



Iowa Department of Human Services

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GENERAL LETTER NO. 8-F-83

ISSUED BY: Bureau of Financial, Health and Works Supports
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 8, Chapter F, **COVERAGE GROUPS**, pages 2, 16, 17, 31, 32, 115, 116, 129, 145 through 149, 154, 158, 161, 165, 166, 167, 172, 175, 178, 182, and 205, revised.

Summary

Chapter 8-F is revised to:

- ◆ Add the 2014 Social Security cost-of-living increase of 1.5% and update figures affected by this adjustment.
- ◆ Update the resource limits for qualified Medicare beneficiaries (QMB), specified low-income Medicare beneficiaries (SLMB), and expanded low-income Medicare beneficiaries (E-SLMB).
- ◆ Remove references to the IowaCare Program as the program ended on December 31, 2013.

Effective Date

January 1, 2014

Material Superseded

This material replaces the following pages from Employees' Manual, Title 8, Chapter F:

<u>Page</u>	<u>Date</u>
2, 16, 17	September 10, 2010
31, 32	January 27, 2012
115, 116	September 10, 2010
129	July 22, 2011
145-149, 154, 158, 161	January 25, 2013
165, 166	September 10, 2010
167	January 25, 2013
172	September 10, 2010
175	January 25, 2013
178	March 29, 2013
182	September 10, 2010
205	June 1, 2012

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

Coverage Group	Medical Aid Type	Fund Code*	Facility Case Aid Type
Extended Medicaid due to receipt of support	37-0	A, C	
Child Medical Assistance Program (CMAP)	37-2	R	
Mothers and Children (MAC)	92-0	A, C	
Iowa Family Planning Network	90-6	A, C	
Breast and Cervical Cancer Treatment (BCCT)	37-3	A	
Ineligible for FMAP due to residence in a medical institution	30-8	A, C	37-7 People under 21 in PMIC or MHI 39-0 Nursing facility care 73-1 Skilled nursing care
SSI recipient in own home; recipient of mandatory supplements	14-0 64-0	1 1, 2	
SSI recipient in medical institutions	13-1 13-7 14-0 63-1 64-0 63-3 14-0 63-8 64-0	1 1 1 1, 2 1, 2 1, 2 1 1, 2 1, 2	13-1 Aged, nursing facility 13-7 Aged, MHI 63-1 Disabled, nursing facility 63-3 State resource center ICF/MR 63-8 Community-based ICF/MR
Eligible for SSI but not receiving SSI benefits	14-3 64-3	A A, C	
Essential person	14-2 64-2	A A, C	
Ineligible for SSI or SSA due to requirements that do not apply to Medicaid	14-2 64-2	A A, C	

Notice Requirements and Appeal Rights

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

Presumptive eligibility is granted on a daily basis. Eligibility 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 with a spenddown. 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 with a spenddown), 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 medical claims she has incurred for services that are 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 with a spenddown 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 she 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.

The age requirement does not apply to women who have a pregnancy end while they are on Medicaid. Assume that a woman who applies for IFPN or has a pregnancy end while on Medicaid is of reproductive age.

Other Medical Coverage

Legal reference: 441 IAC 75.1(41)"a"

Policy:

A person who is not otherwise enrolled in Medicaid may be eligible for IFPN.

- ◆ A woman whose pregnancy ends while the woman is on Medicaid is eligible for IFPN. This includes Medicaid eligibility through Medically Needy with a spenddown or a Medicare Savings Plan.
- ◆ A person who is covered under group or private health insurance is eligible for IFPN if the person claims good cause for not cooperating in filing a claim for health insurance. A person can claim good cause due to confidentiality if the person is fearful of the consequences.

NOTE: Do not complete form 470-2826 or 470-2826(S), *Insurance Questionnaire*, when a person can claim good cause for confidentiality.

1. Ms. D receives Medicaid under the FMAP coverage group. She gives birth to a second child on March 25. The FPW system establishes an IFPN case for Ms. D for the months of March through May of the following year. Ms. D continues to be eligible for FMAP with IFPN as underlying eligibility.

