STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8, Chapter A

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Medicaid
Administration

Page

Overview

This chapter provides general administrative information about Iowa's Medicaid program. The Medicaid program is a health care payor: It pays for health care services and long-term care services and supports vulnerable Iowans who are eligible.

The Medicaid program is funded by federal and state governments and is managed by the Iowa Department of Human Services (referred to as "the Department" or "DHS"). The Department's Medical Services Division leads the Iowa Medicaid Enterprise, which administers the Iowa Medicaid Program.

A wide range of medical and health services are available through the Iowa Medicaid program. Services are covered only if they are medically necessary. Medicaid members have free choice of a doctor, dentist, pharmacy, and other providers of services. NOTE: People who are eligible for both Medicaid and Medicare receive prescription drug coverage through Medicare Part D.

A provider that chooses to participate in the Medicaid program must accept the payments that Medicaid makes and make no additional charges to the member for services covered under the program.

Federal policies for the Medicaid program are in the Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Parts 430 through 489. Iowa Code Chapter 249A authorizes Iowa's participation in the program. The policies specific to the Medicaid program are in Iowa Administrative Code (IAC) 441, Chapters 73 through 91.

This chapter describes:

- Department responsibilities for:
  - Setting Medicaid eligibility policies and determining member eligibility,
  - Determining what services are covered and paying claims, and
  - Meeting Medicaid administrative requirements;
- Appeal policies; and
- Information about other programs that provide benefits to Medicaid members.

Definitions

"Aged" means a person who is 65 years of age or older.

"Applicant" means a person who is requesting medical assistance on the person's own behalf, or a person for whom medical assistance is requested, or a person requesting medical assistance on behalf of another person.

"Blind" for Non-MAGI-related or Social Security Administration purposes, means a person must have central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Client" means any of the following:

- A Medicaid applicant,
- A Medicaid member,
- A person who is conditionally eligible for Medicaid, or
- A person whose income or assets are considered in determining eligibility for an applicant or member.

"Client participation" is the amount the client is required to pay for care in an institution.

"CMAP" means the Child Medical Assistance Program and is used only for children under age 21 either placed in licensed foster care for whom non-IV-E foster care maintenance payments are made or with non-IV-E adoption assistance with Iowa or with a state with which Iowa has a reciprocity agreement.

"Common-law marriage" is a legal and valid marriage in Iowa. When a common-law marriage exists, the department views the adults the same as any other married couple. Accept a couple's attestation that a common-law marriage exists unless questionable. See 8-I, Determining if a Common-Law Marriage Exists, for more information.

"Community spouse" means a person who is not in an institution or on a waiver but who is married to a person who is in an institution or is applying for or receiving waiver services or PACE.

"Coverage group" means a group of persons who meet certain common eligibility requirements.

"CSRU" means the Child Support Recovery Unit (the Department's Bureau of Collections, including its field offices).

"Department" means the Iowa Department of Human Services.

"Dependent" means a person who can be claimed by another person as a dependent for federal income tax purposes. (Dependent person for the State Supplementary Assistance Program is defined in 6-B).

"Dependent children" means children who meet the nonfinancial eligibility requirements of the applicable MAGI-related coverage group.

"Disability Determination Services" or **"DDS"** is a state agency in the Division of Vocational Rehabilitation Services of the Iowa Department of Education. The Department has an agreement with DDS to determine disability for State Supplementary Assistance and NonMAGI-related Medicaid.

"Disabled person" for NonMAGI-related or Social Security Administration purposes, is a person who is unable to engage in substantial gainful activity because of a physical or mental impairment that has lasted or is expected to last for 12 continuous months or result in death. EXCEPTION: The MEPD coverage group does not apply the substantial gainful activity test to determine disability. A disabled person must meet only the physical or mental impairment criteria.

"Electronic Data Sources" or **"EDS"** means federal and state data sources with which the department conducts data matches for the purpose of determining eligibility. Federal data sources include Internal Revenue Service (IRS), Social Security Administration (SSA) and Department of Homeland Security. State data sources include IWD Wage and Unemployment Compensation, SSA, IRS, and Public Assistance Reporting Information System (PARIS).

"Eligibility Integrated Application Solution" or **"ELIAS"** is the system used by the Department to determine Medicaid eligibility.

"E-SLMB" means the NonMAGI-related expanded specified low-income Medicare beneficiary coverage group.

"Family Investment Program" or **"FIP"** is the name of Iowa's Temporary Assistance for Needy Families program. The purpose of FIP is to provide financial and other assistance to needy, dependent children and the parents or relatives with whom they live.

"Federal financial participation" (FFP) is the rate at which the federal government reimburses the state for providing Medicaid services.

"Family-related Medically Needy" describes the Medically Needy coverage group whose eligibility criteria are derived in relation to the Family Medical Assistance Program, directed toward pregnant women, children, and their parents or caretakers, except for excess income.

"Intermediate care facility for people with mental illness" or **"ICF/MI"** means an intermediate care (nursing) facility for people with mental illness.

"Iowa Health and Wellness Plan" or **"IHAWP"** means the coverage group directed toward the adult population of individuals ages 19 through 64.

"IME" means the Iowa Medicaid Enterprise.

"Institutionalized spouse" means a married person who lives in a medical institution or nursing facility, or participates in a home- and community-based services waiver (or PACE) and who is likely to remain living in these circumstances for at least 30 consecutive days and whose spouse is not in a medical institution or nursing facility, on a waiver program, or PACE. "Spouses" include people who are married under state law or common law and people who are separated.

"Intermediate care facility for persons with an intellectual disability" or **"ICF/ID"** means a medical institution used primarily for the diagnosis, treatment, or rehabilitation of people who have an intellectual disability. In a protected residential setting, the facility provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or related services to help each resident function at the resident's greatest ability.

"Local office" means the county office of the Department of Human Services, or a state mental health institute, or hospital school.

"MAC" means the MAGI-related mothers and children coverage group to pregnant women, infants under age one, and to children who have not reached age 19.

"MAGI" means the modified adjusted gross income.

"MAGI-exempt" describes Medicaid coverage groups for MAGI-related special populations who are exempt from the income test.

"MAGI-related" describes Medicaid coverage groups for pregnant women, children under 19, parents and caretakers, and the adult population (IHAWP).whose eligibility criteria are derived from the MAGI tax-based methodology determination.

"Managed care organization" or **"MCO"** means an organization that provides members with comprehensive health care services, including physical, behavioral, and long term care services and supports. MCOs make these services available to the member for a fixed monthly rate (capitation payment) that is paid by Medicaid.

"Medicaid for Kids with Special Needs" or **"MKSN"** means a medical coverage group for children with disabilities.

"**Medical Assistance Advisory Council"** or **"MAAC"** means the group that advises the Department about health and medical care services and participates in policy development. The MAAC is composed of representatives from:

- Provider groups.
- The General Assembly.
- The Department of Public Health.
- Consumers.
- The public.

Legal reference: 42 CFR 431.12, 441 IAC 79.7(249A))

"Medical institution" means:

- Acute care hospitals
- Psychiatric institutions, including:
    - State mental health institutes (MHIs)
    - Psychiatric hospitals
    - Psychiatric medical institutions for children (PMICs)
- Long-term care facilities, including:
    - Nursing facilities (NFs)
    - Nursing facilities for people with mental illness (ICF/MI)
    - Hospital-based or non-hospital-based skilled nursing facilities (SNFs)
    - Intermediate care facilities for persons with an intellectual disability (ICF/IDs)

Residential care facilities (RCFs) are **not** medical institutions and are not Medicaid providers.

"Medicare savings programs" is a limited Medicaid coverage group assisting low-income people with the payment of Medicare premiums, coinsurance, and deductibles. These groups include QDWP, QMB, SLMB, and E-SLMB.

"Member" means a person who has been determined eligible and has been enrolled to receive Medicaid. Member may be used interchangeably with "recipient".

"MEPD" means the NonMAGI-related coverage group for employed people with disabilities.

"Minimum Essential Coverage" (MEC) means any insurance plan that meets the Affordable Care Act requirement for having health coverage. Examples of plans that qualify include: Marketplace plans; job-based plans; Medicare; and Medicaid & CHIP.

"Modified Adjusted Gross Income" (MAGI) is the tax-based methodology used to determine income eligibility and household size for Medicaid coverage groups for pregnant women, children under 19, parents and caretakers, and the adult population (IHAWP).

"Needy specified relative," means a non-parental specified relative, as listed in 8-C, Specified Relatives, who meets all the eligibility requirements to be included in the family-related Medically Needy eligible group.

"NonMAGI-related" describes Medicaid coverage groups whose eligibility criteria are derived from the Supplemental Security Income (SSI) program for people who are aged, blind, or disabled, except for income and resource limits.

"Nursing facility" or **"NF"** means a medical institution that provides care for people who need nursing care and other services in addition to room and board because of their mental or physical condition.

"PACE" means a program for all-inclusive care for the elderly. A PACE provider receives a monthly capitated payment for enrollees and is responsible for ensuring that enrollees receive any services determined necessary for their health and well-being.

"Parent" means a natural or biological parent, an individual legally recognized as the parent of a child based on the conception, gestation, or birth of the child during a legal marriage, an adoptive parent, or the spouse of another parent (step-parent), unless parental rights have been legally terminated.

"PMIC" means a psychiatric medical institution for children.

"Prudent-person concept" refers to the authority given to the income maintenance workers to review and analyze information given by the client and decide whether the information is sufficient for making an eligibility determination, or if further checking should be done. The "prudent person" must be vigilant, cautious, perceptive, and guided by generally sound judgment.

"QDWP" means the NonMAGI-related coverage group for qualified disabled and working people.

"QMB" means the NonMAGI-related qualified Medicare beneficiary coverage group.

"Reasonable Compatibility" means the standard by which the total attested countable income for each person's household size is compared with the total amount from available Electronic Data Sources used by DHS. In order for attested income to meet the standards for 'reasonable compatibility' it must meet one of three criteria:

- Both the total attested income and the total income from the Electronic Data Sources are above, at, or below the applicable income limit for Medicaid or HAWK-I, or
- The total attested income is within 10% of the total income from Electronic Data Sources, or
- The total attested income exceeds the total income from electronic data sources.

If the attested income meets any of the reasonable compatibility criteria, the income is considered to be verified. "Reasonably compatible" is another term used in place of "reasonable compatibility" and carries the same meaning as "reasonable compatibility".

"RCF" means a residential care facility licensed by the Iowa Department of Inspections and Appeals.

"Recipient" means a person who is receiving assistance, including receiving assistance for another person (also referred to as a "member").

"Recovery" is the process by which an overpayment is collected from the client. Department staff are responsible for establishing the amount of the overpayment and making the referral to the Department of Inspections and Appeals. DIA is responsible for collection actions.

"Retroactive period" means the three calendar months immediately preceding the month in which a Medicaid application is filed for:

- A pregnant woman
- An infant (under one year of age)
- A child under 19 years of age
- A resident of a nursing facility licensed under Iowa Code chapter 135C

"Retroactive certification period" is one, two, or three calendar months before the month in which application for Medicaid is filed. Under Medically Needy, the retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately before the month of application.

"SLMB" means the NonMAGI-related specified low-income Medicare beneficiary coverage group.

"SNF" means a nursing facility certified to provide skilled care under the Medicare program.

"Spouse" is a legally married person under state law. This includes common-law and separated spouses.

"State Data Exchange" or **"SDX"** means the system by which the Social Security Administration transmits information related to SSI or federally administered State Supplementary Assistance beneficiary eligibility and benefit amounts to the beneficiary's state of residence. The SDX file is designed to disperse SSI eligibility data from the Department central office to the local office.

"State Supplementary Assistance" or **"SSA"** means a program that provides cash payments for aged, blind, or disabled people who have a certain need that is not met by SSI basic payments. The policies governing this program are based on SSI policies.

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent by ceremonial or common-law marriage. A stepparent is considered a "parent" for the purpose of determining eligibility under a coverage group that is subject to MAGI methodology.

"Supplemental Security Income" or **"SSI"** means federal cash payments issued by the Social Security Administration to aged, blind, or disabled people to bring the person's total income up to a prescribed level based on living arrangement. To qualify for SSI, the person's income and resources must fall within limits established by federal law.

"Supply" means that the Department receives the requested information by the specified due date.

"Third-Party Liability Unit" is a unit at the Iowa Medicaid Enterprise or a unit within the MCO that has responsibility to identify any third-party financial source that would pay medical bills.

"Third-party payments" are payments made by a party other than Medicaid or the client for medical expenses that otherwise would be met through the Medicaid program.

"Waiver services" are medical services provided to people who need at least nursing level of care but who are not living in an institution.

Eligibility

The Department's Iowa Medicaid Enterprise (IME) is responsible for formulating Medicaid eligibility policy and procedure within the framework of state and federal law and regulations. See Chapter 8-F, *Coverage Groups* for more information on ways that people can qualify for Medicaid benefits.

The Department is organized into five geographic service areas, each led by a service area manager. Income maintenance workers in the Department's service areas determine Medicaid eligibility. However, in certain circumstances, eligibility determination is done by staff of the Social Security Administration or by qualified providers.

Service areas are responsible for maintaining the Medicaid eligibility records for all members. Each member's case is processed by an income maintenance worker, who enters eligibility information into a centralized automated system.

Medical Assistance Eligibility Card

Legal reference: 441 IAC 76.13(2), 441 IAC 80.5(1)

The Department issues a *Medical Assistance Eligibility Card*, form 470-1911, to all Medicaid members. The *Medical Assistance Eligibility Card* is issued at time of approval (or when spenddown is met for a medically needy person).

EXCEPTIONS:

- Members determined presumptively eligible for Medicaid have form 470-2580 or 470-2580(S), *Presumptive Medicaid Eligibility Notice of Action*, as evidence of eligibility rather than the *Medical Assistance Eligibility Card*.
- An individual who is eligible only for limited emergency Medicaid for aliens will be issued a Notice of Action, form 470-0485, 470-0485(S), 470-0485(M), or 470-0485(MS), which will include certification information.

The card lists the member's name, state identification number, and date of birth. Replacement cards can be issued upon a member's request.

Only the member named on the card can use the card. Members are responsible for:

- Notifying the provider of service that they are Medicaid members.
- Showing the card or providing the health care provider with information needed to verify Medicaid eligibility.

Providers must check ELVS or the web portal to identify existing health insurance coverage and any service restrictions, such as lock-in. Services are covered only when provided under the Medicaid coverage group under which the member enrolled.

Eligibility Verification System

The Department's Eligibility Verification System (ELVS) and secure web site allow a provider to verify:

- 24 months of member eligibility.
- Eligibility for PACE enrollees.
- Eligibility for qualified Medicare beneficiaries.
- Conditional eligibility for Medically Needy members.
- The amount of spenddown balance for Medically Needy.
- Managed Care (MCO) coverage
- Third-party resources.
- Lock-in restrictions.
- The date and amount of the provider's last remittance.

The ELVS telephone number for the Des Moines area is **515-323-9639** and for the rest of the state is **1-800-338-7752**. A touch-tone phone is needed, and providers must know:

- Their provider number,
- The date of service, and
- Either the member's state identification number or the member's date of birth and social security number.

To set up access to the secure web site, providers must contact EDISS at **1-800-967-7902**.

Benefits

Members who are not required to be in managed care and are not PACE enrollees have primary responsibility to find and select providers who accept Medicaid. If a member asks you for help in finding a provider, refer the member to https://hhs.iowa.gov/ime/members/find-a-provider.

Coverage of Medicaid services is explained in more detail in 8-M, *Medicaid Services*, and in 8-F, *Coverage Groups*. If the member asks you about coverage of a particular service, refer the member to https://hhs.iowa.gov/ime/members/what-services-are-available.

Iowa Medicaid Enterprise

To learn more about IME and to visit the Contact Directory, go to https://hhs.iowa.gov/ime/about.

When Members Are Responsible for Payment of Medical Bills

Legal reference: 441 IAC 79.1(13), 441 IAC 79.9(4), 441 IAC 80.4(1), 441 IAC 80.5(1)

The member is responsible for paying for all or part of medical services when:

- Medicaid does not cover the services.
- The member receives services during a period when the member was not eligible for Medicaid.
- The provider does not participate in Medicaid. Members are responsible for making sure their providers accept Medicaid.
- A specified copayment is required.
- The bill is used to meet spenddown for the Medically Needy coverage group.
- The member is enrolled in an MCO and uses a provider who is not on the MCO's list of providers.
- The member fails to notify the provider of the member's Medicaid eligibility during the Medicaid claim-filing period. EXCEPTION: The member is **not** responsible for payment if the length of time for determination of retroactive eligibility prevents a member from timely informing the provider.
- The member is enrolled in the PACE program and uses a non-PACE provider for nonemergency services.

For more information on member responsibilities and copayments, go to:

- If enrolled in an MCO; https://hhs.iowa.gov/iahealthlink/benefits and click on Member Managed Care Program Handbook.
- If fee-for-service (FFS); https://hhs.iowa.gov/ime/members/FFS and click on Your Guide to Medicaid Fee-for-Services (FFS).

Recovery

Legal reference: 42 CFR 435.930(b) and 455.12, Iowa Code Section 249A.53, 441 IAC 75.28(2) and 76 (Rules in Process)

Policy: The Department is responsible for recovering overpayments from a member for all Medicaid funds incorrectly paid to or on behalf of the member. The Department also recovers overpayments from providers. Provider overpayments are processed by the Iowa Medicaid Enterprise (IME).

The Department is also responsible for recovering medical assistance paid on behalf of the member from the estates of deceased Medicaid members. See 8-D, *Estate Recovery*, for information on when estate recovery applies.

Comment: Member errors, agency errors, or administrative errors can result in incorrect expenditures. Examples of situations in which overpayments occur are:

- Services were incorrectly provided because the member was ineligible.
- The member loses an appeal, and assistance was continued pending the decision.

Procedure:

1. Determine the period of time during which the overpayment occurred.
    - When the overpayment is caused by an **agency** error, go back to the month the error was made and redetermine eligibility as it should have been determined from that point forward.

> Mr. A receives his first check from XYZ Inc. on January 23. He reports the new job on January 25. The worker forgets to verify the income from the new job until the case is pulled for the annual review in July. The worker verifies the income at that time.
>
> The process that should have taken place is: The worker would have written a letter to Mr. A requesting verification of the new job and allowed ten days to return the verification. The due date would have been in early February. Once the verification was received, if there was a change in eligibility, it would have been effective March 1, allowing a ten-day notice for any negative action.
>
> If the worker had acted timely on the new job report, eligibility would not have been affected until March 1. Therefore, if an overpayment exists, it would begin effective March 1 because it was an agency error.

- When the overpayment is caused by a **member** error, go back to when the error occurred and redetermine eligibility as if the information was timely reported. If an overpayment exists, it begins the month following the month of the member error. EXCEPTION: When the member does not report the receipt of a lump-sum payment timely, the overpayment begins the month the lump sum was received.

> 1. The worker discovers at the annual review in July that Mr. B began a new job at XYZ Inc. the previous January and didn't report it. Mr. B received his first check from XYZ Inc. on January 13. He did not report this income within ten days of receipt of his first check. If an overpayment exists, it would begin effective February 1.
> 2. Same as Example 1, except Mr. B received the first check on January 23 and did not report the receipt of his first check until March 1. If an overpayment exists, it would begin effective February 1.

2. If the reason for the Medicaid overpayment is because of any type of income for any household member, including "absent parent" in the home or an unreported spouse:
   - Request income information and give them ten days to provide the information.
   - Explain to the member that failure to provide the income information would:
     - Result in the Department not being able to determine eligibility, and
     - Result in a larger overpayment.
3. Send a letter requesting verification. If the member does not provide information, all benefits are subject to recoupment.
4. When income information is provided, determine if family members continue to be Medicaid eligible. Use the information that is now available to determine eligibility and the overpayment.
5. If family members are over income for Medicaid, determine the spenddown amount for Medically Needy for each certification period. This is not a matter of whether the person wants Medically Needy or not, but is a matter of calculating the correct overpayment amount. See Medically Needy Overpayment.
6. If the household received Medicaid but was ineligible, calculate an overpayment.
7. Complete the Initial Claim Entry on line. EXCEPTION: For overpayments before July 1, 1997, contact central office for assistance.
8. Wait to determine the amount of the Medicaid overpayment for six months after the "To Date" on the claim to allow time for claims to be submitted. (While providers have 12 months to submit a claim, the majority of Medicaid claims are submitted in the six-month period after service is given.) See Amount to Recoup.

Comment: See 6-G for information about how to establish a claim for an overpayment, repayment options available to members, and types of collection actions.

Members usually repay the Department directly. In the case of overpayment due to incorrect calculation of client participation for a member in a nursing facility, PMIC, ICF/ID, or mental health institute, the member repays the facility. The Department then recovers the funds from the facility through a vendor adjustment. See 8-I, *Client Participation*.

Amount to Recoup

Policy: Consider the following when determining the Medicaid claim amount:

When:	**Recoup:**
The overpayment was a member error, and the member is completely ineligible for Medicaid…	All Medicaid claims paid, including capitation fees.
The overpayment was an agency error…	All Medicaid claims paid **except** for capitation fees.
The member is ineligible for full Medicaid but continues to be eligible for Qualified Medicare Beneficiary (QMB)…	All Medicaid claims, including capitation fees. **Do not** include Medicare Part A or Part B premiums, Medicare deductibles, Medicare copayments or co-insurance.
The member is ineligible for full Medicaid but continues to be eligible for Specified Low-Income Medicare Beneficiary (SLMB)…	All Medicaid claims, including capitation fees. **Do not** include Medicare Part B premiums.
The member is ineligible for HCBS waiver services but continues to be eligible for Medicaid…	Claims paid for HCBS waiver services only.
The member is ineligible for nursing facility services but continues to be eligible for Medicaid…	Claims paid for nursing facility services only.
The member is not eligible for full Medicaid, but would be eligible for Medically Needy with a spenddown…	Medicaid claims paid up to the spenddown amount, plus claims paid for any waiver or any nursing facility services. If the member continues to: ▪ Be eligible for QMB **do not** include Medicare Part A or Part B premiums, Medicare deductibles, Medicare co-payments or co-insurance. ▪ Be eligible for SLMB **do not** include Medicare Part B premiums. See Medically Needy Overpayment for more information.
The member is ineligible because the member is an inmate in a public institution…	All Medicaid claims paid including capitation fee. **Do not** include inpatient hospital services that are provided at a nonpenal institution.
The member is eligible for Medicaid but not eligible for residential care facility assistance…	Claims paid for State Supplementary Assistance only.

Medically Needy Overpayment

Policy: When income information is provided, the amount of the overpayment shall not exceed the amount of the Medically Needy spenddown. When income information is not provided, the spenddown amounts for Medically Needy cannot be determined and the full amount of Medicaid claims paid must be recouped.

Procedure:

1. When the Medicaid overpayment is because the person is over the resource limit for Medicaid, determine if the person's resources are within the resource limits for other coverage groups, i.e., the Medicare Savings Programs, Medically Needy, MEPD.
2. Give the member the opportunity to provide the income information and explain that the overpayment will not exceed the spenddown amounts. If the member appeals and has not been provided this opportunity, the Department may lose the appeal and the ability to collect on the overpayment.
3. When income is provided, determine the amount of the Medically Needy spenddown for each certification period of the overpayment.
   - Use only a three-month certification period for retroactive months.
   - A one-month certification period may be used for overpayments when there is not a second month in the certification period for the overpayment or there is only one month in the retroactive period.

1. Ms. A, a pregnant woman, applies April 1. The Medicaid application is approved with three months of retroactive eligibility. It is later determined that Ms. A was over income for the months of January through June. Ms. A does provide income verification.

   Spenddown amounts are determined for the following certification periods:

   - January, February, and March (retroactive months)
   - April and May
   - June

2. Mrs. B has an overpayment for the months of November through March. There are no retroactive months. This is one Medicaid claim with three certification periods.

   Spenddown amounts are determined for the following certification periods:

   - November/December Spenddown of: $ 1,782.88
   - January/February Spenddown of: $ 1,782.88
   - March Spenddown of: $ 891.44

   Medicaid paid the following medical expenses for Mrs. B:

   - November/December $ 5,000
   - January/February $ 400
   - March $ 1,000

Certification Period	Spenddown	Medicaid Paid	Overpayment
November/December	$ 1,782.88	$ 5,000	$ 1782.88
January/February	$ 1782.88	$ 400	$ 400.00
March	$ 891.44	$ 1,000	$ 891.44

Total amount of overpayment = $3074.32 ($1782.88 +$400 + $891.44)

NOTE: When calculating an overpayment that will include a Medically Needy spenddown, **do not** update the Medically Needy spenddown amounts on the Automated Benefit Calculation (ABC) system or in the Medicaid Management Information: Medically Needy (MMIS MN) subsystem.

4. When a member appeals an overpayment because a prescription was used to meet spenddown, but the member did not receive the prescription, include the following statement on the appeal summary:

"When a pharmacy submits claims for payment for prescriptions to Iowa Medicaid Enterprise (IME), the claim will be denied if the person is not eligible for Medicaid. If the person is conditionally eligible for Medically Needy with a spenddown at that time, the Medically Needy subsystem applies the denied claim to the spenddown for that certification period.

"The system assumes that the service was received when Medicaid claims are submitted. When the person is not eligible for Medicaid, the pharmacy may not give the prescription to the person if the person cannot pay for it. When this happens, the amount of the claim is incorrectly applied towards meeting the spenddown for Medically Needy.

"There are also situations where the pharmacy fills a prescription that is not picked up. Again, the claim has been used to meet the spenddown when the person has not received the service.

"In either situation, when the pharmacy is aware that Medically Needy is involved, the pharmacy submits a deletion form to IME to remove the claim from being used to meet spenddown.

"If the spenddown has not been met, the claim is deleted. If spenddown has already been met, then the person has become Medicaid-eligible without having incurred all of the medical expenses used to establish eligibility and may have an overpayment.

"The amount of the claims for prescriptions that were not received was used to meet spenddown. Since the person did not receive the drugs, the person was not obligated to pay medical expenses that were used to meet spenddown. As a result, the person was made Medicaid eligible and received services for which the person was not eligible."

If the appellant disputes the amount of the overpayment, ask if the appellant has any documentation to show that the appellant is obligated to pay or has paid these pharmacy claims.

Mr. Z, who is potentially eligible for Medically Needy for May and June, has a spenddown of $150. Mr. Z takes his prescription to Pharmacy M on May 15. Pharmacy M submits a claim through the Point of Sale (POS) system and finds out that Mr. M. has not met his spenddown.

Pharmacy M does not give Mr. Z his prescription, since he cannot pay the $175 cost. The POS system does not know that Mr. Z did not receive the prescription. It sends the claim to MMIS. MMIS submits the claim to the Medically Needy subsystem and Mr. Z meets his spenddown.

Pharmacy M faxes the *Medically Needy Expense Deletion Request* to the Medically Needy Unit at IME. The Medically Needy Unit determines that Mr. Z has met spenddown using the prescription that he did not receive.

The Medically Needy Unit sends the income maintenance worker a letter stating that Mr. Z did not incur the expense for the prescription. The worker checks the Medically Needy subsystem and determines that the $175 submitted by Pharmacy M on May 15 was used to meet spenddown.

On the first of January, six months after the end of the certification period, the worker obtains information from the Overpayment Recovery Detail system to determine the amount of claims that Medicaid paid for Mr. Z for the months of May and June.

Medicaid paid $2,595.55 in claims for Mr. Z. Since Mr. Z did not incur $150 in medical expenses and therefore, did not meet his spenddown, an overpayment for $150 is completed.

Department Responsibilities

The Department has general administrative responsibilities for:

- Maintaining confidentiality of Medicaid-related information
- Maintaining facility inspection reports
- Preventing discrimination by staff or vendors
- Providing notification of Department actions that meets legal requirements.

Confidentiality

Legal reference: 42 CFR 431.300-431.306, 45 CFR 160.102 and 164.504, Iowa Code Section 22.7(2) and 217.30, 441 IAC 9.1 through 9.15(3)

Federal Medicaid regulations require that the Department release information about a Medicaid applicant or member **only** for purposes directly connected with the administration of the Medicaid program unless specifically authorized by the applicant or member.

As a health plan, Medicaid is subject to the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) and corresponding federal regulations on the standards the Department must meet to protect the privacy of protected health information. Health care providers are also subject to HIPAA standards.

Requests for information are made using:

- Form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, when the request is for a third party/service, such as a law firm.
- Form 470-3952, *Request for Access to Health Information*, when a client requests their own Personal Health Information (PHI).

When either form is received at a DHS office, the worker must send it on to the DHS Security and Privacy Office to be reviewed. Legitimate requests for information will then be gathered from the Data Warehouse and provided to the requester via a File Transfer Protocol (FTP).

See 1-C, *Confidentiality and Records* for additional information on the policies and responsibilities regarding confidentiality of protected health information.

Maintenance of Facility Inspection Reports

Legal reference: 42 CFR 431.115

Department offices must make publicly available survey information from the Department of Inspections and Appeals for:

- Hospitals.
- Nursing facilities.
- Intermediate care facilities for persons with an intellectual disability.
- Home health agencies.
- Independent laboratories.

The following forms regarding facilities must be available for public inspection through web site access at the local offices:

- Form HCFA-2567L, *Statement of Deficiencies*.
- Form HCFA-2567B, Post-Certification Revisit Report.

These forms contain information about facility deficiencies noted by the Department of Inspections and Appeals (DIA) and the facility's plan to correct the deficiencies. The local office is responsible for:

- Making a computer available for the public to view the reports on the DIA web site.
- Giving the public the DIA's web site address, www.dia.iowa.gov,and these instructions:
    - Choose the "Health Facilities Division" option.
    - Click on the link under "Health Facilities Division's web site by clicking here."
    - Select the "Entity Search" option.

If the person reviewing the DIA reports has questions about any deficiencies contained in the reports, refer the person to the DIA, rather than trying to answer the questions yourself. If the person wants a complete copy of the survey, request a copy from DIA.

Nondiscrimination

Legal reference: Title VI of the Civil Rights Act of 1964, as amended; 42 CFR 430.2(b), Iowa Code Section 216.2(13)(b) and 216.7, Iowa Civil Rights Act of 1965, as amended; Iowa Executive Order #15, dated April 2, 1973

Department staff and vendors supplying goods or services to members for which the Department makes direct payment may not discriminate based on:

- Age
- Color
- Creed
- Mental disability
- National Origin
- Physical disability
- Political belief
- Race
- Religion
- Sex

Notification

Legal reference: 42 CFR 435.912, 42 CFR 435.917, Iowa Code Section 249A.4, 441 IAC 7.7(1) and 76.16(1)

Give members adequate notice of any action taken that affects the member's eligibility. See When Notice Is Required. **Every** notice the Department issues must be "adequate." Some notices must also be timely.

Adequate notice can be given no later than the date benefits would have been received. **"Adequate notice"** means a written notice of decision sent to the member that specifies:

- The action taken and the reasons for it.
- The effective date.
- The Employees' Manual chapter number and subheading describing the policy basis for the action.
- The rule or law reference, when the notice of decision relates to a negative action.
- The client's right to request a fair hearing.
- How assistance may be continued when a hearing is requested (if applicable).

"Timely notice" means a written notice given at least ten calendar days before the effective date of adverse action, except in cases of probable fraud (which require notice of five calendar days). The **timely notice period** extends from the day after a notice is issued to the effective date of action. A timely notice period must be at least ten calendar days.

When Notice Is Required

Legal reference: 42 CFR 431.213, 435.912, and 435.917, 441 IAC 7.7(17A), 7.7(1), 7.7(6), and 76.16.(1)

Issue an adequate notice whenever you take action on a case:

- An application is approved, rejected, or withdrawn.
- Medicaid is canceled. This includes cancellation due to termination of SSI payments or termination of foster care or subsidized adoption payments.
- Medicaid is reinstated or reinstatement is denied. See 8-G, *Reinstatement*.
- A change in a member's circumstances affects eligibility, including increase, reduction, suspension, or cancellation of benefits.

The notice must also be **timely** to take adverse action on a case, such as when Medicaid is canceled, suspended, or reduced, except as noted under When Timely Notice Is Not Required.

Send a *Notice of Decision* or a *Notice of Action* for an application only when a final decision of eligibility has been made. When determining eligibility under more than one coverage group, you do not need to send a *Notice of Decision* or a *Notice of Action* for each coverage group considered.

When a member resolves the original reason for a cancelation but should be canceled for a new reason, timely and adequate notice of the new action must be sent unless the new reason does not require timely notice.

Timely Notice When Probable Fraud Exists

Legal reference: 42 CFR 431.214, 441 IAC 7.7(3)

When the Department receives information that indicates Medicaid should be discontinued, suspended, terminated, or reduced because of probable fraud, timely notice is required.

Verify any information received about probable fraud. Obtain your supervisor's approval before taking any action. Document the basis for your action in the case record.

Timely notice in cases involving probable fraud must be issued at least **five** calendar days before an action becomes effective. Specify that an appeal must be filed within five days rather than ten days, as stated on the back of the *Notice of Decision* or *Notice of Action*. Count the day after the notice is mailed as day one.

Send this notice by certified mail, return receipt requested.

When Timely Notice Is Not Required

Legal reference: 42 CFR 431.213 and 431.231(d), 441 IAC 7.7(2)

Notice must be adequate but does not need to be timely when:

- The member dies, and the death is verified by a relative, newspaper obituary, nursing home, or hospital.
- The member gives you a clear, written, signed statement that the member no longer wants Medicaid.
- The member gives you a signed statement containing information that results in the end or reduction Medicaid benefits. The statement must indicate the member understands the consequences of supplying the information.
- The member is admitted or committed to an institution where the member does not qualify for Medicaid payments.
- You do not know the location of the member, and the post office has returned the member's Medicaid card with no known forwarding address.
- The member has been approved for Medicaid in another state.
- The member's physician prescribes a change in the level of medical care.
- The member was previously notified that Medicaid benefits would be granted for a specified period, and the period has ended.
- Assistance is simultaneously approved and terminated for a past period, such as the retroactive period.

Notice Forms

Information for more than one action can be on the same notice. When notice is generated by the ABC system, form 470-0485 or 470-0485(S), *Notice of Decision*, is issued.

Use form 470-0486 or 470-0486(S), *Notice of Decision*, when manually issuing notice for Medically Needy denials or cancelations, Refugee Assistance, and other ABC programs when appropriate.

Use form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, when manually issuing notice for SSI-related coverage groups or State Supplementary Assistance.

Use form 470-2330, *Notice of Decision for Medically Needy*, when manually issuing notice for Medically Needy. Attach a copy of form 470-2341, *Medically Needy Spenddown Computation* to the *Notice of Decision for Medically Needy*.

When notice is generated by the ELIAS system, form 470-0485, *Notice of Action*, is issued.

Use form 470-0485(M) or 470-0485 (MS) when manually issuing notice for cases in ELIAS.

Appeals

Legal reference: 42 CFR 431.200, 431.220, 441 IAC 7.5(17A)

The client has a right to appeal any decision and to request an appeal hearing. No one may limit or interfere with this right. Examples of adverse actions in which a hearing may be granted include:

- The denial of medical assistance.
- The delay in acting on the client's application with reasonable promptness.
- The suspension, reduction, or termination of medical assistance.
- The decision regarding attribution of resources.

See 1-E, *Appeals and Hearings*, for a complete explanation of the Department's appeal process, including worker and client responsibilities, time limits, and appeal decisions.

If a person gains eligibility after an appeal decision, providers can submit claims for covered services that have **not** been paid to the IME. If the date the service was rendered is more than 365 days before eligibility was established, the provider must attach to the original claim form a statement from the IM worker that:

- Indicates the date on which the Department was notified of the eligibility determination and
- Lists the retroactive months.

Prepare the statement and explain to the client what instructions to give to providers in this situation. Providers must submit claims within 365 days after the eligibility determination.

The following sections address:

- When paid bills can be reimbursed after the appeal decision.
- Bills that cannot be reimbursed.
- The reimbursement process.

Reimbursement After Appeal Decisions

Legal reference: 441 IAC 75 (Rules in Process)

Members and county agencies can receive direct reimbursement for certain paid medical bills. When an appeal decision by the Department or the Social Security Administration on an eligibility issue favors the member, members and county relief agencies are entitled to reimbursements if all of the following conditions apply:

- The medical bills were for services covered by Medicaid. The Iowa Medicaid Enterprise (IME) determines whether the medical bills are covered and the Medicaid rate.
- The medical bills were actually paid in the appeal period (the time between the date of denial of the initial application and the issuance of the *Notice of Decision* or *Notice of Action* that approves Medicaid).

- The medical bills were for services incurred in the period now determined to have been denied in error. The period of eligibility can be as early as the first of the third month before the month of application. The ending date is the date on the *Notice of Decision* or *Notice of Action* that approves Medicaid eligibility.

This policy does not apply to appeals resulting from cancellation of ongoing cases. It applies only to denied applications.

1-6-09	SSI application is filed.
6-16-09	SSI application is denied.
7-5-09	Request for reconsideration is filed (part of Social Security appeal process).
8-15-09	SSI is denied after reconsideration.
9-10-09	Request for hearing is filed.
12-4-09	SSI is approved due to hearing. Eligibility is granted back to date of SSI approval, 2-1-09.
3-4-10	Department *Notice of Decision* or *Notice of Action* approving Medicaid is issued. Medicaid is approved back to 10-1-08, as there are unpaid medical bills for services received in each of the three retroactive months, and all Medicaid eligibility criteria were met in those months including all retroactive period criteria as defined in 8-A, Definitions. (If there were no unpaid bills in those months or retroactive period criteria was not met, eligibility would begin 1-1-09.)

