon retirement or disability), the adult child may also become eligible for benefits based on the parent's account. Survivor's benefits are available for the disabled adult child also. It is possible for the adult child to draw benefits from the parent's account as well as drawing benefits on the adult child's own social security account.

> Mr. P, a 28-year old resident of an ICF-MR, was receiving SSI because of a disability that began before he turned 22. He had no income. His father started to draw social security retirement benefits. Mr. P began receiving $600 a month social security benefits from his father's social security account and he lost SSI.
>
> Mr. P continues to be eligible for Medicaid under the coverage group for people ineligible for SSI or SSA due to social security benefits paid from a parent's account.

The SDX identifies people who lost SSI eligibility due to social security benefits from a parent's account with a medical eligibility code of "D" and a code indicating that the person is over income for SSI. The Social Security Administration does not review ongoing eligibility for this Medicaid coverage group. The DHS income maintenance worker must complete reviews and determine ongoing eligibility.

### Due to Social Security Increase of October 1972

**Legal reference:** 42 CFR 435.134, 441 IAC 75.1(12)

Medicaid may be available to a person who meets all of the following conditions:

- Was entitled to receive social security benefits in August 1972.
- Was receiving Old Age Assistance, Aid to the Blind or Aid to the Disabled in August 1972 or would have received such assistance except that the person was in a medical institution.
- Would be eligible for SSI or SSA now if the amount of the 20% increase in social security benefits received in October 1972 is disregarded, **or** the person would be eligible if this increase was disregarded except the person is in a medical institution.

Contact the Social Security Administration to verify the amount of the October 1972 increase. A person does not have to have been continuously eligible since October 1972 to be eligible under this coverage group.

**Due to Earnings Too High for an SSI Cash Payment (1619b Group)**

**Legal reference:** 20 CFR 416.2101, 42 CFR 435.120

Medicaid coverage may be available to some former SSI recipients who no longer qualify for SSI benefits because their earnings are too high for an SSI payment (as determined by the Social Security Administration).

Eligibility may exist for people in this group if the person:

- Continues to be blind or have a disabling impairment.
- Meets all other SSI requirements except for earnings.
- Would be seriously inhibited from continuing to work if Medicaid eligibility was terminated.
- Earns income that is not a reasonable equivalent to the benefits the person would have, including SSI, SSA and Medicaid, if the earnings did not exist. This level is determined by the Social Security Administration.

This coverage group is also known as the "1619b" group. For purposes of Medicaid eligibility, a person meeting these criteria is considered to be an SSI recipient, even though no SSI benefit is received.

The Social Security Administration determines initial and continuing eligibility for this coverage group. Information about these clients appears on the SDX. See 14-E for SDX codes to identify former SSI recipients who remain eligible for Medicaid due to 1619(b) eligibility.

The ABC aid type is the same as for regular cash SSI-eligible persons. See **Summary of Aid Types and Fund Codes**.

**Due to Actuarial Change for Widowed Persons**

**Legal reference:** 441 IAC 75.1(23), P.L. 99-272, 42 CFR 435.137

Medicaid is available to all current social security recipients who meet the following conditions:

- They were eligible for social security in December 1983.
- They were eligible for and received a widow's or widower's disability benefit and SSI or SSA for January 1984.

- They became ineligible for SSI or SSA because their widow's or widower's benefit increased as a result of the elimination of the reduction formula in January 1984. This must be the sole reason they lost eligibility for SSI or SSA.
- They would be eligible for SSI or SSA benefits if the increase resulting from the elimination of the reduction factor and later cost-of-living adjustments were disregarded.
- They have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.
- They applied for Medicaid before July 1, 1988.

In January 1984, the Social Security Administration eliminated a "reduction formula" that had been used to calculate social security benefits for disabled widows and widowers. As a result, social security benefits increased. The increase caused some members of this group to lose eligibility for SSI, SSA, and Medicaid. Congress established a new eligibility group to allow ongoing Medicaid eligibility for these persons.

No new persons can enter this coverage group after July 1, 1988. For those who applied before July 1, 1988, and were approved under this group, review whether the person has been continuously eligible for social security widow's or widower's benefit. Also review whether the person still meets SSI or SSA standards, including income, if the specified social security increases are disregarded.

Determine countable income using SSI policies. Deduct from current gross social security income the amount of the increase resulting from the elimination of the reduction factor. (The Social Security Administration provided this reduction factor.) Add all countable income to the remainder. Compare this sum to the SSI or SSA income limit.

Mrs. M, a 63-year-old widow living alone in her home, received SSI and social security income in 1983. Mrs. M became ineligible for SSI in February 1984 due to the increase in social security benefits due to elimination of the actuarial reduction formula. Medical eligibility was then established under the coverage group for widowed persons ineligible for SSI or SSA due to the social security actuarial change.

Mrs. M's current gross monthly income is $435.00 in social security benefits and $169 civil service income. The increase in social security benefits from elimination of the actuarial reduction formula is $35. The COLA increases amount to $120.70.

| | | |
|---|---|---|
| $ | 435.00 | Current gross social security |
| - | 35.00 | Actuarial increase |
| - | 120.70 | COLA |
| $ | 279.30 | |
| + | 169.00 | Civil service income |
| $ | 448.30 | |
| - | 20.00 | General income exclusion |
| $ | 428.30 | The worker compares this computed income to $564 (current SSI benefit level for one) |

Mrs. M continues to be eligible for this coverage group, since her income is less than the SSI benefit rate.

**Due to Receipt of Widow's Social Security Benefits**

**Legal reference:** Public Law 100-203, 441 IAC 75.1(27), 42 CFR 435.138

Medicaid may be available to widowed people who meet all of the following conditions:

- They applied for and received or were considered recipients of SSI or SSA.
- They apply for and receive Title II widow's or widower's insurance benefits, or any other Title II old age or survivor's benefits.
- They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.
- They are no longer eligible for SSI or SSA solely because they received social security benefits.

Eligibility for this group began July 1, 1988. Determine eligibility by subtracting the social security benefits at the time of cancellation of SSI or SSA from current social security benefits. Add in other income and compare the result to the correct household SSI standard amount.

The Social Security Administration indicates on the SDX people who receive federally administered SSA and who might qualify for this program. The Social Security Administration does not review ongoing eligibility for this program.

Mr. W, a 55-year-old disabled person, receives SSI January through March 1996. Mr. W's spouse passes away, and in April 1996, Mr. W begins receiving $600 per month in widower's social security benefits.

Mr. W is not eligible for Medicare Part A and is ineligible for SSI solely because of widower's social security benefits. Mr. W is eligible for Medicaid under the coverage group for people ineligible for SSI (or SSA) due to receipt of widow's social security benefits.

## Due to Reevaluation of Childhood Disability

**Legal reference:** 441 IAC 75.1(38); Balanced Budget Act of 1997

Medicaid may be available to children under the age of 18 who meet both of the following conditions:

- They were receiving SSI on August 22, 1996.
- They were canceled from SSI due to the revised childhood disability criteria established under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193).

P.L. 104-193 changed criteria for childhood disability effective August 22, 1996. Certain children were required to have their disability reevaluated under the revised criteria. These reviews determined that some children were no longer disabled. They became ineligible for SSI and ineligible for Medicaid based on SSI eligibility.

The Balanced Budget Act of 1997 restored Medicaid eligibility to the children who lost their SSI benefits due to the reevaluation under the revised disability criteria. Eligibility for this group began July 1, 1997, the earliest possible date of SSI cancellation.

Children who meet the previous criteria for disability must continue to meet all other SSI-related eligibility criteria to be eligible for Medicaid under this coverage group. Conduct an annual review of eligibility factors other than disability.

Obtain a disability review on the review date originally established when the child was on SSI as disabled, if that date is known. Otherwise, obtain a disability review on the date of the next annual eligibility review.

These children may be placed in an FMAP coverage group if it is advantageous to the household in which they reside. However, if they lose eligibility under FMAP, they must always have eligibility reviewed under the SSI coverage group.

Children who are potentially eligible for this coverage group should have a pink form filed in the permanent section of their case record indicating possible eligibility for Medicaid. The form lists step-by-step instructions for determining eligibility.

## People in Medical Institutions

Medicaid is available to people living in medical institutions who:

- Would be eligible for SSI if they did not live in the institution.
- Have income within 300% of the SSI standard and are otherwise eligible for SSI.
- Were receiving Medicaid in a medical institution in December 1973.

### Ineligible for SSI Due to Residence in a Medical Institution

**Legal reference:** 42 CFR 435.211, 441 IAC 75.1(6)

When a person enters a medical institution in which Medicaid will be paying at least 50% of the cost of care, the SSI program reduces the person's maximum benefit rate to $30 per month. This means that people who were eligible for SSI while living in their home will lose SSI eligibility when they enter a medical institution if their income is greater than $30.

Medicaid is available to a person who would be eligible for SSI or SSA if the person was not living in a medical institution. Begin eligibility on the first day of the month the person entered the institution. Begin payment for the nursing facility on day of entry, provided level of care has been met. Retroactive benefits may also be available for up to three months before the month of application if all requirements are met.

1. Mr. A, a 67-year-old person living in a nursing facility, has been using his resources to pay privately. In July 1996, Mr. A applies for Medicaid because his resources have been depleted and are now less than $2,000. Mr. A's only income is social security of $400.

   Because Mr. A's income does not exceed the SSI payment standard for an individual living at home, his correct coverage group beginning July 1996 is "people ineligible for SSI due to residence in a medical institution."

2. Ms. J enters a nursing facility and applies for Medicaid on July 20. Her only income is social security of $400. In the month of July, her resources were $2,200. As of August 1, Ms. J's resources are reduced to $1,900.

   For the month of July, eligibility is determined under the Medically Needy group. Because Ms. J's income is less than the SSI payment standard for one person living at home, and her resources are less than the SSI resources standard, beginning August 1, her correct Medicaid coverage group is then "people ineligible for SSI due to residence in a medical institution."

   Eligibility is not determined under the "300% income level" coverage group. The 30-day stay requirement does not apply for the month of August.

## 300% Income Level

**Legal reference:** 42 CFR 435.236, P.L. 100-360, 441 IAC 75.1(7), 75.5(4), 75.13(2)

Medicaid is available to a person who meets all of the following requirements:

- Receives care in a hospital, nursing facility, NF/MI, psychiatric medical institution, or ICF/MR and has been institutionalized for 30 consecutive days.
- Meets the level of care requirements for the institution, as determined by the Iowa Foundation for Medical Care or Medicare. See 8-I, **Medical Necessity**.
- Either:
  - Is aged 18 or older and meets all Supplemental Security Income (SSI) eligibility requirements except income, **or**
  - Is under age 18 and meets all Supplemental Security Income (SSI) eligibility requirements except income and resources.
- Has gross monthly income that is more than SSI standards but that does not exceed 300% of the federal SSI benefit for one which currently is $1,692. If both spouses enter a medical institution and live in the same room, the income limit is two times $1,692, or $3,384.

For all people in this coverage group, count income using SSI policies. For adults, count resources using SSI policies. For children under age 18, disregard resources of all household members. **Note:** See also **FMAP-RELATED COVERAGE GROUPS: People in a Medical Institution Within the 300% Income Limit**.

1. Tim, age 12, resides in a PMIC. He receives Medicaid and facility care under the coverage group for people who are ineligible for SSI due to residing in a medical institution, in which resources are an eligibility factor for children. Tim has monthly countable income of $100.

   In August, during the annual review, the worker determines Tim's resources have permanently increased to $2,700 and will continue to be the same as of the first moment of the first day of September. The worker completes an automatic redetermination and finds Tim eligible under the 300% group.

   Tim is eligible under the 300% group, because his income exceeds the maximum for his living arrangement ($30) and because resources of all household members are disregarded when determining eligibility for children under age 18 in this coverage group.

2. Sam, age 8, resides in an ICF/MR and receives $10 in monthly SSI and $20 in other countable income. Sam receives Medicaid and facility care under the coverage group for SSI recipients in medical institutions, in which resources are an eligibility factor for children.

   In August, during the annual review, the worker determines Sam's resources have permanently increased to $2,700 and will continue to be the same as of the first moment of the first day of September. The worker completes an automatic redetermination.

   Sam is eligible under the coverage group for people who are eligible for SSI but not receiving, in which resources of all household members are disregarded in determining eligibility of persons under age 18. However, in order for the facility payment to continue, the worker places Sam in the 300% group, using the applicable aid type.

Do not approve eligibility until after the applicant has been in a medical institution for 30 consecutive days. A period of 30 days begins at 12 a.m. midnight on the day of admission to the medical institution and ends no earlier than 11:59 p.m. of the 30th day following the beginning of the period.

However, once the "30-day stay" requirement is met, eligibility under this group can be granted back to the initial date of entry, the application date, or the retroactive period, whichever is applicable.

If the resident is discharged after the 30-day period is met, this does not affect eligibility for the application month, even if you have not completed an eligibility determination before the client is discharged.

The 30-consecutive-day provision is met even if the person:

- Dies before being in the institution 30 consecutive days.
- Is temporarily absent for not more than 14 full consecutive days if the person remains under the jurisdiction of the institution. To be under the institution's jurisdiction, the person must have been physically admitted to the institution.
- Transfers between one type of institution to another (for example, from a hospital to a nursing facility). Time spent as a resident of a mental health institute counts toward meeting the 30-day residency requirement, even for people over age 20 but under age 65 who are not eligible for Medicaid in the mental health institute.

Examine eligibility under this coverage group for people in an institution who are under the age of 21 who are not blind or disabled based on SSI criteria and who do not qualify for Medicaid under another coverage group. Use SSI policy to determine the countable income of all children in an institution.

If the child will be in the facility a full calendar month, do not consider parental income for either SSI-related or FMAP-related children. If the child will not be in the facility a full calendar month for the month of entry, deem parental income in the month of entry to a child under 18 (or under 21, if in school) for the initial month of eligibility. Follow SSI deeming policies in 8-E, **Deeming SSI-Related Income**.

To examine eligibility under this coverage group:

1. Check that the client has not transferred assets to become eligible for Medicaid. See 8-D, **TRANSFER OF ASSETS**. If so, this disqualifies the person in a facility for nursing facility services.

   Other services may be covered if the person is eligible for this group. To accomplish this, manually determine eligibility and put the person in an aid type that does not pay the facility but pays for other medical services (such as 64-3 and 14-3). Do not do this for waiver cases.

2. Determine assets to be attributed to the spouse of an institutionalized person. See 8-D, **ATTRIBUTION OF RESOURCES**.

3. Use SSI policy to calculate the client's gross income. See 8-E. Do not allow the earned income disregard and the general disregard of income.

   Compare the gross income to the 300% limit of $1,692. If **both** spouses enter a medical institution and live in the same room, the income limit is two times $1,692 or $3,384.

4. If the person meets all requirements (including level of care), eligibility begins the first of the month of application or entry to a medical institution, whichever is later. People who have lived in a medical institution as private-pay patients may be eligible under this coverage group in the retroactive period.

5. Determine client participation according to procedures in 8-I, **CLIENT PARTICIPATION**.

**Since December 1973**

**Legal reference:** 42 CFR 435.132, 441 IAC 75.1(5)

Medicaid is available to people who were in a medical institution and were receiving Medicaid in December 1973. Coverage continues if the person:

- Has countable resources that are less than the limits in effect in December 1973.
- Meets the eligibility requirements in effect for assistance in December 1973.
- Has countable income that is less than the current monthly Medicaid rate for the facility in which the person lives, plus the personal needs allowance.

If a person loses eligibility under this coverage group, the person can probably establish eligibility under another coverage group.

Contact the Bureau of Eligibility Services for eligibility requirements and levels in effect in December 1973.

## People in Medicare Savings Programs

Several Medicaid coverage groups are designated as 'Medicare savings programs," because their purpose is to assist low-income people with the payments of Medicare premiums, coinsurance, and deductibles. These groups include:

- Qualified disabled and working people.
- Qualified Medicare beneficiaries.
- Specified low-income Medicare beneficiaries.
- Expanded specified low-income beneficiaries.

### Qualified Disabled and Working People (QDWPs)

**Legal reference:** P.L. 100-239, 441 IAC 75.1(33)

Limited Medicaid benefits are available to people under age 65 who received social security disability (SSD) benefits but whose benefits were discontinued because of excess income from earnings. They may continue to be disabled but no longer meet Social Security's definition of disability because of "substantial gainful activity."

**Note:** Medicare refers to the QDWP group as a Medicare Savings Program. People applying for QDWP may refer to the coverage group as the Medicare Savings Program.

After the person ceases to be disabled because of income above the "substantial gainful activity" level, social security disability benefits continue for a trial work period for nine months. The Social Security Administration then provides Medicare Part A for seven years and nine months without charge for most people.

When this period ends, the client may continue to receive Medicare Part A coverage but must pay for the premium. The intent of the QDWP program is to assist with paying the cost of the Medicare Part A premium.

Medicaid pays the cost of the hospital premium under Medicare Part A for people eligible under QDWP. This is the **only** benefit QDWP clients receive.

The Social Security Administration uses the following conditions to determine who qualifies to purchase Medicare Part A:

- The person is under 65.
- The person was previously entitled to extended Medicare benefits without a charge after social security disability benefits ended due to substantial gainful activity.
- The person continues to have the same disabling condition that was the basis for receipt of social security disability benefits, or to be a disabled qualified railroad retirement beneficiary, or to be blind.
- The person has worked continuously for 8 1/2 years (while receiving extended social security disability cash benefits for the first 9 months and then 7 years and 9 months of extended Medicare benefits after termination of social security disability cash benefits). (Determine that Medicare benefits stopped due to work.)

  **Note:** Before July 1997, the person would have received 9 months of social security disability benefits and then 36 months of extended Medicare benefits.
- The person is not entitled to any other Medicare benefits.

The Social Security Administration notifies the person that Medicaid payment for Medicare Part A may be an option at the same time it notifies the person that the person may continue Medicare Part A benefits by paying the premium. The Social Security Administration will inform the person of the general requirements for Medicaid eligibility and where to apply.

Establish eligibility under the QDWP coverage group if:

- The person is eligible for and enrolled in Part A Medicare. If the person chooses not to enroll, deny eligibility under this coverage group.
- Resources do not exceed twice the maximum allowed by the SSI program. Resources are treated according to SSI policies. See 8-D, **GENERAL SSI-RELATED RESOURCE POLICIES**. The resource limits for the QDWP group are $4,000 for an individual and $6,000 for a couple.
- Net countable monthly income does not exceed 200% of the federal poverty level for the applicable family size.

| Size of Family | 200% of Poverty Level |
|---|---|
| Individual | $1,552 |
| Couple | $2,082 |

Compare the net countable income to the individual limit when income is not deemed from the ineligible spouse to the eligible spouse.

