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Employees' Manual
Title 8
Chapter F

MEDICAID COVERAGE GROUPS



Iowa Department
of Human Services

	<u>Page</u>
Overview	1
Summary of Aid Types and Fund Codes	1
Presumptive Eligibility for Children	5
Income Guidelines	5
Citizenship.....	6
Length of Presumptive Period	6
IM Responsibilities	8
Notice Requirements	8
Appeal Rights	9
Pregnant or Postpartum Women and Newborns	10
Presumptive Eligibility for Pregnant Women.....	10
Application Processing	12
Income Guidelines	13
After an Eligibility Decision Has Been Made.....	14
Notice Requirements and Appeal Rights	16
Continuous Eligibility for Pregnant and Postpartum Women.....	16
Postpartum Eligibility.....	19
Newborn Children of Medicaid-Eligible Mothers.....	22
Duration of Coverage	24
When the Newborn Reaches Age One	27
Iowa Family Planning Network	29
Application Processing	29
Choice of IFPN Eligibility	30
Effective Date of IFPN Eligibility	30
Nonfinancial Eligibility.....	30
Age.....	30
Other Medical Coverage.....	31
Claiming Confidentiality	32
Household Size.....	32
Income	33
Countable Income.....	33
Deductions From Gross Income	34
Case Maintenance.....	36
Reporting Requirements	36
Acting on Reported Changes.....	36
Annual Recertifications	37
Transferring Case Records.....	38

	<u>Page</u>
Breast and Cervical Cancer Treatment.....	38
Responsibilities of the Screening Program	39
Referrals to a BCCEDP	40
Referrals When Screening Was Paid Through Komen Funds.....	41
Application Processing	41
Mandatory Medicaid Coverage Groups.....	43
Eligibility Period	44
Retroactive Coverage Under BCCT.....	45
Length of Treatment	46
Responsibilities of the Client.....	47
Annual Review	48
Notice of Decision	49
Case Maintenance.....	50
Health Insurance Changes.....	50
Reporting Changes to Quality Assurance	51
Replacing Lost Medical Assistance Eligibility Cards	51
Automatic Redetermination for BCCT	52
Presumptive Eligibility	53
Application Processing	54
Evidence of Presumptive Eligibility.....	55
Presumptive Eligibility Period.....	55
Notice Requirements and Appeal Rights	57
FMAP-Related Coverage Groups	57
Family Medical Assistance Program (FMAP).....	58
People Who Are Ineligible for FMAP	61
Ineligible Due to Receipt of Support (Extended Medicaid)	61
Adding People to the Eligible Group	62
Transitional Medicaid.....	63
Determining Eligibility	66
Requirements After Eligibility Is Established.....	71
Notices and Reporting	72
Income Requirements	75
Good Cause for Failing to Report or Meet Earnings Requirement	77
Effective Date of Change	79
Adding People to the Eligible Group.....	81
TM Review Requirements.....	84
Ineligible for FMAP Due to Residence in a Medical Institution.....	85
Child Medical Assistance Program (CMAP)	86
CMAP Income Guidelines.....	86
People Living Apart From Parents or Spouse	87
People Living in FMAP or MAC Households	88
People Living With Parents	89
People Living With a Spouse.....	90

	<u>Page</u>
Mothers and Children (MAC) Program	92
Eligibility Requirements	93
MAC Resource Limit	97
MAC Income Limits	99
Income Requirements	100
Determining Countable Income.....	102
Receipt of Lump Sum	104
Express-Lane Eligibility for MAC	108
Composite MAC/Medically Needy Households	114
Composite MAC/FMAP Households.....	116
Continued MAC Coverage of Children Receiving Inpatient Care.....	118
Medicaid/ <i>hawk-i</i> Composite Families.....	120
People in a Medical Institution Within the 300% Income Limit	122
Medicaid for Independent Young Adults (MIYA)	122
Eligibility Requirements	123
Household Size.....	124
MIYA Income Limits	125
Income Requirements	126
Determining Countable Income.....	126
Verification of Income	127
Change in Income.....	127
Reporting Requirements	128
Information Provided.....	128
Continuous Eligibility for Children.....	128
Foster Care, Adoption or Guardianship Subsidy, Waiver, or PMIC.....	130
Exceptions to Continuous Eligibility for Children.....	131
New Continuous Eligibility Period.....	132
Cooperation with DIA and QC	132
Child Ages Out of the Current Coverage Group.....	132
Transitional or Extended Medicaid	134
Newborn Status.....	135
Pregnant Woman	136
Ending Continuous Eligibility.....	136
SSI-Related Coverage Groups	137
SSI Recipients.....	138
Continuous Eligibility for SSI-Related Children	139
Essential Persons.....	139
People Eligible for SSI Benefits But Not Receiving Them	140
SSA Recipients and Dependent Relatives.....	140

	<u>Page</u>
People Ineligible for SSI (or SSA).....	141
Due to Requirements That Do Not Apply to Medicaid.....	141
Due to Social Security COLAs (503 Medical Only)	142
Due to Social Security Benefits Paid From Parent's Account.....	150
Due to Social Security Increase of October 1972	151
Due to Earnings Too High for an SSI Cash Payment (1619b Group).....	152
Due to Actuarial Change for Widowed Persons	153
Due to Receipt of Widow's Social Security Benefits	155
Due to Reevaluation of Childhood Disability	156
People in Medical Institutions	157
Ineligible for SSI Due to Residence in a Medical Institution	157
300% Income Level	158
People in Medicare Savings Programs	162
Qualified Disabled and Working People (QDWPs)	162
Qualified Medicare Beneficiaries (QMBs)	166
Relationship Between QMB and Other Coverage Groups	174
Specified Low-Income Medicare Beneficiaries (SLMBs)	174
Relationship Between SLMB and Other Coverage Groups	177
Expanded Specified Low-Income Medicare Beneficiaries (QI-1).....	178
Medicaid for Employed People With Disabilities.....	180
Age.....	180
Disability	181
Income From Employment	182
Intent to Return to Work if Employment Ends	184
Resources.....	187
Family Income Less Than 250% of Federal Poverty Level.....	188
Premiums	191
Months Between Application Date and Approval Date	193
Retroactive Months	194
How to Establish Premium Periods.....	194
Blocking Premium Payments	200
Premium Billing, Due Dates and Collection	201
Payment Address.....	204
Posting of Premium Payments	206
Relationship to Medically Needy	209
Relationship to QMB and SLMB Coverage	211
Medicaid for Kids With Special Needs (MKSN)	212
Age.....	212
Disability	213
Family Income Limits	214
Health Insurance Enrollment	215
MKSN Case Examples.....	218

Overview

This chapter provides the Medicaid eligibility standards for Family Medical Assistance (FMAP)-related and Supplemental Security Income (SSI)-related coverage groups. For additional coverage groups available to some children, see 8-H, [FOSTER CARE, ADOPTION AND GUARDIANSHIP SUBSIDY](#).

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 sections explain the coverage groups for women who need family planning services or treatment for breast or cervical cancer. FMAP-related and SSI-related policies do not apply to these coverage groups.

The fourth section describes coverage groups for families and children that derive most of their eligibility requirements from the FMAP-related groups, followed by a similar section for coverage groups that are based on the general policies of the 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 Assistance.

Coverage Group	Medical Aid Type	Fund Code*	Facility Case Aid Type
Family Medical Assistance Program (FMAP)	30-8	A, C	
Transitional Medicaid (TM)	37-0	A, C	

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	

Summary of Aid Types and Fund Codes

Coverage Group	Medical Aid Type	Fund Code*	Facility Case Aid Type
Ineligible for SSI or SSA due to Social Security COLAs (503 medical only)	14-2	A	
	64-2	A, C	
Ineligible for SSI or SSA due to Social Security benefits paid from parent's account	14-2	A	
	64-2	A, C	
Ineligible for SSI or SSA due to Social Security increase of October 1972	14-2	A	
	64-2	A, C	
Ineligible for SSI due to substantial gainful activity (1619b)	14-0	1	
	64-0	1, 2	
Ineligible for SSI or SSA due to actuarial change for widowed persons	14-2	A	
	64-2	A, C	
Ineligible for SSI or SSA due to receipt of widow's social security benefits	14-2	A	
	64-2	A, C	
Ineligible for SSI due to residence in a medical institution	13-0	A	13-0 Aged, nursing facility
	13-8	A	13-8 Aged, MHI
	63-0	A, C	63-0 Disabled, nursing facility
	63-2	A, C	63-2 Resource center ICF/MR
	63-7	A, C	63-7 Community ICF/MR
	73-1	A, C	73-1 Skilled nursing care
In a medical institution and under the 300% income level	13-6	A	13-6 Aged, nursing facility
	37-7	C	37-7 Child, MHI or PMIC
	63-6	A, C	63-6 Disabled, nursing facility
	73-1	A, C	73-1 Skilled nursing care
	73-2	A, C	73-2 Resource center ICF/MR
	73-3	A, C	73-3 Community ICF/MR
	73-4	A, C	73-4 Hospital
	73-5	A	73-5 MHI

Coverage Group	Medical Aid Type	Fund Code*	Facility Case Aid Type
Qualified disabled and working people (QDWPs)	90-2 QMB indicator W	9	
Qualified Medicare beneficiaries	90-0 90-2 QMB indicator Q	9 9	
Specified low-income Medicare beneficiaries	90-0 90-2 QMB indicator L	9 9	
Expanded specified low-income Medicare beneficiaries	90-0 90-2 QMB indicator E	9 9	
Medically Needy	37-E	A, C, P, S, R	
Medicaid for employed people with disabilities	60-M	A, C, P	
Medicaid for kids with special needs	64-7	C	
Presumptive eligibility for pregnant women	88-8	A	
Presumptive eligibility for breast and cervical cancer treatment (BCCT)	88-9	A	
Presumptive eligibility for children	88-5	C	

* Explanation of fund codes:

- | | |
|----------------------------|-------------------------------------|
| A = Adult, Medicaid only | 1 = Adult, receives cash assistance |
| C = Child, Medicaid only | 2 = Child, receives cash assistance |
| P = Conditionally eligible | 3 = Adult, state funding only |
| R = CMAP | 4 = Child, state funding only |
| S = Considered person | 9 = Limited benefits |

Presumptive Eligibility for Children

Legal reference: 441 IAC 75.1(44); Sec. 1920A of the Social Security Act

Policy:

Children under the age of 19 who have been identified as being potentially eligible for Medicaid or **hawk-i** may be presumed eligible by a “qualified entity” and may receive temporary Medicaid coverage pending a formal eligibility determination by the Department. A child determined to be presumptively eligible is eligible for full Medicaid benefits during the presumptive period.

Eligibility is based on the statements made by the family on the application. There are no verification requirements for the presumptive eligibility program. A child cannot be determined presumptively eligible more than once in a 12-month period of time.

Procedure:

| The family shall complete form 470-4855, *Application: Presumptive Health Care Coverage for Children*. The qualified entity uses the information provided on the application to make entries into the presumptive eligibility system via the provider portal for an eligibility determination.

The qualified entity shall print a notice of decision indicating the result and give it to the applicant. Both approved and denied presumptive applications will automatically be sent to the Department for a formal Medicaid eligibility determination.

Comment:

Whether a child is currently receiving Medicaid or **hawk-i** is self-declared on the presumptive application. The presumptive eligibility system will capture whether a child has already received presumptive coverage in the past 12 months.

Income Guidelines

Policy:

In order for a child to be determined presumptively eligible, gross family income cannot exceed 300% of the federal poverty level for the family size.

Procedure:

When comparing family income to the limits, the income of all related siblings under age 19 and their parents is considered. No deductions are allowed. The qualified entity shall accept the statements of the family on the application regarding the family income when determining presumptive eligibility.

Citizenship

Policy:

Only children who are citizens or qualified aliens may be determined presumptively eligible.

Procedure:

Verification is not required. The qualified entity shall accept the statements of the family on the application regarding the child's status when determining presumptive eligibility.

Comment:

Although verification of citizenship status is not required to establish presumptive eligibility, verification is required to establish ongoing Medicaid eligibility. Refer to [8-C, Citizenship](#), for more information.

Length of Presumptive Period

Legal reference: 441 IAC 75.1(44)"d"

Policy:

Presumptive eligibility is granted on a daily basis. The presumptive eligibility period begins with the date on which a qualified entity determines that the child is eligible for the presumptive eligibility program.

The presumptive eligibility period ends with the earliest of the following:

- ◆ The day Medicaid eligibility is established, or
- ◆ The last day of the month when **hawk-i** eligibility is established, or
- ◆ The day Medicaid eligibility is denied if no referral to **hawk-i** is made, or
- ◆ The day **hawk-i** eligibility is denied, or

- ◆ The last day of the next calendar month if:
 - The application for Medicaid is withdrawn and a referral to **hawk-i** is not done, or
 - The application is not pended on the Automated Benefit Calculation (ABC) system.

Procedure:

When the qualified entity makes entries into the presumptive eligibility system from the presumptive application, the OASIS application is populated and sent to the Department. The Department must pend the OASIS application on the ABC system to ensure that presumptive eligibility does not end prematurely.

Refer an application to the **hawk-i** program when Medicaid is denied for a presumptively eligible child because family income exceeds Medicaid limits.

Comment:

Presumptive eligibility continues until a final decision is made on the Medicaid application by the Department. This includes situations where a child has been determined over income for Medicaid and has been referred to the **hawk-i** program. If Medicaid is denied for some other reason and a referral to **hawk-i** is not made, presumptive eligibility ends on the day of the Medicaid decision.

1. The school nurse determines that Billy is presumptively eligible on April 2. The application is forwarded to the Department. On April 6, the IM worker requests income verification from the family to establish eligibility for ongoing Medicaid benefits.

The family does not provide the requested information by the due date of April 16. The IM worker issues a *Notice of Decision* denying Medicaid eligibility on April 17. Billy's presumptive eligibility ends on April 17.

2. Same situation as Example 1 except the family does provide income verification as requested. The IM worker determines that the child is over income for Medicaid. The worker issues a *Notice of Decision* denying Medicaid eligibility and makes a referral to the **hawk-i** program on April 17.

On April 18, it is determined that the child is eligible for **hawk-i** beginning May 1. Presumptive Medicaid eligibility continues until April 30.

3. Same situation as Example 2 except that on April 18 the Department's third-party administrator determines that **hawk-i** eligibility does not exist and issues a *Notice of Decision* denying **hawk-i** coverage. Presumptive Medicaid eligibility also ends April 18.

IM Responsibilities

Legal reference: 441 IAC 75.1(44)“b”

Policy:

A full Medicaid eligibility determination shall be completed on all presumptive applications. This includes approved and denied presumptive applications.

If the family income is over Medicaid limits when determining ongoing Medicaid eligibility, the child shall be referred to the *hawk-i* program.

Procedure:

The qualified entity will enter presumptive applications into the presumptive eligibility system. This process will generate an OASIS application to the Department. The OASIS application notes at the top of the first page: “This application is the result of presumptive determination. Some State IDs are established already.”

All approved presumptive applications must be pended on the ABC system so that presumptive eligibility does not end prematurely.

Use the state identification (SID) number associated with the child’s name on the OASIS application when you pend the case on ABC. The SID number will be listed on the application with the name. Using the SID will ensure that the presumptive period will end at the appropriate time.

If there is a duplicate SID number, after the presumptive period has ended, contact Quality Assurance (QA) to remove the duplicate SID number.

Comment:

Presumptive eligibility is a day-to-day Medicaid program. When presumptive eligibility ends due to reasons listed under [Length of Presumptive Period](#) and a mistake was made, there is no way to reinstate the presumptive eligibility.

Notice Requirements

Policy:

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

Adequate and timely notice requirements do not apply to a child who is:

- ◆ Denied presumptive eligibility by a qualified entity, or
- ◆ Determined to be presumptively eligible by a qualified entity but whose presumptive eligibility ends due to a denial as the result of a formal Medicaid or **hawk-i** eligibility determination.

Comment:

The initial notice of decision informs the family that the application will be forwarded to the Department for a formal Medicaid eligibility determination. If presumptive eligibility has been approved, the notice of decision also:

- ◆ Serves as proof of the child's presumptive coverage (instead of a *Medical Assistance Eligibility Card*).
- ◆ Indicates the date on which the presumptive eligibility period begins.
- ◆ Indicates the date on which the presumptive eligibility period ends.
- ◆ Explains to the family that the application will be sent to the Department for a formal Medicaid determination.
- ◆ Tells the provider to access the Eligibility Verification System (ELVS) before providing services to make sure there has been no change in the child's coverage, since presumptive eligibility is granted on a daily basis.

Appeal Rights

Policy:

There are no appeal rights under the presumptive program because presumptive health care coverage is temporary and is not a formal determination for ongoing Medicaid coverage. Appeal rights are allowed when an eligibility decision is made regarding ongoing Medicaid or **hawk-i** eligibility.

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 applies for Medicaid while she is pregnant, is determined eligible, and remains eligible for Medicaid for the month in which her pregnancy ends may remain eligible for Medicaid for the 60-day postpartum period without regard to income or resources.

NOTE: Postpartum eligibility applies only to women who do not qualify for Medicaid under another coverage group once the pregnancy ends.

- ◆ A child born to a Medicaid-eligible mother shall receive Medicaid without an application through the child's first year of life as long as the child remains an Iowa resident. This includes children born to women who are eligible for emergency services.

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 the Department of Human Services (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 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.

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

Income maintenance 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 pend, deny, or approve the application on the Automated Benefit Calculation system 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)

Policy:

Form 470-2927 or 470-2927(S), *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](#), Qualifying to Determine Presumptive Eligibility for Pregnant Women.

In some situations, the pregnant woman may not want to apply for full Medicaid at all, or she may want to file a separate Medicaid application at a later date. The qualified provider will explain to the pregnant woman that:

- ◆ If she applies for full Medicaid and the Department denies that application for any reason, presumptive Medicaid will end on the day the full Medicaid application is denied. A pregnant woman cannot be determined presumptively eligible again during the same pregnancy.
- ◆ If she applies only for presumptive Medicaid initially, she can still file an application for full Medicaid or for limited Medicaid for emergency services at a later date.

If the woman does choose to apply with the Department for full Medicaid at the same time as she applies for presumptive eligibility, the date the qualified provider received the presumptive application is the application date that the Department uses for purposes of determining the effective date of ongoing Medicaid eligibility. An OASIS application is automatically created and sent to the Department.

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 300% of the federal poverty guidelines, 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 the Department and eligibility determined.)

If the countable family income exceeds 300% of the poverty guideline, presumptive eligibility is denied.

After an Eligibility Decision Has Been Made

Legal reference: 441 IAC 75.1(30)

The qualified provider issues form 470-2580 or 470-2580(S), *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 the Department by the last day of the month following the month of the presumptive eligibility determination.
- ◆ Serves as proof of the 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; and
 - Tells the provider to access the Eligibility Verification System (ELVS) 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 Automated Benefit Calculation (ABC) system nightly to identify if:

- ◆ A Medicaid application has been pended on the system. If so, 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.
- ◆ 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 that month.

The presumptive eligibility system automatically updates its files to reflect what has been entered on the ABC system and also updates ELVS.

1. Ms. P is determined presumptively eligible for Medicaid on June 25. She files an application for Medicaid on August 31 (the last day of the month following the month of the presumptive eligibility determination), which is pended on the eligibility system.

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.

June 25: Determined presumptively eligible.

July 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 June 1. Ms. P still has until August 31 to file a Medicaid application.

June 1: Determined presumptively eligible.

July 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 with the Department on June 14. Ms. P reports on the application that she has \$25,000 in bonds. The worker denies the Medicaid application on June 25 due to excess resources. Therefore, Ms. P's presumptive eligibility ends on June 25.

June 1: Determined presumptively eligible.

June 14: Medicaid application filed.

June 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. 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.

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. She has bills for Medicaid-covered services for June. The worker determines that Ms. T was eligible under the MAC coverage group for the month of June. (Increased income created ineligibility for July.)

Ms. T is granted continuous eligibility because (1) she would have been eligible in June as a pregnant woman had she applied; (2) she has bills for covered Medicaid services in June; and (3) increased income is the only reason that she is currently ineligible. 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, she 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. She 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 member. If a Medically Needy member'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 as though she were still pregnant 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. Document 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 will continue through the month of the first birthday.

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 on June 20. On June 27, the baby is born. The application is processed on June 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 June 27 and will end on August 25. However, Ms. W is eligible for Medicaid beginning May 1 and she remains Medicaid-eligible through August 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); Public Law 111-3

Policy:

Medicaid is available to newborn children if the mother establishes Medicaid eligibility for the month of the child's birth under an FMAP-related or SSI-related coverage group, including eligibility for limited emergency services.

The mother can establish eligibility before the birth or retroactively, after the birth. An application is not required to add the newborn child to Medicaid.

The newborn is eligible for Medicaid as a newborn child of a Medicaid eligible woman beginning with the month of birth through the infant's first birthday. See [Duration of Coverage](#).

Procedure:

Add the newborn to the Medicaid case no later than ten days after the birth is reported to the local office. Do not delay adding the newborn for Medicaid even if there is a delay adding the child for other programs.

When establishing the 12-month eligibility period for the newborn status, accept a verbal or written statement from the following as verification of the birth date, unless questionable:

- ◆ Responsible household member.
- ◆ Representative of the facility where the birth took place.
- ◆ Any other person or publication deemed to be a valid authority.

If the statement is questionable, request written verification and allow the household until:

- ◆ The first day of the second month after the mother was discharged from the hospital (e.g., if the mother is discharged September 2, the due date is November 1), or
- ◆ Ten calendar days, if that due date is later, based on the date of application.

Cancel the newborn's Medicaid with timely notice if verification is not received. Reopen Medicaid for the newborn retroactively if verification is received before the newborn's first birthday and the newborn is otherwise eligible.

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, the baby is added to Ms. R's case as the newborn child of a Medicaid-eligible mother.
2. Ms. L reports to the local 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. The local newspaper reports the birth date as May 17.

Since there is an inconsistency in the birth date, the worker requests written verification of the birth date from the member. The information is not received by the August 1 due date, and the newborn's Medicaid is canceled effective September 30, with timely notice.

On December 15, Ms. L provides verification of the child's birth date and it matches Ms. L's original report. The worker reopens the child's Medicaid eligibility as a newborn effective August 1. No application is required for the reopening.