The appeal period is the time between June 16, 2009 (date of denial of initial application) and March 4, 2010 (date Medicaid was approved).

PERIOD OF ELIGIBILITY

Retro-active Period	**Application Period**		**Appeal Period**		**Approval Date**
	Application date:	Denial date:			
10-1-08 12-31-08	1-6-09	6-16-09	6-17-09	3-3-10	3-4-10
Any Medicaid-covered services received in and paid for in this period cannot be reimbursed.			Any Medicaid-covered services received in and paid for in this period can be reimbursed.		The medical provider must submit bills for unpaid medical services received on or after this date to the IME for payment.
Any Medicaid-covered services received in this period but…			paid in the appeal period can be reimbursed.		

There is no retroactive time limit on bills that can be reimbursed, as long as these requirements are met.

Bills That Cannot Be Reimbursed

Legal reference: 441 IAC 75 (Rules in Process)

Medical bills cannot be reimbursed if a person or agency paid the bill and the member does not have to repay the money. Examples of this type of situation are when:

- The member receives insurance payments.
- The member receives a legal settlement and the settlement designates funds for medical bills.
- A provider refunds the member and bills Medicaid.

Medical bills for the member that are paid by county relief agencies cannot be reimbursed if:

- The member is repaying the county.
- The provider refunds the agency and bills Medicaid.

Reimbursement Process

Members and county agencies use form 470-2224, *Verification of Paid Medical Bills*, to file a claim. When the form is returned to the IM worker with necessary documentation, the IM worker

- Completes section II of the form according to instructions in 6-Appendix, and
- Submits the form with **original signatures** to the interim assistance reimbursement coordinator at the Iowa Medicaid Enterprise (IME) within 60 days.

Payment is issued from Iowa Medicaid Enterprise. When the county agency paid the provider, reimbursement is made directly to the agency. When the member (or someone acting on the member's behalf) paid the provider directly, reimbursement is made directly to the member.

A Medically Needy member can choose whether to receive reimbursement or to allow the bills to be applied to spenddown. However, reimbursement is not made unless the spenddown has been met. Explain the options to Medically Needy members.

Property Tax Relief

Legal reference: Iowa Code Chapters 425 and 427

Iowa law provides certain low-income residents with:

- Relief on tax payments for real property through tax suspension and property tax credit.
- Rent reimbursement.

It is to a member's advantage to file for both a tax suspension and a tax credit. A tax suspension means the taxes do not have to be paid until the property is transferred. A tax credit reduces or eliminates the amount of tax to be paid when the property is transferred.

Because the Department serves the population that qualifies for tax suspension and other low-income people who might qualify for a property tax credit or rent reimbursement, the Department is required to:

- Inform members who might qualify about the program.
- Provide verification to members who own property and who receive the benefits that qualify them for automatic tax suspension.
- Verify continued eligibility for tax suspension annually for the county board of supervisors.

Homestead property tax credit and rent reimbursement are explained in Comm. 121 or Comm. 121(S), *Important Notice to Property Owners and Renters*. Give this pamphlet to elderly and disabled applicants. Document this in the case record.

Homestead Property Tax Credit for the Elderly or Disabled

Legal reference: Iowa Code Sections 425.16 - 425.40

Certain elderly and disabled residents are entitled to a tax credit of up to $1,000.00 of their tax liability on their homestead property. To qualify in 2023, household income must be less than $25,328.00 per year, and the person must be:

- 65 years of age or older on December 31, 2022, or
- Totally disabled as of December 31 of the previous year.

Property owners must file for the tax credit with the county treasurer in the county where their homestead is located. The amount of the credit depends upon the household's income.

Property Tax Suspension

Legal reference: Iowa Code Section 427.9

A person may be eligible for suspension of property taxes when the person:

- Receives Supplemental Security Income (SSI), or
- Receives State Supplementary Assistance (SSA), including the supplement for Medicare and Medicaid eligibles, or
- Lives in a health care facility and the Department is paying for part of the care.

Taxes may be suspended if the person owns or is purchasing real property. The person may be either the sole owner or a joint owner of the property. The property does not have to be homestead property.

Tax suspension is automatic once the board of supervisors for the county in which the property is located receives verification that the person is eligible. Taxes on real property are suspended, without penalty, until the property is transferred to someone else.

Eligibility for tax suspension ends when eligibility for SSI or SSA or residence in a health facility ends. Taxes that were suspended while the person was on assistance do not become due until the property is sold or transferred.

The Department is responsible for providing verification to members who may be eligible for property tax suspension. When a person is approved for Medicaid due to SSI eligibility, SSA eligibility, or Medicaid payment for care in a health care facility, the system automatically issues a *Notice of Decision or Notice of Action* with the following statement:

> You get SSI or State Supplementary Assistance or you live in a facility in which the Department of Human Services is paying some or all of the cost. You may not have to pay property taxes at this time. Take this notice to your county Board of Supervisors to discuss having your property taxes delayed.

This notice can serve as verification of eligibility for tax suspension. However, you must provide written verification if the member requests it. Suggested language is as follows:

> _____ (is a recipient of [Supplemental Security Income] [State Supplementary Assistance] is living in a health care facility and the Iowa Department of Human Services is paying part or all of the cost of care.) Therefore, this person appears to qualify for property tax suspension.
>
> _____(Worker signature, title, and date)_____

The county board of supervisors shall annually supply to the local Department office a list of names and social security numbers of people receiving tax suspension due to:

- Eligibility for State Supplementary Assistance or SSI, or
- Residing in a health care facility with the Department paying for part of the care.

Upon receipt of the list, indicate if the identified people continue to receive benefits that qualify them for tax suspension and return the list to the board of supervisors. No release of information is required to respond to this list.

Rent Reimbursement

Legal reference: Iowa Code Sections 425.16 through 425.40

The Department administers the program. Participants may apply online at https://benefits.stateofiowahhs.org/program/rentreimbursement. Policies regarding eligibility for this program can be found in 6-H, *Rent Reimbursement*.

Department of HUMAN SERVICES

Employees' Manual
Title 8, Chapter B

Revised April 19, 2019

Medicaid

Application Processing

Page

Overview

This chapter explains the procedures for processing Medicaid applications. The mechanics of filing and handling applications are covered first, followed by interview and verification procedures. Time lines for processing applications and effective date of eligibility are given in the next sections.

The remaining pages of the chapter address eligibility for the retroactive period, referrals to the Child Support Recovery Unit (CSRU) and representation.

Filing a Medicaid Application

Legal reference: 42 CFR 435.403, 435.906, 435.908, Iowa Code Section 249A.3, 441 IAC 76 (Rules in Process) and 86.3(2)

All people have the right to apply, without delay, for Medicaid for themselves or on behalf of another. Give an application to anyone who asks for one regardless of the person's county of residence. If the request is by mail or telephone, send the application in the next outgoing mail.

See 8-F, *FMAP-Related Coverage Groups- Express-Lane Eligibility*, for children under age 19 who are eligible without an application under the express-lane eligibility process.

An application for SSI benefits is automatically considered an application for Medicaid if SSI is approved. A denied SSI application is not considered a Medicaid application, and the filing date is not protected for Medicaid purposes. See Collecting Eligibility Information from SSI Recipients.

When requested, assist the applicant with completing an application. Applicants can authorize other people to represent them during the application process. Other people can also help the applicant during the application process.

An application may be filed on behalf of a deceased person. Eligibility is based on whether the person would have been eligible had application been made on or before the date of death and whether there are unpaid medical bills. However, eligibility cannot be established any earlier than three months before the month of application.

An application may be filed on behalf of a person temporarily out of the state. This situation usually happens when someone is visiting outside the state and has an accident or sudden illness. Apply all of Iowa's policies regarding application processing and eligibility. See 8-C, *Residency*, for more information about determining when a client is a resident of Iowa.

Which Application Form to Use

Legal reference: 42 CFR 435.907, 435.909, 441 IAC 76 (Rules in Process)

Determine which of the following application forms to use based on the assistance the applicant is requesting:

Application Form	Who Should Use the Form
Application for Health Coverage and Help Paying Costs, forms 470-5170 or 470-5170(S)	♦ Medicaid (MAGI-related and Non-MAGI-related) ♦ Hawki (Children's Health Insurance Program or CHIP) ♦ Iowa Health and Wellness Plan (IHAWP) ♦ State Supplementary Assistance ♦ Help paying for health insurance costs ♦ Women who need treatment for breast or cervical cancer.
Application for Foster Care and Subsidized Adoption Medicaid, forms 470-5535 or 470-5535(S)	A child in foster care or subsidized adoption

Application Referrals from and to the Federally Facilitated Marketplace (FFM)

Legal reference: 42 CFR 435.1200(d) and (e), Iowa Code Section 249A.4, 441 IAC 76 (Rules in Process) and 76.3

Electronic application referrals that the Federally Facilitated Marketplace (FFM) (also known as healthcare.gov) has screened as potentially Medicaid eligible must be accepted. Medicaid eligibility shall be determined based on the referral without requiring submission of another application.

When an applicant or member is determined to be ineligible for Medicaid but may be eligible for assistance at the FFM, the case shall be referred to the FFM for a determination of eligibility for financial assistance in paying for healthcare coverage.

Who Must Sign the Application

Legal reference: 42 CFR 435.907 and 435.909, 441 IAC 76 (Rules in Process) and 76.9

To be considered a valid application, an application must have the following:

- A legible name,
- An address, and
- A signature under penalty of perjury.

Before eligibility can be **approved**, the application form must be signed by:

- The applicant (including a child living independently), or
- An adult in the applicant's household or family, including:
  - A spouse,
  - A parent of an applicant child, including either parent of an unborn child,
  - A non-parental caretaker of an applicant child,
  - A tax-filer who claims the applicant as a dependent
- A responsible person acting on behalf of a minor applicant or an incompetent, incapacitated, or deceased applicant, such as:
  - A guardian or conservator,
  - A friend or relative with knowledge of the applicant's circumstances, or
  - A person or organization that has signed form 470-3356, *Inability to Find a Responsible Person*.
- An authorized representative.

If an authorized representative signs the application on behalf of the applicant, the signature of the applicant or responsible person must be on the application before eligibility can be approved. See Representation.

NOTE: If the applicant is under a guardianship or conservatorship that was established voluntarily, the applicant may sign the application. When a person voluntarily asks the court to appoint a guardian or conservator, the court may do so without making a determination that the person is incompetent.

Applications that are filed electronically, whether signed and faxed or scanned and e-mailed, do not have to be signed again.

Where the Application Must Be Filed

Legal reference: 441 IAC 76 (Rules in Process) and 86.3(3)

An application may be filed online at http://dhsservices.iowa.gov or any local DHS office; or any DHS outstation at a disproportionate share hospital, federally qualified health center in Iowa, or other facility in Iowa where outstationing activities are provided (i.e., mental health institute or hospital school).

Applications may be submitted in person, by mail, by telephone at 1-855-889-7985, or by email or fax to a local DHS office.

An application may also be filed at the office of a qualified entity under the Presumptive Medicaid program, a WIC office, a maternal health clinic, or a well-child clinic.

Date of Application

Legal reference: 441 IAC 76 (Rules in Process) and 86.3(4)

Policy: An application is considered filed on the date when the application containing a legible name, address, and signature of the client or representative is received at a location defined under Where the Application Must Be Filed.

For SSI recipients, the date the SSI application was filed with the Social Security Administration, as shown on the SDX, is the date of application for Medicaid. See Effective Date for SSI Recipients and 14-E, *SSI State Data Exchange*, for SDX information.

Procedure: An application left at a closed office will be considered received on the first day that is not a weekend or state holiday following the day that office was last open.

> County A is a less-than-full-time office and open on Monday and Wednesday. The office was last open Wednesday, April 24. When the office re-opens on the following Monday, staff find several applications that have been left under the door. All applications are date-stamped as being received Thursday, April 25.

A faxed or electronic application shall be considered as an original application. A faxed or electronic application is considered filed on the date it is received when it comes in during normal business hours.

If the application comes in after normal business hours (during the evening, weekend, or holiday), the application is considered received on the first day that is not a weekend or state holiday following the day that office was last open.

When a person fills out an incorrect application form, the person must complete the correct form before eligibility can be established. Use the filing date on the incorrect application as the filing date when the correct application is received. Attach the incorrect application to the correct application and file it in the case record. On all applications, use the filing date as the application date.

Withdrawal of Application

Legal reference: 42 CFR 435.907 and 435.914(b)(1), 441 IAC 76.10(249A) and 86.3(5)

Applicants may withdraw the application entirely or for any month covered by the application, if the request is made before the eligibility determination has been made.

EXCEPTION: The Medically Needy coverage group requires that concurrent months be included in the certification period. A Medically Needy applicant may withdraw the application for the month in which the application is filed, if the applicant wants to have the certification period begin the following month.

The request to withdraw the application may be oral or in writing. Document the withdrawal in the case record. Issue an adequate notice of decision if the entire application is withdrawn. If only a month of the application is withdrawn, and a notice of decision will be issued when the remaining application is processed, a separate notice is not necessary.

Procedures for SSI Applicants or Potential SSI Eligibles

Legal reference: 441 IAC 76.5(249A)

Persons who would be eligible for Supplemental Security Income (SSI) may apply at the Social Security Administration district office for both SSI and Medicaid. Normally it is to a low-income person's advantage to apply for SSI because of the money payment. However, application for SSI is not a condition of eligibility for Medicaid.

If a person applying for Medicaid at a DHS office has income less than the SSI payment standard for the person's living arrangement, refer the person to the Social Security Administration district office to apply for SSI benefits:

- If the person chooses not to apply with the Social Security Administration, process the application as you would any Non-MAGI-related application. See 8-F, *Non-MAGI-Related Coverage Groups: People Eligible for SSI Benefits But Not Receiving Them*.
- If the person has already applied for or intends to apply for SSI or Social Security disability benefits (SSDI) within ten working days of the Medicaid application, see Concurrent Medicaid and Social Security Disability Determinations.

If the Social Security Administration has made an SSI eligibility determination, the information is sent to the Department via the SSI State Data Exchange (SDX) system. Information from the SDX is used to process SSI recipients for Medicaid. Chapter 14-E explains the SDX system and how to use and interpret the fields.

If the individual is not active on Medicaid, the worker will receive the *Notification of SSI Approval* in WISE.

If the individual is currently active on Medicaid, the worker will receive an alert.

The Social Security Administration may presumptively determine an SSI applicant to be disabled. "Presumptive" disability is indicated by code "P" in the disability field on the SDX. If all other Medicaid eligibility criteria are met, the person is eligible for Medicaid for a maximum of six months. See 8-C, *Presumptive Disability*.

When more than 60 days have passed since the person filed for SSI, you can send form 470-0363, *Certification of Eligibility of SSI Applicant*, to determine the status of the person's SSI eligibility determination. You may also use this procedure before 60 days have passed if the applicant has an urgent need. Form 470-0363 completed by the Social Security Administration indicating that a person is eligible for SSI may be accepted as verification in place of an SDX.

Concurrent Medicaid and Social Security Disability Determinations

Legal reference: 42 CFR 435.909 and 435.541, 441 IAC 75 (Rules in Process)

Policy: When a person has applied concurrently for both Social Security disability benefits and Non-MAGI-related Medicaid, the Department is required to await the outcome of the Social Security Administration disability determination.

If the applicant is eligible only for Medically Needy, see 8-J, *SSI-Related Medically Needy*.

Procedure: If a Non-MAGI-related applicant has not been determined to be disabled by the Social Security Administration, take the following actions:

1. Ask the applicant to apply for SSI and Social Security disability (SSDI) benefits from the Social Security Administration. The applicant will either:
   - State that an application has already been filed, or
   - Agree to apply for benefits within ten working days of the Medicaid application date.
2. When the applicant has already applied or agrees to apply for SSI and SSDI, complete form 470-2631, *Notice of Pending Medicaid Applications,* and send it to:
   - The Social Security Administration, and
   - Disability Determination Services (DDS).

   DDS completes the status of the disability determination on Section II of the form and returns the form to the IM worker within 15 calendar days.
3. If DDS does not have a referral from the Social Security Administration, follow up on the DDS response by contacting the applicant to verify that the benefit application has been filed with the Social Security Administration.
4. If DDS has a pending disability determination for this person:
   - Make a note in the narrative, and
   - Set a reminder to check completed disability determination on the Data Sources in WISE
5. If DDS has already completed the disability determination for Social Security, check the Data Sources in WISE
   - If the SDX shows SSI was approved, then approve Medicaid if all other eligibility requirements are met.
   - If the SDX shows SSI was denied due to disability, deny Medicaid as "not disabled."

6. If the SSI was denied due to other eligibility requirements, such as income or resources, contact the Social Security Administration to see if an eligibility decision for SSDI will be made within 30 days.
   - If so, wait for the Social Security Administration decision on SSDI.
   - If not, then get a copy of the disability determination from the Social Security Administration and get the income and resource verification from the applicant. Complete the application processing.
7. When a final Social Security disability determination has been made, contact the Social Security Administration to see if the full eligibility determination will be made within ten days.
   - If so, wait for the Social Security Administration decision.
   - If not, get a copy of the Social Security Administration disability decision and determine Medicaid eligibility.

Medicare Savings Program Applications

Legal reference: 441 IAC 76.6

Policy: When the Social Security Administration (SSA) sends data on an *Application for Extra Help with Medicare Prescription Drug Plan Costs* to the Department, that data is considered an application for the Medicare Savings Programs.

Medicare Savings Programs (MSP) include qualified Medicare beneficiaries (QMB), specified low-income beneficiaries (SLMB), expanded specified low-income beneficiaries (E-SLMB), and qualified disabled working persons (QDWP).

The date that SSA received the Extra Help application is the application filing date for purposes of establishing eligibility for the Medicare Savings Programs. The date the Department receives the data from SSA begins the 30-day processing time to determine eligibility.

The applicant's signature on the Extra Help application from which the data was generated shall be treated as the signature for the MSP application. Income and resource data provided by the SSA shall be considered verified unless the applicant provides different information.

The Department will issue form 470-4846, *Medicare Savings Programs Additional Information Request*, which the applicant must complete and return within ten days to provide the rest of the information needed to establish eligibility.

Comment: Medicare beneficiaries apply to the SSA for Extra Help. The *Application for Extra Help with Medicare Prescription Drug Plan Costs* tells beneficiaries that:

- They may be able to get help from Medicaid with their Medicare costs under the Medicare Savings Programs; and
- By completing the Extra Help application, they also start the application process for a Medicare Savings Program benefit, unless they check the 'No' box on the application form indicating they do not want to apply for MSP.

Procedure: SSA sends DHS data on a daily basis for all Iowa Medicare beneficiaries who do not check the 'No' box for the Medicare Savings Program on the Extra Help application. SSA does not forward the data to DHS until it has made a decision on eligibility for Extra Help. The application data is forwarded to DHS regardless of whether Extra Help was approved or denied.

When data sent by the SSA indicates the applicant is not a Medicare beneficiary or is over income or over resources for MSP, the ABC system automatically denies the application and generates a *Notice of Decision* sent to the applicant.

For all other cases, ABC generates form 470-4846, *Medicare Savings Programs Additional Information Request*, populated with the data from SSA. (See 6-Appendix for a list of this data.) The form is sent to the applicant at the mailing address the applicant provided to the SSA.

When the applicant returns the form:

1. Determine if the mailing address and living address are the same. If the addresses are different and the living address is in another state, deny the application on the basis of the applicant's residency.
2. Determine eligibility for MSP using the policies in Employees' Manual 8-F.
   IMPORTANT:
   - A "V" following the case number printed on page 1 of form 470-4846 indicates that the Department accepts the information that was printed on the form as verified. If the applicant has made changes to the printed income or resource information, verify the change.
   - An "NV" behind the case number indicates that the information on the form is not verified and must be verified.
3. Make ELIAS system entries to approve or deny the application. If no decision has been entered by the 30th day, the system will automatically send a *Notice of Decision* denying the MSP application for failure to return form 470-4846.

The Medicare Savings Programs (MSPS) screen displays data from the SSA that was used to deny the application. Use this information to support a denial of eligibility for MSP in the event the applicant appeals the denial decision. See 14-B(4), *MSPS = LIS-Application History*.

1. SSA receives Ms. Z's application for Extra Help on January 15. SSA determines that Ms. Z is eligible for Extra Help on March 1. Ms. Z indicated that she wanted to also apply for the Medicare Savings Program.

   On March 1, SSA sends Ms. Z's data from the Extra Help application to the Department. The Department receives the data on March 1. Ms. Z's application date for MSP is January 15. The Department has 30 days beginning March 1 to determine Ms. Z's eligibility for MSP.

   On March 1, the Department sends her form 470-4846, *Medicaid Savings Programs Additional Information Request*. The cover letter tells Ms. Z to return the form by March 11.

   Ms. Z reviews the forms and does not make any changes to the data printed in the form. She returns the form on March 8. The worker determines that Ms. Z is eligible for QMB effective April 1.

2. Same situation as above except that Ms. Z is determined to be eligible for SLMB. Ms. Z's eligibility is effective January 1.

   If Ms. Z indicates that she has medical expenses for the three months before January 1 and she meets the SLMB eligibility requirements before January 1, Ms. Z would need to meet a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. If she does, Ms. Z could be eligible for SLMB benefits effective October 1.

Interviews

Legal reference: 42 CFR 435.905 through 914; 441 IAC 76 (Rules in Process) and 76.5

An interview shall not be required when determining Medicaid eligibility for MAGI households. Applicants or members who are being evaluated for Non-MAGI-related Medicaid may be required to attend a face-to-face or telephone interview to:

- Clarify information on the application,
- Clarify questionable information, or
- Ensure there is a better understanding of programs.

It is important to treat applicants and members equitably and to use the "prudent person concept." See 8-A, *Definitions*, for "prudent person concept."

An interview shall not be required for children as defined by the Medicaid program.

Grant an interview if the applicant, member, or authorized representative requests one.

Procedure: To require a face-to-face interview or a phone interview, you must request a scheduled time with the applicant or member. When an interview is needed or is requested by an applicant, a member, or an authorized representative, schedule a date, time, place, and method of the interview (in the local office, home visit, or by phone, etc.).

Grant requests to reschedule when you determine that the applicant, member, or authorized representative is making every effort to cooperate with the interview process. Interviews rescheduled at the request of the applicant, member, or authorized representative may be agreed upon verbally and documented without written confirmation.

Failure to attend the interview you requested, including a scheduled phone interview, is cause to deny or cancel the adults on the application.

Contact the applicant or member whenever you need to clarify information in order to determine eligibility.

When you ask a client to come in to the local office for an interview, do not deny or cancel the children if the adult fails to attend the interview. However, if you request information at the same time as you set up an interview and the information is not provided within ten days, you may cancel or deny the entire household for failure to provide requested information.

Information Provided

Legal reference: 42 CFR 435.905

When conducting the interview or by other means, explain to the client:

- The programs for which the client may be eligible such as:
  - MAGI-related Medicaid
  - Non-MAGI-related Medicaid
  - Medically Needy
  - Home- and community-based service waivers
  - State Supplementary Assistance
  - FIP
  - Food Assistance
- The policies and procedures for the client's coverage group.
- The factors of eligibility that must be verified, including what is needed as verification, and that documents that are the property of the client are not returned to the client.
- The penalties for giving false information.
- The client's right to receive a ten-day advance notice of adverse actions and the right to appeal any decisions on Medicaid eligibility.
- The social service programs available. Make referrals when necessary.
- The client's responsibility to:
  - Report changes within ten days of the change and report any changes in medical resources. See 8-G, *Reporting Changes*.
  - Cooperate with the Quality Control and Economic Assistance Fraud Bureaus. See 8-C, *Cooperation With Investigations and Quality Control*.
  - Apply for and accept other benefits for which the client is eligible. See 8-C, *Benefits From Other Sources*.
  - Cooperate with the HIPP Unit and the Third-Party Liability Unit and refund third-party payments for services paid by Medicaid. See 8-C, *Cooperation with the Health Insurance Premium Payment (HIPP) Unit* and *Cooperation with the Third-Party Liability Unit*.

Give or mail to applicants or anyone inquiring about the Medicaid program the following pamphlets that explain coverage, conditions of eligibility, benefits of the program, related services available and client rights and responsibilities:

- Comm. 20, Your Guide to Medicaid, Fee-for-Service
- Comm. 30, Medicaid for the Medically Needy
- Comm. 51, Information Practices
- Comm. 123 and Comm. 123(S), Important Information for You and Your Family Members About the Estate Recovery Program
- Comm. 209, Information About Your Privacy Rights
- Comm. 233 and Comm. 233(S), Rights and Responsibilities
- Comm. 255 and 255(S), Benefits of the Health Insurance Premium Program
- Comm. 258 and 258(S), Verifying Citizenship/Identity and/or Immigration Status
- 470-0306 or 470-0307(Spanish), Application for Food Assistance.

EXCEPTIONS: Do not give this application to people living in a medical institution or to children entering foster care unless supervised apartment living is the first foster care placement.

For all applicants under the age of 21, discuss the availability and benefits of the EPSDT "Care for Kids" program. Make sure the client understands the program and the advantages of screening. Give or mail to the applicant Comm. 4, *Care For Kids*. See 8-M, *Care for Kids (EPSDT)*, for more information.

To MAGI-related applicants, also give:

- Comm. 27, Medicaid for Families and Children
- Iowa WIC Program income guidelines

The Department of Public Health revises the WIC flyer annually in March to incorporate updated WIC income guidelines. The revised flyer is effective April 1. Public Health sends a blanket supply of the revised flyer to local offices. Destroy previous versions of the flyer. Get additional supplies of the WIC flyer cost-free by calling 1-800-532-1579.

To applicants who are aged, blind, or disabled, also give:

- Comm. 28, Medicaid for SSI-Related Persons.
- Comm. 60, Medicaid for the Qualified Medicare Beneficiary.

- Comm. 121 and Comm. 121(S), Important Notice to Property Owners and Renters.
- Comm. 180, Medicaid for Employed People with Disabilities.

To applicants who are in a nursing facility, also give Comm. 52, *Medicaid for People in Nursing Homes and Other Care Facilities*. If the applicant has a spouse at home, also give Comm. 72, *Protection of Your Resources and Income*.

Voter Registration Procedures

Legal reference: National Voter Registration Act (NVRA) of 1993, Section 7, Iowa Code Section 48A.19, 721 IAC Chapter 23

The Department is responsible for helping clients complete voter registration forms and for mailing the forms to the county election office. (The actual voter registration occurs at the election office.) Issue voter registration forms:

- With all applications,
- With the *Review/Recertification Eligibility Document (RRED)*, and
- When the client moves within Iowa.

When an interview is held, ask if the client wants to register to vote. If the client wants to register and has not filled out the voter registration form, have the client complete it at the interview. Offer to help the client complete the form. Be careful when helping the client that you do not influence the client's voter registration options in any way.

If you are conducting a phone interview, ask the questions and send the form to the client for signature. No follow-up is necessary after the form has been mailed.

Review the client's rights as listed on the form. If the client chooses not to check "yes" or "no," leave the section blank and consider that the client has chosen not to register to vote. If the client chooses not to sign the form, print the client's name and the date where indicated, and initial the form.

If there isn't an interview, mail the form to the client and document your action.

If the client returns the form, follow your office procedures for handling it. Tear off the voter registration information section and give it to the client. Keep the declination part of the form. See 6-Appendix for a copy of the *Voter Registration* form and for office procedures for handling the form after completion.

Verification

Legal reference: 42 CFR 435.907(e), 435.911(c)(2), and 435.952(c)–(d); 441 IAC 76 (Rules in Process) and 86.3(7)(c)

Applicants must provide requested verification. Notify the applicant in writing what additional information or verification is needed. Provide this notice to the applicant personally, by mail, or by facsimile. Give the applicant ten calendar days to supply the information.

Explain the following to the applicant in writing:

- An applicant who must obtain information from a third party should not leave the information with the expectation that the third party will return it timely.
- The applicant is responsible for following up with the third party to be sure the third party has the information ready to pick up or has mailed the information to the Department in time to be received by the due date.
- The applicant may ask the Department for more time to get the information if the third party does not have the information ready or it will not arrive by the due date.

When the applicant is making every effort to obtain the information from a third party but is unable to do so in ten days and notifies you about the problem, you can allow additional time. Help the applicant to get the needed information, as requested.

An applicant who provides a signed release to a specific individual or organization for specific information has met the requirement for supplying requested information or verification to give you permission to get it. The general release does not meet this requirement unless the applicant asks for help.

Before denying a MAGI-related application, a request must be sent to applicants and members for information that cannot be obtained electronically, or is obtained electronically but is not reasonably compatible with information provided by or on behalf of an individual.

Deny the application if the applicant does not provide the requested information by the specified due date and does not authorize the Department to obtain the information within the requested time.

If the applicant is unable to get information from a spouse who is no longer in the household, do not deny the application. Contact the applicant to obtain the best information available. Ask the applicant about bank accounts, records showing deposits of the spouse's income, information from the divorce proceedings, and tax returns.

Ask the applicant to provide information that would help to verify what the applicant is telling you about a spouse who is no longer in the home. From the information provided, determine eligibility. If the applicant fails to provide the requested information, deny the application.

Pregnant Women

Legal reference: 42 CFR 435.956(e), 441 IAC 75 (Rules in Process)

When establishing Medicaid eligibility for pregnant women, attestation of the date of conception, due date, and number of children expected shall be accepted unless questionable.

IRS Tax Information

Legal reference: Sections 1137(a)(6) and 1942(b)(1) of the Social Security Act, Iowa Code Section 249A.4,

By signing the application, applicants authorize DHS to verify application information with electronic data sources including IRS tax information. When redetermining eligibility, such as at annual review, DHS shall not attempt to verify income with IRS tax information unless the member provides written permission on an appropriate form.

Reasonable Opportunity Period (ROP) for Verifying Citizenship or Alien Status

Legal reference: 42 CFR 435.956(a)(5) through (b)(1) through (3) and 435.911(c), 42 U.S.C. 1396a(46)(B)(i)-(ii); Iowa Code Section 249A.4; 441 IAC 75 (Rules in Process)

An applicant or member whose attested U.S. citizenship or eligible alien status cannot be verified through an electronic data match shall be allowed a 90-day Reasonable Opportunity Period (ROP) to provide proof. Medicaid shall be provided during the ROP if the person is otherwise eligible. If proof is not received by the end of the 90-day ROP, benefits end subject to timely notice requirements.

Acceptance of Other Income Benefits

Legal reference: 42 CFR 435.608, Iowa Code Section 249A.4, 441 IAC 75 (Rules in Process)

Medicaid applicants and members must apply for and accept any income benefits for which they are eligible. (See 8-C, *Benefits From Other Sources*.)

Moving and Returned Mail

Legal reference: 441 IAC 75.10(249A)

Policy: A member must remain an Iowa resident for Medicaid eligibility purposes; however, a move within Iowa is not required to be reported.

Procedure: When mail is returned to the Department, handle the mail as follows:

- When the Post Office has attached a forwarding address and it is in Iowa:
  - Use this address and update the DHS systems.
  - It is not necessary to contact the member.
  - Send any returned mail to the member at the correct address and keep a copy in the case record.
- When the Post Office has attached a forwarding address and it is out-of-state, contact the member to ensure they are no longer an Iowa resident.
- When there is no forwarding address (i.e., address unknown, undeliverable), deny the case for unable to locate using the only address DHS has on file.
- When there is hand-writing on the returned mail, attempt to contact the member to resolve the issue. Deny the case for unable to locate if you are unable to contact the member.

Comment: Reporting a change in a mailing or living address within Iowa is always desired and is beneficial to the household in order to continue proper communication with the Department.

Processing Standards

Legal reference: 42 CFR 435.912(c)(3)(i)-(ii), Iowa Code Section 249A.4

The following sections explain:

- Processing guidelines that apply to all Medicaid applications.
- Grace period following the denial of an application.
- Guidelines for processing applications for children.

Guidelines for All Applications

Process applications on the earliest possible date. Determine eligibility and issue a written notice of decision for MAGI-related, Non-MAGI-related, and Medically Needy Medicaid by making system entries no later than the 45th day following the date of application.

If the 45th day falls on a weekend or holiday, process the application by making system entries the next working day.

When the application is for Non-MAGI-related Medicaid, including Non-MAGI-related Medically Needy, and a blindness or disability determination is pending, the time limit is 90 days. See Concurrent Medicaid and Social Security Disability Determinations.

If a person's eligibility is dependent upon a 30-day period of residency in a medical institution, delay the eligibility decision until the 30-day period has been met, unless the person is ineligible due to some other factor.

The time limit for approving or denying a Medicaid application can be waived in unusual circumstances. Examples of unusual circumstances include:

- You and the applicant have made every reasonable effort to get necessary information but have not been able to do so within the time frames.
- Retroactive Medicaid was requested for a person whose proof of citizenship and identity has not yet been provided as described in 8-C, *Reasonable Opportunity Period*.
- Emergencies, such as fire or flood.
- Other conditions beyond the administrative control of the local office.

You must document the reason for the delay.

You cannot deny an application because of the time period alone. To deny the application, there must be either failure to act on the part of the applicant or a determination of ineligibility.

An applicant must cooperate with the application process. This may include providing information or verification, attending required interviews or signing documents. Failure to cooperate with the application process shall serve as a basis to deny an application.

Unnecessary Application

Legal reference: 42 CFR 435.912, Iowa Code Section 249A.4, 441 IAC 441 7.7(1)

A Notice of Decision or a Notice of Action must be issued to approve or deny all applications, including unnecessary applications.

Grace Period Following the Denial of an Application

Legal reference: 42 CFR 435.902, 441 IAC 76 (Rules in Process)

Policy: A "grace period" is a specified period of time during which an applicant has the opportunity to "cure" the reason for the denial of an application. The grace period is defined as the 14 calendar days immediately following the date of denial.

"Day one" of the 14-day grace period is the day following the date printed on the notice of decision. If the 14th day falls on a weekend or a state holiday, the 14th day is extended to the next working day for which there is regular mail service.

A previously denied application shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the date of denial. Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

If the applicant is eligible, the original filing date of the application establishes the effective date of eligibility. The effective date of eligibility is the first day of the month an application was filed or the first day of the month in which all eligibility factors were met, whichever is later.

Comment: The grace period does not apply to late payment of premiums or noncooperation actions. Denial reasons for which a grace period may apply include, but are not limited to, failure to provide information necessary to determine eligibility and inability to locate the applicant.

If the application was denied because mail was returned or the Department was otherwise unable to locate the applicant, a new application is not required if the household contacts the Department within the 14 days, provides a current Iowa address, and eligibility can otherwise be established.

Procedure: Based on the circumstances of your case, take the appropriate action as follows:

- **No information provided:** When no information is provided by the 14th day after the date of denial, no further action is required.
- **Partial information provided:** When some of the information is returned, but there is still information needed to determine eligibility:
  - Attempt to contact the household to let the household know what is needed and that if the information is not received so that a decision can be made by the end of the grace period, the household will have to reapply. A written request for the previously requested information is not required.
  - If the information is not provided by the end of the grace period, no further action is necessary.
- **Requested information provided and a change has occurred:** If the original requested information is provided, but the household also reports a change for which verification is necessary:
  - Make every effort to verify the information and inform the applicant that you cannot reconsider the application unless the change is verified by the end of the grace period. If a generic release is on file, use it to obtain the information if possible. A written request for the new information is not required.
  - If the new information is not verified so that an eligibility determination can be made by the end of the 14-day grace period, send a manual "remain denied" notice (see below for language). This is because the original reason for denial has been cured, but you cannot process the application due to a change in circumstances that is required to be verified.

> Your application for Medicaid is still denied because you did not give us the information we asked for. We cannot determine if (insert persons name) (is/are) eligible. 441 IAC 74.3 and IAC 76 (Rules in Process)

- **Unable to verify change within grace period:** When an additional change is reported and it is unlikely the information can be verified and eligibility established by the end of the 14-day grace period, attempt to notify the applicant that they will need to file a new application.

1. Mr. A, a Medicaid applicant, fails to provide an employer's statement of earnings that was requested by the Department. The IM worker issues a denial notice on April 1, which is dated April 2. Mr. A provides the employer's statement on April 16. There have been no other changes in the household circumstances. The IM worker reopens Mr. A's application and processes it.
2. Ms. B, a Medicaid applicant, fails to provide an employer's statement of earnings that was requested by the Department. The IM worker issues a denial notice on April 5, which is dated April 6. Ms. B provides the employer's statement on April 21. Since the 14-day grace period has expired, Ms. B must file a new application and the original denial stands.
3. Mr. C, a Medicaid applicant, fails to provide three pieces of information requested by the Department. The IM worker issues a denial notice on May 10, which is dated May 11. Mr. C provides two of the items on May 13.

   The worker attempts to contact Mr. C since not all the items needed to determine eligibility came in. The third item is received on May 25. There have been no other changes in the household circumstances. The IM worker processes the application.
4. Mr. D, a Medicaid applicant, fails to provide three pieces of information requested by the Department. The IM worker issues a denial notice on May 15, which is dated May 16. Mr. D provides two of the items on May 17.

   The worker attempts to contact Mr. D since not all the items needed to determine eligibility came in. The third item is received on May 31. Since the 14-day grace period has expired, the original denial stands and Mr. D must file a new application.
5. Ms. E, a Medicaid applicant, fails to provide three pieces of information that were requested by the Department. The IM worker issues a denial notice on July 21, which is dated July 22. Ms. E provides two of the items on July 31 and the third item on August 1.

   Also on August 1, Ms. E reports that she has changed jobs. The IM worker explains that in order for the original application to be reconsidered, Ms. E has until August 5 to provide verification of the old job ending and the beginning of the new job. Otherwise, Ms. E will have to reapply.