To determine net countable monthly income, follow SSI policies. See 8-E, **INCOME POLICIES FOR SSI-RELATED COVERAGE GROUPS**. Allow the earned and unearned deductions. Consider the income prospectively.

- The person is **not** eligible for any other Medicaid benefits. If a person is eligible under another coverage group, the person is not eligible for QDWP.
- The person meets all other general eligibility requirements as other SSI-related Medicaid recipients (except for substantial gainful activity).

1. Mr. Z, aged 45, is currently receiving Medicare Part A benefits. His income does not exceed 200% of poverty, and his resources do not exceed twice the SSI resource limit. If all other program requirements are met, Mr. Z's application may be approved for the QDWP group.

2. Ms. Y, aged 42, had been receiving social security disability benefits since age 30. She was found not to be disabled four years ago when her income from earnings exceeded the substantial gainful activity level, even though her medical condition remained unchanged. Her disability benefits stopped three years ago, but her Medicare coverage continued without any charge for Part A.

   Her extended Medicare Part A without a premium is now ending. Ms. Y chooses to purchase Medicare Part A after her extended benefits end. She applies for Medicaid under QDWP. She has her three minor children living with her.

   The worker determines that Ms. Y would be eligible for Medicaid under FMAP-related Medically Needy with no spenddown. She is not eligible for the QDWP coverage group. The application is processed for Medically Needy. Medicaid does not provide for payment of the Medicare Part A premium.

Social Security verifies that the person is entitled to Medicare Part A through the continuing disability review procedures. When a person is no longer entitled to Medicare Part A, Social Security will notify the Centers for Medicare and Medicaid Services (CMS). CMS then notifies the state of the person's termination.

Mr. X, aged 31, has a disabling medical condition and continues to work. Social Security has notified him that he can continue with Medicare Part A coverage, but that he will have a premium to pay. Social Security also notifies him about the QDWP program and the general guidelines for eligibility.

Mr. X applies for QDWP. He has $2,200 in gross monthly earnings. Mrs. X, aged 30, has $1,500 in gross earnings. They have one child, aged 10, who has no income.

**Step 1:** Determine if Mr. X is eligible.

| | |
|---|---|
| $ 2,200.00 | Gross monthly earnings |
| - 20.00 | Income exclusion |
| $ 2,180.00 | |
| - 65.00 | Work exclusion |
| $ 2,115.00 | |
| - 1,057.50 | 1/2 remainder |
| $ 1,057.50 | Mr. X's net countable income is below the 200% of the poverty level for a household size of one |

**Step 2:** To determine income eligibility for Mr. X, income is diverted to the ineligible child. A maximum of $282 may be allowed to meet the child's needs. Mrs. X is an ineligible spouse, because she is not disabled and is not entitled to Medicare Part A.

Mrs. X's earned income:

| | |
|---|---|
| $ 1,500 | Mrs. X's gross earned income |
| - 282 | Allocated for the ineligible child |
| $ 1,218 | |

$1,218 is more than $282. Mrs. X, the ineligible spouse, has income to deem to Mr. X.

**Step 3:** Mr. and Mrs. X's earned income is added together:

| | |
|---|---|
| $ 1,218.00 | Mrs. X's earned income after the deeming |
| + 2,200.00 | Mr. X's gross earned income |
| $ 3,418.00 | |
| - 20.00 | Income exclusion |
| $ 3,398.00 | |
| - 65.00 | Work exclusion |
| $ 3,333.00 | |
| - 1,666.50 | 1/2 remainder |
| $ 1,666.50 | Net countable income |

The $1,666.50 is compared to 200% of the poverty level for Mr. and Mrs. X, a two-person household. Mr. X is income-eligible under the QDWP group.

The effective date of assistance for this coverage group is either the first day of the month in which application is filed or an eligibility decision is made, whichever is earlier. Determine eligibility for retroactive Medicaid benefits after checking that there is no retroactive eligibility under another coverage group.

Complete a review of eligibility factors for QDWP cases at a minimum of every 12 months. Complete a redetermination when changes are reported or made known.

Terminate eligibility no later than the first of the month in which the client turns age 65 or when the person is no longer entitled to Part A Medicare.

> Mr. V, age 36, files an application on April 13. The date of decision is April 25. The effective date of eligibility for QDWP is April 1.

## Qualified Medicare Beneficiaries (QMBs)

**Legal references:** P.L. 100-360, 441 IAC 75.1(29)

Under the "qualified Medicare beneficiary" (QMB) coverage group, Medicaid pays for the Medicare Part A and B premiums, coinsurance, and deductibles for people who are entitled to hospital insurance under Medicare Part A. These are the **only** services for which people under QMB are eligible, unless they are also concurrently eligible for full Medicaid benefits under another coverage group.

**Note:** Medicare refers to the QMB group as a Medicare Savings Program. People applying for QMB may refer to the coverage group as the Medicare Savings Program.

To be eligible for QMB, a person must meet all of the following requirements:

- Be entitled to Medicare Part A.
- Have monthly income that does not exceed 100% of the federal poverty level by family size. (The standard is defined by the United States Office of Management and Budget and is revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.)
- Have resources that do not exceed twice the maximum allowed by the SSI program. Treat resources according to SSI policy. See 8-D, **GENERAL SSI-RELATED RESOURCE POLICIES**. The resource limit for the QMB group is $4,000 for one person and $6,000 for a couple.
- Meet all other SSI-related Medicaid general eligibility requirements.

To be "entitled" to Medicare Part A means that the person is enrolled and eligible to receive Part A benefits **or** meets the requirements to enroll. See 8-M, **Medicare Part A**, to determine dates of Medicare eligibility and who may qualify for Part A. The state buy-in establishes Part A entitlement for a qualified Medicare beneficiary who is entitled to Medicare Part B but not entitled to free Part A.

People who are not already receiving Medicare Part B must file an application with the Social Security Administration to enroll in Part A and Part B. A person who chooses not to enroll for Medicare Part A benefits cannot be QMB-eligible. This does not affect the person's eligibility for other Medicaid coverage groups.

When Medicaid eligibility ends, the client is responsible for paying the Medicare Part A and B premiums.

QMB applicants are not required to apply for FIP, SSI, or State Supplementary Assistance cash benefits. A person who is eligible for full Medicaid benefits under another coverage group may also be concurrently eligible for QMB. Medicaid eligibles who receive SSI and who are entitled to receive Medicare Part A are concurrently eligible for QMB.

Federal financial participation for Medicare premiums is available for people who meet QMB requirements. Therefore, it is necessary to identify these people on the IABC system. Clients who are eligible for QMB and for Medically Needy with a spenddown have both a QMB case and a separate case for Medically Needy.

Enter the poverty level on the IABC system for each person on the case. Also enter a "Q" in the QMB indicator for each person on Medically Needy with a zero spenddown or in a QMB aid type. (See 14-B-Appendix, **TD03 POV**, for aid types you do not need to examine QMB eligibility or enter QMB coding for.)

1. Ms. K, age 68, is receiving social security benefits and is currently receiving Medicare benefits (Part A and B). Her income and resources are within limits for the QMB group. All other program requirements are met. Ms. K's application may be processed for QMB coverage.

2. Mr. L, age 70, is receiving SSI. Even though he does not qualify for social security benefits, having no work history, he is eligible for Part A Medicare. He has not enrolled for Part A Medicare before because the cost was too high. Mr. L has heard that Medicaid may now pay the Part A Medicare premium.

Since Mr. L is entitled to Medicare Part B and would be eligible for QMB, the state buy-in establishes Medicare Part A entitlement for Mr. L.

3. Mr. B applies for Medicaid on January 30. He is receiving $550 per month in social security disability benefits. He is not eligible for Medicare Part A until he has been disabled for 24 months, which is June 1.

   Since Mr. B is not entitled to Part A Medicare, he is not eligible under the QMB group. Since he is disabled, the worker examines eligibility under Medically Needy or other SSI-related coverage groups.

4. Ms. W, age 78, applies for Medicaid on February 1. She is living in her own home. She receives social security benefits but never applied for Medicare. Since Ms. W has a work history, she is eligible to enroll in Part A at any time.

   The IM worker refers Ms. W to the Social Security Administration to apply for Medicare (Parts A and B). If she enrolls for Medicare, the worker continues determining eligibility for Medicaid.

Determine the person's net countable income following SSI policies. Allow the earned and unearned income exclusions. Consider income prospectively.

Compare the person's net countable income to 100% of the federal poverty level. Current monthly limits are:

| Size of Family | 100% of Poverty Level |
|---|---|
| Individual | $ 776 |
| Couple | $1,041 |

Exclude the social security COLA increase received in the current calendar year for January through the month following the month in which the federal poverty level is published. Central Office will notify you when to recalculate the poverty level using the social security COLA increases received in January.

Mrs. J receives $650 from social security and $100 gross earned income per month. On January 1, her social security increases to $667 and her gross earned income increases to $175 due to increased hours. The federal poverty level is published in February. For the months of January, February, and March, Mrs. J's social security COLA increase is disregarded.

Income is considered as follows for January, February, and March:

| | | |
|---|---|---|
| $ | 650 | Gross social security income |
| - | 20 | Income exclusion |
| $ | 630 | Countable social security income |
| | | |
| $ | 175 | Gross earned income |
| - | 65 | Work exclusion |
| $ | 110 | |
| - | 55 | 1/2 remainder |
| $ | 55 | Countable earned income |
| | | |
| $ | 630 | Countable social security income |
| + | 55 | Countable earned income |
| $ | 685 | Countable monthly net income |

The countable monthly net income is compared to 100% of the poverty level.

For the month of April, Mrs. J's countable monthly net income is recalculated using the social security COLA increase. This amount is compared to the new 100% of poverty level effective April 1.

Compare net countable income to the individual limit when income is not deemed from the ineligible spouse to the eligible spouse. Compare net countable income to the couple limit when income is deemed from the ineligible spouse to the eligible spouse.

1. Mrs. G and her three children receive FMAP. Mr. G (stepparent) receives $600 monthly in social security disability benefits and is entitled to Medicare. To determine Mr. G's QMB eligibility, the income is computed as follows:

| FMAP Determination | | | QMB Determination | |
|---|---|---|---|---|
| $ | 600 | Gross social security income | $ 600 | Gross SS income |
| - | 365 | Standard of Need for Mr. G | - 20 | General income exclusion |
| $ | 235 | Diverted to FMAP eligible group | $ 580 | Compared to 100% of the poverty level |

Mr. G is eligible for QMB coverage, provided all other eligibility factors are met. In the QMB determination, deeming of income does not apply to Mr. G because he is not an ineligible spouse.

2. Mr. K files an application on April 1. Mr. K's monthly income is:

| | | |
|---|---|---|
| $ | 700 | Gross social security |
| + | 100 | Retirement pension |
| $ | 800 | |
| - | 20 | General income exclusion |
| $ | 780 | Countable monthly income |

Since the monthly net income exceeds 100% of the poverty level, Mr. K is not eligible for QMB. However, Mr. K is potentially eligible for Medically Needy. Also, eligibility for SLMB is examined.

3. Mr. and Mrs. B file an application July 20. Mr. B receives $575 social security benefits, and Mrs. B receives $405 social security benefits each month. Mr. B and Mrs. B are both entitled to Medicare Part A. Their countable resources are $4,000. Their income is considered as follows:

| | | |
|---|---|---|
| $ | 575 | Mr. B's gross social security |
| + | 405 | Mrs. B's gross social security |
| $ | 980 | Total income |
| - | 20 | General income exclusion |
| $ | 960 | Countable monthly net income |

The Bs could qualify for the Medically Needy program with a spenddown and have eligibility for the limited Medicaid services under the QMB program until spenddown is met. Medicaid will cover the cost of the couple's Medicare premiums, deductibles, and coinsurance until spenddown is met.

4. Mr. A, age 43, is disabled and entitled to Medicare. He has $625 monthly gross social security. Mrs. A, age 40, has $225 monthly gross social security. Child A, age 15, has $225 monthly gross social security.

**Step 1:** The worker determines if Mr. A is eligible.

| | | |
|---|---|---|
| $ | 625 | Monthly social security |
| - | 20 | Income exclusion |
| $ | 605 | Mr. A's net countable income is below 100% of the poverty level for a household of one |

**Step 2:** To determine income eligibility for Mr. A, the worker computes the allocation of income to the ineligible child. A maximum of $282 may be allocated to meet the needs of the child, from Mrs. A, the ineligible spouse.

| | | |
|---|---|---|
| $ | 225 | Mrs. A's gross unearned income |
| - | 57 | Allocation for ineligible child since the child has $225 income ($282 - |
| $ | 168 | $225) |

$168 is less than $282. Therefore, Mrs. A, the ineligible spouse, does not have income to deem to Mr. A.

**Step 3:** Since there is no earned income, only the unearned income of Mr. A is used.

| | | |
|---|---|---|
| $ | 625 | Mr. A' s gross social security |
| - | 20 | Income exclusion |
| $ | 605 | Net countable income |

The $605 is compared to 100% of the poverty level for a one-person household. Mr. A is income-eligible under QMB.

The date of decision is the date the eligibility information is entered into the ABC system. Eligibility for QMB begins the first day of the month after the month of decision which means there is no QMB coverage for the month of application or the month of decision. This may affect the applicant's choice of coverage groups.

There is no retroactive eligibility for QMB. However, examine retroactive eligibility under another coverage group, such as Medically Needy.

1. Ms. J, age 70, files an application on June 3. Her monthly countable net income is $575 per month and is under 100% of the poverty level. Her countable resources are $3,500. Ms. J claims to have unpaid medical expenses for April and May.

   The worker explains there is Medicaid eligibility for the retroactive period under the Medically Needy program. Medically Needy eligibility would be based on a spenddown. If Ms. J declines assistance under the Medically Needy program, there is no retroactive eligibility.

Ms. J decides to accept the retroactive assistance. The QMB case is first approved on the ABC system. The eligibility information is entered on the ABC system June 27 with an effective date of July 1. The ABC system prevents retroactive medical cards from being issued on a QMB aid type.

Next, the worker sets up a medically needy case with a different FBU. The medically needy case is approved with the effective date of June 1 and indicates retroactive eligibility for the second and third month.

2. Mr. B, age 83, applies for Medicaid on February 20. He wants assistance with his Medicare premiums, deductibles, and coinsurance. Eligibility is determined for QMB. The date of decision is March 12. The effective date of eligibility for QMB is April 1.

3. The household consists of Mr. K, age 72, and Mrs. K, age 59, who is disabled. The Ks file an application on January 5. The date of decision is January 29, which means that the effective date of eligibility for QMB is February 1.

Review eligibility when changes are reported or made known. Complete a redetermination if the recipient no longer meets QMB requirements.

### Relationship Between QMB and Other Coverage Groups

**Legal reference:** P.L. 100-360, 441 IAC 75.1(29), 76.2(2)

An applicant who is eligible under more than one coverage group can choose under which coverage group eligibility is determined. Screen all applications for QMB and for eligibility under another coverage group.

Explain the options under each group so the client can make an informed choice. Medicaid provides for some services not covered under Medicare, such as dental expenses and prescription drugs.

When a person is approved for an SSI or FIP cash grant, and is entitled to Medicare Part A, the person is eligible for QMB the following month.

Because QMB provides only limited Medicaid coverage, the relationship between QMB and other coverage groups is complex especially in two areas:

- When a client is concurrently eligible for QMB and Medically Needy, the client is entitled to only QMB benefits until spenddown is met. Once spenddown is met, the client is entitled to all Medicaid benefits that are payable under Medically Needy.
- When a QMB client is also eligible for full Medicaid benefits and is living in a skilled nursing facility or MHI, client participation is not charged until Medicare coverage is exhausted. See 8-I, **CLIENT PARTICIPATION**.

## Specified Low-Income Medicare Beneficiaries (SLMBs)

**Legal reference:** 441 IAC 75.1(34)

Limited Medicaid benefits are available to a person who meets all the following conditions:

- Is entitled to Medicare Part A which provides benefits for hospital care.
- Monthly income exceeds 100% of the federal poverty level for the family size but is less than 120% of this level.

| For family size: | Income is over: | But is less than: |
|---|---|---|
| Individual | $776 | $931 |
| Couple | $1,041 | $1,249 |

- Resources do not exceed twice the maximum allowed by the SSI program. Resources are treated according to SSI policies. The resource limits for the SLMB group are $4,000 for an individual and $6,000 for a couple. See 8-D, **GENERAL SSI-RELATED RESOURCE POLICIES**.
- Meets general SSI-related Medicaid eligibility requirements.

Medicaid will pay the cost of the Medicare Part B premiums for these "specified low-income Medicare beneficiaries" (SLMBs). This is the **only** service Medicaid will cover. Medicare copayments, deductibles, and Part A are not covered in this coverage group.

**Note:** Medicare refers to the SLMB group as a Medicare Savings Program. People applying for SLMB may refer to the coverage group as the Medicare Savings Program.

When Medicaid eligibility ends, the recipient is responsible for paying the Medicaid Part B premiums.

A person who wants this coverage must enroll in Medicare Part A and B. A person who chooses not to enroll for Medicare Part A benefits cannot be eligible under SLMB. The state will not enroll people for Medicare Part A under SLMB. If the person does not enroll for Part A, it does not effect the person's eligibility for other Medicaid coverage groups.

Mr. S, aged 70, is receiving social security benefits and is currently receiving Medicare Part A and B benefits. His income and resources are within limits for the SLMB coverage group. All other general Medicaid eligibility requirements are met. Mr. S's application may be processed for the SLMB coverage group.

Federal financial participation for Medicare Part B is available for all people who meet SLMB requirements. Therefore, it is necessary to identify these people on the ABC system. Enter the poverty level on the system for each person on the case.

For the aid types 90-0, 90-2, and 37-E with a spenddown, also enter an "L" in the QMB indicator on TD03 for each person who is eligible as a SLMB. (People eligible only for the SLMB coverage group do not receive a medical card.)

When the buy-in tape is sent and the client is coded eligible for SLMB, the Third Party system checks to see if the client has Part A entitlement. If the client does not have Part A entitlement, the Third Party system rejects the record and the state is not billed for the client's Medicare Part B premium.

All people who meet the SLMB requirements are sent on the buy-in tape as SLMB-eligible, including those who have full Medicaid benefits, unless the client refuses SLMB coverage.

Calculate net countable monthly income using SSI policies. Allow the earned and unearned income exclusions. Consider the income prospectively.

