October 10, 2025

GENERAL LETTER NO. 8-F-110

ISSUED BY: Bureau of Medicaid Eligibility Policy
Division of Community Access and Eligibility

SUBJECT: Employees' Manual, Title 8, Chapter F, **Medicaid Coverage Groups**, Contents 1-3, 1, 6-11, 43, 66-138, revised.

Summary

This chapter is revised to

- Correct the spelling of non-MAGI throughout the chapter
- Removed reference to ABC system where needed
- Updates/clarification added to pregnancy and postpartum with the 12-month postpartum period. Scenarios updated.
- Updated the amount for MEPD resource limits for couples
- Updated premium income table amounts for MEPD

Effective Date

October 15, 2025.

Material Superseded

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

Page	Date
Contents 1-3	February 28, 2025
1, 6-11, 43, 66-138	February 28, 2025

Additional Information

Refer questions about this general letter to your area eligibility determinations manager.

Page

Page

Page

Overview

This chapter provides the Medicaid eligibility standards for MAGI-related and non-MAGI-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 deemed newborns, which apply to both MAGI-related and non-MAGI-related people. The next sections explain the coverage groups for women who need treatment for breast or cervical cancer. MAGI-related and non-MAGI-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 MAGI-related groups, followed by a similar section for coverage groups that are based on the general policies of the non-MAGI-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.

For cases in ELIAS, ELIAS uses an ELIAS aid code. Currently, all ELIAS aid codes are mapped back to the corresponding ABC aid type as listed in SSNI and MMIS. See EDBC Roles, Statuses, and Aid Codes for a list of ELIAS aid codes.

Pregnant or Postpartum Women and Deemed Newborns

Three conditions for Medicaid eligibility cross all coverage groups:

- Once a pregnant woman establishes Medicaid eligibility (except for Medically Needy when a spenddown has not been met), she remains eligible throughout the pregnancy with a few exceptions.
- A woman who is eligible and enrolled in Medicaid on the date her pregnancy ends may remain eligible for Medicaid for the 12-month postpartum period with a few exceptions.
- 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.

Continuous Eligibility for Pregnant and Postpartum Women

Legal reference: 42 CFR 435.170, 441 IAC 75.18(249A)

A pregnant woman who was eligible and enrolled in Medicaid while still pregnant remains continuously eligible for Medicaid throughout the pregnancy and postpartum period without regard to changes in circumstances, with a few exceptions.

Exceptions to CE during pregnancy and postpartum:

- The individual requests voluntary termination
- The individual ceases to be a state resident
- The agency determines that the eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual
- The individual dies

Continuous eligibility does not apply if the pregnant woman was only enrolled under Medically Needy with a spenddown that has not been met, under state-only funding, or during a presumptive eligibility (PE) period. The woman must continue to meet all other eligibility requirements during the rest of her pregnancy. (See also Postpartum Eligibility.) NOTE: A woman who is eligible and enrolled in Medicaid while still pregnant whose benefits are limited to emergency services is continuously eligible without regard to changes in income during the pregnancy and/or postpartum period.

A pregnant woman eligible and enrolled in 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 who is determined eligible and is enrolled for a retroactive month **while she is still pregnant** continues to be eligible This policy **does not** apply to women who would have been eligible or potentially eligible only under Medically Needy with a spenddown that has not been met or state-only in the retroactive period.

NOTE: While a pregnant woman remains continuously eligible during her pregnancy, with limited exceptions, it is possible for a pregnant woman to change coverage groups during her pregnancy unless she is eligible as a Hawki member or chose to remain on IHAWP during her pregnancy and postpartum period.

1. Mrs. K, aged 25 and pregnant, receives Medicaid under FMAP. On August 15, she reports that her husband started receiving Social Security disability in the amount of $1,200 per month.

   The worker determines that the household's income now exceeds FMAP limits for a four-member household (Mr. K, Mrs. K, their three-year-old son, and one unborn child). Mrs. K is continuously eligible. She would move to transitional Medicaid and may remain eligible through her 12-month postpartum period.
2. Ms. T, age 37, is six months pregnant when she applies for Medicaid on 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.

