IOWA Health and Human Services

Employees' Manual
Title 8, Chapter F

Revised February 28, 2025

Medicaid
Coverage Groups

Page

Page

Page

Overview

This chapter provides the Medicaid eligibility standards for MAGI-related and NonMAGI-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 NonMAGI-related people. The next sections explain the coverage groups for women who need treatment for breast or cervical cancer. MAGI-related and NonMAGI-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 NonMAGI-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.

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

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

Coverage Group	Medical Aid Type	Fund Code*	Facility Case Aid Type
In a medical institution and under the 300% income level	13-6	A	13-6 Aged, nursing facility
	37-7	C	37-7 Child, MHI or PMIC
	63-6	A, C	63-6 Disabled, nursing facility
	73-1	A, C	73-1 Skilled nursing care
	73-2	A ,C	73-2 Resource center ICF/MR
	73-3	A, C	73-3 Community ICF/MR
	73-4	A, C	73-4 Hospital
	73-5	A	73-5 MHI
Qualified disabled and working people (QDWPs)	90-2 QMB indicator W	9	
Qualified Medicare beneficiaries	90-0 90-2 QMB indicator Q	9 9	
Specified low-income Medicare beneficiaries	90-0 90-2 QMB indicator L	9 9	
Expanded specified low-income Medicare beneficiaries	90-0 90-2 QMB indicator E	9 9	
Medically Needy	37-E	A, C, P, S, R	
Medicaid for employed people with disabilities	60-M	A, C, P	
Medicaid for kids with special needs	64-7	C	
Presumptive eligibility for pregnant women	88-8	A	

Coverage Group	Medical Aid Type	Fund Code*	Facility Case Aid Type
Presumptive eligibility for breast and cervical cancer treatment (BCCT)	88-9	A	
Presumptive eligibility for children	88-5	C	

* Explanation of fund codes:

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

Presumptive Eligibility

Legal reference: 42 CFR 435.1100-1103, 435.1110, 441 IAC 75 (Rules in Process), 76.1, 76.7

Medicaid shall be temporarily available to persons who are determined to be presumptively eligible for Medicaid. Presumptive eligibility shall be determined by a qualified entity (QE) and is based solely on the applicant's attested circumstances as provided to the QE and entered by the QE directly online into the Medicaid Presumptive Eligibility Portal (MPEP) system. There are no verification requirements for a presumptive eligibility determination.

Refer to the Medicaid Provider Manual, All Providers, II. Member Eligibility for policies and procedures related to presumptive eligibility determinations.

Both approved and denied applications will automatically be sent to the Department for a formal Medicaid or Hawki eligibility determination, unless the applicant specifically opts out of receiving a full determination in writing.

Refer to NJA0067, *Presumptive Eligibility* for the link to the Business Process for bringing the presumptive eligibility determination into ELIAS and processing the ongoing medical application, if applicable.

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), she remains eligible throughout the pregnancy without regard to income.
- 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 without regard to income.

  NOTE: Postpartum eligibility applies only to women who do not qualify for Medicaid under another coverage group once the pregnancy ends.
- A child born to a Medicaid-eligible mother shall receive Medicaid without an application through the child's first year of life as long as the child remains an Iowa resident. This includes children born to women who are eligible for emergency services.

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 any changes in income.

Continuous eligibility does not apply if the pregnant woman was only enrolled under Medically Needy with a spenddown, 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.

When an increase in income makes a pregnant woman ineligible for Medicaid (except for Medically Needy with a spenddown), she is determined continuously eligible and placed in the MAC coverage group. If a pregnant woman is already eligible under MAC, she is not required to verify income changes and may be considered "continuously eligible.

A pregnant woman 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 as long as an increase in income is the only factor that makes her currently ineligible. This policy **does not** apply to women who would have been eligible or potentially eligible only under Medically Needy with a spenddown or state-only in the retroactive 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 and is placed in the MAC coverage group.

   Mrs. K remains eligible throughout her pregnancy as long as she continues to meet all non-income criteria of the MAC program. If she is eligible and enrolled in Medicaid on the last day of her pregnancy, her eligibility continues through the last day of the month of the 60-day postpartum period, regardless of any changes in her family income.
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. (Increased income created ineligibility for July.)

Ms. T is granted continuous eligibility because (1) she would have been eligible in June as a pregnant woman had she applied; (2) she has bills for covered Medicaid services in June; and (3) increased income is the only reason that she is currently ineligible. Ms. T is placed in the MAC coverage group beginning with the month of June.

Eligibility continues throughout the pregnancy under the MAC coverage group as long as Ms. T continues to meet all other eligibility criteria of the MAC program. If Ms. T is eligible and enrolled in Medicaid on the last day of her pregnancy, she continues to be eligible through the last day of the month of the 60-day postpartum period, without regard to any changes in her income.

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 **not** continuously eligible because she was not both eligible and enrolled in Medicaid while still pregnant.
4. Ms. L applied for Medicaid on July 5, her baby was born on July 6, and her application was processed on July 7. Ms. L met all eligibility requirements for the month of July and her beginning date of eligibility is July 1. Ms. L's income exceeded Medicaid limits beginning in the month of August. Ms. L is **not** continuously eligible because she was not both eligible and enrolled in Medicaid while still pregnant.
5. 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 only. Ms. G subsequently reapplies for Medicaid on January 10 for another emergency medical condition during the same pregnancy. 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, Ms. G is now continuously eligible without regard to income. Ms. G is approved for limited emergency Medicaid coverage for January

NOTE: Refer to NJA 0095, Continuous Medicaid Eligibility for Pregnant and Postpartum Women for the process in ELIAS when a noncompliance record incorrectly denies/discontinues the woman eligible for MAGI Pregnant/Postpartum for failure to provide income.

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 with 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. If a Medically Needy member's certification period expires during the postpartum eligibility period, she must file an application.

If a woman is eligible and enrolled in Medicaid on the last day of her pregnancy but is not eligible under any coverage group once her pregnancy ends, she continues to be eligible for 12 months of postpartum coverage in the same coverage group under which she received Medicaid while pregnant.

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

During the postpartum period, the woman must meet **all** eligibility factors as though she were still pregnant except income criteria.

When the pregnancy terminates (for any reason), the woman is still entitled to postpartum coverage if she meets all other eligibility factors.

At the end of the 12-month postpartum period, eligibility is redetermined by the system. If ongoing eligibility is not established, the individual is canceled and a **Notice of Action** is issued with timely notice.

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 July 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 and June only. Mrs. W is **not** continuously eligible for postpartum coverage because she was not both eligible and enrolled in Medicaid while still pregnant, so her application is denied for July.

3. Ms. J, age 27, is pregnant and receives Medicaid under the MAC coverage group. The father of her unborn child does not live with her. On July 12, the baby is born.

   Ms. J is now the parent of a child. Therefore, Medicaid eligibility for Ms. J can continue after the postpartum period under the FMAP coverage group.

4. The household consists of Mr. F, age 29, who works full time, and Mrs. F, age 25, who is pregnant. Mrs. F is currently receiving Medicaid under the Medically Needy program for an October-November certification period. The baby is born October 15.

   Mrs. F continues to remain eligible for Medicaid for November. She must reapply for Medically Needy if she wants to continue to receive postpartum eligibility for December, because her certification period has expired. She must meet the spenddown obligation for the new certification period, if applicable, before receiving Medicaid postpartum coverage for December.

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 NonMAGI-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 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.

1. Ms. R is pregnant and receives Medicaid under the MAC coverage group. On May 19, the billing clerk of the hospital calls Ms. R's worker and reports that Ms. R's child was born on May 18. Based on this report, the baby is added to Ms. R's case as the deemed newborn child of a Medicaid-eligible mother.
2. Ms. L reports to the local office on June 15 that her child was born on June 7. The worker adds the deemed newborn to Ms. L's case effective June 1. The local newspaper reports the birth date as May 17.

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

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

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

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

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

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

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

   On July 20, the hospital informs the local office that Mrs. K gave birth to her baby on July 18. Policy requires that the baby be added to the eligible group. The day the birth of the child is reported becomes the application date. Add the baby to the existing Medicaid case within ten days, effective July 1.

2. Ms. T, age 19, is pregnant and receives Medicaid under the MAC coverage group. On May 2, she reports to the local office that her baby was born in April.

   The worker adds the baby to Ms. T's case as the deemed newborn child of a Medicaid-eligible mother for the months of April and ongoing. On May 11, Ms. T reports she relinquished custody of the child to an adoption agency on May 4. Eligibility under "deemed newborn status" continues as long as we know where the baby lives and the infant is an Iowa resident.

3. Ms. A is an undocumented immigrant living in Iowa. She delivered a baby at a local hospital in June. Ms. A applies for Medicaid in August and requests retroactive Medicaid back to June. If Medicaid eligibility is approved for the birth under limited Medicaid for emergency services, the child is eligible for "deemed newborn status."

The following sections give more information on:

- The duration of deemed newborn coverage
- Procedure when the child reaches age one

Duration of Coverage

Legal reference: 441 IAC 75 (Rules in Process)

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

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

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

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

On July 4, Ms. G returns to Iowa. Even though Ms. G has continuously received Medicaid, and her child is under one year of age, Ms. G must file an application and meet all program requirements if she wishes to receive Medicaid for the child. Her child is no longer eligible for the deemed newborn coverage group.

Coverage of a deemed newborn child under another coverage group in Iowa does not preclude the child from attaining or reattaining deemed newborn eligibility within the one-year period.

When the Deemed Newborn Reaches Age One

Legal reference: 441 IAC 75 (Rules in Process)

Policy: A child who has remained eligible because of deemed newborn status during the first year must be found eligible for Medicaid under another coverage group to continue Medicaid eligibility past the child's first birthday. Eligibility under the deemed newborn status ends on the last day of the month in which the child in deemed newborn status turns age one.