   Ms. E does not provide verification of the end of the old job or the beginning of the new job. The IM worker issues a "remain denied" notice since Ms. E had provided the original requested information but did not provide the new verification.

6. Mr. F, a Medicaid applicant, fails to provide three pieces of information that were requested by the Department. The IM worker issues a denial notice on August 30, which is dated August 31. Mr. F provides two of the items on September 2 and the third item on September 6.

   Also on September 6, Mr. F reports that he has changed jobs. The IM worker explains that in order for the original application to be reconsidered, Mr. F has until September 14 to provide verification of the old job ending and the beginning of the new job. Otherwise, Mr. F will have to reapply for Medicaid.

   Mr. F provides verification of the old job ending and the beginning of the new job on September 7. The application is processed with the new information and a notice is sent informing Mr. F of the decision.

Effective Date of Eligibility

Legal reference: 42 CFR 435.915(b), 441 IAC 76.13(249A) and 86.5(514I)

The effective date of eligibility for Medicaid is the first day of the month an application was filed or the first day of the month all eligibility factors were met, whichever is later. EXCEPTION: Eligibility under the qualified Medicare beneficiary coverage group begins the first day of the month after the month of decision.

See 8-F, *Express-Lane Eligibility*, for the effective date of eligibility for children under age 19 who are eligible without an application under the express-lane eligibility process.

For **MAGI-related** coverage groups, eligibility for Medicaid begins on the first day of the month when eligibility was established any time during the month.

For **Non-MAGI-related** coverage groups and State Supplementary Assistance, the applicant must meet all eligibility criteria and be resource-eligible as of the first moment of the first day of the month in order to be eligible for the month.

Effective Date for SSI Recipients

Legal reference: 441 IAC 76.5(249A)

An SSI recipient is eligible for Medicaid as of the first of the month before the month that the person attains SSI eligibility, unless either:

- The person's Iowa residency date is later, or
- There is a Medicaid policy that precludes eligibility, as listed in 8-F, *SSI Recipients*.

Mr. M lives in Nebraska and files an application for SSI in January. In March, Mr. M moves to Iowa. Social Security processes Mr. M's application in March and establishes SSI eligibility effective January 1.

Even though Mr. M was determined SSI-eligible in March, he is not eligible for Iowa Medicaid in January and February because he was not an Iowa resident. The earliest Mr. E's Iowa Medicaid eligibility can begin is March 1.

Beginning with determinations made on or after August 22, 1996, the effective date of approval under the SSI program is the later of:

- The month following the month of application for SSI, or
- The month following the month the client first meets all SSI eligibility factors.

1. Mr. A files for SSI on January 15. Mr. A meets all SSI eligibility criteria for January. SSI payment is approved effective February 1.
2. Mr. B files for SSI on January 15. Mr. B does not meet all SSI eligibility criteria until February (turns 65 in February). The earliest date that SSI payment will begin is March 1 (the month following the month that all SSI eligibility factors are first met).

For the month immediately before the effective date of approval, the Social Security Administration has already determined that the client meets all SSI eligibility factors. (The client does not receive an SSI payment due to SSI's effective date of approval policy.) Thus, for Medicaid purposes, it is not necessary to verify eligibility factors independently for that month.

Determine Medicaid eligibility for that month in the same manner as if the client was an SSI cash recipient.

1. Mr. A files for SSI on June 15. SSI cash payments are approved effective July 1. In order for SSI payments to begin effective July 1, the Social Security Administration must have determined that Mr. A met all SSI eligibility criteria for the month of June. Thus, it is not necessary to verify information independently for June.

   Mr. A is eligible for Medicaid in the month of June and ongoing (and potentially the retroactive months if he meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*).
2. Mr. B files for SSI on January 15. SSI cash payments are approved effective March 1. In order for SSI payments to begin effective March 1, the Social Security Administration must have determined that Mr. B met all SSI eligibility criteria for the month of February.

   Mr. B did not meet all eligibility criteria for the month of January (or SSI would have begun February 1). It is not necessary to verify information independently for the month of February. It is necessary to verify information and determine the reason that Mr. B was ineligible for January.

Use the SSI application date as the Medicaid application date. The effective date of eligibility can be no earlier than three months before the date of application for SSI if the individual meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. This date is on the SDX.

When the date of the SSI application is in a different month from the month that SSI eligibility begins, determine if there is Medicaid eligibility for:

- The month of SSI application.
- All months between the date of application and the month of eligibility for SSI.
- The retroactive period.

Establishing Beginning Months of Eligibility for MEPD

Legal reference: 441 IAC 75.6(6)"b""4"and "6"

Policy: Medicaid for Employed People with Disabilities (MEPD) applicants may choose to have either MEPD or Medically Needy coverage for months between the date of application and the date that the case is approved on the ABC system.

Comment: Application processing may be delayed due to waiting for a disability determination decision. This may result in a delay of several months between the date of application and the date of approval. "Back months" are the months between the date of application and the month when the case is actually approved.

"Conditional eligibility" for MEPD means the member must pay a premium before getting Medicaid eligibility for a month.

If the member wants to have Medically Needy for some back months, see the procedures in 8-F, *Relationship to Medically Needy*.

Procedure: The MEPD Billing System applies premium payments in a specified order. The person who enters the payments in the MEPD system cannot change the order of how the payment will be applied to pay for "back months."

Before entering conditional approval for back months, it is important to check with the applicant to see if the applicant wants Medicaid for each of the back months. Do **not** give the applicant conditional MEPD eligibility for a month when the applicant does not want MEPD benefits.

Corrections can be made on the MEPC screens after the initial and back months are assessed for MEPD premiums.

Changing Conditionally Approved Months for MEPD	
Situation:	Worker Action:
After conditional eligibility has already been entered for "back months," the member tells the worker that there are some months for which the member does not want to pay premiums.	Ask the member to sign a statement that lists the "back months" for which the member does not want Medicaid. Do not block months until the signed statement is received.
♦ If the premiums for those months have **not** been paid…	"Block" the months when the member does not want MEPD coverage so that payments are not applied to premiums for those months. Enter "B" for the months that need to be blocked on the member's MEPC screen.
♦ If the premiums for those months **have** been paid…	Do **not** block the month, as Medicaid eligibility was already given.
The worker needs to "block" a paid month due to an error in giving conditional eligibility for that month.	"Block" the month by entering "B" for that month on the member's MEPC screen. The system will: ♦ "Back out" the premium payment for the blocked month. ♦ Hold the premium payment as a credit or apply it to another unpaid month. ♦ Issue an alert from WISE requesting recoupment of the paid Medicaid claim for that month.
A month is blocked in error.	"Unblock" the month on the MEPC by entering a "U" for unblock over the "B" on the month line. Remember, once a month is blocked, the member will not be given Medicaid eligibility for that month until it is unblocked.

Comment: See 14-B(9), *Change to MEPD Premium: Using MEPC* and 8-F, *Relationship to Medically Needy*.

Determining Eligibility for the Retroactive Period

Legal reference: 42 CFR 435.914 and 435.915(a), 441 IAC 76.13(3) and 86.5

Medicaid benefits may be available for any or all of the three months before the month in which the application is filed. This time is called the "retroactive period." The person must meet a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. EXCEPTION: The following coverage groups do not have retroactive eligibility:

- Presumptive Medicaid benefits.
- Qualified Medicare Beneficiary (QMB).
- Home- and community-based services waivers.
- Program for all-inclusive care for the elderly (PACE).

Persons whose citizenship or alien status has not been verified, even though they are eligible during a 90-day reasonable opportunity period, are not eligible for retroactive coverage.

For children under age 19 who are eligible without an application under the express-lane eligibility process described at 8-F, *Express-Lane Eligibility*, the "retroactive period" is any of the three months before the effective date of the child's express-lane eligibility.

To be eligible for retroactive benefits, an applicant must meet both of these conditions:

- The applicant has paid or unpaid medical bills for Medicaid-covered services received during the retroactive period, **and**
- The applicant would have been eligible for Medicaid benefits in the months services were received, if a valid application had been filed.

An applicant does not need to be eligible in the month of application to be eligible for the retroactive period. If an application is submitted on behalf of a deceased person, determine the deceased person's retroactive eligibility using the same requirements.

When retroactive coverage is requested, evaluate the three months before the month of the current application to see if eligibility exists even if some of those months were denied on a previous application.

1. Ms. A, a pregnant woman, files an application on July 8. She indicates on the application that she wants retroactive benefits. The worker requests in writing that Ms. A provide income verification for the months April through June. Ms. A fails to provide the income information and is denied Medicaid for the retroactive period. The application is approved for ongoing eligibility.

2. Same as Example 1, except that Ms. A is also denied for ongoing benefits due to failure to provide requested information. She reapplies on August 15, and this time cooperates in providing information needed to establish eligibility. She is eligible for the retroactive period of May through July, the three months before the month of the reapplication, and also for ongoing benefits.

Determine eligibility for the retroactive period on a month-by-month basis. This includes using a third or fifth paycheck when calculating monthly income. The coverage group under which the person is eligible in the retroactive period may be different for each month. EXCEPTION: See Retroactive Eligibility for Medically Needy Recipients.

If the self-attested income that the household reported verifies with electronic data sources or is cohort approved and results in ongoing eligibility, this amount can be used to determine retroactive eligibility. If the self-attested income does not verify with electronic data sources, the worker will need verification of actual income to determine eligibility for the retroactive period.

Issue a notice of decision when retroactive eligibility is denied.

When approving an application for retroactive Medicaid only, include the month when eligibility ended on either the *Notice of Decision* approving the retroactive months or on a separate notice. The notice does not need to be timely when assistance is simultaneously approved and ended for retroactive eligibility.

A member who did not know that there were bills in the retroactive period at the time of application can ask to have eligibility for retroactive benefits determined at a later date. The retroactive period is the three months before the month of the most recently **approved and active** Medicaid application. Retroactive eligibility cannot be determined later on an application that was denied or canceled for ongoing benefits.

Also, a person may request retroactive coverage but may fail to provide the information needed to determine eligibility. Even though a notice of decision was issued, the member may request to have eligibility determined again for the same retroactive period if the application was approved for ongoing benefits **and** it remains the most recently approved Medicaid application.

Although a member may request retroactive benefits at any time, payment will not be authorized for services provided 23 months or more before the current month unless extenuating circumstances exist. See 8-M, *Submitting Claims*, for more information.

Benefits can be approved for SSI approvals beyond the two years by submitting special updates when the SSI eligibility determination went beyond the two years.

Verification Requirements

When determining retroactive eligibility, accept a client's statement that the client has paid or unpaid medical bills (unless questionable). See 8-F, *Continuous Eligibility for Pregnant and Postpartum Women*, for requirements when establishing continuous eligibility for pregnant women at the time of application.

Clearly document in the case record how eligibility or ineligibility for each month was established. Information to be documented includes:

- Verification of income and resources.
- Household composition for each month.
- Beginning date of disability, if applicable.

Retroactive Eligibility for Medically Needy Recipients

Legal reference: 441 IAC 75 (Rules in Process) and 76.13(3)

A Medically Needy certification period is considered as one unit. Even though the period may include one or more months, determine eligibility for the entire certification period only. The retroactive period for Medically Needy is a one-month, two-month, or three-month period, depending on which month the client first incurred a medical expense. See 8-J.

1.	Ms. S, a pregnant woman, applies for Medically Needy on March 5. The certification period is March and April. Ms. S claims to have unpaid bills for December and January, which are within the three-month retroactive period. The worker requests income and resource information for all three months of the retroactive period (December - February). If income or resource verification is not provided for December through February, eligibility for the retroactive period cannot be determined.
2.	Ms. B, a pregnant woman, applies for Medically Needy on April 15. The certification period will be April and May. She states that there are no unpaid medical bills for the retroactive period (January - March). In June, Ms. B reports that there is an unpaid medical bill for January. The worker establishes eligibility for the three-month retroactive period. Income from all three months is used in computing spenddown. Spenddown for the retroactive period is $100. The unpaid bill is $500. The amount in excess of the spenddown ($400) is Medicaid-payable in the retroactive period.

Retroactive Eligibility for SSI Recipients

Legal reference: 441 IAC 76.13(3) and 76.13(3)"d"

For an SSI recipient to be eligible for retroactive benefits, they must meet a category of eligibility during the retroactive period as defined in 8-A, *Definitions*. In addition:

- The person must have been eligible for Medicaid benefits in the months services were received (if an application had been filed), and
- The person must have paid or unpaid medical bills for Medicaid-covered services received during the retroactive period. The SDX shows unpaid medical claims in the UNPAID RETRO field.

A person who is presumptively disabled (disability code P on the SDX) is not entitled to retroactive benefits until a final determination has been made that the person is eligible for disability.

Examine retroactive eligibility for an SSI recipient as you would any other applicant. During the retroactive period, the person must have been either:

- At least 65 years of age, or
- Under 18 years of age, or
- Blind, or
- Disabled, and
- Meet a category of eligibility for the retroactive period as defined in 8-A, *Definitions*.

Accept the member's statement regarding the date of onset of blindness or disability, unless there is evidence to the contrary.

Referrals to CSRU

Legal reference: 42 CFR 433.145, 441 IAC 75.14(249A) and 75 (Rules in Process)

Policy: As a condition of eligibility, Medicaid applicants and members must assign their rights to payments for medical support to the Department unless good cause exists.

The Child Support Recovery Unit (CSRU) seeks cash medical support as well as financial support for people in the Medicaid eligible group.

A Child Support referral is mandatory in the following situations:

- There is an active CSRU case;
- The applicant requests CSRU services;
- The applicant or member receives cash medical support;
- The application is for a child in foster care; or
- The applicant is also applying for FIP.

Do not make a referral to CSRU:

- When the applicant does not want CSRU services and CSRU does not have an active case on the absent parent.
- When both parents are in the home, even when paternity has not been established.
- If the applicant or member has proven that good cause exists.
- On a parent whose parental rights have been terminated by the court.
- On the parents of an underage parent who is a payee.
- When a child in subsidized adoption is placed in foster care and no child support order currently exists.
- When a parent's absence is solely because of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service.

  NOTE: A parent whose absence is solely because of the performance of active duty in the uniformed services of the United States is considered to be absent for purposes of determining Medicaid eligibility. (See 8-C, *Absence*.) However, a parent who is absent for this reason is not referred to CSRU.

See 8-C, *Cooperation With Support Recovery*.

1. Ms. D applies only for Medicaid for herself and her daughter, Lisa. Lisa's father is not in the home. Ms. D says on the application that:

   - She does not want a referral to CSRU, and
   - There is no court order for cash medical support.

   The IM worker checks ICAR and finds there is not an active child support case in the ICAR system. The IM worker processes the application and does **not** complete a referral to CSRU.

2. Mr. W applies only for Medicaid for himself and his two children. He says on the application that:

   - He does not want to pursue child support, and
   - The absent parent **is court-ordered** to pay cash medical support.

   The IM worker explains to Mr. W that a referral will be made to CSRU because of the cash medical support order; that he is required to cooperate with CSRU to receive Medicaid for himself; and that if he does not cooperate, he will not receive Medicaid for himself.

3. Mr. Q applies for FIP, Medicaid, and Food Assistance for himself and his children. His children's mother is absent from the home. Mr. Q says on the application that:

   - He does not want to cooperate in obtaining medical support,
   - CSRU is not helping him, and
   - There is no court order for cash medical support.

   The worker tells Mr. Q that as a condition of eligibility for FIP he must cooperate with CSRU in obtaining financial support or the household will be subject to sanction of cash benefits. The worker completes a CSRU referral and it will be "active" for both FIP and Medicaid programs.

   If Mr. Q later fails to cooperate with CSRU, then CSRU will notify the worker to apply the appropriate sanctions to the FIP, Medicaid, and Food Assistance benefits.

Referral Procedures

Procedures: If the household has more than one absent parent and there is no active CSRU case, the applicant can determine which absent parents are to be referred, if any.

For foster care cases, link both parents. If the ICAR referrals have not been made, complete the referral.

Pregnant Women

Legal reference: 441 IAC 75 (Rules in Process)

Policy: As a condition of her eligibility, the woman must agree to cooperate in establishing paternity and obtaining support for the children for whom she receives Medicaid (except for pregnant women under MAC). However, a woman will be referred only as listed under Referrals to CSRU.

Procedure: Do not make a referral regarding the father of the unborn child until the 60-day postpartum period has ended. Then refer only if the mother requests a CSRU referral or is otherwise required.

See also 8-C, *Cooperation With Support Recovery*, and 8-F, *Mothers and Children (MAC) Program*.

1. Ms. A is pregnant and lives alone. She applies for Medicaid. No CSRU referral is made and no information is requested regarding the father of the unborn child. The worker does not make a referral until the 60-day postpartum period has ended, and then only if Ms. A requests CSRU services.
2. Ms. B is pregnant and lives with her two children. She applies for Medicaid for herself and the children. Eligibility is examined under the FMAP coverage group.

   The worker makes the referral to CSRU only if Ms. B wants CSRU services or if CSRU already has an active ICAR case. When the 60-day postpartum period ends, the worker refers the newborn if a referral was made on the other children of this absent parent.
3. Ms. D is pregnant and receives Medicaid under the MAC coverage group for herself and her daughter. Ms. D wishes to have CSRU establish paternity and support for her daughter. The worker makes the referral to CSRU for the daughter.
4. Same as Example 5. The referral is made to CSRU. However, Ms. D changes her mind and does not cooperate with CSRU. Her Medicaid is not canceled, because she receives Medicaid under MAC as a pregnant woman, and is, therefore, exempt from the cooperation requirement.

Representation

Legal reference: 441 IAC 76.9

A Medicaid applicant or member may need or want to be represented by another person or organization.

- When an applicant or member is a minor, incompetent, incapacitated, or deceased, a "responsible person" is allowed to act on the client's behalf.
- A competent person may name an "authorized representative" to participate in pursuing Medicaid eligibility.

The policies and procedures for these two types of representation are discussed in this section.

Responsible Person

Legal reference: 42 CFR 435.907(a), 441 IAC 76.1 and 76.9(1) and (3)

When an applicant or member is unable to act on their own behalf because they are a minor, incompetent, incapacitated, or deceased, another person may act responsibly for the client. The responsible person must be:

- A family member, friend, or other person who has knowledge of the client's financial affairs and circumstances, and a personal interest in the client's welfare,
- An adult in the child's household or family, or
- A legal representative, such as a conservator, guardian, executor, or someone with power of attorney.

A responsible person assumes the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

A responsible person may designate an authorized representative to represent the incompetent, incapacitated, or deceased applicant or member. (See Authorized Representative.) However, this does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

Provide copies of all correspondence and documents that you would normally provide to the applicant or member to the responsible person and to the representative, if the responsible person has authorized one.

When there is no person as described above to act as a responsible person, any individual or organization can act as the responsible person if the individual or organization:

- Conducts a diligent search for someone who meets the criteria for a responsible person but cannot locate such a person, and
- Completes form 470-3356, *Inability to Find a Responsible Person*.

Authorized Representative

Legal reference: 42 CFR 435.907(a) and 435.923, 441 IAC 76.1 and 76.9(2)-(3)

Policy: A competent applicant or member or a responsible person (see Responsible Person) may authorize any individual or organization to represent the applicant or member in the application process or for ongoing eligibility. See Authorization to Represent for authorization requirements.

Authorized representatives may participate in the application process or in the ongoing eligibility process. Authorized representatives are allowed to:

- File applications.
- Check on the progress of an application or ongoing eligibility.
- Request reschedules of interviews or extensions for providing documentation or verification.

Appointment of an authorized representative does not relieve a competent applicant or member or a responsible person of the primary responsibility to cooperate with the application process or for establishing ongoing eligibility. The applicant, member, or responsible person is still required to:

- Attend interviews, when requested.
- Sign documents.
- Supply information or verifications.
- Meet all other requirements necessary to determine eligibility.

Procedure: When an applicant, member, or responsible person has named an authorized representative, send the authorized representative copies of all correspondence sent to the applicant or member that will affect eligibility.

When a competent applicant names an authorized representative, send all correspondence to the applicant and copies of all correspondence that pertains to the eligibility determination to the authorized representative.

For a minor, or incompetent, incapacitated, or deceased applicants, send correspondence to the responsible person and copies to the authorized representative.

For members under Medicaid for Employed People with Disabilities (MEPD), also provide a copy of each *MEPD Billing Statement*, form 470-3902, to the authorized representative.

Make entries on the member's MEPD STMT screen to generate a copy of the *MEPD Billing Statement*. See 14-C, *STMT = MEPD Billing Statement Screen*, (REPRINT (WRKR) field) for entry instructions. After the entries are updated, the worker will receive the duplicate bill and send it to the authorized representative.

Authorization to Represent

Legal reference: 441 IAC 76.1(7)"b"

An authorization to represent is a written document or statement signed and dated by the competent applicant or member or by a responsible person that identifies the individual or organization that will act as the person's authorized representative.

If the authorization identifies the period or the dates of medical services it is to cover, the authorization is valid for the initial application and any additional application filed by the representative or applicant for the stated period or dates of medical services, as well as appeals relating to the application.

If the authorization does not indicate the period or dates of medical services it is to cover, the authorization shall be valid until the applicant, member, or responsible person modifies the authorization, or notifies the department that the representative is no longer authorized to act on behalf of the applicant or member or until the authoriz3ed representative informs the department that the representative no longer is acting in such capacity.

If an applicant, member, or responsible person notifies the Department in writing that the client or responsible person no longer wants an authorized representative to act on the person's behalf, the Department will no longer recognize that individual or organization as the authorized representative.

IOWA Health and Human Services

Employees' Manual
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Overview

All Medicaid clients must meet certain nonfinancial eligibility requirements. This chapter describes those requirements that apply to all Medicaid coverage groups in alphabetical order. These sections are followed by sections on nonfinancial requirements specific only to MAGI-related clients and to NonMAGI-related clients.

Assignment of Medical Support

Legal reference: 42 CFR 433.145, 441 IAC 75.14(4), 75 (Rule in Process)

As a condition of eligibility, Medicaid applicants and members must assign to the Department their rights to payments for medical support unless good cause exists. The support can be from any person for whom the client can legally make assignment. This includes the client's own rights to support, as well as those of other family members for whom application is made.

By signing the application form, the client or responsible person assigns payments from the client's health insurance to the Department. If other medical benefits are available to the client (possibly as a result of an injury or other trauma), the applicant assigns to the Department the rights to payment from the responsible party. This assignment begins upon the effective date of Medicaid eligibility.

Medical support payments made by an absent parent are assigned by entries on the Iowa Collections and Reporting (ICAR) system. Assignment is effective the same date that you enter information to approve the applicant's Medicaid eligibility into the ABC system. A Medicaid assignment does not apply to cash support payments that are not intended for medical support.

Assignment remains effective for the entire period for which assistance is granted. See Cooperation with Child Support Services for medical support determined through the child support services unit.

Benefits from Other Sources

Legal reference: 441 IAC 75 (Rules in Process)

Medicaid applicants and members are required to apply for and accept benefits from other sources as a condition of eligibility. This section covers application for and acceptance of:

- Medical benefits
- Income

Medical Benefits

Legal reference: 441 IAC 75 (Rules in Process)

Medicaid applicants and members must apply for and accept any medical resources that are reasonably available to them **without charge** when such resources are reasonably available to them. A medical resource is considered "reasonably available" when it may be obtained by filing a claim or an application.

Such medical resources include:

- Health and accident insurance.
- Eligibility for care through Veteran's Administration.
- Specialized health care services.
- Medicare, when the state will pay the premiums through the buy-in process.

EXCEPTION: Requirement to Apply for Medicare When Not Eligible for Free Medicare Part A.

- Medicaid applicants and members who are over 65 that do not qualify for free Medicare Part A are required to apply for **Conditional Medicare Part A** and **Medicare Part B** if they:
  - Are not already enrolled in a major medical plan,
  - Have income at or below 100% of the poverty level and assets within the Medicare Savings Plan limit, and
  - Do not receive Medicare Part B
- Medicaid applicants and members who are over 65 that do not qualify for free Medicare Part A are required to apply for **Medicare Part B only** if they:
  - Are not already enrolled in a major medical plan,
  - Have income above 100% of the poverty level and/or have assets within the Medicare Savings plan limit, and
  - Do not receive Medicare Part B.
- Medicaid applicants and members who already receive Medicare Part B are **not** required to apply for Conditional Medicare Part A as buy-in will automatically occur for Part A if QMB eligible.

- Elderly Legal Permanent Residents (LPR) are not eligible for Conditional Medicare Part A until they have lived in the USA for 60 continuous months. If the 60-months are interrupted by a trip outside of the USA that lasts at least one month, then the 60-month period starts anew with the date they return to the USA.
  - If date of entry is less than 60 months ago, set a reminder in WISE for the last month of the 60 month period and send them a request to apply for Conditional Medicare Part A and Part B as necessary in that month.

NOTE: Members may not apply for Conditional Medicare by using the online Medicare application. They must either enroll in person at their local Social Security office or they may call Social Security and schedule a telephone interview for assistance with the Conditional Medicare application.

Deny or cancel Medicaid benefits of the individual by entering a noncompliance reason in ELIAS when a Medicaid applicant or member fails to file a claim or application or to cooperate in the processing of that claim or application without proving good cause. See Cooperation in Obtaining Medical Resources and Cooperation With Investigations and Quality Control for additional information.

Income Benefits

Legal reference: 42 CFR 435.608, 441 IAC 75 (Rules in Process)

Medicaid applicants and members must apply for and accept any income benefits for which they are eligible, unless they can prove an incapacity that prevents them from doing so. To “apply for and accept” means that the client:

- Files an application for benefits.
- Actively tries to obtain them by complying with all requests for information or evidence to establish eligibility.

EXCEPTIONS:

- A person does not have to apply for SSI benefits. A person who chooses not to apply for SSI benefits may still receive Medicaid under the coverage group for people eligible for SSI benefits but not receiving them. See 8-F, NonMAGI-Related Coverage Groups: People Eligible for SSI Benefits but Not Receiving Them.
- Applicants for or members of QMB or SLMB are also not required to apply for FIP or State Supplementary Assistance.

- A person does not need to apply for a retirement account if applying for or receiving MAC or FMAP-related medical needy. See 8-F, Mothers and Children (MAC) Program, and 8-J, Resource Policies.
- A person does not need to apply for or accept any income benefit that would be considered exempt income. See 8-E, Types of NonMAGI-Related Income and Types of MAGI-Related Income.

The client may be entitled to cash benefits, such as:

- Social Security benefits.
- Annuities.
- Pensions.
- IPERS.
- Railroad benefits.
- Job insurance benefits.
- Workers' compensation.
- Union benefits.
- Veterans' benefits available to:
  - The veteran.
  - The surviving spouse.
  - The veteran's minor child.
  - Some parents of service personnel or veterans who died on or after January 1, 1957.

Veterans Affairs (VA) "improved" pension payments are limited to $90 per month after a veteran or surviving spouse enters a medical institution unless the person has a spouse or dependent. Unless a person's VA pension is or will be limited to $90 per month, the person must apply for an improved pension.

However, people who began receiving a veterans' pension before January 1, 1979, and also receive SSI or mandatory state supplementation are not required to **accept** an improved pension. This is because the cash program sets the policy as to whether the client must apply for the improved pension.

If you decide the client may be entitled to other cash benefits, use form **470-0383, Notice Regarding Acceptance of Other Benefits** to notify the client of the requirement to apply for the benefits. See 6-Appendix. The client indicates intent to apply by completing Part B of the form and returning it to your office.

Allow the client ten calendar days from the date this notice was given or mailed to the client to complete and return the form. If the client gives you a signed refusal to apply or does not return the form, deny or cancel Medicaid for the person who failed or refused.

Deny or cancel Medicaid for the client by entering a noncompliance reason in ELIAS when the client fails or refuses to:

- Comply with any income benefit, or
- Timely apply for any income benefit, or
- Accept any income benefit.

EXCEPTIONS: Do not deny or cancel Medicaid when good cause exists or when the client is mentally or physically incapable. If the client is incapable, either ask the client's representative to pursue the other benefits or you may help the client apply if the client's representative has authorized you to do so.

Citizenship

Legal reference: 42 CFR 435.406(a)(1), 441 IAC 75.11(2)"a", P. L. 104-193

To be eligible for Medicaid, a person must be one of the following:

- A citizen of the United States,
- A U.S. national, or
- A qualified alien. See 8-L, Aliens for more information on eligibility criteria.

A "U.S. citizen" is defined as a person born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Mariana Islands.

People born abroad to U.S. citizen parents are generally, but not always, considered U.S. citizens.

A "U.S. national" is a person born in American Samoa, including Swain Island. However, the Independent State of Samoa (also known as Western Samoa) is not part of American Samoa, so individuals from this country are not U.S. nationals.

People who are not citizens or nationals by birth can become citizens through a process called "naturalization." In addition, certain children born abroad who were not U.S. citizens at the time of birth may establish citizenship automatically under the Child Citizenship Act.

Declaring Citizenship or Alien Status

Legal reference: 42 CFR 435.407, 441 IAC 75.11(2)"b", P. L. 99-603, Sec. 121, P. L. 104-193

Medicaid applicants must:

- Declare their citizenship or alien status as part of the application process.
- Have their status verified. (See Verifying Citizenship and Identity for citizenship verification requirements. For information about acceptable forms of verification for aliens, see 8-L.)

As a condition of eligibility, an attestation of citizenship or alien status shall be made for all applicants and members:

- On a state-approved Medicaid application or review form, or
- On form 470-2549, Statement of Citizenship Status.

Applicants and members must attest to their citizenship or alien status. The attestation may be signed by:

- The applicant or member, or
- Someone acting responsibly on the applicant's or member's behalf if the applicant or member is incompetent or deceased, or
- By any adult member of a family or household for whom Medicaid is being requested or received.

If this attestation is not made, the person for whom the attestation is required is not eligible for Medicaid (except emergency medical assistance).

Persons Exempt from Verification

Legal reference: 42 CFR 435.406, 435.407; 441 IAC 75 (Rules in Process), Sections 211(a) and 211(b)(3) of Public Law 111-3

Policy: Unless specifically exempted, all Medicaid applicants or members who claim to be United States citizens are required to have their citizenship and identity verified as a condition of eligibility.

The requirement to verify citizenship and identity **does not** apply to the following people who claim to be United States citizens:

- Current recipients of Supplemental Security Income (SSI), including 1619b individuals.
- Current recipients of Social Security disability income (SSDI) (benefits based on the person's disability).
- Current Medicare beneficiaries.
- People who were initially eligible for Medicaid due to deemed "newborn" status. This exemption continues even when "newborn" status ends, because people born in the U.S. to Medicaid-eligible mothers are permanently exempt from proving citizenship and identity.
- People born in another state who were initially eligible due to having deemed newborn status in that state. This includes people born to CHIP-eligible mothers if the other state's CHIP program covers pregnant women.

  NOTE: Children born to Medicaid–eligible or CHIP–eligible mothers in another state do not qualify for deemed newborn status in Iowa because the mother was not receiving Iowa Medicaid at the time of the child's birth.
- Children who are or were exempted while in out-of-home placement (e.g., foster care or relative placement) under the placement and care responsibility of the Department through a court order or voluntary placement agreement, regardless of the placement's licensing or payment status.
- Children who are or were exempted while in IV-E-funded subsidized adoption or subsidized guardianship.
- Applicants for presumptive Medicaid eligibility (but they are no longer exempt when they apply for ongoing Medicaid).
- Individuals who have previously presented satisfactory documentary evidence of citizenship.

NOTE: A person claiming to be an alien rather than a U.S. citizen **must** have their alien status verified as described in 8-L, Aliens. These exceptions **do not** apply to aliens.

All other Medicaid applicants or members claiming to be United States citizens **are** required to have their citizenship and identity verified as a condition of eligibility. See Loss of Exemption for procedures when a member becomes subject to verification after approval.

Procedure: Maintain any documentation needed to support the exempt status in the permanent section of the person's case file. Examples of documents showing an exempt status include:

- State Data Exchange (SDXD) printout showing current receipt of SSI.
- Benefit award letter from Social Security Administration.
- Income and Eligibility Verification System (IEVS) printout or copy of Medicare card showing current receipt of Medicare.
- Mother's SSNI screen print showing Medicaid eligibility in the month of the birth or other proof that the person had deemed "newborn" status.
- Other documents showing the person meets one of the exempt statuses.

Verifying Citizenship and Identity

Legal reference: 42 CFR 435.406, 435.407, and 435.949; 441 IAC 75.11(2)"c"; Sections 211(a) and 211(b)(3) of Public Law 111-3

Policy: Unless specifically exempted, all Medicaid applicants or members claiming to be United States citizens are required to have their citizenship and identity verified as a condition of eligibility. In most cases, Medicaid is available while the client is verifying citizenship and identity. See Reasonable Opportunity Period.

Documentation that citizenship and identity has been verified for each person subject to this requirement must be maintained in the Department's records. A hard copy of the document does not need to be retained. For this purpose, the Department's records include:

- The Inquiry Citizenship (ICIT) screen when proof was obtained electronically through the IEVS match with the Social Security Administration.
- The Vital Statistics List page in ELIAS.
- Copies of paper documents maintained in the Medicaid or Hawki case file.
- Notation in the Medicaid or Hawki electronic case file of the type of citizenship and identity verification received in either electronic or paper format.

Procedure: Electronic data matching is the primary method of verifying attested U.S. citizenship status. When possible, proof of citizenship and identity will be obtained via an automated match either through electronic data sources (EDS) in ELIAS or through Income and Eligibility Verification System (IEVS). When using the Vital Statistics Detail page in ELIAS, the verification will be displayed on the Vital Statistics List page.

When citizenship and identity is verified through the automated IEVS match, a record of the proof will be maintained electronically and displayed on the ICIT (Inquiry Citizenship) screen.

When acceptable proof is instead provided by the applicant or member, enter coding in the US and ID fields on each person's TD03 screen in the Automated Benefit Calculation (ABC) system to document that both citizenship and identity have been verified. Acceptable codes are listed in 14-B-Appendix and in "Easy Help." For cases in ELIAS, use the Vital Statistics Detail page.

See Reasonable Opportunity Period and Documentation Process for instructions on how to proceed when acceptable proof is not obtained via electronic data matching and was not provided by the applicant or member.

When a paper document is used as verification, a hard copy does not need to be retained if the verification is noted in the electronic case file.

If a member has more than one case record and citizenship and identity verification is in only one case file, note in the other case records where the documentation can be found.

Comment: Members are required to provide proof of citizenship and identity only once. Once provided, proof cannot be required again as a condition of Medicaid eligibility, unless there is reason to question the proof that was previously provided.

A person cannot receive Medicaid if that person is ineligible for a nonfinancial reason. Failure to provide proof of citizenship or identity within the reasonable opportunity period will result in Medicaid being denied or canceled. See 14-B-Appendix, Notice Codes for valid notice reasons.

Reasonable Opportunity Period (ROP)

Legal reference: 435.956(b), 435.911(c), 441 IAC 75(11)(2)(c)

Policy: Individuals whose attested U.S. citizenship status cannot be verified through an electronic data match shall be allowed a reasonable opportunity period (ROP) to provide proof of U.S. citizenship and identity. The ROP begins with the date a written request to provide the information is issued to the person or the date the **Notice of Action** is received and continues for 90 days. The date of receipt is considered to be 5 days after the date of the **Notice of Action**.

Medicaid shall be provided during the 90-day ROP if the person is otherwise eligible. If proof is not received by the end of the 90-day ROP, benefits end subject to timely notice requirements.

Procedure: Whenever possible, proof of citizenship and identity will be obtained through electronic data matching. The system will update eligibility coding if the match is consistent.

When the match is inconsistent or unavailable, the system will generate form **470-4858** or **470-4858(S), Request for Verification of Citizenship and Identity**, or form **470-4909** or **470-4909(S), Request for Proof of Citizenship and Identity**, as applicable to the case situation. The system tracks the ROP. (See Inconsistent Match or No Match for specific procedures.)

NOTE: These forms are not available for worker issuance because this would interfere with system tracking of the 90-day ROP. You may print a copy of the form from the electronic case file if necessary (e.g., if the client loses the original).

Approve Medicaid for new applicants and continue Medicaid for members during a 90-day ROP. See Retroactive Eligibility if an applicant has requested coverage in retroactive months.

For ABC cases, if acceptable proof is provided, record the receipt in the US and ID fields on the person's TD03 screen. To keep the system from incorrectly blocking subsequent Medicaid approvals, record receipt of the proof on TD03 even if the person is not currently in an active Medicaid status.

For ELIAS cases, if acceptable proof is provided, select the document type from the U.S. Citizenship Verification and Identity Verification fields. Then change the Verified field to a "verified" status.

If acceptable documentation has not been provided within 90 days, the systems will cancel the individual with timely notice.

Comment: Once a 90-day ROP begins, it does not change even if Medicaid is canceled for a different reason before the end of the 90-day period. The ROP lasts 90 days even if the person does not receive Medicaid during the entire 90-day period.

If a person who has been denied or canceled for another reason reapplies, begin a new 90-day ROP. This will be done automatically for cases in ELIAS.

No extensions are allowed for the 90-day ROP for providing proof of citizenship and identity. However, reinstatement and grace period policies do apply when proof is provided before the effective date of cancellation or within 14 days of cancellation or denial.

Continuous eligibility does not apply to children whose citizenship and identity is not verified within the 90-day ROP or the subsequent reinstatement and grace period.

ELIAS generates notification to the household about the ROP and explains what qualifies as acceptable proof, tracks the 90-day period, and cancels with timely notice if information is not received.