Ms. D is subsequently canceled from FMAP effective July. IFPN automatically becomes the primary coverage beginning in July and will continue through May of the following year.
2. Ms. M, age 17, lives with her parents. She does not want them to know she is seeking family planning services. She can claim good cause.
3. Mrs. K is married. Her husband has health insurance that covers family planning services. Mrs. K's husband does not want her to receive family planning services. If Mrs. K claims good cause and she is otherwise eligible, she could receive IFPN.
4. Ms. S lives by herself and has health insurance that covers family planning services. She cannot claim good cause and is not eligible for IFPN.

IFPN eligibility does **not** exist for:

- ◆ A woman whose delivery was covered under the emergency coverage group. See 8-L, [Limited Eligibility for Certain Aliens](#).
- ◆ A teen who is enrolled in **hawk-i**. Call **hawk-i** Customer Service at 1-800-257-8563 to verify **hawk-i** enrollment. If a teen becomes enrolled after IFPN is approved, the IFPN Help Desk will notify you to close the teen's IFPN case.
- ◆ A person who is currently receiving Medicaid and whose eligibility for IFPN was **based** on income at or below 300% of the federal poverty level.

Household Size

Legal reference: 441 IAC 75.1(41)"c"(1)

The household size includes the following people living together who are not receiving Supplemental Security Income:

- ◆ The person who is applying for or receiving IFPN benefits,
- ◆ The person's spouse, and
- ◆ The person's dependent children.

A mandatory household member cannot be excluded.

1. Ms. M, age 17, lives with her parents. She has no spouse and no children. Her household size is one.
2. Ms. S, age 17, has a one-year-old child and lives with her parents. Her household size is two.
3. Ms. F, age 43, lives with her spouse who receives SSI. Her household size is one.
4. Mr. H, age 36, lives with his spouse and two children, ages 5 and 8. One child receives SSI. His household size is three.

However, since the income is below 300% 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. See 8-J, [Applying Medical Expenses to Spenddown](#), for more information on attaining Medically Needy eligibility.

2. Mr. and Mrs. V, Child A (age 6 months), Child B (age 18 months) and Child C (age 14 years) apply for Medicaid. Mr. V has earned income of \$3,000 per month. Mrs. V has earned income of \$2,000 per month. Mrs. V verifies monthly child care of \$200.

To establish MAC eligibility, income is considered as follows:

<u>Mr. V</u>		<u>Mrs. V</u>	
\$ 3,000	Gross monthly income	\$ 2,000	Gross monthly income
– <u>600</u>	20% earned income ded.	– <u>400</u>	20% earned income ded.
\$ 2,400	Countable earned income	\$ 1,600	
		– <u>200</u>	Child care expense
		\$ 1,400	Countable earned income

Since the couple's total countable earned income of \$3,800 does not exceed 300% 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:

<u>Mr. V</u>		<u>Mrs. V</u>	
\$ 3,000	Gross monthly income	\$ 2,000	Gross monthly income
– <u>600</u>	20% earned income ded.	– <u>400</u>	20% earned income ded.
\$ 2,400	Countable earned income	\$ 1,600	
		– <u>200</u>	Child care expense
		\$ 1,400	Countable earned income

\$ 3,800 Total countable earned income
– 733 MNIL for a five-member household
\$ 3,067
x 2 Months
\$ 6,134 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.

Child B and Child C are referred to the *hawk-i* program.

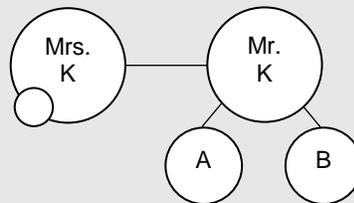
Composite MAC/FMAP Households

When establishing MAC eligibility for household members who are not included in the FMAP eligible group:

- ◆ Do not consider the needs or income of people who are receiving FMAP benefits.
- ◆ Do not consider any income that has been diverted to the FMAP eligible group.
- ◆ Do not count any FIP grant received. 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 age 9, Mr. K's child
Child B age 7, Mr. K's child



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

A child entering a household during the 12-month continuous eligibility period shall be assigned the same annual review date as other children in the eligible group, rather than be given a different 12-month period of continuous eligibility.