An application or review form is not required. If additional information is needed in order to complete a redetermination, request this information in writing before the month of the first birthday.

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

Ms. K, age 17, receives Medicaid under MAC. Her child is eligible for Medicaid as a deemed newborn child of a Medicaid-eligible mother. This child turns one on June 4. In June, the system completes an automatic redetermination. Eligibility is redetermined to MAC for the child and MAC eligibility continues for Ms. K.

Breast and Cervical Cancer Treatment

Legal reference: Breast and Cervical Cancer Prevention and Treatment Act of 2000; 42 CFR 435.213; 441 IAC 75 (Rules in Process); 42 USC 1396a(aa); Public Law 107-121

Medicaid is available under the breast and cervical cancer treatment (BCCT) coverage group to an individual under the age of 65 who meets the following eligibility requirements:

- Does not have creditable health insurance coverage;
- Is not eligible for Medicaid in one of the mandatory coverage groups;
- Was screened and diagnosed:
  - Through the National Breast and Cervical Cancer Early Detection Program (BCCEDP), or
  - through funds from family planning centers, community health centers, or non-profit organizations;
- Needs treatment for cancerous or precancerous condition of the breast or cervix; and
- Must be one of the following:
  - A citizen of the United States,
  - A United States national, or
  - A qualified alien.

See 8-L, Aliens for more information on eligibility criteria.

The following sections explain:

Responsibilities of the Screening Program

The National Breast and Cervical Cancer Early Detection Program (BCCEDP) is responsible for determining that the individual:

- Is in need of treatment for cancerous or precancerous condition of the breast or cervix.
- Is under age 65.
- Meets income guidelines.
- Does not have creditable health insurance coverage, except when the individual:
  - Has exhausted their lifetime benefits for breast or cervical cancer treatment, or
  - Has an exclusion clause in their health insurance coverage for breast or cervical cancer treatment.

"Creditable coverage" is defined in the Health Insurance Portability and Accountability Act. Most health insurance is considered creditable coverage, including insurance that has limits on benefits or high deductibles. For the purposes of this coverage group, the Indian Health Services tribal organization, or Urban Indian organization available to Native Americans is **not** creditable coverage.

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

- The individual will be instructed to present verification of the screening and diagnosis through the BCCEDP, to the DHS office.
- The individual will usually complete an **Application for Health Coverage and Help Paying Costs, form 470-5170** or **470-5170(S)**, at the program office. The program will attach the proof of screening form to the application.

However, if you are aware that an individual is eligible but the verification is not attached to the application, either:

- Make a written request for the individual to obtain it and provide it to you, or
- Ask the individual to sign a specific release, if needed, so you can request verification from the program.

The individuals that receive screening or services must meet eligibility requirements established by the Iowa Care For Yourself Program.

If the BCCEDP is a qualified provider, the provider may also determine presumptive Medicaid eligibility for the BCCT coverage group. For requirements to be a presumptive eligibility provider, refer to the Medicaid Provider Manual, All Providers, II. Member Eligibility for policies and procedures related to presumptive eligibility determinations.

Referrals to a BCCEDP

Only coordinators that receive DHS training and are approved by the Iowa Department of Public Health can be qualified entities for BCCT.

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

- Breast and cervical cancer screening services
- Verification of breast and cervical cancer screening services

Call 1-866-339-7909 or 1-515-242-6200 to identify the nearest program and contact information. Do not suggest that the individual is eligible or make any determination. Simply refer them by saying, “There is a program I suggest you call. Their staff should be able to determine if you are eligible for any services or assistance.”

Application Processing

DHS income maintenance is responsible for determining that the applicant:

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

The following are required before determining eligibility under BCCT:

- A completed application, except in an automatic redetermination.
- A determination the individual is not eligible under a mandatory coverage group.
- Verification of screening and diagnosis from the Iowa Department of Public Health (IDPH).

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

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

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

If you have reason to believe that the applicant has creditable coverage, request a statement from the insurance company documenting the scope of coverage or that coverage has been dropped or exhausted. If you verify that the applicant does have creditable coverage, report this to the local BCCEDP.

Mandatory Medicaid Coverage Groups

The individual must not be eligible for Medicaid under any of the mandatory Medicaid coverage groups. The mandatory Medicaid coverage groups are:

- Family Medical Assistance Program (FMAP)
- People ineligible for FMAP due to the receipt of alimony or other spousal support
- Transitional Medicaid
- Mothers and children (MAC)
- Postpartum eligibility
- Children receiving IV-E foster care, IV-E subsidized adoption, or IV-E Subsidized Guardianship
- Iowa Health and Wellness Plan (IHAWP)

- Expanded Medicaid for Independent Young Adults (EMIYA)
- Mandatory State Supplementary Assistance recipients
- Essential persons
- SSI recipients
- People ineligible for SSI (or SSA) due to:
  - Requirements that do not apply to Medicaid
  - The October 1972 social security COLA
  - Social security COLAs (also referred to as the 503 Group)
  - Receipt of widow's social security benefits
  - Actuarial change for widowed persons
  - Social security benefits paid from a parent's account

If the individual is eligible under a mandatory coverage group, establish Medicaid eligibility under that group, even if they are eligible under the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

> Ms. A has been diagnosed with breast cancer by a health care provider authorized by the BCCEDP and is in need of treatment. She applies for Medicaid and provides proof of diagnosis from the BCCEDP.
>
> The worker determines that Ms. A is eligible for MAGI-related Medicaid coverage. Her 16-year-old son lives with her and she meets all of the other eligibility criteria. Medicaid eligibility for Ms. A is established under MAGI-related.

Eligibility Period

Legal reference: 441 IAC 75 (Rules in Process)

The effective date of BCCT coverage is the first of the month the individual applied for Medicaid. Receiving presumptive eligibility does not change this effective date. If the individual was diagnosed in an earlier month and incurred medical bills, examine retroactive BCCT eligibility if they meet a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. See Retroactive Coverage Under BCCT.

Eligibility under the BCCT coverage group continues until the individual:

- Is covered under creditable insurance coverage; or
- Is eligible under a mandatory coverage group; or

- No longer receives treatment for breast or cervical cancer or precancerous condition; or
- Reaches age 65.

NOTE: If the individual turns 65 on the first day of the month, their eligibility ends as of the last day of the previous month. If the individual turns 65 on any day other than the first of the month, eligibility ends on the last day of the birth month.

An individual is not limited to one period of eligibility. A new verification form is not required unless treatment has stopped and started again.

The following sections give more information on:

- Determining retroactive eligibility under BCCT
- Determining the length of treatment

Retroactive Coverage Under BCCT

BCCT eligibility can cover the retroactive period if the individual has met all relevant BCCT eligibility requirements and meets a category of eligibility for the retroactive period as defined in **8-A, Definitions**.

An individual isn't eligible for Medicaid until they are diagnosed and in need of treatment. Eligibility before being screened, diagnosed, and having a need for treatment would require an eligibility determination under another coverage group. See **8-B, Determining Eligibility for the Retroactive Period**.

1. Ms. A applies for Medicaid May 4. The verification form showing that she was diagnosed with cervical cancer April 28 accompanies her application form. Residing with Ms. A is her 16-year-old son.

   After all verification is submitted, the IM worker determines that Ms. A would be eligible only for Medically Needy with a spenddown, so eligibility under the BCCT coverage group is established effective May 1.

   Ms. A requests retroactive coverage to cover her screening costs. If Ms. A would not have been eligible under any mandatory Medicaid coverage group in April, the worker can establish Medicaid eligibility for April under the BCCT coverage group because she was diagnosed in April, as long as she meets a category of eligibility for the retroactive period as defined in **8-A, Definitions**.

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

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

Length of Treatment

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

Request the individual provide proof of when treatment will end. If they need assistance, have them sign form 470-3951, *Authorization to Obtain or Release Health Care Information*.

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

- Complete an automatic redetermination, since the date treatment will end pertains only to the BCCT coverage group.
- Cancel Medicaid under the BCCT group.
- Issue a *Notice of Action* unless the individual is eligible under another coverage group (except for Medically Needy with a spenddown).

The BCCEDP will not be treating the individual. Accept the statement of the medical professional providing the individual's treatment as to when treatment is expected to end. Set a reminder for the first working day of the month in which treatment is expected to end.

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

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

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

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

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

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

   Early in July, the worker sends a release to Mrs. D asking her to sign and return it. Mrs. D complies, and the provider now states that Mrs. D's treatment did end in July. Since Mrs. D will no longer be eligible under the BCCT coverage group, the worker completes an automatic redetermination.

3. Mrs. F begins receiving Medicaid under the BCCT coverage group in August. The provider treating Mrs. F provides a statement, in September, saying treatment will continue into the month of February. The worker sets a reminder for the first working day in February.

   Early in February, the worker sends a release to Mrs. F that she signs and returns. The provider now states that Mrs. F's treatment will continue into the month of April. The worker sets a reminder for the first working day in April.

Responsibilities of the Client

An individual eligible for Medicaid under the BCCT is **required** to report only when:

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

The individual is **asked but not required** to report when their treatment ends. Accept the medical professional's statement as to when treatment will end. Act on the individual's report of when treatment has ended. For more information, see Length of Treatment.

An individual eligible for Medicaid under BCCT is **not required** to report:

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

Annual Review

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

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

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

1. Ms. K is diagnosed with breast cancer and applies for Medicaid in June 2009. Ms. K's 16-year-old son lives with her. The worker determines that, due to family income, Ms. K would only be conditionally eligible for Medically Needy with a spenddown. Medicaid eligibility for Ms. K is established under BCCT effective June 1, 2009.

   When conducting the annual review in May 2010, the worker requests information about family income and household composition. The worker determines that the household composition is the same and the family income continues to make Ms. K only conditionally eligible for Medically Needy with a spenddown.

