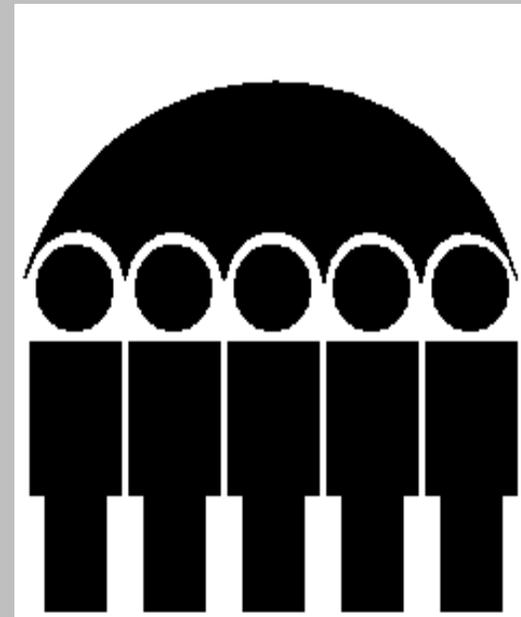


MEDICAID

For SSI-related persons



Iowa Department of
Human Services

Comm. 28 (Rev.7/10)



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No person shall be discriminated against because of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief when applying for or receiving benefits or services from the Iowa Department of Human Services, or any of its vendors, service providers, or contractors.

If you have any reason to believe that you have been discriminated against for any of the above reasons, you may write to the Iowa Department of Human Services, the Iowa Civil Rights Commission (if you feel you were treated differently **because of** your race, creed, color, national origin, sex, religion, or disability); or the United States Department of Health and Human Services, Office for Civil Rights.

IOWA DEPARTMENT OF HUMAN SERVICES
Diversity Programs Unit 1st Fl
1305 E Walnut St
Des Moines IA 50319-0114

IOWA CIVIL RIGHTS COMMISSION
211 E Maple St 2nd Fl
Des Moines IA 50309-1858

US DEPARTMENT OF HEALTH AND HUMAN
SERVICES
Office for Civil Rights Region VII
601 E 12th St Rm 248
Kansas City MO 64106-2808

Medicaid

for SSI-related Persons

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INTRODUCTION

This pamphlet is designed to answer some of the most commonly asked questions concerning Medicaid for Supplemental Security Income-related people. The information may be difficult to understand. If you have any questions, please contact your county Department of Human Services office.

WHAT IS MEDICAID?

Medicaid is an assistance program that pays for certain medical and health care costs for people who qualify. The Medicaid program is funded by the federal and state government, and is managed by the Iowa Department of Human Services (DHS).

The Medicaid program is sometimes referred to as the Title 19 program. This should not be confused with Medicare. Medicare is an insurance program handled by the Social Security Administration.

WHAT IS SSI-RELATED MEDICAID?

“SSI-related Medicaid” is a program for most people who qualify for Supplemental Security Income (SSI) and for people who are aged, blind, or disabled and who meet SSI requirements except for excess income or resources.

REQUIREMENTS

DO I QUALIFY?

You may get full Medicaid coverage if you meet any of the following requirements:

- ◆ You get SSI or a payment through the State Supplementary Assistance (SSA) program.
- ◆ You live in a medical facility (hospital or nursing facility) and you meet all the requirements for the SSI program except for income or resources.
- ◆ You have been eligible for SSI or SSA and Social Security at one time but no longer qualify for SSI or SSA because of a Social Security cost of living increase.
- ◆ You would be eligible for SSI or SSA but you do not wish to receive cash assistance.
- ◆ You are disabled and working and your income or resources are more than SSI limits (see page 4 for more details). In this case you may qualify for the Medicaid for Employed People with Disabilities (MEPD) program. For more information, please see the pamphlet “*Medicaid for Employed People with Disabilities*,” which is available from your DHS worker.
- ◆ Your income or resources are more than SSI limits (page 4 has more details). In this case you may qualify for the SSI-related Medically Needy Program. For more information, please see the pamphlet “*Medicaid for the Medically Needy*,” which is also available from your DHS worker.
- ◆ You are receiving waiver services through one of the state’s Home and Community Based Services (HCBS) waiver programs.