A child (not in "newborn" status) who turns one year old remains continuously eligible until the annual review, regardless of the change in the income limit when the child reaches age one.

Minor parents and children under the age of 19 who are representing themselves must cooperate with the Department in order to be eligible for Medicaid.

1. Mrs. O and her 6-year-old apply for Medicaid in April. Eligibility is denied for April but approved for May and ongoing. Continuous eligibility begins with the month of May and continues until the next annual review.
2. Mr. and Mrs. G and their two children, ages 3 and 15, begin receiving Medicaid under FMAP on May 1. The children are continuously eligible from May 1 through April 30.

On July 5, Mr. G reports that he started a new job. Since the parents receive Medicaid, verification of the new income is requested. Verification received July 18 indicates that family income is now over FMAP limits.

The worker determines that the family is not eligible for Transitional Medicaid and automatically redetermines eligibility for the parents to Medically Needy (MN). The children remain continuously eligible for Medicaid under FMAP with the parents as considered persons.

At the next annual review, if family income still exceeds FMAP limits, eligibility for the children will be examined under MAC or MN or the children will be referred to *hawk-i*.

3. Mr. F's 12-year old son, Tom, receives Medicaid under MAC and is continuously eligible. Mr. F reports a new job and the countable income exceeds 133% of the federal poverty level.

Since Mr. F is not receiving Medicaid and Tom is continuously eligible, the new income is not verified or entered into the computer system. Eligibility is examined at the next annual review based on the family's projected income.

Before the next annual review, Mr. F's other son, Jim, age 15, moves in. Jim has child support income that would otherwise make the eligible group over income. However, the household's income for the children is not considered until the next annual review.

To examine 503 eligibility:

1. Determine if the person had concurrent eligibility for both social security and SSI or State Supplementary Assistance (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. Multiply that entitlement by the percent of increase in the COLA for each year since cancellation using the table that follows.

July 1977	5.9%	January 1996	2.6%
July 1978	6.5%	January 1997	2.9%
July 1979	9.9%	January 1998	2.1%
July 1980	14.3%	January 1999	1.3%
July 1981	11.2%	January 2000	2.5% *
July 1982	7.4%	January 2001	3.5%
1983	0	January 2002	2.6%
January 1984	3.5%	January 2003	1.4%
January 1985	3.5%	January 2004	2.1%
January 1986	3.1%	January 2005	2.7%
January 1987	1.3%	January 2006	4.1%
January 1988	4.2%	January 2007	3.3%
January 1989	4.0%	January 2008	2.3%
January 1990	4.7%	January 2009	5.8%
January 1991	5.4%	January 2010	0
January 1992	3.7%	January 2011	0
January 1993	3.0%	January 2012	3.6%
January 1994	2.6%	January 2013	1.7%
January 1995	2.8%	January 2014	1.5%

* The 2000 amount was adjusted for a CPI error.

Add the result to the immediately preceding entitlement. Use that total to calculate the next increase, if any.

Before July 1982, the Social Security Administration **rounded** COLA benefits to the nearest dime (e.g., \$179.555 became \$179.60). Since July 1982, Social Security has **dropped** benefits to the nearest dime (\$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 so, 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.

Mr. A's current gross social security income is \$900. He was canceled in May 1998. His gross social security income was then \$461.60.

To determine his eligibility, the worker must determine what his gross social security would be if he received only COLA increases since his cancellation. If there were no increases other than COLAs, this calculation should equal the current gross social security of \$900. Allow for the \$2 difference due to rounding.