If the newborn's name is not immediately known, make the first name entry using "Baby Boy" or "Baby Girl" and the last name entry using the mother's last name, unless a different last name is known. Correct the newborn's name on the system when the name becomes known.

NOTE: If the mother receives SSI, do not add the newborn to the mother's SSI case. Add the newborn to an existing FMAP-related case or open a new MAC case for the newborn.

Issue adequate notice when eligibility under this coverage group is established, using reason code 812 ("_____ is the newborn of a mother who is eligible for Medicaid...").

Comment:

The newborn is not required to have a social security number in order to be added for Medicaid. This verification is required when the child is no longer eligible as a newborn. See [8-C, Social Security Number](#).

The newborn is not required to verify citizenship and identity, because children born to Medicaid-eligible mothers are permanently exempt from verifying citizenship and identity. See [8-C, Verifying Citizenship and Identity](#).

1. Household composition: Mr. K, age 30, Mrs. K, age 25 and pregnant, and Child K, age 2. Mr. and Mrs. K have no income and receive Medicaid under FMAP.

On July 20, the hospital informs the local office that Mrs. K gave birth to her baby on July 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 within ten days, effective July 1.
2. Ms. T, age 19, is pregnant and receives Medicaid under the CMAP coverage group. On May 2, she reports to the local office that her baby was born in April.

The worker adds the baby to Ms. T's case as the newborn child of a Medicaid-eligible mother for the months of April and ongoing. On May 11, Ms. T reports she relinquished custody of the child to an adoption agency on May 4. Eligibility under "newborn status" continues as long as we know where the baby lives and the infant is an Iowa resident.
3. Ms. A is an undocumented immigrant living in Iowa. She delivered a baby at a local hospital in June. Ms. A applies for Medicaid in August and requests retroactive Medicaid back to June. If Medicaid eligibility is approved for the birth under three-day emergency services, the child is eligible for "newborn status."

The following sections give more information on:

- ◆ [The duration of newborn coverage](#)
- ◆ [Procedure when the child reaches age one](#)

Duration of Coverage

Legal reference: 441 IAC 75.1(20)

Policy:

Newborn coverage begins with the month of the birth and extends through the month of the first birthday, if the child remains an Iowa resident.

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.

However, the child may be removed from "newborn status" if it is beneficial for the other members as long as an eligibility determination is completed.

Procedure:

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 for the child on the ABC system's TD03 screen. This will prevent the newborn from being counted in the eligible group size in the ABC system calculations.

1. Ms. B, age 19, is on CMAP and is 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. The worker enters a "Y" in the NWBN field on the ABC system TD03 screen when adding the infant to identify the infant as receiving "newborn status."

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. Ms. B is a one-member household if she is otherwise eligible in her own right. 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 in the TD03 screen 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. An eligibility determination for the child would be required.

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.)

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 were 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.

Issue adequate and timely notice when the child loses eligibility under the newborn coverage group. Use reason code 814. Redetermine eligibility.

Comment:

Newborn status is available only to infants born to women who received Iowa Medicaid at birth. “Newborn” status is not available to a child under age one whose mother received Medicaid when the child was born, then moved to Iowa and applied for Medicaid. The newborn must maintain Iowa residence.

Ms. G, age 19, receives Medicaid as an SSI recipient. On April 10, she reports the birth of her child on April 2. The child is not added to Ms. G’s SSI case. A MAC case is opened up for the infant because the newborn is a child of a Medicaid-eligible mother.

On May 3, Ms. G reports she is moving to Illinois. The worker cancels her assistance June 1. Ms. G applies for and receives Medicaid in Illinois for the month of June.

On July 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, age 24, is pregnant and receives Medicaid under MAC. She gives birth on April 5. The 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 the ABC TD03 screen for the newborn. A "P" is entered in the NWBN field and the month in which the postpartum period expires is entered in the MED LIMIT field on the TD03 screen 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. Her verified income is over the MAC income limit for the family. Medicaid for Ms. B is canceled. Since the baby is still under the age of one, Medicaid for the baby is reopened as the newborn child of a Medicaid-eligible mother beginning with September. Continuous eligibility would also apply.

When the Newborn Reaches Age One

Legal reference: 441 IAC 75.1(20)

Policy:

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 child's first birthday. Eligibility under the newborn status ends on the last day of the month in which the child in newborn status turns age one.

Procedure:

Complete an automatic redetermination of eligibility under other Medicaid coverage groups during the month of the child's first birthday. The Automated Benefit Calculation system issues a tickler as a reminder when the child's first birthday approaches.

An application or *Review/Recertification Eligibility Document (RRED)* is not required. If additional information is needed in order to complete a redetermination, request this information in writing before the month of the first birthday.

During the twelfth month of “newborn” eligibility, redetermine the child’s eligibility for Medicaid.

- ◆ If the child is no longer eligible for Medicaid, remove the code of “Y” from the TD03 NWBN field, cancel Medicaid eligibility, and refer the child to *hawk-i*.
- ◆ If the child remains eligible for Medicaid, remove the NWBN code.

NOTE: System-generated RREDs will not be issued when the only active person on the case is in newborn status.

Comment:

1. Ms. K, age 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 no longer 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 voluntarily exclude the child. See [8-C, Eligible Group: Who Must Be in the FMAP Eligible Group: People Voluntarily Excluded from the Eligible Group](#).

Iowa Family Planning Network

Legal reference: 441 IAC 75.1(41)“a”

Policy:

Iowa provides limited Medicaid coverage for family planning-related services through the Iowa Family Planning Network (IFPN) to:

- ◆ Any woman who has a pregnancy end on or after February 1, 2006, and who was receiving Medicaid on the date when the pregnancy ended; and
- ◆ Persons of reproductive age, ages 12 through 54, with countable income at or below 300% of the federal poverty level.

IFPN provides limited coverage for services related to pregnancy prevention.

Application Processing

Legal reference: 441 IAC 75.1(41)“b”

Policy:

Both DHS income maintenance workers and designated family planning agencies and clinics can process applications for people who must meet the 300% income limit. See [8-B, Where the Application Must Be Filed](#).

No application for IFPN is necessary for a woman whose pregnancy ends while she is on Medicaid. Only DHS can establish IFPN eligibility for women who have a pregnancy end while receiving Medicaid.

Procedure:

Process applications according to the policies at [8-B, Processing Standards](#).

At the time of application, give the applicant the following information:

- ◆ *Comm. 20, Your Guide to Medicaid*,
- ◆ *Comm. 209 or 209(S), Information About Your Privacy Rights*, and
- ◆ *Comm. 243, Primary Care Access*. This pamphlet explains where a woman can access primary care services in Iowa. It lists rural health clinics and federally qualified health centers that usually can provide care on a sliding fee schedule.

The Family Planning Waiver (FPW) system will automatically determine IFPN eligibility for every female Medicaid member entitled to IFPN coverage after a pregnancy has ended.

Claims paid by the Iowa Medicaid Enterprise (IME) will identify women who had a pregnancy end while on Medicaid. IME will send a record to the FPW system to establish an IFPN case when the IM worker has not already established the case.

NOTE: The certification period will be determined by the FPW system, IFPN will be underlying the postpartum period.

Choice of IFPN Eligibility

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

Screen the application to determine if eligibility may exist under other Medicaid coverage groups. See [Nonfinancial Eligibility](#). Explain the difference between IFPN and regular Medicaid and let the applicant choose which coverage group to apply for.

If the applicant opts for IFPN services, ask the applicant to sign form 470-4314, *Election of Iowa Family Planning Network*, and document in the case record that the application was screened and the applicant's decision.

Effective Date of IFPN Eligibility

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

A person found eligible for IFPN coverage is certified for a period of 12 months. The effective date of IFPN eligibility is the first day of the month when the application was filed or the first day of the month when all eligibility factors were met, whichever is later. IFPN eligibility cannot be granted for any month before the month of application.

Nonfinancial Eligibility

To determine eligibility for IFPN coverage, use the policies and procedures in [8-C, Nonfinancial FMAP-Related Eligibility](#), with the following exceptions.

Age

Legal reference: 441 IAC 75.1(41)"a"(2), (3)

IFPN eligibility is limited to persons of reproductive age. To be eligible based on income, a person must be at least 12 years old but less than 55 years old.

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)

Policy:

A person who is not otherwise enrolled in Medicaid may be eligible for IFPN. A teen that is enrolled in *hawk-i* is 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.

EXCEPTION: 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 person who is covered under group or private health insurance is eligible for IFPN.

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. S lives by herself and has health insurance that covers family planning services. If all other eligibility requirements are met, Ms. S is eligible for IFPN.

Claiming Confidentiality

Legal reference: 441 IAC 75.2(3)

Policy:

A person can claim good cause due to confidentiality if the person is fearful of the consequences. A person can also claim good cause for not cooperating in filing a claim for health insurance.

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

1. 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.
2. 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.

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.

Income

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

In determining IFPN eligibility, the household's countable monthly income shall not exceed the amounts shown in the chart below for a household of the same size.

Iowa Family Planning Network Monthly Income Limits: 300% of Poverty								
HH Size	1	2	3	4	5	6	7	Additional
Limit	\$2970	\$4005	\$5040	\$6075	\$7110	\$8145	\$9183	\$1045 each

NOTE: The income limit does not apply if a woman qualifies because she was receiving Medicaid when her pregnancy ended.

The gross income (before taxes and other deductions) received by any person included in the household size must be counted. Income received by a parent for a teen (e.g. child support, social security benefits) is not counted for the teen's eligibility unless the parent makes it available to the teen.

Proof of income shall be documented in the case record. Proof may include copies of pay stubs, an employer's statement, an award letter, an income tax return, etc.

Countable Income

Legal reference: 441 IAC 75.1(41)"c"(2) and (3)

Count only the following income in determining IFPN eligibility:

- ◆ Money, wages or salary: Count wages according to [8-E, TYPES OF FMAP-RELATED INCOME](#). Lump-sum income received due to employment is not counted. Project income according to [8-E, Budgeting for FMAP-Related Households](#).
- ◆ Self-employment: Calculate countable self-employment income according to policies at [8-E, FMAP-RELATED SELF-EMPLOYMENT INCOME](#).
- ◆ Unemployment insurance benefits: If unemployment insurance benefits are reduced, count the actual amount the person receives.
- ◆ Child support: Count the actual monthly amount paid. The \$50 exemption is not allowable.

- ◆ Social security and railroad retirement benefits: Count the actual amount received.
- ◆ Worker's compensation and disability payments: Count the actual amount received.
- ◆ Veterans' pensions, compensation checks, and G. I. benefits: Count the actual amount received.
- ◆ Alimony: Count the actual amount received.

Do not count types of income that are not listed. If a person received income weekly or biweekly, disregard a third or fifth check in determining monthly income. Enter the countable income amounts into the Family Planning Waiver system.

Deductions From Gross Income

Legal reference: 441 IAC 75.1(41)"c"(4)

Gross income shall be reduced by the following amounts before income is compared to the limit for a household of the same size.

- ◆ 20% of the gross earned income.
- ◆ Child or incapacitated adult care expense for work-related hours that is not paid by a third-party source such as the Child Care and Development Block Grant, or the Child Care Assistance Program:
 - Up to \$200 per month per child under age two.
 - Up to \$175 per month per adult or child age two or older.
- ◆ Payments made for court-ordered child support, alimony, or spousal support.

Proof of payments for court-ordered child support, alimony, or spousal support shall be documented in the case record.

1. Ms. S, age 17, applies for IFPN. She lives with her parents, who are both employed. Ms. S attends high school and works part time at a local convenience store making \$125 weekly. The income of her parents is not counted. The earnings Ms. S makes from her part-time job are not counted, as she is a full-time high school student.

2. Ms. M, age 15, applies for IFPN. She lives with her mother who is employed. Ms. M's father is deceased and her mother receives social security benefits for Ms. M of \$600 per month.

The social security benefit is not counted, since Ms. M does not have access to this income. The mother's earnings are not counted. Ms. M has no income to count. She is eligible for IFPN.

3. Ms. A, age 35, lives with her husband and two children. The children receive Medicaid under the MAC coverage group. Ms. A's husband gets \$300 weekly unemployment benefits. Ms. A is eligible for IFPN since the family income of \$1,200 is less than 300% of the federal poverty level for a household of four.

4. The household consists of Ms. R, age 25, and her daughter, age 3. Ms. R is employed and has a monthly gross earned income of \$1800. Her child care cost is \$75 weekly. Ms. R is over income for FMAP. Her daughter is MAC-eligible.

Monthly gross income	\$ 1,800.00
Minus 20%	<u>360.00</u>
	\$ 1,440.00
Minus child care expense	<u>175.00</u>
Countable income	\$ 1,265.00

Ms. R is eligible for IFPN since her countable income is less than the 300% of the federal poverty level for a household size of two.

5. Ms. D, age 42, lives with her husband and her son, who dropped out of high school and who is age 17. She is unemployed. Her husband receives unemployment insurance benefits of \$320 per week, and her son earns \$100 per week from working part time.

Monthly gross earned income	\$ 400.00
Minus 20%	<u>80.00</u>
	\$ 320.00
Plus unemployment	<u>1,280.00</u>
Countable income	\$ 1,600.00

Ms. D is eligible since the countable income is less than 300% of the federal poverty level for a household size of three.

Case Maintenance

Reporting Requirements

Legal reference: 441 IAC 76.15(249A)

Client reporting requirements include:

- ◆ Supplying requested information or verification.
- ◆ Reporting changes.

The client must supply complete and accurate information needed to establish initial and ongoing eligibility. IFPN follows the policy found at [8-G, Supplying Information and Verification](#).

The client or someone acting on the client's behalf must report the following and any other changes that affect eligibility:

- ◆ Health insurance starts or begins to cover family planning services,
- ◆ There is a change in mailing or living address,
- ◆ A woman becomes pregnant, or
- ◆ The person is no longer capable of reproducing (e.g., had sterilization surgery, hysterectomy, vasectomy, etc.).

Acting on Reported Changes

Legal reference: 441 IAC 75.1(41)"c"(5) and 76.15(249A); 42 CFR 435 and 435.919

After assistance has been approved, changes occurring during a month are effective the first day of the next calendar month, provided timely notice can be given. When timely notice is required and cannot be given, the effective date is the first day of the second month following the month the change was reported.

EXCEPTION: A person found to be income-eligible upon application or annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

1. Ms. B is approved for IFPN with a January – December certification period. Ms. B reports on October 5 that she moved to Illinois. Ms. B's IFPN eligibility is canceled effective November 1.

2. Ms. D is approved for IFPN in May. In July, she receives a promotion that results in her countable income being over 300% of the federal poverty level. Ms. D remains eligible for IFPN through April, since her increased income is disregarded for the remainder of her 12-month certification period.
3. Mr. L is approved for IFPN in July because his countable income does not exceed 300% of the federal poverty level for a household size of two, Mr. L and his wife. Mr. L has countable income of \$2,000 and Mrs. L has no income.

In December, Mrs. L moves out. Mr. L's income is now over the limit for a household size of one, but he continues to be eligible for IFPN for the remainder of the 12-month certification period.

When a woman becomes pregnant, do an automatic redetermination to establish eligibility under MAC or other appropriate Medicaid coverage group. When the case record has been managed by a family planning clinic, the clinic will:

- ◆ Determine eligibility under presumptive Medicaid for a pregnant woman if the clinic is a presumptive provider; or
- ◆ Forward the case record to the local office for a redetermination into MAC or another appropriate Medicaid coverage group.

Annual Recertifications

Legal reference: 441 IAC 76.14(249A) and 441 IAC 76.14(2)"a"(2)5

Form 470-4071, *Family Planning Medicaid Review*, will be system-generated to the IFPN member at least 30 days before the end of the certification period.

A person who files a timely form 470-4071, *Family Planning Medicaid Review*, and is determined eligible will have a new 12-month certification period established beginning with the month following the last month of the previous certification period.

If form 470-4071, *Family Planning Medicaid Review*, is not completed and received by the end of the certification period, the person must reapply, using form 470-2927 or 270-2927(S), *Health Services Application*, and be determined eligible in order to establish a new certification period. Eligibility does not continue if a review is not completed.

Transferring Case Records

The IFPN case record follows the IFPN member between family planning clinics and Department offices.

If a closed IFPN case record is at a Department office and the person reapplies at a family planning clinic, the clinic worker will request transfer of the case record to the clinic. If the Department has not maintained a separate IFPN case record:

- ◆ Send the last application or review and any IFPN forms or documentation. This includes the *Family Planning Eligibility Summaries* and any *Notices of Decision* related to IFPN eligibility.
- ◆ Do not send any part of the Department case record that does not pertain to the IFPN coverage group.

A Department worker may also ask for a closed IFPN case to be transferred from a family planning clinic office.

Breast and Cervical Cancer Treatment

Legal reference: Breast and Cervical Cancer Prevention and Treatment Act of 2000;
441 IAC 75.1(40)"a"

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

- ◆ Does not have creditable health insurance coverage;
- ◆ Is not eligible for Medicaid in one of the mandatory coverage groups;
- ◆ Was screened and diagnosed:
 - Through the Breast and Cervical Cancer Early Detection Program (BCCEDP), or
 - Using funds from the Susan G. Komen Foundation;
- ◆ Needs treatment for cancerous or precancerous condition of the breast or cervix;
and

- ◆ Must be one of the following:
 - A citizen of the United States,
 - A United States national, or
 - A qualified alien.

See 8-L, [ALIENS](#), for more information on eligibility criteria.

The following sections explain:

- ◆ [Responsibilities of the screening program](#)
- ◆ [Referrals to the Breast and Cervical Cancer Early Detection Program](#)
- ◆ [Application processing](#)
- ◆ [The BCCT eligibility period](#)
- ◆ [Responsibilities of the BCCT client](#)
- ◆ [Annual reviews](#)
- ◆ [Case maintenance](#)
- ◆ [Presumptive eligibility](#)

Responsibilities of the Screening Program

The Breast and Cervical Cancer Early Detection 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 under age 65.
- ◆ 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.

“Creditable coverage” is defined in the Health Insurance Portability and Accountability Act. 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.

A woman who has been screened and diagnosed through the BCCEDP and is in need of treatment will be referred to DHS to apply for Medicaid.

- ◆ The woman will be instructed to present the Department of Public Health's form, *Medicaid Treatment Option Eligibility Verification*, to the DHS office.
- ◆ The woman will usually complete a *Health Services Application*, form 470-2927 or 470-2927(S), at the program office. The program will attach the proof of screening form to the application.

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 specific release if needed so you can request verification from the program.

If the BCCEDP is a qualified provider, the provider may also determine presumptive Medicaid eligibility for the BCCT coverage group. For requirements to be a presumptive eligibility provider, see [8-M](#), Qualifying to Determine Presumptive Eligibility for BCCT.

Referrals to a BCCEDP

Only BCCEDP staff or a trained designee can determine if a woman is eligible for the BCCEDP (screening services) or for referral for Medicaid under BCCT.

If a woman with a breast or cervical condition contacts DHS and someone other than the woman paid for a mammogram to be done, but she has no verification form from BCCEDP and is not eligible for a mandatory Medicaid coverage group, you may refer her to the nearest BCCEDP. Referrals to a local BCCEDP may be made for:

- ◆ Breast and cervical cancer screening services
- ◆ The Medicaid Treatment Option Eligibility Verification form

Call 1-800-369-2229 or 1-515-242-6200 to identify the nearest program and contact information. Do not suggest that the woman is eligible or make any determination. Simply refer her by saying, "There is a program I suggest you call. Their staff should be able to determine if you are eligible for any services or assistance."

Referrals When Screening Was Paid Through Komen Funds

Women who had breast screening or diagnostic testing paid with funds from the Susan G. Komen Foundation are eligible for BCCT coverage. It is important to determine if a woman may be eligible because Komen funds paid for those services.

If a woman is not sure if Komen funds paid for her screening or diagnosis, ask her to:

- ◆ Provide verification from the medical provider's billing office; or
- ◆ Sign a specific release of information if needed so you can contact the provider.

If a local BCCEDP and the woman are unable to verify eligibility, contact the BCCT policy specialist via e-mail with the following information:

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

Application Processing

DHS income maintenance is responsible for determining that the applicant:

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

The following are required before determining eligibility under BCCT:

- ◆ A completed paper application, except in an automatic redetermination.
- ◆ A determination the woman is not eligible under a mandatory coverage group.
- ◆ A signed *Medicaid Treatment Option Eligibility Verification* form from the Iowa Department of Public Health (IDPH).

When citizenship has not previously been verified for an ongoing BCCT applicant whose eligibility is processed on the PRSM system:

- ◆ Manually issue Comm. 258 and request proof of citizenship and identity using the language on form 470-4909 or 470-4909(S), *Request for Proof of Citizenship and Identity*, in 6-Appendix.
- ◆ Track the 90-day reasonable opportunity period and cancel Medicaid if proof is not provided within 90 days. (See [8-C](#), [No Match](#).)

After approval, request verification of when treatment will end. If the applicant needs assistance, have her sign form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*.

There are no resource tests for this group. Income eligibility is determined by the BCCEDP. Collect financial information only to the extent necessary to determine if the applicant is eligible for Medicaid under a mandatory coverage group. See [Mandatory Medicaid Coverage Groups](#).

Accept the statement on the verification form regarding the absence of creditable health insurance coverage.

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.

BCCT coverage is not automated through the ABC system. To approve Medicaid under BCCT, you must:

- ◆ Manually issue a *Notice of Decision*, using notice reason code 017.
- ◆ Contact Quality Assurance at 1-800-373-6306 or send an e-mail to: [DHS, QA-Eligibility](#) and report the following:
 - The county and worker number of the IM worker handling the ongoing case.
 - The month in which eligibility under BCCT begins (see [Eligibility Period](#)).
 - The eligible person's full name.
 - The eligible person's mailing address and county of residence.
 - The eligible person's date of birth.
 - Which document you used to verify U.S. citizenship and identity.
 - The eligible person's social security number and state ID number, if one has been issued. If a state ID number has not been issued, Quality Assurance will issue one.

Medicaid cards will automatically be issued and the Medicaid Eligibility file (SSNI) updated when Quality Assurance makes entries on the Presumptive Medicaid Eligibility (PRSM) system.