You may qualify for limited Medicaid services if you meet the following requirements:

- ◆ You have Medicare Part A and you meet the eligibility requirements for the Qualified Medicare Beneficiary program (QMB). For more information, see the pamphlet “*Medicaid for the Qualified Medicare Beneficiary*,” which is available from your DHS worker.
- ◆ You have Medicare Part A and you meet the eligibility requirements for the Specified Low Income Medicare Beneficiary (SLMB) program, or Expanded Specified Low Income Medicare Beneficiary (E-SLMB).
- ◆ You qualify to purchase Medicare Part A and you do not qualify for Medicaid under any other coverage group and you meet all other eligibility requirements for the Qualified Disabled and Working Persons program (QDWP). For more information, contact your DHS worker.

WHAT ARE THE PROGRAM REQUIREMENTS?

The SSI-related Medicaid program requires that you be aged, blind, or disabled; that your income and resources be within certain limits; and that you meet other factors of eligibility.

- ◆ **Aged:** You are age 65 or older, **or**
- ◆ **Blind:** Regardless of age, your vision is 20/200 or less or your visual field is limited to 20 degrees or less with the best corrective eye glasses. If your visual impairment is not severe enough for you to be considered blind, you may still qualify as a disabled person, **or**
- ◆ **Disabled:** You have a physical or mental impairment which prevents you from doing work for at least 12 months or which is expected to result in death. A child under 18 can also qualify as being disabled.

The Medicaid for Employed People with Disabilities program (MEPD) requires that you meet the medical listing of impairments used for SSI disability except that your earned income will not be a consideration.

- ◆ **Income:** You must report all income including interest, lump sums, earned income and unearned income (such as Social Security, Veteran’s Benefits or annuities). It is required that your income not exceed certain limits, depending on the program for which you qualify.

SSI and SSA Programs

These programs have different income limits depending on your needs and circumstances. See your DHS worker to determine your income limits.

If you stay in a medical facility, your total monthly income (without any deductions) cannot be more than three times the basic SSI benefit for one person.

QMB Program

Your income must be within 100% of the federal poverty level. Please see the pamphlet “*Medicaid for the Qualified Medicare Beneficiary*” for more information.

SLMB Program

Your countable income is over 100% of the federal poverty level but less than 120% of the federal poverty level.

E-SLMB Program

Your countable income is equal to or greater than 120% of the federal poverty level but less than 135% of the federal poverty level.

QDWP Program

Your countable income does not exceed 200% of the federal poverty level.

Medically Needy Program

The Medically Needy program may not pay all of your medical expenses, which means you may be responsible to pay some of your medical expenses. The amount for which you may be responsible is based on your total countable income. Please see the pamphlet “*Medicaid for the Medically Needy*” for more information.

Medicaid for Employed People with Disabilities

You must be disabled, have earned income from work and your net family income must be less than 250% of the federal poverty level for your family size. You will be required to pay a monthly premium when your monthly gross income is above 150% of the federal poverty level. For more information, please see the pamphlet “*Medicaid for Employed People with Disabilities,*” which is available from your DHS worker.

- ◆ **Resources:** Resources are things you own, such as your home, contracts for the sale of real estate, personal property, trusts, life estates, stocks and bonds, savings and checking accounts, or cash.

In determining the countable value of your resources, take into account the following guidelines because not all resources are counted:

- Your home is not counted if you live in it, or you are away and plan to return to it or if your spouse or a dependent relative is living in it.
- Life insurance policies are not counted if the total combined face value of all policies owned by you is \$1,500 or less. If the total face value is more than \$1,500, only the cash value is counted.
- The value of one vehicle is not counted if it is used by the household for transportation to a job or to a medical provider (at least four times per year), or if it is modified for use by a handicapped person. If your vehicle is not one of the types just listed, only the portion of the current market value that exceeds \$4,500 may be counted as a resource.

- Personal and household goods or burial funds may not count, depending on their value.
- There are different guidelines on the countable value of your resources if one spouse of a married couple enters a medical facility. Please see the pamphlet “*Protection of Your Income and Resources*” for more information.