<u>Date of COLA</u>	<u>% of COLA</u>	<u>Result Before Rounding</u>	<u>Entitlement</u>
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	515.8218	\$515.80
1-04	2.1	526.6318	\$526.60
1-05	2.7	540.8182	\$540.80
1-06	4.1	562.9728	\$562.90
1-07	3.3	581.4757	\$581.40
1-08	2.3	594.7722	\$594.70
1-09	5.8	629.2690	\$629.20
1-12	3.6	651.8512	\$651.80
1-13	1.7	662.8806	\$662.80
1-14	1.5	672.7420	\$672.70

These calculations show that if there were no other increase, the current gross social security income would be \$672.70. Since the actual amount is \$900.00, the conclusion is that there was an increase of \$227.30 in social security benefits other than COLAs.

5. Determine countable income by adding:
- ◆ The social security benefit at the time of cancellation,
 - ◆ Any increase other than the COLA increases calculated in Step 4, and
 - ◆ Any other current income.

Do not deduct overpayments from the gross social security entitlement. Allow all disregards of income as provided by SSI or State Supplementary Assistance (SSA).

Compare this countable income to the current income limit 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 August 1986. Her gross social security benefit in August 1986 was \$360.40 and her gross is now \$863.00. She also has VA benefits of \$57 monthly, for a total income of \$920.

The worker determines that there was an increase in social security other than COLAs. The Social Security Administration verifies this amount to be \$140 monthly.

To calculate income eligibility for SSI:

\$ 360.40	Social security at time of SSI cancellation
+ 140.00	Non-COLA social security income
+ <u>57.00</u>	Veterans income
\$ 557.40	
- <u>20.00</u>	General income exclusion
\$ 537.40	Countable income to compare to \$721, the need standard for her current situation. Since countable income is less than need, Mrs. Z 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 2005 when she was canceled from SSI. She continues living independently, and now has \$599.00 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 \$140 per month attributable to a non-COLA increase.

The calculation of income eligibility is as follows:

\$ 394.90	Social security in March 1995
+ <u>140.00</u>	Non-COLA increase
\$ 534.90	
+ <u>217.50</u>	Countable earned income (\$500 - 65 ÷ 2)
\$ 752.40	
- <u>20.00</u>	General income exclusion
\$ 732.40	Countable income

Miss Y's countable income is over the SSI income limit of \$721 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. He is still in an RCF. His current gross social security is \$1,039. The State Supplementary Assistance per diem rate that has been established for the RCF that Mr. W lives in is currently \$25.20 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:

\$25.20 per diem in the RCF x 31 =	\$ 781.20
Personal need	+ <u>100.00</u>
Need standard	\$ 881.20

The countable income is \$725, 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. He still will 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 \$581 and Mrs. B now has gross social security of \$288. Mr. B started to receive a veterans pension in 1994, which is now \$300 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
+ <u>165</u>	Mrs. B's social security in 1/91
\$ 498	
+ <u>300</u>	Veterans benefits
\$ 798	
- <u>20</u>	General income exclusion
\$ 778	Net countable income

Mr. and Mrs. B are eligible for Medicaid under the 503 coverage group, since their countable income of \$778 is less than their need standard of \$1,082.

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 State Supplementary Assistance (SSA) income limit.

Mrs. M, a 63-year-old widow living alone in her home, received SSI and social security income in 1983. She 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 \$535.00 in social security benefits and \$269 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.

\$ 535.00	Current gross social security
- 35.00	Actuarial increase
- <u>120.70</u>	COLA
\$ 379.30	
+ <u>269.00</u>	Civil service income
\$ 648.30	
- <u>20.00</u>	General income exclusion
\$ 628.30	The worker compares this computed income to \$721 (the current SSI benefit level for one person)

Mrs. M continues to be eligible for this coverage group, since her income is less than the SSI benefit rate.

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, Ms. J's resources are \$2,200. As of August 1, her resources are reduced to \$1,900.

For the month of July, eligibility is determined under the Medically Needy group. Beginning August 1, because Ms. J's income is less than the SSI payment standard for one person living at home and her resources are then less than the SSI resources standard, her correct Medicaid coverage group is "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 \$2,163. If both spouses enter a medical institution and live in the same room, the income limit is two times \$2,163, or \$4,326.