Mandatory Medicaid Coverage Groups

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

NOTE: A woman is never eligible under a mandatory coverage group if:

- ◆ She has no children in the home under the age of 19,
- ◆ She is not pregnant, and
- ◆ 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 FMAP coverage. Her 16-year-old son lives with her and she meets all of the other 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)

The effective date of BCCT coverage is the first of the month the woman applied for Medicaid. Receiving presumptive eligibility does not change this effective date. Because Quality Assurance (QA) cannot backdate eligibility when the woman received presumptive eligibility, complete a *Request for Special Update*, form 470-0397, when eligibility exists before the presumptive period.

If the woman was diagnosed in an earlier month and incurred medical bills, examine retroactive BCCT eligibility. See [Retroactive Coverage Under BCCT](#).

Eligibility under the BCCT coverage group continues until the woman:

- ◆ Is covered under creditable insurance coverage; or
- ◆ Is eligible under a mandatory coverage group; or
- ◆ No longer receives treatment for breast or cervical cancer or precancerous condition; or
- ◆ Reaches age 65.

NOTE: If the woman turns 65 on the first day of the month, 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 verification form is not required unless treatment has stopped and started again.

The following sections give more information on:

- ◆ [Determining retroactive eligibility under BCCT](#)
- ◆ [Determining the length of treatment](#)

Retroactive Coverage Under BCCT

BCCT eligibility can cover the retroactive period if the woman has met all relevant BCCT eligibility requirements.

A woman isn't eligible for Medicaid until she is diagnosed and in need of treatment. Eligibility before being screened, diagnosed, and having a need for treatment would require an eligibility determination under another coverage group. See [8-B, Determining Eligibility for the Retroactive Period](#).

1. Ms. A applies for Medicaid May 4. The verification form showing that she was diagnosed with cervical cancer April 28 accompanies her application form. 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 May 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 April, the worker can establish Medicaid eligibility for April under the BCCT coverage group because she was diagnosed in April.

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

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

Quality Assurance can make entries for retroactive coverage at the same time of initial approval if you tell them the earliest retroactive month for BCCT eligibility.

If you determine retroactive eligibility after you have called Quality Assurance, complete form 470-0397, *Request for Special Update*. Send the update to Quality Assurance regardless of the coverage groups under which retroactive eligibility exists. The aid type for BCCT is 37-3.

Length of Treatment

The length of treatment is **not** a condition of initial Medicaid eligibility under BCCT. Verification of when treatment will end is generally due by the end of the month following the month of the eligibility decision.

Request the woman provide proof of when treatment will end. If she needs assistance, have her sign form 470-3951, *Authorization to Obtain or Release Health Care Information*.

A woman who fails to provide proof of when treatment will end or to sign and return the release of information loses BCCT eligibility. You must:

- ◆ Complete an automatic redetermination, since the date treatment will end pertains only to the BCCT coverage group.
- ◆ Contact Quality Assurance to cancel Medicaid under the BCCT group.
- ◆ Issue a manual *Notice of Decision* unless the woman is eligible under another coverage group (except for Medically Needy with a spenddown).

The BCCEDP will not be treating the woman. Accept the statement of the medical professional providing the woman's treatment as to when treatment is expected to end. Manually tickle the case for the first working day of the month in which treatment is expected to end.

Do not recoup Medicaid under BCCT if the woman fails to:

- ◆ Provide proof of when treatment will end after application approval, or
- ◆ Report that treatment ended before the predicted date.

1. Ms. E begins receiving Medicaid under BCCT in March. The provider treating her provides a statement saying that treatment will continue into July. The worker tickles the case for the first working day in July.

Early in July, the worker sends a release to Ms. E, asking her to sign and return it. Ms. E complies, and the provider reports that Ms. E's treatment ended in June.

Since Ms. E is no longer eligible under the BCCT coverage group, the worker completes an automatic redetermination. Medicaid for the month of July is not subject to recoupment, since the worker acted on the best information available.

2. Mrs. D begins receiving Medicaid under the BCCT coverage group in March. In April, the provider treating her provides a statement saying that treatment will continue into July. The worker tickles the case for the first working day in July.

Early in July, 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 July. Since Mrs. D will no longer be eligible under the BCCT coverage group, the worker completes an automatic redetermination.

3. 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.

Responsibilities of the Client

A woman eligible for Medicaid under the BCCT is **required** to report only when:

- ◆ Creditable health insurance coverage begins, or
- ◆ Her living or mailing address changes.

The woman is **asked but not required** to report when her treatment ends. Accept the medical professional's statement as to when treatment will end. Act on the woman's report of when treatment has ended. For more information, see [Length of Treatment](#).

A woman eligible for Medicaid under BCCT is **not required** to report:

- ◆ Income changes
- ◆ Resource changes
- ◆ Household composition changes
- ◆ Turning age 65 (It is the responsibility of DHS to track this and act on it.)

Annual Review

Legal reference: 42 CFR 435.916; 441 IAC 76.7(249A)

Central office will notify workers and supervisors by e-mail when a woman receiving Medicaid under BCCT is due for an annual review. The notifications will be sent toward the end of the two months before the month the review should be completed. NOTE: Reporting the correct county and worker numbers will ensure that the correct worker is contacted about the annual review.

Ms. A began receiving Medicaid under the BCCT coverage group July 2009. Ms. A's worker will be notified at the end of April 2010 and at the end of May 2010 that Ms. A is due for an annual review during June 2010.

At the annual review, determine whether the woman continues to:

- ◆ Be in need of treatment. (Verify through the treating physician.)
- ◆ Be ineligible for a mandatory coverage group.
- ◆ Lack creditable health insurance coverage. (See [Health Insurance Changes.](#))
- ◆ Be under age 65. A woman remains eligible the entire month of the woman's birthday, unless the birthday is on the first day of the month.

No review form is required. Document all information discussed and how you came to an eligibility decision. You may require an interview or the client may request an interview. See [8-B, Interviews.](#)

1. Ms. K is diagnosed with breast cancer and applies for Medicaid in June 2009. Ms. K's 16-year-old son lives with her. 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 June 1, 2009.

When conducting the annual review in May 2010, 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 only conditionally eligible for Medically Needy with a spenddown.

Since Ms. K is under age 65, does not have creditable health insurance coverage, and continues to receive treatment, her 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 is established under BCCT effective September 1, 2003. The worker conducts the annual review in August 2004. Since Mrs. R's youngest child is over 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.

Contact Quality Assurance at 1-800-373-6306 when the annual review is completed. (See [Reporting Changes to Quality Assurance](#).) Medicaid will not continue beyond the annual review month unless you contact Quality Assurance.

Ms. B begins receiving Medicaid under the BCCT coverage group in 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.

Quality Assurance does not need to be notified when a woman fails to comply with the review process since, Medicaid will not continue past the review month.

Notice of Decision

Legal reference: 42 CFR 435.919, 441 IAC 76.4(249), 7.7(1)

No notice of decision needs to be issued if BCCT eligibility:

- ◆ Continues, or
- ◆ Ends but Medicaid eligibility is continuing under another coverage group, other than Medically Needy with a spenddown.

Adequate and timely notice is required when Medicaid eligibility is ending, including when the woman fails to comply with the annual review process. Manually issue notices about BCCT.

Case Maintenance

The following sections address procedures for:

- ◆ [Handling changes in health insurance](#)
- ◆ [Reporting changes to Quality Assurance](#)
- ◆ [Replacing a lost *Medical Assistance Eligibility Card*](#)
- ◆ [Conducting an automatic redetermination](#)

Health Insurance Changes

Determine if a woman has creditable health insurance coverage when:

- ◆ She reports a change in her health insurance coverage, or
- ◆ She reports that health insurance coverage has begun.

The following types of coverage are considered creditable coverage:

- ◆ Medicare Part A **or** Part B
- ◆ A group health plan
- ◆ Armed forces insurance
- ◆ A state health risk pool
- ◆ A medical care program of a tribal organization
- ◆ Medical care provided directly, through insurance, or by reimbursement
- ◆ Medicaid, including meeting spenddown during a Medically Needy certification period

A woman is ineligible for BCCT if she has creditable health insurance coverage. A woman does **not** have creditable health insurance coverage if:

- ◆ Her coverage is limited, such as dental, vision, or long-term care, or coverage only for a specified disease or illness.
- ◆ Her policy does not cover treatment of breast or cervical cancer.
- ◆ She is in a period of exclusion for treatment of breast or cervical cancer (such as a pre-existing condition).
- ◆ She has exhausted her lifetime limit on all benefits under her plan.

Reporting Changes to Quality Assurance

When the following changes occur or are reported, contact Quality Assurance at 1-800-373-6306.

- ◆ The annual review is completed. See [Annual Review](#).
- ◆ The client has a new mailing address.
- ◆ The client moves to a new county.
- ◆ The case is assigned to a new worker number.
- ◆ Medicaid eligibility exists under another coverage group (to close BCCT).
- ◆ You determine there is no eligibility and cancel Medicaid.
- ◆ You reinstate a woman to BCCT after notifying Quality Assurance that the woman was ineligible.

Replacing Lost Medical Assistance Eligibility Cards

To replace an annual medical card, access the Online Card Replacement Application (OCRA) in the income maintenance page of the DHS Field Intranet.

Enter the state identification number of the member who needs a replacement card, or enter the member's last name and birth date, click "search," and click on the state identification number displayed.

Make sure all of the member's information on the PRSM screen is correct. If not, contact Quality Assurance at 1-800-373-6306 to update PRSM.

When the information is correct, click on the "Send a Card" box. Then click on "continue" at the bottom of the screen. At the next screen, choose a reason the medical card is being replaced. Make notes as appropriate. Click on "Submit Request." Medical cards will be issued within 7 to 14 days.

Providers may verify Medicaid eligibility under BCCT in the same ways as for any other Medicaid member.

Automatic Redetermination for BCCT

Legal reference: 42 CFR 435.930(2); 441 IAC 76.11(249A)

Policy:

Complete an automatic redetermination when:

- ◆ Eligibility under another coverage group ends.
- ◆ Eligibility under BCCT ends.

Procedure:

When a woman is no longer eligible under another coverage group, determine if treatment under BCCT is continuing. If treatment continues, eligibility under BCCT exists based on the initial *Medicaid Treatment Option Eligibility Verification*.

A new application is required after the effective date of BCCT cancellation.

Request verification of:

- ◆ Current treatment for breast cancer or cervical cancer, and
- ◆ When treatment is expected to end.

Mrs. C applies for Medicaid in April. She provides the verification form that shows she is 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 FMAP 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. The only coverage group other than BCCT 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 medical provider. If Mrs. C is still under treatment, the worker establishes Medicaid eligibility under the BCCT coverage group.

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

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 and diagnosed for breast or cervical cancer under the BCCEDP or using Susan G. Komen funds, and
- ◆ Is found to need treatment for breast or cervical cancer or a pre-cancerous condition.

There are no income, resource, or citizenship 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 precancerous 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(40)

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.

The qualified provider enters the applicant's information on the presumptive eligibility system through the Iowa Medicaid Portal Access (IMPA) to generate a state identification number and *Presumptive Eligibility Notice of Decision* for the woman.

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 the Department 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 the presumptive eligibility determination was made.
- ◆ Tells the health care provider to access the Eligibility Verification System (ELVS) 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. When an application is 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 automatically updates its files to reflect what has been entered on the ABC system and also updates ELVS.

Notice Requirements and Appeal Rights

Legal reference: 441 IAC 75.1(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 qualified provider, but her 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; or
 - Her Medicaid application is denied. 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(249A)

Medicaid eligibility policy for pregnant women, families, and children is based on the Family Medical Assistance Program (FMAP). FMAP-related coverage groups include:

- ◆ [Family Medical Assistance Program \(FMAP\)](#).
- ◆ [Ineligible for FMAP due to residence in a medical institution](#).
- ◆ [Ineligible for FMAP due to the receipt of support](#).
- ◆ [Transitional Medicaid](#).
- ◆ [Child Medical Assistance Program \(CMAP\)](#).
- ◆ [Mothers and Children \(MAC\) program](#).
- ◆ [Medical institution 300% group](#).
- ◆ Pregnant 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. See 8-J, [MEDICALLY NEEDED](#).

The applicant has the right to choose the coverage group under which eligibility will be determined. Provide enough information so the applicant can make an informed choice between possible coverage groups. **EXCEPTION:** Examine eligibility for the Medically Needy coverage group only when the household is over income or over resources for all other coverage groups.

Ms. T, age 18 and pregnant, lives with Mr. J, age 23. She has income from a part-time job. 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, explain the program requirements and eligibility factors of each coverage group to Ms. T so she may make an informed choice.

Medicaid is also available to most children under age 21 who are placed in subsidized adoption, subsidized guardianship, or foster care living arrangements. See 8-H, [FOSTER CARE, ADOPTION AND GUARDIANSHIP SUBSIDY](#), for more information.

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 exclude the common child voluntarily. 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 two-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.](#)

Also see [Continuous Eligibility for Children](#) for more information on handling an increase in household income that affects a child's eligibility.

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 of Children](#) 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 income 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. The worker refers 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, who is in the military; and Child B, their 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 up to four months to persons and families ineligible for FMAP (not CMAP) in whole or in part because of child or spousal support, minus the \$50 exemption.

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. They are eligible for 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, 2009, due to increased child support. The family received FMAP in August and September of 2008 and in January 2009. Mrs. B and her two children are eligible for the four months of extended Medicaid.

Members 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 the IM worker until April 25. The child support, minus the \$50 exemption, is enough to cancel FMAP.

Since the receipt of child support was not timely reported, extended Medicaid begins April 1. 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 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 FMAP. 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 household's eligibility 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 home from foster care, if they would have been included if 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 and 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 **receive** 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 Medicaid member 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 June 1 for failure to provide information. They reapply for Medicaid July 5. On July 7, Mrs. M reports beginning a job July 5. The worker processes the application July 27.

The Ms are eligible for Medicaid under FMAP for July, but they are over income for August. Because they are considered members at the point they are successfully entered on the system, they are eligible for transitional Medicaid effective August 1.

2. Same as Example 1, except the worker processes the application August 2. The Ms have Medicaid eligibility under FMAP for July, but they are over income for August. Because they were members in July, they are eligible for transitional Medicaid.
3. Same as Example 1, except the family is over income for July and ongoing. There is no transitional Medicaid eligibility, because they are not members 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. If the only child in a household receives SSI and could be in the FMAP eligible group, the FMAP parent may be eligible for transitional Medicaid if otherwise eligible.

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.

A needy specified relative who is canceled from FMAP due to an increase in earned income is eligible to receive transitional Medicaid. The child will receive transitional Medicaid with the specified relative.

When transitional Medicaid ends, do an automatic redetermination to Medically Needy for the caretaker relative and to CMAP for the children.

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 May 23. Timely notice cannot be given for June 1. FMAP is canceled July 1. Transitional Medicaid begins July 1. There is no overpayment for June.
2. Mr. J and his two children are receiving FMAP. He starts work but fails to report this to his worker until two months later.

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 2.
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 3.
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 house hold consists of Mrs. J and her two children. On June 10, Mrs. J reports that she received a pay raise on June 1 and that her daughter moved out of the household on June 7.

Ignoring the change in 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 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 exceeds 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. The family receives FMAP. Ms. L's countable earned income is \$380 per month. She receives an increase in earned income. Her countable earned income is now \$420. When she reports her raise, 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. Ms. M and her family receive Medicaid under FMAP. On April 15, Ms. M turns in her annual review form indicating she does not have any income. The worker contacts Ms. M to confirm this information since she previously had some income.

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. He 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 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 ineligible, is the newborn child of a Medicaid-eligible mother, or 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, 470-2663(S), 470-2663(M), or 470-2663(MS), *Transitional Medicaid Notice of Decision/Quarterly Income Report*. See [8-G, Requirements for a Complete Report](#).
- ◆ The eligible group must continue to include a child, as defined by FMAP.

- ◆ The eligible group must continue to include an eligible or ineligible specified relative whose income is used and who had earned income in each of the previous three months (unless good cause exists). (See [Good Cause for Failing to Report or Meet Earnings Requirements](#).)
- ◆ 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. If the family income decreases to within the FMAP limit, explain the benefits to the family so they can make an informed decision.

If the family applies for or requests another coverage group, complete a redetermination of eligibility.

If the household fails to return the completed quarterly report by the 21st of the report month, do **not** reinstate transitional Medicaid unless you determine that good cause exists.

This is true even when the report is returned complete before the effective date of cancellation. Complete an automatic redetermination 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 make you eligible to get Transitional Medicaid through **/**/**. You will have the same Medicaid coverage that you had before. The transitional benefits will be canceled if your family no longer includes a child who was part of the original eligible group. After the date above, you may be eligible for an additional six months of Transitional Medicaid if the caretaker relative is still employed, your income is within guidelines, and you report your income when asked by the Department.

Se le notificó que sus beneficios Medicaid fueron cancelados. Medicaid continuará mientras evaluamos otros programas. Si usted no fuera elegible para otro programa, sus beneficios Medicaid serán cancelados a partir del **/**/**. Se le notificará si es elegible para un programa Medicaid diferente."

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 sends form 470-2663 or 470-2663(S), *Transitional Medicaid Notice of Decision/Quarterly Income Report*, to the family in the third, sixth, and ninth months. If a form 470-2663(M) or 470-2663(MS) is manually issued, include a self-addressed postage-paid envelope for the family to use to return it.

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:

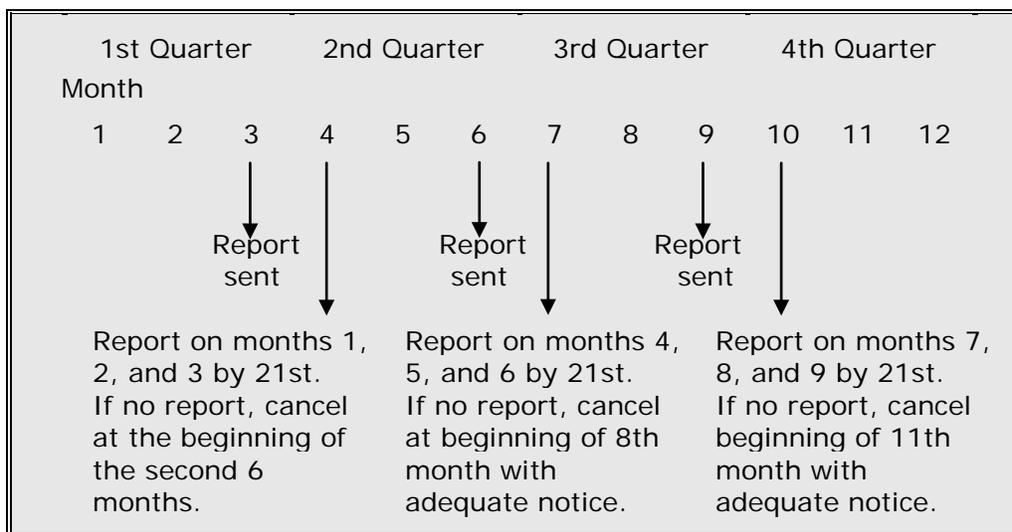
"You are currently receiving transitional Medicaid coverage through *(date entered on the initial notice)*. You may be eligible for an additional six months of coverage. Please complete each section of the attached report form for each month indicated below and return it by *(Quarterly Report due date)* 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 Report or Meet Earnings Requirement](#). 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 Report or Meet Earnings Requirement](#).

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:

$\frac{(\text{Total quarterly gross earned income of eligible group} - \text{Total quarterly actual child care paid})}{3} = \text{Countable average monthly income to compare to 185\% of poverty}$

Transitional Medicaid Monthly Income Limit: 185% of Poverty								
HH Size	1	2	3	4	5	6	7	8
Limit	\$1,800	\$2,426	\$3,051	\$3,677	\$4,303	\$4,929	\$5,555	\$6,181
For each additional person, add \$626.								

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 Report or Meet Earnings Requirement

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

The household can establish good cause for not returning form 470-2663, 470-2663(S), 470-2663(M), or 470-2663(MS), *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 someone in the member's family.
- ◆ There was a family emergency or household disaster, such as a fire, flood, or tornado.
- ◆ There were other reasons beyond the member's control for not returning the report.
- ◆ The household did not receive the form for a reason that was not the member's fault. Lack of a forwarding address is considered to be the member'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 nonrecurring 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 provides information that establishes good cause before the effective date of cancellation, 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 June, due no later than July 21. On July 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, August 1.

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

On July 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 August 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 August 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 August 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 12-month TM period the change occurred, and
- ◆ How the change was reported.

When the change is reported timely, determined the effective date as follows:

Change	Occurred	Reported	Effective Date
Child who is not in school or will not finish school before reaching age 19: <ul style="list-style-type: none"> ◆ Turns 18 on the first day of the month ◆ Turns 18 on a day other than the first day of the month 	During any month of the 12-month TM period During any month of the 12-month TM period	Any method Any method	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. Remove child from TM effective the first day of the month after the birthday month. If child is the only child in the TM group, cancel TM effective the first day of the month after the birthday month.
Child who is 18 and in school completes school	During any month of the 12-month TM period	Any method	Remove child from TM effective the first day of the month after the month in which child completed school.

Change	Occurred	Reported	Effective Date
TM group no longer contains a child or no longer contains a specified relative	During any month of the 12-month TM period	On quarterly report Other than on the quarterly report	Cancel TM effective the first day of the month after the month of change. Adequate notice is required. Timely notice is not required. Cancel TM effective the first day of the month after a ten-day timely notice period. Timely and adequate notice is required.
Other TM eligible group composition changes	During any month of the 12-month TM period	On quarterly report Other than on the 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 . 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 In the second 3 months In the third 3 months In the fourth 3 months	Any method Any method Any method Any method	The first day of the seventh month of TM The first day of the eighth month of TM The first day of the eleventh month of TM None

When a change other than income is **not** reported timely, redetermine eligibility for all months beginning with the month following the month in which the change occurred.

When a change in income is not reported timely under the TM coverage group, the effective date of the change is the month in which the change would have been effective if it had been reported timely.

For example, an unreported change in income during the second month of TM that is discovered in the tenth month of TM would have been effective the seventh month of TM had it been reported timely.

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 eligibility, 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 count 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 and 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.

TM 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](#).