For adults, it is required that the countable value of your resources not exceed certain limits, depending on the program for which you qualify. If your resources do exceed the limits, you cannot receive benefits from that program.

Children may still be able to get Medicaid under certain programs even if the value of your resources is over the limit.

◆ **What are the resource limits?**

- SSI and SSA Programs
\$2,000 for an individual and \$3,000 for a married couple living together.
- QMB, SLMB and E-SLMB
\$6,600 for an individual and \$9,910 for a couple. Please see the pamphlet “Medicaid for the Qualified Medicare Beneficiary: for more information about QMB. For more information about SLMB and E-SLMB, please contact your worker.
- QDWP Program
\$4,000 for an individual and \$,6,000 for a couple. For more information about QDWP, please contact your worker.
- Medically Needy Program
\$10,000 for one or more persons. Please see “*Medicaid for the Medically Needy*” for more information.
- Medicaid for Employed People with Disabilities
Your countable resources must be \$12,000 or less for an individual and \$13,000 or less for a couple. There are additional resources that are exempt from consideration for eligibility for MEPD. For more information, please see the pamphlet “*Medicaid for Employed People with Disabilities,*” which is available from your DHS worker.

Each of these program limits are considered differently if one spouse enters a medical facility and the other remains at home. Please see the pamphlet “*Protection of Your Income and Resources,*” for more information. Ask your DHS worker for a copy.

Transfer of assets: You may not qualify for Medicaid payment for certain services if you transferred (gave away or sold) resources or income for less than fair market value. This depends on when the resources or income were transferred and to whom they were given or sold.

Listed below are some guidelines on the transfer of assets at less than fair market value. They may be difficult to understand. More information is available from your DHS worker.

- ◆ Assets (resources or income) transferred to someone other than your spouse after August 10, 1993, and within 36 (or 60 months for transfers to or by a trust) months of application for medical assistance, may cause denial of Medicaid payment for certain services. You may qualify for Medicaid payment for other services.
- ◆ Assets transferred on or after July 1, 1993, and within 60 months of an application, or while a person is receiving Medicaid, may result in a claim being filed against the person who received the asset for either the amount of Medicaid paid on the recipient’s behalf or the uncompensated value of the transferred asset, whichever is less whether eligibility is affected or not.

Nursing facility payments can be granted in cases of hardship when a transfer of resources has been made to someone other than the spouse after July 1, 1990. Medicaid can pay for nursing facility services in cases of hardship.

Undue hardship exists only when all of the following conditions are met:

- ◆ Application of the transfer of asset penalty would deprive the individual of food, clothing, shelter, medical care, or other necessities of life, such that the individual's health or life would be endangered.
- ◆ The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.
- ◆ The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:
 - The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.
 - Household goods.
 - A vehicle required by the client for transportation.
 - Funds for burial of \$4,000 or less.

Note: If you applied for Medicaid and a penalty period was imposed because you gave away or sold resources and did not receive the fair market value for the resources, the penalty period continues for the time period established. However, if the resources are returned to you, the penalty period may be revised.

◆ **Other Factors of Eligibility:**

- **Citizenship:** You must be a citizen, an alien lawfully admitted for permanent residency, or otherwise permanently residing in the United States under color of law. ("Color of law" means that the Immigration and Naturalization Service has given permission for your residency and does not plan to deport you.)

- **Residency:** Generally, you are a resident of Iowa if you are voluntarily living in the state for other than a temporary purpose. Considerations in determining your residency are based on your capability to express intent to temporarily or permanently live in Iowa, your age (if you are under 21), your employment status, and whether you live in a medical facility. If you have been placed in a facility in Iowa by another state, you are considered to be a resident of the state that placed you in the facility.
- **Other Benefits:** As a person applying for Medicaid, you must apply for and be receiving, all other benefits for which you are eligible. Other benefits include Social Security, Iowa Public Employees Retirement System (IPERS), Railroad Retirement, Veteran's Benefits, pensions from private employment, etc.
- **Social Security Number:** You must provide your own Social Security number. If you do not have a number, you will be required to show proof you have applied for one.
- **Cooperation in Establishing Paternity and Obtaining Support:** A parent or caretaker relative of a child under the age of 18 for whom Medicaid is applied for or received is required to:
 1. Cooperate in establishing who the child's father is, if this has not been legally established, and
 2. Cooperate in obtaining support when the parents are not living with the child.