Ms. T is granted eligibility effective June 1 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. If Ms. T is eligible and enrolled in Medicaid on the last day of her pregnancy, she will be eligible for the 12-month postpartum period beginning the month following the last day of her pregnancy.

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. 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 continuously eligible because she was both eligible and enrolled in Medicaid while pregnant.
4. Ms. G is a pregnant undocumented alien who applied for Medicaid in October. She verified an emergency medical condition with dates of service in October only and met all other eligibility requirements in that month, so she was approved for limited Medicaid for emergency services coverage for the month of October. Ms. G is continuously eligible through her pregnancy and postpartum period. A claim is submitted for Ms. G for December for non-emergency services. The claim is denied as Ms. G is only continuously eligible for limited emergency services. On January 10, Ms. G submits a Verification for Emergency Health Care Services (VEHCS) Form 470-4299 for services received on January 2nd and 3rd. She also reports an increase in income. Her income exceeds program limits for January, but she meets all other eligibility requirements that month. Since she was previously eligible and enrolled in Medicaid while pregnant and Ms. G is continuously eligible, and has provided a new VEHCS, Ms. G's emergency services rendered on January 2nd and 3rd are covered.

Postpartum Eligibility

Legal reference: 441 IAC 75 (Rules in Process)

Medicaid continues to be available during the 12-month postpartum period to a woman who was eligible and enrolled in Medicaid on the date her pregnancy ends.

The postpartum period begins the month following the last day of pregnancy and continues through the last day of the month in which the 12-month period ends.

An application is not required, unless the woman is a Medically Needy member and their spenddown has not been met. If a Medically Needy member's certification period expires during the postpartum eligibility period and their spenddown has not been met, she must file an application.

Continuously eligible MAGI pregnant/postpartum women retain their eligibility even if they move into a different household.

When the pregnancy terminates (for any reason), the woman is still entitled to postpartum coverage.

NOTE: While a postpartum woman remains continuously eligible during her postpartum period, with limited exceptions, it is possible for a postpartum woman to change coverage groups during her pregnancy and postpartum period unless she is eligible as a Hawki member or chose to remain on IHAWP during her pregnancy and postpartum period.

At the end of the 12-month postpartum period, a review form will be sent and eligibility is redetermined. If there are other individuals in the home, the review will align with the other individuals.

1. The household consists of Mr. U, age 40, who works full time, and Mrs. U, age 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. After the postpartum period ends, a redetermination of Mrs. U's eligibility is completed. Countable income now exceeds the MAC income limits.

   Since there is no other coverage group under which Medicaid eligibility can be established other than Medically Needy with a spenddown, Medicaid eligibility for Mrs. U is timely canceled effective May 1. Medicaid eligibility for the baby as a deemed newborn will continue through the month of the first birthday.

2. The household consists of Mr. W, age 29, who works full time, and Mrs. W, age 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 met all eligibility criteria including income for the month of June and for the retroactive coverage month of May. She was over the income limit beginning in July.

   Mrs. W is approved for May, June and ongoing coverage. Mrs. W is continuously eligible for postpartum coverage because she was both eligible and enrolled in Medicaid while still pregnant.

3. Ms. J, age 18, is pregnant and receives Medical Assistance under the Hawki coverage group. Ms. J turns 19 in May. Even though Ms. J is 19, she will remain on Hawki as a pregnant woman through her pregnancy and postpartum period. On July 12, the baby is born. Ms. J remains on Hawki coverage for her postpartum period even though she is over 18 years old. She will remain on Hawki through the remainder of her postpartum period. The baby will be approved for deemed newborn coverage.

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 IHAWP coverage group. Mrs. F chooses to remain on IHAWP when she reports her pregnancy and will remain on IHAWP coverage for the remainder of her pregnancy and postpartum period. The baby is born October 15. Mrs. F will remain on IHAWP for the remainer of her postpartum period and the baby will be approved for deemed newborn coverage.

5. The household consists of Ms. L, age 35, who works full-time and is pregnant. Ms. L is currently receiving Medicaid under the Medically Needy program for a certification period of August-September. Ms. L does not meet her spenddown during the months of her certification period.

   Ms. L must reapply for Medically Needy if she wants to continue to receive Medicaid eligibility because her certification has expired. She must meet the spenddown obligation for the new certification period to obtain CE eligibility as a pregnant/postpartum woman.