When a household has received Transitional Medicaid (TM) for 10 or more months, the ABC system will issue a *Review/Recertification Eligibility Document* (RRED) at system month end before the TM period ends. If this RRED is not returned on time, TM certification will end and no further action is required by the worker.

If a household has received less than 10 months of TM and TM ends, the following WAR message will be issued to the worker concerning auto redetermination: WAR – INITIATE AUTO REDETERMINATION FOR EXT MED EXP. The worker will send a RRED if needed.

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 to get FMAP benefits for other family members.

1. Mr. A, age 41, is in a nursing home. He cannot continue to be included in the FMAP eligible group with his family since it has been verified that he will not be returning home within 12 months. Because the family 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 is currently living in the local hospital. She 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 one unborn child in determining household size unless the existence of more than one fetus 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](#). NOTE: See [Continuous Eligibility for Children](#) if an increase in household income affects a child's eligibility.

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 \$600 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. However, because she is pregnant, 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 (unless annulled) or 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.
- ◆ FMAP-eligible or MAC-eligible.

In determining whether children are living independently from parents, see [8-C, Nonfinancial FMAP-Related Eligibility: Eligible Group and Absence](#).

1. Bob, aged 15, lives with a friend of his mother. As long as Bob's income is within the FMAP limits for one person, he is eligible 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 as Joe's and Jan's incomes are 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 or MAC Households

Legal reference: 441 IAC 75.1(15)

People under age 21 who live in a family in which some members receive FMAP or MAC may be eligible for CMAP if their needs are not included in the FMAP or MAC eligible group. 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-related policy must be considered together for CMAP eligibility when they are not included in the FMAP or MAC eligible group. Brothers or sisters (whole or half blood or adoptive) who are not in the FMAP or MAC eligible group must be considered together if they are under 21 unless the sibling is:

- ◆ Emancipated due to marriage (unless 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.
4. Mr. and Mrs. P have four children, ages 20, 17, 12, and 5. Mr. and Mrs. P are "considered" persons on the MAC case for the three children under age 19. The 20-year-old may be a household of one under CMAP, if otherwise eligible.

People Living With 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 total income of all family members, including parents, does 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.

EXCEPTION: When a parent is included in the household size as a “considered” person on an FMAP or MAC case, the CMAP case can be a separate eligible group without including the parent. The parent is not considered in determining income or family size for CMAP eligibility.

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 may be eligible under the CMAP coverage group. Married people under 21 do not have to have children to be eligible for Medicaid under CMAP.

The total income of the person, the person’s spouse (regardless of the spouse’s age), and any minor children (including unborn children) must not exceed the FMAP income limit for a family of that size.

However, when the spouse is over 21 and is receiving FMAP or MAC, the needs and income of the FMAP or MAC group are not used in the CMAP determination.

1. Mrs. D, age 24, Mr. D, age 19 and a stepparent, and Child A, age 5, Mrs. D’s child from a previous relationship, have requested Medicaid on an initial application. Mr. D has gross earnings of \$456 per month. Mrs. D and Child A have no income.

Determine FMAP eligibility for Mrs. D and Child A. Mr. D’s income is counted but he’s not included in the household size.

\$ 456.00	Gross income
– 91.20	20% earned income deduction
\$ 364.80	Countable income is less 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
- <u>211.58</u>	58% work incentive deduction
\$ 153.22	Countable income is less than \$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
- <u>91.25</u>	20% earned income deduction
\$ 365.00	Countable income 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 does not pass Test 2, so he is not CMAP-eligible. His eligibility is examined under Medically Needy.

\$ 365.00	Income after 20% subtracted
- <u>483.00</u>	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
- <u>100.00</u>	20% earned income deduction
\$ 400.00	
- <u>365.00</u>	Countable income meets Mr. D's needs; he is not CMAP eligible
\$ 35.00	
- <u>20.30</u>	58% work incentive deduction
\$ 14.70	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 \$14.70 that was not applied toward the FMAP group.

\$ 365.00	Meets Mr. D's needs.
+ <u>14.70</u>	Income not deemed to eligible group
\$ 379.70	Countable income is less than the \$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.
- ◆ Age.
- ◆ Countable resources and the resource limits. (See [MAC Resource Limit.](#))
- ◆ Income limits. (See [MAC Income Limits.](#)) Do not allow the 58% work incentive deduction for applicants or members.

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](#)
- ◆ [Express-Lane eligibility for MAC](#)
- ◆ [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,"
75.17(249A)

Pregnant women are eligible for the MAC coverage group if:

- ◆ The household's countable income does not exceed 300% of the federal poverty level (see [MAC Income Limits](#)); AND
- ◆ For women aged 19 or older, the household's liquid resources do not exceed \$10,000 (see [MAC Resource Limit](#)); AND
- ◆ The woman states she is pregnant.

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 applies for Medicaid before her pregnancy ends and is determined eligible for the month her pregnancy ends, coverage 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, age 24, is pregnant and she lives alone. She verifies that her monthly income is less than 300% of the federal poverty level for two people (herself and the unborn child) and her liquid 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 woman how this decision affects the household.

Ms. A, age 25, is pregnant. She 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 voluntarily in order to prevent Mr. B's resources making her ineligible. Continuous eligibility applies to the two-year old. At annual review, eligibility is re-examined and countable income is compared to 133% of poverty for a two-person household. 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 300% 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, age 4 months. If the household's countable monthly income does not exceed 300% 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 300% of the federal poverty level, examine eligibility under Medically Needy.

At the child's first birthday, determine if the child continues to be eligible for Medicaid. 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.

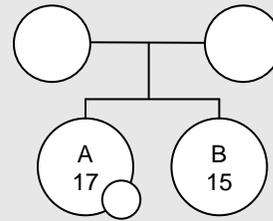
1. Mr. and Mrs. P apply for Medicaid for their daughter, Jennifer, whose birthday is May 11. Jennifer is eligible under the MAC coverage group. When Jennifer turns 19, her MAC eligibility will end effective June 1.
2. The same as Example 1, except that Jennifer's birthday is April 1. When Jennifer turns 19, her MAC eligibility will end effective April 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.

See [Continuous Eligibility for Children](#) for more information on handling an increase in household income that affects a child's eligibility.

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 is diverted to meet their needs and the needs of Child B. Any income remaining after diversion is 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 300% of the poverty level 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 is five (Child A, the unborn, Child B and the parents) unless Child B is voluntarily excluded.

Child A would be eligible under MAC if the income of the eligible group does not exceed 300% of the poverty level for a five-member group.

Child B would be eligible under MAC if the income of the eligible group does not exceed 133% of the poverty level for a five-member group. If income exceeds the limit, eligibility under Medically Needy would be explored for the parents and Child B, and Child B would be referred to *hawk-i*.

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.
- ◆ 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 member 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”

Policy:

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

- ◆ 300% of the federal poverty level for pregnant women and infants.
- ◆ 133% of the federal poverty level for children ages 1 through 18.

<u>Household Size</u>	Monthly Income Limit	
	Children 1 through 18: <u>133% of Poverty</u>	Pregnant Women and Infants: <u>300% of Poverty</u>
1	\$1,294	\$2,918
2	\$1,744	\$3,933
3	\$2,194	\$4,948
4	\$2,644	\$5,963
5	\$3,094	\$6,978
6	\$3,544	\$7,993
7	\$3,994	\$9,008
8	\$4,444	\$10,023
Add for each additional:	\$450	\$1,015

Procedure:

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

Comment:

When there are people on the same case who are Medicaid-eligible or “considered” at 133% of poverty and 300% of poverty, the *Notice of Decision* will show only the 133% calculation. However, the system does do a calculation for 300% 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:

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

Follow FMAP policy when establishing household size:

- ◆ When a woman states she is pregnant, count one unborn child as if it were born and living with her. 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.
- ◆ Exclude the needs, income, and resources of SSI members 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.](#))

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 them 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 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 her 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 are the responsibility of the client. Verification is required only when the child care expense is questionable.
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 \$3,700. She has no child-care expenses. To determine MAC eligibility, consider Ms. A's income as follows:

\$ 3,700	Gross monthly income
– 740	20% earned income deduction
\$ 2,960	Net earned income

Ms. A's net earned income is less than 300% of the poverty level for a two-member household). Her son is eligible for Medicaid under MAC.

2. Ms. B applies for Medicaid for her four-month-old daughter. Ms. B receives social security disability benefits of \$1,075 per month. Her daughter receives social security benefits of \$400 per month. The absent father of the infant pays \$500 per month in child support. To determine eligibility for Medicaid under MAC, consider income as follows.

\$ 1,075	Ms. B's social security
+ 400	Child's social security
+ 450	Child support (\$500 - \$50 exemption)
\$ 1,925	Total unearned income

Since the unearned income does not exceed 300% 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 \$1,925 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 Medicaid under MAC. 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 Medicaid under MAC, since the countable income of \$550 (\$600 minus \$50 child support exemption) does not exceed 300% of the federal poverty level for a two-member household.

When the child turns one year old, if the family income exceeds 133% of the federal poverty level for a two-member household the worker will determine if the child is continuously eligible. At annual review, if the countable income exceeds the income limit, the worker will cancel MAC eligibility, examine eligibility under Medically Needy, and make a referral to *hawk-i*.

5. Mrs. Z applies for Medicaid for her one-year-old son. Mrs. Z has no income. Mr. Z, a stepparent, is also in the home and has monthly earnings of \$1,700. 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 Mr. Z's needs (FMAP Schedule of Living Costs for one person)
\$ 995	

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

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. See [8-E](#), [Recurring Lump Sum](#) and [Budgeting the Lump Sum](#).

- Mr. and Mrs. Z receive Medicaid for their child, age three, under MAC. Mr. Z's countable monthly income of \$1,800 is indicative of their future income. In May, Mr. Z receives an inheritance of \$3,000. The period of proration begins with May, the month of receipt. The calculation is as follows:

\$ 1,800 Countable projected monthly income
 + 3,000 Nonrecurring lump sum
 \$ 4,800 Total countable income to prorate

\$4,800 divided by \$849 (FMAP Standard of Need for a three-member household) = 5.65 months (the period of proration)

May	June	July	August	September	October
\$849	\$2,649	\$2,649	\$2,649	\$2,649	\$2,355
	(\$1,800 + \$849)	(\$1,800 + \$849)	(\$1,800 + \$849)	(\$1,800 + \$849)	(\$1,800 + \$555) remainder of lump sum

There is no eligibility for MAC until November. Issue a notice of decision allowing a timely (ten-day) notice. Complete an auto-redetermination under the Medically Needy program. Make a referral to *hawk-i*.

If the lump sum was timely reported, do not recoup. If the lump sum was not timely reported, begin recoupment with the month the lump sum was received, if recoupment is appropriate.

- Ms. B, age 25, is a pregnant woman receiving Medicaid under MAC as a household of two. Her countable projected monthly income of \$3,600 does not exceed 300% of poverty for a two-member household.

In August, Ms. B receives a \$5,000 nonrecurring lump sum. Ms. B remains continuously eligible for the remainder 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.

When Ms. B's postpartum period expires effective March 1, the worker completes an automatic redetermination and considers any remaining months of the prorated income. The period of proration is ten months (August through May). The lump sum plus Ms. B's countable income of \$3,600 makes Ms. B conditionally eligible for Medically Needy with a spenddown.

<u>March</u>		<u>April</u>	
\$ 3,600	Countable income	\$ 3,600	Countable income
+ <u>719</u>	Lump sum proration	+ <u>719</u>	Lump sum proration
\$ 4,319		\$ 4,319	
- <u>483</u>	MNIL for one person	- <u>483</u>	MNIL for one person
\$ 3,836		\$ 3,836	
\$ 3,836			
+ <u>3,836</u>			
\$ 7,672	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.

<u>May</u>		<u>June</u>	
\$ 429	Lump sum remainder		
- <u>483</u>	MNIL for one person		
\$ 0	Spenddown	\$ 0	Income

Ms. B is eligible for Medicaid under Medically Needy with no spenddown for May.

In June, Ms. B is eligible for Medicaid under FMAP since she has no income.

3. Household composition: Mr. and Mrs. C; Child A, age 16; Child B, age 12; and Child C, age 6 months. The children receive Medicaid under MAC because the Cs' countable projected monthly income of \$2,300 does not exceed 133% or 300% 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
+ <u>2,300</u>	Countable projected monthly income
\$ 17,300	Total countable income

$\$17,300$ divided by FMAP Standard of Need for a five-member household = 16 months of proration beginning with the month of receipt.

To determine the total countable monthly income, the worker adds the countable portion of the lump sum ($\$1,092$) to the countable projected monthly income ($\$2,300$). Since the total countable income ($\$3,392$) does not exceed 300% of poverty for a five-member household, Child C continues to be eligible under MAC.

Although the total monthly countable income ($\$3,392$) exceeds 133% of poverty for a five-member household, Child A and Child B are continuously eligible until the annual review. At the annual review, if income exceeds 133% of poverty, eligibility is examined under the Medically Needy coverage group and the children are referred to the *hawk-i* program.

4. Ms. E, age 34, is pregnant with twins (not verified) and is has a son Child F, age 12. They receive Medicaid under FMAP as a household of three, counting only one unborn child. They have no income.

In May, Ms. E receives a nonrecurring lump sum of $\$3,500$ and reports this to her worker. The period of proration is five months beginning with May, the month of receipt. ($\$3,500 \div 849 = 4.12$ months). Child F is continuously eligible. Ms. E is no longer eligible for Medicaid under FMAP.

An automatic redetermination is completed to the MAC coverage group for Ms. E. During this time, Ms. E verifies she is having twins. In examining MAC eligibility, the worker compares $\$849$ to 300% of poverty for four persons for Ms. E, and 133% of poverty for four persons for Child F.

NOTE: Had Mrs. E's twins been verified before the lump sum was received and prorated, the standard of need would have been for four people or $\$986$. The period of proration would have been four months ($\$3,500 \div \$986 = 3.54$ months).

Express-Lane Eligibility for MAC

Legal reference: 42 U.S.C. § 1396a(e)(13) as amended by Section 203 of Public Law 111-3, Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); Iowa Code Chapter 249A as amended by 2009 Iowa Acts Chapter 118; 441 IAC 75.11(2) and 76.1(8)

Policy:

Under express-lane eligibility, a determination of eligibility made by the Food Assistance program at the time of either Food Assistance application or Food Assistance review is used to determine when a child meets initial eligibility requirements for the Mothers and Children (MAC) coverage group.

A child will be eligible under MAC without filing a separate medical assistance application when the child meets the following express-lane eligibility requirements:

- ◆ The child is under the age of 19;
- ◆ The child is eligible for Food Assistance;
- ◆ The child fulfills Medicaid requirements of attestation and verification of qualified alien or citizen status; and
- ◆ A household member requests the child's Medicaid enrollment within 30 calendar days of issuance of express-lane eligibility form 470-4851, *Express Lane Medicaid for Children*. Either an adult member of the child's household or a child receiving Food Assistance as head of household must sign and return the form.

Express-Lane eligibility does **not** apply, and form 470-4851, *Express Lane Medicaid for Children*, will **not** be issued when:

- ◆ The child is already receiving Medicaid or has a pending application.
- ◆ The child's Food Assistance household includes other persons who are receiving FMAP-related Medicaid.
- ◆ The countable total income of the child's Food Assistance household exceeds the MAC income limits.
- ◆ The child was previously granted express-lane eligibility and the household has not had at least a two-month break in Food Assistance eligibility since that time.

All children in the same Food Assistance household who are approved for MAC through the express-lane eligibility process will be placed on the same MAC case at the time of the initial Medicaid approval. This includes:

- ◆ Children who are not members of the same eligible group under MAC guidelines, and
- ◆ Children who may not be eligible for Medicaid under standard Medicaid requirements for MAC.

At the time of the annual Medicaid review, children may be split into separate MAC cases or canceled as necessary to meet standard Medicaid eligibility requirements.

MAC express-lane eligibility begins on the first day of the month of the child's Food Assistance effective date. If the child meets the criteria for retroactive eligibility in [8-B, Determining Eligibility for the Retroactive Period](#), the "retroactive period" may include any of the three months before the effective date of the child's express-lane eligibility for Medicaid.

Food Assistance eligibility will **not** be used to determine Medicaid eligibility at the time of the MAC review. Reviews of Medicaid eligibility will be made based on standard Medicaid eligibility requirements and procedures found in [8-G, FMAP-Related Eligibility Reviews](#).

Procedure:

For system entry instructions, see [14-B\(7\), Approving an Application](#). The valid codes for the express lane (EL) TD03 field are:

- A Express lane form sent
- B Child approved under express lane
- C Express lane ineligible
- D Express lane not requested
- E Express lane ended

The following chart shows the action steps followed when a child is has express-lane eligibility for MAC.

Step	Action
One	<p>ABC system:</p> <ul style="list-style-type: none"> ◆ Generates form 470-4851, <i>Express Lane Medicaid for Children</i>, and form 470-2826, <i>Insurance Questionnaire</i>, for those children. ◆ Issues Comm. 258, <i>Verifying Citizenship and Identity</i>, when proof of U.S. citizenship is not already coded in the TD03 us and ID fields and the children have already received their 90-day reasonable opportunity period. ◆ Enters code "A" in the TD03 EL field to indicate that form 470-4851 has been sent to the family.
Two	<p>Family:</p> <ul style="list-style-type: none"> ◆ The child's household must request the child's Medicaid enrollment by signing and returning form 470-4851, <i>Express Lane Medicaid for Children</i>, within 30 calendar days of issuance. ◆ Either an adult member of the child's household or a child receiving Food Assistance as head of household must sign the form.
Three	<p>Worker:</p> <p>When the signed 470-4851 is received within 30 days, enter the code "B" (child approved under Express Lane) into each child's TD03 EL field to show that Medicaid has been requested. See 14-B(7) for special entries.</p>

The following chart shows actions to take for different situations:

Situation	Action by Worker
Form 470-4851 is returned but is not signed.	Return form 470-4851 to the family with a request for a signature. Allow 10 days for the form to be returned.
Client provides form 470-4851 within the 30-day period but is required to provide citizenship and identification proof before Medicaid is granted. (Occurs only when child already received Medicaid during "reasonable period of opportunity" and did not provide proof.)	For children that must verify citizenship and identification before Medicaid approval, the client must send proof by the end of the 30-day period. If the proof is not received by the 30th day, do not approve Medicaid under express-lane eligibility procedures.

Situation	Action by Worker
<p>Form 470-4851 is issued on June 1. The form is returned to DHS on August 15.</p>	<p>The form was not received by the 30th day. Enter code "C" for "ineligible for express lane" in the TD03 EL field for each child listed on the form.</p>
<p>Form 470-4851 is issued on June 1. As of that date there is no Medicaid application pended for the children. On June 10, the family files a Medicaid application which includes the children named on form 470-4851. On June 15, FMAP Medicaid is approved for the entire family. On June 29, form 470-4851 is returned to DHS.</p>	<p>After form 470-4851 is returned, enter a "C" for "ineligible for express lane" in the TD03 EL field for each child named on form 470-4851.</p>
<p>Client provides form 470-4851 within the 30-day period but worker is unable to process within 30 days.</p>	<p>Process the 470-4851 after the 30-day period ends.</p>

Situation	Action by Worker
<p>Client sends a signed request on a paper other than form 470-4851.</p>	<p>Check the TD03 EL field. If form 470-4851 has been issued, the entry will be code "A."</p> <ul style="list-style-type: none"> ◆ If the entry is "A," send another 470-4851. (See 6-Appendix.) Allow ten days for the form to be returned. ◆ If the entry is not "A," the children are not eligible. Inform the client that express-lane eligibility is not available for the children. Give the client information on how to apply for Medicaid.
<p>Form 470-4851 was issued, but client reports it was not received or it was lost after it was received.</p>	<p>Check the TD03 EL field. If form 470-4851 has been issued, the entry will be code "A."</p> <ul style="list-style-type: none"> ◆ If the family is still within 30-day period to request express-lane eligibility, re-issue form 470-4851 manually and allow ten days for return. (See 6-Appendix.) ◆ If the family is past the 30-day period to respond, tell the client that express-lane eligibility is not available for the children. Give the client information on how to apply for Medicaid.
<p>Form 470-4851 was not generated, but client requests MAC express-lane eligibility for client's children.</p>	<p>Inform the client that express-lane eligibility is not available for the children. Give the client information on how to apply for Medicaid.</p>
<p>The client provides form 470-4851 within the 30-day period. Information obtained for the Food Assistance application establishes that the child is not a qualified alien according to Medicaid standards.</p>	<p>Do not approve Medicaid under Express Lane Eligibility procedures for a child who is not a qualified alien for Medicaid.</p>

Comments:

1. The Food Assistance household includes Ms. B and her two children, Ashley (age 8) and Carly (age 5), and Ms. B's mother, Mrs. R. The children have never been on Medicaid and have not had their reasonable period of opportunity to verify citizenship and identity.

The household applies for Food Assistance and is approved effective October 15. Both children meet express-lane eligibility for the MAC group, except for proof of citizenship and identity. The family is issued:

- ◆ Form 470-4851, *Express Lane Medicaid for Children* (listing both children), and
- ◆ Form 470-2826, *Insurance Questionnaire*.

Ms. B provides form 470-4851 to the local office within the 30-day period and requests MAC for both children. The IM worker enters code "B" for "child approved under Express Lane" in the EL field for each child. The children are approved for MAC eligibility beginning October 1 (the first day of the month that the Food Assistance began).

The ABC system automatically initiates a request for proof of citizenship and identity when the children are approved for Medicaid. See [8-C, Documentation Process](#), for more information.

If the children have unpaid medical bills for July, August, or September, retroactive Medicaid can be considered. However, eligibility for Medicaid in the retroactive months must be determined using standard Medicaid guidelines for all eligibility factors (e.g., citizenship proof, income, eligible group, etc.).

2. Same as Example 1, but both girls have previously had their period of reasonable opportunity and did not provide proof of citizenship and identity at that time. When form 470-4851 is issued, a request for proof of citizenship and identity is also sent. Mrs. B returns form 470-4851 to request MAC for both children. She provides citizenship and identity verification for Ashley but not for Carly.

The IM worker enters the code for "child approved under Express Lane" in the TD03 EL field only for Ashley when she approves her for MAC. The IM worker cannot approve Carly for Medicaid without proof of citizenship and identity because Carly has already used her reasonable period of opportunity. The Notice of Decision will show that only Ashley is approved for MAC.