   Since Ms. K is under age 65, does not have creditable health insurance coverage, and continues to receive treatment, her eligibility under BCCT continues.

2. Mrs. R is diagnosed with cervical cancer and applies for Medicaid in September 2001. Also living with Mrs. R is her husband and two children, ages 18 and 22. The worker determined that due to family income, Mrs. R would only be eligible for Medically Needy with zero spenddown.

   Medicaid eligibility for Mrs. R is established under BCCT effective September 1, 2003. The worker conducts the annual review in August 2004. Since Mrs. R's youngest child is over age 19, the worker simply confirms with Mrs. R that she does not have a child under the age of 19 living with her.

   No income information is requested, since Mrs. R is not eligible for a mandatory coverage group. Since Mrs. R is under age 65, continues to not have creditable health insurance coverage, and continues to receive treatment, eligibility under BCCT continues.

Notice of Decision

Legal reference: 42 CFR 435.917, 441 IAC 76 (Rules in Process), 7.7(1)

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

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

Adequate and timely notice is required when Medicaid eligibility is ending, including when the individual fails to comply with the annual review process.

Case Maintenance

The following sections address procedures for:

- Handling changes in health insurance
- Conducting an automatic redetermination

Health Insurance Changes

Determine if an individual has creditable health insurance coverage when:

- They report a change in their health insurance coverage, or
- They report that health insurance coverage has begun.

The following types of coverage are considered creditable coverage:

- Medicare Part A **or** Part B
- A group health plan

- Armed forces insurance
- A state health risk pool
- Medical care provided directly, through insurance, or by reimbursement
- Medicaid, including meeting spenddown during a Medically Needy certification period

An individual is ineligible for BCCT if they have creditable health insurance coverage. An individual does **not** have creditable health insurance coverage if:

- Their coverage is limited, such as dental, vision, or long-term care, or coverage only for a specified disease or illness.
- Their policy does not cover treatment of breast or cervical cancer.
- They are in a period of exclusion for treatment of breast or cervical cancer (such as a pre-existing condition).
- They have exhausted their lifetime limit on all benefits under their plan.
- They have a waiting period of uninsurance.

Automatic Redetermination for BCCT

Legal reference: 42 CFR 435.930; 441 IAC 76.17(249A)

Policy: Complete an automatic redetermination when:

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

Procedure: When an individual is no longer eligible under another coverage group, determine if treatment under BCCT is continuing. If treatment continues, eligibility under BCCT exists based on the initial verification of screening and diagnosis.

Mrs. C applies for Medicaid in April. She provides the verification that shows she is in need of treatment for breast cancer. However, the worker determines that Mrs. C is eligible for Medicaid under MAGI-related, because her 12-year-old son lives with her and she meets all other MAGI-related Medicaid eligibility criteria.

In May, Mrs. C reports beginning income that results in her countable income exceeding the MAGI-related Medicaid limit for two people. The only coverage group other than BCCT under which Mrs. C can establish eligibility is Medically Needy with a spenddown.

The worker asks Mrs. C to either provide verification that she is still under treatment for breast cancer or sign a release of information so that the worker can contact the medical provider. If Mrs. C is still under treatment, the worker establishes Medicaid eligibility under the BCCT coverage group.

If Mrs. C is no longer receiving treatment for the breast cancer, eligibility should be considered under another coverage group.

MAGI-Related Coverage Groups

Legal reference: P. L. 104-193; 441 IAC 75 (Rules in Process)

Medicaid eligibility policy for pregnant women, parents and other caretakers, and children is based on family-related medical assistance under MAGI. MAGI-related coverage groups include:

- Family Medical Assistance Program (FMAP).
- Ineligible for FMAP due to the receipt of support.
- Transitional Medicaid.
- Mothers and Children (MAC) program.
- Medical institution 300% group.
- Pregnant and postpartum women. See Pregnant or Postpartum Women and Deemed Newborns.
- Deemed newborn children of Medicaid-eligible mothers. See Deemed Newborn Children of Medicaid-Eligible Mothers.
- Iowa Health and Wellness Plan (IHAWP).

NOTE: Refer to 8-H, Foster Care, Adoption and Guardianship Subsidy for specialized children coverage groups.

Medicaid is also available to most children under age 21 who are placed in subsidized adoption, subsidized guardianship, or foster care living arrangements. See 8-H, Foster Care, Adoption and Guardianship Subsidy for more information.

Family Medical Assistance Program (FMAP)

Legal reference: 441 IAC 75 (Rules in Process)

Medicaid may be available under the Family Medical Assistance Program (FMAP) to children and their parents or other caretakers who meet financial and nonfinancial eligibility requirements.

Parents or other caretakers must live with a child for whom they assume primary responsibility for that child's care in order to be eligible.

FMAP is available to a child under age 18 regardless of school attendance, including the month the child turns 18 unless the birthday falls on the first of the month. FMAP is also available to an 18 year old child who is a full-time student in a secondary school, or the equivalent level of vocational or technical training, and reasonably expected to complete the program before age 19.

1. Mr. S applies for Medicaid for himself. Also in the home is Mr. S's son who receives SSI. Mr. S's son receives Medicaid as an SSI recipient. Mr. S is categorically eligible for Medicaid under FMAP because he has a child in his care.
2. Ms. F applies for Medicaid for herself. Also in the home is Ms. F's daughter who receives Medicaid under an HCBS waiver. The child is considered institutionalized only for the child's eligibility.

   In determining Medicaid eligibility for Ms. F, the daughter shall be considered under Ms. F's care. Therefore, Ms. F is categorically eligible for Medicaid under FMAP.

To determine eligibility for this coverage group, use the policies and procedures in:

- 8-C, Nonfinancial MAGI-Related Eligibility.
- 8-E, Income Policies for MAGI-Related Coverage Groups.

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

NOTE: Medicaid is not linked to FIP. Therefore, it is possible to be ineligible for FIP and still be eligible for Medicaid benefits or to be eligible for FIP and ineligible for Medicaid.

Do not consider this coverage group for:

- Children who do not live with a parent or other caretaker.
- Children age 18 (unless they are attending school).
- Adults who are not a parent or other caretaker.
- Pregnant women with no children other than the unborn child.
- Adults who do not live with a child and assume primary responsibility for the care of a child.

1. Ms. L applies for Medicaid for herself and her two-year-old son. She has no income. Since Ms. L and her son meet the financial eligibility factors, both are eligible for Medicaid under the FMAP coverage group.
2. Mr. and Mrs. Z and their two children apply for Medicaid. Mr. and Mrs. Z are filing taxes jointly and claiming both children. Both Mr. and Mrs. Z are employed, but their countable income is less than the FMAP limit for a four-member household. The Z family is eligible for FMAP if all other eligibility factors are met.
3. Mr. P is a caretaker of his five-year old neighbor who is currently living with him. If all other eligibility factors are met, Mr. P and his five-year-old neighbor are eligible for FMAP.

People Who are Ineligible for FMAP

Medicaid benefits are available to people who are ineligible for FMAP due to:

- Receipt of alimony or other spousal support (extended Medicaid), or
- Increased income from employment (transitional Medicaid), or
- Being a resident in a medical institution.

Ineligible Due to Receipt of Support (Extended Medicaid)

Legal reference: 42 CFR 435.115; 441 IAC 75 (Rules in Process)

Medicaid continues up to four months to persons and families ineligible for FMAP in whole or in part because of alimony or other spousal support.

To qualify, at least one member must have received FMAP in three of the six months immediately before the month of cancellation. Do not consider any month in which the assistance is subject to recoupment in this three-month calculation.

1. Mrs. K and her three children are canceled from FMAP effective June 1 due to receipt of alimony. They are eligible for extended Medicaid if they received **FMAP** in three of the previous six months.
2. Mrs. B and her two children are canceled from FMAP effective February 1, 2009, due to increased spousal support. The family received FMAP in August and September of 2008 and in January 2009. Mrs. B and her two children are eligible for the four months of extended Medicaid.

Members may request cancellation of FMAP because they are receiving alimony or other spousal support directly. However, grant extended Medicaid only if the alimony or other spousal support exceeds the FMAP income limit.

A family receiving Medicaid under FMAP starts receiving spousal support directly on March 22 but does not report this to the IM worker until April 25. The spousal support is enough to cancel FMAP.

Since the receipt of spousal support was not timely reported, extended Medicaid begins April 1. Had the spousal support been reported timely, FMAP cancellation would not be effective until May 1, allowing a ten-day notice. Extended Medicaid would begin May 1.

Begin the four months of extended Medicaid with the month following the month the family became ineligible for FMAP due to receipt of alimony or other spousal support. During these four months, the family must continue to meet all FMAP eligibility requirements except income.

If FMAP is reinstated but later lost again due to the receipt of alimony or other spousal support, begin a new four-month period if the family qualifies.

Adding People to the Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

The extended Medicaid eligible group includes:

- Every person who was in the FMAP eligible group in the last month FMAP was received.

- Every person whose needs and income were included in determining the household's eligibility when FMAP benefits were terminated.

Also add the following people to the eligible extended Medicaid group:

- People returning to the home whose needs and income would be taken into account in determining the FMAP eligibility if the household were applying in the current month.
- Dependent children returning home from foster care, if they would have been included if at home while the household was on FMAP.
- People who were not included in the FMAP eligible group because they were receiving SSI, if they have since lost SSI.
- People who were not included in the eligible group, such as a child in deemed newborn status.

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

Transitional Medicaid

Legal reference: P. L. 100-485, 441 IAC 75 (Rules in Process)

Transitional Medicaid is available to individuals who **receive** FMAP and who are no longer eligible due to:

- Increased earned income of the dependent child, parent, or other caretaker, or
- A combination of increased earned income and other factors that create ineligibility.

A Medicaid member is a person who has been successfully approved on the system. Transitional Medicaid is not available to applicants.