In ELIAS, the worker cannot see if an ROP has been granted. The worker can review past **Notice of Actions** to determine if an ROP has been granted.

For information specific to the ROP for immigrants, see 8-L, Aliens.

Loss of Exemption

Policy: When a member who was previously exempt from the citizenship and identity verification requirements loses the exempt status, Medicaid eligibility continues during the 90-day ROP.

Children losing an exempt status who are already continuously eligible are not required to verify citizenship and identity until the next annual review.

Procedure: The system will need to be updated to reflect that the member is no longer exempt from verifying citizenship and identity. EXCEPTION: For a child who is continuously eligible but loses an exempt status, do not make updates until the annual review.

Form **470-4909** or **470-4909(S), Request for Proof of Citizenship and Identity**, will be system-generated to request proof of citizenship and identity from the person, and the 90-day ROP will begin. Continue Medicaid during the 90-day ROP.

If acceptable proof is provided, record the documentation in the system.

Do not cancel the person's Medicaid due to lack of proof of citizenship and identity during the 90-day ROP. When proof is provided but is questionable or not acceptable:

- Contact the person by phone or by mail.
- Explain why the proof submitted is not acceptable, how acceptable proof can be obtained, and, if appropriate, offer to assist in obtaining the proof.
- Document phone contacts in the case file.

Retroactive Eligibility

Policy: Retroactive months are outside the ROP. Retroactive Medicaid eligibility shall **not** be approved until proof of citizenship and identity is received, and provided that retroactive coverage is needed and all retroactive eligibility requirements have been met as detailed at 8-B, Determining Eligibility for the Retroactive Period, and 8-A, Definitions: Retroactive Period.

Procedure: Process the Medicaid application as soon as it is received to begin the electronic data match process for verifying citizenship and identity. This will reduce processing delays on the retroactive portion of the Medicaid application.

Comment: Proof of citizenship and identity may be obtained directly from the applicant to allow the retroactive portion of the Medicaid application to be acted on without delay.

If proof is requested for the purpose of approving retroactive Medicaid, inform the person that submission of proof is optional unless electronic data matching does not verify the person's citizenship (including identity), but retroactive Medicaid cannot be approved until proof of citizenship and identity is received.

If the applicant provides proof of citizenship and identity, record the documentation in the system. If optional proof is not provided, take no negative action.

Documentation Process

Legal reference: Section 211(a) of Public Law 111-3; 441 IAC 75 (Rules in Process)

Policy: A person who attests to U.S. citizenship and provides name, social security number, and date of birth meets the citizenship and identity documentation requirements if the electronic data match verifies the person's citizenship (and identity).

A written request for verification shall be issued if:

- The electronic data match returns a response that does not verify the person's citizenship (and identity), or
- An electronic data match cannot be requested because the person does not have a social security number.

Procedure: The system will automatically attempt an electronic data match when a person:

- Is pended or approved on the system, and
- The system indicates documentation has not been provided.

Proof of citizenship and identity may be obtained directly from the applicant so that documentation is already on file in case the electronic data match is unable to verify the person's citizenship and identity.

> Mr. B files an application for Medicaid in person at the local office on June 28. An electronic data match will occur when his information is entered into the system.
>
> Since Mr. B is already in the local office, the IM worker records Mr. B's verification of identity since Mr. B provided his driver's license as proof of identity.

When a verification request will not be generated for a person who is required to verify citizenship and identity and has not done so, follow the procedures under No Match. A request for proof of citizenship and identity will **not** be sent when the worker indicates verification is not needed (e.g., person is exempt, verification is already on file, person is an alien).

Consistent Match (Verified)

Policy: When the electronic data match response to a request for proof of citizenship and identity is a consistent match, the person's citizenship (and identity) are verified. The person has met the citizenship and identity documentation requirements.

Procedure: No further action is needed for that person's ongoing Medicaid.

Comment: A response about an individual's citizenship (and identity) can be used **only** for the purposes of determining Medicaid or Hawki eligibility. These citizenship data matches **cannot** be used to determine eligibility for other programs (Food Assistance, FIP, CCA, etc.).

Inconsistent Match (Not Verified)

Policy: When the electronic data match response to a request for proof of citizenship and identity is an inconsistent match, the person's citizenship (and identity) are not verified. The system will generate a written request for verification of citizenship and identity to notify the person that:

- The person has 90 days to provide verification by either:
  - Correcting any errors in the name, social security number, or date of birth given to the Department so that SSA can verify the person's citizenship and identity;
  - Correcting any errors in the SSA's records and providing proof of citizenship and identity from SSA when this is done; or
  - Providing proof of citizenship and identity from the list of documents described under Acceptable Documentation.
- If proof of citizenship and identity is not provided within 90 days:
  - Medicaid eligibility will end and
  - Retroactive Medicaid, if requested, will be denied.

If the corrections produce a response that verifies the person's citizenship and identity, the system will update the coding. If retroactive eligibility has been entered in the system, a WISE alert will be sent to tell you that retroactive Medicaid coverage was requested and a decision may still be needed on retroactive eligibility.

If the person provides acceptable proof during the 90-day ROP, record the documentation in the system.

If proof is provided but is questionable or not acceptable:

- Contact the person by phone or by mail.
- Explain why the proof submitted is not acceptable, how acceptable proof can be obtained, and offer to assist in obtaining the proof if appropriate.
- Document phone contacts in the case file.

Do not cancel the person's Medicaid due to lack of proof of citizenship and identity during the 90-day ROP. If the person has not provided acceptable documentation within 90 days, the system will:

- Cancel the individual with timely notice.
- Send a WISE alert if the system shows retroactive coverage was requested, to tell you to deny retroactive eligibility.

See Retroactive Eligibility for additional information about retroactive Medicaid coverage and citizenship and identity requirements.

No Match (Not Verified)

Policy: An electronic data match request for proof of citizenship and identity will **not** be sent when:

- The person does not have a social security number or
- A request was already sent and the person's name, date of birth, social security number, or sex has not been changed on the system.

A written request for verification shall be issued. Medicaid shall be approved during the 90-day ROP.

Procedure: When proof of citizenship and identity is required for a person but cannot be requested via electronic data sources, a written request for proof will be system-generated. The request notifies the person that if proof of citizenship and identity is not provided within 90 days:

- Medicaid eligibility will end and
- Retroactive Medicaid, if requested, will be denied.

Form **470-4909** or **470-4909(S), Request for Proof of Citizenship and Identity** and **Comm. 258, Verifying Citizenship and Identity** will be system-generated and sent to a person who:

- Is approved on the system,
- Has all 9s or all 0s in the social security number field, and
- The system indicates documentation has not been provided.

NOTE: If a person with all 9s or all 0s later provides a social security number, entry of the social security number will cause a request for proof of citizenship and identity to be sent via electronic data sources.

If acceptable proof is provided during the 90-day ROP, record the documentation on the system. See Retroactive Eligibility for additional information.

If proof is provided but is questionable or not acceptable:

- Contact the person by phone or by mail.
- Explain why the proof submitted is not acceptable, how acceptable proof can be obtained, and, if appropriate, offer to assist in obtaining the proof.
- Document phone contacts in the case file.

Do not cancel the person's Medicaid due to lack of proof of citizenship and identity during the 90-day ROP. If the person has not provided acceptable documentation within 90 days, the system will:

- Cancel the individual with timely notice.
- Send a WISE alert to tell you to deny retroactive eligibility, if applicable.

See Retroactive Eligibility for additional information about retroactive Medicaid coverage and citizenship and identity requirements.

Acceptable Documentation

Legal reference: 42 CFR 435.407, 441 IAC 75 (Rules in Process), P. L. 111-3

Policy: Documents that are acceptable verification of U.S. citizenship and identity are categorized as either primary or secondary. Primary documents are acceptable proof of both citizenship and identity. When secondary documents are used to verify citizenship, separate proof of identity is also required.

See the ROP Reference Guide for a list of documents that are acceptable as verification of citizenship and identity.

An individual may use affidavits to verify both citizenship and identity. However, accept affidavits only as a last resort when no other form of verification is available. Affidavits must be signed under penalty of perjury but need not be notarized.

Original documents or copies certified by the issuing agency are **not** required. A photocopy, fax, scanned, or other copy must be accepted to the same extent as an original document, unless information on the copy submitted is inconsistent with other available information or the validity of the documentation is questionable.

Procedure: When a client submits original documents to prove citizenship or identity, **do not** date-stamp the originals. Instead, if retaining the documents, photocopy the originals and return them to the client. Date stamp the copy and place it in the case file. Make a notation in the electronic case file, of the type of citizenship and identity verification received.

Each state must conduct its own verification of citizenship and identity. However, Iowa can accept another state's copy of a document or another state's data match with that state's vital records.

Documents submitted by a person whose last name has changed (e.g., due to marriage or divorce) may be accepted if the documents match in every way except the last name. If there is reason to question whether the documents belong to the same person, request an official document verifying the change (e.g., marriage license, divorce decree).

Persons who have changed both their first and last names **must** produce documentation of the official change from a court or governing agency.

Health Insurance Premium Payment (HIPP) Program

Legal reference: 441 IAC 75.21(14)

The Health Insurance Premium Payment (HIPP) program is operated by the HIPP Unit at the Iowa Medicaid Enterprise (IME). The purpose of the HIPP program is to pay the cost of health insurance for Medicaid members when it is determined that doing so would result in cost savings to the Medicaid program.

Refer all households with a member who has health insurance available to the HIPP Unit, except under the circumstances listed in 8-M, Situations Not Covered by HIPP.

To make a referral to the HIPP Unit have the member, applicant, or parent contact the HIPP Unit as follows:

Toll-free phone: 1-888-346-9562
Local phone: (515) 974-3282
Fax: (515) 725-0725
Interoffice mail: IME/HIPP

NOTE: Refer to NJA0093, Cooperation for the process to enter a HIPP referral in ELIAS and/or the process when Medicaid has been requested and a noncompliance still exists.

Referral to the HIPP Program Not Needed

Legal reference: 441 IAC 75.21(5) and 75.21(14)"b"

A referral to the HIPP program is not needed when the only Medicaid-eligible member:

- Has Medicare.
- Is eligible for Medicaid only under one or more of the following coverage groups:
  - Medicaid for Kids with Special Needs (MKSN)
  - Medically needy
- Has health insurance maintained by another entity (e.g., an absent parent maintains insurance on the Medicaid member's children or the policyholder is not in the Medicaid household).
- Has an insurance plan designed to provide temporary coverage.
- Has an indemnity insurance policy that supplements the policyholder's income or pays a predetermined amount for medical services (e.g., $50 per day for hospital services instead of 80% of the charge).
- Has an insurance plan offered on the basis of school attendance or enrollment.
- Is the policyholder and an absent parent. CSS is responsible for obtaining cash and medical support for children in households where a parent is absent.
- Uses the health insurance premium as a deduction in computing the client participation.
- Is the policyholder or potential policyholder and is an undocumented alien.

Cooperation in Obtaining Medical Resources

Legal reference: 42 CFR 433.146-148 and 435.610; 441 IAC 75 (Rules in Process) and 75.14, 75.21(249A)

All applicants and members are required to cooperate with certain processes related to obtaining medical resources as a condition of eligibility for Medicaid, unless good cause exists for failure to cooperate. This includes pregnant minors living independently. The applicant's signature on the application form shall constitute agreement to the assignment.

Deny Medicaid benefits to an applicant who fails to cooperate in determining the availability of medical resources. However, do not deny Medicaid benefits of a child due to the failure of the child's parent or specified relative to cooperate.

This section covers procedures for:

- Cooperation with the Third-Party Liability Unit
- Good cause for failure to cooperate

Cooperation with the Third-Party Liability Unit

Legal reference: 42 CFR 433.138, 433.145-148, and 435.610(a); 441 IAC 75 (Rules in Process) and 80.3(2)

A Third-Party Liability Unit is part of the Iowa Medicaid Enterprise Revenue Collection Unit and the managed care contractors. The primary purpose of the Third-Party Liability Units is to identify and collect monies from any available medical resource that can pay all or part of a member's medical expense.

A member or a person acting on the member's behalf must cooperate with Third-Party Liability by providing information and verification about any medical or third-party resources by completing form 470-2826, Insurance Questionnaire.

Third-party resources include:

- Medicare
- Insurance policies
  - Private health insurance
  - Group health insurance
  - Liability insurance
  - Automobile medical insurance
  - Family health insurance carried by an absent parent

- Railroad Retirement benefits
- Worker's compensation
- Veterans Affairs benefits
- TRICARE (military health insurance)
- Liability lawsuits (tort action)
- Orders for restitution as a result of a criminal conviction

Send the completed **Insurance Questionnaire** to the IME Third-Party Liability Unit:

- By interoffice mail to RevCol/IME
- By fax to 515-725-1352
- By E-mail to revcol@hhs.iowa.gov

Collect and report all necessary information about an accident, including:

- The name of the insurance company.
- The policy number or claim number.
- The type of accident (motor vehicle, slip and fall, worker's compensation).
- The name and address of any attorney or insurance adjuster involved in the case.

NOTE: Refer to NJA0093, Cooperation for the process of a Third Party Liability noncompliance in ELIAS and/or the process when Medicaid has been requested and a noncompliance still exists.

Failure to Cooperate With Third-Party Liability Unit

Legal reference: 441 IAC 75 (Rules in Process)

When a person fails to cooperate with Third-Party Liability, a sanction must be applied to Medicaid eligibility.

EXCEPTION: See Good Cause for Failure to Cooperate.

Apply a sanction to a minor parent who does not cooperate. NOTE: Do not apply a sanction to a child when a parent or specified relative fails to cooperate.

A person under sanction counts in the household size.

Good Cause for Failure to Cooperate

Legal reference: 441 IAC 75.21, 75 (Rules in Process)

The Third-Party Liability or the IM worker may be responsible for determining if good cause for failure to cooperate exists. Good cause for failure to cooperate exists when the applicant, member, parent, or family has one or more of the following situations:

- Serious illness or death of a member of the family.
- A family emergency or a household disaster, such as a fire, flood, or tornado.
- Verified good cause reasons beyond the applicant, member, or parent's control.
- Not receiving a request for information for a reason that was not the member's or responsible parent's fault. A member or parent's failure to provide a forwarding address does not qualify.

Cooperation with Investigations and Quality Control

Legal reference: 441 IAC 75.29 and 76.8(249A)

Medicaid clients must cooperate with Quality Control reviewers when their case is selected for verification of eligibility. Apply a sanction to the Medicaid case if Quality Control sends you form **470-0479, Noncooperation Notice** on an active client.

Do not sanction children who are continuously eligible. See 8-F, Cooperation with DIAL and QC.

Department of Inspections, Appeals, and Licensing (DIAL) conducts front-end investigations of applicant and member cases. DIAL also conducts fraud investigations.

DIAL will send you the results of an investigation. Take into consideration the findings of the investigator. The evidence in the findings is considered verified information. Do not delay determining eligibility pending receipt of the investigator's report.

Apply a sanction to the Medicaid case if the DIAL report says the client is not cooperating. When a sanction is applied, Medicaid is not available until cooperation occurs.

EXCEPTIONS:

- Do not apply a sanction when the eligibility requirements under investigation or review would not result in the person being ineligible. (For example, do not apply a sanction to children on the case when the investigation involves resources, since resources are not considered when determining eligibility for children.)
- Do not apply a sanction if the DIAL investigation involves only the circumstances of someone whose income and resources do not affect Medicaid eligibility.
- If the report from DIAL involves an SSI recipient, do not apply a sanction unless the report is that the client moved out of state. Inform the Social Security Administration's district office of any reported findings that may affect SSI eligibility using form **470-0641, Report of Change in Circumstances--SSI-Related Programs**.

If you have sanctioned a case for failure to cooperate, do not re-establish eligibility until you are notified that the client is cooperating or that the client no longer needs to cooperate.

When a person under an existing DIAL sanction applies for Medicaid, do not determine eligibility until DIAL sends notification that the person has cooperated. Eligibility may then be determined beginning on the date of the application. NOTE: Remove the noncompliance in ELIAS.

NOTE: Refer to **NJA0093, Cooperation** for the process when Medicaid has been requested and a noncompliance still exists.

Cooperation with Child Support Services

Legal reference: 42 CFR 433.146-148 and 435.610, 441 IAC 75.14(249A)

Policy: Applicants and members in households with children must agree to cooperate in obtaining court-ordered medical support when there is an absent parent. The only exceptions are when good cause for refusal to cooperate exists. (See Good Cause for Refusal to Cooperate.) Applicants demonstrate their willingness by signing the application.

Applicants and members must cooperate in obtaining support for themselves and for any other person in the household when:

- Medicaid is requested for that person, and
- The applicant or member can legally assign rights to court-ordered medical support for that person.

A referral to CSS will be made only as listed in 8-B, Referrals to CSS.

> Mrs. J, age 40, is an SSI recipient. Her two children, ages 10 and 12, receive Medicaid coverage. Mr. J, the father of the children, is absent from the home. The children have court-ordered medical support from their absent father. Mrs. J is required to cooperate in obtaining support as a condition of her Medicaid eligibility.

Cooperation with Child Support Services (CSS) is **not** required when:

- The referred person is no longer considered a child by the program.
- A pregnant woman is eligible for Medicaid under the Mother and Children (MAC) coverage group. See Pregnant Women Who Are Exempt from Cooperation for more information.

Referrals are not required when:

- There is good cause for not cooperating. See Good Cause for Refusal to Cooperate for an explanation of client responsibilities, good cause, and what you need to do when a client claims good cause.
- The children in the household are not applying for or receiving Medicaid.

> Mrs. L is an SSI recipient. Her two children, ages 6 and 7, do not receive Medicaid. Mrs. L is not required to cooperate in obtaining support as a condition of her Medicaid eligibility.

- Children are living on their own and no parent or other caretaker is acting in a parental capacity over them.

The following sections contain more information on:

- What the client must do to cooperate
- Good cause for failure to cooperate
- Failure to cooperate
- If sanctioned parent decides to cooperate

What the Client Must Do to Cooperate

Legal reference: 441 IAC 75.14(1)“a”, “b”, “c”, and “d”

Unless good cause exists, clients must cooperate in the following areas:

- Identifying and locating the absent parent of a child for whom Medicaid is requested.

- Establishing the liability of the absent parent of a child for whom Medicaid is requested.
- Obtaining any court-ordered medical support payments for the client and for a child for whom Medicaid is requested.
- Supplying enough information about the absent parent, the receipt of court-ordered medical support, and the establishment of liability (when needed) to establish Medicaid eligibility and permit an appropriate referral to the CSS.
- Appearing at the CSS local office to provide verbal or written information to establish liability when needed and secure medical support for the children in the eligible group. This includes information or documentary evidence that the client knows about, possesses, or could reasonably obtain.
- Appearing as a witness at judicial or other hearings or proceedings.
- Providing information, or attesting to the lack of information, under penalty of perjury.
- Paying to the Department any medical support payments that the client receives after the date of decision.
- Completing and signing documents needed by the state's attorney for any relevant judicial or administrative purpose.

Child Support Services shall make the determination of whether or not the adult member has cooperated.

Special previsions apply to:
- Minors living independently of their parents.
- Pregnant women under the MAC coverage group.

Minors Living Independently of Parents

Legal reference: 441 IAC 75.14(249A)

When a minor and the minor's child are living independently of the minor's parents, the minor must cooperate with Child Support Services (CSS) only on the absent parent of the minor's child. Do not require the minor to cooperate in establishing liability or obtaining medical support from the minor's parents.

However, if the minor is living with an adult who is acting in a parental capacity, request the parent or other caretaker to cooperate with CSS.

1. The households consist of Ms. J; her daughter, Mary, age 17; and Mary's daughter Ann, age 2. This household receives Medicaid under the MAGI-related Medicaid coverage group. The worker requires Mary to cooperate with CSS on Ann's father. The worker also requires Ms. J to cooperate with CSS on Mary's absent father.
2. Mr. J, age 32, receives Medicaid for Larry, his nephew, age 4. The worker requires Mr. J to cooperate with CSS in obtaining medical support from Larry's parents, because Mr. J is acting in a parental capacity.

Pregnant Women Who Are Exempt from Cooperation

Legal reference: 441 IAC 75 (Rules in Process)

Pregnant and postpartum women who are eligible for Medicaid under the Mother and Children (MAC) coverage group do not have to cooperate in establishing liability and obtaining medical support for their Medicaid eligible born children.

Pregnant women eligible under a coverage group other than MAC must cooperate in establishing liability and obtaining support. If the woman fails or refuses to cooperate, cancel eligibility under her current coverage group, complete an automatic redetermination and establish eligibility under MAC.

1. Ms. D, age 32 and pregnant, receives Medicaid for herself and her two children, ages 6 and 8, as a household of four. Ms. D failed to cooperate with CSS. (Ms. D has an active CSS case).

   Ms. D's Medicaid eligibility is automatically redetermined under the MAC coverage group since cooperation is not an eligibility factor under MAC for pregnant women.

   Ms. D is informed that she will be required to cooperate when her postpartum period expires.
2. Ms. B, age 23 and pregnant, receives Medicaid for herself and her two children, ages 2 and 4, under MAC coverage group. Ms. B previously requested CSS services and a referral to CSS was made.

   Ms B has now failed without good cause to cooperate with CSS. The IM worker takes no further action, since no sanction can be applied until the postpartum period expires.

Good Cause for Refusal to Cooperate

Legal reference: 441 IAC 75.14(3) and (9)

Policy: Each applicant and member has the opportunity to claim good cause for refusing to cooperate with the CSS in establishing liability or securing medical support payments.

Procedure: Give applicants and members form **470-0169, Requirements of Support Enforcement**. This form explains the right to claim good cause as an exception to the cooperation requirement, and how to file a claim. Document in the case record that the form was provided.

Issue form **470-0170, Requirements of Claiming Good Cause** whenever the member:

- Asks for a copy, or
- Wants to make a claim of good cause, or.
- Indicates on the application that the member does not want to cooperate with CSS

The member has the burden of proof that good cause circumstances exist. To meet this requirement, the member must:

- Specify the circumstances claimed as good cause for not cooperating.
- Corroborate the good cause circumstances.
- Provide enough information to permit an investigation, when requested.

If an **applicant** claims good cause, do not act on the application until the time frame for providing the evidence has lapsed or until the applicant provides the evidence, whichever is sooner. You have good cause to delay the eligibility determination if the time frame for providing the evidence exceeds the time frame for processing applications.

If the applicant is making efforts but is unable to provide the evidence within the required time frame, continue pending the application until all members are eligible. Or, at the applicant's request, determine eligibility for the immediately eligible members. In the latter case, the date the ineligible person provides the required evidence is the date of application to add that person.

If a **member** claims good cause, continue Medicaid pending receipt of the evidence in the required time frame. If the member fails to provide the needed proof by the due date, cancel the member's Medicaid. See Failure to Cooperate in Obtaining Support.

Once the applicant or member has provided all necessary proof, process the good cause claim. See Making the Decision About Good Cause.

Comment: The following sections give more information on:

- Determining if good cause exists
- Evidence of physical and emotional harm
- Client responsibilities when filing a good cause claim
- Worker responsibilities when a good cause claim is filed
- Making the decision about good cause

Determining if Good Cause Exists

Legal reference: 441 IAC 75 (Rule in Process)

Good cause exists when cooperation in establishing liability and securing support is against the best interest of the child. Cooperation is against the best interests of the child only if one of the following exists:

- The child for whom medical support is sought was conceived as a result of incest or forcible rape.
- Legal adoption proceedings are pending before a court of competent jurisdiction.
- The applicant or member has been working with a public or licensed private social agency less than three months to decide whether to keep the child or relinquish the child for adoption.
- It is reasonably anticipated that cooperation would result in physical or emotional harm to the child for whom medical support is being sought.
- It is reasonably anticipated that cooperation would result in physical or emotional harm to the parent or other caretaker with whom the child is living which reduces the person's capacity to care for the child adequately.

Evidence of Physical and Emotional Harm

Legal reference: 441 IAC 75.14

Physical and emotional harm must be of a serious nature in order to justify a finding of good cause.

A finding of good cause because of emotional harm must be based on a demonstration of an emotional impairment that substantially affects the person's functioning. Consider the following when deciding if good cause exists based on anticipated **emotional** harm:

- The current and past emotional state of the person subject to emotional harm.
- The emotional health history of the person subject to the emotional harm.
- The intensity and probable duration of the emotional impairment.
- The degree of cooperation required.
- The involvement of the child in the liability establishment or medical support enforcement activity to be undertaken.

When a claim is based on the client's anticipation of **physical** harm, and corroborative evidence is not submitted in support of the claim, investigate the claim if you believe that:

- The claim is credible without corroborative evidence.
- Corroborative evidence is not available.
- Grant good cause if the claimant's statement and the investigation which is conducted provide sufficient evidence that the client has good cause for refusing to cooperate.
- Your immediate supervisor must approve or disapprove your decision. Record the findings in the case record.

Client Responsibilities When Filing a Good Cause Claim

Legal reference: 441 IAC 75.14

The client must prove the existence of good cause circumstances. Evidence must be provided within 20 days from the date of the claim. If your supervisor approves, you may allow more time in exceptional cases where the evidence is especially difficult to obtain.

A good cause claim may be supported with the following types of evidence:

- Birth certificates or medical or law enforcement records that indicate the child was conceived as the result of incest or forcible rape.

- Court documents or other records that indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.
- Court, medical, criminal, child protective services, social services, psychological, or law enforcement records that indicate that the putative father or absent parent might inflict physical or emotional harm on the child, parent, or other caretaker.
- Medical records that indicate emotional health history and present emotional health status of the parent or other caretaker or the child for whom support would be sought.
- Written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the parent or other caretaker of the child for whom support would be sought.
- Written statements from a public or licensed private social agency that the member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.
- Sworn statements from persons other than the member or applicant with knowledge of the circumstances that provide the basis for the good cause claim.

Written statements from the client's relatives and friends are not sufficient to grant good cause but may be used to support other evidence provided.

If requested, the member must also provide additional evidence that may be needed, and help with an investigation of good cause. Failure to meet these requirements is sufficient basis for determining that good cause does not exist.

Worker Responsibilities When a Good Cause Claim Is Filed

Legal reference: 441 IAC 75.14

Immediately notify Child Support Services whenever a client files a claim for good cause. Enter all information relating to the claim and determination of good cause into the case record.

When a client asks for help in getting evidence, offer suggestions about how to obtain the necessary documents. Make a reasonable effort to obtain necessary documents that the client has been unable to obtain.

Further investigation of good cause may be necessary if the client's claim and the supporting evidence are not enough to make a decision. Notify the client in writing if additional supporting evidence is needed, and what type of documents are needed.

If you need to contact the putative father or absent parent, notify the client first. The client can choose to:

- Give additional supporting evidence to avoid the need for the contact.
- Withdraw the application or have the case closed.
- Withdraw the good cause claim.

Consult Child Support Services before contacting an absent parent, and document details in the case record. If there is any indication the absent parent may try to harm the child or caretaker either physically or emotionally, be especially careful not to reveal any information about their location.

Confer with the CSS before making a final decision about good cause.

Making the Decision About Good Cause

Legal reference: 441 IAC 75.14

Within 45 days from the date the claim is filed, determine whether or not good cause exists. Determine each good cause claim at the earliest possible date. Do not use the 45-day time frame as a waiting period before determining good cause nor as a basis to deny the good cause claim.

Extend the time frame only if:

- You cannot obtain evidence needed to verify the claim within 45 days, or
- The client cannot provide supporting evidence within the 20-day limit.

Document any time extensions in the case record.

Grant good cause if the claimant's statement and the investigation which is conducted provide sufficient evidence that the client has good cause for refusing to cooperate. Your immediate supervisor must approve or disapprove your decision. Record the findings in the case record.

Notify Child Support Services within two working days after the final decision to deny or grant good cause has been made. Give Child Support Services the opportunity to participate in any appeal hearing.

Notify the client of your final decision in writing. This notification must explain the decision and the basis for the decision.

If the decision is that good cause does **not** exist, give the client the opportunity to cooperate. Notify the client that continued refusal to cooperate will result in the loss of Medicaid for the adult who fails to cooperate.

If the decision is that good cause **does** exist and a referral to CSS is required, consult with the CSS to decide whether medical support enforcement can proceed without risk of harm to the child, parent, or other caretaker if the enforcement activities do not involve their participation. (See 8-B, Referrals to CSS.)

When medical support enforcement activities will proceed without the cooperation of the parent or other caretaker, notify the client in writing.

At least once every six months, review the circumstances that led to the determination of good cause when the circumstances are subject to change.

If circumstances have changed and good cause no longer exists, notify the client in writing that child support enforcement activities will proceed, if a referral is required. Also, notify CSS within two working days of the determination that good cause no longer exists.

Failure to Cooperate in Obtaining Support

Legal reference: 441 IAC 75.14

Deny or cancel Medicaid benefits for an applicant or member whom CSS reports failed to cooperate in obtaining medical support or establishing liability without good cause. Sanction only the parent or other caretaker for failing to cooperate.

If the parent of a child who is receiving SSI or NonMAGI-related Medicaid fails to cooperate and that parent is receiving Medicaid on another case, cancel the parent's Medicaid coverage. If the parent cooperates on or after the effective date of cancelation, the parent will need to reapply.

1. Mrs. M, age 31, is receiving SSI and Medicaid. Without good cause, she fails to cooperate in obtaining medical support for her two children who are receiving Medicaid. Mrs. M's Medicaid is canceled. However, the children continue to receive Medicaid if otherwise eligible.

2. Ms. T receives Medicaid for herself and one child. Ms. T refuses without good cause to cooperate in obtaining medical support for the child. Ms. T's Medicaid is canceled for failure to cooperate. The child continues to be eligible.

If the Sanctioned Parent or Other Caretaker Decides to Cooperate

Legal reference: 441 IAC 76.12(1)"b"

A client who is not receiving Medicaid due to failure to cooperate may be eligible to receive Medicaid when the client indicates a willingness to cooperate. When adding the client back to an existing household, the date the client expresses a willingness to cooperate is the date of application. The parent or other caretaker may contact you or CSS to express willingness to cooperate. Contact with either office establishes the date of application.

NOTE: An application must be filed when the client cannot be added to an existing household.

If the client contacts you to indicate a willingness to cooperate, tell the client to contact CSS. State in writing that the client has ten calendar days to contact and cooperate with CSS. Make it clear to the client that the client cannot receive Medicaid benefits until the client has followed through on the action required by CSS.

Grant an extension if appropriate. If the client fails to cooperate by the due date, deny the application. The client remains ineligible for Medicaid.

Do **not** take action to approve the parent or other caretaker until CSS gives notice that the parent or other caretaker has cooperated. Approve the client's Medicaid beginning with the first day of the month that the client has cooperated with CSS. If the client is otherwise eligible and meets retroactive eligibility criteria as defined in 8-A, Definitions, approve Medicaid up to three months before the date of application.

When the client contacts CSS to indicate a willingness to cooperate, you may not find out that the client has cooperated until CSS notifies you. The notification from CSS will contain the date the client initially contacted CSS and expressed willingness to cooperate. If necessary, contact CSS to confirm the date the client first indicated a willingness to cooperate to determine the correct date of application.

Document details in the case record of any contact with the client or with CSS.

When the parent or other caretaker expresses a willingness to cooperate before the effective date of their loss of Medicaid, notify CSS. When CSS notifies you that the parent or other caretaker has cooperated, reinstate their Medicaid.

When the parent or other caretaker expresses a willingness to cooperate on or after the effective date of losing Medicaid, the earliest effective date they can be added and approved for Medicaid is the first day of the month in which the parent or other caretaker expressed a willingness to cooperate.

NOTE: Refer to NJA0093, Cooperation for the process when Medicaid has been requested and a noncompliance still exists.

1. On December 1, CSS notifies the IM worker that Mrs. A failed to cooperate. On December 3, the IM worker sends **Notice of Decision or Notice of Action** canceling Mrs. A's Medicaid effective January 1.

   On December 10, Mrs. A calls the IM worker and expresses her willingness to cooperate. On December 26, CSS notifies the IM worker that Mrs. A has cooperated. The IM worker reinstates Mrs. A's Medicaid effective January 1.
2. The same as Example 1, except CSS does not notify the IM worker until January 10 that Mrs. A has cooperated. The worker reinstates Mrs. A's Medicaid effective January 1 because she indicated her willingness to cooperate before the effective date of cancellation of her medical assistance.
3. Same as Example 1, except Mrs. A does not contact the IM worker until January 2 to express her intent to cooperate. On January 4, CSS notifies the IM worker that Mrs. A has cooperated. The worker reopens Mrs. A's Medicaid effective January 1.
4. Same as Example 3, except CSS does not notify the IM worker until February 1 that Mrs. A cooperated in January. The worker reopens Mrs. A's Medicaid effective January 1.

Sanctions and Appeals

Legal reference: 42 CFR 431.200, 431.220, and 433.147; 441 IAC 7.5(17A), 75 (Rules in Process), 75.14(249A), 75.21(249A), 76.8(249A), and 80.3(249A)

A sanction is a penalty for not cooperating with the Department. The penalty is the loss of Medicaid eligibility. A person may be sanctioned for failure to cooperate with:

- Child Support Services (CSS)
- Third-Party Liability (TPL) Unit
- Department of Inspections, Appeals, and Licensing (DIAL)
- Quality Control (QC)

When you reinstate or reopen a case that includes a sanctioned person, you will receive a **Notice of Decision or Notice of Action**. If you receive an appeal on this **Notice of Decision or Notice of Action**, you will need to include the following in your appeal summary:

- An explanation of when the sanction was originally issued,
- The original **Notice of Decision or Notice of Action** sanctioning the person, and
- The current **Notice of Decision or Notice of Action** reinstating or reopening the household.

The household has rights to appeal the sanction based only on the original **Notice of Decision** sanctioning the individual. However, the way Medicaid was calculated may be appealed, which is true for all decisions.

If a sanctioned person applies for Medicaid and the sanction has not been cured, the sanctioned person should receive a **Notice of Decision or Notice of Action** that gives the person the right to appeal the sanction.

Residency

Legal reference: 42 CFR 435.403 and 435.956(c), 441 IAC 75.10(249A), Iowa Code Section 249A.3

A person must be a resident of Iowa to be eligible for Iowa Medicaid. In general, a resident of Iowa is a person who is living in the state with the intent to remain permanently or for an indefinite period. However, other rules may apply, based on age, institutional or foster care status, ability to indicate intent, or disability.

How these factors affect residency is explained in this section. See Nonfinancial MAGI-Related Eligibility: Residency, for additional policies specific to MAGI cases.

Accept the person's statement, unless questionable. The person does not need to live in the state for a specified period nor maintain a permanent residence or fixed address. If a person in an institution satisfies the residency rules, eligibility cannot be denied because the person did not establish residency in Iowa before entering the institution.

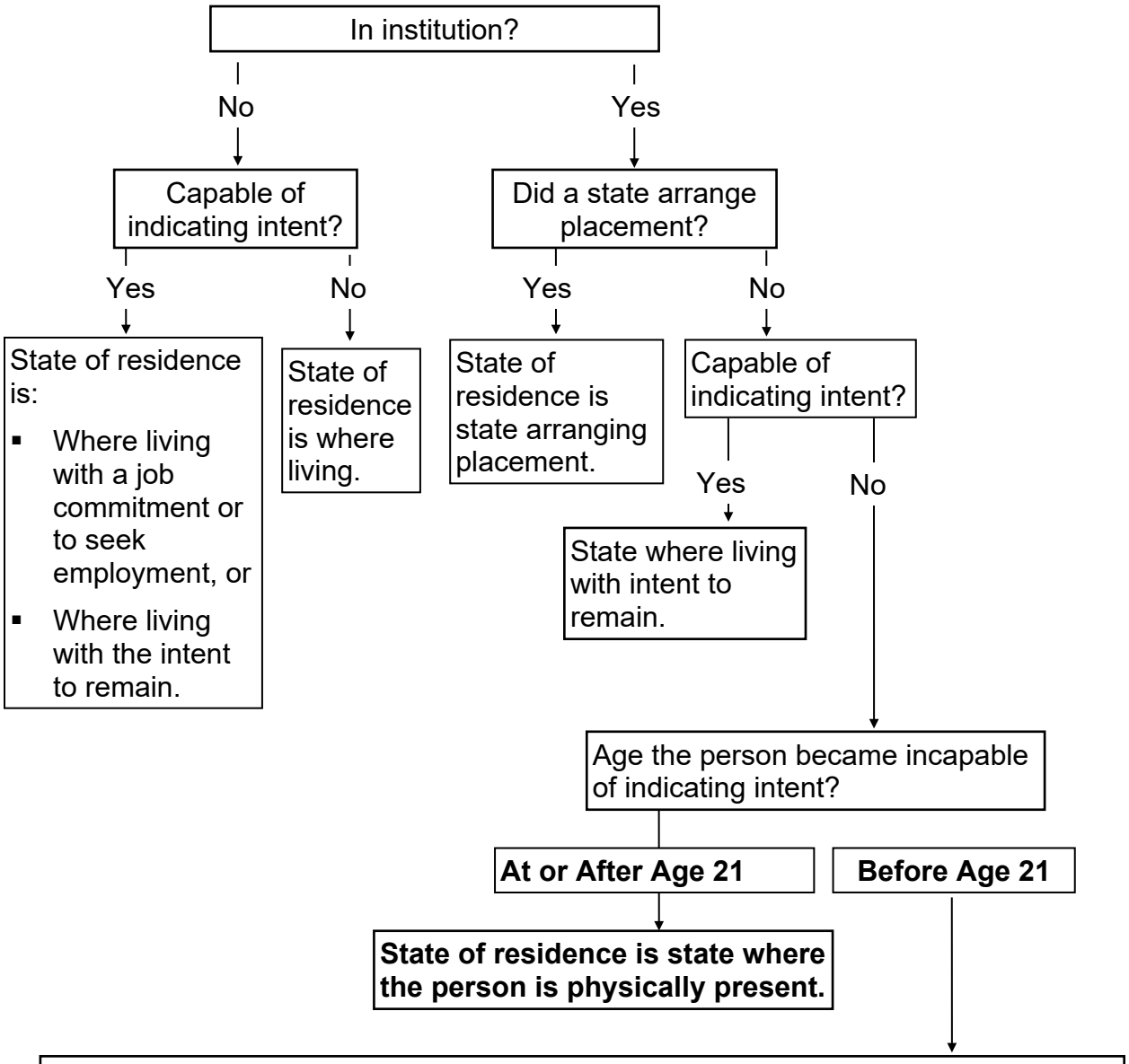
If two or more states cannot resolve a disagreement about which state is a person's state of residence, the state where the person is physically located is the state of residence. Before approval in Iowa, a person receiving care in another state must take all steps available to obtain Medicaid in that state, including appealing any adverse decision.