Exclude the social security COLA income from January through the month following the month in which the federal poverty level is published. Central Office will notify you when to recalculate the poverty level using the social security COLA increases received in January.

See 8-E, **Deeming SSI-Related Income**, when deeming to a spouse is applicable.

1. Mr. T files an application on May 1. His monthly income is:

| | | |
|---|---|---|
| $ | 650 | Gross social security |
| + | 150 | Retirement pension |
| $ | 800 | |
| - | 20 | Income exclusion |
| $ | 780 | Net countable monthly income |

Since the net countable monthly income exceeds 100% of the poverty level but does not exceed 120% of the poverty level, there is eligibility for SLMB.

The worker examines Mr. T's application for eligibility for other Medicaid coverage groups and determines that Mr. T is also potentially eligible for the Medically Needy coverage group with a spenddown.

2. Mr. L files an application. Mr. L's monthly income is:

| | | |
|---|---|---|
| $ | 578 | Gross social security |
| - | 20 | Income exclusion |
| $ | 558 | Net countable monthly income |

Since the net countable monthly income does not exceed 100% of the poverty level, there is no eligibility for SLMB. The worker examines Mr. L's application for eligibility for other Medicaid coverage groups and determines that Mr. L is eligible for QMB and potentially eligible for Medically Needy with a spenddown.

The effective date of assistance is the first of the month in which application is made or the first day of the month in which all eligibility criteria are met, whichever is later.

Determine if the client wants coverage for the three months before the application month (even if the client has already paid those Medicare premiums for those months).

### Relationship Between SLMB and Other Coverage Groups

**Legal reference:** 441 IAC 75.1(34)

Current Medicaid recipients who meet the SLMB requirements are also eligible for SLMB. These people have concurrent eligibility. A person applying for SLMB may also be eligible for Medicaid under another coverage group.

When concurrently eligible, recipients can receive all Medicaid benefits provided under the other coverage group, in addition to the payment for Medicare Part B premium.

Recipients who are concurrently eligible for SLMB and Medically Needy with a spenddown are entitled only to Medicaid payment of Part B until spenddown is met. Once spenddown is met, these people are entitled to all Medicaid services that are payable under the Medically Needy coverage group.

## Expanded Specified Low-Income Medicare Beneficiaries (QI-1)

Medicaid will pay the cost of the Medicare Part B premiums for "expanded specified low-income Medicare beneficiaries" (expanded SLMBs). This is the **only** service Medicaid covers. Medicare copayments, deductibles, and Part A premiums are not covered in this coverage group. (People eligible only for the E-SLMB coverage group do not receive a *Medical Assistance Eligibility Card*.)

**Note:** Medicare refers to the E-SLMB group as "qualifying individuals 1" (QI-1) or a Medicare Savings Program. People applying for E-SLMB may refer to the coverage group as QI-1 or as the Medicare Savings Program.

These limited Medicaid benefits are available to a person who meets all of the following conditions:

- Is entitled to Medicare Part A, which provides benefits for hospital care.
- Has monthly income of at least 120% of the federal poverty level for the family size but less than 135% of this level.

| For family size: | Income is at least: | But is less than: |
|---|---|---|
| Individual | $ 931 | $1,048 |
| Couple | $1,249 | $1,406 |

- Has resources that do not exceed twice the maximum allowed by the SSI program. Resources are treated according to SSI policies. The resource limits for the SLMB group are $4,000 for an individual and $6,000 for a couple. (See 8-D, **GENERAL SSI-RELATED RESOURCE POLICIES**.)
- Meets general SSI-related Medicaid eligibility requirements.
- Is not eligible for any other Medicaid coverage group.

A person who wants this coverage must enroll in Medicare Part A and B. A person who chooses not to enroll for Medicare Part A benefits cannot be eligible under expanded SLMB. The state will not enroll people for Medicare Part A under expanded SLMB. When Medicaid eligibility ends, the recipient is responsible for paying the Medicaid Part B premiums.

Calculate net countable monthly income using SSI policies. Allow the earned and unearned income exclusions. Consider the income prospectively.

Exclude the social security COLA income from January through the month following the month in which the federal poverty level is published. Central Office will notify you when to recalculate the poverty level using the social security COLA increases received in January.

See 8-E, **Deeming SSI-Related Income**, when deeming to a spouse is applicable.

Mr. X files an application on May 1. His monthly income is:

| | | |
|---|---|---|
| $ | 695 | Gross social security |
| + | 300 | Retirement pension |
| $ | 995 | |
| - | 20 | Income exclusion |
| $ | 975 | Net countable monthly income |

Since the net countable monthly income is more than 120% of the poverty level but less than 135% of the poverty level, there is eligibility for expanded SLMB.

100% federal financial participation for Medicare Part B is available for all people who meet SLMB requirements. Therefore, it is necessary to identify these people on the ABC system. Enter the poverty level on the system for each person on the case.

For the aid types 90-0 and 90-2 with a spenddown, also enter an "E" in the QMB indicator on TD03 for each person who is eligible as an expanded SLMB.

The effective date of assistance is the first of the month in which application is made or the first day of the month in which all eligibility criteria are met, whichever is later. Determine if the client wants coverage for the three months before the application month (even if the client has already paid those Medicare premiums for those months).

All people who meet the expanded SLMB requirements are sent on the buy-in tape as SLMB-eligible. When the buy-in tape is sent, the Third Party system checks to see if the client has Part A entitlement. If the client does not have Part A entitlement, the Third Party system rejects the record, and the state is not billed for the client's Medicare Part B premium.

Reserve page 112 for future use

## Medicaid for Employed People With Disabilities

**Legal reference:** 441 IAC 75.1(39)

Medical assistance is available to people who are disabled and have earned income when:

- The person is under age 65.
- The person is still considered to be disabled based on SSI medical criteria for disability. Engaging in substantial gainful activity (SGA) is not considered in determining disability for this coverage group.
- The person has earned income from employment or self-employment.
- The person meets general SSI-related Medicaid eligibility requirements.
- The person is not eligible for any other Medicaid coverage group other than QMB, SLMB, or Medically Needy.
- Resources are less than $12,000 for an individual and $13,000 for a couple.
- Net family income is less than 250% of the federal poverty level.
- Any premium assessed for the month of eligibility has been paid.

This coverage group is called “Medicaid for employed people with disabilities” or “MEPD.

The following sections give more information on requirements for:

- Age.
- Disability.
- Earned income.
- Resources.
- Family income limits.
- Payment of premiums.
- The relationship between MEPD and Medically Needy.

### Age

**Legal reference:** 441 IAC 75.1(39)“a”(2)

To qualify for MEPD, the disabled person must be under age 65.

## Disability

**Legal reference:** 441 IAC 75.1(39) )"a"(1)

To qualify for MEPD, a person must be disabled based on the medical criteria for SSI disability. This includes:

- People who receive social security disability or railroad retirement benefits based on the same disability criteria used by the Social Security Administration.
- People whose Social Security disability (SSDI) benefits have stopped but who continue to be eligible for Medicare.
- People who are not in those groups but are found to meet the medical criteria for disability through a disability determination completed for the Department by Disability Determination Services. Engaging in substantial gainful activity is not considered in deciding if a person is disabled for this coverage group.

## Earned Income

**Legal reference:** 441 IAC 75.1(39) )"a"(4)

To qualify for MEPD, the applicant must have earned income from employment or self-employment.

If the applicant does not have earned income in the month of decision, do not approve current or ongoing eligibility. But if the applicant had earned income in the month of application or in the retroactive months and lost earned income before the month of decision, approve the months with earned income and deny current and ongoing eligibility.

> Mr. B files an application March 10th. He has earned income in the month of March but the income ends in March. The application is processed in April. As the earned income ended in March, eligibility can be approved for March, but current and ongoing eligibility is denied.

A person is considered to have earned income from employment or self-employment when the person has income that is considered earned income for SSI-related Medicaid. See 8-E, **TYPES OF SSI-RELATED INCOME**.

### Intent to Return to Work if Earned Income Ends

**Legal reference:** 441 IAC 75.1(39)"c"

People approved for this coverage group whose employment later ends due to a change in their medical condition or loss of job can remain eligible for this coverage group for six months after the month the employment ended if their intent is to return to employment within the six months.

To remain eligible, the client must provide a written statement about the intent to return to work and continue to pay assessed monthly premiums.

1. Mrs. C reports March 10th that she has stopped working. She receives her final check in March. She provides a statement of her intent to return to employment within six months. Eligibility can continue for six months (April through September.)

2. Mr. G files and application March 10th. His employment ends in March and he receives his final paycheck in April. He provides a written statement of intent to return to employment within six months. The decision on eligibility is made in April. As Mr. G will have earned income in April, the application is approved effective for March and ongoing months.

### Resources

**Legal reference:** 441 IAC 75.1(39),a.,(5) and d.

The resource limits for this coverage group are higher than other Medicaid coverage groups: $12,000 for an individual and $13,000 for a couple.

Additional resources are exempt under this coverage group that are not exempt under other SSI-related Medicaid coverage groups. The additional exempt resources are:

- Retirement or pension funds that are exempt from execution as listed in Iowa Code section 627.6(8)(f), regardless of the amount of contributions, the interest generated, or the total amount in the fund or account.

  Such funds include but are not limited to simplified employee pensions plans, self-employed pension plans, Keogh plans, individual retirement accounts, Roth individual retirement accounts, savings incentive matched plans for employees and similar plans for retirement. If there is a question whether to exempt a retirement account, ask your supervisor.

- Funds placed in a medical savings account that is exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C.§220). A person who has such an account will have documentation from a bank or other financial institution that set up the account.
- Funds in assistive technology accounts saved for the purchase, lease, or acquisition of assistive technology, assistive technology devices or assistive technology services.

  To be exempt a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist must establish the need for such technology and that the technology can reasonably be expected to enhance the individual's employment.

See 8-D, **Resources Exempted for Medicaid for Employed People With Disabilities**, for additional information.

## Family Income Less Than 250% of Federal Poverty Level

**Legal reference:** 441 IAC 75.1(39)a.(3)

To determine if the family income is less than 250% of the federal poverty level, count the total income of the family. Allow all disregards and exemptions that are allowed for other SSI-related Medicaid coverage groups, including the $20 dollar general income deduction, the $65 work exclusion, and 50% remainder deduction from earned income.

Total the unearned income of all family members and allow one $20 general income deduction. Total the earned income of all family members and allow the $65 work exclusion and 50% remainder deduction from the total income. Add the net unearned income and net earned income and compare the sum to 250% of the federal poverty level for the family size.

"Family" is defined as follows:

- If the client is under 18 and unmarried, the "family" includes all of the following who live in the same household as the client:
  - The parents of the client.
  - All siblings under age 18 and unmarried.
  - Any children of the client.

- If the client is aged 18 or older or is married, the "family" includes all of the following who live in the same household as the client:
  - The client's spouse and
  - Any unmarried children of the client or the client's spouse under the age of 18.

Income limits for various family sizes are:

| Household Size | 250% of Poverty |
|---|---|
| 1 | $1,940 |
| 2 | $2,603 |
| 3 | $3,265 |
| 4 | $3,928 |
| 5 | $4,590 |
| 6 | $5,253 |
| 7 | $5,915 |
| 8 | $6,578 |

If the family size is over 8, add $663 for each additional family member.

Mr. F lives with his wife and their three children, who are all unmarried and under age 18. The household size is five. Mr. F has $600 in social security disability income and earned income of $600 per month. Mrs. F has $1,000 in earned income. She and each child receive $100 a month social security due to Mr. F's disability.

To calculate income for the 250% test, add all unearned income of the family:

| | |
|---|---|
| $ 600 | For Mr. F |
| + 100 | For Mrs. F |
| + 300 | For children ($100 each child) |
| $ 1,000 | Unearned income |
| – 20 | General income deduction |
| $ 980 | Net countable unearned income |

Add all earned income of the family.

| | |
|---|---|
| $ 600.00 | For Mr. F |
| + 1,000.00 | For Mrs. F |
| $ 1,600.00 | Earned income |
| - 65.00 | Work exclusion |
| $ 1,535.00 | |
| - 767.50 | One half remainder |
| $ 767.50 | Net countable earned income |

Add $980 net countable unearned and $767.50 net countable earned income = $1,747. As income for the family is less than 250% of the poverty level for five, Mr. F meets income eligibility criteria.

## Premiums

**Legal reference:** 441 IAC 75.1(39)"a"(6)

If the family income is less than 250% of the federal poverty level, determine whether a premium should be assessed. Assess a premium when the eligible person's gross income is above 150% of the federal poverty level according to the following schedule. When the person's gross income is at or below 150% of poverty, no premium is assessed.

| PREMIUM SCHEDULE | |
|---|---|
| **If income of the eligible person is above:** | **The monthly premium is:** |
| 150% of federal poverty level ($1,164) | $22 |
| 174% of federal poverty level ($1,350) | $42 |
| 198% of federal poverty level ($1,537) | $62 |
| 222% of federal poverty level ($1,723) | $81 |
| 246% of federal poverty level ($1,909) | $101 |
| 270% of federal poverty level ($2,095) | $121 |
| 294% of federal poverty level ($2,281) | $141 |
| 318% of federal poverty level ($2,468) | $161 |
| 342% of federal poverty level ($2,654) | $180 |

| If income of the eligible person is above: | The monthly premium is: |
|---|---|
| 366% of federal poverty level ($2,840) | $200 |
| 390% of federal poverty level ($3,026) | $221 |
| 438% of federal poverty level ($3,399) | $247 |
| 486% of federal poverty level ($3,771) | $273 |
| 534% of federal poverty level ($4,143) | $299 |
| 582% of federal poverty level ($4,516) | $325 |
| 632% of federal poverty level ($4,904) | $355 |

Mr. F has gross unearned income of $600 and gross earned income of $600. His total income is $1,200, which is over 150% of poverty. Mr. F has a premium of $20 per month.

Determine premiums for retroactive months on a month-by-month basis, using actual income for those months. Manually issue a *Notice of Decision* to the client with the premium amount for each retroactive month.

Determine ongoing premiums for a six-month period. When a case is newly approved, more than one premium period may need to be established, depending on when the approval occurs.

Only one premium amount will apply to all premium periods that need to be established at the time of an approval. To determine this premium amount:

1. Determine the premium periods for the approval.
2. Determine what the premium amount would be for each premium period in the approval.
3. Apply the lowest premium amount established to all premium periods involved in the approval.

MEPD requires that a set premium amount be determined for a six-month period. The premium amount established for the six-month period will never be increased due to an increase in income during that period, but it can decrease if the person reports a change in income that would decrease the premium amount.

Have the client complete form 470-3693, *Earned Income Statement for Premium*, for all succeeding premium periods. See 8-G, **Premium Redetermination for MEPD**.

The following sections explain:

- How to establish premium periods
- Premium billing and collection
- Posting of premium payments
- The effect of a client's failure to pay the premiums
- Reopening a case canceled for failure to pay the premium

## How to Establish Premium Periods

Determine premium periods as follows:

- The first premium period begins with the month of the effective date of eligibility (the date in the TD05 POS DT field on ABC). It includes the effective date month plus five months.
- Each succeeding premium period includes the month following the last month of the previous premium period plus five months. Example:

An MEPD application is filed March 7, 2000, and approved effective March 1. The six-month premium period is March, April, May, June, July, and August.

SIX-MONTH COUNT FOR PREMIUM PERIODS

| 1st premium period | | | | | | 2nd premium period | | | | | | 3rd premium period | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 | 4 | 5 | 6 |
| 03/ 00 | 04/ 00 | 05/ 00 | 06/ 00 | 07/ 00 | 08/ 00 | 09/ 00 | 10/ 00 | 11/ 00 | 12/ 00 | 01/ 01 | 02/ 01 | 03/ 01 | 04/ 01 | 05/ 01 | 06 01 | 07/ 01 | 08/ 01 |
| 1st 6-month premium period 03/00 through 08/00 | | | | | | 2nd 6-month premium period 09/00 through 02/01 | | | | | | 3rd 6-month premium period 03/01 through 08/01 | | | | | |

When a case is approved in the **first month through the fifth month** of the first premium period, only one premium period needs to be established. **Note:** Review entries for the next premium period must be entered on ABC by cutoff in the sixth month of the premium period.

Application Approved in Month Five of the First Six-Month Premium Period

An MEPD application is filed March 7, 2000, and approved on July 18, effective March 1.

| Months 1 through 5 of the premium period | | | | Premium review entries required in the sixth month of the premium period. | |
|---|---|---|---|---|---|
| 1 March | 2 April | 3 May | 4 June | 5 July | 6 August |

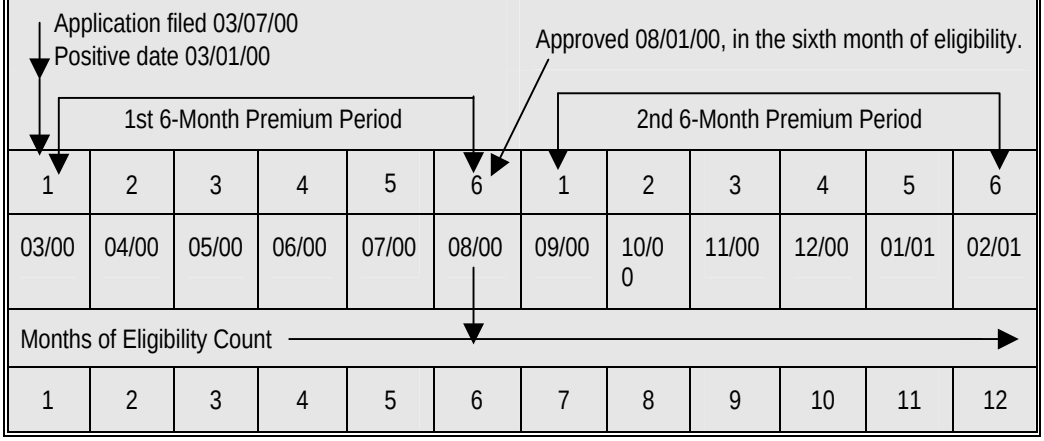
When the case is approved **after the fifth month** of eligibility, you must establish:

- The premium period the case is in at the time of approval.
- Any premium periods before the current premium period.
- The premium period following the current premium period, in some cases.

When the application is approved in the **sixth month** of a premium period, establish both the first premium period and the premium period following it when you enter the approval. Example:

Approval in the Sixth Month of the First Premium Period

The application is filed March 7, 2000. It is approved August 1 (in the sixth month of first premium period), with an effective date of March 1, 2000. The first premium period is March 2000 (the positive date month) through August 2000 (plus five months). The next premium period is September 2000 (plus five months) through February 2001.