1. The M family has been receiving Medicaid under FMAP for the past six months. They are canceled effective June 1 for failure to provide information. They reapply for Medicaid July 5. On July 7, Mrs. M reports beginning a job July 5. The worker processes the application July 27.

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

2. Same as Example 1, except the worker processes the application August 2. The Ms have Medicaid eligibility under FMAP for July, but they are over income for August. Because they were members in July, they are eligible for transitional Medicaid.
3. Same as Example 1, except the family is over income for July and ongoing. There is no transitional Medicaid eligibility, because they are not members and they were canceled for failure to provide information.

Individuals of the transitional Medicaid group may consist of:

- The people living in the household whose needs and income were included in determining the FMAP eligibility when the FMAP benefits were terminated.
- Ineligible people who were included in the eligible group and whose income was counted in the FMAP eligibility determination.
- Children, parents, or other caretakers who reside or begin to reside in the household during the transitional period.
- Children who lose deemed newborn status.

The earned income must be the earnings of the dependent child, parent, or other caretaker. The parent or other caretaker must either:

- Be in the eligible group, or
- Have returned to the home and be a person whose income and needs must be considered in the eligibility determination.

1. Ms. T reports the return of the father of the children. Ms. T's income and the returning parent's income create ineligibility for FMAP. Therefore, the family (Ms. T, the returning parent, and children) is eligible for transitional Medicaid.
2. Mrs. O reports the return of her husband, the father of her children. Mrs. O is not employed. Mr. O's income makes the family ineligible for FMAP. Therefore, the family (Mrs. O, Mr. O, and children) is eligible for transitional Medicaid.

A member of the FMAP household must have received FMAP in Iowa at least three of the previous six months in order to be eligible for transitional Medicaid.

Do not consider any month in which Medicaid was received under FMAP incorrectly and the individual should have received Medicaid under another coverage group.

The other caretaker who is canceled from FMAP due to an increase in earned income is eligible to receive transitional Medicaid. The child will receive transitional Medicaid with the other caretaker.

When transitional Medicaid ends, do an automatic redetermination to another coverage group for the other caretaker and for the children.

Transitional Medicaid begins with the effective date of termination of FMAP.

When ineligibility occurred in a prior month, the first month of transitional Medicaid is the first month that FMAP was erroneously granted, unless it is determined that FMAP was received through fraud, according to the transitional Medicaid definition of fraud. See Determining Eligibility for more information on determining if fraud exists.

1. Mrs. M timely reports an increase in earned income May 23. Timely notice cannot be given for June 1. FMAP is canceled July 1. Transitional Medicaid begins July 1. There is no overpayment for June.
2. Mr. J and his two children are receiving FMAP. He starts work but fails to report this to his worker until two months later. When the worker receives the verification of his new job, it shows Mr. J and his children are not eligible for transitional Medicaid because, according to the transitional Medicaid definition of fraud, Mr. J fraudulently received FMAP. Eligibility for Mr. J and the children is explored under other coverage groups.

Transitional Medicaid coverage lasts for up to 12 months.

Procedure: When an increase in income has been reported timely, transitional Medicaid shall be available for a period of up to 12 months. When at least one person on a case becomes transitional Medicaid eligible, the system will set the review month to 12 months from the start of transitional Medicaid.

When an increase in income has not been reported timely, transitional Medicaid shall be available for up to 12 months from the month the change occurred, allowing for timely notice. When at least one person on a case becomes transitional Medicaid eligible, the RE Due Month will need to be manually changed to 12 months from the month transitional Medicaid would have begun had the change been reported timely.

The following sections give more information on:

- Determining eligibility.
- Requirements after eligibility is established.
- Notices.
- Effective date of changes.
- Adding people to the eligible group.
- Review requirements.

Determining Eligibility

Legal reference: 441 IAC 75 (Rules in Process)

When the only change in circumstances being considered is an increase in earned income, the FMAP eligible group is eligible for transitional Medicaid if the increase in earned income creates ineligibility for FMAP and all other eligibility factors are met.

When other changes in circumstances are being considered at the same time as the increase in earned income, use the following steps to determine if the FMAP eligible group is eligible for transitional Medicaid.

1. Would the increase in earned income have resulted in FMAP ineligibility if the other changes in circumstances hadn't happened?
   - Yes. The FMAP eligible group is eligible for transitional Medicaid, if all other eligibility factors are met.
   - No. Go to question 2.
2. Would the other changes in circumstances have resulted in FMAP ineligibility if the earned income hadn't increased?
   - Yes. The FMAP eligible group is not eligible for transitional Medicaid. Explore eligibility under other coverage groups.
   - No. Go to question 3.

3. Does the increase in earned income combined with the other changes in circumstances result in FMAP ineligibility?
   - Yes. The FMAP eligible group is eligible for transitional Medicaid, if all other eligibility factors are met.
   - No. FMAP eligibility continues.

1. Mrs. K begins employment in the same month in which her child begins to receive Social Security benefits. The earned income alone is sufficient to create FMAP ineligibility. The household is eligible for transitional Medicaid.
2. Mrs. M is working, and her earnings increase. She has one child. In March, the child begins receiving Social Security benefits. Mrs. M's increase in earnings alone is not enough to create ineligibility. The increased unearned income is enough to create ineligibility.

   The household is not eligible for transitional Medicaid, since the unearned income alone is enough to result to ineligibility. An automatic redetermination is completed.
3. The house hold consists of Mrs. J and her two children. On June 10, Mrs. J reports that she received a pay raise on June 1 and that her daughter moved out of the household on June 7.

   Ignoring the change in household size, Mrs. J's increased earnings are compared to the FMAP limit for a three-person eligible group. The countable income exceeds limits. Therefore, Mrs. J and the remaining child are eligible for transitional Medicaid if all other eligibility factors are met.
4. Mrs. E and her child receive Medicaid under FMAP. On January 10, Mrs. E reports that her child received her first social security check on January 3 and that Mrs. E began working on January 8.

   First, ignoring the social security, Mrs. E's new earnings are compared to the FMAP limits for a two-person eligible group. The countable income does not exceed limits.

   Then, ignoring the new earnings, the new social security benefits are compared to the FMAP limits for a two-person eligible group. The countable income does not exceed limits.

Finally, the combined new earnings and new social security benefits are compared to the FMAP limits for a two-person eligible group. The countable income exceeds limits. Mrs. E and her child are eligible for transitional Medicaid if all other eligibility factors are met.

5. Mrs. M and her child receive Medicaid under FMAP. In March, Mrs. M's earnings increase and her child begins receiving social security benefits. First, ignoring the social security income, Mrs. M's increased earnings are compared to FMAP limits for a two-person eligible group. The countable income does not exceed FMAP limits.

   Then, ignoring the increase in earnings, Mrs. M's earnings before the increase and the new social security income are compared to FMAP limits for a two-person eligible group. The countable income does exceed limits.

   Mrs. M and her child are not eligible for transitional Medicaid, since the increased earnings alone did not create FMAP ineligibility, and the other change in circumstances alone did create FMAP ineligibility.

6. The household consists of Ms. L and two children. The family receives FMAP. Ms. L's countable earned income is $380 per month. She receives an increase in earned income. Her countable earned income is now $420. When she reports her raise, she also reports that one of her children has moved out of the home.

   Step 1. Does the increase in earned income result in FMAP ineligibility if the other changes in circumstances had not happened? No ($420<$426). Go to step 2.

   Step 2. Does the loss of a household member result in FMAP ineligibility if the earned income had not increased? Yes ($380>$361).

   There is no transitional Medicaid eligibility, since the loss of a household member alone causes ineligibility for FMAP. FMAP is canceled for income exceeding the two-person FMAP limit, **not** due to the increased earned income.

A household is **not** eligible for transitional Medicaid if:

- The income of a stepparent who is not a member of the FMAP eligible group makes the household ineligible for FMAP.
- The income of a stepparent who is a member of the eligible group but has not assumed the role of caretaker (e.g., incapacitated) makes the household ineligible for FMAP.
- The member received FMAP in any of the last six months immediately preceding the month of discontinuance as a result of fraud. Fraud is defined as:
  - an individual who obtains, by means of a willfully false statement or representation, by knowingly failing to disclose a material fact, any assistance or benefits to which the individual is not entitled, or
  - an individual who has knowingly withheld information by willfully providing false statement in order to qualify for benefits for which they were not entitled.

If it is determined that fraud has occurred, an EDBC Override will need to be completed in ELIAS. Send an email to the DHS, SPIRS Help Desk to get the correct Aid Code and household composition.

The following information will need to be provided to SPIRS:

- Case Number
- Date of Birth
- Pregnancy, if applicable
- Deemed newborn status, if applicable
- Refugee Status, if applicable

1. Ms. M and her family receive Medicaid under FMAP. On April 15, Ms. M turns in her annual review form indicating she does not have any income. The worker contacts Ms. M to confirm this information since she previously had some income.

   On June 15, the IM worker receives an IEVS report indicating that Ms. M has unreported earned income. Ms. M provides an employer's statement verifying that she began employment in March.

   Had the earnings been reported, Ms. M would have been determined prospectively ineligible for FMAP as of April 1. April would have been the first month of the transitional Medicaid period.

   However, since Ms. M knowingly provided false information and was ineligible to receive FMAP for the months of April, May, and June, Ms. M is not entitled to receive transitional Medicaid coverage. FMAP ineligibility occurred on April 1, and an automatic redetermination is completed.
2. Same as Example 1, except that after Ms. M verifies her earnings, the worker determines that Ms. M would have remained eligible for FMAP. In July, Ms. M reports that she got a better job. Prospectively, Ms. M's new increased earnings create ineligibility for FMAP as of August 1.

   Ms. M's previous failure to report her earnings does not disqualify her from transitional Medicaid, since her failure to report did not result in FMAP ineligibility. Therefore, August is the first month of the transitional Medicaid period.