If the other state has denied an application or canceled benefits and is not currently providing Medicaid because the other state does not consider the person a resident of that state, the person is considered a resident of Iowa.

The discussion of residency policies is organized as follows:

- Two sections on the factors in determining residency for adults (aged 21 or over) and children.
- Four sections that further explain the concepts used in determining residency:
  - Living in Iowa for employment
  - Intent to live in Iowa
  - Incapability of expressing intent
  - State placements
- Two sections that address special situations:
  - Persons in medical institutions outside Iowa who claim Iowa residence
  - Persons receiving Medicaid from another state who move into Iowa

Determining Residency for Persons Aged 21 or Over



The state of residence is:

- Parent's or legal guardian's state of residence at the time of entry into living arrangement, or
- The current state of residence of the parent or legal guardian who files the application, if the person is institutionalized in that state or if the parents reside in separate states.
- The state where the person is institutionalized, if the person has been abandoned by his or her parents and a legal guardian has not been appointed.

Residency policies for persons aged 21 or over depend on whether the person lives in an institution.

Not in an Institution

Legal reference: 441 IAC 75.10(2)

If the person aged 21 or over is not in an institution, determine if the person is capable of expressing intent. (See Incapability of Expressing Intent.)

Capacity	State of Residence
Capable of expressing intent	State where the person is living: ▪ With a job commitment or seeking employment. (See Living in Iowa for Employment Purposes.) ▪ With intent to remain there permanently or indefinitely. (See Intent to Live in Iowa.)
Not capable of expressing intent	State where the person is living (i.e., physically present).

In an Institution

Legal reference: 42 CFR 435.403, 441 IAC 75.10

If the person aged 21 or older is in an institution, find out whether a state arranged placement.

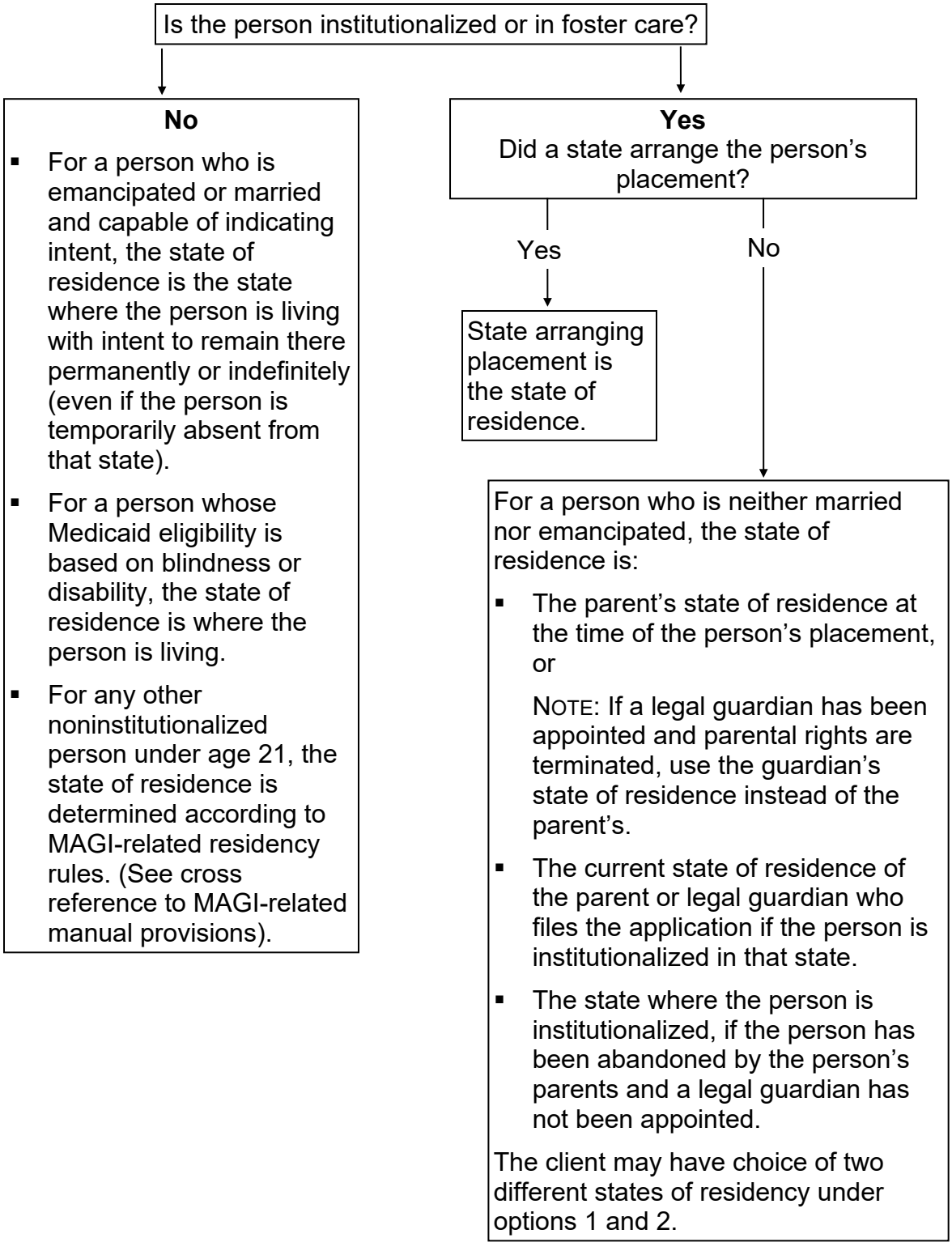
When a state arranged placement, the state of residence is the state making the placement. See State Placement.

When a state did **not** make the arrangement, state of residence is determined by whether the person is capable of expressing intent as explained in the following chart. See Incapability of Expressing Intent.

Capacity	State of Residence
Capable of expressing intent	State where the person is living with intent to remain there permanently or indefinitely. See Intent to Live in Iowa. (If the person was a resident of another state before being institutionalized in a second state, and the person intends to return to the first state, the state of residence is the first state.)
Not capable of expressing intent	▪ If the person was 21 or older when the person became incapable of expressing intent, state where the person is physically present. ▪ If the person was under 21 when the person became incapable of expressing intent: • The parent's or legal guardian's state of residence at the time of placement; or • The current state of residence of the parent or legal guardian who files the application, if the person is institutionalized in that state, or if the parents reside in separate states; or • The state where the person is institutionalized, if the person has been abandoned by the person's parents and a legal guardian has not been appointed.

Unless questionable, accept the statement of the representative regarding the age when the person became incapable of expressing intent.

Determining Residency for Persons Under Age 21



Residency policies for a person who is under aged 21 depend on whether or not the person lives in an institutional or foster care setting.

Not in an Institution or in Foster Care

Legal reference: 441 IAC 75.10(2)

When the person under age 21 is **not** institutionalized and is not in foster care, the state of residence depends upon the person's situation:

- For a person who is emancipated or married and capable of expressing intent, the state of residence is the state where the person is living with intent to remain there permanently or indefinitely. This applies even if the person is temporarily absent from that state.
- For a person whose Medicaid eligibility is based on blindness or disability, the state of residence is where the person is living.
- For children receiving adoption assistance under Title IV-E, the state of residence is the state where the child lives.

  A baby whose adoption is being done by an Iowa adoption agency is not considered an Iowa resident if neither the biological mother nor the adoptive parents are Iowa residents. But if either the biological mother or the adoptive parents are Iowa residents, the baby is an Iowa resident.

  Once adopted, the baby's residency is that of the adoptive parents.
- For any other noninstitutionalized person, use MAGI-related residency rules to determine state of residency. See Nonfinancial MAGI-Related Eligibility: Residency.

In an Institution or in Foster Care

Legal reference: 441 IAC 75.10

When the person under age 21 is institutionalized or in foster care, the state of residency depends upon whether or not a state arranged the placement:

- If a state arranged placement, the state of residency is that state. However, a Title IV-E-eligible child placed out of state by HHS is eligible for Medicaid from the other state. A Title IV-E-eligible child placed in Iowa by another state is eligible for Iowa Medicaid.
- If a state did **not** arrange the placement, the state of residence for an institutionalized person under 21 is:
  - The parent's or legal guardian's state of residence at the time of placement, or

- The current state of residence of the parent or legal guardian who files the application, if the person is institutionalized in that state, or
- The state where the person is institutionalized, if the person has been abandoned by the person's parents and a legal guardian has not been appointed.

NOTE: In the first and second options listed above, if parental rights have been terminated, use the guardian's state of residence instead of the parent's. Also, under the first and second options, the client may have a choice of two different states of residency.

Living in Iowa for Employment Purposes

Legal reference: 42 CFR 435.403, 441 IAC 75.10(2), Iowa Code Section 249A.3

When a person enters Iowa for employment purposes, this fact, in and of itself, qualifies the person as a resident of Iowa for Medicaid eligibility. Entering the state for employment purposes means either having a job commitment or coming to Iowa to seek employment.

> Ms. V moves to Iowa to look for a job. If she can find one in six months, she will stay in Iowa. Her intent is to live for a definite period for the purpose of seeking employment. She is an Iowa resident.

This provision applies even if:

- The person intends to return to another state once employment has ended, or
- The person retains ownership of a homestead in the other state.

A person could be eligible for Medicaid in two states at the same time. This occurs when a person is temporarily absent from a state and remains eligible in that state but is also eligible in another state where the person is living for employment purposes. However, a person cannot receive Medicaid in both states at the same time.

Discuss with the person the pros and cons of eligibility in Iowa as opposed to the other state (i.e., use of Medicaid card between states, coverage provisions, etc.). The person can choose in which state the person would prefer Medicaid eligibility.

Intent to Live in Iowa

Legal reference: 42 CFR 435.403, 441 IAC 75.10(249A)

Generally a person's state of residency is the state where the person is living with intent to remain there permanently or indefinitely. To make a determination of intent, evaluate all facts and circumstances surrounding the person's living arrangement. EXCEPTION: See Living in Iowa for Employment Purposes.

Following is a list of factors to consider:

- Location of personal and real property and intent to return to that property.
- Where the spouse and/or family live.
- Place of employment or business.
- Driver's license and automobile registration.
- Where state and local taxes are paid.
- Membership in unions, fraternal organizations, churches, clubs, and other associations.
- Voter registration and voting practices.
- Placement on waiting lists with medical facilities (for persons who were Iowa residents before entering an out-of-state facility).

Temporary Absence

A person who has been living in Iowa with intent to remain permanently or indefinitely continues to be an Iowa resident while temporarily out of the state if the person intends to:

- Return to Iowa and
- Remain in Iowa permanently or indefinitely.

Incapability of Expressing Intent

Legal reference: 42 CFR 435.403, 441 IAC 75.10(249A)

A person is considered incapable of expressing intent if:

- The person has an IQ of 49 or less or has a mental age of 7 or less, or
- The person has been declared legally incompetent by a court, or

- Medical documentation from a physician, psychologist, or other person licensed by the state in the field of intellectual disability indicates the person is incapable of expressing intent.

1. Ms. V, a 76-year-old woman, comes to Iowa to enter a nursing facility. She intends to return to Wisconsin. She is not an Iowa resident.
2. Mr. C, age 24, was living in Los Angeles when he is involved in a car accident. He remains in a coma. Mr. C is moved to a hospital in Iowa to be close to his parents. Mr. C becomes an Iowa resident. His residency is where he is living, because he became incapable of expressing intent after age 21.
3. Mr. M, a 25-year-old living in an Iowa ICF-MR, was injured at age 15. The court issued an order that he was not competent and appointed a legal guardian. After placing Mr. M in an ICF-MR, his guardian moved to Florida. Mr. M is an Iowa resident because his entry into the living arrangement occurred while his guardian was a resident of Iowa.

State Placement

Legal reference: 42 CFR 435.403, 441 IAC 75.10(249A)

"State placement" is an arrangement by any state agency, including an agency under contract with the state for such purposes, for a person to be placed in an institution in another state.

Providing information to the person or acting on behalf of a person is **not** state placement. Examples of actions that are not considered state placement are:

- Providing information about the availability of services or medical benefits in another state.
- Assisting the person in locating an out-of-state institution.
- Approving Medicaid eligibility for a person in an out-of-state facility.

If the person who is living out of state alleges placement by a state agency, obtain verification from the placing agency.

Generally, if HHS has not been declared the person's legal guardian or does not have some other legal relationship to the person, HHS does not arrange for a person's entry into an institution. Arrangements for a person to enter a facility are generally made by the person entering the facility or by someone acting on the person's behalf, such as a responsible relative or hospital staff.

If there is a question about whether HHS was the placing agency, check whether or not HHS was legally responsible for the person's welfare at the time the person entered the institution. If HHS was not legally responsible, then generally HHS could not be considered to have placed the person.

Eligibility in Out-of-State Medical Institutions

When a person wants Iowa Medicaid to pay for care in an out-of-state facility, the issue of residency must be decided. Under federal Medicaid regulations, when a person in an institution satisfies the residency requirements, no state can deny eligibility on the grounds that the person did not establish residency in the state before entering the institution.

If a person was not an Iowa resident before entering an out-of-state facility, Medicaid eligibility cannot be established until the person actually moves to Iowa, unless:

- The person was placed by Iowa, or
- The person is under 21 and residency must be determined by the residency of the person's parents.

When an Iowa resident enters an out-of-state facility, the person's intent for living out of state must be established:

- If the person expects to remain in that facility permanently or indefinitely, the person is considered to be a resident of the state in which the person is living.
- If the person entered the out-of-state facility with the intent of remaining in that facility but now wants to return to Iowa, the person must return to Iowa before Medicaid can be approved based on residency.
- If the person can establish that the person's intent when the person entered the facility was to return to Iowa, and the person still intends to return to Iowa, the person can be approved for Iowa Medicaid while in the out-of-state facility.

When a person uses the person's own funds or other resources to pay for care in a facility with the intention of living there permanently or for an indefinite period of time, then the person has made a commitment to that facility and it appears to be the person's home. If the facility is out-of-state, then that is considered the state of residence the person chose.

If the person applies for Iowa Medicaid and states a desire to return to Iowa, then the person must establish that the person always intended to return to Iowa, e.g., the person's name may be on a waiting list at an Iowa facility. Residency can also be established by actually returning to Iowa with intent to remain.

One of the main reasons for Iowa residents to seek out-of-state care is the lack of a reasonable alternative in Iowa. See Intent to Return to Iowa From an Out-of-State Facility and Guidelines for Discharge Planners.

Payment for out-of-state skilled care requires prior approval from central office. See Approval for Out-of-State Skilled Care.

When a person is approved for Iowa Medicaid in an out-of-state facility based on an intent to return to Iowa, the local office must periodically verify this intent.

Intent to Return to Iowa from an Out-of-State Facility

Legal reference: 441 IAC 75.10

If a person has a reasonable explanation for entering an out-of-state facility and has the intent to return to Iowa, the person can be approved for Medicaid based on residency. If there is no intent to return to Iowa, cancel the case with timely notice and refer the client to the state in which the client is living to apply for Medicaid.

If no reasonable nursing facility arrangement can be made for a person in Iowa, you can approve payment for an out-of-state facility if the person intends to return to Iowa. A "reasonable" nursing facility arrangement is one that a person who intends to return to Iowa would reasonably be expected to accept. Consider such factors as:

- Level of care.
- Location.
- Participation in Iowa Medicaid.

"Reasonable" does not mean within a certain mile range of an area, but location of available facilities may be a consideration in determining intent to return to Iowa. If a reasonable arrangement can be made in Iowa but the person chooses an out-of-state facility, this raises questions about the person's intent to return to Iowa.

If comparable Iowa facilities would accept the person but do not have a bed immediately available, the person should be put on a waiting list.

Clients do not have to put their names on waiting lists with every available facility and accept the first opening available. To show intent to return, they only have to put their name on waiting lists for the facilities of their choice that will accept them. Payment to the out-of-state facility would be approved until the bed in state becomes available.

Generally, you do not need to check each month with the facility named by the client to see if the facility has an opening for the client. However, if the facility is known to have frequent openings, track those cases and check with the facility monthly if there has been no report from the client.

Failure to go on waiting lists or to accept an opening indicates that the client no longer intends to return to Iowa. The client has chosen the other state as state of residence. Unless failure to comply can be explained, cancel Iowa Medicaid based on residence.

If no comparable Iowa facilities would accept the client, meaning the facility would not put the client on a waiting list, then payment in an out-of-state facility can be made if the client intends to return to Iowa.

Assess the availability of an in-state facility at the next annual review. The client may change intent about returning to Iowa after living in the out-of-state facility for some time. If so, the client loses Iowa residence.

Use “prudent-person” judgment to determine if the client really does intend to return to Iowa when:

- There is no acceptable facility in Iowa, or
- There appears to be a facility in Iowa that is comparable to the out-of-state facility but the client expresses no intent to return to Iowa if an opening occurs there.

To do this, discuss the following with the client or the client’s representative and make a decision about intent:

- Reason for entry into the out-of-state facility.
- A statement of when the client intends to return.
- A statement of under what circumstances the client would return.
- A statement of why any available facilities in Iowa are not acceptable.

Guidelines for Discharge Planners

Advise local hospital social workers not to make any out-of-state placements of Medicaid members if the member wants to continue to receive Iowa Medicaid unless the local office has determined that Iowa Medicaid will pay the out-of-state facility.

For members who want to maintain Iowa residency, the first placement options should be in Iowa. The person's name should immediately be placed on the waiting list for an Iowa facility, so that when the person is ready for discharge from the hospital, the bed may be available.

For short-term placements, the member may choose an out-of-state facility, as long as the member intends to return to Iowa. Review these placements annually for intent to return to Iowa.

For long-term placements, the hospital should try to place the patient where the patient wants to live on a long-term basis immediately from the hospital. A patient who wants to apply and live in another state can be placed in that state.

If it is agreeable to the patient, the patient could be placed in another state until an in-state placement is available. The patient will need to return to Iowa to remain eligible for Iowa Medicaid. Patients and families intending to apply for Medicaid need to be advised of that requirement.

Approval for Out-of-State Skilled Care

Legal reference: 441 IAC 81.20

For fee-for-service, skilled care in an out-of-state facility requires approval from the Iowa Medicaid Enterprise (IME). For individuals under a Managed Care Organization (MCO), the MCO will make the approval. Payment will be approved for out-of-state skilled care when the following criteria are met:

- The facility is eligible to participate in the Iowa Medicaid program.
- The facility has been certified for Medicare and Medicaid participation by the state where it is located.
- The placement is recommended because:
  - Moving the person back to Iowa would endanger the person's health,
  - Services are not readily available in Iowa, or

- The out-of-state placement is cost-effective.

- The placement is temporary until services are available to the resident in Iowa or the program of treatment is completed.

When the type of skilled care needed is available from any skilled facility, out-of-state payment will not be approved if there is a skilled facility in the area that will accept the resident, unless the client can explain why that facility is not acceptable and how the client intends to return to Iowa.

When the out-of-state skilled care is designed for very specialized types of rehabilitation services, the placement may be approved on the basis that no appropriate facility is available in Iowa, if the client intends to return.

When a person is on Medicare, Medicare will pay for 100 days of skilled care. For a Medicare-covered skilled stay, members may go to any Medicare skilled facility they choose. However, if the person wants Medicaid to pay the cost of out-of-state care once the Medicare coverage is exhausted or otherwise wants Medicaid, the person would have to meet residency requirements and a determination of intent must be made.

When a Medicaid-Eligible Person Moves to Iowa

Legal reference: 441 IAC 75.10(2)

Policy: If a Medicaid-eligible person from another state becomes an Iowa resident, grant Iowa Medicaid eligibility beginning with the month of Iowa residency if:

- The person meets all eligibility criteria and
- The person surrenders the other state's medical card, if a card was issued for any months for which the person is requesting Iowa Medicaid.

EXCEPTION: The person does not have to surrender the other state's medical card if the person has good cause not to do so. Good cause exists when:

- The other state does not issue medical cards.
- The other state's medical card is a plastic magnetic strip or a computer chip card that contains more than Medicaid-related information.
- Some Medicaid-eligible members of the person's household in the other state did not move with the person to Iowa, and the card was left with those members.
- The other state's medical card was lost, mutilated, or destroyed.

- The other state's medical card was thrown away because of the person's impending move to Iowa, since the person assumed that the card would not be valid in Iowa.
- The other state's medical card was already surrendered to the other state.

Procedure: The case record must contain:

- A scanned copy of the medical card, or
- A scanned copy of the surrendered card and documentation of its return to the other state, or
- Sufficient documentation to show that the client did or did not have good cause for not surrendering the card.

When the person moves to Iowa in the middle of the month, grant Iowa Medicaid if Iowa eligibility exists in the month when the applicant lived in both states. If the applicant used the other state's card in Iowa before choosing Iowa Medicaid, an Iowa medical card may be issued.

Verify the effective date of cancellation of Medicaid in the other state. Use either the notice of decision or other documents issued by the other states or by a collateral contact with the other state's Medicaid agency.

1. Ms. W and her children move to Iowa on September 13 from Hawaii, where she and her children were eligible for Medicaid. She applies for Medicaid. She cannot find a provider to accept the Hawaiian medical card and surrenders it to the worker. Ms. W and her children are determined Medicaid eligible in Iowa beginning the month of September.
2. Mr. B, an SSI recipient, moves to Iowa from Texas on March 2. He applies for Medicaid in Iowa on March 8 and completes form **470-0364(M), SSI Medicaid Information**.

   The worker calls Texas on March 10 and verifies that Mr. B's case will be canceled effective April 1. When the worker asks for Mr. B's March medical card from Texas, he refuses to surrender it to the worker and when asked why, offers no good cause reason.

   Mr. B is not granted good cause in March for not surrendering the Texas medical card. The worker records this in the case file. If all other eligibility factors are met, Mr. B is determined Medicaid eligible in Iowa beginning the month of April.

3. Mr. and Mrs. A and their child move to Iowa from Missouri in May. They file a Medicaid application on May 20. The A's report their medical card from Missouri for May was lost during their move to Iowa. The worker verifies that the A's Medicaid in Missouri was canceled effective May 31.

   The A's are granted good cause for not surrendering the Missouri medical card and the worker documents this in the case file. If all other eligibility factors are met, the A's are determined Medicaid eligible in Iowa beginning with the month of May.

Residents of Institutions

An "institution" is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more people unrelated to the proprietor. The following sections give policy information on:

- Residents of institutions for mental disease.
- Residents of public nonmedical institution.

For policies applicable to residents of medical institutions, see 8-I, Medical Institutions.

Residents of Institutions for Mental Disease

Legal reference: 42 CFR 435.1009(a)(2), 435.1009(c), 440.160, and 441.151

"Institutions for mental disease" include mental health institutions (MHIs) and psychiatric medical institutions.

A person who is over age 21 and under age 65 is not eligible for Medicaid when the person lives in an institution for mental disease. EXCEPTION: A person who enters a psychiatric medical institution for children before turning age 22 may receive Medicaid through age 22.

When a Medicaid member who is over age 21 and under age 65 enters an institution for mental disease and is expected to remain for more than a calendar month, cancel the person's Medicaid.

EXCEPTION: Medicaid members enrolled with an MCO who are age 21 to 65 and are in an MHI for 15 or fewer days per month are eligible for payment to the MHI through the MCO. In this situation, do not cancel the member when they enter the MHI. Review the member's eligibility and if they continue to be eligible under the same coverage group, leave the case active. The MHI facility worker will need to add the MHI stay to ISIS.

Although a person who is between age 21 and age 65 and is living in an institution for mental disease may qualify for SSI benefits, the person is still categorically ineligible for Medicaid unless the exception listed in this section applies.

Residents of Public Nonmedical Institutions

Legal reference: 20 CFR 416.211, 42 CFR 435.1009-1010; 441 IAC 75.12(249A)

Policy: Federal Medicaid regulations prohibit the use of federal Medicaid funds for people who are inmates of a public, non-medical institution.

A "public institution is one that is the responsibility of a government unit or over which a governmental unit exercises administrative control. It includes, but is not limited to:

- Publicly operated penal institutions,
- Jails,
- Work release centers, or
- Wholly tax-supported care facilities, such as some county residential care facilities

Department of Corrections (DOC) prisons and county jails are public institutions.

EXCEPTION: A publicly operated community residence that serves fewer than 16 residents is not considered a public institution. For example, a county-owned and operated residential care facility that has fewer than 16 beds may be a publicly operated community residence. To be a "publicly operated community residence," the facility:

- Must provide some services beyond food and shelter, such as social services, help with personal living activities, or training in social and life skills.
- Must not be a jail, prison, or other holding facility for people who have been arrested or detained pending charges.
- Must not be located on the grounds of or immediately adjacent to any large institution or multiple-purpose complex.

Procedure: Effective January 1, 2012, members who have been incarcerated for 30 days or more and continue to retain their eligibility status while incarcerated are eligible to have their Medicaid benefits limited to inpatient hospital claims only.

Workers will be notified of members who are incarcerated for more than 30 days via a WISE alert. WISE alerts will also be generated when a member has been released. Medicaid may be reinstated without an application when a member is released from the public institution.

When an individual calls to report their release from incarceration, the worker should follow up to verify the date of release by checking online sources and/or contacting the facility to verify the date of release.

Full Medicaid is not available to individuals considered to be inmates. “Inmates” are people living in a public, non-medical institution regardless of whether they have been convicted or are awaiting trial, release, etc.

The following are considered to be inmates of a public institution, and **are not eligible for full Medicaid**:

- A Department of Corrections (DOC) inmate (regardless of the inmate’s status, i.e., convicted, awaiting trial, etc.).
- An inmate of a jail (regardless of the inmate’s status, i.e., convicted, awaiting trial, etc.).
- Someone who is on work release and living in a halfway house/residential facility.
- Someone who is serving a sentence in a halfway house/residential facility.

If someone is listed as serving a special sentence or you find something questionable, request additional information regarding their individual status. Regardless of the label attached to any particular custody status, an important consideration of whether an individual is an “inmate” is his or her legal ability to exercise personal freedom.

If full Medicaid benefits are paid while an inmate is incarcerated, HHS will seek repayment of the incorrect benefits paid from the member or provider.

In order to get either type of Medicaid, the person must also meet all other eligibility requirements for Medicaid, including, but not limited to:

- Income and asset limits.
- Citizenship and Identity
- Have a medical necessity for the service that is provided (i.e., if in a nursing facility, require the level of care provided by the facility.

An inmate of a public nonmedical institution is not eligible for **NonMAGI-related** Medicaid except as listed under NonMAGI-Related Eligibility Under Levings Rule.

Halfway House

Legal reference: 42 CFR 435.1010

Some people in halfway houses (called "community residential facilities") are serving a prison sentence or have been placed on a work release program. Other people in halfway houses are on probation or parole and are ordered to live in a halfway house as a condition of the probation or parole.

People serving a prison sentence and those who have been placed on a work release program are considered inmates and are not Medicaid-eligible. But people placed on probation or parole who are living in a halfway house are not considered inmates and can be eligible for Medicaid, as long as they meet the other eligibility criteria.

To determine eligibility, you must verify whether the person living in a halfway house is serving a sentence, is on a work release program, or is on probation or parole.

Inpatient Medical Institutions

Legal reference: 42 CFR 435.1010

A "medical institution" is one that:

- Provides medical care
- Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards
- Is authorized under State law to provide medical care; and
- Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

An inmate of a penal institution who is admitted as an inpatient of a medical institution (hospital, nursing facility, juvenile psychiatric facility) that is not on the grounds of the penal institution and is not owned or operated by the penal institution may be eligible for Medicaid. The person must meet the other eligibility criteria before Medicaid can be approved.

An inmate of a penal institution is not eligible for Medicaid when taken to a prison hospital or dispensary or when receiving outpatient care.

1. Ms. M is a disabled person who is serving a prison sentence. She received Medicaid before being incarcerated. She is taken by ambulance to the local, private hospital in a nearby town where she is treated and released, and then returned to prison.

   Ms. M is not eligible for Medicaid for her ambulance trip or treatment at the hospital because she was not admitted as an inpatient.
2. Mr. N is a prison inmate. Mr. N was eligible for Medicaid as a disabled person before being incarcerated. Mr. N is injured and must be treated as an inpatient in the prison hospital for several days. Mr. N is not eligible for Medicaid since he was treated in a hospital operated by the penal institution.
3. Mr. L is active on Medicaid. The worker receives a WISE alert that Mr. L has been incarcerated for more than 30 days. Mr. L's Medicaid is limited to inpatient hospital claims until the worker receives an alert indicating Mr. L's release.

NonMAGI-Related Eligibility Under Levings Rule

Legal reference: AR-88-6(8), 604F.2d 591

For NonMAGI-related groups, an inmate of a public nonmedical institution is **not** eligible for payment of Medicaid services other than inpatient hospital. EXCEPTION: Due to a U.S. District Court ruling, *Levings vs. Califano*, residents of public nonmedical institutions can be eligible for SSI (and therefore also NonMAGI-related Medicaid) if they:

- Live in the institution on a voluntary basis and
- Are paying for the full cost of their care in the institution or will be paying for the full cost if SSI or State Supplementary Assistance is approved.

For the purposes of the Levings exception, assume the person is a voluntary resident unless there is evidence to the contrary. If the person has a legal guardian or court-appointed representative, the person is a voluntary resident if the guardian or representative has the right to remove the person from the institution.

If a court order instructs that a person be placed in a specific institution, the person is not living in the facility voluntarily. However, if a court instructs only that a person be placed in a facility providing a certain type of care (without indicating a specific facility), and the person chooses a public institution, the person's residence in the institution is voluntary, as long as the person retains the right to leave that institution.

A person is paying for "all of the institutional care" if the person pays the facility's usual charges for food, shelter, and other services. The person's payment to the facility must come from personal income or resources or from third-party payments to the institution (e.g., Medicare or private insurance payments).

Payment of all or part of the cost of care by a local government agency (e.g., county governments, state health or welfare agencies) is not considered a third-party payment under this exception.

The Social Security Administration has determined that State Supplementary Assistance payments are considered as personal income. This means that if a person is or will be paying the entire cost of RCF care with a combination of State Supplementary Assistance and other income, this exception applies.

Social Security Number

Legal reference: 42 CFR 435.910, 441 IAC 75 (Rules in Process)

A social security number or proof that an application for a number has been made is required for each person for whom Medicaid is being requested or received. This requirement does not apply to:

- A child in "newborn" status (see 8-F, Newborn Children of Medicaid-Eligible Mothers), or
- An unlawful alien, or
- Any person for whom Medicaid is not being requested or received, such as parents whose children receive Medicaid but who don't receive Medicaid themselves, or
- A person who is not eligible to receive a social security number as determined by the Social Security Administration, or
- A person who does not have a social security number **and** may only be issued a social security number for a valid non-work reason as determined by the Social Security Administration, or

- A person who is a member of a recognized religious sect who conscientiously opposes applying for or using a social security number.

As long as the applicant is cooperating in obtaining a number for a person, the person remains eligible for Medicaid. Cancel or deny Medicaid for clients who do not provide a valid social security number or who do not cooperate in obtaining a social security number.

A person who is not eligible to receive a social security number or a person who may only be issued a social security number for non-work reasons must provide verification from the Social Security Administration.

A person who will not apply for or use a social security number due to religious beliefs must provide verification from the church elder or other officiant that it is against the church doctrine.

The following sections explain:

- How clients can apply for a number
- Acting on an error report

How Clients Can Apply for a Social Security Number

Legal reference: 42 CFR 435.910"e", 441 IAC 75 (Rule in Process)

Assist the client to apply for a social security number as needed. There are several different ways to apply:

- The client can apply directly to the Social Security Administration (SSA).
- You can issue form **SS-5** or **SS-5-SP**, **Application for a Social Security Number Card** to the client to apply for a social security number. Either you or the client can submit the form.

  The Social Security Administration will automatically notify the Department when the number has been assigned, if form **SS-5** or **SS-5-SP** is completed as instructed in 14-G, Enumeration.
- The client can apply for a number for a newborn child at the hospital where the child was born, under the "Enumeration at Birth" project.

  Form **SSA-2853, Information About When You Will Receive Your Baby's Social Security Card**, is available through the hospital. Proof of an application for a social security number is not required for an infant that is born in a hospital and goes home with the mother.

The client must give you one of the following forms that are issued by the Social Security Administration as proof the an application has been made:

- Form **SSA-2853, Information About When You Will Receive Your Baby's Social Security Card**, when application is made through the "Enumeration at Birth" project.
- Form **SSA-5028, Proof of Application**.
- Form **SSA L669, Request for Evidence in Support of an SSN Application - U.S. Born Applicant**.
- Form **SSA L670, Request for Evidence in Support of an SSN Application - Foreign Born Applicant**.

The client must report the social security number to you within ten days of receipt.

If the client does not provide a number within two months, contact the client to determine the cause of the delay. You may also require verification from the Social Security Administration if it appears that the client is not cooperating.

Acting on an Error Report

Legal reference: 441 IAC 75 (Rules in Process)

Social security numbers are verified by the Social Security Administration. When a social security number entered into the system does not match its records, the Social Security Administration will indicate the reason there was not a match.

If you receive notification of an error, check the system and the case record to see if the discrepancy is the number, the name, or the date of birth.

If the social security number was correctly entered into the system but cannot be verified, first check that the name matches what the Social Security Administration has on its records.

If there is not a match, either HHS records or Social Security Administration records must change so that there is a match or the discrepancy is resolved. Issue a written notice to the client to contact the Social Security Administration and resolve the discrepancy.

If the applicant or member must apply for a new social security number, allow the person ten calendar days to provide form **SSA-5028, Proof of Application**. If the form is not provided within ten calendar days or if the person has not requested an extension, the person is ineligible for Medicaid due to failure to provide a valid social security number.

Nonfinancial NonMAGI-Related Eligibility

In addition to the general Medicaid nonfinancial eligibility requirements listed above, applicants for NonMAGI-related Medicaid must also meet the categorical requirements of age, blindness, or disability and are subject to different policies regarding household size (eligible group). These policies are explained in the following sections:

- Household size.
- Presence of age, blindness, or disability.
- Department disability determination process.
- Disability denial.
- Presumptive disability.
- Disability determination on reapplications.

Household Size

Legal reference: 20 CFR 416.1160, 416.1163, 416.1166, and 416.1202; 441 IAC 75 (Rules in Process)

For NonMAGI-related Medicaid purposes, a person is always treated as an individual, unless the person has a spouse who is also an eligible person. In that case, treat the person and the spouse as a couple.

EXCEPTION: For the Medicaid for Employed People with Disabilities (MEPD) coverage group, determine countable income based on "family size." Family size is determined as follows:

- If the disabled person is under age 18 and unmarried, include parents, unmarried siblings under age 18, and children of the person who live with the person.
- If the disabled person is aged 18 or older, or is married, include the person's spouse and any children of the person or of the person's spouse who are living with the person, under age 18, and unmarried.

There may be situations where income is deemed to a NonMAGI-related eligible person from an ineligible spouse or parent. Also, in some instances when deeming from an ineligible spouse, an eligible spouse's income should be compared to the income limits for a couple. See 8-E, Deeming NonMAGI-Related Income.

When a NonMAGI-related person is living with a spouse, consider the resources of the spouse (whether an ineligible or eligible spouse) and compare the couple's total resources to the resource limit for a couple. See 8-D, NonMAGI-Related Resource Limits.

1. Child A is disabled and lives with his parents and a sibling, Child B, who is also disabled. To determine Child A's eligibility, his income and resources are compared to the eligibility limits for an individual (although income and resources from his parents may be deemed to him). Child B is also treated as an individual.
2. Mr. L, who is disabled, lives with Child D, who is also disabled. Mr. L's eligibility is determined by comparing his income and resources to limits for an individual. Child D's eligibility is also determined by comparing his income and resources (including any deemed income or resources) to the limits for an individual.
3. Mr. G, who is disabled, lives with Mrs. G, who is not aged, blind, or disabled (an ineligible spouse). Mr. G's worker determines that deeming from Mrs. G to Mr. G is not applicable. Mr. G's eligibility is determined by comparing his income to the limits for an individual. Mr. G's resource eligibility is determined by comparing both spouses' resources to the resource limit for a couple.

When a married couple who are both eligible for Medicaid separate, continue to treat them as a married couple for the month of separation. Beginning with the month after the month of separation, treat each spouse separately for Medicaid eligibility.

"Separation" means a change in living arrangement that results in the couple no longer living together. This includes one spouse moving to a nursing facility or medical institution.

If a married couple with only one Medicaid-eligible spouse separates for any reason, consider the spouses to be separate for eligibility beginning with the month after the month of separation.