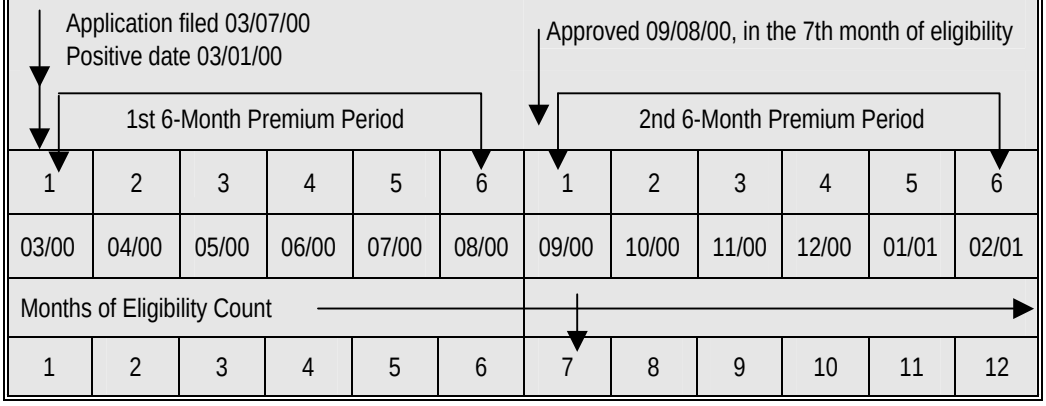

Enter the positive date month and last month of the premium period following the current premium period in the fields used for premium period on ABC. ABC TD05 entries for the example above include:

- Medical entry reason "E."
- Medical APP DT of 03/07/00.
- Medical POS DT of 03/01/00.
- Medical LAST REV of 03/00 and NEXT REV of 02/01 for the premium period.
- Income for the premium period that resulted in the lowest premium amount in CNT UI and CNT EI.

When the approval is in **months one through five of a succeeding premium period**, establish the first premium period and all periods through the current premium period when you enter the approval. Example:

Approval in the First Month of the Second Premium Period

The application is filed March 7, 2000. It is approved September 8 (in the seventh month of eligibility and the second month of the second premium period) with an effective date of March 1, 2000. The first premium period is March 2000 (positive date month) through August 2000 (plus five months). The next premium period is September 2000 (plus five months) through February 2001.




Enter the positive date month and last month of the current premium period in the fields used for premium period on ABC. ABC TD05 entries for the example above include:

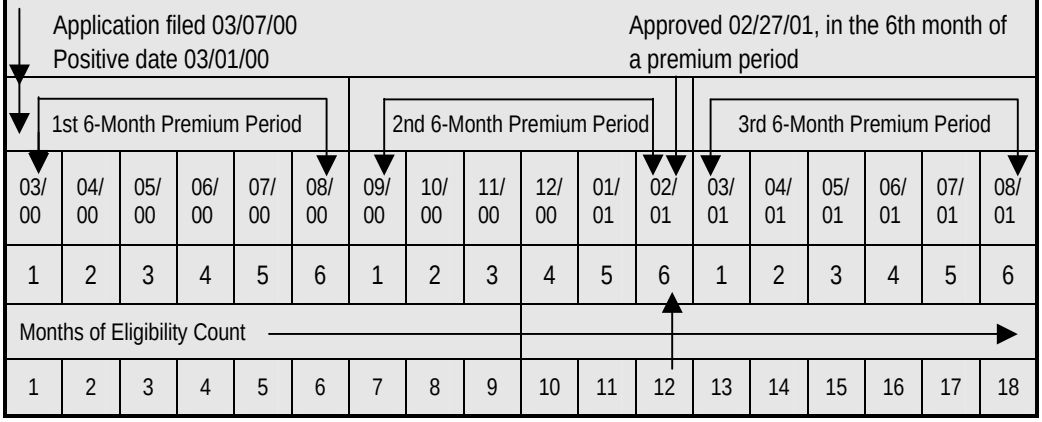
- Medical entry reason "E" on TD05.
- Medical APP DT of 03/07/00.
- Medical POS DT of 03/01/00.
- Medical LAST REV of 03/00 and NEXT REV of 02/01 for the premium period.
- Income for the premium period that resulted in the lowest premium amount in CNT UI and CNT EI.

When the approval is in **the sixth month of a succeeding premium period**, determine all premium periods through the date of approval and the premium period following the period that applies to the month entries are being made on ABC. Example:

Approval in the Sixth Month of the Second Premium Period

The application is filed March 7, 2000. It is approved February 27 (in the twelfth month of eligibility and the fifth month of the second premium period) with an effective date of March 1, 2000. The first premium period is March 2000 (positive date month) through August 2000 (plus five months). The next premium period is September 2000 (plus five months) through February 2001.

Because the case is already in the sixth month of the second premium period, it is also necessary to establish the third premium period, from March 2001 (plus five months) through August 2001.




Enter the positive date month and last month of the premium period following current premium period in the fields used for premium period on ABC. ABC TD05 entries for the example above include:

- Medical entry reason "E" on TD05.
- Medical APP DT of 03/07/00.
- Medical POS DT of 03/01/00.
- Medical LAST REV 03/00 and NEXT REV 08/01 for the premium period.
- Income for the premium period that resulted in the lowest premium amount in CNT UI and CNT EI.

## Premium Billing and Collection

**Legal reference:** 441 IAC 75.1(39)"b"

When a case is approved on ABC and a premium is owed, the billing system will send a bill to the client. No *Medical Assistance Eligibility Card* will be issued for a month with a premium owed until the premium is paid.

All payments are due on the 14th day of a month. The month a particular premium is due depends on what month the premium is for:

- The premium for the month the case is approved is due on the 14th day of the month following the month the case is approved.
- Premiums for the months before the month the case is approved are due on the 14th day of the third month following the month the case is approved.
- Premiums for the months following the month the case is approved are due on the 14th day of the month the premium is to cover.

Premiums for a current month are due the 14th of the month the premium is to cover. If there is not enough time to allow 14 days to pay and still have the payment due on the 14th of that month, the premium payment is due the 14th of the following month.

The first bill sent on a new approval is a bill for all months of current eligibility:

- If a case is approved before cut-off in a calendar month, the billing statement will be for the month of approval and all months back to the month of the positive date of eligibility on ABC.
- If a case is approved after cut-off in a calendar month, the billing statement will be for the month of approval, all months back to the month of the positive date of eligibility on ABC, and the next calendar month.

Any premiums for months before the month of the initial billing are due three months from the month in which the case is first billed.

A bill will be sent for the three months for all unpaid months. If payment is not received by the 14th of the third month, the bill can no longer be paid.

After a case is approved, a billing statement will be mailed on a monthly basis.

Monthly billing statements are generated in the MEPD billing system the end of day on the 15th of the month. If the 15th falls on a weekend or holiday, the statement will be generated the end of day of the first working day after the 15th of the month.

| January | February | March |
|---|---|---|
| Application filed January 22. | Application approved on February 10, beginning with the month of application (January). | |
| **January is:**<br>• Month of application.<br>• Positive date of eligibility on ABC.<br>• Month before the month that eligibility is approved. | **February is:**<br>• Month that eligibility is approved. | **March is:**<br>• Month following the month that eligibility is approved. |
| The premium is due the 14th of the third month following the month when eligibility is approved. | The premium is due the 14th of the month, but there are not 14 days to pay. | The premium will be due the 14th and there are 14 days to pay. |
| The client has until May 14 to pay this premium but may pay it sooner. | The February premium is due on March 14. | The March premium is due on March 14. |
| Billed on first billing statement. | Billed on first billing statement. | Billed on first **monthly** billing statement. |

## Payment Address

**Legal reference:** 441 IAC 75.1(39)"b"(6)

The Quality Assurance Unit in central office collects the premiums. Premium payments may be submitted in the form of cash, money orders, or personal checks. A client may request to pay in advance on a quarterly or semiannual basis.

If a client brings the premium payment to the local office, do not accept it. Instead, give the client a preaddressed postage-paid MEPD envelope, form 470-3724, to mail. See 6-Appendix for *MEPD Billing Statement*.

Local offices should maintain a supply of the MEPD envelopes to give to clients who misplace the envelopes in the billing statement. Order envelopes for MEPD premium payments from the Supply Unit, Level A, in central office.

When a client is sending payment in and not using a preaddressed MEPD envelope, the address for payments is:

Iowa Department of Human Services
Supply Unit, A-Level, Room 77
1305 East Walnut St.
Des Moines Iowa 50319-0114

**Note:** This address is different from the address on the preaddressed postage-paid envelope.

**Posting of Premium Payments**

**Legal reference:** 441 IAC 75.1(39)"b"(4)

Premium payments will be applied in a specified order as follows:

1. Apply to the current month, if unpaid.
2. Hold to apply to the following month when received:
   - After the billing statement has been issued for that month and
   - Before the last working day of the current month.

   Any excess funds in the MEPD account between the first of the month and the date the billing statement is generated will be applied to old unpaid months, as follows:
3. Apply to the month before the current month, if unpaid.
4. Apply to the oldest unpaid month and forward until all old prior months have been paid.

When all outstanding months have been paid, any excess funds will be held as a balance and applied to future months as the payment becomes due. Any excess funds will be refunded upon the client's request, after two calendar months of inactivity, or after two months of zero premiums.

An MEPD application filed January 22 and approved April 10. The positive date on ABC is January 1. Premium due dates and the application of the premium payments are shown an the chart below, based on the following payment scenarios:

A. Payment for one month is received on April 29. The payment is applied to April (A-1), the month of receipt.

B. Payment for one month is received on May 5. The payment is applied to May (B-1), the month of receipt.

C. Payment for two months' premiums is received on April 29. The payment is applied to April (C-1), the month of receipt, and May (C-2), the month following the month of receipt, since it was received after the following month's (May) billing statement was generated.

D. Payment for two months' premiums is received on May 5. The payment is applied to May (D-1), the month of receipt, and April (D-2), the month before the month of receipt, since it was received before the following month's (June) billing statement was issued.

E. Payment for three months' premiums is received on May 10. The payment is applied to May (E-1), the month of receipt; April (E-2), the month before the month of receipt, since it was received before the issuance of the following month's billing statement; and January (E-3), the oldest prior month.

F. Payment for three months' premiums is received on May 29. The payment is applied to May (F-1), the month of receipt; June (F-2), the month following the month of receipt, since it was received after the issuance of the following month's billing statement; and April (F-3), the month before the month of receipt.

G. Payment for four months' premiums is received on May 29. The payment is applied to May (G-1), the month of receipt; June (G-2), the month following the month of receipt, since it was received after the issuance of the following month's billing statement; April (G-3), the month before the month of receipt; and January (G-4), the oldest prior month.

H. Payments are received on April 12, April 15, and April 17. The May billing statement is issued April 16. The April 12 payment is applied to April (H-1), the month of receipt.

The April 15 payment is applied to March (H-2) as the current month is paid and the payment was received before the following month's (May) billing statement was issued.

The April 17 payment is held as the current month is paid and the following month's billing statement has been issued. The payment will be applied to May on the fifth working day before the end of April (the beginning of the new system month) (H-3).

| Month | Premium Due | Months Applied | | | | | | |
|---|---|---|---|---|---|---|---|---|
| January | July 14 | | | | E-3 | | G-4 | |
| February | July 14 | | | | | | | |
| March | July 14 | | | | | | | H-2 |
| April | May 14 | A-1 | C-1 | D-2 | E-2 | F-3 | G-3 | H-1 |
| May | May 14 | B-1 | C-2 | D-1 | E-1 | F-1 | G-1 | H-3 |
| June | June 14 | | | | | F-2 | G-2 | |

## Effect of Nonpayment of Premiums

**Legal reference:** 441 IAC 75.1(39)"b"(2) and (3)

Eligibility is contingent upon payment of any premium assessed. A *Medical Assistance Eligibility Card* shall not be issued for a month until the premium for the month is received. The client must pay the premium within three months of the month of eligibility or the month of initial billing, whichever is later, to receive a *Medical Assistance Eligibility Card.*

When a premium that is due the 14th of the month the payment is to cover is not received by the due date, the client will be canceled. You will receive an e-mail to cancel the case.

The case can be reinstated if payment is received before the effective date of cancellation. The case can be reopened once in a six-month period if payment is received in the month following the month it is due.

An automatic redetermination of eligibility is required when a person approved for MEPD with a premium does not pay the premium and is canceled. Redetermine eligibility under Medically Needy. Wait to complete the automatic redetermination until the end of the month following the month the payment was to cover, due to the reopening provisions under MEPD.

## Reopening a Case Canceled for Failure to Pay Premium

**Legal reference:** 441 IAC 75.1(39)"b"(5)

**One** reopening is allowed in a six-month period when a person does not remit payment by the end of the month of coverage. To qualify for a reopening, payment must be received in the month following the month it is to cover and the person must be otherwise eligible.

Advise clients of the reopening provisions when a case has been canceled for nonpayment of an ongoing premium and the client wants to reapply for MEPD in the month following the month of cancellation. By exercising this provision, the client may regain eligibility without filing a new application.

**Note:** Explain that to exercise this option, the client must also pay for the current month's premium as well to remain eligible.

When payments are made after the due date, you will be notified via e-mail. You must determine if the case can be reinstated or reopened.

## Refunds

**Legal reference:** 441 IAC 75.1(39)"b"(4)

Refunds are automatically issued when the recipient has paid in more than is owed as follows:

- When there are funds in the MEPD premium account and there have been two consecutive months of inactivity on the MEPD case, or
- When the premium has been reduced to zero for two consecutive months.

When there are excess funds in the MEPD account, the Department will issue a refund upon the recipient's request. Notify Quality Assurance to issue the refund by sending an e-mail to: **DHS, Quality Assurance**. The e-mail should include the recipient's name, state ID number, the amount to be refunded, and the reason.

**Relationship to Medically Needy**

When a person will qualify both for MEPD with a premium and for Medically Needy with or without a spenddown, the person may choose which coverage group eligibility is established under.

People who chose Medically Needy with a spenddown over MEPD with a premium may change their mind and request that eligibility be redetermined under MEPD during a current Medically Needy certification period.

When a client on an active Medically Needy case with a spenddown wants MEPD:

- Approve MEPD beginning with the month the client elects as the first month for MEPD.

  Do not take any action to end the Medically Needy spenddown process at this time. It does not matter what the Medically Needy spenddown status is or if a medical card has been issued for a month when MEPD eligibility will be approved.

- The billing system will identify all cases with overlapping Medically Needy and MEPD eligibility. The following actions will occur:

  - When the case has been changed from Medically Needy to MEPD, the aid type will be corrected on SSNI after the premium has been paid.
  - When a Medically Needy spenddown case becomes a zero-premium MEPD case, the billing system will issue an informational e-mail (WIF) message 456, which states "ESTD to fiscal agent" to release spenddown.
  - When an MEPD case with a premium was a Medically Needy spenddown case, the MEPD Billing System will notify you by e-mail (WIF) after the premium has been paid with the message "ESTD/fiscal agent" to release spenddown.

When you receive the e-mail notice (WIF) that a premium has been paid:

- Shorten the Medically Needy certification period.
- Adjust the spenddown amount.
- Notify the client the certification has been changed or shortened.
- Send an ESTD to fiscal agent for months to be removed from Medically Needy.

You may also need to request the fiscal agent to back out bills for the months that the client is eligible for MEPD. Any bill used towards meeting spenddown for these months will be backed out and paid under MEPD if it was incurred in a month that now is under MEPD eligibility.

The fiscal agent's Medically Needy unit will notify you if a recoupment needs to be completed for Medically Needy. Example of a recoupment situation:

> The Medically Needy certification period is April and May with a spenddown of $500. Spenddown is met with a $500 bill for services incurred on May 1. The case is approved for MEPD for the month of May.
>
> The worker requests that the certification period be shortened to the month of April with a spenddown of $250. This creates a recoupment for the month of April for $250. The fiscal agent will notify the worker to complete a claim for Medically Needy up to $250.

People who chose to have eligibility determined under MEPD with a premium may later decide they do not want to pay the premium and request that eligibility be redetermined under Medically Needy. A person cannot be switched to Medically Needy with a spenddown for any month for which a MEPD premium has been paid, unless a change has occurred and the person can no longer qualify under MEPD.

If the person has not paid the premium for the month and the person requests the change to be effective, the person may be switched to Medically Needy in that month. If the premium has been paid, deny the request for a change to Medically Needy for the month.

## Relationship to Qualified and Specified Low-Income Medicare Beneficiaries

A recipient of MEPD may also qualify for the qualified Medicare beneficiary (QMB) or specified low-income Medicare beneficiary (SLMB) program. When the recipient qualifies for MEPD and QMB or SLMB, ensure that a QMB or SLMB case is opened for the MEPD recipient. By opening the QMB or SLMB case, the state receives federal dollars for the cost of Medicare Part B.

There must be two separate cases set up on the ABC system: one for the MEPD eligibility and one for the QMB or SLMB eligibility. If there is an address change reported for the MEPD recipient, the address must be changed on both the MEPD case and the QMB or SLMB case at the same time.

Failure to change the address on the QMB or SLMB case at the same time you change the address on the MEPD case may result in the billing statement being sent to the old address. This is because the address used in the MEPD billing system comes from the Medicaid Eligibility system (SSNI).

If the MEPD case is not active at cutoff (the MEPD case may be temporarily closed for reasons such as premium not paid by the 14th of the month), the billing system will pick up the active QMB or SLMB case address.

STATE OF IOWA
TERRY E. BRANSTAD, GOVERNOR
DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

July 2, 1996

**GENERAL LETTER NO. 8-F-10**

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, Title page, revised; Contents, page 1, revised, pages 2 and 3, new; pages 1 through 16, revised; and pages 17 through 111, new.

**Summary**

This general letter transmits the revised 8-F, ***Coverage Groups***.

The existing chapter VIII-F, ***Early and Periodic Screening, Diagnosis, and Treatment***, has been incorporated into the revised 8-M, ***Medicaid Services***.

There is no new policy information in this chapter.

**Effective Date**

August 1, 1996

**Material Superseded**

Remove all existing pages from Employees' Manual, Title VIII, Chapter F, and destroy them.

Also obsolete the following interpretative memos:

- MS-VIII-89-3, "MAC/ADC Composite Households."
- MS-VIII-88-15, "Definition of Increased Earnings or Hours of Employment."
- MS-VIII-88-10, "CMAP Eligibility for Siblings."
- MS-VIII-88-9, "Treatment of Income of Students in Independent Living Situations When Determining CMAP Eligibility."
- MS-VIII-92-7, "QMB Eligibility and Part A."
- MS-VIII-90-19, "Transitional Medical/Medically Needy Cases."