When ineligibility for FMAP has already been determined based on a change other than increased earned income, a subsequent increase in earned income in the same month as the change that caused ineligibility does not make the family eligible for transitional Medicaid.

Mr. A and his two children receive Medicaid under FMAP. He receives unemployment compensation. On April 10, Mr. A reports that one of his children permanently moved out on April 5 to live with relatives.

Countable income of Mr. A and the remaining child exceeds FMAP limits for a two-person eligible group. Effective May 1, eligibility for the child is established under MAC and conditional eligibility for Mr. A is established under IHAWP. A notice of decision is issued April 12.

On April 15, Mr. A reports that he will begin working April 20 and his first check will be received April 30. Although his earned income would exceed the FMAP limits for a two-person eligible group, eligibility has already been established under another coverage group for May based on the earlier reported change. Therefore, Mr. A and his child are not eligible for transitional Medicaid.

Requirements After Eligibility Is Established

Legal reference: 441 IAC 75 (Rules in Process)

During all 12 months of the transitional Medicaid period, the household must continue to cooperate with Quality Control, DIAL, CSS Third-Party Liability, and the Health Insurance Premium Payment Unit.

If a person fails to cooperate, sanctions are applied.

The eligible group must:

- Continue to include a parent or other caretaker whose income is used or an ineligible parent or other caretaker whose income is used, and
- Continue to include a child, as defined by FMAP policy, and
- Timely report any changes in the household composition.

The requirement of the eligible group to include a child is met if:

- A child is absent, as described in 8-C, Absence, or
- The only child in the home is an SSI recipient, or
- The only child in the home is a “considered” person.

A family receiving transitional Medicaid is not required to report income changes except at review time. If you receive a report of change in income, take no action until the review. If the family income decreases to within the FMAP limit, explain the benefits to the family so they can make an informed decision.

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

Notices

When a person moves from FMAP to transitional Medicaid, a *Notice of Action* is not generated. There may be situations when a household has individuals in different coverage groups. When at least one FMAP member becomes eligible for transitional Medicaid, the other household members may join the transitional Medicaid group.

In this situation, the ELIAS system automatically generates a *Notice of Action* to an IHAWP or Hawki individual to inform them they no longer owe a premium.

Effective Date of Change

Legal reference: 441 IAC 75 (Rules in Process)

When a transitional Medicaid eligible group reports a change in circumstances, the effective day of the change depends on the type of change. When the change is reported timely, determined the effective date as follows:

Change	Effective Date
Child who is not in school or will not finish school before reaching age 19:	
▪ Turns 18 on the first day of the month	Remove child from TM effective the first day of the birthday month. If child is the only child in the TM group, cancel TM effective the first day of the birthday month.

Change	Effective Date
▪ Turns 18 on a day other than the first day of the month	Remove child from TM effective the first day of the month after the birthday month. If child is the only child in the TM group, cancel TM effective the first day of the month after the birthday month.
Child who is 18 and in school completes school	Remove child from TM effective the first day of the month after the month in which child completed school.
TM group no longer contains a child or no longer contains a parent or other caretaker	Cancel TM effective the first day of the month after a ten-day timely notice period. Timely and adequate notice is required
Other TM eligible group composition changes	Remove people allowing for adequate and timely notice. Add people according to 8-G, Adding a New Member to an Existing MAGI-Related Case.
Changes in income	The first day of the month following the month of change.

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

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

Adding People to the Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

The transitional Medicaid eligible group includes:

- Every person who was in the FMAP eligible group in the last month FMAP was received.
- Every person whose needs and income were included in determining the FMAP eligibility of the household when FMAP benefits were terminated.

Also add the following people to the eligible transitional Medicaid group:

- People returning to the home whose needs and income would be taken into account in determining the FMAP eligibility if the household were applying in the current month.
- Dependent children returning to the home from foster care, if they would have been included if they were at home while the household was on FMAP.
- People who were not included in the FMAP eligible group because they were receiving SSI, if they have since lost SSI.
- People who were not included in the eligible group, such as a child in deemed newborn status or other MAGI-related coverage groups.

1. Ms. M receives FMAP for herself and Child A. Child B receives SSI and is not included in the FMAP eligible group. Ms. M becomes employed and her earnings create FMAP ineligibility. Ms. M and Child A are placed on transitional Medicaid. Due to Ms. M's increased income, Child B also loses SSI eligibility.

   Since Child B would have been included in the FMAP eligible group except for the receipt of SSI, Child B is added to the transitional Medicaid group effective the first day of the month following the last month in which Child B received SSI.

2. Ms. A and her two children are receiving FMAP. Ms. A's earned income creates FMAP ineligibility, and Ms. A and her children begin receiving transitional Medicaid March 1. On May 7, Ms. A reports that one of her children has left the home and is residing with the father. The child is removed from the transitional Medicaid eligible group effective June 1.

   On July 28, Ms. A reports the child returns home. Because the child would be part of the FMAP group if applying in the current month, the child is added to the transitional Medicaid group effective July 1.

3. Mr. and Mrs. B and their three children begin receiving transitional Medicaid August 1. On January 20, Mrs. B gives birth. The baby may be added to the transitional Medicaid group effective January 1 or be eligible for Medicaid as the deemed newborn child of a Medicaid-eligible mother effective January 1.

4. Mrs. C and her three children begin receiving transitional Medicaid May 1. In July, Mrs. C reports that the father of the children returned to the home. He has no income. Mr. C's needs and income would be considered in determining Medicaid eligibility if they were applying in the current month. Mr. C is added to the transitional Medicaid group effective July 1.
5. Mr. and Mrs. D and their child begin receiving transitional Medicaid June 1. In September, Mrs. D reports and verifies she is pregnant with twins. The transitional Medicaid eligible group household size is increased. The unborn twins would be members of the FMAP group if applying in the current month.
6. Ms. F and her two children begin receiving transitional Medicaid April 1. In May, Ms. F reports her third child returned to the home after a six-month foster care placement. The child is added to the transitional Medicaid group effective the first day of the month following the month in which the child left the foster care placement.
7. Mrs. G and her child begin receiving transitional Medicaid May 1. Also in the household is Mr. G, an SSI recipient, who is disabled. Mr. G loses SSI eligibility effective August 1 due to the receipt of social security disability payments. Mr. G is added to the transitional Medicaid group effective August 1.
8. Mr. L begins receiving transitional Medicaid for himself and his son, John, on July 1. Mr. L reports on October 5 that his 15-year-old son, Adam, moved in with the family October 2. Adam is added to transitional Medicaid group effective October 1.
9. Ms. K and her son, James, have received transitional Medicaid for three months (January - March). Ms. K reports to her worker on April 21 that her son, Ken, aged 15, returned to her home on April 14. Ken receives $500 per month Social Security.

   The worker adds Ken to the transitional Medicaid group April 1. The Social Security Ken receives does not affect transitional Medicaid eligbility.

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 NonMAGI-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

- Are not pregnant at time of application or renewal. NOTE: Women are who enrolled in IHAWP who later become pregnant will have the option of either staying enrolled in IHAWP or having a redetermination completed to another coverage group.

IHAWP Household With a Child Under 21

When the following criteria is met, children under the age of 21 are required to have minimum essential coverage (MEC) in order for the parent or other caretaker to receive IHAWP coverage.

Children under the age of 21 must meet minimum essential coverage (MEC) when:

- The child is living with the IHAWP client; and
- The child is claimed as a tax dependent of the IHAWP client.

In these situations, if the child does not have MEC, there can be no IHAWP eligibility for the parent or other caretaker. The worker must deny/cancel the IHAWP coverage.

Monthly Contributions

Members enrolled in the Iowa Health and Wellness Plan with household income at or above 50 percent of the federal poverty level may be required to pay monthly contributions. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

If applicable, monthly contribution amounts are as follows:

- $5 for a member with household FPL between 50 and 100 percent;
- $10 for a member with household FPL above 100 percent.

A monthly billing statement is generated by IME each month to members responsible for a monthly contribution.

A member may be canceled if a monthly contribution is 90 days past due. In order to regain eligibility, an application must be filed. An application is not required when the person can be added to an existing MAGI-related eligible group.

Change Reporting Requirements Specific to IHAWP Members

In addition to all other Medicaid change reporting requirements, an IHAWP member shall report any of the following changes no later than ten calendar days after the change takes place:

- The member enters a nonmedical institution, including but not limited to a penal institution.
- The member turns 65.
- The member becomes entitled or enrolled in Medicare Part A or Part B or both.
- A child under the age of 21 living with the member loses minimum essential coverage (MEC), if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
- The member is confirmed pregnant.

Mothers and Children (MAC) Program

Legal reference: 42 CFR 435.116, 441 IAC 75 (Rules in Process)

Medicaid is available through the mothers and children (MAC) coverage group to pregnant women, infants under age one, and to children who have not reached age 19.

To be eligible, pregnant women, infants under age one, and children must meet FMAP eligibility requirements except for:

- Living with a parent or other caretaker.
- School attendance.
- Age.
- Income limits. (See MAC Income Limits.)

There are also specific requirements for:

- Pregnant women.
- Infants under one year of age.
- Children aged one through 18.
- Children who lose MAC eligibility because of an age change while inpatients in a medical institution.

The following sections give more information on:

- MAC eligibility requirements
- MAC income limit and requirements
- Express-Lane eligibility for MAC
- Composite MAC/medically needy households
- Composite MAC/FMAP households
- Continued MAC coverage of children receiving inpatient care

Eligibility Requirements

Legal reference: 42 CFR 435.116, 441 IAC 75 (Rules in Process)

Pregnant women are eligible for the MAC coverage group if:

- The household's countable income does not exceed 215% of the federal poverty level (see MAC Income Limits); AND
- The woman states she is pregnant.

