STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

March 8, 2024

GENERAL LETTER NO. 8-F-108

ISSUED BY: Iowa Medicaid

SUBJECT: Employees' Manual, Title 8, Chapter F, ***Medicaid Coverage Groups***, 60-63, 66, 68, 70, 73-75, 79, 80, 83, 85, revised.

Summary

This chapter is revised to

- Add the 2024 Social Security cost-of-living increase of 3.2 percent and update figures affected by this adjustment.
- Update the resource limits for qualified Medicare beneficiaries (QMB), specified low-income Medicare beneficiaries (SLMB), and expanded low-income Medicare beneficiaries (E-SLMB) to $9,430 for an individual and $14,130 for a couple.

Effective Date

January 1, 2024.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

Page	Date
60-63, 66, 68, 70, 73-75, 79	April 14, 2023
80, 83	July 14, 2023
85	April 14, 2023

Additional Information

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

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 2001	3.5%
July 1978	6.5%		January 2002	2.6%
July 1979	9.9%		January 2003	1.4%
July 1980	14.3%		January 2004	2.1%
July 1981	11.2%		January 2005	2.7%
July 1982	7.4%		January 2006	4.1%
1983	0		January 2007	3.3%
January 1984	3.5%		January 2008	2.3%
January 1985	3.5%		January 2009	5.8%
January 1986	3.1%		January 2010	0
January 1987	1.3%		January 2011	0
January 1988	4.2%		January 2012	3.6%
January 1989	4.0%		January 2013	1.7%
January 1990	4.7%		January 2014	1.5%
January 1991	5.4%		January 2015	1.7%
January 1992	3.7%		January 2016	0
January 1993	3.0%		January 2017	0.3%
January 1994	2.6%		January 2018	2.0%
January 1995	2.8%		January 2019	2.8%
January 1996	2.6%		January 2020	1.6%
January 1997	2.9%		January 2021	1.3%
January 1998	2.1%		January 2022	5.9%
January 1999	1.3%		January 2023	8.7%
January 2000	2.5%*		January 2023	3.2%
* 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.

Date of COLA	% of COLA	Result Before Rounding	Entitlement
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
1-17	0.3	686.1523	$686.10
1-18	2.0	699.822	$699.80
1-19	2.8	719.3944	$719.30
1-20	1.6	730.9047	$730.90
1-21	1.3	740.4064	$740.40
1-22	5.9	784.09037	$784.00
1-23	8.7	852.30623	$852.30
1-24	3.2	879.58002	$879.50

These calculations show that if there were no other increase, the current gross social security income would be $879.50. Since the actual amount is $900.00, the conclusion is that there was an increase of $20.50 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
+	57.00	Veterans income
$	557.40	
-	20.00	General income exclusion
$	537.40	Countable income to compare to $943, 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 $435.90 gross social security income in March 2005 when she was canceled from SSI. She continues living independently, and now has $722.00 social security income and $600 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 $291 per month attributable to a non-COLA increase.

The calculation of income eligibility is as follows:

$	435.90	Social security in March 1995
+	291.00	Non-COLA increase
$	726.90	
+	267.50	Countable earned income ($600 - 65 ÷ 2)
$	994.40	
–	20.00	General income exclusion
$	974.40	Countable income

Miss Y's countable income is over the SSI income limit of $943 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 $1,042. 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	+	123.00
Need standard	$	904.20

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 $782 and Mrs. B now has gross social security of $488. 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
+ 165	Mrs. B's social security in 1/91
$ 498	
+ 300	Veterans benefits
$ 798	
- 20	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 $1,415.

Due to Social Security Benefits Paid From Parent's Account

Legal reference: Public Law 99-643, 441 IAC 75 (Rules in Process)

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.

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 $536.00 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 $121.70.

$	536.00	Current gross social security
–	35.00	Actuarial increase
–	121.70	COLA
$	379.30	
+	269.00	Civil service income
$	648.30	
–	20.00	General income exclusion
$	628.30	The worker compares this computed income to $943 (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: 42 CFR 435.138, 441 IAC 75 (Rules in Process), P.L. 100-203

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.