When neither spouse is receiving Medicaid, and the spouses separate before application, treat them as separate individuals for application processing.

> Mr. and Mrs. S live together. Mr. S receives Medicaid as a NonMAGI-related person. In June, he and Mrs. S separate. Mr. S is considered as an individual for July. Only his income and resources are considered. No income or resources owned exclusively by Mrs. S are considered for Mr. S's eligibility for July.

See 8-I, Income and Resources of Married Persons when one or both spouses are in a medical institution.

Presence of Age, Blindness, or Disability

Legal reference: 20 CFR 416.801 and 416.901; 42 CFR 436.540, 436.541; 441 IAC 50.2(1), 50.2(3)"d",75.1(249A), and 75 (Rules in Process); Balanced Budget Act of 1997 (P. L. 105-33)

Policy: To be eligible for Medicaid under a NonMAGI-related coverage group, a person must:

- Be 65 years of age or older, or
- Be blind or disabled based on the criteria used for Supplemental Security Income (SSI).

The criteria for establishing disability for adults (over age 18) are:

- The person must be unable to earn income in the amount of "substantial gainful activity" because of a severe physical or mental impairment.

  EXCEPTION: This requirement does not apply to Medicaid for employed people with disabilities.

- The impairment must be medically documented and must be expected to last continuously for 12 months or result in death.

To be eligible for SSI on the basis of blindness, a person must have central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

The criteria for establishing disability for children (under age 18) are:

- The child must be unable to earn income in the amount of "substantial gainful activity" because of a severe physical or mental impairment.
- The impairment must have a physical or mental disability that results in marked and severe functional limitation and must be expected to last continuously for 12 months or result in death.

Children who were receiving SSI as of August 22, 1996, but lost eligibility due to the change disability criteria made on that date may qualify as disabled if they continue to meet the criteria in effect before the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P. L. 104-193).

When a person is applying on the basis of disability and the existence of a disability cannot be documented through receipt of federal disability benefits, the Department must determine whether the applicant is disabled.

Comment: The Social Security Administration (SSA) determines disability for claimants for SSI and Social Security Disability Insurance (SSDI). SSA makes no distinction between blindness and other disabilities when approving benefits.

The Department has a contract with the Disability Determination Services (DDS) Bureau of the Iowa Department of Education to determine disability using the same criteria as SSA uses to determine eligibility for SSI or SSDI.

Procedure: When the person is applying for benefits on the basis of **age**:

1. Check for verification of age through receipt of federal benefits as follows:

Situation	Action
The applicant is over 65 and has social security income.	Accept the Social Security Administration's verification that the person is age 65 or older.
The applicant claims to be at least 65 and has not applied for social security or SSI.	Refer the person to the Social Security district office to apply for benefits and give the person form **470-0383, Notice Regarding Acceptance of Other Benefits**.

2. If age is verified, process the application.

When the person is applying for benefits on the basis of **blindness or disability**:

1. Make sure the applicant's coverage group requires a disability determination. (Determination of blindness is not necessary if both eyes are missing.)

Groups that **do** require disability determination include:	Groups that **do not** require a disability determination include children under 21 in the 300% group applying for the following HCBS waivers:
▪ Medically Needy (if applying as disabled) ▪ Medicaid for Employed People with Disabilities ▪ Medicaid for Kids with Special Needs ▪ Ill and handicapped waiver ▪ Physical disability waiver ▪ Persons applying for the following HCBS waivers under **NonMAGI-related** eligibility • AIDS/HIV waiver • Brain injury waiver • Children's mental health waiver • Intellectual disabilities waiver	▪ AIDS/HIV waiver ▪ Brain injury waiver ▪ Children's mental health waiver ▪ Intellectual disabilities waiver

2. For all applicants claiming disability, determine whether the presence of disability can be verified through receipt of federal benefits by checking SDX and IEVS. For specific situations, see the following chart:

Situation	Action
The applicant is under 65 and gets SSI.	Verify the disability on the SDX screens in WISE. Electronic Data Sources (EDS) will verify disability in ELIAS.
The applicant is under 65 and gets SSDI.	Verify the disability on the IEVS TPQ2 screen if not verified by EDS.
The applicant is under 65 and gets Social Security survivor benefits.	Verify any disability on the IEVS TPQ2 screen if not verified by EDS. NOTE: A person does not have to be disabled to receive survivor benefits.

Situation	Action
The applicant was canceled from SSDI due to losing disability status because of substantial gainful activity (SGA) but remains eligible for extended Medicare benefits.	The only coverage group the applicant can qualify for is MEPD, which skips the SGA requirement. Request a disability determination by the Bureau of Disability Determination Services.
The applicant qualifies under Railroad Retirement permanent disability benefits.	Send form **470-0461** or **470-0461(S), Authorization for Release of Information** to the Railroad Retirement Board to verify whether the person is getting benefits based on Social Security criteria for disability. Verify the type of RR benefits the person receives. Options include: ▪ Disabled former railroad worker ▪ Disabled adult child ▪ Disabled survivor of a railroad worker who is at least age 50 Consider the person disabled for Medicaid if the benefits are received due to permanent disability.
The applicant has a Railroad Retirement benefit due to temporary inability to work.	Disability must be determined, because this person is not considered disabled according to Social Security requirements.
The applicant receives disability income from the Veterans Affairs Department but does not receive disability benefits from Social Security.	Disability may need to be determined, because this person does not automatically qualify as disabled according to Social Security requirements.

3. If age, blindness, or disability is verified, establish the correct Medicaid coverage group and process the application.
4. If disability is not verified, determine the status of any SSA activity. See When the Department Follows an SSA Disability Determination.

5. If the Department is not required to wait for an SSA disability decision, refer the applicant for a disability determination by the Department. See When the Department Determines Disability.

Comment: For more information on disability requirements and procedures, also see:

- 8-B, Concurrent Medicaid and Social Security Disability Determinations.
- 8-J, Disability Criteria.
- 8-F, People Ineligible for SSI (or SSA): Due to Reevaluation of Childhood Disability.

When the Department Follows an SSA Disability Determination

Legal reference: 20 CFR 416.901-999d

Policy: The Department is required to follow decisions on disability made by the federal Social Security Administration (SSA), with the following exceptions on denials:

- The Department does not rely on an SSDI denial to deny eligibility for Medically Needy. If the client does not meet the eligibility requirements for any other group except for Medically Needy, then the Department must determine disability.
- The Department will determine disability when the client is claiming that a new disabling condition or a worsening of the original condition has occurred after a final SSA denial.

Procedure: Always determine the status of any Social Security Administration activity before processing applications based on disability, regardless of the coverage group for which the person is applying. The SSA status may be:

- Benefits have been approved.
- The person has not applied with SSA for benefits.
- An application for benefits is pending.
- An application for benefits has been denied. (See SSA Disability Denial and Appeal Process for more information.)

When SSA-administered disability benefits have been approved, proceed with the Medicaid eligibility determination.

Use the following chart to determine what action to take based on the SSA status.

Status	Action
Client receives SSI	Determine Medicaid eligibility.
Client has **not** applied for SSI but agrees to file an SSI application within ten days.	Notify both SSA and DDS about the concurrent application with form **470-2631, Notice of Pending Medicaid Application** within 15 working days. Possible DDS responses are: ▪ Have SSA claim and are processing. If so, hold the Medicaid application until the determination has been made. ▪ Have SSA claim and recently completed disability determination. If so, check for an SDX message. ▪ Do not have a claim. If so, check for an SSI denial for reasons other than disability. If the client has not applied or SSA denies the client for reasons other than disability, proceed with a disability determination by the Department. Contact the client to explain that the Department will determine disability.
Client has never applied for SSI and is **not** willing to do so.	Proceed with disability determination by the Department if the client meets all other eligibility requirements.

Status	Action
Client **has** applied for disability benefits. Initial SSA decision is **pending**.	Notify both SSA and DDS about the concurrent application with form **470-2631, Notice of Pending Medicaid Application** within 15 working days. Possible responses are: ▪ Have SSA claim and are processing. If so, hold the Medicaid application until the determination has been made. ▪ Have recently completed a disability determination. If so, check for an SDX. ▪ Do not have a claim. If so, check for an SSI denial for reasons other than disability. If SSA denies the client for reasons other than disability, proceed with a disability determination by the Department. Contact the client to explain that HHS will determine disability.
Client **has** applied for disability benefits. SSA denied disability, but decision is **not** "final."	Deny the Medicaid application based on the SSA denial. Manually issue a **Notice of Action** using the language listed below this chart. Determine if Medicaid eligibility exists under another coverage group. See SSA Disability Denial and Appeal Process.
Client **has** applied for disability benefits. SSA denied disability and decision is "**final**." Client states there is no new disabling condition and the original has **not** worsened	Deny the Medicaid application based on the SSA denial. Manually issue a **Notice of Action** using the language listed below this chart. Determine if Medicaid eligibility exists under another coverage group. See SSA Disability Denial and Appeal Process. EXCEPTION: For an SSDI denial on a Medically Needy applicant, see 8-J, When a Client Has Been Denied Disability Benefits.

Status	Action
Client **has** applied for disability benefits. SSA denied disability within the last 12 months and decision is "**final**." Client states the disabling condition has **worsened** and claims a new 12-month disability period.	Ask the following questions: ▪ Has the SSA refused to reconsider the claim on the worsening of the condition? ▪ Has the client lost eligibility for SSI due to other factors (income, resources, etc.)? If the answer to both questions is "no," deny the Medicaid application based on the SSA decision and refer the client back to SSA. Manually issue a **Notice of Action** using the language listed below this chart. Determine if Medicaid eligibility exists under another coverage group. If the answer to either question is "yes," proceed with a disability determination by the Department if the client is otherwise eligible.
Client **has** applied for disability benefits. SSA denied disability within the last 12 months and decision is "**final**." Client states there is a **new** condition that is expected to last 12 months.	Determine whether the client has a different condition than those considered by SSA. ▪ Request a copy of the denial explanation from the applicant. ▪ Compare the information on the denial explanation to the disability information on the Medicaid application. If there is a new disabling condition, proceed with disability determination by the Department unless the client reapplies at SSA.

Comment:

1. Ms. R applies for Medicaid on August 1. She was denied SSI benefits on June 15 because the SSA determined she was not disabled based on her reported disabilities of arthritis and shortness of breath. Ms. R is not claiming any new disabilities. She says the arthritis has gotten worse.

   This is a change in an existing condition that was considered by SSA. It does not represent a different condition or an addition to the conditions considered by SSA, so the SSI Medicaid application is denied based on the SSA decision. (This is assuming no other conditions apply, such as an SSA refusal to consider the worsening of her condition.)

   The IM worker refers Ms. R back to SSA to determine eligibility for SSI, because Ms. R claims a change in her arthritis (the original condition). If Ms. R were ineligible for SSI because of income or resources, a HHS disability determination would be done instead of referring Mrs. R. back to SSA.

2. Same as Example 1, except that Ms. R also has a broken leg that is expected to heal in six months. The broken leg is an additional condition to the conditions existing at the time of the SSA disability decision. However, since it does not meet the durational requirement of 12 continuous months, the worker denies Medicaid based on the previous SSA decision for SSI.

3. Same as Example 2, except the break is so severe that it is expected to be 16 months before Ms. R will be able to return to work. Because this is a different disabling condition than previously claimed with SSA and it meets the durational requirements of 12 months, the Department will determine disability unless Ms. R refiles a claim with SSA.

Presumptive Disability

Legal reference: 20 CFR 416.931-933, 441 IAC 50.2(1) and 75 (Rules in Process)

Policy: If all other eligibility criteria are met for Medicaid, eligibility for Medicaid begins with the month that a Social Security Administration (SSA) presumptive disability decision is made. Medicaid eligibility continues for up to six months or until a final determination of disability is made, if earlier.

Comment: "Presumptive disability" means a person has a medical condition indicating a high degree of probability that the person is disabled, but available evidence is not sufficient to quickly make a final determination of disability.

Procedure:

1. The SSA determines presumptive disability for SSI benefits and notifies the Department of this determination.
2. Approve the case under SSI Medicaid. Determine eligibility for the retroactive period, as defined in 8-A, Definitions, only **after** the **final** disability determination has been made. Manually issue a **Notice of Action** using the following language:

   > Social Security found _____ to be presumptively eligible for disability. Medicaid is approved **/**/** through **/**/**. You will keep getting Medicaid after this date if Social Security finds you are disabled.
   >
   > Your Medicaid will end if Social Security finds that you are not disabled.
   >
   > EM 8-C Presumptive Disability; 20 CFR 416.931-933, 441 Iowa Admin. Code 50.2(1), 75 (Rules in Process).

3. When SSA makes the final determination that the person is disabled, establish ongoing eligibility for Medicaid benefits under the applicable coverage group.

   If the final decision is that the person was disabled during the retroactive period, as defined in 8-A, Definitions, issue a manual **Notice of Action** identifying:

   - Approval of ongoing eligibility.
   - Months of retroactive eligibility.
   - Any other months of eligibility when presumptive benefits were not received.

4. If SSA determines during the six-month presumptive period that the person is not permanently disabled, or if there is no decision by the end of the six-month period, cancel the case because SSA did not establish permanent disability.

Manually issue a **Notice of Action** using the following language:

> ____ is not blind or disabled. The Social Security Administration denied benefits as you are not disabled at this time.
>
> We are required to follow Social Security's decision. If you are approved for disability benefits at a later date, please tell us within 10 days of the date on your notice from Social Security.
>
> EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75 (Rules in Process)

Determine if Medicaid eligibility exists under another coverage group.

SSA Disability Denial and Appeal Process

Legal reference: 42 CFR 435.541; 441 IAC 50.1(249), 50.2(1), and 75 (Rules in Process)

Policy: The Department is required to deny Medicaid eligibility based on a final Social Security Administration (SSA) decision that an applicant is not disabled. EXCEPTIONS:

- Medically Needy eligibility cannot be denied based on an SSDI (Title II) denial of disability.
- The Department must make a disability determination on medical impairments when the SSA has denied disability benefits because the person is engaging in substantial gainful activity but the person could qualify under Medicaid for Employed People with Disabilities (MEPD).
- The Department will determine disability when the client is claiming that a new disabling condition or a worsening of the original condition has occurred after a final SSA denial.

Comment: There is a specific meaning for a "final" SSA decision. When the SSA determines that a claimant (applicant) is not disabled, the person may appeal the decision. There are four levels to the SSA appeal process:

Appeal Level	Process
1. Initial determination	The claimant has 65 days from the date the SSA denial is issued to request a reconsideration of the disability determination.
2. Reconsideration	The claimant has 65 days from the date the SSA reconsideration is issued to request an appeal hearing with a SSA administrative law judge (ALJ).
3. Decision by an SSA ALJ	The claimant has 65 days from the date the SSA appeal denial is issued to request a review by the SSA Appeals Council. In some cases the ALJ may not issue a decision, but instead may recommend a decision and send it on to the Appeals Council. Recommended decisions are not considered a new SSI decision for Medicaid purposes until acted on by the Appeals Council.
4. Review by the Appeals Council	The Appeals Council hears cases sent in by the ALJ or upon the request of a claimant. The Appeals Council decides if a request for hearing before the Council will be granted. The Appeals Council can, on its own, take a case from an ALJ before a hearing is conducted. If the Appeals Council denies the request for review, the decision of the ALJ becomes final. A decision on disability by the Appeals Council is the final decision for SSA.

Disability may be denied or approved at any level. The claimant may stop the appeal at any level if the claimant does not want benefits from SSA. A "final" decision is reached when either:

- The person has gone through the full SSA appeal process, been denied at all levels, and cannot go further in the SSA system.
- A denial was made at any level of the SSA appeal process and the person did not appeal to the next level within 65 calendar days.

Procedure: Use the following procedures when the SSA has made a disability denial:

Status	Action
SSA decision is not final.	Deny the Medicaid application issuing a manual **Notice of Action** using the language listed in the following chart. Determine if Medicaid eligibility exists under another coverage group.
SSA decision on SSDI is final but the applicant could be eligible for **Medically Needy** coverage	Proceed with Department disability determination. See When the Department Determines Disability.
SSA final decision denies disability based on substantial gainful activity but the applicant could be eligible for **MEPD** coverage	Check for SDX payment status code N44. Proceed with Department disability determination. See When the Department Determines Disability.
SSA decision is final. The original condition has **not** worsened and client does not claim a new 12-month period of disability	Deny the Medicaid application issuing a manual **Notice of Action** using the language listed in the following chart. Determine if Medicaid eligibility exists under another coverage group.
SSA decision is final. Client claims a **new** disabling condition that will last at least 12 months.	Determine whether the client has a different condition than those considered by SSA. ▪ Request a copy of the denial explanation from the applicant. ▪ Compare the information on the denial explanation to the disability information on the Medicaid application. If there is a new disabling condition, proceed with a disability determination by the Department unless the client reapplies at SSA.

Status	Action
SSA decision has been final for at least 12 months. Client claims a change or deterioration in the disability that is expected to last 12 months.	Proceed with a Department disability determination unless the client reapplies with SSA. See When the Department Determines Disability.

_____ is not blind or disabled. The Social Security Administration denied benefits as you are not disabled at this time.

We are required to follow Social Security's decision. If you are approved for disability benefits at a later date, please tell us within 10 days of the date on your notice from Social Security.

EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75 (Rules in Process)

Status	Action
SSA decision is final within the last 12 months. Client claims a change or deterioration in the disability that is expected to last 12 months.	Ask the following questions: ▪ Has the SSA refused to reconsider the claim on the worsening of the condition? ▪ Has the client lost eligibility for SSI due to other factors (income, resources, etc.)? If the answer to both questions is "no," deny the Medicaid application based on the SSA decision and refer the client back to SSA. Determine is Medicaid eligibility exists under another coverage group. If the answer to either question is "yes," proceed with a disability determination by the Department if the client is otherwise eligible.

Comment: The only payment status code on the SDX that means disability was denied due to substantial gainful activity is N44.

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.

When SSA Denies Disability After Disability Approval By DDS or SSA

Legal reference: 441 IAC 75 (Rules in Process)

Policy: A member may have been approved for Medicaid or State Supplementary Assistance based on the Department's or the Social Security Administration's (SSA's) determination of disability but at a later date the Social Security Administration (SSA) makes a determination the person is not disabled. The Department is required to follow the final SSA decision.

Comment: Since the SSA allows 65 calendar days to file an appeal, an SSA decision cannot be considered final until the 65 day appeal period has expired. It is important to understand the difference between an SSA decision that is final and one that is not final, because they affect Medicaid eligibility differently.

Procedure: Use the procedures in the following chart for the correct action at each step in the decision process when the SSA denies disability for a Medicaid member who has been determined to be disabled by DDS or SSA:

Status	Action
HHS receives notification that SSA has denied disability for a person who was approved based on a DDS or SSA disability decision.	1. Continue Medicaid or State Supplementary Assistance for 65 days from the date of the SSA denial. 2. Set a reminder to track the 65 days. 3. On the 66th day, check to see if an SSA appeal has been filed.

Status	Action
If the member has **not** filed an appeal with SSA by the end of the 65 days, the SSA decision is a **final decision**.	Cancel benefits with timely notice using a manual **Notice of Action** with the language listed below.
If the member appeals the denial within 65 days, the SSA decision is not a final decision.	Continue benefits until there is a final decision from SSA. This could be either: ▪ A decision issued at the Social Security Appeals Council level; or ▪ The most recent decision that the member does not pursue to the next appeal level by the end of 65 days.

To cancel the Medicaid case, use the language below.

> The Social Security Administration has determined that ____ is no longer disabled.
>
> EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75 (Rules in Process)

See also:

- Reapplying After Cancellation for a Nondisability Reason
- SSA Disability Denial and Appeal Process
- 8-F, People Ineligible for SSI (or SSA): Due to Reevaluation of Childhood Disability

Mr. C is determined eligible for Medicaid in November based on the Department's disability determination. In April of the following year, Mr. C applies for SSI but on June 5, he is denied SSI as not disabled.

The worker continues Mr. C's Medicaid eligibility for 65 days until the time to appeal has expired (August 8). As of August 8, Mr. C has not filed an appeal. On August 9, the worker issues a timely notice canceling Medicaid benefits for Mr. C effective September 1 and determines if Mr C would be Medicaid eligible under another coverage group.

When the Department Determines Disability

Legal reference: 20 CFR 416.901, 416.971, 416.972, 416.973; 441 IAC 75 (Rules in Process)

Policy: The Department must determine an applicant's disability when the applicant:

- Is applying for a coverage group that requires a determination of disability according to Social security Administration (SSA) standards, and
- Has not been approved for disability through an SSA disability determination.

The Department must make a determination on disability within 90 calendar days of the date of application. The time can exceed 90 calendar days if:

- The applicant or examining physician causes a delay, or
- There is an emergency beyond the control of the Department or the applicant.

Procedure: The Department's process for determining disability is a **shared responsibility** of the IM worker and Disability Determination Services (DDS).

NOTE: When the applicant has also applied for disability benefits from the SSA, wait on the SSA disability decision unless the applicant is eligible for only Medically Needy and the SSA is looking at SSDI (Title II) eligibility only.

When the Department must determine disability, first decide if the person performs substantial gainful activity. EXCEPTION: Skip this step when determining eligibility under Medicaid for Employed People with Disabilities (MEPD).

Make this decision within 15 calendar days of the application date. See Substantial Gainful Activity for an Employee and Substantial Gainful Activity for a Self-Employed Person for instructions.

If the person **is not** engaged in substantial gainful activity (except for MEPD), send the medical evidence to the DDS. Do this no later than 15 calendar days from the application date. (See Submitting Medical Evidence to DDS.)

Follow the steps listed below when an HHS determination is required.

Step 1: IM worker determines if the client engages in substantial gainful activity (SGA). Clients whose current earnings are at or higher than the SGA level are earning too much to meet disability requirements.

Determination:

- **Yes**, the client engages in SGA.

  Deny disability. Determine if Medicaid eligibility exists under another coverage group.

- **No**, the client does not engage in SGA

  Go to step 2.

Step 2: DDS evaluates the client's medical impairments and compares them to a list of qualifying impairments published in federal regulations.

Determination:

- **Yes**, impairment is listed.

  Go to step 3.

- **No**, severe impairments

  Deny Medicaid as not disabled. Determine if Medicaid eligibility exists under another coverage group.

Step 3: DDS staff determines whether the client has an impairment of a severity that meets or equals the severity of impairments listed in the federal regulations.

Determination:

- **Yes**, impairment meets severity

  Go to step 4.

- **No**, impairment does not meet severity

  Deny Medicaid as not disabled. Determine if Medicaid eligibility exists under another coverage group.

Step 4: DDS staff determines whether the client has the ability to perform past work activities.

Determination:

- **Yes,** the client can do past work

  Deny Medicaid as not disabled. Determine if Medicaid eligibility exists under another coverage group.

- **No,** the client cannot perform past work

  Go to step 5.

Step 5: DDS staff determines whether the client is able to perform other work activities at the SGA level.

Determination:

- **Yes,** the client can do other work

  Deny Medicaid as not disabled. Determine if Medicaid eligibility exists under another coverage group.

- **No,** the client cannot perform other work activities

  Approve Medicaid based on disability if client meets all other eligibility requirements

Mr. J, age 50, applies for Medicaid on the basis that he is disabled. Mr. J's countable resources are over $2,000, he is single, he has no dependent children, and he is not employed. The worker determines that Mr. J may be eligible only for the Medically Needy coverage group based upon disability.

Mr. J provides proof that he has applied for SSDI and that disability was denied by the SSA four months earlier. The worker initiates a disability determination because the Department cannot rely on an SSA denial of disability for Medically Needy applicants.

The following sections give further instructions on:

- Determining substantial gainful activity for an employee
- Determining substantial gainful activity for a self-employed person
- Submitting medical evidence to DDS

Substantial Gainful Activity for an Employee

Legal reference: 20 CFR 416.974, Program Operations Manual System POMS 10505.020, 441 IAC 75 (Rules in Process)

The first test of disability determination is evaluation of "substantial gainful activity" (SGA). SGA means the performance of "significant" physical or mental activities in work for substantial pay or profit.

- "Significant physical or mental activities" are useful in a job or business and have economic value. Self-care, household tasks, unpaid training, therapy, school attendance, clubs, and social programs **are not** considered SGA.
- Work may pay either in cash or in kind.
- The current earnings threshold for determining "substantial" activity is $1,620.

A person who is engaged in SGA despite physical or mental limitations is not disabled (unless the person would qualify under MEPD).

Comment: There is no SGA if the person's former job made many job accommodations or the person became more incapacitated and cannot find another similar job. Loss of work detrimental to health does not result in SGA.

There may be SGA if the person worked for longer than six months despite the impairment, lost the job, and applied for Medicaid in the same month. If there is reasonable doubt, do not consider the person engaged in SGA.

Procedure: To determine SGA for an employed person, calculate the person's countable income by averaging gross income over the time the income was earned after the disability occurred. EXCEPTION: Do not consider the earned income limits under SGA for eligibility under the Medicaid for Employed People with Disabilities (MEPD) coverage group.

Use the following procedure to determine if an employed client's countable monthly income demonstrates SGA:

Step	Action
Determine average monthly earnings.	Count earnings from employment and self-employment. Determine seasonal income by averaging income over the season to arrive at a monthly countable income. See 8-E, Income Policies for NonMAGI-Related Coverage Groups.
Determine excluded earnings.	Do not count: ▪ Earnings of volunteers under the Small Business and Domestic Volunteer Acts. ▪ Employer subsidies to an impaired person that are not earned through the person's productivity. Ask the employer to determine the subsidy. If the employer cannot calculate the subsidy, compare the work to similar work of an unimpaired person, and the value of that work by the prevailing wage scale.
Determine deductions.	Deduct work expenses related to the person's disability. See 8-E, Deduction for Impairment-Related Work Expenses.
Compare remainder to $1,620 per month.	When the countable earnings exceed $1,620 per month, the applicant does not meet the first requirement of being disabled under SSA standards. Deny Medicaid as not disabled. See When the Department Denies Disability. When the countable earnings are less than $1,620 per month, complete a disability determination, as the client is not engaged in SGA. When countable earnings are less than $1,620 per month and there is evidence that an individual may be engaging in SGA, or appears to be in a position to defer compensation, or by special arrangement, is able to suppress earnings, proceed to the next tests.
Do the Compar-ability Test.	Compare the client's work to that of unimpaired people in the area. Look at time, energy, skills, and responsibility. If the work is the same as that done by unimpaired people, the client has SGA and is not disabled.

Step	Action
Do the Worth Test.	Determine if the client's work activity is worth more than $1,620 per month. If so, the client is engaging in SGA, even if the client's work activity is not comparable to that of an unimpaired person. The value of work in the military must be compared to similar work in a nonmilitary setting. Military wages may continue and the client may be placed on limited duty. Ask your area income maintenance administrator or the HHS SPIRS Help Desk to contact Medicaid Policy to determine the actual value of the work.

Mrs. P applies for Medicaid based on disability. She states that her disability is fibromyalgia. The worker evaluates Mrs. P's employment status for SGA.

Mrs. P continues to work at the same job with the same duties (meeting the Comparability Test), but her medical condition has caused her to reduce her work schedule from 40 hours per week to 20 hours per week, which has cut her earnings in half (the Worth Test). Her hourly wage is $21 per hour. Her average monthly pay is $1,806.

The worker determines that Mrs. P does not meet the SGA test for disability for most Medicaid coverage groups because she continues to do the same work and her earnings were over $1,620.

However, because Mrs. P is still employed, she appears to be eligible for MEPD. The worker makes a referral to DDS for a disability determination; noting on the **Disability Transmittal** to skip the step of determining SGA.

Substantial Gainful Activity for a Self-Employed Person

Legal reference: 20 CFR 416.975, 441 IAC 75 (Rules in Process)

Policy: There are three tests for "substantial gainful activity" (SGA) for a self-employed person. If the person does not meet the criteria in **all three** tests, the person is **not** engaged in SGA, and a HHS disability determination must be done.

Name of Test:	What this means:
1. Significant services **and** substantial income a. Significant services	This test is met if significant services are **combined with** substantial income. When a person (with the exception of a farm landlord who rents farmland to another farmer) gives significant services by participating in the following: ▪ Gets a social security earnings credit on the federal income tax return. ▪ Advises or consults with the renter and inspects production periodically. ▪ Furnishes a large portion of the machinery and financing.
b. Substantial income	When a person has: ▪ Countable income over $1,620 per month. ▪ Countable income that meets the community standard of livelihood for a self-employed person with a similar business.
2. Comparability of work	If work activities are comparable to that of an unimpaired person in the community engaged in the same or similar business, the person is engaged in SGA.
3. Work activity	If the value of the work is more than $1,620 per month based on the amount an employer would pay any employee to do the same job, the person engages in SGA.

Procedure: To determine SGA for a self-employed person, consider the three tests in order, as explained in the following chart. EXCEPTION: Do not determine SGA for the Medicaid for Employed People with Disabilities (MEPD) group.

If the earnings are comparable to unimpaired people in the community in the same business, there is substantial income and the person engages in SGA.

If there is “material participation” and “substantial income,” this means there is SGA, unless material participation has been reduced or has stopped. Determine if the significant services are the same at the time of application as before the person’s impairment.

If the self-employment was less than six months and has stopped, or the income level indicating substantial gainful activity continued for less than six months, there is no SGA.

If there is reasonable doubt whether the person meets SGA, assume the person does not meet SGA criteria.

Test 1: Significant Services and Substantial Income

1. Use only the income of the person’s productivity, not the productivity of the person’s agent (employee or assistant).
2. Subtract any business expenses from the gross self-employment income. Also subtract:
   - Unpaid help by a spouse, children, or others.
   - Soil bank income if included in farm income from the tax return.
   - Impairment-related expenses if not deducted as a business expense.
   - Business expense paid for by a third party, such as business rent paid by Vocational Rehabilitation or space furnished by a third party.
3. Determine if the income is the same as before the onset of disability. To determine if the onset of disability affected the person’s ability to engage in SGA, use the income of at least the last five years. If the person’s income is the same as before the onset of disability, there is substantial income and the person engages in SGA.
4. If the person’s income is not the same as before the onset of disability, then determine if the earnings are comparable to unimpaired people in the community in the same business. (For farming, add in the value of produce grown for home consumption.)

Test 2: Comparability of Work
Evaluate work activity using: ▪ Hours worked ▪ Skills ▪ Energy output ▪ Efficiency ▪ Duties ▪ Job responsibilities
Test 3: Work Activity
Evaluate by determining countable income: ▪ A person who earns more than $1,620 per month meets the criteria for engaging in SGA, which results in not being considered disabled. ▪ See the procedures for Substantial Gainful Activity for an Employee.

Comment:

Mr. Q applies for Medically Needy on the basis of disability. His wife is employed and her earnings put their joint income higher than the MEPD income limit of 250% of the federal poverty level.

Mr. Q explains that he is not able to work full time because of his heart condition, but he has a self-employment business building bookcases, which averages $600 per month net income after business expenses are deducted. He pays his adult son $50 per month to deliver the lumber to his home workshop and to deliver the finished bookcases.

The worker evaluates Mr. Q's self-employment for SGA by applying the three tests in order:

Test 1. Significant services **and** substantial income:

- Mr. Q is not able to do all the work for his business himself.
- Mr. Q earns less than $1,620 per month.
- Mr. Q's income has dropped significantly from his previous full-time earnings.
- There is no one else in the local community who builds custom bookcases, so the worker cannot compare Mr. Q's income to the same type of work done by others.

Test 2. Comparability of work:

- Mr. Q formerly worked at least 40 hours per week and often more due to overtime assignments.
- Mr. Q currently has to take frequent rest breaks as he tires easily due to the heart condition. He works an average of ten hours per week.

Test 3. Work activity: Mr. Q earns less than $1,620 per month.

The worker determines that Mr. Q does not engage in SGA, so he is referred for a Department disability determination.

Submitting Medical Evidence to DDS

Legal reference: 441 IAC 75 (Rules in Process)

Policy: If the applicant does not meet the requirements for substantial gainful activity, then the Department must make a referral to the Bureau of Disability Determination Services (DDS) for a disability determination.

Comment: DDS may request additional information from the applicant and may require the applicant to have a medical examination. DDS pays for medical information and transportation.

Procedure: Use the **Disability Determination Checklist, RC-0103** as a guide.

Submit to DDS:	Explanation:
Form **470-2465, Disability Report for Adults** or Form **470-3912, Disability Report for Children** (under 18)	The applicant or the applicant's representative completes the form, which includes a release of information. Check the report to make sure the correct person signed the form, as follows: ▪ If the release is for mental health information, only an applicant 18 years of age or older or a legal representative can sign the form. ▪ If the release is for substance abuse information, only the applicant can sign the form, regardless of age.

Submit to DDS:	Explanation:
Form **470-2472, Disability Transmittal**	This form contains case-related information that helps DDS determine disability. For an MEPD applicant, check the status, "MEPD – SGA not considered" in first step of disability determination.
Form **470-4459** or **470-4459(S) Authorization to Disclose Information to the Iowa Department of Human Services**	The release allows DDS to contact sources to get the information needed to determine disability. Send a signed release for each source listed on the applicable **Disability Report** and the additional sources of information for children. This includes releases for any doctors who provide care in a hospital.
Additional records, if available:	This could include: ▪ Supplemental vocational information. ▪ Any information from the Social Security Administration. ▪ Copies of medical reports or letters from a provider about the applicant's medical condition from the last 12 months. ▪ For an adult applicant, evidence about work activity, even if the work done was not SGA. ▪ For a child applicant: • School information • Any work history • Any involvement with vocational rehabilitation or other social services

Submit to DDS:	Explanation:
Records about a deceased applicant	Send either: ▪ Medical records including a note certifying the cause and date of death signed by a medical practitioner, or ▪ A death certificate. (When a person dies at home and has no history of medical treatment for the cause of death, a death certificate is required.)

If an applicant moves before a disability determination is completed, provide the new address to DDS by entering it on a copy of the **Disability Transmittal, form 470-2472**, and sending the form to DDS.

If HHS denies a Medicaid application for nondisability reasons (over resources, no longer a resident, etc.) after a disability determination has been sent to DDS, notify DDS to stop the disability determination by using **Disability Transmittal, form 470-2472**.

Disability Approved by DDS

Legal reference: 441 IAC 50.1(249) and 75 (Rules in Process)

Policy: Disability Determination Services (DDS) makes the disability determination decision on behalf of the Department.

Comment: DDS must make a determination on disability within 75 calendar days of the referral from HHS. If DDS cannot complete the disability determination within 75 calendar days, DDS will notify the local office of the delay.

DDS issues the disability decision on form **470-2472, Disability Transmittal** which is returned to the IM worker along with the entire disability file. The finding that the applicant is disabled is entered in Part II, Item 1 on the form.

Procedure: When DDS determines the person is disabled, and all other eligibility requirements are met, approve the Medicaid case.

HHS Responsibility for Disability Review and Redetermination

Legal reference: 42 CFR 435.541, 441 IAC 75 (Rules in Process), P. L. 104-193; P. L. 105-33

Policy: When a member who is eligible for Medicaid because of disability is not receiving disability benefits through the Social Security Administration (SSA), the Department is responsible for:

- Conducting reviews of the disability if required, and
- Redetermining disability when the member reaches the age of 18.

Comment: When disability is established, a date for review of the disability may be established to determine if the person continues to meet the disability or blindness requirements. Redetermination is required when a disabled child turns 18, since disability must then be determined using adult criteria. This is a separate process from a disability review.

Procedure: No action is required when SSA is responsible for reviews unless SSA finds that the member is no longer disabled.

Member Status	Responsibility for Disability Review
Receiving SSI or SSDI cash benefits	The SSA processes the disability reviews.
Not receiving SSI or SSDI cash benefits	The income maintenance worker must schedule the disability review and initiate the review with Bureau of Disability Determination Services (DDS).

For detailed procedures when the Department is responsible, see the following sections:

- Disability Reviews
- Redetermination at Age 18

Disability Reviews

Legal reference: 42 CFR 435.541, 441 IAC 75 (Rules in Process), P. L. 104-193; P. L. 105-33

Policy: A review may be required to verify that the member continues to meet disability requirements.

Comment: DDS lists the review date in the "Diary Date" box on form 470-2472, Disability Transmittal. Diary dates are by month, year, and "reason," which is the number of years until the next review.

If disability was gained through an appeal of the Department's denial of medical assistance, a review date may be established in the final decision issued on the appeal. If the review date is not given on the final decision, contact the HHS SPIRS Help Desk.

The Social Security Administration (SSA) sends review dates to the states for children who were canceled from SSI due to the revised disability criteria under Public Law 104-193 but receive Medicaid due to the provisions of the Balanced Budget Act of 1997.

The Department's central office sends individual notices regarding review dates for children canceled due to revised disability criteria. Do not contact SSA for review dates for children in this coverage group.

Procedure: When the Department is required to complete a disability review, send a request for a disability review to DDS. Schedule the disability review at the Medicaid eligibility review date closest to the review date scheduled by:

- DDS for determinations made on behalf of the Department, or
- The SSA for a child qualified under previous disability criteria, or
- The administrative law judge in an appeal of the disability determination.

Use **RC-0103, Disability Determination Checklist**, as a guide to making the review referral to DDS. Include the following documents in a disability review referral:

Document:	Preparation:
A new form **470-2472, Disability Transmittal**	Notify DDS of the need for special review requirements by writing in the "Comment" section of the form: ▪ For MEPD disregard SGA, or ▪ For a child under the standards in effect before enactment of P. L. 104-193.