Deemed Newborn Children of Medicaid-Eligible Mothers

Legal reference: 42 CFR 435.117, 441 IAC 75 (Rules in Process); Public Law 111-3

Policy: Medicaid is available to deemed newborn children if the mother establishes Medicaid eligibility for the month of the child's birth under a MAGI-related or non-MAGI-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 deemed newborn child to Medicaid.

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

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

When establishing the 12-month eligibility period for the deemed 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 deemed newborn's Medicaid with timely notice if verification is not received. Reopen Medicaid for the deemed newborn retroactively if verification is received before the deemed newborn's first birthday and the deemed newborn is otherwise eligible.

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.

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

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 MAGI-Related Case Maintenance.

The ELIAS system will issue a **Medicaid/Hawki Review, form 470-5168** by the fifth of the month prior to the review month. If this review form is not returned on time, transitional Medicaid certification will end and no further action is required by the worker.

Iowa Health and Wellness Plan (IHAWP)

Legal reference: 441 IAC 74; 441 IAC 75(Rules in Process)

The Iowa Health and Wellness Plan (IHAWP) coverage group is available to persons who are age 19 through age 64 who meet the following eligibility requirements:

- Are not eligible for medical assistance in a mandatory MAGI-related or non-MAGI-related coverage group; and
- Have countable income at or below 133 percent of the federal poverty level for their household size; and
- Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act; and

There are no income requirements or limits with this coverage group. However, for foster care youth who aged out prior to January 1, 2023, if the person provides income information, evaluate the income to see if they could receive Medicaid through a different mandatory coverage group. If the person can receive Medicaid through a different mandatory coverage group other than IHAWP, they are not eligible for EMIYA. This is not necessary for someone who aged out on or after January 1, 2023.

People who receive Medicaid through EMIYA will go through passive renewal at review time. If the review form is not returned, Medicaid will continue through EMIYA until attaining the age of 26.

Continuous Eligibility for Children

Legal reference: 42 CFR 435.926, 441 IAC 75.19(249A)

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.

Continuous eligibility applies equally to all children without regard to whether their eligibility was provided under MAGI or non-MAGI coverage groups. Continuous eligibility policies must also be applied even when it is necessary to move a child from one Medicaid case to another. Refer to NJA0096, Continuous Medicaid Eligibility for Children for procedural instructions applying to various scenarios for continuous eligibility in ELIAS.

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: Continuous eligibility does not apply if the child:

- is found to not have been initially eligible,
- was eligible under state-only funding,
- was eligible for retroactive Medicaid only,
- did not have either U.S. citizenship and identity, or non-citizenship/alien status, verified within the reasonable opportunity period, or
- was eligible only under the Medically Needy coverage group.

EXCEPTION: Children who received Subsidized Guardianship through the Medically Needy coverage group may remain continuously eligible.

When "deemed newborn status" ends, ELIAS automatically completes a redetermination to determine ongoing Medicaid eligibility.

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

Continuous eligibility for a child takes precedence over 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.

Continuous Eligibility Does Not End Until Next Annual Review is Due

A child (not in "deemed 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.

A child who meets temporary absence for less than three months may be continuously eligible. See 8-C, Temporary Absence for Less Than Three Months.

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

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

When a child ages out of FMAP, ELIAS automatically redetermines other eligibility or defaults to maintain continuous eligibility for the child.

The annual review month will remain unchanged if the child remains on the same case but the coverage group 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.

Transitional Medicaid

Transitional Medicaid eligibility takes precedence over continuous eligibility processes for a child. ELIAS moves a child losing FMAP due to increased earned income into the Transitional Medicaid coverage group if all TM requirements are met. A child losing eligibility under the FMAP coverage group shall not remain on FMAP under continuous eligibility provisions unless there is no TM eligibility for the child.

When a child only remains eligible for FMAP due to continuous eligibility provisions, the months the child receives FMAP due to continuous eligibility do not count toward the TM requirement of receiving FMAP for at least 3 of the last 6 months.

If there is an increase in earned income when a child's continuous eligibility is ending, the child shall not be redetermined to the Transitional Medicaid coverage group. Eligibility under TM may begin only after all eligibility factors are met again.