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA
TERRY E. BRANSTAD, GOVERNOR
DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

October 22, 1996

**GENERAL LETTER NO. 8-F-11**

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, pages 30, 37, and 41, revised.

**Summary**

A person disqualified for the Family Investment Program because of an intentional program violation may still be eligible for Medicaid.

**Effective Date**

November 1, 1996

**Material Superseded**

Remove from Employees' Manual, Title 8, Chapter J, pages 30, 37, and 41, dated July 2, 1996, and destroy them.

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

December 17, 1996

**GENERAL LETTER NO. 8-F-12**

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, pages 84-88, 91-94, 96, 100, and 106, revised.

**Summary**

This chapter has been revised to reflect the 1997 Social Security cost of living allowance (COLA) increase of 2.9%.

**Effective Date**

January 1, 1996

**Material Superseded**

Remove from Employees' Manual, Title 8, Chapter F, pages 84-88, 91-94, 96, 100, and 106, all dated July 2, 1996, and destroy them.

**Additional Information**

Contact your regional benefit payment administrator if you need additional information.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

May 20, 1997

**GENERAL LETTER NO. 8-F-13**

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, pages 43, 45-48, 50, 52, 53, 55, 58, 59, 70, 98, 100, 104-106, 108 and 110, revised.

**Summary**

This general letter transmits the revised federal poverty levels for mothers and children, transitional Medicaid, qualified Medicare beneficiary, specified low-income Medicare beneficiary, and qualified disabled asnd working persons groups.

Example 1 on page 45 has been corrected.

**Effective Date**

April 1, 1997, for all coverage groups except QMB and SLMB.

The effective date for QMB and SLMB is May 1, 1997.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| 43, 45-48, 50, 52, 53, 55, 58, 59, 70, 98 | July 2, 1996 |
| 100 | December 17, 1996 |
| 104,105 | July 2, 1996 |
| 106 | December 17, 1996 |
| 108, 110 | July 2, 1996 |

**Additional Information**

Contact your regional benefits adminstrator if you need additional information.

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

December 16, 1997

**GENERAL LETTER NO. 8-F-14**

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, pages 84 through 88, 91, 92, 93, 94, 96, 100, and 106, revised; and page 92a, new.

**Summary**

This chapter has been revised to reflect the 1998 Social Security cost of living allowance (COLA) increase of 2.1%.

This general letter also includes policy for the new SSI-related coverage group for children that was created as a result of the Balanced Budget Act (BBA) of 1997 and was implemented in Manual Letter 8-F-2, dated October 7, 1997.

Implementation instructions directed that this coverage group was to include both children who had lost SSI benefits due to reevaluation of disability under P.L. 104-193 and children who were found no longer disabled for SSI-related Medicaid due to reevaluation of disability under the revised criteria. HCFA has since clarified that the state cannot cover children who were receiving SSI-related Medicaid only and were found not to be disabled under the revised criteria.

Therefore, this coverage group is available only to children who were receiving SSI benefits as of August 22, 1996, and were found no longer disabled under the revised disability criteria. Children who were receiving SSI-related Medicaid and were determined no longer disabled under the revised criteria need to be canceled from the SSI-related coverage group effective January 1, 1998.

As all cases where disability was subject to reevaluation by the Department were sent through central office for an initial screening, we can identify the children who were found no longer disabled and who will now no longer qualify for Medicaid under the BBA provisions. Central office will notify each benefit payment administrator of the cases in that region. As of this date, this change affects only two children.

**Implementation Instructions**

Send a hand-issued notice of cancellation to the affected clients. See Manual Letter 8-C-29, dated May 13, 1997, for language to use to cancel Medicaid due to reevaluation of disability under the revised criteria.

**Effective Date**

January 1, 1998

**Material Superseded**

Remove from Employees' Manual, Title 8, Chapter F, Contents (page 2), dated July 2, 1996; pages 84 through 88, 91, 92-94, and 96, dated December 17, 1996, and pages 100 and 106, dated May 20, 1997, and destroy them.

**Additional Information**

Contact your regional benefit payment administrator if you need additional information.

STATE OF IOWA
TERRY E. BRANSTAD, GOVERNOR
DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

January 6. 1998

**GENERAL LETTER NO. 8-F-15**

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Medicaid Coverage Groups***, Title page, revised; Contents (pages 1 and 2), revised; pages 1 through 111, revised; and page 112, new.

**Summary**

This general letter transmits several changes:

- Medicaid is being "delinked" from FIP cash assistance:

  Since Title XIX was added to the Social Security Act in 1965, families who were eligible for cash assistance under the Family Investment Program (FIP), were with a few exceptions, automatically eligible to receive Medicaid.

  Policies governing the FIP cash program were the basis of eligibility for Medicaid expansions in later years as more coverage groups were created to provide Medicaid to families, pregnant women, and children. These programs came to be known as "FIP-related" coverage groups.

  When Congress passed the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193), states were given new flexibility to administer their FIP cash programs and a five-year lifetime limit was set on receiving cash assistance. There was concern that if the link between Medicaid and FIP remained, people would lose Medicaid eligibility and become uninsured.

  As a result, Congress "delinked" Medicaid from FIP, and the term "FIP-related Medicaid" no longer applies.The intent of "delinking" Medicaid from FIP is to preserve Medicaid eligibility, regardless of changes made in FIP, by "freezing" the Medicaid eligibility policies that were in place as of July 16, 1996.

  Although the PRWOA mandates states to maintain the policies that were in place as of July 16, 1996, states do have some latitude as to which July 16, 1996, policies they use. For example, if a state had waivers in place, the state can choose to keep some or all of the waiver policies for Medicaid. Additionally, the state can choose to adopt income and resource policies that are more liberal than the policies that were in place on July 16, 1996.

The Family Medical Assistance Program (FMAP) has been designated as the coverage group under which families (both adults and children) that meet the FIP eligibility criteria in place on July 16, 1996, will receive Medicaid. Since Medicaid eligibility must be determined independently of FIP, the administrative rules and Employees' Manual have been amended so that Medicaid policy can "stand alone."

This chapter has been revised to delete references to "FIP-related" Medicaid coverage groups and to incorporate new policies around FMAP-related coverage groups. This results in the following changes:

- Persons who receive FIP do not automatically qualify for Medicaid.
- In order to receive transitional or extended Medicaid, the family must be canceled from FMAP due to earnings or support and must have received FMAP in at least three of the previous six months. A combination of FIP and FMAP will be allowed for the first six months of implementation to transition to the delinking provisions.
- Children of FMAP-eligible parents will receive coverage under FMAP, not CMAP.
- Cross references to Chapters 8-D, ***Resources***, and 8-E, ***Income***, have been added to the chapter. Although these references use the term "FMAP-related," revisions to these chapters are not yet completed. Continue to follow FIP-related policy in Title 4 (in addition to current Medicaid policy, as appropriate) until the FIP income and resource policies are incorporated into Title 8.

♦ Policy is being amended so that persons who are canceled from FMAP due to earnings alone or in combination with other changes in the household are eligible to receive transitional Medicaid coverage. This new policy does not apply to persons who become ineligible for FMAP due to the receipt of support (extended Medicaid).

♦ The 30-day waiting period for unemployed parents applying for FMAP is removed. The effective date of eligibility for these people is the same as it is for anyone else (i.e., the first of the month in which they apply).

♦ The revised income limit for the specified low-income Medicare beneficiary coverage group to over 100% of the federal poverty level but less than 120% of the federal poverty level is being incorporated into the manual.

♦ The Balanced Budget Act of 1997 mandated two new SSI-related coverage groups for persons who are not otherwise eligible for Medicaid:

- Expanded specified low income Medicare beneficiaries
- Home health specified low income Medicare beneficiaries.

The expanded SLMB group will pay only the Medicare Part B premium. The home health SLMB will pay only the home health portion of the Medicare Part B premium. Both of these coverage groups are 100% federally funded.

To be eligible to receive expanded SLMB or home health SLMB, a person must meet the same eligibility criteria as the current SLMB coverage group except for the income level.

- The income limit for the expanded SLMB is 120% of the federal poverty level to less than 135% of the federal poverty level.
- The income limit for the home health SLMB is 135% of the federal poverty level to less than 175% of the federal poverty level.

♦ The aid type table is revised to reflect that the aid types for coverage groups specifically for blind persons are obsolete and to identify the appropriate medical aid type and case aid type to use for persons in facilities when appropriate. Blind persons in aid types that are obsolete are being combined with the corresponding disabled aid type.

♦ The manual has been revised through out to further clarify various policies and examples.

**Effective Date**

Policies relating to the delinking of Medicaid from FIP cash assistance, including transitional Medicaid policies related to delinking, are effective retroactively to December 1, 1997.

The COLA revisions and elimination of the 30-day waiting period for unemployed parents are effective January 1, 1998.

Implementation of the expanded SLMB and home health SLMB coverage groups is effective with applications filed on or after January 1, 1998.

Transitional Medicaid policies related to cancellation of FMAP due to a combination of earned income and other circumstances are effective February 1, 1998.

**Material Superseded**

Remove the entire Employees' Manual, Title 8, Chapter F, and destroy it. This includes:

| Page | Date |
|---|---|
| Title page | July 2, 1996 |
| Manual Letter 8-F-2 | October 7, 1997 |
| Contents (Page 1) | July 2, 1996 |
| Contents (Page 2) | December 16, 1997 |
| Contents (Page 3) | July 2, 1996 |
| 1-111 | July 2, 1996, or October 22, 1996, or May 20, 1997, or December 16, 1997 |

**Additional Information**

Refer questions about this general letter to your regional benefits payment administrator.

STATE OF IOWA
TERRY E. BRANSTAD, GOVERNOR
DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

June 16, 1998

**GENERAL LETTER NO. 8-F-16**

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Medicaid Coverage Groups***, Contents (page 2), revised; pages 54 and 56 through 72, revised.

**Summary**

The Balanced Budget Act of 1997 (Public Law 105-32) added a new Title XXI to the Social Security Act. Title XXI provides funding to States to create health care programs for targeted low-income, uninsured children. States can use the Title XXI funding to:

- Expand existing Medicaid programs,
- Create a non-Medicaid child health care program, or
- Take a combination approach.

The Iowa Legislature passed House File 2517 which directs the Department to develop a combination approach for providing coverage to uninsured children. This General Letter transmits the policy for "phase one" which is a Medicaid expansion.

The Mothers and Children (MAC) program is being expanded to provide coverage to children ages one through 18 whose family income does not exceed 133% of the federal poverty level. The income limit for pregnant women and infants (under age one) remains at 185% of the federal poverty level.

The Employees' Manual has been revised to:

- Remove references to children having to have been born after September 30, 1983.
- Remove references to income limits for these children not exceeding 100% of the federal poverty level.
- Update poverty levels to reflect the 1998 levels.

Additionally, the IABC system has been modified so that eligibility for this coverage group will be system-calculated. Therefore, the instructions on how to calculate poverty level manually have been deleted.

**Implementation**

In June, Central Office will issue mailing labels by county and worker for all active cases in aid types 92-0 and 91-0. Complete desk reviews on these cases in June and July to identify those households with older children who are now eligible to be added to the MAC case due to the expansion. Affix the mailing label to form letter 470-3510 (sample attached). This notice explains the changes and asks clients to contact you if they want the child added to the case.

Also in June and July, complete desk reviews on state-only foster care cases (aid type 40-9) to determine if the children in foster care who are receiving Medicaid with 100% state dollars are eligible under the MAC program due to the expanded eligibility. Use your monthly case listing report to identify these cases.

After June month-end, Central Office will generate a mailing to all Medically Needy cases that meet the following criteria:

- Have a status of N; and
- Became inactive in April, May, or June; and
- Had a child in the household less than 19 years of age.

The notice will provide information about the expanded coverage and advise clients to file an application if they think they may qualify. (A copy os the notice text is attached.)

**Effective Date**

July 1, 1998

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (page 2) | January 6, 1998 |
| 54, 56-72 | January 6, 1998 |

**Additional Information**

Contact your regional benefit payment administrator if you need additional information.

Attachments: 470-3510
Comm. 144

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

Date: _____

**I M P O R T A N T  N O T I C E**

This letter is to tell you about changes in the Medicaid program that will begin on July 1, 1998. **A law has been passed that raises the age and income limits so that more children can get Medicaid.** Starting on July 1, 1998, your child can get Medicaid if:

- They are under the age of 19; and
- Your countable family income is less than 133% of the federal poverty level.

Our records indicate that the younger children in your family are already on Medicaid. **We cannot give Medicaid to your older children until you tell us to add them to your case. If you want to add your older children to your Medicaid case, you need to:**

[X] Call me or send me something in writing asking that they be added to the Medicaid case.

[ ] Send me the following information:

_____

_____

_____

_____

Please call me if you have any questions.

| Income Maintenance Worker | Phone |
|---|---|
| | |

470-3510 (7/98)

Iowa Department of Human Services

# IMPORTANT NOTICE

There are changes in the Medicaid program that will begin on July 1, 1998. A law has been passed that **raises** the age and income limits so that **more children can get Medicaid.**

Starting on July 1, your children can get Medicaid if:

- They are **under the age of 19**; and
- Your countable **family income is less than 133% of the federal poverty level**; and
- Your "liquid" **resources** (e.g. cash, stocks, bonds, bank accounts, etc.) **are less than $10,000**. (Other resources like your car, home, other property, etc. do not count towards this limit.)

**INCOME LIMIT**
(after some deductions are allowed to earned income)

| **Household Size*** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| **Monthly Income** | $893 | $1,203 | $1,513 | $1,824 | $2,134 | $2,444 | $2,755 | $3,065 |

For each additional person **over 8**, add $311.

*** Note:** If there is a pregnant woman in your household, count the unborn baby too.

**TO APPLY FOR MEDICAID,** either call or stop by the Department of Human Services office in the county where you live. Ask for a Health Services Application, form number 470-2927.

Comm. 144 (6/98)

STATE OF IOWA
TERRY E. BRANSTAD, GOVERNOR
DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

September 8, 1998

**GENERAL LETTER NO. 8-F-17**

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Medicaid Coverage Groups***, pages 32 through 36, 39, 42, 43, 46, 47, 48, 96, 97, 98, 100 through 104, 106, and 108 through 112, revised.

**Summary**

This letter transmits revisions to the Transitional Medicaid policy on who is included in the family. The definition of "family" for Transitional Medicaid now includes:

- All persons living in the household whose needs and income were included in determining FMAP eligibility at the time the benefits were terminated. This allows, for example, a returning absent parent whose income terminates FMAP eligibility to be included in the Transitional Medicaid group.
- A child who is born or a person who returns to the home after FMAP benefits are terminated.

The Balanced Budget Act and a letter of interpretation from the Health Care Financing Administration allow the state to pay the home health portion of the Medicare Part B premium for home health specified low-income Medicare beneficiaries. The payment of the home health portion of the Medicare Part B premium will be made retroactively on an annual basis. This payment will be made in April of each year for the previous calendar year.

The Employees' Manual also has been revised to update poverty levels for Transitional Medicaid and for the limited Medicaid benefit coverage groups.

**Effective Date**

Poverty levels were effective April 1, 1998.

Transitional Medicaid changes and payment of the home health portion of Medicare Part B are effective October 1, 1998.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| 32-36, 39, 42, 43, 46-48 96-98, 100-104, 106, 108-112 | January 6, 1998 |

**Additional Information**

Contact your regional benefit payment administrator if you need additional information.

STATE OF IOWA
TERRY E. BRANSTAD, GOVERNOR
DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

December 15, 1998

**GENERAL LETTER NO. 8-F-18**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, pages 50, 77, 79, 81 through 89, 92, 94, 98, and 101 through 104, revised.

**Summary**

This chapter has been revised to:

- Reflect the 1999 Social Security cost of living allowance (COLA) increase of 1.3%.
- Clarify that the Social Security Administration does not review or determine ongoing Medicaid eligibility for the coverage groups "people ineligible for SSI or SSA due to Social Security benefits paid from a parents account" or "people ineligible for SSI or SSA due to receipt of widows Social Security benefits." Reviews and ongoing eligibility must be completed by the DHS income maintenance worker.

**Effective Date**

January 1, 1999

**Material Superseded**

Remove from Employees' Manual, Title 8, Chapter F, pages 50, 77, 79, 81 through 89, 92, and 94, dated January 6, 1998, and pages 98, and 101 through 104, dated September 8, 1998, and destroy them.

**Additional Information**

Contact your regional benefit payment administrator if you need additional information.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

January 19, 1999

**GENERAL LETTER NO. 8-F-19**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, page 62, revised.

**Summary**

Policy on determining countable income for the MAC coverage group is corrected as follows:

- Removing "Payments made for dependents not living in the home" under **Determining Countable Income** for parents.
- Adding that the child support paid by a parent for persons not living in the home must be court-ordered and may be for current or back support.
- Adding "Diversions for an ineligible or excluded person's needs, if appropriate."

Policy on considering income of stepparents is corrected by:

- Limiting deductions to dependents, "who are or could be claimed as dependents for federal income tax purposes."
- Replacing "court-ordered" with "verified" child support or alimony.

**Effective Date**

Upon receipt.

**Material Superseded**

Remove from Employees' Manual, Title 8, Chapter F, page 62, June 16, 1998, and destroy it.

**Additional Information**

Contact your regional benefit payment administrator if you need additional information.

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 22, 1999

**GENERAL LETTER NO. 8-F-20**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, Contents (pages 1 and 2), revised; and pages 26 through 31, 49, 51 through 53, 55 through 58, 60, 61, 71, 76, 77, 90, 91, and 92, revised; and page 92a, new.

**Summary**

This general letter transmits two policy changes.

- A change has been made in when disability is to be reviewed on children who were canceled from SSI due to revised childhood disability criteria established under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 but remained eligible for Medicaid due to provisions of the Balanced Budget Act of 1997.

  Current policy requires that these children have disability reviewed two years from the date of the child's cancellation from SSI. Since cancellations from SSI could occur as early as July 1, 1997, state review of disability could be initiated on these children on July 1, 1999. With this change, reviews of disability for children eligible under this coverage group are based on the date originally designated through the SSI disability determination.

  HCFA has notified states that the Social Security Administration will provide the disability review date originally assigned when disability was established for SSI eligibility. However, this information is not yet available to Iowa due to the need for system enhancement to receive the information. Once system changes have been made, the information will be transmitted to the field.