Document:	Preparation:
The previous form **470-2463, Explanation of Disability Determination**, or the Personalized Disability Explanation issued by DDS.	If this form is not available, note on the Disability Transmittal the reason it is not included.
Proposed Decision and Final Decision	If disability was approved through an appeal of a Medicaid denial, include a copy of the proposed and final appeal decisions.
A new form **470-2465, Disability Report for Adults**, or form **470-3912, Disability Report for Children** if the member is under age 18	Request a new report from the client or the person acting on the client's behalf. Check the report for completeness. Since the form includes a release of information, verify that the correct person signed it: ▪ If the disability is related to mental health, only a client 18 years of age or older or a legal representative can sign the form. ▪ If the disability is related to substance abuse, only the client can sign the form, regardless of age.
New copies of form **470-4459** or **470-4459(S), Authorization to Disclose Information to the Iowa Department of Human Services**	Send a signed release to allow DDS to get information from each source listed on the **Disability Report** and the additional sources of information for children. This includes releases for any doctors who provide care in a hospital.
A complete copy of the previous disability file.	If HHS does not have a copy of the previous disability file because the SSA made the previous disability determination decision, note on the **Disability Transmittal** the reason the file is not attached.

If DDS notifies you that the member no longer meets disability requirements, follow the procedure under When the Department Denies Disability to cancel the Medicaid case.

Redetermination at Age 18

Legal reference: 20 CFR 416.987, 441 IAC 75 (Rules in Process)

Policy: The Department must request a redetermination of disability based on adult criteria when a child reaches the age of 18 **unless** the child is receiving SSI.

If the child is found no longer disabled based on a redetermination using adult criteria, cancel medical assistance based on denial of disability no sooner than the month after the child's eighteenth birthday.

Procedure: For a disability redetermination, send the following information to DDS no earlier than 30 days before the child's 18th birthday:

Document:	Preparation:
A completed form **470-2472, Disability Transmittal**	Note that the SGA step should be skipped, if the redetermination is for the MEPD group.
The previous form **470-2463, Explanation of Disability Determination** or the Personalized Disability Explanation issued by DDS.	If this form is not available, note on the **Disability Transmittal** the reason it is not included.

Document:	Preparation:
A completed form **470-2465, Disability Report for Adults**	Request the report from the client or the person acting on the client's behalf. Check the report for completeness. Since the form includes a release of information, verify that the correct person signed it: ▪ If the disability is related to mental health, only a client 18 years of age or older or a legal representative can sign the form. ▪ If the disability is related to substance abuse, only the client can sign the form, regardless of age.
New copies of form **470-4459** or **470-4459(S), Authorization to Disclose Information to the Iowa Department of Human Services**	Send a signed release to allow DDS to get information from each source listed on the Disability Report and the additional sources of information for children. This includes releases for any doctors who provide care in a hospital.
A complete copy of the previous disability file	If HHS does not have a copy of the previous disability file, note on the Disability Transmittal the reason the file is not attached (such as, the SSA made the previous decision and the file is not available to HHS).

If DDS notifies you that the 18-year-old no longer meets disability requirements, follow the procedure under When the Department Denies Disability to cancel the Medicaid case.

Denial of Medicaid Based on Disability Denial

Legal reference: 441 IAC 75 (Rules in Process)

Policy: NonMAGI-related Medicaid eligibility can be denied based on a disability determination decision made:

- By the Social Security Administration (SSA). or
- By the Bureau of Disability Determination Services (DDS) on behalf of the Department of Health and Human Services.

Procedure: When the Medicaid denial is based on a denial of disability from the SSA, manually issue a **Notice of Action** using the language below.

Determine if Medicaid eligibility exists under another coverage group.

> ____ is not blind or disabled. The Social Security Administration denied benefits as you are not disabled at this time.
>
> We are required to follow Social Security's decision. If you are approved for disability benefits at a later date, please tell us within 10 days of the date on your notice from Social Security.
>
> EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75 (Rules in Process)

See the following sections for more procedures:

- When the Department Denies Disability
- Appeal of a Medicaid Denial Based on a Disability Denial
- When SSA Denial Is Reversed in an SSA Appeal

When the Department Denies Disability

Legal reference: 441 IAC 50.1(249), 50.2(1), 75 (Rules in Process)

Policy: Medicaid eligibility based on disability shall be denied or canceled when the Department determines that an applicant or member is not disabled.

Comment: When there is a DDS denial of disability, DDS issues the decision using form **470-2463, Explanation of Disability Determination** or a Personalized Disability Explanation. The form is sent to the IM worker along with the entire disability file. The finding that the client is not disabled is also entered in Part II, 2 of the **Disability Transmittal, form 470-2472**.

Procedure: Send the client:

- A copy of form **470-2463, Explanation of Disability Determination** or the Personalized Disability Explanation and
- A **Notice of Action** denying the application or cancelling assistance because the person is not disabled.

For an **applicant**, it is important to issue a manual **Notice of Action** using the following language.

> …you are not blind or disabled. You will get a separate letter that tells you about the disability decision.
>
> EM 6-B SSA Policies Applicable to All Programs; EM 8-C Presence of Age, Blindness, or Disability; EM 8-J SSI-Related Medically Needy; EM 8-J Age Criteria; 8-J Blindness Criteria; EM 8-J Disability Criteria; 441 Iowa Admin. Code 50.1(249), 50.2(1), 75 (Rules in Process).

If a member's disability is denied due to a **review** of disability or due to a **redetermination** of disability for an 18-year-old using adult criteria, cancel the Medicaid coverage group and redetermine to another coverage group.

Comment: For more information, see:

- Appeal of a Medicaid Denial Based on a Disability Denial
- When SSA Denies Disability After HHS Disability Approval
- When SSA Denial Is Reversed in an SSA Appeal
- Disability Reviews
- Redetermination at Age 18

Appeal of a Medicaid Denial Based on a Disability Denial

Legal reference: 441 IAC 7.8(17A)

Policy: An applicant has the right to appeal a denial of Medicaid based on the determination that the applicant is not disabled, according to the policies and procedures in 1-E, Appeals and Hearings.

Procedure: Use the following steps to process appeals regarding denial of Medicaid based on the denial of disability.

Step 1: Send the appeal request along with a copy of the **Notice of Action** within 24 hours to the HHS Appeals Section at the following address:

HHS Appeals Section Fifth Floor
1305 E Walnut Street
Des Moines, IA 50319-0114

Step 2: Within ten calendar days, submit a summary of the action taken to the Appeals Section. Include the following information:

- The NonMAGI-related coverage groups under which the person is eligible.
- The reason benefits were denied: either
  - A Social Security Administration (SSA) decision or
  - A DDS decision from a HHS referral.

If benefits were denied based on an SSA decision, include:

- The date of the decision.
- Proof of the SSA denial of disability

Step 3: If the disability determination was done by DDS for HHS, send a complete copy of the disability file to each of the following:

- HHS Appeals Section
- The appellant
- The appellant's representative
- DDS at the following address:

Disability Determination Services Bureau
Disability Hearing Unit,
535 SW 7th Street,
Des Moines, Iowa 50319

NOTE: Keep the original disability determination file with the case record.

The Department of Inspections, Appeals, and Licensing (DIAL) notifies the HHS worker, the appellant, the appellant's representative, and DDS (if appropriate) of the hearing date.

The worker is the representative for the Department (HHS) and must attend the hearing to explain HHS procedures leading to the denial of Medicaid.

If DDS made the disability determination on behalf of HHS, the DDS representative attends the hearing to:

- Explain DDS procedures,
- Explain the disability determination decision, and to
- Answer questions from the administrative law judge, the appellant, or the appellant's representative.

On rare occasions, the administrative law judge (ALJ) may determine that additional medical examinations are required to make a decision. DDS is responsible for obtaining these services.

After the ALJ issues a written order to DDS describing the required tests or examinations, DDS requests the disability file from the local office. DDS may ask the worker to obtain signed releases from the appellant as needed. DDS will then schedule the tests, provide the results to the ALJ, and return the disability file to the local office.

If the Final Decision states that the appellant is disabled, and all other eligibility requirements are met, approve Medicaid. Under this circumstance, if a date is not given for a Continuing Disability Review (CDR), contact the HHS, SPIRS help desk for guidance.

When SSA Denial Is Reversed in an SSA Appeal

Legal reference: 441 IAC 50.2(1) and 75 (Rules in Process)

Policy: When an applicant reports that the Social Security Administration (SSA) appeal process has reversed the denial of disability and the person is now determined to be disabled, the Department must determine if this change affects Medicaid eligibility.

Procedure: If Medicaid was denied based on the Department's disability determination and not based on an SSI or Title II denial, the SSA reversal has no effect on the Medicaid denial. Advise the client to file a new Medicaid application.

If the SSA reverses an SSI denial, approve Medicaid based on the SSI eligibility. Determine Medicaid eligibility based on the date of the Medicaid application.

Compare the disability onset dates established by the SSA to the dates of the Medicaid application. Obtain the date of onset as follows:

- The IEVS Third-Party Query (TPQY) response lists a specific month, day, and year as the onset date for a SSDI (Title II) disability decision. See the last page of the TPQY.
- For SSI, the onset date is usually shown as the first day of the month that disability is established as shown on the SDX screen.

If SSA disability onset date is …	**Then…**
Before the date of the Medicaid application …	Allow applicable retroactive months of eligibility for individuals who meet a category of eligibility for the retroactive period as defined in 8-A, Definitions.
On or before the date of the Medicaid denial …	Allow applicable retroactive months of eligibility for individuals who meet a category of eligibility for the retroactive period as defined in 8-A, Definitions.
After the date of the date of the Medicaid denial notice …	The person is not entitled to Medicaid based on the denied Medicaid application. The person must file a new Medicaid application.

Comment:

Ms. L applies for Medicaid based upon disability in February 2008. The IM worker refers Ms. L for a Department disability determination because she has resources higher than the limit for NonMAGI-related coverage groups but lower than the limit for the Medically Needy program.

DDS evaluates Ms. L and determines that she does not meet the criteria for disability.

Ms. L applies for SSDI in July 2008. The SSA denies that she is disabled. Ms. L asks for all levels of the SSA appeal process. In the final level of appeal, Ms. L is approved for disability effective May 2008.

Although Ms. L is determined to be disabled by SSA, the Department requires a new application because the original denial was not based on the SSA disability denial.

Reapplications Based on Disability

Legal reference: 20 CFR 416.913, and 416.920; 441 IAC 50.2(1) and 75 (Rules in Process)

Policy: The Department must reevaluate the disability status of an applicant each time a Medicaid application is filed.

Procedure: Evaluate the current claim for disability when a person reapplies for Medicaid based on disability:

- After a denial because the person was not determined to be disabled, or
- After a cancellation due to the determination that the person is no longer disabled.

See the following sections:

- Reapplying After Disability Is Denied
- Reapplying After Cancellation for a Nondisability Reason

Reapplying After Disability Is Denied

Legal reference: 20 CFR 416.913 and 416.920; 441 IAC 50.2(1), 75 (Rules in Process)

Policy: When a person reapplies for Medicaid following a denial or cancellation based on a decision of disability or blindness by the Bureau of Disability Determination Services (DDS):

- HHS continues to use the initial denial of disability when the person does not claim a worsening of the disabling condition or a new disabling condition.
- A new referral to DDS must be made when the person claims a worsening of the condition or a new disabling condition.

Procedure: If the person claims a worsening of the disabling condition or a new disabling condition, send all previous disability reports to DDS along with any new material.

If the person claims there is no change in condition, no disability exists. Manually issue a **Notice of Action** using the language below. Determine if eligibility exists under another coverage group.

> _____ is not blind or disabled. If your medical condition gets worse or you have a new condition, then you may re-apply for Medicaid.
>
> EM 8-C, Reapplying after Disability is Denied; 441 Iowa Admin. Code 75 (Rules in Process), 20 CFR 416.913 and 416.920.

Comment:

Mr. K applies for Medicaid as a disabled person because of arthritis in May 2008. The worker makes a referral to DDS. In July 2008, DDS determines that Mr. K is not disabled due to the arthritis. The worker issues a **Notice of Action** in July 2008, denying Medicaid as Mr. K is not disabled. The worker determines if eligibility exists under another coverage group.

In January 2009, Mr. K again applies for Medicaid. He does not claim a new disabling condition nor a worsening of his arthritis. The worker denies his Medicaid application as not disabled.

Reapplying After Cancellation for a Nondisability Reason

Policy: In most instances, disability or blindness does not need to be reestablished for a person reapplying for Medicaid when the cancellation was done due to nondisability reasons.

A disability determination is required when:

- The person states there has been improvement in the condition.
- The person has turned age 18, which means the disability must be redetermined under adult disability standards.
- A review of disability or blindness is due or should have been completed during the period that the person was not on Medicaid. The review date may have been scheduled either by the Department or by the Social Security Administration.

Procedure: Follow procedure under When the Department Determines Disability to complete a referral for disability determination.

Nonfinancial MAGI-Related Eligibility

This section deals with additional nonfinancial eligibility policies specific to MAGI-related applicants and members. These additional requirements include:

- Absence
- Residency
- Specified relatives
- Verification of pregnancy

Absence

Legal reference: 441 IAC 75.53

Do not include in the eligible group any person who is absent from the home and does not meet the temporary absence provisions:

- Consider a parent to be absent from the home when the parent is committed, imprisoned, or admitted to an institution.
- Consider a parent to be absent from the home when the parent is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

- Consider a parent to be absent from the home when the parent is absent because of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service.

> Mr. A is on active duty with the U.S. Army, based in another state. His wife, Mrs. A, and their children live in Iowa. Mr. and Mrs. A do not consider themselves estranged. Mr. A is absent only because of his active duty military service.
>
> If Mrs. A applies for Medicaid, Mr. A is not included in the eligible group and his income is considered only to the extent he makes it available. NOTE: Although Mr. A is considered "absent," a referral to CSS is not made. See 8-B, Referrals to CSS.

- Do **not** consider a parent to be absent from the home when the parent is absent solely because of a pattern of employment. Examples include salespeople and truck drivers.

> 1. Mr. and Mrs. B receive Medicaid for themselves and their children. Mr. B takes a job as a truck driver. Due to the nature of the job, he will be home only one or two days a week and on the road the rest of the week.
>
>   Mr. B is away solely because of his employment. He is not considered to be absent. He must be included in the eligible group and his income considered in determining eligibility for the family.
> 2. Mr. C and Ms. D receive Medicaid for themselves and their common child. Mr. D takes a job with a carnival that will require him to be away from home for six months.
>
>   Mr. C is away solely because of his employment. He is not considered to be absent. He must be included in the eligible group and his income considered in determining eligibility for the family.

Questionable Cases

Legal reference: 441 IAC 75 (Rules in Process)

In questionable cases, you may need verification before you can consider a parent absent and determine eligibility. Do not take action based on suspicion or complaint alone when you believe that an "absent parent" is not absent. Try to get several items that support your belief.

The following are examples of situations that could justify more verification:

- The case was recently denied or canceled because the "absent parent's" income or resources were considered.
- The absent parent moves in and out of the home frequently.
- Living expenses exceed income.
- The parent's absence occurs when the parent is on strike or during slack times for a self-employment business, etc.
- There is no verifiable residence for the absent parent.
- The verifiable residence for the absent parent is very close to the child's home.

The absent parent may be out of contact with the family, especially if the separation was recent. The client may verify the circumstance by providing a statement from the landlord, minister, lawyer, or other knowledgeable nonrelative. Apply the "prudent person" concept and document the basis for the decision on all questionable cases.

Temporary Absence

Legal reference: 42 CFR 435.403(j)(3), 441 IAC 75.53

Policy: Include in the eligible group the needs of a person who is temporarily out of the home, if otherwise eligible. A temporary absence exists when the person is:

- Out of the home to secure education or training.
- In a medical institution for less than a year as verified by a physician's statement.
- Out of the home for another reason and the person intends to return to the home within three months.

Document the temporary absence and request verification as needed.

Absence for Education

Legal reference: 441 IAC 75.53

Policy: Include in the eligible group a person who is temporarily out of the home for the purpose of education or training. “Education and training” means any academic or vocational training program which prepares the person for a specific professional or vocational area of employment.

Procedure: If a child was in the home before leaving for education or training, a temporary absence exists as long as the child remains a dependent. Continue assistance if the child remains a member of the relative’s family group.

When a child is attending Job Corps, the Iowa Braille and Sight Saving School, or the Iowa School for the Deaf, consider the child to be in a public educational or vocational training institution and include the child in the eligible group if otherwise eligible.

A parent or other caretaker who is temporarily out of the home for training or education may be included in the eligible group, provided the parent or other caretaker was in the home before leaving to secure education or training.

Absence in a Medical Institution

Legal reference: 441 IAC 75.53

Include in the eligible group a person who is temporarily absent from the home and in a medical institution. Assistance may be approved for a person who is confined to or living in a medical institution as long as the person:

- Is anticipated to be in a medical institution for less than a year, as verified by a physician’s statement.
- Will be returning directly to the home from the medical institution.

When determining the 12-month period, the first full calendar month after the person enters the medical institution is considered “month one.”

A "medical institution" is a facility that provides medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license.

A medical institution may be public or private. Medical institutions include:

- Hospitals
- Nursing facilities
- Intermediate care facilities for persons with an intellectual disability
- Psychiatric medical institutions for children
- Psychiatric institutions
- State hospital schools
- Mental health institutions

EXCEPTION: Children in a psychiatric medical institution for children (PMIC) who are in court-ordered foster care status are not considered in the eligible group at home.

A person, who enters a medical institution from foster care, or from any place other than the home, is not considered in the eligible group at home. This is true even if the person anticipates being in the medical institution for less than a year and returning to the home upon leaving the medical institution.

EXCEPTION: Include in the eligible group a child who has remained in a medical institution since birth, but is expected to enter the home in less than one year.

1. Mrs. A applies for assistance for herself and her child, who has been in the hospital for five months. The child left the home to enter the hospital and is expected to return to the home in two months.

   Mrs. A and the child are eligible, because the total time the child is expected to be out of the home and in a medical institution is less than one year.

2. Mrs. B applies for assistance for herself and her child who has been in a nursing facility for ten months. The child is expected to return to the home in four months.

   There is no MAGI-related Medicaid eligibility because the total length of time the child is expected to be out of the home is greater than one year.

3. Mrs. C applies for MAGI-related Medicaid for herself and a child. The child was in foster care for two months before entering the medical institution. The child is expected to return to the home within three months.

   There is no MAGI-related Medicaid eligibility, because the child did not enter the medical institution from the home.

If the person does not return within one year, remove the person's needs from the eligible group.

Absence for Less than Three Months

Legal reference: 441 IAC 75.53 and 75.12(249A)

Include in the eligible group a person who is temporarily absent from the home. A "temporary absence" exists when a person is out of the home for reasons other than in a medical institution or for education or training and it is expected that the person will return to the home within three months.

NOTE: A person who is expected to be absent from the MAGI-related eligible group for less than three months due to incarceration is still eligible for Medicaid. See Residents of Public Nonmedical Institutions.

A child may be out of the home for purposes such as visiting the absent parent or vacation. The child remains eligible if the child's absence is anticipated to last less than three months.

Even though the parent's or other caretaker's responsibility for care and control is lost, continue eligibility as long as the loss is temporary. For example, a child visiting the other parent can be included in the eligible group, as long as the absence is expected to be less than three months and all other factors of eligibility are met.

Assistance may be approved for a person when the total length of time the person is anticipated to be out of the home is less than three months. If the person does not return home within three months, remove the person's needs from the eligible group.

When determining the three-month period, the first full calendar month after the person has left the home is considered "month one." For applicants, the total length of time is from the date the person left the home (not the date of application) until the date the person is expected to return.

1. Jim, a member of the MAGI eligible group, leaves home on May 2 to visit his father. He is expected to return home August 29. His needs continue to be included in the MAGI eligible group.
2. Mrs. A applies for assistance for herself and four children. Three of her children live with her. The fourth child has been living with his father for the past two months and will be returning to Mrs. A's home in two months.

   Mrs. A is eligible to receive assistance for the three children living in the home. The fourth child is not eligible until he returns to the home because his total length of absence from the home is anticipated to be greater than three months.
3. Mrs. B applies for assistance for herself and one child. The child was living with her grandmother for one month. Before this, the child had been living with Mrs. B. The child will be returning to Mrs. B's home in one month.

   If the grandmother is not receiving assistance for the child, the worker continues assistance for Mrs. B and the child, because the total length of absence is anticipated to be less than three months.

MAGI Household Size

Legal Reference: 441 IAC 75 (Rules in Process)

For the purpose of determining financial eligibility, each applicant's or member's household size is determined individually based on federal tax policy and with regard to the applicant's or member's federal tax status.

The application and renewal forms ask whether an individual plans to file a tax return for the year. The individual's household is constructed based on their plan to file a federal income tax return, regardless of whether or not they actually file a return at the end of the year, or be claimed as a tax dependent. It is not necessary to have filed a federal income tax return in previous years.

Different households may exist within a single family, depending on each of the family members' familial and tax relationships to each other.

Applicant or Member is a Tax-Filer

Legal Reference: 441 IAC 75 (Rules in Process)

An applicant or member who expects to file a federal tax return for the year in which the applicant or member requests Medicaid and does not expect to be claimed as a tax dependent by another taxpayer is considered a "tax-filer". A tax-filer's Medicaid household size shall include:

a. The tax-filer,

b. The tax-filer's spouse (if living together), or if expected tax status is married filing jointly (regardless if a spouse is absent from the home or whether the absence meets the definition of temporary), and

c. Each dependent that the tax-filer expects to claim.

Applicant or Member is a Tax Dependent

Legal Reference: 441 IAC 75 (Rules in Process)

An applicant or member who expects to be claimed as a tax dependent on a federal tax return for the year in which the applicant or member requests Medicaid is a "tax dependent". A tax dependent's Medicaid household size is the same as the tax-filer who claims the dependent.

EXCEPTION: The dependent's household size is determined the same as a non-filer who is not claimed as a tax dependent when the dependent meets one of the following exceptions:

a. Expects to be claimed by someone other than a spouse or parent (biological, adoptive or step).

b. Is a child under 19 who expects to be claimed by one parent while living with both parents who do not expect to file a joint return.

c. Is a child under age 19 who expects to be claimed by a non-custodial parent in accordance with a:

- Court order or binding separation, divorce, or custody agreement establishing physical custody controls, or
- If there is no such order or agreement, or if there is a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

Applicant or Member is a Non-Filer (does not file taxes) and is Not Claimed as a Tax Dependent

Legal Reference: 441 IAC 75 (Rules in Process)

A non-filer who is not claimed as a tax dependent can be an applicant or member who:

- Does not expect to file a federal tax return for the year in which Medicaid is requested,
- Does not expect to be claimed as a tax dependent for the year in which Medicaid is requested, or
- Meets one of the following exceptions:

  a. Expects to be claimed by someone other than a spouse or parent (biological, adoptive or step).

  b. Is a child under 19 who expects to be claimed by one parent while living with both parents who do not expect to file a joint return.

  c. Is a child under age 19 who expects to be claimed by a non-custodial parent as described above in Applicant or Member is a Tax Dependent.

The household size shall consist of the applicant or member, and each of the following who is living with and in relation to the applicant:

1. Parent (natural, adopted and step) when the applicant or member is a child under the age of 19.
2. Spouse;
3. Child (natural, adopted and step) under the age of 19;
4. Sibling (natural, adopted and step) under the age of 19 when the applicant or member is a child under the age of 19.

Married Couples

Legal Reference: 441 IAC 75 (Rules in Process)

In the case of a married couple living together, each spouse will be included in the household size of the other spouse, regardless of federal tax status.

In the case of a married couple filing jointly, each spouse will be included in the household size of the other spouse, even when they are not living together.

Pregnancy

Legal Reference: 441 IAC 75 (Rules in Process)

In establishing eligibility for a pregnant woman or any person whose household includes a pregnant woman, the unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household size.

The applicant's or member's attestation of the pregnancy, date of conception, due date, and number of children expected to deliver shall serve as verification unless questionable.

The composition of a MAGI household that includes a pregnant woman counts all eligible individuals, the pregnant woman, and the number of children she is expecting to deliver.

When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until custody is relinquished.

Applicant or Member Attestation of Federal Tax Status

Legal Reference: 441 IAC 75 (Rules in Process)

The department shall accept the applicant's or member's statement of their federal tax status and claimed dependents, or such statement from an adult who is living with and in the Medicaid household size of an applicant or member who is a child.

In cases where tax status or tax dependency cannot be established, the individual's household is determined following non-filer rules.

Determining If a Common-Law Marriage Exists

Legal reference: Legislative Guide to Marriage Law/Iowa Legislative Services Agency at https://www.legis.iowa.gov/docs/central/guides/marriage.pdf; IowaLegalAid.org at http://www.iowalegalaid.org/resource/common-law-marriage-in-iowa

When determining if someone is a parent or other caretaker, there may be situations where a common-law marriage exists or the applicant or member claims a common law marriage exists. Accept a couple's claim that a common-law marriage exists unless you have reason to question the claim.

If you question the claim, a common law marriage exists if **both** people:

- Are free to marry
- Have intended or have agreed to be married
- Continue to live together
- Publicly declare themselves to be husband and wife.

The following items can further indicate that a common-law marriage exists:

- Joint income tax forms
- Joint purchase of property (house, car, etc.)
- Mortgages or loans
- Insurance policies
- School records
- Employment records
- Birth records
- Joint bank accounts
- Statements to friends or relatives
- Hotel or motel registrations

Evidence must represent the couple as husband and wife. One item is not enough evidence, but several items might indicate a common-law marriage.

A common-law marriage is a legal and valid marriage. When a common-law marriage exists, treat the adults the same as any other married couple.

Adoption

Legal reference: 441 IAC 75 (Rules in Process)

When a mother intends to place her child for adoption shortly after birth, the child is considered as living with the mother until the legal release of custody is signed and custody is actually relinquished. Iowa law requires that when a child is voluntarily placed for adoption, a release of custody cannot be signed less than 72 hours after the child's birth.

The adoption does not sever a biological relationship.

Joint Custody

Legal reference: 441 IAC 75 (Rules in Process)

A child can receive Medicaid in one household only.

Living with a parent or other caretaker implies the existence of a relationship involving an accepted responsibility on the part of the caretaker for the primary care of the child. A non-parental caretaker must attest to having primary responsibility for the child's care.

In joint custody situations, the child shall be considered to be living with the custodial parent or other caretaker (which is determined as follows) when a child lives in the home of one parent or other caretaker some of the time and also lives in the separate home of the other parent or another caretaker:

- As specified in a court order or binding separation, divorce or custody agreement, or,
- If there is no such order, the parent or other caretaker with whom the child spends most nights shall be considered the custodial parent or other caretaker.
    - When a child spends equal amounts of time in the home of each parent and both parents apply for Medicaid for the child, the parents must decide which parent will continue with the application. Likewise, when a child spends equal amounts of time in the home of a parent and the home of another caretaker, the parent or other caretaker must decide which caretaker will continue with the application.
    - If the parents, or the parent and other caretaker, cannot reach a decision, the department will make the determination based on the totality of the available circumstances.

The following questions may be helpful when deciding who the child is living with if the child appears to be spending equal amounts of time in each home and the parents cannot decide who will receive Medicaid. This is not a complete or final list of questions but gives some general guidance.

- Which parent lives in the same school district as the child's school?
- Who purchases most of the child's clothing?
- Which parent does the school contact in an emergency?
- Where are most of the child's clothing and toys stored?
- Who does most of the child's laundry?
- Who maintains medical records and sets up medical appointments?
- Who has the final say as to what the child can or cannot do if there is a disagreement?

Upon the determination that a child is living with a parent or other caretaker, the Medicaid household for the child is determined as described above in MAGI Household Size.

Verification of Pregnancy

Legal reference: 441 IAC 75 (Rules in Process)

If a woman's eligibility is dependent upon pregnancy, accept a woman's statement, unless questionable, as verification for the following:

- The claim that she is currently pregnant.
- The probable date of conception to establish retroactive eligibility.

If the pregnancy is questionable, accept a signed statement from any of the following:

- A maternal health center
- A family planning clinic
- A physician's office
- A certified nurse midwife
- Another physician-directed provider, such as a rural health clinic or birthing center.

Medicaid Resources

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Overview

Pursuant to 42 CFR 435.603(g) and 441 IAC 75.70(249A), there is no resource test for MAGI-related Medicaid.

This chapter describes Medicaid resource requirements. Resource policies that apply to all coverage groups are described in the first part of the chapter:

- Attribution of resources between an institutionalized spouse and a community spouse.
- Estate recovery for members who are over age 55 or in a medical institution.
- Transfers of assets.
- Trusts.

The remaining part of this chapter provides resource requirements for people whose eligibility is based on their relationship to the Supplemental Security Income program (Non-MAGI-related coverage groups), including persons who are aged, blind, or disabled.

Attribution of Resources

Legal reference: 441 IAC 75 (Rules in Process)

When one spouse enters a medical institution or applies for a home- and community-based services (HCBS) waiver or Programs for All-Inclusive Care for the Elderly (PACE) services, resources are “attributed” to the “community spouse” to protect sufficient resources for the community spouse’s maintenance.

A “community spouse” is a person who is not in an institution but who is the spouse of a person who is in an institution or applying for or receiving PACE or waiver services. The community spouse could live:

- In the couple’s own home.
- In a custodial home, such as a residential care facility.
- In an apartment.
- With relatives.
- In another nonfacility or noninstitutional setting.

Complete the attribution using the resources the couple had as of the first day of the month that:

- The institutionalized spouse enters a medical institution (on or after September 30, 1989) expecting to stay 30 consecutive days or more, or
- The Medical Services Unit at the Iowa Medicaid Enterprise (IME) or Managed Care Organization (MCO) determines that the Medicaid HCBS waiver or PACE applicant meets level of care.

Information needed to attribute resources is included on the Medicaid application forms. Use form 470-2577, *Resources Upon Entering a Medical Institution*, to attribute resources when:

- The month of entry to the institution and the month of application are different, or
- A married Medicaid member requests home- and community-based waiver or PACE services, or
- Either the institutionalized spouse or the community spouse requests attribution but does not apply for Medicaid.

Do not approve Medicaid until the attribution is completed. Complete the attribution within 45 calendar days.

Complete only one attribution per community spouse per case. After an attribution has been completed, do not complete a new attribution if:

- The institutionalized spouse is discharged after the 30 days but later reenters a medical institution.
- The attribution was completed for a waiver or PACE application but the application was denied.
- The attribution was completed for waiver or PACE services and the waiver or PACE spouse later enters a medical facility.
- A person whose attribution was completed in another state applies for institutional care in Iowa. However, if that state has a lower minimum community spouse resource allowance, recalculate the attribution and assign Iowa's minimum.

In specific circumstances, attribution guidelines may be different:

- If both spouses entered an institution but one goes home, complete an attribution for the month the spouse who remains institutionalized entered the institution.
- If the previously institutionalized spouse goes home and then the community spouse enters a medical institution expecting to stay for 30 days or more, complete a new attribution for the new institutionalized spouse.
- If either spouse dies in the month of application or died in the retroactive period, attribute resources for the month of entry to the institution. Use the attributed resources to determine eligibility for months the spouse was living.
- If the applicant marries **after** entering the institution but **before** Medicaid eligibility is determined, complete an attribution of resources for the community spouse. Complete the attribution for the month of entry.
- If a single member or a member who was widowed after the attribution marries **after** entering the institution and **after** Medicaid eligibility for institutional care has been established, do not complete an attribution. If the institutionalized spouse later becomes ineligible for Medicaid and reapplies for Medicaid benefits, complete an attribution for the month of entry.

Revise attribution results when:

- A final appeal establishes a greater amount of protected resources for the community spouse. See If the Applicant Appeals the Attribution Amount.
- The member is later able to verify resources that were owned at the date of entry to the institution. See Calculating the Amount to Attribute to the Community Spouse.
- The amount of resources used in the original attribution was not correct.

If a person who requests an attribution without filing a Medicaid application fails to cooperate in determining attribution, a new determination is not necessary when you receive an IRS report. (However, do complete the attribution and consider the IRS report when the person later applies for Medicaid if you receive verification and can establish what resources existed when the person entered the institution.)

Further details on the attribution procedure are organized as follows:

Resources Excluded from Attribution

Legal reference: 441 IAC 75 (Rules in Process)

Some resources are not considered for attribution, whether owned by one or both spouses. Resources that do not count in the attribution process also do not count when determining eligibility. Do not count for either the attribution process or eligibility:

- One vehicle regardless of value.
- Burial and related expense funds for each spouse that are separately identified and set aside for that purpose. Each spouse may have a fund or multiple funds but no more than $1,500. Subtract from this $1,500 limit the total face value of excluded whole life and term life insurance policies and any amounts in irrevocable trusts or arrangements available to meet burial and related expenses.
- Burial spaces held for either spouse or any other member of the immediate family.
- Disaster Relief Act Assistance and Emergency Act Assistance or other assistance provided because of a Presidential declaration of disaster. Exclude these resources and any interest earned on the funds for nine months, beginning with the date of receipt. (These funds may be excluded for a longer period if good cause is shown.)
- Household goods and personal effects, regardless of value.
- Housing assistance paid by HUD or FMHA for housing occupied by the community spouse.
- Life insurance policies with a total face value of $1,500 or less for each spouse.
- Property in a homestead, including the home and related land.
- Property used for self-support of either spouse if it would be excluded by SSI.
- Real property up to $6,000 if it is earning six percent of equity.
- Relocation assistance provided by a state or local government which is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
- Resources of a blind or disabled person who has a Plan for Achieving Self-Support, as determined by the Division of Vocational Rehabilitation, the Department of Human Services, or the Department for the Blind.

- Resources necessary for self-employment.
- Retirement funds if the member or the member's spouse has to quit a job or claim hardship in order to withdraw them.
- Shares of stock held by natives of Alaska in a regional or village corporation. Exclude for the 20 years in which the stock is inalienable, as provided in Sections 7(h) and 8(c) of the Alaska Native Claim Settlement Act.
- **Underpayment of SSI or Social Security** that is due either spouse for any month before the month it is received. Exclude for six months after receipt.
- **Victim's compensation** from a fund established by a state for victims of crime. Do not count the assistance for nine months from receipt. The applicant must prove that the payment was for expenses incurred or losses suffered as a result of a crime.

See Specific SSI-Related Resources for more descriptive information about these excluded resources. (Note that there are other types of resources described under that heading that are excluded for determining eligibility, but not for attribution.)

Resources affected by a prenuptial or antenuptial agreement are countable as resources unless excluded under the criteria listed above.

Calculating the Amount to Attribute to the Community Spouse

Legal reference: 441 IAC 75 (Rules in Process); P. L. 100-360, P. L. 100-485

Use Non-MAGI-related resource policies when determining which resources to count in completing an attribution. To calculate how much to attribute to each spouse:

1. Determine what resources the couple owned as of the first moment of the first day of the month of entry into the medical institution (or the month the HCBS waiver or PACE applicant meets the institutional level).

   Count all resources that are owned by either spouse. It does not matter which spouse owns the resource. Include the value of resources that are for sale.

   The applicant must provide verification of the value of the resources. Count **only** those resources that can be verified. If the applicant provides partial verification, use that documentation to determine the attribution.

> Mr. and Mrs. G claimed resources of $60,000 on the application for attribution. However, they could provide verification for only $50,000. The attribution was based on the verified resources of $50,000.

Count the uncompensated value of any divested resources owned by either spouse if the resource was owned on the first moment of the first day of the month. "Uncompensated value" is the fair market value of the asset minus the amount that was received for the asset.

NOTE: If either spouse transferred resources at less than fair market value to attain eligibility, see Transfer of Assets for procedures to handle such transfers when determining eligibility.

2. Add together all resources of both spouses.
3. Attribute one-half of the documented resources to each spouse. If necessary, adjust the division so that the community spouse will receive no less than $31,584 (if there is that much) but no more than $157,920.

Value of Combined Resources	$0 - $63,168	$63,168.01 - $315,840	$315,840.01 or more
Amount attributed to:			
Community spouse	$31,584	One-half	$157,920
Institutionalized spouse	Remainder	One-half	Remainder

After the attribution is complete, send each spouse the results on form 470-2588, *Notice of Attribution of Resources*, with copies of the resource documents. The notice includes an explanation of the spouses' appeal rights. (See If the Applicant Appeals the Attribution Amount.)

If a court or administrative appeal decision has ordered an amount greater than half the resources for the community spouse, or more than $157,920, attribute the amount ordered.

1. Mr. A enters a medical institution and his wife remains at home. Mr. and Mrs. A furnish verification of a total of $69,500 in resources. One-half of this is $34,750. Mrs. A is attributed $34,750 and Mr. A is attributed $34,750.
2. Mr. B enters skilled care expecting to stay indefinitely. His wife remains at home. Their total resources are $35,600. One-half of this is $17,800. Since this result is less than $31,584, the minimum amount of $31,584 is attributed to Mrs. B. $4,016 is attributed to Mr. B.

3. Mrs. D enters a hospital and is expected to stay over 30 days. Her husband remains at home. Their total resources are $320,000. One-half of this is $160,000.

   The community spouse cannot be attributed more than $157,920 without a court order or final appeal decision. Therefore, $162,080 is attributed to Mrs. D and $157,920 is attributed to Mr. D ($320,000 - $157,920 = $162,080).

4. Mr. M enters a nursing facility and Mrs. M remains at home. The total value of their resources is $50,000. However, the court has ordered that $40,000 be transferred to Mrs. M for support. In this case, $40,000 is attributed to Mrs. M, even though this amount exceeds the $31,584 minimum; $10,000 is attributed to Mr. M.