Continuous Eligibility Ends Before Next Annual Review

Continuous eligibility shall end before the annual review date for a child if any of the following occurs:

- The child turns age 19,
- The child is found to not have been initially eligible,
- Per the request of the household,
- The child is no longer a resident of Iowa (must be reported by household), or
- The child dies.

Continuous Eligibility Ends At Annual Review

Continuous eligibility ends at the annual review date.

NOTE: Annual reviews are often completed early when applications or changes are processed. 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.

New Continuous Eligibility After Eligibility Reestablished At Annual Review

A new 12-month continuous eligibility period may begin only after all eligibility factors are met at the annual review or at application.

Non-MAGI-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. These are referred to as "non-MAGI-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 Needy.
- 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.
- Deemed newborn children of Medicaid-eligible mothers. See Deemed Newborn Children of Medicaid-Eligible Mothers.

This section explains the non-MAGI-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: 42 CFR 435.120, 441 IAC 75 (Rules in Process)

SSI recipients, including people receiving SSI payments based on presumptive disability, are eligible for Medicaid.

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 Non-MAGI-Related Children

Legal reference: 441 IAC 75.19

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, or the first month in which eligibility is established following the month of application, whichever is latest. See Continuous Eligibility for Children under MAGI-Related Coverage Groups.

Essential Persons

Legal reference: 42 CFR 435.131, 441 IAC 75 (Rules in Process)

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 (Rules in Process)

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

Legal reference: 42 CFR 435.232, 441 IAC 75 (Rules in Process)

Medicaid is available to aged, blind, and disabled applicants and recipients of State Supplementary Assistance payments unless:

- The SSA recipient 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.

NOTE: Resources continue to be a Medicaid eligibility factor for children or adults who are eligible as an SSA recipient.

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.

Due to Requirements That Do Not Apply to Medicaid

Legal reference: 42 CFR 435.122, 441 IAC 75 (Rules in Process)

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.

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 (Rules in Process)

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 **470-5590** or **470-5590(S)**, **Ten-Day Report of Change for Medicaid/Hawki**. 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 2002	2.6%
July 1978	6.5%		January 2003	1.4%
July 1979	9.9%		January 2004	2.1%
July 1980	14.3%		January 2005	2.7%
July 1981	11.2%		January 2006	4.1%
July 1982	7.4%		January 2007	3.3%
1983	0		January 2008	2.3%
January 1984	3.5%		January 2009	5.8%
January 1985	3.5%		January 2010	0
January 1986	3.1%		January 2011	0
January 1987	1.3%		January 2012	3.6%
January 1988	4.2%		January 2013	1.7%
January 1989	4.0%		January 2014	1.5%
January 1990	4.7%		January 2015	1.7%
January 1991	5.4%		January 2016	0
January 1992	3.7%		January 2017	0.3%
January 1993	3.0%		January 2018	2.0%
January 1994	2.6%		January 2019	2.8%
January 1995	2.8%		January 2020	1.6%
January 1996	2.6%		January 2021	1.3%
January 1997	2.9%		January 2022	5.9%
January 1998	2.1%		January 2023	8.7%
January 1999	1.3%		January 2024	3.2%
January 2000	2.5%*		January 2025	2.5%
January 2001	3.5%			
* The 2000 amount was adjusted for a CPI error. Add the result to the immediately preceding entitlement. Use that total to calculate the next increase, if any.				

Before July 1982, the Social Security Administration **rounded** COLA benefits to the nearest dime (e.g., $179.555 became $179.60). Since July 1982, Social Security has **dropped** benefits to the nearest dime ($179.555 becomes $179.50).

If there were no increases other than COLAs, your calculation should be equal to the current social security income. If the calculation is off less than $2 from the current actual gross social security benefit, the difference is likely due to rounding. Consider the figures equal.

Due to an error or another factor, the social security entitlement may have decreased. If so, confirm it with the Social Security office.

If there are benefit increases other than COLAs, count those as income in determining current SSI or SSA eligibility. Verify this income from the client's records or the Social Security office.

Mr. A's current gross social security income is $920. 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
1-25	2.5	901.56952	$901.50

These calculations show that if there were no other increase, the current gross social security income would be $901.50. Since the actual amount is $920.00, the conclusion is that there was an increase of $18.50 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 $967, 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 $967 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	+	126.00
Need standard	$	907.20

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 $1,450.