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 \$2,163. If **both** spouses enter a medical institution and live in the same room, the income limit is two times \$2,163 or \$4,326.

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](#).

The Social Security Administration verifies that a 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. J, aged 31, has a disabling medical condition and continues to work. The Social Security Administration 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. J applies for QDWP. He has \$2,200 in gross monthly earnings. Mrs. J, aged 30, has \$1,500 in gross earnings. They have one child, aged 10, who has no income.

Step 1: Determine if Mr. J is eligible.

\$ 2,200.00	Gross monthly earnings
— <u>20.00</u>	Income exclusion
\$ 2,180.00	
— <u>65.00</u>	Work exclusion
\$ 2,115.00	
— <u>1,057.50</u>	1/2 remainder
\$ 1,057.50	Mr. J's net countable income is below 200% of the poverty level for a household size of one

Step 2: To determine income eligibility for Mr. J, income is diverted to the ineligible child. A maximum of \$361 may be allowed to meet the child's needs. Mrs. J is an ineligible spouse because she is not disabled and is not entitled to Medicare Part A.

\$ 1,500	Mrs. J's gross earned income
— <u>361</u>	Allocated for the ineligible child
\$ 1,139	Amount of income to deem from Mrs. J, the ineligible spouse, to Mr. J.

Step 3: Mr. and Mrs. J's earned income is added together:

\$ 1,139.00	Mrs. J's earned income after the deeming
+ <u>2,200.00</u>	Mr. J's gross earned income
\$ 3,339.00	
- <u>20.00</u>	Income exclusion
\$ 3,319.00	
- <u>65.00</u>	Work exclusion
\$ 3,254.00	
- <u>1,627.00</u>	1/2 remainder
\$ 1,627.00	Net countable income

The \$1,627.00 is compared to 200% of the poverty level for Mr. and Mrs. J, a two-person household. Mr. J 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 reference: P. L. 100-360, 441 IAC 75.1(29)

People who are entitled to hospital insurance under Medicare Part A may be eligible for benefits through the "qualified Medicare beneficiary" (QMB) coverage group. 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.

Under QMB, Medicaid pays **only** for the person's Medicare Part A and B premiums, coinsurance, and deductibles, unless the person is also concurrently eligible for full Medicaid benefits under another coverage group. NOTE: Persons are not eligible for QMB if they reside in an MHI and are over age 21 and under age 65.

To be eligible for QMB, a person must meet all of the following requirements:

- ◆ Is entitled to Medicare Part A.
- ◆ Has net countable 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.)

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.

- ◆ Has 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 \$7,160 for an individual and \$10,750 for a couple.
- ◆ Meets all other SSI-related Medicaid nonfinancial eligibility requirements except for disability determination and age.

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 is 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.

4. Mr. A, age 43, is disabled and is entitled to Medicare. He has \$846 monthly gross social security disability. Mrs. A, age 40, has \$211 monthly gross social security. Child A, age 15, has \$211 monthly gross social security.

Step 1: The worker determines if Mr. A is eligible.

\$ 846	Monthly social security
– <u>20</u>	Income exclusion
\$ 826	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 \$361 may be allocated to meet the needs of the child, from Mrs. A, the ineligible spouse.

\$ 211	Mrs. A's gross unearned income
– <u>150</u>	Allocation for ineligible child since the child has \$211 income
\$ 61	(\$361 – \$211)

\$61 is less than \$361. 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.

\$ 846	Mr. A's gross social security
– <u>20</u>	Income exclusion
\$ 826	Net countable income

The \$826 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.

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.

- ◆ 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 \$7,160 for an individual and \$10,750 for a couple. See 8-D, [General SSI-Related Resource Policies](#).
- ◆ Meets all other nonfinancial SSI-related Medicaid eligibility requirements except for disability determination and age.