Failure to cooperate without good cause will result in ineligibility for Medicaid for the parent or caretaker relative. Your DHS worker can provide information on claiming good cause.

WHAT REQUIREMENTS ARE THERE FOR MEDICAL FACILITY RESIDENTS?

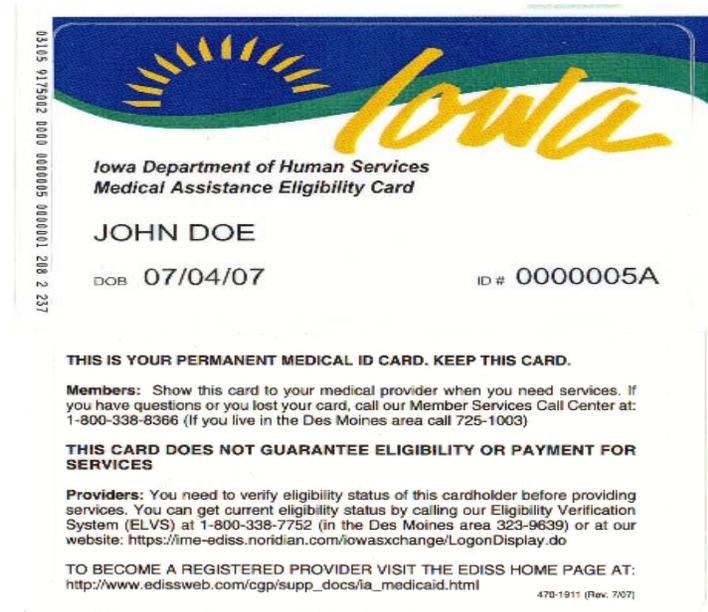
To qualify for Medicaid as a medical facility resident (staying in a hospital or nursing facility), you must meet the following requirements:

- ◆ **Income Limit:** Your income cannot be more than three times the SSI benefit for one person.
- ◆ **Length of Stay:** A 30-consecutive-day stay in a medical or nursing facility is required if your income is more than the basic SSI benefit rate. Payment to the nursing facility can be approved for care you receive during the month that you entered the facility as well as for ongoing care.
- ◆ **Need for Care:** When you live in a nursing facility, you must be approved by the Iowa Foundation for Medical Care as needing the care provided by the nursing facility. Inform the nursing facility when you apply for Medicaid, and they will obtain approval for your care. Without this approval, Medicaid payments will not be made to the facility.
- ◆ **Client Participation:** This refers to the amount of your income you must pay to the medical facility at the beginning of each month for your care while you live in the facility. Medicaid pays the difference between your monthly “client participation” and the Medicaid-approved cost of care in the facility. Certain deductions from your income are allowed in determining client participation. Please see the pamphlet *“Medicaid Information for People in Nursing Homes and Other Facilities,”* for more information (available from your DHS worker).
- ◆ **Other:** Please see the pamphlet mentioned above for a detailed and complete list of requirements for residents of medical facilities. Also see the pamphlet *“Protection of Your Income and Resources,”* which explains how Medicaid can help when a spouse enters a medical facility.

RECEIVING MEDICAL CARE

HOW DO I GET MEDICAL CARD?

When you qualify for Medicaid, you will receive a “*Medical Assistance Eligibility Card*.” The card is good only for each month you are eligible. Carry your card with you and always show it to your medical provider every time you request service. If you lose your card, contact your county DHS office for a replacement. Your card may not be used by any person other than those listed on the card.



CAN I CHOOSE THE MEDICAL PROVIDER?

You generally have free choice of the doctor, dentist, hospital, pharmacy, etc. that provides your medical service. However, if your provider does not participate in the Medicaid program, Medicaid will not pay for the service you receive. To avoid any misunderstanding, you should always show your *Medical Assistance Eligibility Card* and make sure the provider understands that you are a Medicaid recipient before the service is provided.