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.
- 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 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-ID, 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 (Rules in Process)

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.

Due to Actuarial Change for Widowed Persons

Legal reference: 42 CFR 435.137, 441 IAC 75 (Rules in Process), P.L. 99-272

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/widower's disability benefit and SSI or SSA for January 1984.
- They became ineligible for SSI or SSA because their widow/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/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/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 $967 (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.

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.

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 (Rules in Process)

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, 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 $2,901. If both spouses enter a medical institution and live in the same room, the income limit is two times $2,901, or $5,802.

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.

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 21 in this coverage group.

2. Sam, age 8, resides in an ICF/ID 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 12 midnight 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 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 Non-MAGI-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 $2,901. If **both** spouses enter a medical institution and live in the same room, the income limit is two times $2,901 or $5,802.

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.

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, Section 6012; 441 IAC 75 (Rules in Process)

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 Non-MAGI-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	$2,609
Couple	$3,525

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 Non-MAGI-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 non-MAGI-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, 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 $483 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
– 483	Allocated for the ineligible child
$ 2,017	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:

$ 2,017.00	Mrs. J's earned income after the deeming
+ 2,200.00	Mr. J's gross earned income
$ 4,217.00	
– 20.00	Income exclusion
$ 4,197.00	
– 65.00	Work exclusion
$ 4,132.00	
– 2,066.00	1/2 remainder
$ 2,066.00	Net countable income

The $2,066.00 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.

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 Non-MAGI-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 Non-MAGI-Related Resource Policies. The resource limit for the QMB group is $9,660 for an individual and $14,470 for a couple.
- Meets all other non-MAGI-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.

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 $900 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 non-MAGI-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	$1,305
Couple	$1,763

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 $971 from social security and $125 gross earned income per month. On January 1, her social security increases to $1,002 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):

$ 971	Gross social security income
– 20	Income exclusion
$ 951	Countable social security income
$ 175	Gross earned income
– 65	Work exclusion
$ 110	
– 55	½ remainder
$ 55	Countable earned income
$ 951	Countable social security income
+ 55	Countable earned income
$1,006	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 ($1,002).

Income is considered as following for March:

$1,002	Gross social security income
– 20	Income exclusion
$ 982	Countable social security income
$ 175	Gross earned income
– 65	Work exclusion
$ 110	
– 55	½ remainder
$ 55	Countable earned income

$ 982	Countable social security income
+ 55	Countable earned income
$1,037	Countable monthly net income

This amount of $1,037 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.

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

$ 900	Gross social security
+ 600	Retirement pension
$1,500	
– 20	General income exclusion
$1,480	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 $946 monthly gross social security disability. Mrs. A, age 40, has $311 monthly gross social security. Child A, age 15, has $311 monthly gross social security.

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

   $ 1046 Monthly social security
   – 20 Income exclusion
   $ 1026 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 $483 may be allocated to meet the needs of the child, from Mrs. A, the ineligible spouse.

   $ 311 Mrs. A's gross unearned income
   – 172 Allocation for ineligible child since the child has $311
   $ 139 income ($483 – $311)

   $139 is less than $483. 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.

$ 1046 Mr. A' s gross social security
– 20 Income exclusion
$ 1026 Net countable income

The $1026 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	$1,305	$1,565
Couple	$1,763	$2,115

To determine net countable monthly income, follow SSI policies. See 8-E, Income Policies For Non-MAGI-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 $9,660 for an individual and $14,470 for a couple. See 8-D, General Non-MAGI-Related Resource Policies.
- Meets all other nonfinancial non-MAGI-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.

> 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 system. Enter the poverty level on the system for each person on the case.

Enter the poverty level on the ABC system for each person on the Medically Needy case. Also, enter an "L" in the QMB indicator for each person on Medically Needy with a zero spenddown who is eligible for SLMB.

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 Non-MAGI-Related Income when deeming to a spouse is applicable.

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

   $1,000 Gross social security
   + 350 Retirement pension
   $1,350
   – 20 Income exclusion
   $1,330 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:

   $ 967 Gross social security
   – 20 Income exclusion
   $ 947 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.