Pregnant women who are eligible under MAC do not have to cooperate in establishing paternity and obtaining support for their Medicaid-eligible born children. See 8-C, Pregnant Women Who Are Exempt from Cooperation.

Coverage can begin three months before the month of application, but no earlier than the first day of the month of conception.

Once eligibility for MAC is established, coverage continues throughout the woman's pregnancy, even if the household's income changes. However, the woman must continue to meet all other eligibility factors.

If a pregnant woman loses eligibility under another coverage group because of excess income, grant continuous eligibility and change the coverage group to MAGI Pregnant Women. (See Continuous Eligibility for Pregnant and Postpartum Women.)

When a woman is eligible and enrolled in Medicaid before her pregnancy ends, coverage continues for the 12-month postpartum period, even if there are changes in the household's income. (See Continuous Eligibility for Pregnant and Postpartum Women.)

Ms. T, age 24, is pregnant and she lives alone. She verifies that her monthly income is less than 215% of the federal poverty level for two people (herself and the unborn child). Therefore, Ms. T is eligible for MAC coverage.

As long as Ms. T continues to meet all other eligibility factors throughout her pregnancy, she continues to be eligible under this coverage group, without regard to changes in household income. If Ms. T is eligible on the last day of her pregnancy, she continues to be eligible through the 12 months following the end of the pregnancy, regardless of her income.

Infants under one year of age are eligible under MAC if household income does not exceed 300% of the federal poverty level. See MAC Income Limits.

Mr. and Mrs. D apply for Medicaid under the MAC coverage group for their son, Tim, age 4 months. If the household's countable monthly income does not exceed 300% of the federal poverty level for a three-member household, Tim is eligible under the MAC coverage group as an infant.

If the countable monthly income exceeds 302% of the federal poverty level, examine eligibility under Medically Needy.

At the child's first birthday, determine if the child continues to be eligible for Medicaid. If the child's first birthday falls on the first day of the month, eligibility as an infant ends on the last day of the previous month. If the child's first birthday falls on any other day of the month, eligibility ends on the last day of the birth month.

Children ages 1 through 18 are eligible under MAC if countable household income does not exceed 167% of the federal poverty level. See MAC Income Limits. If the child's nineteenth birthday falls on the first day of the month, eligibility ends on the last day of the previous month. If the child's nineteenth birthday falls on any day other than the first of the month, eligibility ends on the last day of the birth month.

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

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

MAC Income Limits

Legal reference: 441 IAC 75 (Rules in Process)

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

- 215% of the federal poverty level for pregnant women.
- 300% of the federal poverty level for infants under age 1.
- 167% of the federal poverty level for children ages 1 through 18.

	Monthly Income Limit		
Household Size	Children 1 through 18: **167% of Poverty**	Infants under age 1: **300% of Poverty**	Pregnant Women: **215% of Poverty**
1	$2,178	$3,913	$2,804
2	$2,944	$5,288	$3,790
3	$3,709	$6,663	$4,775
4	$4,475	$8,038	$5,761
5	$5,240	$9,413	$6,746
6	$6,006	$10,788	$7,732
7	$6,771	$12,163	$8,717
8	$7,536	$13,538	$9,702

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

Income Requirements

Legal reference: 441 IAC 75 (Rules in Process)

Consider the income and household size of everyone in the household according to MAGI policy.

Follow MAGI policy when establishing household size. When a woman states she is pregnant, count one unborn child as if it were born and living with her. If the existence of more than one unborn child has been verified, count the actual number of unborn children as if they were born and living with the mother.

Express-Lane Eligibility for MAC

Legal reference: 42 U.S.C. § 1396a(e)(13) as amended by Section 203 of Public Law 111-3, Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); Iowa Code Chapter 249A as amended by 2009 Iowa Acts Chapter 118; 441 IAC 75.11(2) and 76.4

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

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

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

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

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

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

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

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

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

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

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

Step	Action
One	**ELIAS system**: ♦ Generates form **470-4851, Express Lane Medicaid for Children** and form **470-2826, Insurance Questionnaire** for those children. ♦ Issues **Comm. 258, Verifying Citizenship and Identity** when proof of U.S. citizenship is not already verified and the children have already received their 90-day reasonable opportunity period.
Two	**Family:** ♦ The child's household must request the child's Medicaid enrollment by signing and returning form **470-4851, Express Lane Medicaid for Children** within 30 calendar days of issuance. ♦ Either an adult member of the child's household or a child receiving Food Assistance as head of household must sign the form.
Three	**Worker:** Add the month and year when Food Assistance started to the Requested Medical Type Detail Page. For Other Program Assistance Detail Page, add the begin date of the Food Assistance eligibility.

The following chart shows actions to take for different situations:

Situation	Action by Worker
Form 470-4851 is returned but is not signed.	Return form 470-4851 to the family with a request for a signature. Allow 10 days for the form to be returned.
Client provides form 470-4851 within the 30-day period but is required to provide citizenship and identification proof before Medicaid is granted. (Occurs only when child already received Medicaid during "reasonable period of opportunity" and did not provide proof.)	For children that must verify citizenship and identification before Medicaid approval, the client must send proof by the end of the 30-day period. If the proof is not received by the 30th day, do not approve Medicaid under express-lane eligibility procedures.
Form 470-4851 is issued on June 1. The form is returned to DHS on August 15.	The form was not received by the 30th day. The child is not eligible under Express-Lane
Form 470-4851 is issued on June 1. As of that date there is no Medicaid application pended for the children. On June 10, the family files a Medicaid application which includes the children named on form 470-4851. On June 15, FMAP Medicaid is approved for the entire family. On June 29, form 470-4851 is returned to DHS.	After form 470-4851 is returned, the children are not eligible under Express-Lane.
Client provides form 470-4851 within the 30-day period but worker is unable to process within 30 days.	Process the 470-4851 after the 30-day period ends.

Situation	Action by Worker
Client sends a signed request on a paper other than form 470-4851.	If form 470-4851 has been issued, ▪ Allow ten days for the form to be returned. ▪ If form 470-4851 has not been issued, inform the client that express-lane eligibility is not available for the children. Give the client information on how to apply for Medicaid.
Form 470-4851 was issued, but client reports it was not received or it was lost after it was received.	If form 470-4851 has been issued, and ▪ The family is still within the 30-day period to request express-lane eligibility, re-issue form 470-4851 manually and allow ten days for return. (See 6-Appendix.) ▪ If the family is past the 30-day period to respond, tell the client that express-lane eligibility is not available for the children. Give the client information on how to apply for Medicaid.
Form 470-4851 was not generated, but client requests MAC express-lane eligibility for client's children.	Inform the client that express-lane eligibility is not available for the children. Give the client information on how to apply for Medicaid.
The client provides form 470-4851 within the 30-day period. Information obtained for the Food Assistance application establishes that the child is not a qualified alien according to Medicaid standards.	Do not approve Medicaid under Express Lane Eligibility procedures for a child who is not a qualified alien for Medicaid.

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

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

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

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

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

   If the children have unpaid medical bills for July, August, or September, retroactive Medicaid can be considered. However, eligibility for Medicaid in the retroactive months must be determined using standard Medicaid guidelines for all eligibility factors (e.g., citizenship proof, income, eligible group, category of eligibility for the retroactive period as defined in 8-A, Definitions, etc.).

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

   The IM worker codes ELIAS to approve Medicaid under Express Lane" only for Ashley when she approves her for MAC. The IM worker cannot approve Carly for Medicaid without proof of citizenship and identity because Carly has already used her reasonable period of opportunity. The Notice of Action will show that only Ashley is approved for MAC.

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

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

   The IM worker receives the forms on the 20th day after they were issued and enters coding in ELIAS to approve Medicaid under Express Lane for "MAC eligibility for both sons beginning July 1 (the first day of the month that the Food Assistance began).

When a Food Assistance review (RRED) and a **Medicaid/Hawki Review, form 470-5168** is filed for a child, this is not an initial eligibility determination for Medicaid. The child is already receiving Medicaid, so express-lane eligibility procedures do not apply. Medicaid eligibility is reviewed under standard Medicaid eligibility requirements and procedures.

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

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

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

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

Composite MAGI Households

If a household with income above FMAP limits has some members who might be eligible for MAGI-related Medicaid coverage and some who would not, determine eligibility under both MAGI-related Medicaid and the Medically Needy coverage groups. Examine MAGI-related Medicaid eligibility before Medically Needy.

If some household members are eligible under each group, establish two separate cases. Examples of MAGI/Medically Needy composite households include:

- Households with parents aged 19 or older and their children.
- Households with a pregnant woman who also has insured children over the age of one when family income is equal to or less than 375% of the federal poverty level but more than 167% of the federal poverty level.
- Households with infants and insured children when family income is equal to or less than 375% of the federal poverty level but more than 167% of the federal poverty level.

When determining eligibility, the household size is usually the same for each program, but may be different. Include the following in both eligible groups:

- People who are categorically eligible under MAGI-related Medicaid.
- People who are categorically eligible under Medically Needy.
- Any additional people who must be considered when determining household size.

Enter MAGI-eligible people as considered people on Medically Needy spenddown cases. Do not include them on zero-spenddown cases. See 8-C, Nonfinancial Eligibility, and 8-J, Medically Needy, for more information.

1. Household composition: Mrs. J, who is pregnant with one unborn child; Mr. J; Child A (age 13 months); and Child B (age 5).

   The family applies for Medicaid and the household's net monthly countable income is $6,000. Since this amount exceeds 167% of the federal poverty level for a five-member household (including the unborn child), Child A and Child B are not eligible for Medicaid under the MAC program.

   However, since the income is below 215% of the federal poverty level for a five-member household, Mrs. J is eligible for Medicaid under the Pregnant Women coverage group.

   Eligibility under the Medically Needy program is examined for Mr. J and eligibility under Hawki is examined for the children. See 8-J, Applying Medical Expenses to Spenddown for more information on attaining Medically Needy eligibility.