If your provider of service does not participate in the Medicaid program and you receive a service from that provider, you can be billed. If you or anyone in your household needs mental health services or substance abuse treatment services and is eligible for Medicaid and under age 65, you may be required to receive those services through the Iowa Plan for Behavioral Health. Look at your Medicaid medical card. If you are required to receive mental health or substance abuse through the Iowa Plan, there will be messages on the card including a toll free phone number that you may call for referral or additional information. If there is not a message on your Medicaid medical card, then you are not enrolled with the Iowa Plan and you may choose your own provider for services. If you are enrolled with an HMO, you must seek Mental Health Services through the HMO.

WHEN WILL COVERAGE BEGIN?

Medicaid coverage may begin on the first day of the month that the county DHS office receives your application (except for the QMB program, which begins the first day of the month after DHS determines that you qualify). If you need assistance with medical bills before this time, you may qualify for the three months before you applied for Medicaid (except for the QMB program). Be sure to discuss this with your DHS worker when you apply.

EXAMPLES

Mr. A applies for Medicaid on April 25. He does not have any unpaid medical bills in the three months before the month of his Medicaid application (January, February, and March). On May 12, the county DHS office determines Mr. A qualifies for Medicaid. Coverage begins as of April. If Mr. A had unpaid medical bills in January, February or March, he could have asked the worker to determine if he was eligible for those months.

Mr. B applies for the QMB Medicaid program on June 20. On July 5, DHS determines Mr. B qualifies for Medicaid under the QMB program. Coverage begins on August 1.

WHAT MEDICAL SERVICES ARE COVERED?

The different types of services available through Medicaid are covered only if they are medically necessary. A detailed list and explanation of the services covered and not covered by Medicaid is included in the pamphlet “*Your Guide to Medicaid*.”

If you are eligible only for QMB, Medicaid pays only for the Medicare premiums, deductibles and co-insurance for services covered by Medicare.

If you are eligible only for SLMB or E-SLMB, Medicaid pays only for the Medicare Part B premium.

APPLICATION

HOW AND WHERE DO I APPLY?

When starting the application process, you should contact the Social Security office or the county DHS office to determine if your income is within SSI limits.

If you are living at home and your income and resources are within SSI Limits:

- ◆ Apply for SSI at the district Social Security office. You are also applying for Medicaid at the same time.
- ◆ The Social Security office will determine if you qualify to receive monthly cash assistance under the SSI program. If you qualify, you may also be eligible for Medicaid.
- ◆ Your county DHS office will request additional information from you for the Medicaid program once your application for the SSI program is approved.
- ◆ You should apply at your county DHS office if you want Medicaid coverage only and do not wish to receive SSI cash assistance or believe you may not qualify for SSI.

If you are living at home and your income or resources exceed SSI limits: Apply at the DHS office in the county where you live.

If you are living in a medical facility: Apply at the DHS office in the county where the medical facility is located.

PAYMENT

MUST I PAY ANYTHING FOR MEDICAL CARE?

You may be required to share some of the costs of the services you receive. This sharing is called co-payment. People staying in nursing facilities who are approved for Medicaid to pay for nursing facility care do not have to pay co-payments. If co-payment applies to the service you are receiving, the medical provider will tell you the amount you must pay. See the pamphlet “*Your Guide to Medicaid*” for further information on co-payment.

Except for co-payment, all Medicaid providers are required to accept payments from Medicaid as payment in full for services covered by Medicaid. **No additional costs should be charged to you.** If you get a bill, other than for co-payment, or if you are refused medical care because another bill was not paid by Medicaid, you should call the medical provider or the central DHS office (free) at **1-800-338-8366**. This number is only for problems you have with a bill.

HOW ARE PAYMENTS MADE?

DHS sends a check to the medical provider for services you receive that are covered by Medicaid. When necessary medical care is not available in your community, reimbursement for your transportation cost to the nearest provider is made if you check with your DHS worker prior to traveling. You must file a claim with the county DHS office to receive reimbursement.