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, 441 IAC 75 (Rules in Process), 75 (Rules in Process), 75. (Rules in Process), P. L. 100-360

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/ID and has been institutionalized for 30 consecutive days.
- Meets the level of care requirements for the institution, as determined by the Iowa Medicaid Enterprise, Managed Care Organization, or Medicare. See 8-I, *Medical Necessity*.
- Is age 65 or older, blind, disabled, or is under the age of 21.
- Meets all SSI eligibility requirements except income. EXCEPTION: Do not consider resources for children under 21.
- 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 $2,829. If both spouses enter a medical institution and live in the same room, the income limit is two times $2,829, or $5,658.

For all people in this coverage group, count income using SSI policies. For adults, count resources using SSI policies. For children under age 21, disregard resources of all household members. NOTE: See also FMAP-Related Coverage Groups: People in a Medical Institution Within the 300% Income Limit.

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 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 21 for the initial month of eligibility. Follow SSI deeming policies in 8-E, *Deeming NonMAGI-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 a coverage group that does not pay the facility but pays for other medical services. 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 $2,829. If **both** spouses enter a medical institution and live in the same room, the income limit is two times $2,829 or $5,658.

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 as long as they meet a category of eligibility for the retroactive period as defined in 8-A, *Definitions*.

5. Determine client participation according to procedures in 8-I, *Client Participation*.

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, 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 $2,500 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
–	20.00	Income exclusion
$	2,180.00	
–	65.00	Work exclusion
$	2,115.00	
–	1,057.50	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 $472 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
–	472	Allocated for the ineligible child
$	2,028	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:

$	2,028.00	Mrs. J's earned income after the deeming
+	2,200.00	Mr. J's gross earned income
$	4,228.00	
–	20.00	Income exclusion
$	4,208.00	
–	65.00	Work exclusion
$	4,143.00	
–	2,071.50	1/2 remainder
$	2,071.50	Net countable income

The $2,071.50 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.

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 (Rules in Process)

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 NonMAGI-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 NonMAGI-Related Resource Policies*. The resource limit for the QMB group is $9,430 for an individual and $14,130 for a couple.
- Meets all other NonMAGI-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. Clients who are eligible for QMB in ELIAS and for Medically Needy in ABC 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 Medically Needy case. Also enter a "Q" in the QMB indicator for each person on Medically Needy with a zero spenddown.

Step 2: To determine income eligibility for Mr. A, the worker computes the allocation of income to the ineligible child. A maximum of $472 may be allocated to meet the needs of the child, from Mrs. A, the ineligible spouse.

$ 311	Mrs. A's gross unearned income
– 161	Allocation for ineligible child since the child has $311 income ($472 –
$ 150	$311)

$150 is less than $472. 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
– 20	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 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.

1. 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.
2. 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 (Rules in Process), 76 (Rules in Process)

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-I, *Client Participation*.

Specified Low-Income Medicare Beneficiaries (SLMBs)

Legal reference: 441 IAC 75 (Rules in Process)

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	$1,215	$1,458
Couple	$1,644	$1,972

To determine net countable monthly income, follow SSI policies. See 8-E, *Income Policies For NonMAGI-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 $9,430 for an individual and $14,130 for a couple. See 8-D, *General NonMAGI-Related Resource Policies*.
- Meets all other nonfinancial NonMAGI-related Medicaid eligibility requirements except for disability determination and age.

Medicaid will **only** pay the 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.

For family size:	Income is at least:	But is less than:
Individual	$1,458	$1,641
Couple	$1,972	$2,219

To determine net countable monthly income, follow SSI policies. See 8-E, *Income Policies For NonMAGI-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 $9,430 for an individual and $14,130 for a couple. (See 8-D, *General NonMAGI-Related Resource Policies*.)
- Meets all other NonMAGI-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 NonMAGI-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:

$ 1,190	Gross social security
+ 300	Retirement pension
$ 1,490	
– 20	Income exclusion
$ 1,470	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 system. Enter the poverty level on the system for each person on the case.

For Medically Needy with a spenddown, also enter an "E" in the QMB indicator on TD03 for each person who is eligible as an expanded SLMB.

- 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 to see if Electronic Data Sources (EDS) returned a verified disability.
- Check SDX in WISE. 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 $1,550 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 (Rules in Process)

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.