- House File 760, enacted by Seventy-eighth Session of the Iowa General Assembly, directs the Department to disregard resources in determining initial and ongoing Medicaid eligibility of children in coverage groups for which the Department has the authority to do so.

  This change does not affect the types of resources to be considered, whose resources to consider, or how the countable value of a resource is determined. It does provide that resources of all household members will be disregarded when determining eligibility of children in the affected coverage groups.

Revisions have been made in this chapter under each coverage group to indicate which coverage groups are affected by this change and which remain unchanged.

**Effective Date**

Both changes are effective July 1, 1999.

For applications, disregard resources in the eligibility determinations of children on any applications processed on or after July 1, 1999, for July and later months. Determine eligibility in months before July 1999 according to policies in place during those months.

For ongoing cases, effective with the month of July 1999, ignore any increases in household resources for children in the affected coverage groups. Additionally, adjust eligibility of children based on this change no later than at time of review.

When some household members have attained Medicaid eligibility by the voluntary exclusion of a child whose resources would have created ineligibility, explain the effect of this policy change on the excluded child and the effect of adding that child to the eligible group at the first contact with the household on or after July 1, but no later than at the time of the annual review.

1. Mr. and Mrs. A and their two children receive Medicaid. Due to countable household resources of $7,500, Mr. and Mrs. A are receiving Medicaid under Medically Needy with zero spenddown. Their children are receiving Medicaid under MAC.

   Mr. and Mrs. A's certification period expires at the end of September. They apply to be recertified in August. A new zero spenddown certification period of October through March is established.

   When the new certification period is established, the eligibility of the children is adjusted. Since the countable income of the household does not exceed the CMAP limit for a four-member household, the children can now receive Medicaid under CMAP. All household resources are disregarded in determining their eligibility.

2. Mrs. B receives Medicaid for two of her three children under MAC. She has voluntarily excluded the third child, because the child is a beneficiary of a trust with a countable value of $175,000. Mrs. B chooses not to receive Medicaid. Countable household income exceeds the CMAP limit for a three-member household but does not exceed 133% of poverty for a three-member household.

   The annual review on the MAC case is due in February. The worker has no contact with Mrs. B between July 1 and the review. At the review, the worker informs Mrs. B that it is no longer necessary for her to exclude the child with the trust in order for the other two children to be Medicaid-eligible.

If Mrs. B chooses to add the excluded child to the Medicaid eligible group, the earliest date the child can be eligible is the first of March (the month following the month in which the request was made). Since the trust is a resource, it is disregarded in the eligibility determination of the children. However, if the trust produces income, the income is considered according to policies concerning income produced by a resource.

**(**Mrs. B can still choose to exclude the child with the trust, even though eligibility may exist.)

3. Same as Example 2, except that Mrs. B contacts the worker in July about her new address. At that time, the worker explains to her the effect of the policy change on the excluded child and the effect that adding the excluded child to the eligible group would have on the other children. Mrs. B requests that the excluded child be added. The earliest date the child can be made eligible is the first of August.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (page 1) | January 6, 1998 |
| Contents (page 2) | June 16, 1998 |
| 26-31, 49, 51-53, 55 | January 6, 1998 |
| 56-58, 60, 61, 71 | June 16, 1998 |
| 76 | January 6, 1998 |
| 77 | December 15, 1998 |
| 90, 91 | January 6, 1998 |
| 92 | December 15, 1998 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 21, 1999

**GENERAL LETTER NO. 8-F-21**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, pages 81 through 85, 88, 89, 92 through 96, 98 through 104, and 106 through 112, revised.

**Summary**

This chapter has been revised to:

- Reflect the 2000 Social Security cost of living allowance (COLA) increase of 2.4%.
- Reflect the 1999 federal poverty level.
- Clarify the reimbursement of the home health portion of Medicare Part B.

**Effective Date**

COLA changes are effective January 1, 2000.

Poverty changes were effective May 1, 1999.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Manual Letter 8-ZERO-7 | March 30, 1999 |
| 81-85, 88, 89 | December 15, 1998 |
| 92 | June 22, 1999 |
| 93 | January 6, 1998 |
| 94 | December 15, 1998 |
| 95 | January 6, 1998 |
| 96 | September 8, 1998 |
| 98 | December 15, 1998 |
| 99 | January 6, 1998 |
| 100 | September 8, 1998 |

| | |
|---|---|
| 101-104 | December 15, 1998 |
| 106 | September 8, 1998 |
| 107 | January 6, 1998 |
| 108-112 | September 8, 1998 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

February 8, 2000

**GENERAL LETTER NO. 8-F-22**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, Contents (page 3), new; pages 59, 60, and 87, revised; and pages 113 through 122, new.

**Summary**

This General Letter:

- Implements a new SSI-related Medicaid coverage group effective March 1, 2000.
- Corrects the 1619(b) eligibility criteria page on 87.
- Transmits the update to the MAC poverty levels that was inadvertently omitted from General Letter 8-F-21.

The new Medicaid coverage group is called "Medicaid for employed people with disabilities" (MEPD). MEPD is an optional coverage group provided for in the Balanced Budget Act of 1997 and mandated by the Iowa Legislature in 1999 Iowa Acts, Chapter 94. The intent of the coverage group is to allow people with disabilities to work and to still have access to Medicaid.

To qualify for this coverage group, a person must:

- Be under age 65.
- Continue to be disabled based on the medical criteria for SSI for disability.
- Have earned income from employment or self-employment.
- Have net family income of less than 250% of the federal poverty level for the family size.

This coverage group has a higher resource limit than other Medicaid coverage groups: $12,000 for an individual and $13,000 for a couple. Resources are treated the same as for other SSI-related Medicaid coverage groups, with exception that additional resources of retirement accounts, medical savings accounts, and assistive technology accounts are exempt for eligibility under this coverage group.

A sliding-scale premium is assessed, based on the person's income. The Department assesses a premium when gross income of the eligible person is above 150% of the federal poverty level. Premiums start at $20 per month. The current maximum premium is $201. When a premium is assessed for a month, the premium must be paid before a Medicaid card is issued for the month.

**Implementation Instructions**

All applicants for this coverage group need to receive a copy of the MEPD pamphlet, which includes the premium chart. This allows applicants to determine if they will have a premium and the amount they need to be prepared to pay if a premium will be assessed.

MEPD will require a separate case number. A client may qualify for QMB or SLMB and MEPD at the same time. Maintain separate QMB, SLMB, facility, and food stamp cases when the client is also eligible for these benefits.

A client who receives E-SLMB, HH-SLMB or QDWP cannot be eligible for those programs and MEPD at the same time. Advise the client of the requirements and benefits for each coverage group and allow the client to decide.

People eligible under a coverage group with full Medicaid benefits other than Medically Needy should not be placed in MEPD. If an applicant would be eligible for Medically Needy and for MEPD with or without a premium, the person may chose either Medically Needy or MEPD.

When a person is currently on Medically Needy with a zero spenddown and qualifies for MEPD, the person must be offered the choice of coverage groups at the time of the next review but may be switched to MEPD sooner upon request.

Review all Medically Needy spenddown cases to find people who will qualify under MEPD. Send clients who **will** qualify for MEPD a letter advising of them of their potential eligibility. (Language for the letter is included with this General Letter. The letter advises clients to contact the worker if they want their eligibility to be determined under this coverage group.)

A person who is currently on Medically Needy with a spenddown with a February/March 2000 certification period who would qualify for MEPD as of March 1st may be switched from Medically Needy into MEPD for the month of March 2000 if spenddown has not been met.

If a client requests eligibility under MEPD and a medical card has not been issued for the month or the client hasn't met spenddown, close the Medically Needy case and open a MEPD case for the client. Follow instruction in 14-I-26, **Medicaid Eligibility Through Another Aid Type**. Use the ABC system to issue a notice to the client approving eligibility under MEPD.

**Effective Date**

March 1, 2000

**Materials Superseded**

Remove from Employees Manual, Title 8, Chapter F, page 59, dated June 16, 1998, page 60, dated June 22, 1999, and page 87, dated December 15, 1998, and destroy them.

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

Attachment: Language for letter about potential eligibility for MEPD.

The Iowa Department of Human Services implemented a new SSI-related Medicaid coverage group called Medicaid for Employed People with Disabilities (MEPD) effective March 1, 20000. This coverage group is for people under age 65 with disabilities who have earned income.

Under this group, the eligible person must pay a monthly premium when the person's gross income (including both earned and unearned income) is above 150% of the federal poverty level (currently $1030). Premiums start at $20 and go to $201 when the eligible person's gross income reaches 390% of the federal poverty level (currently $2,690). No premium is charged when the eligible person's gross income is 150% of poverty or less.

The Department sets the premium amount for a six-month period. The amount of the premium cannot be increased in that period, but it can be decreased if the person's income decreases.

Eligibility under MEPD generally is more beneficial to a person who has a spenddown under the Medically Needy program. A person who qualifies under MEPD does not need to meet a spenddown and may not have to pay a monthly premium. People who will owe a premium will have a premium that is less than their spenddown and will receive Medicaid as soon as they have paid the premium.

**We have reviewed your Medically Needy file and have determined that:**

- ❑ **You qualify for the MEPD coverage group and will not owe a premium.** If you want your Medicaid coverage switched from Medically Needy to MEPD, please notify your worker. Your coverage will be changed to MEPD beginning with the first month in which you have not already attained Medicaid eligibility.

- ❑ **You would qualify for the MEPD coverage group by paying a premium.** The estimated amount of your monthly premium is_____. If you want your Medicaid coverage switched from Medically Needy to MEPD with a premium, please notify your worker. Your coverage will be switched to MEPD if spenddown has not been met.

Your premium amount will be redetermined every six months. In order to determine what your premium will be for each six-month period, we will send you a form to gather income information before each new six-month period. Additionally, a review of continued eligibility will be completed on an annual basis.

If you have met spenddown, your eligibility under MEPD will not begin until the first month following your current Medically Needy certification period. Failure to contact your worker by the due date will result in your Medicaid coverage continuing under the Medically Needy coverage group.

Please see the enclosed MEPD pamphlet for additional information.

You must continue to report all changes in your circumstances that affect eligibility within ten days. Changes you must report include such things as change in income, resources, family members, addresses, etc.

If you have questions, please contact_____

at_____.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

March 14, 2000

**GENERAL LETTER NO. 8-F-23**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, Contents (pages 1, 2, and 3), revised; pages 4, 5, 11 through 14, 18 through 72, 96, 98, 101 through 104, 106, 108 through 112, 117, 118, 119, and 121, revised; and pages 72a through 72e, new.

**Summary**

This letter incorporates the revised poverty levels for 2000. These new amounts affect the mothers and children, transitional Medicaid, qualified Medicare beneficiary, specified low-income Medicare beneficiary, expanded special low-income Medicare beneficiary, home health specified low-income Medicare beneficiary, qualified disabled and working persons groups, and Medicaid for employed people with disabilities coverage groups.

Page 4 is revised to add the Medically Needy and Medicaid for employed people with disabilities coverage groups to the table and to remove obsolete aid types.

The sections on postpartum and newborn eligibility are revised to:

- Change the type of notification to be sent to a recipient when a pregnancy ends. Previously, the instructions were to send a letter. The new instructions say that a *Notice of Decision* should be sent using reason code 819.
- Remove the suggested wording for the notice sent when eligibility is established as a newborn child of a Medicaid eligible mother and add instructions to use reason code 812.
- Add instructions for ABC system coding when the household contains a child receiving Medicaid as a newborn child of a Medicaid eligible mother.
- Remove the suggested wording of the notice sent at the time of the first birthday of a child receiving Medicaid as a newborn child of a Medicaid eligible mother and add instructions to use reason code 814.
- Remove the suggested wording of the notice sent when a child loses newborn eligibility because the mother is losing Medicaid eligibility and would not be eligible if she were still pregnant and add instructions to use reason code 816.

Page 26 is revised to clarify that eligibility under FMAP does not exist for children living with a specified relative who does not receive Medicaid under FMAP. Clarification was also added to the examples.

Pages 27 – 51 are revised to re-format the section entitled "People Who Are Ineligible for FMAP." Transitional Medicaid policy has been clarified that when the caretaker relative who is employed is sanctioned, the remaining eligible group can continue receiving transitional Medicaid. Several other clarifications and several examples have been added.

Pages 53 and 54 are revised to clarify that, in addition to marriage, a person may also be considered emancipated by order of the court.

Pages 56 and 57 are revised to add examples to illustrate CMAP eligibility determination of a person under age 21 who is married to a person age 21 or older.

Page 61 is revised to add mutual funds to the list of examples of countable liquid resources.

Page 64 is revised to clarify that incapacitated stepparents with no children and non-incapacitated stepparents caring for stepchildren while a parent works are included in the household size.

Pages 66 is revised to clarify that child care expenses are allowable only when the client is responsible for paying expenses.

Page 71 is revised to clarify that there are situations in which the household size of the MAC and Medically Needy groups in a composite household may not always be the same.

Other pages are revised to clarify policy, add clarity to the examples, and add additional examples

**Effective Date**

April 1, 2000 for poverty levels.
The remaining material is effective upon receipt.

**Implementation Instructions**

See General Letter 8-E-47 for instructions on implementing the new poverty levels for Mothers and Children, Transitional Medicaid, QMB, SLMB, expanded SLMB, home health SLMB, and QDWP recipients.

**Material Superseded**

Remove from Employees' Manual, Title 8, and destroy Manual Letter No. 8-Zero-7, dated March 30, 1999.

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (pp. 1, 2) | June 22, 1999 |
| Contents (p. 3) | February 8, 2000 |
| 4, 5, 11-14, 18-25 | January 6, 1998 |
| 26-31 | June 22, 1999 |
| 32-36 | September 8, 1998 |
| 37, 38 | January 6, 1998 |
| 39 | September 8, 1998 |
| 40, 41 | January 6, 1998 |
| 42, 43 | September 8, 1998 |
| 44, 45 | January 6, 1998 |
| 46-48 | September 8, 1998 |
| 49 | June 22, 1999 |
| 50 | December 15, 1998 |
| 51-53 | June 22, 1999 |
| 54 | June 16, 1998 |
| 55-58 | June 22, 1999 |
| 59, 60 | February 8, 2000 |
| 61 | June 22, 1999 |
| 62 | January 19, 1999 |
| 63-70 | June 16, 1998 |
| 71 | June 22, 1999 |
| 72 | June 16, 1998 |
| 96, 98, 101-104, 106, 108-112 | December 21, 1999 |
| 117-119, 121 | February 8, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

May 2, 2000

**GENERAL LETTER NO. 8-F-24**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups***, page 122, revised; and page 123, new.

**Summary**

This letter releases a change in policy when an applicant for Medicaid for employed people with disabilities (MEPD) is certified for Medically Needy with a spenddown.

Current policy states that eligibility under MEPD cannot be approved for months that a client is on Medically Needy with a spenddown when spenddown has been met for the month and a medical card has been issued. The worker is to notify Consultec of the change and end the spenddown process.

Under the revised policy, an applicant for MEPD who is on Medically Needy with a spenddown can be approved for MEPD for the same months of Medically Needy eligibility, regardless of whether or not spenddown has been met and a medical card issued.

When a Medically Needy client with a spenddown also qualifies for MEPD for one or both months of the Medically Needy certification period and requests MEPD, approve the case for MEPD. You will close the Medically Needy case and end the spenddown status later in the process.

MEPD approvals with overlapping Medically Needy certification periods will be identified on the billing system and the following actions will occur:

- For Medically Needy/MEPD cases with a zero premium, workers will be sent an informational WAR 456, "MEPD – ESTD to CTEC."
- For Medically Needy/MEPD cases with a MEPD premium due, Quality Assurance staff will notify workers by E-mail or by phone of the premium payment.

When you receive the informational WAR or the message from QA:

- Shorten the certification period if appropriate and notify the client.
- Send an ESTD to Consultec with the months that need to be removed from Medically Needy.
- Adjust the spenddown amount.

You may also need to:

- Request Consultec to back out bills for the months the client is eligible for MEPD.
- Complete a recoupment.

**Effective Date**

Upon receipt.

**Material Superseded**

Remove from Employees' Manual, Title 8, Chapter F, page 122, dated February 8, 2000, and destroy it.

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 13, 2000

**GENERAL LETTER NO. 8-F-25**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Coverage Groups,*** pages 6, 8, 59, 60, 63, 66, 67, 69, 70 through 72, 72a, 72b, and 72d, revised.

**Summary**

These pages have been revised to reflect the increase in the MAC income limit to 200% of the federal poverty level for pregnant women and infants.

**Effective Date**

July 1, 2000

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| 6, 8 | January 6, 1998 |
| 59, 60, 63, 66, 67, 69-72, 72a, 72b, 72d | March 14, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

July 11, 2000

**GENERAL LETTER NO. 8-F-26**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, pages 99 and 100, revised.

**Summary**

To be "entitled to Medicare Part A benefits" also means the person meets the requirements to enroll in Medicare Part A.

This letter adds instructions that a person who is eligible for QMB and Medically Needy with a spenddown has a QMB case and a separate Medically Needy case.

Aid types that the worker does not need to examine eligibility for QMB or code for QMB are now in 14-B-Appendix, **TD03 POV**.

**Effective Date**

Upon receipt.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, pages 99 and 100, both dated December 21, 1999, and destroy them.

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

September 5, 2000

**GENERAL LETTER NO. 8-F-27**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (page 3), revised; pages 109 through 112, revised; and page 112a, new.

**Summary**

This chapter has been revised to give additional information. Expanded specified low-income beneficiaries (E-SLMB) are referred to as "qualifying individuals 1" (QI-1) by Medicare. Home-health specified low-income beneficiaries (HH-SLMB) are referred to as "qualifying individuals 2" (QI-2) by Medicare. People applying for E-SLMB or HH-SLMB may refer to the coverage groups as QI-1 and QI-2.

**Effective Date**

Upon receipt.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (page 3) | March 14, 2000 |
| 109-112 | March 14, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

October 31, 2000

**GENERAL LETTER NO. 8-F-28**

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (page 3), revised; and pages 119 through 123, revised; and pages 124 through 128, new.

**Summary**

This chapter has been revised to add instructions for approvals of Medicaid for employed people with disabilities (MEPD) and some minor revisions to words in the MEPD section.

Approval instructions include actions to take and the premium amount to assess when:

- A case is approved in the first four months of the first premium period.
- A case is approved in the fifth month of the first premium period or later.