3. The Food Assistance household includes Mr. and Mrs. D and their children: Patty (age 19), Jake (age 14), and Ryan (age 10). The family's FMAP ended two years ago. Verified U.S. citizenship and identity information is already coded in ABC for each family member.

The household applies for Food Assistance and is approved effective July 29. Form 470-4851, *Express Lane Medicaid for Children* (with Jake and Ryan listed), and form 470-2826, *Insurance Questionnaire*, are issued. Mr. D requests MAC for both Jake and Ryan and signs and mails back forms 470-4851 and 470-2826.

The IM worker receives the forms on the 20th day after they were issued, enters the code for "MAC eligibility via ELE" in the TD03 EL field, and approves both sons for MAC eligibility beginning July 1 (the first day of the month that the Food Assistance began).

When a combined Food Assistance and Medicaid *Review and Recertification Eligibility Document* (RRED) is filed for a child, this is not an initial eligibility determination for Medicaid. The child is already receiving Medicaid, so express-lane eligibility procedures do not apply. Medicaid eligibility is reviewed under standard Medicaid eligibility requirements and procedures.

1. Ms. M and her three children are on Food Assistance only. ABC is already coded with proof of U.S. citizenship and identification for each child. Ms. M submits her RRED for the Food Assistance eligibility review. After the IM worker enters the review coding in ABC, form 470-4851, *Express Lane Medicaid for Children*, is issued.

Ms. M signs and returns form 470-4851 and requests Medicaid for each child. The IM worker enters the TD03 code for each child to show that express lane Medicaid has been requested and approves the children for Mothers and Children under express-lane eligibility.

2. The Food Assistance household includes Ms. G and her two children, Grace (age 4) and Hope (age 8), and her boyfriend, Mr. L, and his two children, Josh (age 15) and Jacob (age 10). At the time of the initial Medicaid approval, all four children are approved for MAC through the express-lane eligibility process on the same MAC case.

At the time of the annual Medicaid review, the children are split into separate MAC cases based on MAC eligibility requirements or are canceled as necessary to meet standard Medicaid eligibility guidelines.

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 equal to or less than 300% of the federal poverty level but more than 133% of the federal poverty level.
- ◆ Households with infants and insured children when family income is equal to or less than 300% 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 include them on zero-spenddown cases. See 8-C, [NONFINANCIAL ELIGIBILITY](#), and 8-J, [MEDICALLY NEEDED](#), 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 family applies for Medicaid and the household's net monthly countable income is \$3,500. 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 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.

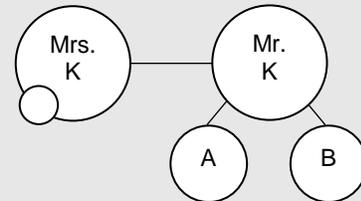
Composite MAC/FMAP Households

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.

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

\$ 600.00	Gross earnings of Mrs. K
- 120.00	20% earned income deduction
- <u>365.00</u>	Diverted to meet the needs of Mrs. K (Schedule of Living Costs for one person)
\$ 115.00	
- <u>66.70</u>	58% work incentive deduction
\$ 48.30	Mrs. K's net income
+ <u>350.00</u>	Mr. K's unemployment
\$ 398.30	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 MAC eligibility for Mrs. K:

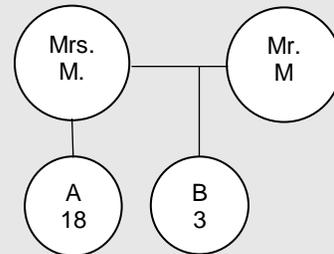
\$ 600.00	Gross earnings of Mrs. K
- <u>120.00</u>	20% earned income deduction
\$ 480.00	
- <u>48.30</u>	Diverted to the FMAP-eligible group *
\$ 431.70	Compare to 300% of poverty for a two-person household **

* Income diverted to the FMAP eligible group is not considered.
 ** FMAP-eligible people are not considered.

Since \$431.70 does not exceed 300% of poverty for two, Mrs. K is eligible under MAC.

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 Mr. and Mrs. M and Child B.

\$ 1,000.00	Gross earnings of Mr. M
– 200.00	20% earned income deduction
\$ 800.00	
– 464.00	58% work incentive deduction
\$ 336.00	Compare to FMAP Schedule of Basic Needs for three (\$426)

Since the countable income of \$336 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
\$ 880.00	Compare to 133% of poverty level for a one-person household (FMAP-eligible people are not considered.)

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

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 June 10, Carey turns one year old. The worker completes an automatic redetermination and issues a notice of decision canceling MAC effective July 1, since the family's income exceeds 133% of poverty.

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

Although the household's income exceeds 133%, it remains less than 300% of the federal poverty level. Therefore, Carey remains Medicaid-eligible under MAC through the end of August, 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 in "newborn" status currently receiving Medicaid under MAC. His first birthday is 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 states that Bobby is currently in the hospital. Because Bobby is a hospital inpatient, he remains eligible for Medicaid under MAC if the household's countable income is within 300% of poverty. (He is aged out of the coverage group but still must meet income guidelines in effect when he entered the hospital.)

One of the family members receives and reports a salary increase while Bobby is still hospitalized. The family's net countable income now exceeds 300% of poverty. Medicaid under MAC is canceled effective the first of the next month allowing a ten-day notice.

An automatic redetermination is completed to the 300% group if the child has been hospitalized for 30 consecutive days.

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 member 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, who both are over age 1. Family income exceeds 133% of poverty but does not exceed 300% 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 are still only conditionally eligible for Medically Needy with a spenddown. Therefore, they remain ***hawk-i*** eligible.

Mrs. A is also conditionally eligible for Medically Needy with a spenddown. Her **hawk-i**-eligible children are "considered persons" in her eligible group and are coded with fund code "S." 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 April 1. In July, Ms. B applies for Medicaid because she is pregnant. The same family income is now below 133% of poverty for a three-member eligible group (Ms. B, her son, and the unborn child).

Ms. B chooses to have her son remain on **hawk-i** until the **hawk-i** annual review. While he is on **hawk-i**, Ms. B's son is a considered person in her eligible group. The size of Ms. B's eligible group is three (Ms. B, the unborn child, 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. While determining eligibility, 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 will be considered persons in the Medicaid eligible group and the Medicaid eligible group size will be five. NOTE: The Cs could also 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 Medicaid Enterprise (IME).
- ◆ 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](#) and [8-N, Determining Coverage Group](#), for more information on determining eligibility.

Medicaid for Independent Young Adults (MIYA)

Legal reference: 42 USC 1396a(a)(10)(A)(ii)(XVII); 441 IAC 75.1(42)

Medicaid coverage under the “Medicaid for independent young adults” (MIYA) group is available to youth between the ages of 18 and 21 who left foster care on or after May 1, 2006, if the youth was in foster care under Iowa’s responsibility for placement and care when the youth turned 18.

To be eligible, youth must meet FMAP eligibility requirements except for:

- ◆ Age.
- ◆ Living with a specified relative.
- ◆ School attendance.
- ◆ Income limits. See [MIYA Income Limits](#). Do not allow the 58% work incentive deduction for applicants or members.

The following sections give more information on:

- ◆ [MIYA eligibility requirements](#)
- ◆ [Determining MIYA household size](#)
- ◆ [MIYA income limits](#) and [requirements](#)

Eligibility Requirements

Legal reference: 441 IAC 75.1(42)

Youth are eligible for the MIYA coverage group if all of the following requirements are met:

- ◆ The youth is 18 years old or older but is under 21 years of age,
- ◆ The youth is not a mandatory household member and eligible under another coverage group (see Example 1 below),
- ◆ The youth resided in foster care (includes court-ordered PMIC placement) when the youth reached age 18,
- ◆ The youth left foster care on or after May 1, 2006,
- ◆ Iowa was responsible for the placement and care of the youth at the time the youth reached age 18, and
- ◆ The household's countable income is less than 200% of the federal poverty level. (See [MIYA Income Limits](#).)

Youth who are eligible under other Medicaid coverage groups with lower income limits can be determined eligible for MIYA. See Example 2 below.

1. Ms. A, age 20, is applying for Medicaid for herself and her infant daughter. Ms. A was in an Iowa-paid foster care placement the month she turned 18. She left foster care placement May 10, 2006.

This household is under the FMAP income guidelines. Ms. A is a mandatory member of the Medicaid group for her daughter. Ms. A's eligibility will be established under the FMAP coverage group. If Ms. A did not want Medicaid for her daughter, Ms. A could have been found eligible for the MIYA coverage group.

2. Mr. B, age 19, has no income and meets the MIYA foster care criteria. Mr. B's eligibility will be established under the MIYA coverage group even though he meets the CMAP eligibility requirements.

A youth is not eligible for MIYA if Iowa did not make a foster care maintenance payment because the youth:

- ◆ Left foster care before the youth's eighteenth birthday.
- ◆ Was on a trial home visit at the time the youth turned 18.
- ◆ Was considered a runaway from the foster care placement at the time the youth turned 18.

Eligibility under the MIYA coverage group can begin three months before the month of application, but no earlier than July 1, 2006.

A youth who is found to be income-eligible upon application or annual review of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size during the 12 months.

If a youth who is identified as having aged out of foster care loses Medicaid eligibility established under another coverage group, redetermine the youth's Medicaid eligibility for MIYA, if appropriate.

Ms. K, age 19, and her child have been receiving Medicaid under the FMAP coverage group. Ms. K's income creates ineligibility for FMAP. Eligibility for transitional Medicaid does not exist. Ms. K's Medicaid eligibility is redetermined to MIYA with a household size of one. The child is redetermined to MAC.

Household Size

Legal reference: 441 IAC 75.1(42)"d"(1)

The household size includes the following people living together who are not receiving benefits under another Medicaid coverage group:

- ◆ The youth who aged out of foster care,
- ◆ The youth's spouse, and
- ◆ Any dependent children living with the youth.

The following examples are people who have aged out of foster care:

1. Ms. M, age 18, returned to live with her parents. She has no spouse and no children. Her household size is one.
2. Ms. S, age 19, has a child age one, and they return to live with her parents. Ms. S is not eligible for Medicaid with her child. Her child receives Medicaid under another coverage group. The household size for Ms. S is one.
3. Mrs. F, age 19, lives with her spouse who receives SSI. Her household size is one.
4. Mrs. H, age 19, lives with her spouse and two children, ages 5 months and 2. One child receives SSI; the other child receives MAC. Her household size is two.
5. Mrs. K, age 20, lives with her spouse and his child, age 5. The spouse and child do not receive Medicaid. The MIYA household size is three.

MIYA Income Limits

Legal reference: 441 IAC 75.1(42)"d"

When determining initial and ongoing eligibility for MIYA, countable income must be less than 200% of the federal poverty level.

MIYA Monthly Income Limits: 200% of Poverty								
HH Size	1	2	3	4	5	6	7	8
Limit	\$1,945	\$2,622	\$3,299	\$3,975	\$4,652	\$5,329	\$6,005	\$6,682
Additional person: \$677 each								

At time of application or review determination, when the net countable income exceeds the established limits under the MIYA coverage group, determine eligibility under the Medically Needy program.

The following sections explain procedures for:

- ◆ [MIYA income requirements](#)
- ◆ [Determining countable income](#)
- ◆ [Verification of income](#)
- ◆ [Change in income](#)

Income Requirements

Legal reference: 441 IAC 75.1(42)“d”

Consider the income of everyone included in the MIYA household size. See [Household Size](#).

Exclude the needs and income of the spouse and dependent children who are receiving Medicaid under any other coverage group.

Determining Countable Income

Legal reference: 441 IAC 75.1(42)“d,” 75.57(249A)

When determining the amount of income to compare to the applicable poverty level, apply the following income deductions in the order listed.

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 that is actually paid by a member of the MIYA household.

In each example below, the applicant meets all other MIYA eligibility criteria not related to income.

1. Ms. A applies for Medicaid for herself. Her gross monthly earned income is \$1,700. She has not been making any court-ordered child support payments. To determine MIYA 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 one-member household. Ms. A is eligible for MIYA.

2. Ms. S, age 18, has a one-year old son, and they live with her parents. Her son receives child support that exceeds the FMAP allowable amount for a household of two. He is covered under MAC. Ms. S has no income and is eligible under MIYA.

3. Mrs. B, age 19, is married to Mr. B, age 25. Mr. B's monthly gross income is \$2,500 and he pays \$300 monthly in court-ordered child support. To determine MIYA eligibility, consider Mr. B's income as follows:

\$ 2,500 Gross monthly income
- 500 20% earned income deduction
\$ 2,000
- 300 Court-ordered child support paid
\$ 1,700 Net earned income

Mrs. B is eligible under MIYA as the countable income is less than 200% of the poverty level for a household size of two.

Verification of Income

Legal reference: 441 IAC 75.57(249A)

Refer to policy found at [8-E](#) for verification procedures for applications and reviews.

Change in Income

Legal reference: 441 IAC 75.1(42)"d"(3)

A person found to be income-eligible upon application or annual review of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size during the 12 months.

Reporting Requirements

The Department shall provide each person determined eligible under the MIYA coverage group with form 470-4376, *Medicaid for Independent Young Adults Change Report*.

MIYA eligibles must report the following changes:

- ◆ When they move or have a new mailing address.
- ◆ When they get other medical insurance or current medical insurance was dropped.

Information Provided

When eligibility under the MIYA coverage group is established, give youth the following brochures that explain coverage, conditions of eligibility, benefits of the program, related services available and client rights and responsibilities:

- ◆ Comm. 20, *Your Guide to Medicaid*.
- ◆ Comm. 51, *Information Practices*.
- ◆ Comm. 91, *The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients*.
- ◆ Comm. 209, *Information About Your Privacy Rights*.

Continuous Eligibility for Children

Legal reference: 441 IAC 75.19(249A), 75.21(1)

Once ongoing Medicaid eligibility has been correctly established for a child under the age of 19, the child shall remain continuously eligible for a period of up to 12 months regardless of any change in household circumstances. Continuous eligibility begins with the month of application or the first month in which eligibility is established following the month of application whichever is latest.

NOTE: Continuous eligibility does not apply if the child was eligible under state-only funding, or eligible for retroactive Medicaid only, eligible as a newborn child of a Medicaid-eligible mother, or eligible only under the Medically Needy coverage group. See [Exceptions to Continuous Eligibility for Children](#).

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.

Jim is determined otherwise eligible for Medicaid. He is added to the eligible group on the Automated Benefit Calculation system's TD03 screen using a C entry reason and C status code, and is granted continuous eligibility until the next annual review.

If Tom and Jim are determined over income for Medicaid at the next annual review, the worker will examine eligibility under the MN program and make a referral to *hawk-i*.

4. FMAP is approved effective February 1 for Mrs. B (caretaker relative) and her three grandchildren who are the children of Ms. Z. On April 1, Mrs. B reports that Ms. Z has taken the children to live with her.

FMAP is canceled for Mrs. B effective May 1. The worker determines that Ms. B is not eligible for any other Medicaid coverage group. The children are continuously eligible for the remainder of the 12 months until the next eligibility review. The worker establishes a CE case with the TD05 NEXT REVIEW date the same as the TD05 NEXT REVIEW date as the previous FMAP case.

On May 15, Ms. Z requests Medicaid for herself. The worker reviews Ms. Z's eligibility and determines she is eligible for FMAP. Ms. Z is added to the children's CE case and the aid type is changed to 308 (FMAP).

Foster Care, Adoption or Guardianship Subsidy, Waiver, or PMIC

Except for children described at [Exceptions to Continuous Eligibility for Children](#), continue Medicaid when a child loses eligibility related to:

- ◆ Foster care,
- ◆ Subsidized guardianship,
- ◆ Adoption subsidy,
- ◆ Home- and community-based services waiver, or
- ◆ PMIC.

Open a new ABC case with a different FBU using an entry reason of C and a status code of C when a child is continuously eligible. Refer to [8-H, Application Processing for Iowa Subsidized Adoption](#), for instructions on setting up a continuously eligible adoption Medicaid case while protecting the confidentiality of the pre-adoption information.

NOTE: Do **not** add family members to a child's continuous eligibility case when the child returns home. However, if siblings at home are also continuously eligible, the child returning home should be added to the siblings' case for the months remaining until the next annual review.

Bud is in foster care and is continuously eligible. After six months of foster care, Bud returns to his family.

1. Bud's family is not receiving Medicaid. Bud's foster care case is closed, and he is reopened on the ABC system as a household of one under a new case using a C entry reason and a C status code. The annual review date is manually adjusted to coincide with the 12-months of continuous eligibility based on his foster care case.
2. Bud's parents and siblings are receiving Medicaid. Bud's foster care case is closed, and he is added to his parent's case and remains continuously eligible until the next annual review of his parent's case.

Exceptions to Continuous Eligibility for Children

The following children are **not** continuously eligible

- ◆ Children who are eligible for Medicaid under state-only funding.
- ◆ Children who are eligible only in a retroactive month.
- ◆ Infants deemed eligible as a newborn child of a Medicaid-eligible mother.
- ◆ Children eligible under the Medically Needy coverage group.
- ◆ Children whose citizenship and identity is not verified within the time limits described in [8-C](#), [Reasonable Opportunity Period](#).

1. Ms. J and her 10-year-old son apply for Medicaid in January 2009 and request Medicaid for the retroactive months of October, November, and December. Eligibility is denied for October and ongoing, but approved for November and December. Since there is no eligibility for the month of application or ongoing, continuous eligibility is **not** granted. A **hawk-i** referral is completed.
2. Mrs. Q and her daughter apply for Medicaid in December and request retroactive Medicaid for September, October, and November. In January, it is determined that Mrs. Q and her daughter are eligible for Medicaid beginning September and ongoing. Continuous eligibility for the daughter begins in December, because continuous eligibility is not available for retroactive Medicaid.

3. Baby Z receives Medicaid as a newborn child of a Medicaid-eligible mother but is turning age one next month. The worker contacts the family to gather information needed to complete a redetermination to another coverage group.

Baby Z is not continuously eligible because of being in "newborn status." No eligibility determination has been completed. If it is determined that Baby Z qualifies for Medicaid under a coverage group with his family, continuously eligibility provisions will apply.

New Continuous Eligibility Period

Establish a new 12-month continuous eligibility period when all eligibility factors are met at the annual review or at application.

NOTE: Annual reviews are often completed early when applications are processed for other programs. This is done in order to align programs and for the benefit of the member so the member does not have to complete more paperwork in a few months' time. However, complete early reviews of eligibility only if it does not have a negative effect on the children's continuous eligibility.

Cooperation with DIA and QC

A child who is continuously eligible shall not lose Medicaid between annual reviews if a parent fails to cooperate with the Department of Inspections and Appeals or Quality Control review. However, at the annual review, a parent must cooperate in order for the child to be determined eligible.

Child Ages Out of the Current Coverage Group

For **FMAP**-related cases:

Maintain continuous eligibility under CMAP or MAC if a child loses Medicaid eligibility under FMAP because of turning age 18.

The annual review month will remain unchanged if the child remains on the same case but the aid type changes. If you open a new case, adjust the annual review month to coincide with the month in which the annual review should have been completed under the previous case.

NOTE: If you must open a new ABC case with a different FBU in order to maintain continuous eligible, use a C entry reason and a C status code.

Mrs. R and her 17-year-old daughter, Paula, are receiving Medicaid under FMAP. Paula is no longer attending school when she turns 18 in April. Paula is not eligible under FMAP because she no longer meets the age requirements.

However, since Paula is eligible under CMAP, change the aid type and continue eligibility until the next regularly scheduled review. Mrs. R is canceled from FMAP, since she no longer has an eligible child but is a considered person on the CMAP case. An automatic redetermination is completed for Mrs. R.

For **SSI**-related cases:

If a child loses SSI due to no longer being disabled, close the SSI-related case and add the child to an existing FMAP-related case if there is one. Otherwise, reopen the child's SSI-related case with 64-2 aid type.

If a child loses SSI due to another reason, change the aid type to 64-2. If SSA gives a diary date that is within the next 12 months, use that date as the next annual review date. If the diary date is outside of the next 12 months, grant 12 months of continuous eligibility.

1. Tommy has been receiving SSI as a disabled child and is now turning age 18. The worker receives notification from Social Security Administration (SSA) that his SSI will end because he does not meet the requirements for disability as an adult. Tommy is continuously eligible for Medicaid.

Tommy is continuously eligible until the annual review. Tommy has siblings who are receiving FMAP-related Medicaid, and he is added to their case. The review date for that case does not change.

2. Mrs. Q's 4-year-old granddaughter, Poppy, receives SSI and Medicaid. Her SSI is canceled because she is no longer disabled. There are no other children in the household receiving Medicaid, so she cannot be added to another Medicaid case.

The worker contacts SSA to find out the date of the next scheduled disability review or diary date. SSA states there are no more scheduled diary dates.

Because there is no diary date and no scheduled Medicaid review date, the worker sets the next review date for one year from the first month the SSI was canceled. Poppy's Medicaid case is changed to a 64-2 aid type so it will come due for a review. Her fund code is changed to "C" since she no longer gets an SSI payment.

Transitional or Extended Medicaid

If a family on FMAP is eligible for Transitional Medicaid (TM) or extended Medicaid, approve eligibility for the entire family under the 37-0 aid type.

Once TM or extended Medicaid ends and an automatic redetermination is completed, determine if there are any months remaining in the 12-month period of continuous eligibility. Any months the child was eligible under TM or extended Medicaid count toward the 12 months of continuous eligibility.

When there are months left in the continuous eligibility period, reopen the case in ABC using a C entry reason and a C status code under the 92-0 aid type. If necessary, adjust the annual review month so the next annual review is not more than 12 months from the previous annual review.

NOTE: Using the reopen coding of a C entry reason and a C status code instead of an approval coding of an A entry reason and an A status code will ensure that the ABC system does not deny the case for being over income.

Ms. S and her two children are receiving Medicaid under FMAP. Ms. S reports a new job and the worker determines the family is no longer eligible under FMAP. They are eligible for Medicaid under Transitional Medicaid (TM). The FMAP eligibility ends and the TM case is set up with all family members included.

One of the TM quarterly reviews is not returned by the 21st day of the review month and good cause is not granted. TM closes but the children remain continuously eligible until the next annual review based on the annual review month of the FMAP case.