Medicaid will pay the **only** cost of the Medicare Part B premiums for these “specified low-income Medicare beneficiaries” (SLMBs). Medicare copayments, deductibles, and Part A are not covered for this coverage group.

NOTE: People applying for SLMB may refer to the coverage group as the “Medicare savings program,” since Medicare uses this term to identify the SLMB group.

A person who wants this coverage must enroll in Medicare Parts 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 affect 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 Part 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.

When Medicaid eligibility ends, the client is responsible for paying the Medicare Part B premiums.

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.

Expanded Specified Low-Income Medicare Beneficiaries (QI-1)

Legal reference: 441 IAC 75.1(36)

Medicaid will pay the cost of the Medicare Part B premiums for “expanded specified low-income Medicare beneficiaries” (expanded SLMBs). 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.

Part B premiums are the **only** service Medicaid covers for this group. Medicare copayments, deductibles, and Part A premiums are not covered. People eligible only for the E-SLMB coverage group do not receive a *Medical Assistance Eligibility Card*.

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 net countable 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	\$1,149	\$1,293
Couple	\$1,551	\$1,745

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.

- ◆ 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 \$7,160 for an individual and \$10,750 for a couple. (See 8-D, [General SSI-Related Resource Policies](#).)
- ◆ Meets all other SSI-related Medicaid nonfinancial eligibility requirements except for disability determination and age.
- ◆ Is not eligible for any other Medicaid coverage group. (If a person is approved for Medically Needy with a spenddown, the person can receive E-SLMB until the spenddown is met.)

Comment:

When SSA denies a disability due to substantial gainful activity (SGA), the decision is based on verification that the person has earnings of at least \$1,070 per month from work. The only payment status code on the SDX that means disability was denied due to substantial gainful activity is N44. If a person's SDX has code N44, process a disability determination for MEPD.

Payment status codes of N31, N32, N42, or N43 indicate denials of disability based on "capacity for substantial gainful activity." This means that, despite a medical impairment, the person has the ability to perform sedentary, light, or medium work that would allow the person to return to customary past work or other work. Do not process a disability determination when the person has one of these codes.

See 8-C, [Presence of Age, Blindness, or Disability](#). Note that attaining substantial gainful activity (SGA) is not considered in determining disability for the MEPD group. See 8-C, [When the Department Determines Disability](#).

Income From Employment

Legal reference: 441 IAC 75.1(39)"a"(4)

Policy:

To qualify for MEPD, the applicant must have earned income from employment or self-employment. "Self-employment" is defined as providing income directly from one's own business, trade, or profession.

Procedure:

Determine whether the applicant has earned income from employment in the month of decision.

- ◆ If the applicant does not have earned income in the month of decision, do not approve current or ongoing eligibility. An exception for ongoing eligibility is found under [Intent to Return to Work if Employment Ends](#).
- ◆ If the applicant had earned income in the month of application or in the retroactive months, but has no earned income during the month of decision,
 - Approve the months with earned income, and
 - Deny current and ongoing eligibility.

Procedure:

The MEPD member returns the coupon from the *MEPD Billing Statement* with the payment in the prepaid envelope provided by the Department. The address on the billing coupon is:

Iowa Medicaid Enterprise
MEPD Premium
P. O. Box 10339
Des Moines, IA 50306-0339

If a member brings the premium payment to the local office, do not accept it. Instead, reprint the billing statement for the member so the member will have a coupon to mail in with the payment. See 14-C, [STMT = MEPD Billing Statement Screen](#).

Local offices should maintain a supply of the MEPD envelopes, form 470-3724, to give to members who misplace the envelopes included with the billing statement. Order envelopes for MEPD premium payments from the Supply Unit, Level A, in central office by e-mailing: Supply@dhs.state.ia.us.

If an MEPD member asks questions about the posting of premium payments, do not tell the member to contact Member Services. Member Services **does not process** the payments. Instead, contact the DHS, SPIRS Help Desk for assistance.

Comment:

See 6-Appendix, [MEPD Billing Statement](#)
See 14-C, [STMT = MEPD Billing Statement Screen](#)