**Effective Date**

Upon receipt.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (page 3) | September 5, 2000 |
| 119 | March 14, 2000 |
| 120 | February 8, 2000 |
| 121 | March 14, 2000 |
| 122, 123 | May 2, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 19, 2000

**GENERAL LETTER NO. 8-F-29**

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (pages 2 and 3), revised; pages 9, 10, 11, 14, 15, 16, 25 through 30, 35 through 38, 40, 45, 47, 48, 49, 51 through 54, 58, 59, 67, 72e, 73, 74, 81 through 85, 89, 92, 94 through 112, and 112a, revised; and page 30a new.

**Summary**

This chapter has been revised to

- Reflect the 2001 Social Security cost of living allowance (COLA) increase of 3.5%.
- Reflect the increase in the home health specified low income Medicare beneficiary refund to $3.09 per month for 2001.
- Group and label coverage groups that Medicare and the Health Care Financing Administration refer to as "Medicare Savings Programs." These are the qualified Medicare beneficiary, specified low-income Medicare beneficiary, expanded specified low-income Medicare beneficiary, home-health specified low-income Medicare beneficiary, and qualified disabled working people groups.

The following revisions are being made due to the elimination of deprivation as an eligibility factor for FMAP-related Medicaid:

- Pages 10 and 14 are revised to remove references to monthly reporting.
- Page 11 is revised to remove a reference to suspensions and to clarify that a pregnant woman eligible under MAC does not have to verify income changes.
- Pages 15, 16, 25, 26, 30, 47, 48, 49, 58, 67, and 72e are revised to delete references to deprivation.
- Pages 15, 25, 26, 29, 30, 40, 45, and 51 are revised to delete the word "caretaker."
- Pages 16, 26, 30, 47, 48, 49, and 67 are revised to clarify the examples.
- Page 27 is revised to add an example.
- Page 29 is revised to explain that a recipient is a person who has been successfully approved on the system and to add examples.

- Page 35 is revised with minor word usage changes.
- Pages 36 and 37 are revised to delete the word caretaker and to add the word “specified.”
- Page 37 is revised to add a reference to another part of the chapter
- Page 52 is revised to delete the example.
- Page 53 is revised to clarify that when one sibling is an unmarried parent, siblings under age 21 may be one eligible group or separate eligible groups. The reference "Temporary Absence From the Home" is changed to "Absence."
- Page 59 is revised to clarify that the father of the unborn is required to be a part of the eligible group if he is in the home.

**Effective Date**

January 1, 2001

**Material Superseded**

Remove the following pages from Employees’ Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (p. 2) | March 14, 2000 |
| Contents (p. 3) | October 31, 2000 |
| 9, 10 | January 6, 1998 |
| 11, 14 | March 14, 2000 |
| 15, 16 | January 6, 1998 |
| 25-30, 35-38, 40, 45, 47-49, 51-54, 58 | March 14, 2000 |
| 59, 67 | June 13, 2000 |
| 72e | March 14, 2000 |
| 73, 74 | January 6, 1998 |
| 81-85, 89, 92, 94-95 | December 21, 1999 |
| 96 | March 14, 2000 |
| 97 | September 8, 1998 |
| 98 | March 14, 2000 |
| 99, 100 | July 11, 2000 |
| 101-104 | March 14, 2000 |
| 105 | January 6, 1998 |
| 106 | March 14, 2000 |
| 107 | December 21, 1999 |
| 108 | March 14, 2000 |
| 109-112, 112a | September 5, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

**THOMAS J. VILSACK, GOVERNOR**
**SALLY J. PEDERSON, LT. GOVERNOR**

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

March 13, 2001

**GENERAL LETTER NO. 8-F-30**

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, pages 41, 63, 97, 98, 101 through 110, 112, 117, and 118, revised.

**Summary**

This chapter is revised to update the poverty levels for 2001. The new amounts affect the mothers and children (MAC), transitional Medicaid, qualified Medicare beneficiary, specified low-income Medicare beneficiary, expanded special low-income Medicare beneficiary, home-health specified low-income Medicare beneficiary, and qualified disabled and working persons groups.

The income levels for Medicaid for employed people with disabilities (MEPD) premiums have also been increased based on the increased poverty levels. MEPD ongoing premiums are due the month before the month they are to cover. Billing statements are sent after cutoff of the month before the month premiums are due. MEPD billing statements for the April premium are sent after February cutoff, with the premiums due in March.

MEPD cases with a premium must be reviewed to determine if the premium the client owes for April should be decreased. To do so, make the following ABC entries:

- Use "H" entry reason.
- Use a positive date of April 1.
- Reenter the premium period currently showing on TD05.
- Reenter income in both the earned income and unearned income fields.

The system will recalculate the premium. If the premium decreases, hand-issue a *Notice of Decision* to notify the client. If there is no decrease in the premium, do not send any notice to the client; just document the action in the case record.

Suggested language:

> Your premium for Medicaid for Employed People with Disabilities has changed effective **/**/** due to a change in the federal poverty levels. Your new premium amount for the remainder of the (first month of current premium period) to (last month of current premium period) premium period is (new premium amount)
>
> EM 8-F Medicaid or Employed People with Disabilities
> 441 Iowa Admin. Code 75.1(39)b(1)

When you approve a case that includes months before April after the poverty level changes have been made on the ABC system, manually determine if the premium for the months before April should have been at a higher level. Complete a recoupment for the difference between what the system-calculated amount and the actual amount owed.

**Effective Date**

April 1, 2001

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| 41 | March 14, 2000 |
| 63 | June 13, 2000 |
| 97, 98, 101-110, 112 | December 19, 2000 |
| 117, 118 | March 14, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

May 22, 2001

**GENERAL LETTER NO. 8-F-31**

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, pages 11, 28, 58, 59, 60, 95, 96, and 111, revised; and page 60a, new.

**Summary**

Page 11 is updated to clarify that a pregnant woman can be continuously eligible if over income for Medicaid rather than a specific coverage group.

Page 28 is updated to remove the reference to monthly reporting.

Page 58 is updated to correct a legal reference.

MAC eligibility requirements are updated on page 60 to clarify the effect of not including an unborn child in the eligible group.

Pages 95 and 96 updates the time period that extended Medicare benefits are received after termination of social security disability benefits from 48 months to 8 1/2 years. Determine that Medicare benefits stopped before approving qualified disabled and working people.

Page 111 is revised to clarify that the home-health portion of the Medicare Part B premium is the only Medicaid benefit a home-health specified Medicare beneficiary receives. This policy has not changed. The amount of the home-health portion of the Medicare Part B premium is $3.09 monthly. The refund is mailed to the recipient annually.

**Effective Date**

Upon receipt.

**Material Superseded**

Remove from Employees' Manual, Title 8, Chapter F, pages 11, 28, 58, 59, 60, 95, 96, and 111, all dated December 19, 2000, and destroy them.

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 26, 2001

**GENERAL LETTER NO. 8-F-32**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (pages 1, 2, and 3), revised; pages 1, 2, and 24, revised; and pages 24a through 24g, new.

**Summary**

This general letter implements a new Medicaid coverage group for women who need treatment for breast or cervical cancer. This new coverage group was funded by the Iowa Legislature in the 2001 appropriations bill, Senate File 537.

The intent of the coverage group is to provide access to treatment for low income-uninsured women who have been screened, diagnosed, and found to need treatment for breast or cervical cancer. This coverage group is neither FMAP-related nor SSI-related and has no income or resource guidelines.

A presumptive eligibility component allows women access to treatment before a formal Medicaid eligibility determination is completed. A woman who has been screened for breast or cervical cancer and found to need treatment can be determined presumptively eligible by a qualified provider. A woman may request eligibility for the presumptive period only or apply for ongoing Medicaid benefits.

**Effective Date**

July 1, 2001

This coverage group is effective for applications processed on or after July 1, 2001. Eligibility may not be established under this group for months before July 2001.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (p. 1) | March 14, 2000 |
| Contents (pp. 2 and 3) | December 19, 2000 |
| 1, 2 | January 6, 1998 |
| 24 | March 14, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

July 24, 2001

**GENERAL LETTER NO. 8-F-33**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, pages 81 through 84, 89, 92, and 94, revised.

**Summary**

This chapter has been revised to reflect the 2001 Social Security Consumer Price Index correction cost-of-living adjustment (CPIC COLA) increase.

**Effective Date**

August 1, 2001

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| 81-84, 89, 92, 94 | December 19, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

August 14, 2001

**GENERAL LETTER NO. 8-F-34**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, pages 30, 33, 34, 36, 37, 41, 42, 47, 49, 51, 52, 58, 64, and 65, revised.

**Summary**

The manual is being updated to reflect a change in the way we sanction adults who do not cooperate with the Department, ineligible adult aliens, and adults who do not have a social security number.

The change will allow sanctioned adults, undocumented adult aliens, and adults who are ineligible due to no social security number to remain a part of the household size.

Ineligible children will not be included in the household size, nor will their income or resources be used in determining eligibility of the eligible group.

Page 30 is revised to clarify the definition of "family."

Page 41 is revised to reflect a change in policy on transitional Medicaid cases. If a stepparent is not a part of the transitional Medicaid eligible group, stepparent's income is not used when determining eligibility of the transitional Medicaid eligible group.

Page 42 is deleted.

**Implementation Instructions**

The first six months of transitional Medicaid is not affected by a stepparent's income. This change is effective for transitional Medicaid recipients during the second six-month period when processing a quarterly report received September 2001 or after.

**Effective Date**

September 1, 2001

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| 30 | December 19, 2000 |
| 33, 34 | March 14, 2000 |
| 36, 37 | December 19, 2000 |
| 41 | March 13, 2001 |
| 42 | March 14, 2000 |
| 47, 49, 51, 52 | December 19, 2000 |
| 58 | May 22, 2001 |
| 64, 65 | March 14, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

November 20, 2001

**GENERAL LETTER NO. 8-F-35**

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, pages 81 through 85, 89, 92, 94, 98, 104, 111, and 112a, revised.

**Summary**

This chapter has been revised to reflect the 2002 Social Security cost-of-living allowance (COLA) increase of 2.6%.

**Effective Date**

January 1, 2002

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| 81-84 | July 24, 2001 |
| 85 | December 19, 2000 |
| 89, 92, 94 | July 24, 2001 |
| 98, 104 | March 13, 2001 |
| 111 | May 22, 2001 |
| 112a | December 19, 2000 |

**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

February 12, 2002

**GENERAL LETTER NO. 8-F-36**

ISSUED BY: Health Support Unit
Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (pages 1 through 3), revised; Contents (page 4), new; pages 24, 24a through 24g, and 60a, revised; and pages 24h through 24r and 60b, new.

**Summary**

The section of this chapter on coverage for women who need treatment for breast or cervical cancer has been expanded and clarified. Information regarding the responsibilities of the screening provider, the income maintenance worker and the client has been added. Guidelines on when to refer a woman from DHS to a screening provider are included.

Examples have also been added to clarify when retroactive eligibility can and cannot be established.

Page 60b is revised to include an example on how to treat pregnant 17- and 18-year-olds.

**Effective Date**

Upon receipt.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (pages 1 through 3) | June 26, 2001 |
| 24, 24a through 24g | June 26, 2001 |
| 60a | May 22, 2001 |

**Additional Information**

Refer questions about this general letter to your service area manager or designee.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

March 12, 2002

**GENERAL LETTER NO. 8-F-37**

ISSUED BY: Unit of Health Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, pages 41, 63, 72, 72a, 97, 98, 101 through 104, 106, 108, 109, 110, 112, 117, and 118, revised.

**Summary**

This chapter is revised to update the poverty levels for 2002. The new amounts affect the mothers and children (MAC), transitional Medicaid, qualified Medicare beneficiary, specified low-income Medicare beneficiary, expanded special low-income Medicare beneficiary, home-health specified low-income Medicare beneficiary, and qualified disabled and working persons groups.

The income levels for Medicaid for employed people with disabilities (MEPD) premiums have also been increased based on the increased poverty levels. The billing system will recalculate the premiums, so that billing statements issued at March cutoff, for May premiums, due in April, will be correct.

A report has been created to identify the cases where the premium is decreased due to the change in the poverty level. The reports will be sent to the field to use in:

- Correcting the premium information in the ABC system.
- Issuing a *Notice of Decision* to notify the recipient of the changed amount.

Each case identified on the report will require entries to correct the premium amount on ABC, unless April is the last month of the current premium period. (In that case, simply document the changed premium amount in the case record.) Make the following ABC entries after March cutoff but before April cutoff to recalculate the premium on ABC.

- Use entry reason "H."
- Use a positive date of April 1.
- Reenter the premium period currently showing on TD05.
- Reenter income in both the earned income and unearned income fields.

Issue a *Notice of Decision* to notify the recipient of the changed amount. Suggested language for the notice is as follows.

> Your premium for Medicaid for Employed People with Disabilities has changed effective **/**/** due to a change in the federal poverty levels. Your new premium amount for the remainder of the
>
> (first month of current premium period) to (last month of current premium period) premium period is (new premium amount)
>
> EM 8-F Medicaid for Employed People with Disabilities
> 441 Iowa Admin. Code 75.1(39)b(1)

A refund will be required for cases with a decrease in premium for April, if the amount billed for April is paid in full. Quality Assurance will issue any refunds that are due for the month of April by May 31, 2002.

When you approve a case that includes months before April after the poverty level changes have been made on the ABC system, manually determine whether the premium for the months before April should have been at a higher level. Complete a recoupment for the difference between the system-calculated amount and the actual amount owed.

**Effective Date**

April 1, 2002

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| 41 | August 14, 2001 |
| 63 | March 13, 2001 |
| 72, 72a | June 13, 2000 |
| 97 | March 13, 2001 |
| 98 | November 20, 2001 |
| 101-103 | March 13, 2001 |
| 104 | November 20, 2001 |
| 106, 108, 109, 110, 112, 117, 118 | March 13, 2001 |

**Additional Information**

Refer questions about this general letter to your service area IM II supervisor.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

May 7, 2002

**GENERAL LETTER NO. 8-F-38**

ISSUED BY: Unit of Health Support, Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (page 4), revised; pages 24a, 24b, 90, 91, 92, and 119 through 128, revised; and pages 129 and 130, new.

**Summary**

This chapter is revised to:

- Implement changes in policy and procedure for premium billing and collection for Medicaid for employed people with disabilities (MEPD).
- Implement a change in the definition of "creditable coverage" due to the Breast and Cervical Cancer Treatment Technical Amendment Act of 2001. Health care available through the Native American Indian Health Services or a tribal organization is no longer considered coverage that excludes a person from the breast or cervical cancer treatment coverage group.
- Incorporate relevant instructions from Manual Letter 8-F-3 on children who lost SSI due to the change in disability criteria.

MEPD rules have been amended to:

- Change the due date for premium payments to the 14th of the month the premium is to cover. (The premium for the month the case is approved is due on the 14th of the month following the month the case is approved. The premiums for the months before the month the case is approved are due on the 14th of the third month following the month the case is approved.)
- Provide that no *Medical Assistance Eligibility Card* is issued for a month until the premium is paid.
- Remove requirement that the Department send reminder notices when a premium is not paid by the due date. If the current month's premium is not paid timely, the client is canceled.
- Change the due date for reviews to the sixth month of a premium period. Workers will send review forms to clients at the end of the fifth month of the premium period.

- Change the method that premium payments are applied to unpaid months. Payments are applied to any unpaid months in the following order (when there is still time to pay):
  1. The month in which the payment is received.
  2. The month following the month in which the payment is received when payment is received in last five working days of a month.
  3. The month before the month in which the payment is received.
  4. The oldest unpaid month and forward until all prior months have been paid.

A billing statement is sent for the month the case is approved, the month following the month a case is approved (if the case is approved in the last five working days of the month) and for months back to the month of the positive date on ABC. There will no longer be "initial" and "beginning" months.

When a premium that is due the 14th of the month the payment is to cover is not received by the due date, the billing system will send an e-mail instructing the worker to cancel the case.

The case can be reinstated if payment is received before the effective date of cancellation. The case can be reopened once in a six-month period if payment is received in the month following the month it is due. The billing system notifies the worker via e-mail when payments are made after the due date. The worker determines if the case can be reinstated or reopened.

**Effective Date**

June 1, 2002

**MEPD Implementation**

With these policy changes, the June premium payment will be due June 14.

- If the June premium is paid by May 14, the next bill will be mailed at the end of June for the month of July, due July 14.
- If the June bill is not paid by May 14, another bill will be sent at the end of May for the month of June, due June 14.

If a client has any <u>initial</u> months' premium payments with a due date in June or later, the due date will remain the same.

If a client has any <u>beginning</u> months' premium payments with a due date of June 14, the June payment will be due June 14. The July premium will be due July 14. A new billing statement will be sent for the month of June and for the month of July.

| Comparison Chart | |
|---|---|
| **Old Policy** | **New Policy** |
| Initial months,<br>Beginning months, and<br>Ongoing months. | Months before the month of approval,<br>The month of approval, and<br>Months after the month of approval. |
| "Initial" months are the month of approval and the months before the month the case is approved, back to the month of the positive date on ABC. Clients have 60 days to pay. | All months from the month of the positive date on ABC up to the month of approval are "months before the month of approval." Clients have until the 14th of the third month following the month of approval to pay. |
| "Beginning" months are the two months following the month of approval. Clients must pay both months by the 14th of the month following the month of approval.<br><br>If the first beginning month is not paid, the client does not have Medicaid eligibility for that month. If the second beginning month is not paid, the client is canceled and must reapply. | The "month of approval" is the month the case is approved on ABC. Clients must pay the premium for that month by the 14th of the month following the month of approval. |
| "Ongoing" months start with the third month after the month of approval.<br><br>Premiums are due on the 14th of the month before the month the premium is to cover. | All of the months following the month of approval are "ongoing" months.<br><br>Premiums are due on the 14th of the month the premium is to cover. |
| If an ongoing month is not paid by the due date, the client is canceled. The case may be reinstated if the premium is paid before the effective date of cancellation.<br><br>The case may be reopened once in a six-month period if payment is received in the month following the month the payment is to cover. | If an ongoing month is not paid by the due date, the client is canceled. The case may be reinstated if the premium is paid before the effective date of cancellation.<br><br>The case may be reopened once in a six month period if payment is received in the month following the month the payment is to cover. |
| Reminder notices are sent when initial and ongoing premiums are not paid. | No reminder notices will be sent. |

| Old Policy | New Policy |
|---|---|
| WAR messages with notice reason number are sent when:<br>♦ A case is to be canceled for nonpayment of beginning month and ongoing premiums.<br>♦ Premiums are paid after the due date. | E-mail messages with notice reason number are sent when:<br>♦ The premium has not been paid by the due date and a case should be canceled.<br>♦ Premium payments are received after the due date. Worker determines if case should be reinstated or reopened or if it is too late for either option. |
| Premium reviews and annual reviews are completed in the fifth month of the premium period. | Premium reviews and annual reviews are completed in the sixth month of the premium period. |
| Increases in premiums for prior months can be collected only through completion of a claim for the difference. | Increases in premiums for prior months can be collected only through completion of a claim for the difference. |
| Decreases in premium for prior months premiums can be corrected only through a refund through QA. | Decreases in premium amounts can be credited to the recipient's account through entry of the changed amount on the MEPC screen. A balance will be shown on the next billing statement and will be credited to any unpaid premiums. |
| Premium payments are applied according to the months as identified by the client. | Premium payments are applied in a specified order:<br>♦ To the current month.<br>♦ To the month following the month a payment is received when the payment is received in the last five working days of a month.<br>♦ To the month before the month in which the payment is received.<br>♦ To the oldest unpaid month and forward until all old prior month have been paid. |

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Manual Letter No. 8-F-3 | August 15, 2000 |
| Contents (page 4) | February 12, 2002 |
| 24a, 24b | February 12, 2002 |
| 90, 91 | June 22, 1999 |
| 92 | November 20, 2001 |
| 119-128 | October 31, 2000 |

**Additional Information**

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

October 29, 2002

**GENERAL LETTER NO. 8-F-39**

ISSUED BY: Unit of Health Support, Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (pages 1 and 2), revised; pages 24g through 24r, revised; and pages 24s through 24v, new.