Newborn Status

When “newborn status” ends, complete an automatic redetermination and determine ongoing Medicaid eligibility.

A child who has “newborn status” does not qualify for coverage under the continuous eligibility provisions because the child is already ‘deemed’ eligible for one year as a newborn and because no Medicaid eligibility determination has yet been completed.

1. Baby C receives Medicaid as a newborn child of a Medicaid-eligible woman. No other family members receive Medicaid. During the automatic redetermination in the month before Baby C turns one year old, DHS must gather financial and non-financial information from the family in order to determine ongoing eligibility.
 - ◆ If information is not provided, the case is closed at the end of the period that Baby C was deemed eligible under “newborn status.”
 - ◆ If all eligibility factors are met under a Medicaid coverage group, eligibility is approved and Baby C has continuous eligibility under that group until the next annual review.
 - ◆ If Baby C is FMAP-related and the family countable income exceeds 133% of the federal poverty level, continuous eligibility does not exist. Eligibility is determined under Medically Needy and a referral to *hawk-i* is completed.
2. Baby M receives Medicaid as a newborn child of a Medicaid-eligible woman. Baby M’s siblings receive Medicaid under MAC as continuously eligible.

During the automatic redetermination before Baby M turns one year old, Baby M’s nonfinancial information is provided for Medicaid eligibility. She is added to her household’s eligible group and has continuous eligibility under that group for the months remaining until the next annual review of the case to which she was added.

3. Baby J receives Medicaid as a newborn child of a Medicaid-eligible woman. No other family members receive Medicaid. During the automatic redetermination in the month before he turns one year old, Baby J is found to be over income for Medicaid.

Baby J remains eligible as a newborn through the month of his first birthday (if his birth date is not on the first of the month), but continuous eligibility is not granted. A *hawk-i* referral is completed.

Pregnant Woman

Continuous eligibility for a child overrides continuous eligibility for a pregnant woman when a woman under the age of 19 is pregnant. When a pregnant woman turns age 19, continuous eligibility for a child ends, but continuous eligibility for a pregnant woman may apply. See [Continuous Eligibility for Pregnant and Postpartum Women](#).

Ms. P is 18 years old, pregnant, and receiving Medicaid under CMAP. Even though she is pregnant, because she is under age 19, she is continuously eligible as a child.

When Ms. P turns age 19, she is no longer a continuously eligible child. Because she is pregnant, if her income exceeds the CMAP income limits, she will be considered a continuously eligible pregnant woman and placed in the MAC coverage group.

Ending Continuous Eligibility

Continuous eligibility shall end for a child if any of the following occurs:

- ◆ The child is found to be ineligible at annual review,
- ◆ The child turns age 19,
- ◆ The child is found to not have been initially eligible,
- ◆ The child is voluntarily excluded at the family's request,
- ◆ The child is no longer a resident of Iowa (including unable to locate),
- ◆ The child enters a jail, or
- ◆ The child dies.

See [8-A, Notification](#), for information on actions that require timely or adequate notice.

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 these are referred to as “SSI-related” coverage groups. They include:

- ◆ SSI recipients.
- ◆ “Essential” persons 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).
- ◆ Medically needy people. See 8-J, [MEDICALLY NEEDED](#).

- ◆ 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.
- ◆ Disabled children who have family income over the SSI income limits, but gross income of no more than 300% of the federal poverty level.
- ◆ People eligible for waiver services. See 8-N, [HOME- AND COMMUNITY-BASED WAIVERS](#), for additional information.
- ◆ People eligible for Programs for All-Inclusive Care for the Elderly (PACE). See [8-M, Program for All-Inclusive Care for the Elderly](#), for more information.
- ◆ Postpartum women. See [Postpartum Eligibility](#).
- ◆ Newborn children of Medicaid-eligible mothers. See [Newborn Children of Medicaid-Eligible Mothers](#).

This section explains the SSI-related coverage groups unless otherwise noted. 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.

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 the 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.

Continuous Eligibility for SSI-Related Children

Legal reference: 441 IAC 75.54(4)

Once ongoing Medicaid eligibility has been established for a child under the age of 19, the child shall remain continuously eligible for a period of up to 12 months regardless of any change in household circumstances.

Continuous eligibility begins with the month of application of the first month in which eligibility is established following the month of application whichever is latest. See [Continuous Eligibility for Children](#) under FMAP-Related Coverage Groups.

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." Their 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).

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.

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 (e.g., the person has declined or chosen not to apply for SSI benefits).

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.

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](#).

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 (SSA) 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 the 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 \$800.

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 470-0499 or 470-0499(S), *Ten-Day Report of Change for FIP and Medicaid*. 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 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 1997	2.9%
July 1978	6.5%	January 1998	2.1%
July 1979	9.9%	January 1999	1.3%
July 1980	14.3%	January 2000	2.5% *
July 1981	11.2%	January 2001	3.5%
July 1982	7.4%	January 2002	2.6%
1983	0	January 2003	1.4%
January 1984	3.5%	January 2004	2.1%
January 1985	3.5%	January 2005	2.7%
January 1986	3.1%	January 2006	4.1%
January 1987	1.3%	January 2007	3.3%
January 1988	4.2%	January 2008	2.3%
January 1989	4.0%	January 2009	5.8%
January 1990	4.7%	January 2010	0
January 1991	5.4%	January 2011	0
January 1992	3.7%	January 2012	3.6%
January 1993	3.0%	January 2013	1.7%
January 1994	2.6%	January 2014	1.5%
January 1995	2.8%	January 2015	1.7%
January 1996	2.6%		

* 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
1-15	1.7	684.1359	\$684.10

These calculations show that if there were no other increase, the current gross social security income would be \$684.10. Since the actual amount is \$900.00, the conclusion is that there was an increase of \$215.90 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 \$733, 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 \$720.00 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 \$261 per month attributable to a non-COLA increase.

The calculation of income eligibility is as follows:

\$ 394.90	Social security in March 1995
+ <u>261.00</u>	Non-COLA increase
\$ 655.90	
+ <u>217.50</u>	Countable earned income ($\$500 - 65 \div 2$)
\$ 873.40	
- <u>20.00</u>	General income exclusion
\$ 853.40	Countable income

Miss Y's countable income is over the SSI income limit of \$733 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>101.00</u>
Need standard	\$ 882.20

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 \$1,100.

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 State Supplementary Assistance (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 also available for a disabled adult child. 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, is receiving SSI because of a disability that began before he turned 22. He has no income. His father starts to draw social security retirement benefits. Mr. P begins receiving \$750 a month social security benefits from his father's social security account and he loses 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, and
- ◆ 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 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 \$733 (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.

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 the current social security benefits;
- ◆ Adding in other income; and
- ◆ Comparing the result to the household's correct 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. His spouse passes away in March. Mr. W's SSI benefit is canceled and he begins receiving \$750 per month in widower's social security benefits in April.

Mr. W is not eligible for Medicare Part A and is ineligible for SSI solely because of widower's social security benefits. He is eligible for Medicaid under the coverage group for people ineligible for SSI due to receipt of widow's social security benefits.

Mr. W will be eligible for this coverage group as long as he continues to meet the eligibility requirements for SSI if his widower social security benefits are disregarded.

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.](#)

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, 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 [8-1, 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 \$2,199. If both spouses enter a medical institution and live in the same room, the income limit is two times \$2,199, or \$4,398.

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 the 300% coverage group for people under the age of 21 in an institution 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 eligibility.
- ◆ 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 \$2,199. If **both** spouses enter a medical institution and live in the same room, the income limit is two times \$2,199 or \$4,398.

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](#).

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	\$1,980
Couple	\$2,670

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 members (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.

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 \$367 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.

\$ 2,500	Mrs. J's gross earned income
— <u>367</u>	Allocated for the ineligible child
\$ 2,133	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:

\$ 2,133.00	Mrs. J's earned income after the deeming
+ <u>2,200.00</u>	Mr. J's gross earned income
\$ 4,333.00	
- <u>20.00</u>	Income exclusion
\$ 4,313.00	
- <u>65.00</u>	Work exclusion
\$ 4,248.00	
- <u>2,124.00</u>	1/2 remainder
\$ 2,124.00	Net countable income

The \$2,124.00 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 \$7,280 for an individual and \$10,930 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.

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 Automated Benefit Calculation (ABC) 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 ABC 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 Medicare benefits (Part A and Part 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 Medicare Part A. He has not enrolled for Part A before because the cost was too high. Mr. L has heard that Medicaid may now pay the Medicare Part A 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 \$700 per month in social security disability benefits. He is not eligible for Medicare Part A until he has been disabled for 24 months, which happens June 1.

Since Mr. B is not entitled to Medicare Part A, 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 Ms. W 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	\$990
Couple	\$1,335

Exclude the social security cost-of-living (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 \$671 from social security and \$175 gross earned income per month. On January 1, her social security increases to \$710 and her gross earned income increases to \$175 due to increased hours. The federal poverty level is published in January. For the months of January and February, Mrs. J's social security COLA increase is disregarded.

Income is considered as follows for January and February (the social security COLA is disregarded):

\$ 671	Gross social security income
— <u>20</u>	Income exclusion
\$ 651	Countable social security income

\$ 175	Gross earned income
— <u>65</u>	Work exclusion
\$ 110	
— <u>55</u>	½ remainder
\$ 55	Countable earned income
\$ 651	Countable social security income
+ <u>55</u>	Countable earned income
\$ 706	Countable monthly net income

The countable monthly net income is compared to 100% of the poverty level.

For the month of March, Mrs. J's countable monthly net income is recalculated using the social security with the COLA increase (\$710).

Income is considered as following for March:

\$ 710	Gross social security income
— <u>20</u>	Income exclusion
\$ 690	Countable social security income
\$ 175	Gross earned income
— <u>65</u>	Work exclusion
\$ 110	
— <u>55</u>	½ remainder
\$ 55	Countable earned income
\$ 690	Countable social security income
+ <u>55</u>	Countable earned income
\$ 745	Countable monthly net income

This amount of \$745 is compared to the new 100% of poverty level effective March 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 MAGI medical. Mr. G (stepparent) receives \$988 monthly in social security disability benefits and is entitled to Medicare. To determine Mr. G's QMB eligibility, the income is computed as follows:

QMB Determination

\$ 988	Gross SS income
— 20	General income exclusion
\$ 968	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 does not have an ineligible spouse.

2. Mr. K files an application on April 1. His monthly income is:

\$ 846	Gross social security
+ 200	Retirement pension
\$1,046	
— 20	General income exclusion
\$1,026	Countable monthly income

Since the monthly net income exceeds 100% of the poverty level, Mr. K is not eligible for QMB. However, he is potentially eligible for Medically Needy. Eligibility for SLMB is also examined.

3. Mr. and Mrs. B file an application July 20. Mr. B receives \$677 social security benefits, and Mrs. B receives \$476 social security benefits each month. Both are entitled to Medicare Part A. Their countable resources are \$4,000. Their income is considered as follows:

\$ 677	Mr. B's gross social security
+ 476	Mrs. B's gross social security
\$1,153	Total income
— 20	General income exclusion
\$1,133	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 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 \$367 may be allocated to meet the needs of the child, from Mrs. A, the ineligible spouse.

\$ 211	Mrs. A's gross unearned income
– <u>156</u>	Allocation for ineligible child since the child has \$211 income (\$367 – \$211)
\$ 55	

\$55 is less than \$367. 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.

1. Ms. J, age 70, files an application on June 3. Her monthly countable net income is \$780 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 Medicaid eligibility for the member 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 April and May.

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 client 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 applicant can make an informed choice. Medicaid provides for some services not covered under Medicare, such as dental expenses and some 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 only to 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, client participation is not charged until Medicare coverage is exhausted. See [8-1, 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 of these conditions:

- ◆ Is entitled to Medicare Part A, which provides benefits for hospital care.
- ◆ Has net countable monthly income that 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	\$990	\$1,188
Couple	\$1,335	\$1,602

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 \$7,280 for an individual and \$10,930 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.

For the aid types 90-0, 90-2, and 37-E with a zero spenddown, also enter an "L" in the QMB indicator on the ABC TD03 screen for each person who is eligible for SLMB. (People eligible only for the SLMB coverage group do not receive a medical card.) Clients who are eligible for SLMB and for Medically Needy with a spenddown must have both a SLMB case and a separate Medically Needy case.

All clients who meet SLMB requirements are sent on the Medicare buy-in tape as SLMB-eligible, including those who have full Medicaid benefits, unless the client refuses SLMB coverage.

When the buy-in tape is sent, the third-party system checks clients coded eligible for SLMB 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.

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:

\$ 893	Gross social security
+ 150	Retirement pension
\$1,043	
- 20	Income exclusion
\$1,023	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:

\$ 867	Gross social security
– 20	Income exclusion
\$ 847	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 under 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)

A person applying for SLMB may also be eligible for Medicaid under another coverage group. Medicaid members who meet the SLMB requirements have concurrent eligibility for SLMB.

When concurrently eligible, members can receive all Medicaid benefits provided under the other coverage group in addition to the payment for Medicare Part B premium.

Clients who are concurrently eligible for SLMB and Medically Needy with a spenddown are entitled only to Medicaid payment of Part B premiums until spenddown is met. Once spenddown is met, they are entitled to all Medicaid services that are payable under the Medically Needy coverage group.

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	\$1,188	\$1,337
Couple	\$1,602	\$1,803

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 \$7,280 for an individual and \$10,930 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.)

A person who wants this coverage must enroll in both Medicare Part A and Part B. The state will not enroll people for Medicare Part A under expanded SLMB. A person who chooses not to enroll for Medicare Part A benefits cannot be eligible under expanded SLMB. When Medicaid eligibility ends, the client 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. See [8-E, Deeming SSI-Related Income](#), when deeming to a spouse is applicable.

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.

Mr. X files an application on May 1. His monthly income is:

\$ 930	Gross social security
+ 300	Retirement pension
\$1,230	
- 20	Income exclusion
\$1,210	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 premiums is available for all people who meet E-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 liability system checks to see if the client has Part A entitlement. If the client does not have Part A entitlement, the third-party liability system rejects the record, and the state is not billed for the client's Medicare Part B premium.

Medicaid for Employed People With Disabilities

Legal reference: 441 IAC 75.1(39)

Policy:

Medicaid for employed people with disabilities (MEPD) is available to people who are disabled and have earnings from employment. To qualify the person must meet all of the following requirements:

- ◆ The person must be under age 65.
- ◆ The person must be determined to be disabled based on Social Security Administration (SSA) medical criteria for disability.
- ◆ The person must have earned income from employment or self-employment.
- ◆ The person must meet general SSI-related Medicaid eligibility requirements.
- ◆ The person must not be eligible for any other Medicaid coverage group other than QMB, SLMB, or Medically Needy.
- ◆ Resources must be less than \$12,000 for an individual or \$13,000 for a couple.
- ◆ Net family income must be less than 250% of the federal poverty level.
- ◆ Any premium assessed for the month of eligibility must be paid.

Comment:

Each of the eligibility criteria are discussed in more detail in this chapter.

Age

Legal reference: 441 IAC 75.1(39)"a"(2)

Policy:

To qualify for MEPD, the disabled person must be under age 65.

Procedure:

Make a tickler for the month that an MEPD member will turn age 65. During that month:

- ◆ Cancel the MEPD case with timely notice by entering ABC notice message 490, "...you are age 65 or older."
- ◆ If appropriate, make a redetermination to Medically Needy.
- ◆ Check to see if a separate case needs to be created for QMB, SLMB or E-SLMB.

Disability

Legal reference: 441 IAC 75.1(39)"a"(1)

Policy:

To qualify for MEPD, a person must be disabled based on the medical criteria for Social Security Administration (SSA) disability. This includes:

- ◆ People who receive social security disability (SSDI) benefits or receive railroad retirement benefits based on SSA disability criteria.
- ◆ People whose SSDI benefits have stopped but are still eligible for Medicare.
- ◆ People who are not in the groups listed above but who meet the medical criteria for disability through a disability determination completed for the Department by Disability Determination Services (DDS).

Procedure:

Always check to see if the applicant or member is receiving SSDI or railroad retirement benefits based on disability or is receiving Medicare.

- ◆ Check SDXD screens. An applicant who is receiving SSI may qualify for Medicaid as an SSI recipient.
- ◆ Check under IEVS and request a TPQ2, if necessary. The TPQ2 screen is used to send a special request for SSA data on a social security claim.
- ◆ Ask the applicant to provide proof of the disability if you cannot find verification using SDXD or IEVS.

If the applicant does not receive any of those benefits, then initiate a disability determination through referral to the Bureau of Disability Determination Services.

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 \$1,090 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.

The applicant must provide proof that the earned income is from employment or self-employment. For example, employment may be proven by current pay stubs.

Proof of self-employment includes, but is not limited to, income tax records showing self-employment expenses and self-employment taxes paid. If it is unclear whether a person's employment is self-employment, ask if the person files an income tax return as a self-employed person on form SE, *Social Security Self-Employment Tax*.

If the self-employment business is too new to require self-employment tax forms, the applicant may provide self-employment business records. By the MEPD annual review, the member must be able to provide proof of self-employment by tax forms or other evidence that would be acceptable to the Internal Revenue Service (IRS).

When the applicant claims to have earned income below the minimum to file income tax returns, consult the IRS or another knowledgeable source to determine if the person is self-employed. An activity may qualify as a business if the primary purpose for engaging in the activity is for income or profit.

Send questions about the adequacy of proof of employment or self-employment, to the DHS, SPIRS Help Desk.

Comment:

See [8-E, Types of SSI-Related Income](#)

See [8-E, SSI-Related Self-Employment Income](#)

1. Mr. B files an MEPD application March 10. He has earned income in the month of March but the income ended in March. The application is processed in April. Since the earned income ended in March, eligibility can be approved for March, but April and ongoing eligibility are denied.
2. Ms. Z says she is a self-employed dog walker and is paid \$50 a week for walking several dogs. The worker asks for proof of self-employment. Ms. Z provides a copy of her most recent federal income tax return that shows the self-employment income and self-employment taxes paid. The worker accepts this as proof that Ms. Z is self-employed.

3. Mr. Y applies for MEPD and says he earns \$25 a week for mowing his neighbor's lawn. The worker asks him if he is employed by his neighbor or if he is self-employed. Mr. Y says he is not employed by his neighbor, so the worker asks for his self-employment tax records. Mr. Y does not have tax records because he has just started his self-employment.

The worker accepts a written statement from Mr. Y that he is self-employed and a statement from his neighbor that the neighbor paid Mr. Y \$25 for mowing the lawn during the month of application. The worker advises Mr. Y that he needs to keep self-employment business records and provide them at the annual review of his MEPD eligibility.

At the annual review, the worker asks Mr. Y to provide his self-employment business records. Mr. Y does not provide the records. The worker cancels Mr. Y's MEPD case.

Intent to Return to Work if Employment Ends

Legal reference: 441 IAC 75.1(39)"c"

Policy:

MEPD members who are unable to maintain employment due to a change in their medical condition or loss of a job may remain eligible for MEPD coverage for six months after the month they last worked if:

- ◆ Their intent is to return to work within the six months, and
- ◆ They continue to meet the other eligibility requirements of MEPD, including the payment of any assessed premiums.

Procedure:

When an MEPD member reports the loss of employment or inability to work due to medical reasons, take these steps:

1. Send form 470-4856, *MEPD Intent to Return to Work*, to the member.
2. After the 470-4856 is returned and the member states the intent to return to employment:
 - ◆ Enter an ABC tickler to check to see if the member has found a new job by the end of the sixth month after member stopped working.

- ◆ Use the *MEPD Income Worksheet*, form 470-3686, to determine if the loss of earned income reduces or eliminates the MEPD premium. If the premium is reduced or eliminated, the premium change begins the month after the month the member reported the decrease of income.
3. If the member is not looking for a new job, or if form 470-4856 is not returned by the due date:
- ◆ Cancel the MEPD case. The MEPD member becomes ineligible for MEPD at the end of the month that the job stopped. If it is too late for timely notice, cancel the next month. Do not use the date of the last paycheck to determine the month that MEPD is canceled.
 - ◆ Make a redetermination to Medically Needy, if all other eligibility requirements are met.

Comment:

1. Mrs. C reports on May 10 that she stopped working and will receive her final check in May. She provides 470-4856, *MEPD Intent to Return to Work*, stating her intent to return to work within six months. MEPD eligibility may continue for the next six months (June through November). The worker enters an ABC tickler for six months to follow up on new employment for Mrs. C.

Mrs. C does not report a new job by timely notice in November, so the worker cancels her MEPD eligibility effective December 1 and redetermines eligibility to Medically Needy, since all other requirements are met.

2. Mr. G files an application March 10. His employment will end in March and he will receive his final paycheck in April. He provides a written statement stating his intent to return to work within six months.

The eligibility decision is made in April. Since Mr. G has earned income in April, the application is approved for MEPD effective for March and ongoing months. The six months for job seeking begin with the month after the month the change occurred (April through September). The worker enters an ABC tickler for a six-month follow-up on Mr. G's employment.

On May 29, Mr. G reports a new job. He will get his first paycheck in June. The worker asks for verification of earned income and receives a pay stub.

The worker uses the *MEPD Income Worksheet* to determine Mr. G's income eligibility and finds his income will be over 250% of the federal poverty level. The worker then cancels Mr. G's MEPD case with timely notice and redetermines eligibility for Medically Needy.

3. Ms. K cannot continue working because of health problems, according to a letter from her doctor. She says she is not going to try to find another job.

The worker checks to see if Ms. K is eligible for Medically Needy or a Medicare savings program (QMB, SLMB, or E-SLMB). The worker cancels Ms. K's MEPD case using ABC notice reason 483, "...you are not working and you have not told us that you plan to return to work within six months."

4. On August 2, Mrs. B reports that she just had major surgery and is going to be off work for three months of recovery. Mrs. B gives her worker form 470-4856, *MEPD Intent to Return to Work*. The six-month period of intent to return to work begins the month after the month of surgery, September, and continues through the following February.

Mrs. B's annual eligibility review occurs in October. Since Mrs. B is still in the "intent to return to work" period, she remains eligible for MEPD because she still meets all other eligibility requirements.