2. Mr. and Mrs. V, Child A (age 6 months), Child B (age 18 months) and Child C (age 14 years) apply for Medicaid. Mr. V has earned income of $3,500 per month. Mrs. V has earned income of $2,500 per month.

   Since the couple's total countable earned income of $6,000 does not exceed 300% of the federal poverty level for a five-member household, Child A is eligible for MAC. Child B and Child C are over income for MAC because the countable income exceeds 167% of the federal poverty level for a five-member household.

   Child B and Child C are examined for eligibility under the Hawki program.

   Eligibility under the Medically Needy program is examined for Mr and Mrs. V. Medical bills for the children that were incurred before the Medicaid eligibility date may be used to meet the spenddown of the Medically Needy household, if the household remains legally obligated for them.

Continued MAC Coverage of Children Receiving Inpatient Care

Legal reference: 441 IAC 75 (Rules in Process)

Infants and children who are currently eligible for MAC remain eligible when they are inpatients in a medical institution, even if they turn age one or 19, as long as they **continue** to meet the income requirements in effect **before** the age change. They remain eligible through the month the continuous inpatient stay ends.

Redetermine Medicaid eligibility under another coverage group and issue timely notice when an infant or child loses eligibility because of an age change and when it is not known if the child is an inpatient in a medical institution.

Do not consider the age change until the infant or child leaves the medical institution. All other eligibility factors continue to apply.

1. Carey is an infant who currently receives Medicaid under MAC. On June 10, Carey turns one year old. The ELIAS system completes an automatic redetermination and issues a **Notice of Action** canceling Medicaid benefits effective July 1, since the family's income exceeds the income limits.

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

   Although the household's income exceeds 167%, it remains less than 300% of the federal poverty level. Therefore, Carey remains Medicaid-eligible under MAC through the end of August, because she meets all MAC eligibility factors for infants, except for age.

2. Sarah, age 18, is currently receiving Medicaid under MAC. In August, an automatic redetermination is completed because of her nineteenth birthday on August 22.

   The household verifies that Sarah is an inpatient in a medical institution and is expected to remain there until late November. She must continue to meet all MAC eligibility factors for children ages one through 18, except for age.

3. Bobby is an infant in "deemed newborn" status currently receiving Medicaid under MAC. His first birthday is April 15. In March, the worker requests income information to redetermine eligibility.

   The household states that Bobby is currently in the hospital. Because Bobby is a hospital inpatient, he remains eligible for Medicaid under MAC if the household's countable income is within 300% of poverty. (He is aged out of the coverage group but still must meet income guidelines in effect when he entered the hospital.)

One of the family members receives and reports a salary increase while Bobby is still hospitalized. The family's net countable income now exceeds 302% of poverty. Medicaid under MAC is canceled effective the first of the next month allowing a ten-day notice.

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

Medicaid/Hawki Composite Families

This section is designed to provide guidance in situations where some family members have health care coverage through the ***Hawki*** program and other family members receive or are applying for Medicaid.

When children in a family receive health care coverage through ***Hawki*** and other family members apply for Medicaid, determine if the children on ***Hawki*** are Medicaid-eligible, according to MAGI-related Medicaid household composition policy. See 8-C, MAGI Household Size for more information.

Mrs. A applies for ***Hawki*** for her two children, who both are over age 1. Family income exceeds 167% of poverty but does not exceed 302% of poverty. ***Hawki*** coverage is approved for the children beginning October 1.

In January, Mrs. A is injured in an accident and applies for Medicaid. Family income still exceeds 167% of poverty, so the children remain ***Hawki*** eligible.

Mrs. A is only conditionally eligible for Medically Needy with a spenddown. Her ***Hawki***-eligible children are "considered persons" in her eligible group and are coded with fund code "S." Eligibility and spenddown for Mrs. A will be based on a three-member eligible group.

If the children are found to be Medicaid-eligible under coverage groups other than Medically Needy with a spenddown, the family can choose to leave the children on ***Hawki*** until the ***Hawki*** annual review or to have the children begin receiving Medicaid. If the family chooses to have the children begin receiving Medicaid, no additional action by the worker processing the Medicaid application is necessary in order for the ***Hawki*** coverage to be canceled.

If the family chooses to have the children continue to receive Hawki, a system override will be required. Contact DHS, SPIRS Help Desk for instructions.

1. Ms. B applies for ***Hawki*** for her son. Family income exceeds 167% of poverty for a two-member eligible group. ***Hawki*** eligibility is established for Ms. B's son effective April 1. In July, Ms. B applies for Medicaid because she is pregnant. The same family income is now below 167% of poverty for a three-member eligible group (Ms. B, her son, and the unborn child).

   Ms. B chooses to have her son remain on ***Hawki*** until the ***Hawki*** annual review. Household size continues to be determined using MAGI-related Medicaid policy.

2. Mr. and Mrs. C apply for ***Hawki*** for their three children. Family income exceeds 167% of poverty for a five-member eligible group. ***Hawki*** eligibility is established for the three children effective June 1.

   In October, Mr. and Mrs. C apply for Medicaid. While determining eligibility, the worker determines that family income is now less than the FMAP limit for a five-member eligible group.

   If the Cs choose to have their children remain on ***Hawki*** until the ***Hawki*** annual review, household size is determined using MAGI-related Medicaid policy. The Cs could also decide to have only one or two of their children begin receiving Medicaid and let the others stay on ***Hawki***.

People in a Medical Institution Within the 300% Income Limit

Legal reference: 441 IAC 75 (Rules in Process)

Medicaid is available to a child under age 21 who meets **all** the following conditions:

- Has received care in a medical institution for 30 consecutive days.
- Meets the level of care requirements for the institution, as determined by the Iowa Medicaid Enterprise (IME).
- Has gross countable monthly income that does not exceed 300% of the SSI benefit standard for one.

Children who are eligible under another coverage group (except Medically Needy) are not eligible under this coverage group.

Disregard the resources of all household members in determining eligibility of people under age 21 in this coverage group. See People in Medical Institutions: 300% Income Level and 8-N, Determining Coverage Group for more information on determining eligibility.

Medicaid for Independent Young Adults (MIYA)

Legal reference: 42 CFR 435.226; 441 IAC 75 (Rules in Process)

Medicaid coverage under the "Medicaid for independent young adults" (MIYA) group is available to youth between the ages of 18 and 21 who left foster care on or after May 1, 2006, if the youth was in foster care under Iowa's responsibility for placement and care when the youth turned 18. To be eligible, youth must meet MAGI-related Medicaid eligibility requirements except for:

- Age.
- Living with a parent or other caretaker.
- School attendance.
- Income limits. See MIYA Income Limits.

The following sections give more information on:

- MIYA eligibility requirements
- Determining MIYA household size
- MIYA income limits and requirements

Eligibility Requirements

Legal reference: 441 IAC 75 (Rules in Process)

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

- The youth is 18 years old or older but is under 21 years of age,
- The youth is not a mandatory household member or receiving Medicaid benefits under another coverage group (see Example 1 below),
- The youth is not eligible to receive Medicaid through another coverage group as determined by the ELIAS system.
- The youth resided in foster care (includes court-ordered PMIC placement) when the youth reached age 18,
- The youth left foster care on or after May 1, 2006,
- Iowa was responsible for the placement and care of the youth at the time the youth reached age 18, and
- The household's countable income is less than 254% of the federal poverty level. (See MIYA Income Limits.)

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

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

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

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

Eligibility under the MIYA coverage group can begin three months before the month of application for children under the age of 19.

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

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

Ms. K, age 19, and her child have been receiving Medicaid under a MAGI-related Medicaid coverage group. Ms. K's income creates ineligibility. Ms. K's Medicaid eligibility is redetermined to MIYA with a household size of one. The child is redetermined to MAC.

Household Size

Legal reference: 441 IAC 75 (Rules in Process)

The household size is based on policy in 8-C, MAGI Household Size.

MIYA Income Limits

Legal reference: 441 IAC 75 (Rules in Process)

When determining initial and ongoing eligibility for MIYA, countable income must be less than 254% of the federal poverty level.

MIYA Monthly Income Limits: 254% of Poverty	
Household Size	Limit
1	$3,313
2	$4,477
3	$5,641
4	$6,806
5	$7,970
6	$9,134
7	$10,298
8	$11,462

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

The following sections explain procedures for:

- MIYA income requirements
- Determining countable income
- Verification of income
- Change in income

Income Requirements

Legal reference: 441 IAC 75 (Rules in Process)

Consider the income of everyone included in the MIYA household size. See Household Size.

Determining Countable Income

Legal reference: 441 IAC 75 (Rules in Process)

When determining the amount of income to compare to the applicable poverty level, apply the MAGI-related Medicaid income policies.

Verification of Income

Legal reference: 441 IAC 75 (Rules in Process)

Refer to policy found at 8-E for verification procedures for applications and reviews.

Change in Income

Legal reference: 441 IAC 75 (Rules in Process)

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

Reporting Requirements

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

MIYA eligibles must report the following changes:

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

Information Provided

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

- **Comm. 020, Your Guide to Medicaid.**
- **Comm. 051, Information Practices.**
- **Comm. 091, The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients.**
- **Comm. 209, Information About Your Privacy Rights.**

Expanded Medicaid for Independent Young Adults (EMIYA)

Legal reference: 42 CFR 435.150, 441 IAC 75 (Rules in Process)

Medicaid for former foster care youth under the "Expanded Medicaid for Independent Young Adults (EMIYA) is available to youth between the ages of 18 and 26 who left foster care on or after January 1, 2014. The person had to receive foster care and be enrolled in Medicaid while in foster care on the date of attaining 18 years of age (or such higher age to which foster care is provided to the person).