Relationship Between SLMB and Other Coverage Groups

Legal reference: 441 IAC 75 (Rules in Process)

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 (Rules in Process)

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	$1,565	$1,761
Couple	$2,115	$2,380

To determine net countable monthly income, follow SSI policies. See 8-E, Income Policies for Non-MAGI-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 $9,660 for an individual and $14,470 for a couple. (See 8-D, General Non-MAGI-Related Resource Policies.)
- Meets all other non-MAGI-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 Non-MAGI-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
+ 500	Retirement pension
$1,690	
– 20	Income exclusion
$1,670	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.

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.

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 (Rules in Process)

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 non-MAGI-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 $24,000 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 (Rules in Process)

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

Disability

Legal reference: 441 IAC 75 (Rules in Process)

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 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 $1,620 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.
- If the applicant had earned income in the month of application, 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.

See 8-E, Types of Non-MAGI-Related Income and Non-MAGI-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 (Rules in Process)

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, set a reminder to check to see if the member has found a new job by the end of the sixth month after member stopped working.

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 and it is requested by the client.

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 sets a reminder 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 sets a reminder 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.

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.

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.

   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 been 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 (Rules in Process), Iowa Code 627.6(8)(f)

Policy: The resource limits for the MEPD coverage group are $12,000 for an individual and $24,000 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 non-MAGI-related coverage 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.

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 (Rules in Process)

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 non-MAGI-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 calculate the poverty level using the social security COLA increases received in January.

MEPD Monthly Income Limits: 250% of Poverty Level	
Household Size	Limit
1	$3,261
2	$4,407
3	$5,553
4	$6,698
5	$7,844
6	$8,990
7	$10,136
8	$11,282

Premiums

Legal reference: 441 IAC 75 (Rules in Process), Section. 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:**
$1,957 or less	At or below 150%	0
Above: $1,957	Above 150%	$43
$2,152	165%	$59
$2,348	180%	$70
$2,609	200%	$82
$2,935	225%	$97
$3,261	250%	$113
$3,913	300%	$141
$4,565	350%	$171
$5,217	400%	$202
$5,869	450%	$233
$7,173	550%	$291
$8,478	650%	$351
$9,782	750%	$413
$11,086	850%	$488
$13,042	1000%	$586
$14,998	1150%	$685
$16,955	1300%	$790
$19,302and above	1480%	$913

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 and the date the ELIAS entries are made to approve MEPD.

“Back months” include all the months from the month when approval entries are made in ELIAS 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.

> Ms. M applies for Social Security Insurance (SSDI) benefits in April 2024. She applies for MEPD on June 12, 2024. On May 15, 2025, the Social Security Administration determines that she is disabled with an effective date of disability of March 21, 2024.
>
> On May 21, 2025, the worker enters eligibility effective June 2024, with a monthly premium of $41. The "back" months include June 2024 through December 2024 and January 2025 through April 2025.
>
> Ms. M. sends a signed statement to her worker explaining that she did not have any unpaid medical bills for November or December 2024, 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 2024. Payments will never be posted to those months, so there won't be any eligibility for those months as long as the block remains.

How to Establish Premium Periods

Legal reference: 441 IAC 75 (Rules in Process)

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.

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” of eligibility are shown on the **Notice of Action**. 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 “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 “back” month has **not** been paid...	You may block the “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 MEPD 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 (Rules in Process)

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 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.
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 system cutoff in a calendar month…	Include: ▪ The month of approval and ▪ All months back to the month of the effective date of eligibility on the system.
If a case is approved after system cutoff in a calendar month…	Include: ▪ The month of approval, ▪ The next calendar month, and ▪ All months back to the month of the effective date of eligibility on the 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: ▪ The month of application. ▪ Positive date of eligibility. ▪ The month before the month that eligibility is approved.	June is: ▪ The month eligibility entries are made.	July is: ▪ The month after the month that eligibility is approved.
The premium is due the 14th of the third month after the month when eligibility is approved (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.

May	June	July
The premium for May is billed on the first **MEPD Billing Statement.**	The premium for June is billed on the first **MEPD Billing Statement.**	The premium for July is billed on the first monthly **MEPD Billing Statement** (issued June 15).