5. Mr. Y returns his *Medicaid Review* form in August without pay stubs or any other verification that he is employed. The worker sends him a request to provide verification of the date that the employment ended and a statement about his intent to work.

The worker also cancels the MEPD case with timely notice, with notice reason 610: "You did not provide requested information/verification needed to determine eligibility," because the information was not returned with the review form.

All the information needed to complete the review is returned before the effective date of cancellation. Mr. Y reports he has not been working since May 15. He sends form 470-4856, *MEPD Intent to Return to Work*, so the worker reinstates the case.

If the information had been returned but with the date of the change to unemployed happening in January, the six-month period would have been February through July. Mr. Y would not be eligible for MEPD and he would have to re-apply for MEPD after he returned to employment. The worker would check for Medically Needy eligibility.

Resources

Legal reference: 441 IAC 75.1(39)"a"(5) and "d," and Iowa Code 627.6(8)(f)

Policy:

The resource limits for the MEPD coverage group are \$12,000 for an individual and \$13,000 for a couple. (NOTE: These resources limits are higher than those for other Medicaid coverage groups.)

Some resources owned by the **MEPD applicant or member** may be exempt when determining MEPD eligibility that are not exempt for eligibility under other SSI-related groups. These exemptions **do not apply** to resources owned by the spouse, even if the spouse is disabled. These exemptions are:

- ◆ Retirement or pension funds that are exempt from execution, 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.
- ◆ 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 a medical savings 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.

For technology-related funds to be exempt, the need for such technology and evidence that the technology can reasonably be expected to enhance the individual's employment must be established by:

- A physician, or
- A certified vocational rehabilitation counselor, or
- A licensed physical therapist, or
- A licensed speech therapist, or
- A licensed occupational therapist.

Procedure:

If there is a question whether to exempt a retirement account, ask the DHS, SPIRS Help Desk.

Comment:

See [8-D](#), Exempt Resources for Medicaid for Employed People With Disabilities.

Family Income Less Than 250% of Federal Poverty Level

Legal reference: 441 IAC 75.1(39)"a"(3)

Policy:

The total income of the family is considered for eligibility. "Family" is defined as follows:

- ◆ If the applicant or member is **under the age of 18 and is unmarried**, the "family" includes all of the following who live in the same household as the applicant or member:
 - The parents of the applicant or member.
 - Siblings who are under age 18 and unmarried.
 - Any children of the applicant or member.
- ◆ If the applicant or member is **aged 18 or older or is married**, the "family" includes all of the following who live in the same household as the applicant or member:
 - The spouse of the applicant or member.
 - Unmarried children of the applicant or member or the spouse who are under age 18.

Allow all disregards and exemptions that are allowed for other SSI-related Medicaid coverage groups, including:

- ◆ \$20 general income deduction,
- ◆ \$65 earnings income deduction, and
- ◆ 50% exclusion from the balance of earned income.

Exclude the social security cost-of-living (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.

MEPD Monthly Income Limits: 250% of Poverty Level								
HH Size	1	2	3	4	5	6	7	8
Limit	\$2,475	\$3,338	\$4,200	\$5,063	\$5,925	\$6,788	\$7,653	\$8,519
Additional person: \$866 each								

Procedure:

Always use form 470-3686, *MEPD Income Worksheet*, to determine if the family monthly income is less than 250% of the federal poverty level (FPL). Entries in the Automated Benefits Calculation (ABC) system will **not** calculate income for MEPD.

Convert weekly income to monthly income by multiplying by 4.3. Convert biweekly income to monthly income by multiplying by 2.15. The *MEPD Income Worksheet* template will:

- ◆ 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 earnings income deduction, and then make a 50% remainder deduction from the total earned income.
- ◆ Subtract any other applicable deductions, including impairment-related work expenses, as entered on the worksheet.

- ◆ Add the net unearned income and net earned income, and compare the sum to 250% of the federal poverty level for the family size. After you click on the “Calculate” button, the following information will display:
 - The total countable family income.
 - The amount of FPL for the family size (not eligible if over 250%).
 - Monthly MEPD premium amount.
 - MEPD poverty level (as calculated for MEPD eligibility).
 - Whether the person is income eligible.

If the family's income is over 250% of the FPL, enter the denial or cancellation in the ABC system with zeros in the notice reason. Send a copy of form 470-3686 to the applicant or member to show how the income was calculated for eligibility, along with a manually issued *Notice of Decision* stating that the person is over income for MEPD. Keep a copy of form 470-3686 in the case file.

NOTE: If the income is over 250% of the FPL, before denying or canceling the case, contact the applicant or member to determine if any impairment-related work expenses were not reported. Send questions about impairment-related work expenses to the DHS, SPIRS Help Desk.

Comment:

See [8-C, Household Size](#)

See [8-E, Determining if a Client is Self-Employed](#)

See [8-E, Determining Income from Self-Employment](#)

See [8-E, Projecting Future Income](#)

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 in Social Security benefits due to Mr. F's disability.

To calculate income for the 250% income test, the *MEPD Income Worksheet* will:

Add all the unearned income:

\$	600.00	For Mr. F
+	100.00	For Mrs. F
+	<u>300.00</u>	For children (\$100 each child)
\$	1,000.00	Unearned income
-	<u>20.00</u>	General income deduction
\$	980.00	Net countable unearned income

Add all earned income of the family:

\$ 600.00	For Mr. F
+ 1,000.00	For Mrs. F
<u>\$ 1,600.00</u>	Earned income
- 65.00	Earned income deduction
<u>\$ 1,535.00</u>	One half remainder
- 767.50	Net countable earned income
<u>\$ 767.50</u>	

Add the net unearned and net earned income of the family:

\$ 980.00	Net countable unearned income
+ 767.50	Net countable earned income
<u>\$ 1,747.50</u>	Total net income

Since the net income for Mr. F's family is less than 250% of the poverty level for five, Mr. F meets MEPD income eligibility criteria.

Premiums

Legal reference: 441 IAC 75.1(39)"a"(6), sec. 5006 of ARRA

Policy:

When the applicant or member's gross income is at or below 150% of the federal poverty level, no premium is assessed. The member will **not** have Medicaid eligibility for a month with a premium owed until the premium is paid.

Use only the gross income of the disabled person to determine the amount of the premium. Exclude the social security cost-of-living (COLA) increase received in the current calendar year for January through the month following the month in which the federal poverty level is published.) The premium amount established for the 12-month period will never be increased during that period due to an increase in income. The premium may decrease if the member reports an income decrease resulting in a lower premium.

People who have identified themselves with race or ethnicity of 'Indian' are excluded from being assessed MEPD premiums.

See [8-G, Premium Change for Current or Past System Months](#).

Premium Schedule		
If the gross monthly income of the person getting MEPD is:	The percentage of the federal poverty level is:	The premium amount is:
\$1,485 or less	At or below 150%	0
Above: \$1,485	Above 150%	\$33
\$1,634	165%	\$46
\$1,782	180%	\$55
\$1,980	200%	\$64
\$2,228	225%	\$76
\$2,475	250%	\$88
\$2,970	300%	\$110
\$3,465	350%	\$135
\$3,960	400%	\$158
\$4,455	450%	\$183
\$5,445	550%	\$228
\$6,435	650%	\$276
\$7,425	750%	\$324
\$8,415	850%	\$383
\$9,900	1000%	\$460
\$11,385	1150%	\$539
\$12,870	1300%	\$622
\$14,652	1480%	\$718
\$15,147	1530%	\$735
\$15,741 and above	1590%	\$767

Procedure:

Use the *MEPD Income Worksheet*, form 470-3686, to determine ongoing premiums for a 12-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 the premium amount:

1. Determine the premium periods for the approval. See the following section on [How to Establish Premium Periods](#).
2. Determine the premium amount for each premium period in the covered by the approval.
3. Apply the lowest premium amount established to all premium periods covered by the approval.

Make specific entries on the Automated Benefits Calculation (ABC) system TD05 screen to assess the correct ongoing premium amount. See [14-B\(9\)](#), Approving an Application: Medicaid for Employed People with Disabilities.

When making entries to approve MEPD applicants and at MEPD review, do not make TD05 income entries for people who have been identified as Indians. The premium will be calculated as zero.

The premium amount calculated by the ABC system will match the premium amount on the *MEPD Income Worksheet*, form 470-3686. If the two premium amounts do not match, determine which is correct before the Notice of Decision is issued.

Months Between Application Date and Approval Date

Procedure:

When a disability determination needs to be completed, it may take two or more months to get a decision on disability.

At the time of approval, there may be more than two months between the effective date of MEPD eligibility (positive date entered on the ABC system TD05 screen) and the date the ABC entries are made to approve MEPD.

“Back months” include all the months from the month when approval entries are made in ABC back to the first month of MEPD eligibility. The member may not need MEPD coverage for all of the back months, so the member may not want to have premium payments credited to those months.

When premiums are assessed, ask the member to provide a signed statement that identifies the back months the member does not want MEPD coverage.

Manually issue a *Notice of Decision* to the member with the premium amount owed for each back month. Eligibility for back months may be entered on the MEPD RETR screen. See [14-C](#), RETR=Retro Screen, for entry instructions.

Comment:

Ms. M applies for Social Security Insurance (SSDI) benefits in April 2012. She applies for MEPD on June 12, 2012. On May 15, 2013, the Social Security Administration determines that she is disabled with an effective date of disability of March 21, 2012.

On May 21, 2013, the worker enters eligibility effective June 2012, with a monthly premium of \$34. The retroactive months are March, April, and May 2012. The “back” months include June 2012 through December 2012 and January 2013 through April 2013.

Ms. M. sends a signed statement to her worker explaining that she did not have any unpaid medical bills for November or December 2012, so she doesn't need MEPD coverage for those two months.

The worker makes entries in the MEPC screen to block MEPD eligibility for November and December 2012. Payments will never be posted to those months, so there won't be any eligibility for those months as long as the block remains.

Retroactive Months

Procedure:

Retroactive months are any or all of the three months before the date of application for which the applicant met all Medicaid eligibility requirements. Determine premiums for retroactive months on a month-by-month basis, using actual income for those months. See [8-B](#), Establishing Beginning Months of Eligibility for MEPD.

How to Establish Premium Periods

Legal Reference: 441 IAC 75.1(39)“b”(1)

Policy:

Each MEPD premium period is 12-months. The premium periods are established according to the number of months of eligibility, beginning with the month of application through the month of approval.

Procedure:

Determine premium periods as follows:

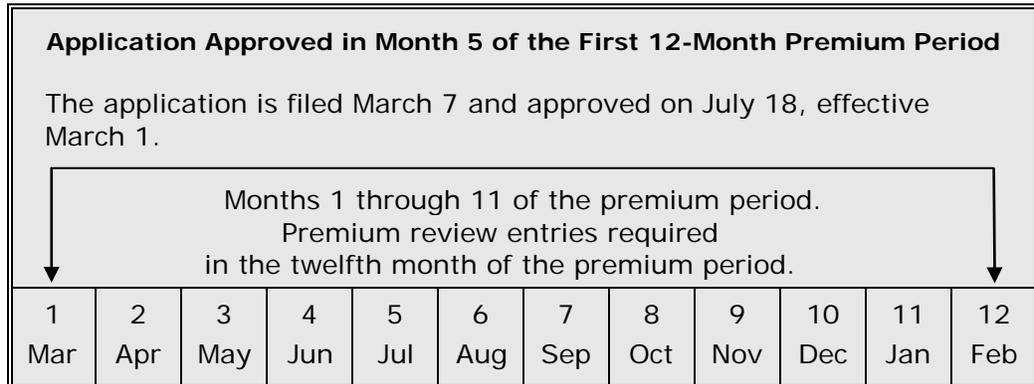
- ◆ Begin the first premium period with the first month of the effective date of eligibility (the date in the TD05 POS DT field on ABC). Include the effective date month plus 11 months.
- ◆ Begin each subsequent premium period with the month following the last month of the previous premium period and include that month plus 11 months.

Example:

Application Approved in the First Month of the First Premium Period											
An MEPD application is filed November 10, 2009, and approved effective November 1, 2009. The 12-month premium period is November through October.											
12-Month Count for Premium Periods											
1st 12-month premium period November 2009 through October 2010											
1	2	3	4	5	6	7	8	9	10	11	12
11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10	07/10	08/10	09/10	10/10
<div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: 80%;"> 2nd 12-month premium period November 2010 through October 2011 </div>											
1	2	3	4	5	6	7	8	9	10	11	12
11/10	12/10	01/11	02/11	03/11	04/11	05/11	06/11	07/11	08/11	09/11	10/11

When a case is approved in the first month through the eleventh month of the first premium period, only one premium period needs to be established.

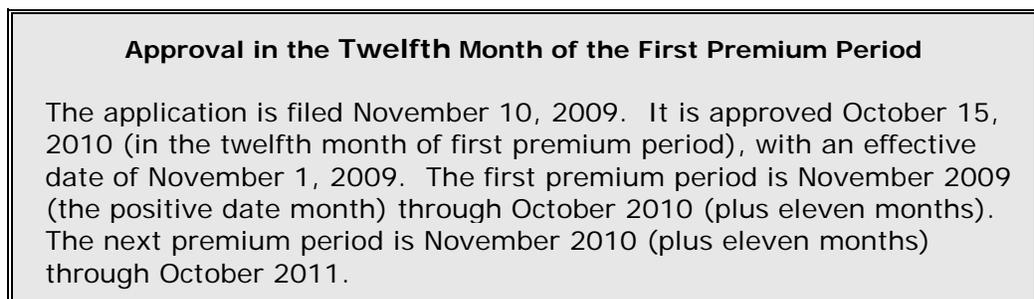
NOTE: Review entries for the next premium period must be entered on the ABC system by timely notice date in the twelfth month of the premium period in order to establish eligibility and the correct premium amount for the next 12-month premium period.



When the case is approved **after the eleventh month** of eligibility, establish:

- ◆ Which premium period the case is in at the time of approval. For example, the first period, second period, or third period.
- ◆ The premium periods before the current premium period.
- ◆ The premium period following the current premium period, if the case is already in the 12th month of the current period.

When the application is approved in the **twelfth month** of a premium period, establish both the first premium period and the premium period following it when you enter the approval.



Application filed 11/10/09 Positive date 11/01/09												Approved 10/15/10, in the twelfth month of eligibility.											
1st 12-Month Premium Period																							
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
11/09	12/09	01/10	02/10	03/10	04/10	05/10	06/10	07/10	08/10	09/10	10/10												
Months of Eligibility Count →																							
1	2	3	4	5	6	7	8	9	1	11	12												
2nd 12-Month Premium Period																							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
11/10	12/10	01/11	02/11	03/11	04/11	05/11	06/11	07/11	08/11	11/11	10/11												
Months of Eligibility Count →																							

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 11/10/09.
- ◆ Medical POS DT of 11/01/09.
- ◆ Medical LAST REV of 11/09 and NEXT REV of 10/11 for the 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 eleven of a succeeding premium period**, establish the first premium period and all subsequent periods when you enter the approval. Example:



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:

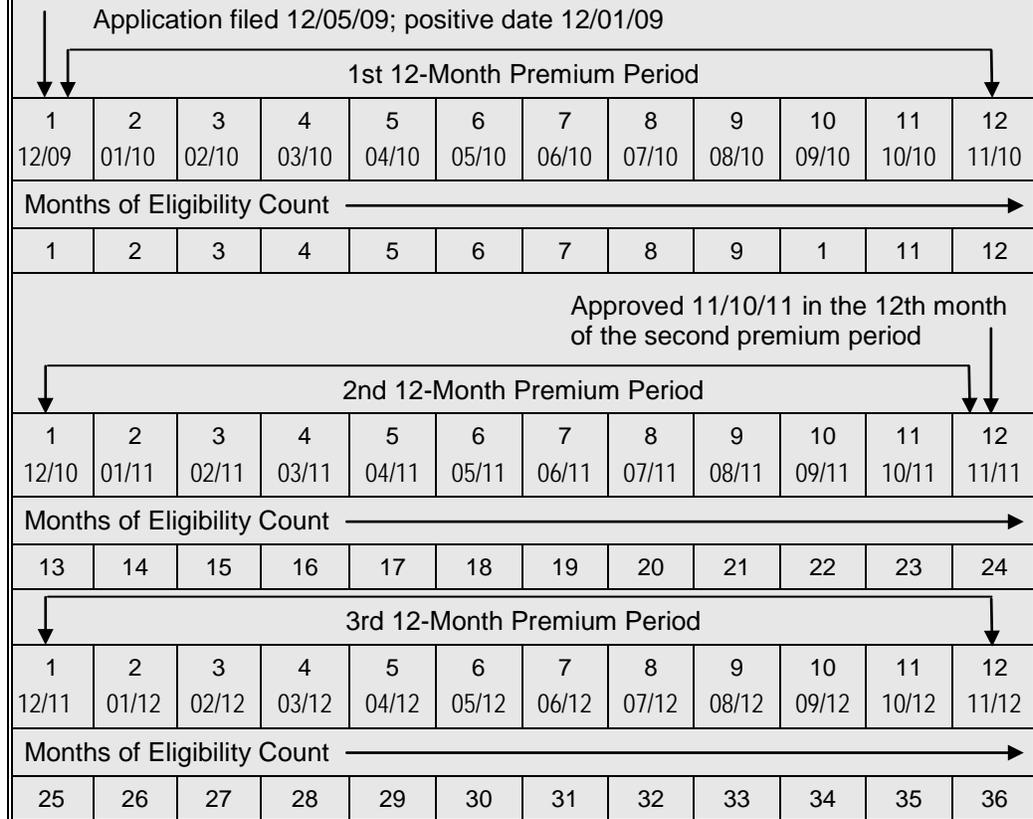
- ◆ Medical entry reason "E" on TD05.
- ◆ Medical APP DT of 12/20/09.
- ◆ Medical POS DT of 12/01/09.
- ◆ Medical LAST REV of 12/09 and NEXT REV of 11/11 for premium period.
- ◆ Income for the premium period that resulted in the lowest premium amount in CNT UI and CNT EI.

When the approval is in **the twelfth month of a subsequent 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 Twelfth Month of the Second Premium Period

The application is filed December 15, 2009. It is approved November 10, 2011 (in the twenty-fourth month of eligibility and the twelfth month of the second premium period) with an effective date of December 1, 2009. The first premium period is December 2009 (positive date month) through November 2010 (plus eleven months). The next premium period is December 2010 (plus eleven months) through November 2011.

Because the case is already in the twelfth month of the second premium period, it is also necessary to establish the third premium period, from December 2011 (plus eleven months) through November 2010.



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 12/15/09.
- ◆ Medical POS DT of 12/01/09.
- ◆ Medical LAST REV of 12/09 and NEXT REV of 11/10 for premium period.
- ◆ Income for the premium period that resulted in the lowest premium amount in CNT UI and CNT EI.

Blocking Premium Payments

Procedure:

For ongoing eligibility, the member may **not** choose which months to pay and which not to pay. Nor may the member choose the order that payments are credited. Premium payments are applied in a specific order by the MEPD billing system.

Central Office staff **cannot** make changes based on notes sent in with the *MEPD Billing Statement* stating the member doesn't want to pay certain months. The MEPD member may choose to change to Medically Needy. See [Relationship to Medically Needy](#) for more information.

The "back months" and retroactive months of eligibility are shown on the *Notice of Decision*. After the member receives the approval notice, the member may notify you of months when MEPD was not needed or the member prefers to have Medically Needy.

If the member does not want MEPD coverage in all of the retroactive or "back" months, ask the member to provide a signed statement listing the months when the member does not need coverage.

Use the MEPC screen to "block" a month so that payments will not be applied. See [14-B\(9\), Change to MEPD Premium: Using MEPC](#). The following chart explains the use of blocking.

Situation	Procedure
If a premium has already been paid for one or more back months...	Do not block the month, as Medicaid eligibility was already granted.
If a premium for a retroactive or "back" month has not been paid...	You may block the retroactive or "back" month, if unpaid.
If a block is entered on a month where the premium has already been paid...	The system will change the payment to an MEPC credit or apply the payment to other months. A WIFS e-mail message will notify you that a recoupment must be completed for Medicaid services paid for the blocked months.
If a month is blocked in error...	You may unblock the month on the MEPC screen by entering a "U" code over the "B" code for that month.

Premium Billing, Due Dates and Collection

Legal reference: 441 IAC 75.1(39)"b"

Policy:

The due date of the payment depends on the date when the premium is assessed. The following chart explains the due date schedule.

When premiums are assessed...	The due date of payment is the...
For the month when the case is approved, and the approval is entered in ABC before system cutoff...	14th day of the month after the month when the case is approved.
For the month when the case is approved, and the approval is entered after system cutoff but before the first day of the next calendar month...	14th day of the month after the month when the case is approved.
For months before the month when the case is approved...	14th day of the third month after the month the case is approved.

When premiums are assessed...	The due date of payment is the...
For months after the month when the case is approved...	14th day of the month the premium is to cover.
For a month when MEPD is reinstated or re-opened after cutoff...	14th day of the following month.

Procedure:

The MEPD billing system issues form 470-3902, *MEPD Billing Statement*, for each month for which a premium is owed. The system generates monthly billing statements at the end of the 15th day of the month, or at the end of day of the first working day after that if the 15th falls on a weekend or holiday.

Bills are mailed to members on the day after they are generated, along with a preaddressed postage-paid return envelope.

Form 470-3928, *MEPD Information About Premium Payments*, is automatically issued to all MEPD members who owe a premium for the first time. A copy of this form is not sent to the worker. This form can be found in 6-Appendix. The form tells members:

- ◆ The due date for ongoing premiums.
- ◆ The address where premium payments are to be sent.
- ◆ That Medicaid pays for medical expenses only after premiums are paid.
- ◆ The benefit of paying in advance of the due date.

MEPD Billing Statements Issued	
Situation	The premium bill will...
If a case is approved before ABC system cutoff in a calendar month...	Include: <ul style="list-style-type: none"> • The month of approval and • All months back to the month of the effective date of eligibility on the ABC system.
If a case is approved after ABC system cutoff in a calendar month...	Include: <ul style="list-style-type: none"> • The month of approval, • The next calendar month, and • All months back to the month of the effective date of eligibility on the ABC system
When there are unpaid months...	Continue to be issued for three consecutive months for any unpaid months.
Every time there is premium or refund activity on an MEPD case...	Be issued to the member as a record of the activity.