Eligibility Requirements for youth who aged out of foster care prior to December 31, 2022

To be eligible for EMIYA coverage, former foster care youth who aged out of foster care prior to December 31, 2022, must meet all of the following requirements:

- Are under age 26;
- Are not eligible for or enrolled in another mandatory Medicaid group;
- Were in foster care under the responsibility of Iowa upon attaining age 18 (or such higher age to which foster care is provided to the person); and
- Were enrolled in Medicaid in Iowa on the date they aged out of foster care.

Eligibility Requirements for youth who aged out of foster care on or after January 1, 2023

Effective January 1, 2023, 1902(a)(10)(A)(i) of the Social Security Act was modified with two eligibility changes outlined below. Former foster care youth who age out of foster care on or after January 1, 2023, will be eligible in the former foster care youth group if they meet all of the below requirements:

- Are under age 26;
- Are not enrolled in an eligibility group (even if they meet the eligibility requirements of such group);
- Were in foster care under the responsibility of any state upon attaining age 18 (or such higher age to which foster care is provided to the person); and
- Were enrolled in Medicaid in any state on the date they aged out of foster care.

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,
- was eligible as a deemed newborn child of a Medicaid-eligible mother,
- did not have either U.S. citizenship and identity, or non-citizenship/alien status, verified within the reasonable opportunity period,

- had eligibility determined under Express Lane procedures, 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 and Appeals 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,
- The child is no longer a resident of Iowa (including unable to locate),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.

NonMAGI-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 "NonMAGI-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 NonMAGI-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 NonMAGI-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 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's or widower's disability benefit and SSI or SSA for January 1984.
- They became ineligible for SSI or SSA because their widow's or widower's benefit increased as a result of the elimination of the reduction formula in January 1984. This must be the sole reason they lost eligibility for SSI or SSA.
- They would be eligible for SSI or SSA benefits if the increase resulting from the elimination of the reduction factor and later cost-of-living adjustments were disregarded.
- They have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.
- They applied for Medicaid before July 1, 1988.

In January 1984, the Social Security Administration eliminated a "reduction formula" that had been used to calculate social security benefits for disabled widows and widowers. As a result, social security benefits increased. The increase caused some members of this group to lose eligibility for SSI, SSA, and Medicaid. Congress established a new eligibility group to allow ongoing Medicaid eligibility for these persons.

No new persons can enter this coverage group after July 1, 1988. For those who applied before July 1, 1988, and were approved under this group, review whether the person:

- Has been continuously eligible for social security widow's or widower's benefit, and
- Still meets SSI or SSA standards, including income, if the specified social security increases are disregarded.

Determine countable income using SSI policies. Deduct from current gross social security income the amount of the increase resulting from the elimination of the reduction factor. (The Social Security Administration provided this reduction factor.) Add all countable income to the remainder.

Compare this sum to the SSI or State Supplementary Assistance (SSA) income limit.

Mrs. M, a 63-year-old widow living alone in her home, received SSI and social security income in 1983. She became ineligible for SSI in February 1984 due to the increase in social security benefits due to elimination of the actuarial reduction formula.

Medical eligibility was then established under the coverage group for widowed persons ineligible for SSI or SSA due to the social security actuarial change.

Mrs. M's current gross monthly income is $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 NonMAGI-Related Income.

To examine eligibility under this coverage group:

1. Check that the client has not transferred assets to become eligible for Medicaid. See 8-D, Transfer of Assets. If so, this disqualifies the person in a facility for nursing facility services.

   Other services may be covered if the person is eligible for this group. To accomplish this, manually determine eligibility and put the person in a coverage group that does not pay the facility but pays for other medical services. Do not do this for waiver cases.

2. Determine assets to be attributed to the spouse of an institutionalized person. See 8-D, Attribution of Resources.

3. Use SSI policy to calculate the client's gross income. See 8-E. Do not allow the earned income disregard and the general disregard of income.

   Compare the gross income to the 300% limit of $2,901. 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 NonMAGI-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 NonMAGI-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 NonMAGI-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 NonMAGI-Related Coverage Groups. Allow the earned and unearned deductions. Consider the income prospectively.

- Has resources that do not exceed twice the maximum allowed by the SSI program. Treat resources according to SSI policy. See 8-D, General NonMAGI-Related Resource Policies. The resource limit for the QMB group is $9,660 for an individual and $14,470 for a couple.
- Meets all other NonMAGI-related Medicaid nonfinancial eligibility requirements except for disability determination and age.

To be "entitled" to Medicare Part A means that the person is enrolled and eligible to receive Part A benefits **or** meets the requirements to enroll. See 8-M, Medicare Part A, to determine dates of Medicare eligibility and who may qualify for Part A. The state buy-in establishes Part A entitlement for a qualified Medicare beneficiary who is entitled to Medicare Part B but is not entitled to free Part A.

People who are not already receiving Medicare Part B must file an application with the Social Security Administration to enroll in Part A and Part B. A person who chooses not to enroll for Medicare Part A benefits cannot be QMB-eligible. This does not affect the person's eligibility for other Medicaid coverage groups.

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

QMB applicants are not required to apply for FIP, SSI, or State Supplementary Assistance cash benefits. A person who is eligible for full Medicaid benefits under another coverage group may also be concurrently eligible for QMB. Medicaid eligibles who receive SSI and who are entitled to receive Medicare Part A are concurrently eligible for QMB.

Federal financial participation for Medicare premiums is available for people who meet QMB requirements. Therefore, it is necessary to identify these people. Clients who are eligible for QMB in ELIAS and for Medically Needy in ABC with a spenddown have both a QMB case and a separate case for Medically Needy.

Enter the poverty level on the ABC system for each person on the Medically Needy case. Also enter a "Q" in the QMB indicator for each person on Medically Needy with a zero spenddown.

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 NonMAGI-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
   $ 968 exclusion
   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 NonMAGI-Related Coverage Groups. Allow the earned and unearned deductions. Consider the income prospectively.

- Has resources that do not exceed twice the maximum allowed by the SSI program. Resources are treated according to SSI policies. The resource limits for the SLMB group are $9,660 for an individual and $14,470 for a couple. See 8-D, General NonMAGI-Related Resource Policies.
- Meets all other nonfinancial NonMAGI-related Medicaid eligibility requirements except for disability determination and age.

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

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

A person who wants this coverage must enroll in Medicare Parts A and B. A person who chooses not to enroll for Medicare Part A benefits cannot be eligible under SLMB. The state will not enroll people for Medicare Part A under SLMB. If the person does not enroll for Part A, it does not affect the person's eligibility for other Medicaid coverage groups.

> 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 NonMAGI-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 NonMAGI-Related Coverage Groups. Allow the earned and unearned deductions. Consider the income prospectively.

- Has resources that do not exceed twice the maximum allowed by the SSI program. Resources are treated according to SSI policies. The resource limits for the SLMB group are $9,660 for an individual and $14,470 for a couple. (See 8-D, General NonMAGI-Related Resource Policies.)
- Meets all other NonMAGI-related Medicaid nonfinancial eligibility requirements except for disability determination and age.
- Is not eligible for any other Medicaid coverage group. (If a person is approved for Medically Needy with a spenddown, the person can receive E-SLMB until the spenddown is met.)

A person who wants this coverage must enroll in both Medicare Part A and Part B. The state will not enroll people for Medicare Part A under expanded SLMB. A person who chooses not to enroll for Medicare Part A benefits cannot be eligible under expanded SLMB. When Medicaid eligibility ends, the client is responsible for paying the Medicaid Part B premiums.

Calculate net countable monthly income using SSI policies. Allow the earned and unearned income exclusions. Consider the income prospectively. See 8-E, Deeming NonMAGI-Related Income when deeming to a spouse is applicable.

Exclude the social security COLA income from January through the month following the month in which the federal poverty level is published. Central Office will notify you when to recalculate the poverty level using the social security COLA increases.

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

$1,190	Gross social security
+ 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 NonMAGI-related Medicaid eligibility requirements.
- The person must not be eligible for any other Medicaid coverage group other than QMB, SLMB, or Medically Needy.
- Resources must be less than $12,000 for an individual or $13,000 for a couple.
- Net family income must be less than 250% of the federal poverty level.
- Any premium assessed for the month of eligibility must be paid.

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

Age

Legal reference: 441 IAC 75 (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 NonMAGI-Related Income and NonMAGI-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.

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 $13,000 for a couple. (NOTE: These resources limits are higher than those for other Medicaid coverage groups.)

Some resources owned by the **MEPD applicant or member** may be exempt when determining MEPD eligibility that are not exempt for eligibility under other NonMAGI-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 NonMAGI-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:**
$1,957or less	At or below 150%	0
Above: $1,957	Above 150%	$41
$2,152	165%	$57
$2,348	180%	$68
$2,609	200%	$79
$2,935	225%	$93
$3,261	250%	$108
$3,913	300%	$136
$4,565	350%	$165
$5,217	400%	$194
$5,869	450%	$224
$7,173	550%	$280
$8,478	650%	$338
$9,782	750%	$397
$11,086	850%	$469
$13,042	1000%	$563
$14,998	1150%	$660
$16,955	1300%	$760
$19,302and above	1480%	$879

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 ABC back to the first month of MEPD eligibility. The member may not need MEPD coverage for all of the back months, so the member may not want to have premium payments credited to those months.

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

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

> Ms. M applies for Social Security Insurance (SSDI) benefits in April 2023. She applies for MEPD on June 12, 2023. On May 15, 2024, the Social Security Administration determines that she is disabled with an effective date of disability of March 21, 2023.
>
> On May 21, 2024, the worker enters eligibility effective June 2023, with a monthly premium of $34. The "back" months include June 2023 through December 2023 and January 2024 through April 2024.
>
> Ms. M. sends a signed statement to her worker explaining that she did not have any unpaid medical bills for November or December 2023, 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 2023. 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 NonMAGI-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.