Payment Address

Legal reference: 441 IAC 75 (Rules in Process)

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 MEPD Premium
Treasurer State of Iowa
P. O. Box 78003
Minneapolis, MN 55480-2800

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 and 14-C, STMT = MEPD Billing Statement Screen.

Posting of Premium Payments

Legal reference: 441 IAC 75 (Rules in Process)

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 following month when the payment is received after a billing statement has been issued for the following month and the current calendar month is paid.
3. 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.
4. 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.

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.

An MEPD application is filed January 22 and approved April 10 for January through April and ongoing months. The positive date on the system is January 1. The following chart shows how the first payments are applied according to the dates the first payments are received.

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	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	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	NOTE: The May bill is issued April 16. 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 (Rules in Process) and 75 (Rules in Process)

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	The MEPD billing system will identify all cases with overlapping Medically Needy and MEPD eligibility. The following actions will occur: ▪ When the case has been changed from Medically Needy to MEPD, the aid type will be 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	If necessary, ask the IME Medically Needy Unit to back out bills for months that the member is eligible for Medicaid under MEPD. ▪ 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-I, Medicaid Eligibility Through Another Coverage Group.
4	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.

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 (Rules in Process), 76 (Rules in Process)

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.

Medicaid for Kids with Special Needs (MKSN)

Legal reference: 441 IAC 75 (Rules in Process) and 75.21(5)“o”

Policy: Medical assistance is available to children under “Medicaid for Kids with Special Needs” (MKSN) 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.
- Household 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.

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

The following sections give more information on requirements for:

- Age
- Disability
- Family income limits
- Health insurance enrollment

Age

Legal reference: 441 IAC 75 (Rules in Process)

Policy: To qualify for MKSN, the disabled child must be under the age of 19.

Disability

Legal reference: 441 IAC 75 (Rules in Process)

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, follow current process to verify disability.

1. Check to verify the child has been determined to be disabled by SSA:
   - If there is no information to verify the disability, and the family claims SSI 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, set 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 (Rules in Process)

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.
- Any children of the MKSN child's spouse.

Follow non-MAGI-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	$3,913	5	$9,413
2	$5,288	6	$10,788
3	$6,663	7	$12,163
4	$8,038	8	$13,538

If the family size is over 8, add $1,345 for each additional member.

Health Insurance Enrollment

Legal reference: 441 IAC 75 (Rules in Process)

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, Medicaid for Kids with Special Needs (MKSN)**.
2	Send form **470-4633, Health Insurance Information for Kids with Special Needs**, and the **Insurance Questionnaire, form 470-2826** or **470-2826(S)**, to the parents to request information about: ▪ 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: 1. Check the correct box on the **470-4633** to describe the status of their child's health insurance coverage, **and** 2. Either: ▪ Complete ***Insurance Questionnaire,*** **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.

Application Processing	
Step	Action
4	If the child is already enrolled in the parent's employer group health insurance: ▪ 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	If the child is not enrolled in the parent's employer group insurance: ▪ 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	If the employer pays at least half the premium cost required to cover the child, then tell the parent: ▪ 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	If the parents cannot enroll the child until a later date, set a reminder to follow up on: ▪ 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: ▪ 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

1. Ms. G applies for MKSN for her son, Bobby. Ms. G is covered by Medically Needy with a spenddown. Since Medically Needy with a spenddown is less than full Medicaid coverage, Ms. G is included in the MKSN household size and her income is counted.

   The worker determines that Bobby meets the income requirements for a household size of two.

   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.

   Disability Determination Services (DDS) determines that Bobby is disabled. The worker sets a reminder for the continuing disability review (CDR) scheduled by DDS for three years in the future.

   The worker verifies that:

   - 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, then Bobby would be required to be enrolled.

2. Eddie and Ellie are disabled 7-year-old twins receiving SSI cash benefits and Medicaid under SSI Medicaid. 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 sets a reminder 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 Ineligible for SSI Due to coverage group 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.

   Since Medicaid ended under the Ineligible for SSI Due to coverage group, the worker includes both Eddie and Ellie on the same MKSN case. The household size is four, including both parents and the two children.

   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

   Ann is not included in the household size because she receives Medicaid as a separate case. The household size is 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 sets 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
- Sets a reminder 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.