The premiums for ongoing months are due by the 14th day of the month the premium is intended to cover. The due date printed on the top half of monthly *MEPD Billing Statements* is the last working day of the month before the month the premium is intended to cover. Use of the earlier due date is meant to encourage members to pay premiums before the first of the month instead of waiting until the 14th.

When an MEPD premium is assessed for a month earlier than 24 months before the current system month, there are special procedures for billing and crediting the premiums. Send an inquiry to the DHS SPIRS Help Desk for assistance.

If an MEPD member requests a new bill, see [14-C, STMT = MEPD Billing Statement Screen](#). A reprint to the member, a reprint to the worker, or a new up-to-date bill may be issued by entries on the STMT screen.

Comment:

See [8-G, MEPD Case Maintenance](#)

See [6-Appendix, MEPD Billing Statement](#)

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

This example shows how due dates are determined.

May	June	July
Application is filed on May 22.	Application is approved on June 10, effective for May (month of application).	
May is: <ul style="list-style-type: none"> • The month of application. • Positive date of eligibility on ABC. • The month before the month that eligibility is approved. 	June is: <ul style="list-style-type: none"> • The month eligibility entries are made in ABC. 	July is: <ul style="list-style-type: none"> • The month after the month that eligibility is approved on ABC.
The premium is due the 14th of the third month after the month when eligibility is approved in ABC (May). The applicant has until May 14th to pay the premium for May coverage, but may choose to pay sooner.	The premium would normally be due June 14, but since the approval decision was entered on June 10, there are not 14 days for the applicant to make the payment before the due date. Therefore, the June premium is due July 14.	The premium is due by July 14.
The premium for May is billed on the first <i>MEPD Billing Statement</i> .	The premium for June is billed on the first <i>MEPD Billing Statement</i> .	The premium for July is billed on the first monthly <i>MEPD Billing Statement</i> (issued June 15).

Payment Address

Legal reference: 441 IAC 75.1(39)“b”(8)

Policy:

Premium payments may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to form 470-3902, *MEPD Billing Statement*. A member may pay in advance.

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 50306-9948

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.

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

Posting of Premium Payments

Legal reference: 441 IAC 75.1(39)“b”(4)

Policy:

The earlier a premium payment is received, the sooner Medicaid eligibility will show on the Eligibility Verification System (ELVS). It is important for members to understand that there will be **no Medicaid eligibility** for a month **until the premium is paid**, even though the due date is not until the 14th of that month.

A member has until the 14th of the month to pay before an MEPD case can be canceled for nonpayment.

When an MEPD case is canceled for nonpayment of the premium, a premium may be paid within three months of the month of coverage or the month of initial billing, whichever is later, for the member to get Medicaid eligibility for a past month.

Any payments received after the 14th of the third month **will not be credited** towards eligibility for the unpaid past month.

Premium payments are applied by the MEPD billing system in this order:

1. Applied to the current month, if unpaid.
2. Applied to the current system month if different from the current calendar month and unpaid.
3. Held as a credit to apply to the next month when received:
 - ◆ After the billing statement has been issued for the next month (after the 15th of the month), and
 - ◆ Before system month end (ABC cutoff).
4. Applied to old unpaid months, as follows:
 - ◆ To the month before the current calendar month, if unpaid, and then
 - ◆ To the oldest unpaid month and forward until all unpaid prior months have been paid.

5. Held as a "credit" and applied to assessed months as the payment becomes due. Excess "credit" will be refunded when:
 - ◆ The worker receives the member's request and then forwards it to the DHS, SPIRS Help Desk via e-mail,
 - ◆ There have been two calendar months of inactivity on the member's MEPD billing account, or
 - ◆ There have been two calendar months of zero MEPD premiums.

Comment:

<p>An MEPD application is filed January 22 and approved April 10 for January through April and ongoing months. The positive date on ABC is January 1. The following chart shows how the first payments are applied according to the dates the first payments are received.</p>		
Date of Payments	Payments Received	Months Paid
April 29	One	1. April, unpaid month of receipt.
April 29	Two	1. April, unpaid month of receipt, and 2. May, the next month after the month of receipt, since it was received after the next month's (May) billing statement was issued on April 15.
May 5	One	1. May, unpaid month of receipt.
May 5	Two	1. May, unpaid month of receipt, and 2. April, unpaid month before the month of receipt, since it was received before the next month's (June) billing statement was issued.
May 10	Three	1. May, unpaid month of receipt, 2. April, unpaid month before the month of receipt, since it was received before the next month's billing statement was issued, and 3. January, oldest unpaid month.

Date of Payments	Payments Received	Months Paid
May 29	Three	<ol style="list-style-type: none"> 1. May, unpaid month of receipt, 2. June, month following the month of receipt, because it was received after the next month's (June) billing statement was issued, and 3. April, the unpaid month before the month of receipt.
May 29	Four	<ol style="list-style-type: none"> 1. May, unpaid month of receipt, 2. June, month following the month of receipt, because it was received after the next month's (June) billing statement was issued, and 3. April, the unpaid month before the month of receipt. 4. January, the oldest unpaid month.
April 12, April 15, April 17	Three	<p>NOTE: The May bill is issued April 16.</p> <ol style="list-style-type: none"> 1. April 12 payment is applied to April, the unpaid month of receipt. 2. The April 15 payment is applied to unpaid March because the current month is paid and the payment was received before the next month's (May) billing statement was issued. 3. April 17 payment is held because the current month is paid and the following month's billing statement has been issued. The payment will be credited to May on the fifth working day before the end of April (the beginning of the new system month).

Relationship to Medically Needy

Legal reference: 441 IAC 75.1(35)“a” and 75.1(39)“a”(5)

Policy:

People who qualify both for MEPD with a premium and for Medically Needy with or without a spenddown may choose which coverage group they want.

Members 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.

Procedure:

Respond to requests from MEPD members with premiums to change to Medically Needy as follows:

- ◆ If a change has occurred and the member no longer qualifies under MEPD, the member can be changed to Medically Needy with a spenddown for any month. It does not matter whether an MEPD premium has already been paid for that month.
- ◆ If the member has not paid the MEPD premium for a month, the member may be changed to Medically Needy in that month.
- ◆ If there has been no change that disqualifies the member from MEPD **and** the member has already paid the MEPD premium for a month, deny the request for a change to Medically Needy for that month.

The following chart gives the processing steps when a Medically Needy member with a spenddown wants to change to MEPD.

Step	Action
1	Approve MEPD beginning with the month the member 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 Medicaid eligibility has been approved for a month when MEPD eligibility will begin.

Step	Action
2	<p>The MEPD billing system will identify all cases with overlapping Medically Needy and MEPD eligibility. The following actions will occur:</p> <ul style="list-style-type: none"> ◆ When the case has been changed from Medically Needy to MEPD, the aid type will be updated 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 WIFS E-mail message 456, which states “ESTD to IME MN Unit” to release spenddown. ◆ When an MEPD case with a premium was a Medically Needy spenddown case, the billing system will send a WIFS E-mail after the premium has been paid with the message “ESTD/IME MN Unit” to release spenddown.
3	<p>If necessary, ask the IME Medically Needy Unit to back out bills for months that the member is eligible for Medicaid under MEPD.</p> <ul style="list-style-type: none"> ◆ Any bill used toward 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. ◆ If the spenddown has been met, send a request to the IME MN Unit to back out medical bills. See 14-1, Medicaid Eligibility Through Another Aid Type.
4	<p>The IME Medically Needy Unit notifies the worker if a Medically Needy recoupment is needed. See an example of a recoupment situation in the Comment section.</p>

Comment:

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. After having met spenddown, the member decides to change to MEPD and 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 IME Medically Needy Unit notifies the worker to complete a claim for Medically Needy up to \$250.

Relationship to QMB and SLMB Coverage

Legal reference: P. L. 100-360, 441 IAC 75.1(29), 75.1(34), 75.1(36), and 76.2(2)

Policy:

An MEPD member may also qualify for the qualified Medicare beneficiary (QMB) or specified low-income Medicare beneficiary (SLMB) program. The expanded specified low-income Medicare beneficiaries (E-SLMB) group is only for those who do not qualify under any other Medicaid group; MEPD members do not qualify for E-SLMB.

Procedure:

Determine if the MEPD member qualifies both for MEPD and for QMB or SLMB. If so, you must set up two separate cases on the ABC system: one for the MEPD eligibility and one for the QMB or SLMB eligibility.

Enter the poverty level for the QMB or SLMB case under the pov field on the TD03 screen. This allows the state to receive federal financial participation for the Medicaid cost of Medicare Part B.

If the member reports an address change, the address must be changed on both the MEPD case and the QMB or SLMB case at the same time.

Comment:

The address used in the MEPD billing system comes from the Medicaid Eligibility System (SSNI). If the MEPD case is temporarily closed because the premium was not paid by the 14th of the month, the MEPD billing system will pick up the active QMB or SLMB case address.

If you don't change the address on the QMB or SLMB case when you change the address on the MEPD case, this will cause the *MEPD Billing Statement* to be sent to the old address.

Medicaid for Kids With Special Needs (MКСN)

Legal reference: 441 IAC 75.1(43) and 75.21(5)"o"

Policy:

Medical assistance is available to children under "Medicaid for Kids with Special Needs" (MКСN) when:

- ◆ The child is under age 19.
- ◆ The child is determined to be disabled based on SSI criteria for disability by either the SSA or DHS.
- ◆ Income is at or below 300% of the federal poverty level for the household size.
- ◆ The child is enrolled in a parent's employer group health insurance when the employer contributes at least 50% of the total cost of annual premiums for that coverage.

There is no resource limit for children in this coverage group.

MКСN members are not eligible for the health insurance premium reimbursement under the Health Insurance Premium Payment (HIPP) program.

Comments:

The following sections give more information on requirements for:

- ◆ [Age](#)
- ◆ [Disability](#)
- ◆ [Family income limits](#)
- ◆ [Health insurance enrollment](#)

Age

Legal reference: 441 IAC 75.1(43)

Policy:

To qualify for MКСN, the disabled child must be under the age of 19.

Procedure:

Make a tickler for the month that the MКСN member will turn age 19. During the month when the MКСN member turns 19:

- ◆ Cancel the MКСN case with timely notice by entering ABC notice message 333, "...you are over the age limit."
- ◆ Make a redetermination to another coverage group if appropriate.

Disability

Legal reference: 441 IAC 75.1(43)

Policy:

To qualify for MKSN, a child must be disabled based on the disability criteria for Supplemental Security Income (SSI). This means that the child must go through the disability determination process through the Social Security Administration or through the Department.

The Department refers determinations to the Bureau of Disability Determination Services (DDS) in the Department of Education. The DDS follows the same standards for the determination of disabilities as the Social Security Administration.

Procedure:

When the parents say the child has been determined to be disabled by the Social Security Administration:

1. Check SDXD to verify the child has been determined to be disabled by the SSA.
 - ◆ If there is no information on the SDXD, and the family claims SSI-related disability for the child, then the family must provide proof of the disability determination. If the family cannot provide proof, make the disability determination referral to DDS.
 - ◆ If the child has already been determined to be disabled for SSI, but is no longer receiving SSI cash benefits, the Department is responsible for conducting the disability review.
2. Contact the Social Security Administration to find out the date of the next scheduled disability review date.
3. If the next scheduled review date is in the future, enter a tickler on the Automated Benefit Calculation (ABC) system as a reminder to initiate the disability review at the appropriate time.

4. If the review is overdue:
 - ◆ Immediately request form 470-3912, *Disability Report for Children*, form 470-4459 or 470-4459(S), *Authorization to Disclose Information to the Iowa Department of Human Services*, and supporting documents from the parents.
 - ◆ After the information is received, make the referral for a disability determination to DDS.

When the child has not been determined to be disabled by the Social Security Administration, the Department must complete the disability determination process. See the *Disability Determination Checklist*, RC-0103, and procedures in [8-C, When the Department Determines Disability](#), for instructions on making the referral.

Family Income Limits

Legal reference: 441 IAC 75.1(43)

Policy:

“Family” includes the MKSN child and family members who **live** with the MKSN child and who are **not** on full Medicaid under another case. Family members include:

- ◆ The parents of the MKSN unmarried child, including stepparents.
- ◆ All siblings under 19 and unmarried.
- ◆ Any children of the MKSN child.
- ◆ The spouse of the MKSN child.

Follow SSI-related income policy to determine income. If the MKSN child is married, do not count the parents’ income. Monthly income limits are:

Household Size	300% of Poverty	Household Size	300% of Poverty
1	2,970	5	7,110
2	4,005	6	8,145
3	5,040	7	9,183
4	6,075	8	10,223

If the family size is over 8, add \$1,040 for each additional member.

Procedure:

The Automated Benefits Calculation (ABC) system will not calculate income eligibility for the MKSN group based on BCW2 screen entries. Use form 470-4632, *Medicaid for Kids with Special Needs Income Worksheet*, to determine if the family net monthly income is no more than 300% of the federal poverty level. Use form 470-4632 to determine income eligibility:

- ◆ At the time of application,
- ◆ When a change of income or household size is reported, and
- ◆ At the annual review.

Form 470-4632 will:

- ◆ Allow all disregards and exemptions that apply to SSI-related Medicaid coverage groups.
- ◆ Total the unearned income of 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 earned income.
- ◆ Add the net unearned income and net earned income and compare the sum to 300% of the federal poverty level for the family size.
- ◆ Show the poverty level and income eligibility.

Keep a copy of the worksheet in the case file. If the child is over income for this group, send a copy of the worksheet to the parents along with a manual *Notice of Decision* stating the child is not eligible for MKSN because the countable income is above the family income limits.

Health Insurance Enrollment

Legal reference: 441 IAC 75.1(43)

Policy:

As a condition of eligibility for the MKSN coverage group, a parent must enroll the child in the parent's employer group health insurance plan when the employer contributes at least 50% of the total cost of annual premiums.

Comment:

This requirement applies only to parents who live with the child, not to a non-custodial parent.

Procedure:

The employer may contribute 100% of the cost for the employee alone, but make lower contributions for premiums required to cover family members. Confirm the amount the employer annually contributes towards the premium amount that would include the child in the health insurance coverage.

The following charts detail the specific procedures that you must use to evaluate the health insurance enrollment requirement for applications and for eligibility reviews.

Application Processing	
Step	Action
1	Notify the parents about their responsibility concerning the health insurance requirement by giving them Comm. 337, <i>Medicaid for Kids with Special Needs</i> (MKSN).
2	Send form 470-4633, <i>Health Insurance Information for Kids with Special Needs</i> , and the <i>Insurance Questionnaire</i> , form 470-2826 or 470-2826(S), to the parents to request information about: <ul style="list-style-type: none"> ◆ The availability of employer health insurance, ◆ The enrollment status of the child in the health insurance plan, and ◆ The employer contribution to the premium amount to provide coverage for the child
3	The parents must: <ol style="list-style-type: none"> 1. Check the correct box on the 470-4633 to describe the status of their child's health insurance coverage, and 2. Either: <ul style="list-style-type: none"> ◆ Complete <i>Insurance Questionnaire</i>, form 470-2826 or 470-2826(S), and return it to the worker, or ◆ Take the second page of form 470-4633 to the employer to be completed and returned to the worker.

Step	Action
4	<p>If the child is already enrolled in the parent's employer group health insurance:</p> <ul style="list-style-type: none"> ◆ Ask the parents to provide verification of the enrollment. ◆ Advise the parents that the child should not be disenrolled, unless the parents provide proof that the employer paid less than 50% of the cost of annual premiums for coverage that includes the child.
5	<p>If the child is not enrolled in the parent's employer group insurance:</p> <ul style="list-style-type: none"> ◆ Request information about the cost of health insurance premiums that are required to provide coverage for the child. ◆ Check the information to see if the employer pays at least half the cost to the premiums that are required to cover the child.
6	<p>If the employer pays at least half the premium cost required to cover the child, then tell the parent:</p> <ul style="list-style-type: none"> ◆ If the parent can enroll the child without a waiting period, then the parent must provide verification of the child's enrollment before Medicaid can be approved. ◆ If the parent verifies the need to wait to enroll the child at a later date, such as during the open enrollment period, Medicaid can be approved since the employer insurance is not currently available to the child.
7	<p>If the parents cannot enroll the child until a later date, enter an ABC tickler to follow up on:</p> <ul style="list-style-type: none"> ◆ The enrollment of the child during the open enrollment period, or ◆ If not enrolled on the follow-up date, that the employer reduced its contribution to less than 50% of the annual cost of premiums to provide coverage to the child.

Medicaid Review Processing	
Step	Action
1	At the annual Medicaid eligibility review, verify whether: <ul style="list-style-type: none"> ◆ The child has remained enrolled in the health insurance, or ◆ The employer has reduced its contribution to less than 50% of the annual cost of premiums to provide coverage to the child.
2	If the employer still contributes at least 50% of the annual cost of premiums required to provide coverage to the child, inform the parents that the child must remain enrolled. If the employer does not pay at least 50% of the annual cost of premiums required to provide coverage for the child, inform the parent that it is not required to enroll the child nor keep the child enrolled.

MKSN Case Examples

<p>1. Ms. G applies for MKSN for her son, Bobby. Ms. G is covered by the Iowa Family Planning Network (IFPN). Since IFPN is less than full Medicaid coverage, Ms. G is included in the MKSN household size and her income is counted.</p> <p>The worker determines that Bobby meets the income requirements for a household size of two by completing the <i>Medicaid for Kids with Special Needs Income Worksheet</i>, form 470-4632.</p> <p>Bobby has not had a disability determination from the Social Security Administration. The worker follows procedures in 8-C, When the Department Determines Disability, to refer Bobby for a DHS determination.</p> <p>Disability Determination Services (DDS) determines that Bobby is disabled. The worker makes a tickler for the continuing disability review (CDR) scheduled by DDS for three years in the future.</p> <p>The worker verifies that:</p> <ul style="list-style-type: none"> ◆ Bobby is enrolled in Ms. G’s employer health insurance under the “family” coverage rate. ◆ The employer does not pay at least half of the annual cost of premiums required to cover Bobby under the family premium rate.

The worker advises Ms. G that:

- ◆ Bobby is not required to be enrolled in the health insurance at that time.
- ◆ If Ms. G decides to terminate Bobby's coverage, then she must report the change to the worker within ten days.
- ◆ If the employer increases its contribution to at least half of the annual cost of the health insurance premiums required to have Bobby covered by the health insurance, the Bobby would be required to be enrolled.

2. Eddie and Ellie are disabled 7-year-old twins receiving SSI cash benefits and Medicaid under the 64-0 medical aid type. Their father, Mr. E, receives a pay raise, and their worker receives notification from SDX of their SSI cancellation due to being over SSI income limits.

The worker contacts the SSI representative to confirm the date of the next disability review. The worker makes a tickler for a disability review date for each child, because it is the Department's responsibility to follow up on disability reviews after the child is canceled from SSI cash benefits.

Eddie and Ellie remain continuously eligible for Medicaid under the 64-2 medical aid type until the next eligibility review. The date of the next Medicaid eligibility review is either:

- ◆ The date of the next disability review, if this date is within the next 12 months, or
- ◆ 12 months after the date of SSI cancellation, if the date of the next disability review is more than 12 months away.

At the Medicaid eligibility review, the worker uses the *Medicaid for Kids with Special Needs Income Worksheet*, form 470-4632, to determine if Eddie and Ellie meet the income requirements for MKSN.

Since Medicaid ended under the 64-2 aid type, the worker includes both Eddie and Ellie on the same MKSN case. The household size is four, including both parents and the two children. The results from the worksheet calculation show that they are under the MKSN income limits.

Mr. E provides proof that Eddie and Ellie are enrolled in his employer health insurance plan and that his employer paid over half the annual cost of premiums for the "employee plus children" coverage.

Mr. E inquires about the Health Insurance Premium Payment (HIPP) program paying for the premiums. The worker explains that the HIPP program could not pay for the premiums because Eddie and Ellie will be on the MKSN group, which is ineligible for the HIPP reimbursements.

The worker explains that a condition of eligibility for MKSN is that Eddie and Ellie remain enrolled in the employer health insurance plan as long as the employer pays at least half of the cost of the premiums to provide coverage to the children.

Several months later Mr. E reports that for the upcoming year, the employer contribution would be reduced to only 40% of the annual cost of premiums. Mr. E sends proof of this change to the worker. The worker notifies Mr. E that he is no longer required to maintain employer health insurance coverage for Eddie and Ellie as a condition of their MKSN eligibility.

NOTE: The policy for continuous eligibility for children went into effect July 1, 2008.

3. Mr. and Mrs. B apply for MKSN for their child, Betty. The household includes:

Mr. B,

Mrs. B

Child, Ann, age 16, who is on Medicaid under an HCBS waiver group

Child, Bill, age 15

Child, Betty, age 7, who received SSI until February 2008, when her income went over the SSI limit

The worker uses form 470-4632, *Medicaid for Kids with Special Needs Income Worksheet*, to calculate MKSN eligibility for Betty. Ann is not included in the household size because she receives Medicaid as a separate case. The household size is four.

The worksheet calculation compares the total gross income to 300% of the federal poverty level for the household size of four. Betty is income-eligible for MKSN.

Betty has been determined to be disabled by the Social Security Administration. Since Betty is no longer eligible for SSI cash benefits, the worker contacts the SSI representative to find out the date scheduled for the next disability review. The worker enters an ABC tickler as a reminder for the disability review date.

Mr. B provides proof that his employer pays more than half of the annual cost of premiums required for the “family” coverage rate. Betty is not currently enrolled in the plan.

The worker explains to Mr. B that he is required to enroll Betty in his employer insurance plan as a condition of eligibility for MKSN. Mr. B provides proof that he cannot enroll Betty until the next open enrollment period. Since Betty cannot be enrolled until the open enrollment period, the worker:

- ◆ Approves MKSN for Betty, and
- ◆ Enters an ABC tickler for five days before the beginning of the open enrollment.

At the open enrollment period, the worker asks Mr. B to provide proof:

- ◆ That Betty was enrolled, or
- ◆ That the employer pays less than half of the cost of premiums.

If Mr. B fails to enroll Betty in his employer group plan during open enrollment, Betty remains continuously eligible until the next eligibility review. Then Betty is canceled from MKSN coverage.