**Summary**

The section of this chapter dealing with the Breast or Cervical Cancer Treatment (BCCT) coverage group is expanded to include instructions regarding case actions that, on most other coverage groups, are handled via the Automated Benefit Calculation (ABC) system. The case actions for BCCT cases must be handled and managed differently than other coverage groups since BCCT cases are not entered on the ABC system. The case actions are:

- Application processing
- Annual reviews
- Canceling eligibility under BCCT
- Establishing retroactive eligibility
- Replacing lost medical assistance cards
- Reimbursing medical transportation expenses

**Effective Date**

Upon receipt.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (pages 1 and 2) | February 12, 2002 |
| 24g-24r | February 12, 2002 |

**Additional Information**

Refer questions about this general letter to your service area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 24, 2002

**GENERAL LETTER NO. 8-F-40**

ISSUED BY: Unit of Health Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (pages 1, 2 and 3,) revised; pages 24i through 24v, 25, 30a, 36, 37, 38, 72e, 81 through 85, 89, 92, 94, 97, 98, 104, 111, and 112, revised; and pages 24w, 24x, 72f, and 72g, new.

**Summary**

Breast and Cervical Cancer Treatment

Clarification has been added regarding women receiving Medicaid under the breast and cervical cancer treatment (BCCT) coverage group who were categorically eligible under a mandatory coverage group but who were over income limits or over resource limits at the time of approval under BCCT. When these women are due for an annual review, a determination must be made regarding continued ineligibility under mandatory coverage groups.

However, no such determination must be made for women who continue to be not categorically eligible under a mandatory coverage group.

Family Medical Assistance Program (FMAP)

Page 25 is revised to clarify that an FMAP eligible group may contain only the parents or only the specified relative.

Transitional Medicaid

Page 30a is revised to clarify that transitional Medicaid eligibility does not exist if the FMAP eligible group does not contain a child.

Pages 36 and 37 are revised to clarify that for both six month periods the transitional Medicaid eligible group must contain either an eligible or ineligible specified relative whose income is used. During the second six month period, the eligible or ineligible specified relative must have earned income in each month, unless good cause exists.

Page 38 is revised to clarify that when a *Transitional Medicaid Notice of Decision/Quarterly Income Report*, form 470-2663, is manually issued, a self-addressed postage-paid envelope must be included for the recipient's use in returning the completed form.

Medicaid/***hawk-i*** Composite Families

A new section has been added dealing with cases where some family members receive health care coverage through the ***hawk-i*** program and other family members are receiving or applying for Medicaid. This new section is not intended to implement new policies or procedures. Instead, it is intended only to clarify current policies and procedures.

This policy change does not affect current Medicaid policy allowing children to be voluntarily excluded from the Medicaid eligible group so that income or resources of the child are not counted in the Medicaid eligibility determination. Children voluntarily excluded for these reasons should still be referred to ***hawk-i***.

Cost of Living Adjustment

This chapter has been revised to reflect the 2003 Social Security cost-of-living adjustment increase of 1.4%.

Home Health Specified Low Income Medicare Beneficiaries (HH-SLMB)

This chapter has been revised to document the HH-SLMB coverage group is discontinued effective December 31, 2002.

**Effective Date**

BCCT, FMAP, and transitional Medicaid policies are effective upon receipt.

Policies for Medicaid/***hawk-i*** composite families, cost of living adjustments, and HH-SLMB are effective January 1, 2003.

**Implementation Instructions for Medicaid/*hawk-i* Composite Families**

Applications

This policy change is effective for Medicaid applications processed on or after January 1, 2003, regardless of the application date. Apply this policy to any month of the application period in which some family members received health care coverage through the ***hawk-i*** program. This includes months before January 2003.

Ongoing Cases

No desk review is needed to identify cases where Medicaid-eligible family members have been voluntarily excluded because they chose to receive health care coverage through the ***hawk-i*** program until the ***hawk-i*** annual review. All cases must be identified no later than the next Medicaid annual review following the issuance of this general letter.

Affected cases are ones where Medicaid-eligible family members have been voluntarily excluded because they chose to receive health care coverage through the ***hawk-i*** program until the ***hawk-i*** annual review. When such a case is identified, complete an automatic

redetermination and include in the Medicaid eligible group the members receiving health care coverage through the ***hawk-i*** program as considered persons.

Including the family members receiving health care coverage through the ***hawk-i*** program as considered people could result in an adverse action for one or more family member currently receiving Medicaid. If this happens, contact the family and give them the option to voluntarily exclude some or all of the people receiving health care coverage through the ***hawk-i*** program due to the income of the people receiving ***hawk-i***. Document the family's decision in the case file.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (pages 1, 2) | October 29, 2002 |
| Contents (page 3) | February 12, 2002 |
| 24i-24v | October 29, 2002 |
| 25, 30a | December 19, 2000 |
| 36, 37 | August 14, 2001 |
| 38, 72e | December 19, 2000 |
| 81-85, 89 | November 20, 2001 |
| 92 | May 5, 2002 |
| 94 | November 20, 2001 |
| 97, 98, 104 | March 12, 2002 |
| 111 | November 20, 2001 |
| 112 | March 12, 2002 |

**Additional Information**

Refer questions about this general letter to your service area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

March 11, 2003

**GENERAL LETTER NO. 8-F-41**

ISSUED BY: Bureau of Financial Support, Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (page 3), revised; and pages 4, 24c, 41, 63, 95, 97, 101, 106, 109, 111, 112, 117, 118, and 130, revised.

**Summary**

This chapter is revised to:

- Update the poverty levels for 2003. The new amounts affect the mothers and children (MAC), transitional Medicaid, qualified Medicare beneficiary, specified low-income Medicare beneficiary, expanded special low-income Medicare beneficiary, and qualified disabled and working persons groups.
- Remove the policy for home-health specified low-income Medicare beneficiaries.

**Implementation for MEPD**

The income levels for Medicaid for employed people with disabilities (MEPD) premiums have also been increased based on the increased poverty levels. The ABC system will:

- Recalculate the premiums, so that billing statements issued at March cutoff for April premiums due in April will be correct.
- Send notices to notify recipients of the premium decreases.

If the premium decreases, the difference will reside as a credit when the premium has been paid in advance.

When you approve a case that includes months before April after the poverty level changes have been made on the ABC system, manually determine whether the premium for the months before April should have been at a higher level. Complete a recoupment for the difference between the system-calculated amount and the actual amount owed.

A client may prefer to be billed for a higher premium rather than have a recoupment completed. The client must give permission in writing for the Department to bill for a higher premium without timely notice. In this case, you may use the MEPD screen to issue a corrected billing statement for any months before April 2003.

**Effective Date**

April 1, 2003

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Manual Letter 8-F-4 | December 10, 2002 |
| Contents (page 3) | December 24, 2002 |
| 4 | March 14, 2000 |
| 24c | February 12, 2002 |
| 41, 63 | March 12, 2002 |
| 95 | May 22, 2001 |
| 97 | December 24, 2002 |
| 101, 106, 109 | March 12, 2002 |
| 111, 112 | December 24, 2002 |
| 112a | November 20, 2001 |
| 117, 118 | March 12, 2002 |
| 130 | May 7, 2002 |

**Additional Information**

Refer questions about this general letter to your service area income maintenance supervisor 2.

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

December 2, 2003

**GENERAL LETTER NO. 8-F-42**

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents, (page 4), revised; pages 81 through 85, 89, 92, 94, 98, 104, 118, 129, and 130, revised; pages 118a and 131, new.

**Summary**

This chapter is revised to:

- Add the 2004 Social Security cost-of-living adjustment increase of 2.1%.
- Incorporate changes in the premium amounts charged for Medicaid for employed people with disabilities (MEPD). Premiums for MEPD are based on a sliding scale. The maximum amount charged is equal to the average cost of state employee's health insurance.

  As the cost of state employee's health insurance has increased, the maximum premium amount has also increased, from $201 to $355. The beginning premium amount has been increased from $20 to $22. More increments have been added to the sliding scale.
- Corrections have been made to instructions in section, "Relationship to Medically Needy." When the new billing system was implemented some instructions regarding the Unit of Quality Assurance (QA) became obsolete; therefore, references to QA have been deleted.
- Add a section on the relationship between MEPD and qualified Medicare beneficiaries and specified low-income Medicare beneficiaries.

**Implementation for MEPD Changes**

The ABC system will use the increased premium amounts to calculate premiums effective with all calculations entered on ABC by December 19.

The ABC system will issue a *Notice of Decision* at timely notice day in December (December 19) to notify recipients of their new premium amount effective with the January 2004 premium.

The billing statements for January 2004 with the new premium amounts will be issued at the regular billing date, which is the ABC system cutoff day, December 23.

When a case is approved after December 19 and the approval includes months before January 2004, make the entry for all months being approved, then:

- ♦ Manually determine the premium amount for the months before January 2004 using premiums in effect for those months.
- ♦ Complete a manually issued *Notice of Decision* to notify the recipient of the amount of the premium for the prior months. Suggested language to use for notice:

  > Your premium for Medicaid for employed people with disabilities for the months of through __ is $___. Your premium is less than your premium for January 2004 and ongoing as premiums for this coverage group were increased effective January 1, 2004. You will receive a billing statement for the amount stated above.
  >
  > EM 8-F Medicaid for Employed People with Disabilities
  > 441 Iowa Admin. Code 75.1(39)"b"

- Use the MEPC screen on ABC to adjust the premium amounts for months before January 2004 so that a correct billing statement will be issued. See 14-B(9), **Change to MEPD Premium**, for MEPC screen instructions.

Revised form 470-3686, *MEPD Earned Income Worksheet*, with the increased premium calculations will be available on Outlook for use effective December 19. Use this form on or after December 19 for calculating premiums for January 2004 and beyond.

**Effective Date**

January 1, 2004

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents (page 4) | May 7, 2002 |
| 81-85, 89, 92, 94, 98, 104 | December 24, 2002 |
| 118 | March 11, 2003 |
| 129 | May 7, 2002 |
| 130 | March 11, 2003 |

**Additional Information**

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

April 6, 2004

**GENERAL LETTER NO. 8-F-43**

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (pages 1 and 2), revised; pages 16, 20, 22, 23, 24, 24a through 24w, 27 through 30, 30a, 37, 38, 41, 42, 43, 55, 56, 63, 74, 76, 97, 101, 106, 109, 117, 118, and 118a, revised; and page 30b, new.

**Summary**

This chapter is revised to:

- Update the poverty levels for 2004. The new amounts affect the mothers and children, transitional Medicaid, qualified Medicare beneficiary, specified low-income Medicare beneficiary, expanded special low-income Medicare beneficiary, qualified disabled and working persons, and Medicaid for employed people with disabilities groups.
- Clarify that newborns should not be added to the mother's case when the mother is an SSI recipient.
- Remove references to monthly reporting.
- Amend the section on breast and cervical cancer treatment (BCCT) coverage to:
  - Clarify that a sanctioned person is not eligible for Medicaid under the Breast and Cervical Cancer Early Detection Program.
  - Change the minimum age when a woman with cervical cancer or a precancerous condition of the cervix can be referred to a qualified provider from 50 to 40.
  - Remove the limited benefits coverage groups from the list of mandatory Medicaid coverage groups, since they do not provide full Medicaid coverage.
  - Reflect changes in making referrals to BCCEDP. Wording has been modified to conform to the Iowa Department of Public Health's rules for this program.
  - Change the release form from 470-0461, *Authorization for Release of Information*, to 470-3951, *Authorization to Obtain or Release Health Care Information*. This is being done to comply with HIPAA guidelines and because most medical providers prefer or require this form.
  - Add that Quality Assurance should be notified when a woman receiving Medicaid under the BCCT coverage group moves so the proper worker is notified of the annual review.

  - Clarify that you cancel eligibility under the BCCT when a woman fails to provide verification of when treatment ends or fails to sign and return the release of information.
  - Clarify that medical transportation reimbursements must be made on a case with a medical aid type.

- Add instructions that a ***hawk-i*** referral shall be done on a child who is voluntarily excluded due to income.
- Amend the section on extended Medicaid to:
  - Clarify an example.
  - Add a section on adding people to the eligible group.
- Amend the section on Transitional Medicaid to:
  - Correct an example.
  - Clarify that a "considered" child under transitional Medicaid is part of the eligible group.
  - Clarify that a voluntarily excluded child is not part of the transitional Medicaid eligible group.
  - Add a link to the policy on requirements for a complete report.
  - Add that if a household returns a complete quarterly report after the due date but before the effective date of cancellation, an automatic redetermination is done to another to coverage group.
  - Add that good cause shall be allowed when prorating a non-recurring lump sum.
  - Add an example showing that when there are people on a MAC case who are eligible or "considered" for Medicaid under 133% and 200% of poverty, the NOD will show only the 133% calculation. The system does do a 200% calculation for eligibility purposes.
- Clarify whom to include when determining family size for MEPD computations when the disabled person is age 18 and older. Include the disabled person's spouse and any of their children who are under the age of 18 and unmarried.
- Correct references that refer to 8-C, **COOPERATION WITH HIPP, TPL, DIA, AND QC**. The correct reference is 8-C, **Cooperation With Third-Party Liability Unit**.
- Remove Manual Letter 8-F-6, on reinstating E-SLMB cases canceled October 1, 2003.

**Implementation of Poverty Level Changes for MEPD**

The income levels for Medicaid for employed people with disabilities (MEPD) premiums have also been increased based on the increased poverty levels. The ABC system will:

- Recalculate the premiums so that billing statements issued at March cutoff for April premiums due in April will be correct.
- Send notices to notify recipients of the premium decreases.

If the premium decreases, the difference will reside as a credit when the premium has been paid in advance.

When you approve a case that includes months before April after the poverty level changes have been made on the ABC system, manually determine whether the premium for the months before April should have been at a higher level. Complete a recoupment for the difference between the system-calculated amount and the actual amount owed.

A client may prefer to be billed for a higher premium rather than have a recoupment completed. The client must give permission in writing for the Department to bill for a higher premium without timely notice. In this case, you may use the MEPC screen to issue a corrected billing statement for any months before April 2004.

**Effective Date**

Poverty level changes are effective April 1, 2004. All other changes are effective upon receipt.

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Manual Letter 8-F-6 | October 14, 2003 |
| Contents (pages 1 and 2) | December 24, 2002 |
| 16 | December 19, 2000 |
| 20, 22, 23 | March 14, 2000 |
| 24 | February 12, 2002 |
| 24a, 24b | May 7, 2002 |
| 24c | March 11, 2003 |
| 24d-24f | February 12, 2002 |
| 24g, 24h | October 29, 2002 |
| 24i-24x | December 24, 2002 |
| 27 | December 19, 2000 |
| 28 | May 22, 2001 |
| 29 | December 19, 2000 |
| 30 | August 14, 2001 |
| 30a, 37, 38 | December 24, 2002 |
| 41 | March 11, 2003 |
| 42 | August 14, 2001 |
| 43, 55, 56 | March 14, 2000 |
| 63 | March 11, 2003 |
| 74 | December 19, 2000 |
| 76 | June 22, 1999 |
| 97, 101, 106, 109, 117 | March 11, 2003 |
| 118, 118a | December 2, 2003 |

**Additional Information**

Refer questions about this general letter to your area income maintenance supervisor 2.

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

September 17, 2004

**GENERAL LETTER NO. 8-F-44**

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, Contents (page 4), revised; pages 125 through 131, revised; and page 132, new.

**Summary**

This chapter is revised to:

- Incorporate rule changes for the Medicaid for employed people with disabilities (MEPD) coverage group. The changes are:
  - The order in which the premium payment is applied.
  - The instances in which an automatic refund is generated by the billing system.
- Include the date when billing statements are issued.

Currently, billing statements are mailed five working days before the end of the month. This did not allow enough time for the client to receive the billing statement and remit the payment so that Medicaid eligibility could be established by the first of the month.

In order to allow clients more time between the receipt of the billing statement and the first of the following month to pay, billing statements will be issued earlier. Billing statements will be generated at the end of the 15th day of the month or, if the 15th day falls on a weekend or holiday, the end of day of the first working day after the weekend or holiday. This will allow the client more time to send in the following month's premium payment.

Currently premium payments received before the last five working days of the month are applied to past months if the current month is already paid. With the rule change, premiums received after the billing statement has been issued will be held and applied to the following month if the current month is paid. If excess funds result from the payment, the excess funds will first be applied to old unpaid months. If there are no old unpaid months, the excess funds will be held as a credit.

A new section about refunds has been added. Currently automatic refunds are generated by the billing system when a case has been inactive for two months. With this change, the billing system will also generate automatic refunds when a case has a zero premium for two calendar months.

Clients may also ask for a refund of any excess amount in their accounts. When a client requests a refund, send an e-mail to DHS, Quality Assurance.

**Effective Date**

October 1, 2004

**Material Superseded**

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

| Page | Date |
|---|---|
| Contents, p. 4 | December 2, 2003 |
| 125-128 | May 7, 2002 |
| 129-131 | December 2, 2003 |

**Additional Information**

Refer questions about this general letter to your area income maintenance supervisor 2.