CAN I STILL QUALIFY IF I HAVE HEALTH INSURANCE?

The fact that you have other insurance coverage does not affect your eligibility for Medicaid. However, it is your responsibility to keep your DHS worker at the county DHS office informed of any health insurance coverage that you currently have. You should also contact the county office within 10 days if you change insurance companies, or if there is a change in what your insurance policy covers. This includes any health insurance carried by you or by someone other than yourself that provides coverage for you. In fact, if you do have health insurance available to you and you are not on Medicare, the Department may pay the premium under the Health Insurance Premium Payment (HIPP) program. See the pamphlet *“The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients,”* for more information and an application for this program.

WHAT HAPPENS IF I RECEIVE A MEDICAL SETTLEMENT FROM ANOTHER SOURCE?

It is also your responsibility to advise the county DHS office of any accident or injury that you may suffer, if there is a possibility that you may receive a settlement or cash payment because of the accident or injury.

By law, DHS does not need your consent to recover medical payments made on your behalf. DHS may make a claim against any person or company that may be responsible for paying the costs of your medical expenses. If you or your attorney request it, DHS will provide documents or claim forms describing the medical services which have been paid for you. These documents may also be provided to a third party when necessary to establish the extent of DHS's claim.

If you receive a direct payment from another source for medical expenses that were already billed to Medicaid, you must refund this payment to DHS. Failure to do so, or failure to cooperate in establishing another person's or company's liability for your expenses, can result in the termination of your Medicaid coverage.

WHAT IF I AM A MEDICARE BENEFICIARY?

If you have Medicare coverage and are also eligible for Medicaid, Medicare deductibles and coinsurance will be paid through the Medicaid program. In most cases, DHS also pays the Social Security Administration directly for your Medicare and Part B premiums.

Rights and Responsibilities

WHAT ARE MY RIGHTS AS AN APPLICANT OR CLIENT?

Appeals and Hearings: If you are dissatisfied with the actions or lack of action by DHS, you should discuss the matter with your DHS worker. If a satisfactory agreement cannot be reached, you have a right to file an appeal and ask for a hearing. If one is allowed, the hearing will be an informal meeting with an Administrative Law Judge from the Department of Inspections and Appeals in which you can present your complaint. All the facts will be reviewed to see if the decision was correct or should be changed.

You may file an appeal, asking for a hearing, by **writing** to your county DHS office or **writing** to:

**Department of Human Services
Appeals Section 5th Fl
1305 E Walnut St
Des Moines IA 50319-0114**

You may also file an appeal electronically at www.dhs.state.ia.us/appeals.asp. Filing an appeal within 30 days of the date on the *Notice of Decision* that you feel is incorrect can protect your right to a hearing. **Discussions with your worker or other DHS staff do not extend this time limit.**

Filing an appeal prior to the effective date indicated on your *Notice of Decision* that you feel is incorrect can allow your benefits, including Medicaid, to continue until your appeal is heard or decided.

WHAT ARE MY RESPONSIBILITIES?

- ! Present your *Medical Assistance Eligibility Card* each time you request service from any medical provider.
- ! Inform your county DHS office of changes in your address, income, resources or household size (marriages, births, and deaths) and any other changes that may affect your eligibility or the amount of benefits (such as the income and resources of persons who are considered part of your Medicaid eligibility). Please report any changes within 10 days if you are currently receiving benefits and within 5 days if you have applied and there has not been a decision on your application. Reporting promptly helps to make sure that the benefits you receive are correct.
- ! Inform your medical providers of any medical resources that you have (Medicare, insurance, damage suits, etc.).
- ! Notify your county DHS office within 10 days of any changes in your medical resources or health care coverage. You may be required to provide information and proof of any medical resources available to you.
- ! File a claim or application for any income or medical resource that may be available to you. If required, you must also cooperate in the processing of any such claim or application.
- ! Refund to DHS any money that you receive from a person or company to pay medical expenses which would otherwise be paid by Medicaid.
- ! Failure to comply with your responsibilities can result in denial or cancellation of Medicaid. It may also result in the establishment of overpayments for which you will be responsible, or possible prosecution for fraud.