If the Applicant Appeals the Attribution Amount

Legal reference: 441 IAC 75 (Rules in Process)

The current minimum monthly maintenance needs allowance (MMMNA) for a community spouse is $3,948. If the income available to the community spouse is less than the MMMNA, the applicant or the community spouse may file an appeal to set aside additional resources that would generate income equal to the difference between the income available to the community spouse and the MMMNA.

The appeal request must be filed within 90 days of the *Notice of Attribution of Resources* (NOA) or any *Notice of Decision* (NOD) regarding medical assistance. If the applicant does not file an appeal within 90 days of an NOA or NOD, the applicant loses the right to a hearing on the attribution for that application. If requested, help the applicant to complete form 470-0487 or 470-0487(S), *Appeal and Request for Hearing*.

If the appeal is filed after one or more applications has been denied, and the appeal allows a substitution of resources that result in the institutionalized spouse now being eligible, the date of approval begins with the most recent application. Only one appeal to allow a substitution of resources will be conducted.

1. Mr. Q enters a facility in January 2002. Mrs. Q remains at home. The Qs file an application for medical assistance in March 2002. An attribution of resources is completed, and the application is denied in April 2002. Another application is filed for Mr. Q in February 2003.

   The worker totals all of the household resources and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in March 2003.

   A third application is filed for Mr. Q in March 2004. The worker again totals all of the household resources and subtracts the community spouse resource allowance assigned in the attribution process. Again the remaining resources continue to exceed the resource limit. The worker issues an NOD denying benefits in March 2004.

   Mr. Q files an appeal in April 2004 regarding the March 2004 NOD. A hearing is granted. Mrs. Q's income is low enough that the cost of an annuity is used to set aside additional resources for Mrs. Q. The final appeal decision attributes additional resources to Mrs. Q.

   The new community spouse resource allowance exceeds the current resources owned by Mr. and Mrs. Q. The March 2004 application decision is reversed. The prior decisions on the March 2002 and March 2003 applications stand as issued.

2. Mrs. Z enters a facility in August 2013. Mr. Z remains at home. The Zs file an application for medical assistance for Mrs. Z in August 2013. An attribution of resources is completed, and the application is denied in September 2013. Another application is filed for Mrs. Z in January 2017.

   The worker totals all of the household resources, and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in February 2017.

   Mrs. Z appeals the NOD in February 2017. A hearing is granted. Mr. and Mrs. Z are unable to obtain an annuity quote. The worker assists them in getting the quote. The administrative law judge issues a decision upholding the original attribution. Once this decision becomes final, no other hearings regarding the attribution will be granted, as the Zs were granted a hearing on the attribution of resources.

3. Mr. M enters a facility in January 2016. Mrs. M remains at home. The Ms file an application for medical assistance for Mr. M in August 2016. An attribution of resources is completed. Mrs. M is attributed $24,000. The Ms have $6,000 in resources. The application is approved.

   The review form is sent out in January 2017 and not returned. The case is canceled effective February 1, 2017. Another application is filed in March 2017. The Ms now have $42,000 in resources.

   The worker subtracts the current year's community spouse resource allowance. The remaining resources exceed the resource limit.

   The worker issues an NOD denying the application in March 2017. Mr. M files an appeal regarding the NOD. A hearing is granted. The final appeal decision attributes additional resources to Mrs. M. The couple's income is low enough that the average of the annuities, $99,424, is used to set aside additional resources for Mrs. M.

   The new community spouse resource allowance exceeds the current resources owned by Mr. and Mrs. M. The March 2017 decision to deny the application based on excess resources is reversed.

Verify the couple's available gross monthly income. Do not count income that is earned by resources used in the attribution process.

When determining gross monthly income, include any income the community spouse or institutionalized spouse may be entitled to but is not receiving. When the community spouse works only part of the year and received income only during the time worked, annualize the income as directed in 8-E, *Determining Income from Self-Employment*.

For couples where one spouse entered an institution before February 8, 2006, county only the community spouse's income.

For couples where one spouse entered an institution on or after February 8, 2006, consider the institutionalized spouse's income that can be made available to the community spouse according to the facility client participation calculation. See 8-I, *Deductions from Client Participation*. Allow a $50 personal needs allowance deduction from the gross countable income of the institutionalized spouse for facility, HCBS waiver, **or** PACE applicants.

1. Mrs. B enters a facility in January 2006. Mr. B remains at home. The Bs file an application for medical assistance for Mrs. B in March 2006. An attribution of resources is completed. The worker totals all of the household resources as of January 1, 2006, and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in April 2006.

   Mrs. B files an appeal regarding the NOD. A hearing is granted. Since Mrs. B entered the facility before February 8, 2006, only Mr. B's income is used when the Bs provide a quote for the cost of an annuity to set aside additional resources for Mr. B.

2. Mr. C enters a facility on April 19, and files an application on April 21. Mr. C has a community spouse, Mrs. C. The Cs have combined total resources that are counted in the attribution, in the amount of $35,400. $31,584 was attributed to Mrs. C and that left $3,816 for Mr. C.

   Mr. C has $1,410 Social Security and $1,500 pension with a total income of $2,910. Mr. C has Medicare and a Medicare supplement with a monthly premium of $150. Mr. C has total unmet medical deductions in the amount of $.335 ($185 Medicare premium + $150 Medicare supplement = $335). Mrs. C has $1,100 Social Security.

   The April application was denied since Mr. C's resources exceed the $2,000 resource limit. Mr. C appealed the attribution and the denial.

   Since Mr. C became institutionalized after February 8, 2006, Mrs. C's income, plus the income that will be made available from Mr. C is used when determining the shortfall of income between the MMMNA and Mrs. C's available income for the attribution process.

$ 1,410	Social Security
+ 1,500	Pension
$ 2,910	
- 50	Personal needs allowance
$ 2,860	Total of Mr. C's income available to Mrs. C
+ 1,100	Mrs. C's income
$ 3,960	Total income available to Mrs. C when determining her shortfall for the annuity quote

$ 3,948	MMMNA
- 3,960	Total income available to Mrs. C
$ 0	Shortfall of income used to determine the cost of an annuity for the attribution

Since there is not a shortfall of income for Mrs. C, additional resources cannot be attributed to Mrs. C. Mr. C remains ineligible until he spends down his resources to $2,000.

If Mr. C is determined eligible, calculate the CP as follows:

$ 1,410	Social Security
+ 1,500	Pension
$ 2,910	
- 50	Personal needs allowance
- 2,848	Mrs. C's deficit
$ 12	Client participation

$ 3,948	MMMNA
- 1,100	Mrs. C's Social Security
$ 2,848	Mrs. C's deficit of income

Since Mr. C has income left after the spousal diversion, this is when you will allow other deductions in the CP calculation, such as unmet medical needs (Medicare and health insurance premiums). Since there is only $12 left, Mr. C will have $12 that he can use to pay towards his Medicare premium or health insurance premium.

3. Mr. D applied for waiver services in April and meets level of care for waiver services on May 5. Mr. D has a community spouse, Mrs. D. The Ds have combined total resources that are counted in the attribution, in the amount of $78,000. $39,000 was attributed to each spouse ($78,000 ÷ 2 = $39,000).

   Mr. D has $1,390 Social Security and $233 pension with a total income of $1,623. Mr. D has Medicare and a Medicare supplement with a monthly premium of $100. Mr. D has total unmet medical deductions in the amount of $285 ($185 Medicare premium + $100 Medicare supplement = $285). Mrs. D has $535Social Security.

   The April application was denied since Mr. D's resources exceed the $2,000 resource limit. Mr. D appealed the attribution and the denial.

   Since Mr. D became institutionalized after February 8, 2006, Mrs. D's income, plus the income that will be made available from Mr. D is used when determining the shortfall of income between the MMMNA and Mrs. D's available income for the attribution process.

$ 1,390	Social Security
+ 233	Pension
$ 1,623	
- 50	Personal needs allowance
$ 1,573	Total of Mr. D's income available to Mrs. D
+ 535	Mrs. Ds income
$ 2,108	Total income available to Mrs. D when determining her shortfall for the annuity quote
$ 3,948	MMMNA
- 2,108	Total income available to Mrs. D
$ 1,840	Shortfall of income used to determine the cost of an annuity for the attribution

   If Mr. D is determined eligible, calculate the CP as follows:

$ 1,390	Social Security
+ 233	Pension
$ 1,623	
- 2,901	Mr. D's maintenance needs
$ 0	Client participation
$ 3,948	MMMNA
- 535	Mrs. D's Social Security
$ 3,413	Mrs. D's deficit of income

In this situation for client participation, Mrs. D has a $3,413 deficit of income and Mr. D has no income left to divert to Mrs. D. If Mr. D had income left after the spousal diversion, this is when you would allow other deductions in the CP calculation, such as unmet medical needs (Medicare and health insurance premiums).

NOTE: Do not annualize the community spouse's income when determining the diversion to the community spouse in the client participation calculation.

The appellant must obtain one estimate of the cost of a single-premium lifetime annuity, based on the community spouse's age at the time of appeal, that would generate income equal to the difference between:

- The couple's available gross income and
- The MMMNA in effect when the appeal was filed.

Neither the applicant nor the community spouse has to purchase an annuity as a condition of Medicaid eligibility.

If the applicant is unable to obtain one estimate, assist the couple by contacting financial institutions. If the institution requires the identity of the applicant, obtain a release of information from the applicant.

If the financial institution is unable to provide an estimate, determine the shortfall between the couple's available gross income and the MMMNA. Multiply the shortfall by 12. Multiply this amount by the community spouse's "Life Expectancy in Years" row from the *Table for an Annuity for Life* from the Mortality Table issued by the Iowa Department of Revenue. (See next page.)

Formula: (MMMNA – couple's available gross monthly income) x 12 x community spouse's life expectancy in years = single-premium lifetime annuity quote.

Complete form 470-3144, *Attribution of Resources Appeal Summary* according to instructions in 6-Appendix. Report the verified available income of the couple. Note and estimate the amount of any benefits for which the community spouse is eligible but is not receiving. Attach copies of the annuity bid to the form.

Send the form to the Appeals Section, 321 E. 12th Street, Des Moines, Iowa 50319.

If the annuity quote is greater than the original attribution amount, the administrative law judge will order that the annuity quote be used instead of the original amount. Send a new *Notice of Attribution of Resources* reflecting the revised amount. (The 90-day transfer policy applies as of the date of Medicaid approval. See Transfers to Establish Ongoing Eligibility.)

If the annuity quote is equal to or less than the original attribution amount, the original attribution is left as is.

Table For an Annuity For Life

2001 CSO-D mortality table based on blending 50% male-50% female (pivotal age 45) age nearest birthday **Source:** Iowa Department of Revenue

Age In Years	Life Expectancy In Years	Age In Years	Life Expectancy In Years	Age In Years	Life Expectancy In Years
0	78.65	26	53.49	52	29.15
1	77.73	27	52.53	53	28.27
2	76.78	28	51.58	54	27.4
3	75.81	29	50.63	55	26.54
4	74.84	30	49.67	56	25.68
5	73.86	31	48.72	57	24.84
6	72.87	32	47.76	58	24.01
7	71.89	33	46.81	59	23.19
8	70.91	34	45.85	60	22.38
9	69.92	35	44.9	61	21.57
10	68.94	36	43.95	62	20.78
11	67.95	37	43	63	20
12	66.97	38	42.05	64	19.24
13	65.99	39	41.11	65	18.49
14	65.01	40	40.16	66	17.75
15	64.04	41	39.22	67	17.02
16	63.07	42	38.28	68	16.31
17	62.11	43	37.35	69	15.6
18	61.15	44	36.42	70	14.91
19	60.19	45	35.49	71	14.23
20	59.23	46	34.57	72	13.56
21	58.27	47	33.65	73	12.91
22	57.32	48	32.74	74	12.28
23	56.36	49	31.84	75	11.66
24	55.4	50	30.94	76	11.06
25	54.45	51	30.04	77	10.47

Age In Years	Life Expectancy In Years	Age In Years	Life Expectancy In Years	Age In Years	Life Expectancy In Years
78	9.91	93	3.94	108	1.35
79	9.36	94	3.67	109	1.25
80	8.83	95	3.43	110	1.16
81	8.32	96	3.21	111	1.08
82	7.84	97	3.03	112	1
83	7.38	98	2.88	113	0.93
84	6.94	99	2.71	114	0.86
85	6.52	100	2.53	115	0.79
86	6.13	101	2.35	116	0.73
87	5.75	102	2.18	117	0.67
88	5.41	103	2.02	118	0.61
89	5.09	104	1.87	119	0.56
90	4.79	105	1.72	120	0.5
91	4.51	106	1.59		
92	4.23	107	1.47		

Increase in the Minimum and Maximum Allowance for Community Spouse

The minimum and maximum resource allowance for the community spouse increases each year beginning in 2017. This fact is noted on form 470-2588, *Notice of Attribution of Resources*. No further notice or action is necessary unless the household applies for Medicaid or requests a revision of the attribution based on the increase in the minimum or maximum allowance.

When a household with the minimum or maximum community spouse attribution files an application or requests a revision of the attribution, assess the case to determine if the revised minimum or maximum must be attributed to the community spouse. (You do not need to increase attributed resources if the institutionalized spouse's eligibility is already established.)

If the new minimum or maximum applies, complete a revision and send a written statement. Do not send a *Notice of Attribution*. Suggested wording is as follows:

> The Department of Human Services completed an attribution of resources for your household in (**month**, **year**). At that time, the community spouse was attributed the maximum (or minimum) resource allowance of (**amount**). You have (filed an application *or* requested a revision of the attribution).
>
> We have revised the attribution, based on an increase in the maximum (or minimum) community spouse resource allowance to (**amount**). As of (**date**), the community spouse is attributed (**current maximum (or minimum)**).
>
> We subtract this amount from your household's total resources at the time of the Medicaid application to determine the institutionalized spouse's countable resources.
>
> If you have questions, please contact me.

Processing a Medicaid Application After Attribution

Legal reference: 441 IAC 75 (Rules in Process), P. L. 100-360, P. L. 100-485

When determining eligibility for the institutionalized spouse, the amount of resources to count is the difference between the couple's total resources at the time of application and the amount attributed to the community spouse.

Follow the requirements of 8-B to process a Medicaid application. However, do not approve Medicaid before completing an attribution of resources.

If the couple does not have an attribution, total the countable resources of both spouses at the first moment of the month of entry. Exempt only those resources listed under Resources Excluded from Attribution. Complete the attribution as directed under Calculating the Amount to Attribute to the Community Spouse.

Determine and verify countable resources of both spouses as of the first moment of the first day of the month for which application is being made (if this is a different month). Subtract the amount of resources attributed to the community spouse as of the date of entry to the facility from the couple's total resources in the month of application. Count the remaining balance towards the Medicaid resource limit for the institutionalized spouse.

Mr. Z enters a nursing facility on May 22, 1994. Mrs. Z files a Medicaid application for him in September 1995. She lists resources of their homestead, one car, a $20,000 CD, a checking account of $55,000, and $5,000 in a savings account.

When Mr. Z entered the facility, the Zs owned the following resources: their homestead, one car, $60,000 in CDs, a checking account of $65,000, and $15,000 in a savings account. Of these resources, the following items are used in completing the attribution:

$ 60,000	CDs
65,000	Checking account
+ 15,000	Savings account
$140,000	Total resources

The worker divides $140,000 by two, which equals $70,000. This amount is attributed to each spouse.

When determining Mr. Z's eligibility, the worker uses the Zs' resources at the time of application:

$ 20,000	CD
55,000	Checking account
+ 5,000	Savings account
$ 80,000	Total resources

The worker then subtracts the community spouse resource allowance ($70,000 for Mrs. Z) from the total resources. This leaves $10,000 available for Mr. Z. He is not resource-eligible for Medicaid payment of nursing facility care.

The attributed amount protected for the community spouse is maintained from the month of entry through the initial determination of the institutionalized spouse's Medicaid eligibility. Even if the total resources have increased or decreased by the time the spouse applied for Medicaid, the amount protected for the community spouse is the value of the resources attributed when the other spouse entered the institution.

However, if resources attributed to the community spouse are below the minimum allowance, and the couple later acquires resources that were not counted for attribution, these resources can be transferred to the community spouse to bring that spouse's resources up to the minimum.

1. When Mr. H enters a medical institution, the resources attributed to Mrs. H are $30,828. When Mr. H applies for Medicaid, the resources of Mr. and Mrs. H are $31,500 as of the first moment of the first day of the month of application.

   The worker subtracts the $30,828 attributed to Mrs. H from the total. Mr. H has $672. He is resource eligible under any Medicaid coverage group.
2. Mr. and Mrs. J are SSI eligible. When Mrs. J enters a medical institution in November, Mr. and Mrs. J have $2,997 in resources. All of the resources are attributed to Mr. J to meet the minimum protection of $31,584. Mrs. J is resource eligible for Medicaid payment of nursing facility care.
3. Mr. and Mrs. K are eligible for Medically Needy. Their resources are $9,800 when Mr. K enters skilled care in December. All of the resources are attributed to Mrs. K to meet the minimum protection of $31,584. Mr. K is resource eligible for Medicaid payment of nursing facility care.
4. Mr. I enters a nursing facility in December. At that time, resources attributed to Mrs. I are $31,584. Mr. I applies for Medicaid six months later. He reports that his resources have increased. The total is $75,000 at the time of application. However, only $31,584 can be attributed to Mrs. I. The other $43,416 is countable to Mr. I.

If the institutionalized spouse's resources exceed limits for nursing facility coverage groups, check eligibility under the qualified Medicare beneficiary (QMB) group or Medically Needy coverage group. Review resource eligibility at redetermination to ensure that the coverage group continues to be correct.

Mr. D enters a nursing facility in November. Mrs. D remains at home. Their resources total $33,950 in November. Mrs. D is attributed $31,584 and $2,366 is attributed to Mr. D. He is resource-eligible for Medically Needy coverage.

Mrs. D asks that the resources be reevaluated in February, since their resources have decreased. As of the first moment of the first day of the month, the combined resources of both spouses are $32,100. Subtracting the $31,584 attributed to Mrs. D, Mr. D has $516 in resources. Mr. D is resource-eligible under any Medicaid coverage group.

When Spouses Are Estranged

Legal reference: 441 IAC 75 (Rules in Process)

Attribute resources for estranged couples. “Estrangement” means a breakdown to the point that the spouses would not be living together if one was not institutionalized or were not living together before one spouse entered the institution. Determine estrangement by talking with the applicant.

If the institutionalized spouse is estranged from the community spouse, do not deny eligibility because of excess resources or failure to provide verification if the applicant can show hardship. To prove hardship, the applicant must demonstrate that:

- The applicant cannot get information about the community spouse’s resources after exploring all legal means.
- The applicant is unable to access the estranged community spouse’s resources after exploring all legal means, even though the community spouse’s resources cause the applicant to be ineligible.

Assignment of Support Rights

Legal reference: 441 IAC 75 (Rules in Process)

Do not deny Medicaid for the institutionalized spouse if the resources owned by the institutionalized spouse are less than eligibility limits and the institutionalized spouse either:

- Has assigned any rights to support from the community spouse to the state, **or**
- Lacks the ability to execute an assignment because of physical or mental impairment.

To decide if the applicant lacks the ability to assign support rights, determine if the applicant has a guardian or conservator. If the applicant did not voluntarily choose to have a guardian or conservator, the client lacks the ability to assign support rights. No further verification is required.

If the applicant chose to have a guardian or conservator but it is alleged that the applicant lacks the ability to assign support rights, verify the lack of assignment ability with a physician’s statement.

If you approve eligibility for an applicant who voluntarily or involuntarily has a guardian or conservator, send the following information to the Bureau of Financial, Health and Work Supports:

- The names and addresses of both spouses.
- The amount of the community spouse resource allowance.
- The amount of resources owned by the community spouse.

The Department will pursue support from the community spouse on a case-by-case basis. The state has the right to bring a support proceeding against a community spouse without an assignment.

The applicant is ineligible if the applicant owns resources that exceed limits, even if the applicant assigns support rights or lacks the ability to assign support rights.

Transfers to Establish Ongoing Eligibility

Legal reference: 441 IAC 75 (Rules in Process)

After the month the institutionalized spouse is determined eligible, do not consider the resources **owned** by the community spouse to be available to the institutionalized spouse.

Resources that are owned wholly or in part by the institutionalized spouse and are not transferred to the community spouse **are** counted when determining ongoing eligibility.

However, do not consider these resources if the institutionalized spouse has declared, in writing, the intent to transfer ownership of the resources to the community spouse. Issue form 470-4888, *Institutional Spouse Intent to Transfer Resources*, to document the member's intent. The member can chose to sign and return the form or can provide a written statement.

If the institutionalized spouse does not intend to transfer resources, establish eligibility for the month of application only. Deny ongoing eligibility at the end of that month.

1. Mr. W, the institutionalized spouse, has $1,900 in resources attributed to him and is eligible for Medicaid. He jointly owns a CD valued at $20,000. To remain eligible for Medicaid payment to the nursing facility, he must transfer $18,000 of the CD to reduce his ownership down to $2,000. He may transfer the total value if he wishes.
2. Mr. J is determined eligible for Medicaid in a medical institution. The amount of resources attributed to Mrs. J (the community spouse) and owned by Mrs. J is $7,000, which is under the $31,584 minimum.

   A year later, Mr. J receives an inheritance of $5,000. The IM worker verifies that when Mr. J received the inheritance, Mrs. J's resources were $6,000. Mr. J intends to transfer $4,000 to Mrs. J since her resources are under the $31,584 minimum. He signs a statement to this effect.

   Mr. J's remaining resources are $1,000 ($5,000 - $4,000 = $1,000). He is below resource limits for Medicaid and continues to be eligible.

When the member intends to transfer the resource, monitor the progress of the transfer. The transfer must take place within 90 days. The member must provide verification of the transfer. Send a notice similar to the following:

> Medicaid has been approved effective _____, since your intent is to transfer resources to your spouse within 90 days of the date of this eligibility determination.
>
> Failure to transfer the resource within 90 days will result in cancellation of Medicaid benefits unless unusual circumstances exist. Please notify this office when the resource is transferred and provide proof that the resource was transferred. 8-D, *Transfers to Establish Ongoing Eligibility*.

Contact the member or authorized representative within 45 days of the notice to check the status of the transfer. Contact the member at the end of 90 days to see if the resources were transferred.

If the institutionalized spouse is not able to transfer excess resources because of circumstances beyond the member's control, you can allow another 90 days. If, at the end of this extended 90-day period, the resources have not been transferred, cancel the case.

In some cases, the transfer of resources may cause Medicaid ineligibility for the community spouse. After the transfer has been made, examine the effect of the transfer on the community spouse's Medicaid eligibility.

Mr. and Mrs. K are eligible for Non-MAGI-related 503 program at home. Mrs. K enters a nursing facility in January. All $2,900 of their resources are attributed to Mr. K, who actually owns them. Mr. K is ineligible for the 503 program if he retains the $2,900 resources. However, he is eligible for the Medically Needy program.

Summary Examples

1. When Mr. R enters a nursing facility, Mrs. R files form 470-2577, *Resources Upon Entering a Medical Facility*. The Rs list resources of a farm that includes their homestead, $4,000 in bonds, $20,000 in stock, two cars, and $6,000 in a checking account.

   Completing the Attribution

   The following items are used to complete the attribution:

$	4,000	Bonds
	20,000	Stocks
	4,500	One car
+	6,000	Checking account
$	34,500	Total resources

   The worker divides $34,500 by 2, which equals $17,250. Because this is less than $31,584, the amount attributed to Mrs. R (the community spouse) is $31,584. The remaining amount of $2,916 is attributed to Mr. R.

   Appealing an Attribution

   After the attribution is complete, Mrs. R files an appeal to set aside additional resources that would generate income equal to the difference between the couple's available income and the MMMNA. The deficit in income is $1,622.

   The cost of an annuity to generate $1,622 per month is $103,119. Because $103,119 is more than the $31,584 attributed to Mrs. R, the attribution will be modified to substitute $103,119 for the $31,584 previously attributed to Mrs. R. No resources are attributed to Mr. R.

Determining Eligibility After the Appeal

After the appeal, Mrs. R applies for Medicaid for Mr. R. The worker subtracts the community spouse allowance of $103,119 from the couple's resources. This leaves no resources available to Mr. R. He is resource-eligible for Medicaid payment for nursing facility care. Mr. R has 90 days to transfer resources to Mrs. R to maintain his eligibility.

2. Mrs. J enters a nursing facility and files form 470-2577, *Resources Upon Entering a Medical Facility*. The Js list resources of a $150,000 farm, a homestead, $10,000 in bonds, $100,000 in CDs, one car, $10,000 in a checking account, and $55,000 in a savings account.

   Completing the Attribution

   The following items are used to complete the attribution:

$	150,000	Farm
	10,000	Bonds
	100,000	CDs
	10,000	Checking account
+	55,000	Savings account
$	325,000	Total resources

   $157,920 is attributed to Mr. J. $167,080 is attributed to Mrs. J.

   Appealing an Attribution

   After the attribution is complete, Mr. J files an appeal to set aside additional resources to generate income equal to the difference between the couple's income and the MMMNA. The couple's available income is $1,844 per month. $3,948 - $1,844 = $2,104 unmet need.

   The average estimate of the cost of an annuity to generate $2,104 per month is $101,000, which is less than the $157,920 attributed to Mr. J. The attribution remains the same.

Determining Eligibility After the Appeal

After the appeal, Mr. J files an application for medical assistance for Mrs. J. The Js have the following resources at the time of application:

$	61,920	CDs
	50,000	Bonds
	10,000	Checking account
+	40,000	Savings account
$	161,920	Total resources

The worker subtracts the community spouse allowance of $157,920. This leaves $4,000 in resources available to Mrs. J. She is ineligible for Medicaid payment for nursing facility care, because she is over the resource limit.

Estate Recovery

Legal reference: 441 IAC 75.28(7)

The cost of medical assistance is subject to recovery from the estate of certain Medicaid members. Members affected by the estate recovery policy are those who:

- Are 55 years of age or older, regardless of where they are living; or
- Are under age 55 and:
  - Reside in a nursing facility, an intermediate care facility for persons with an intellectually disability, or a mental health institute, and
  - Cannot reasonably be expected to be discharged and return home. See Establishing Whether a Member Under Age 55 Can Return Home.

Give a copy of Comm. 123 or Comm. 123(S), *Important Information for You and Your Family Members About the Estate Recovery Program*, to all Medicaid applicants at the time of the application.

An “estate” includes all real property, personal property, or any other asset in which the member had any legal title to or interest in at the time of the death of the member, to the extent of such interest. This includes, but is not limited to, interest in jointly held property, interest in trusts and retained life estates.

All assets included in the Medicaid member’s estate are subject to probate for the purpose of estate recovery. **NOTE**: It is not allowable for assets of a deceased member to be used to pay for travel expenses of family members of the deceased at the time of the member’s death.

Refer questions from members about estate recovery to the Iowa Medicaid Enterprise (IME) Estate Recovery Unit at the toll-free number 1-888-513-5186 or in the Des Moines area, at (515) 246-9841. You may also give members Comm. 266, *Iowa's Estate Recovery Law*, which gives detailed information about estate recovery procedures.

Establishing Whether a Member Under Age 55 Can Return Home

Legal reference: 441 IAC 75.28(7)

Presume that a member in a medical institution who is under age 55 is **unable** to return home. You are required to inform members of this policy by manually issuing form 470-2980, *Estate Recovery Notice for New Approvals*, to all members who are **under age 55 and a resident of a medical institution** at the time of Medicaid approval.

If a member under age 55 is discharged before six months has elapsed, no further action is necessary. Estate recovery will not be pursued because the member was not permanently institutionalized.

A member in a medical institution who is under age 55 has the right to rebut this presumption. To do so, the member must make a written request to the Department after being in the institution for six months.

If a member dies before six consecutive months of institutionalization, the family or another interested party may submit a written request to the Department to rebut the presumption that the member could not have been reasonably expected to be discharged.

Inform members who are under age 55 of their rebuttal rights by manually issuing them form 470-3209, *Estate Recovery Six-Month Follow-Up*, six months after their admission into the medical institution. If the member dies in the medical institution after a stay of less than six months, issue the form to the family or someone acting on the member's behalf.

Send all rebuttal requests to the Medical Services Unit at the Iowa Medicaid Enterprise (IME) either by using the local mail or by U.S. mail to PO Box 36478, Des Moines, Iowa 50315. The IME Medical Services Unit determines whether the member can reasonably be expected to return home and sends a copy of its decision to you and to the member.

If the IME Medical Services Unit determines that the member cannot reasonably expect to return home, the Unit will provide information to the member and to you about whether the member was ever able to return home within the first six months of institutionalization and the date the expectation and ability to return home ceased. File a copy of the determination in the case record.

A member may appeal an adverse decision. The member first appeals through the IME Medical Services Unit for reconsideration. If the member disagrees with the reconsideration decision, the member or someone acting responsibly for the member can appeal an adverse reconsideration decision by IME Medical Services Unit though normal DHS appeal procedures.

Requests for the IME Medical Services Unit determination are timely when filed within 30 calendar days from the date form 470-3209, *Estate Recovery Six-Month Follow-Up*, is issued. The member may still make a request later. However, if the decision then is that the member is reasonably able to return home, assistance received before the date the request was submitted to DHS is still subject to estate recovery.

Estate Recovery Agent

Estate recovery activities are conducted by the Revenue Collection Unit at the Iowa Medicaid Enterprise (IME).

The IME Revenue Collection Unit may request a copy of the member's first and last application or review form to determine if there are resources that could be subject to estate recovery. When sending a copy of the requested forms, record the member's name, state identification number, social security number, and case number on each sheet.

Additionally, the IME Revenue Collection Unit compares monthly Medicaid eligibility files against Vital Statistics records on reported deaths in Iowa to determine when estate recovery can be initiated for an individual.

Amount Due

Legal reference: 441 IAC 75.28(7)

The debt due the Department from the member's estate is equal to all medical assistance provided on the member's behalf on or after:

- The date the person attained age 55, or
- The date a person under age 55 entered a medical institution with no reasonable expectation of returning home.

However, no debt is due for assistance provided before July 1, 1994 (the beginning of the estate recovery program). Effective January 1, 2010, Medicaid payments for Medicare cost-sharing benefits are excluded from estate recovery for the following members:

- Qualified Medicare Beneficiaries (QMB)
- Specified Low-Income Medicare Beneficiaries (SLMB)
- Expanded Specified Low-Income Medicare Beneficiaries (E-SLMB)
- Qualified Disabled Working People (QDWP)
- Dually eligible for a full Medicaid coverage group and QMB
- Dually eligible for a full Medicaid coverage group and SLMB

Medicare cost-sharing benefits include Medicaid payments for Medicare Part A and Part B premiums, copayments, coinsurance, and deductibles.

If a member under the age of 55 is discharged from the facility and returns home before six consecutive months, no debt is assessed for Medicaid payments made on the member's behalf for the time of the institutionalization.

A claim against the estate of a member who was eligible for Medicaid because resources were disregarded under the Long-Term Care Asset Preservation program is computed differently. The amount of the assets disregarded under this program is not subject to estate recovery. EXCEPTION: Medicaid paid before the member attained eligibility due to long-term care asset preservation is still recovered from the estate.

Interest accrues on a debt due beginning six months after the death of a Medicaid member, surviving spouse, or surviving child, or upon the minor child reaching age 21. The Department does not use liens in the estate recovery program.

When Estate Recovery Is Waived

Legal reference: 441 IAC 75.28(7)

Waiver of collection from the estate based on undue hardship is determined on a case-by-case basis. Collection of the debt from the estate of a Medicaid member is waived when collection of the debt would result in:

- Reduction in the amount received from the member's estate by a surviving spouse, or by a surviving child who is under age 21, blind, or permanently and totally disabled at the time of the member's death, or
- Other undue hardship. Undue hardship exists when all of the following are true:
  - The household that claims hardship has gross monthly income, as defined by Family Investment Program (FIP) policy, of less than 200% of the poverty level for a household of the same size.
  - The household that claims hardship has total resources, as defined by FIP policy, that do not exceed $10,000.
  - Application of estate recovery would deprive a person of food, clothing, shelter, or medical care such that the person's life or health would be endangered.

When a person claims undue hardship, refer the person to the program manager for Estate Recovery at the Iowa Medicaid Enterprise.

If collection of all or part of a debt is waived for a surviving spouse or child, or for hardship, the amount waived creates a debt due from:

- The estate of the member's surviving spouse or blind or disabled child, upon the death of the spouse or child,
- A surviving child who was under 21 years of age at the time of the member's death, or upon the child reaching age 21,
- The estate of a surviving child who was under age 21 at the time of the member's death, if the child dies before reaching age 21, or
- The person who received the hardship waiver if the hardship no longer exists or from the estate of the person, whichever is first.

The debt owed by the surviving spouse, child, or person who received the hardship waiver will not exceed the amount in which recovery was waived.

Transfer of Assets

Legal reference: 441 IAC 75.23(249A), P. L. 100-360

"Transfer of assets" occurs when a person transfers resources or countable income for less than fair market value in order to become eligible or maintain eligibility for Medicaid. Transfer of assets includes, but is not limited to:

- Giving away property to someone else.
- Establishing a trust for the benefit of someone else.
- Removing a name from an asset.
- Disclaiming an inheritance on or after July 1, 2000.
- Failure to "take" against a deceased spouse's will on or after July 1, 2000.
- Reducing ownership interest in an asset.
- Transferring or disclaiming the right to income not yet received.
- Use of funds to purchase some annuities.
- Use of funds to purchase some promissory notes, loans, and mortgages.
- Use of funds to purchase some life estates.

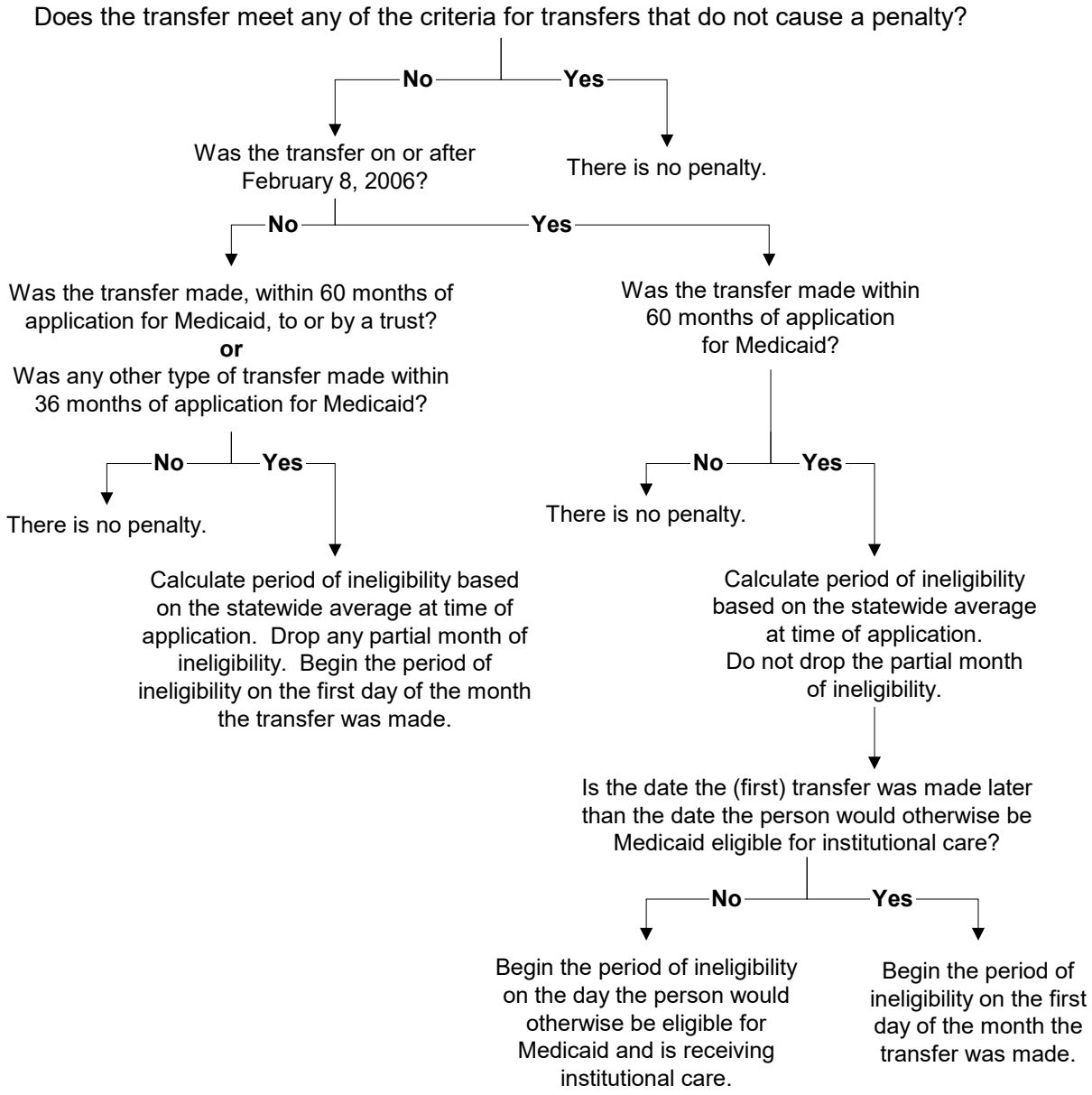
See Determining the Value of a Resource when establishing the fair market value or equity value of a resource. Assume that a person who transfers assets does so to become eligible for Medicaid unless they prove otherwise. See Rebuttal of Transfer of Assets.

Some transfers do not result in a penalty. These are listed under Transfers That Do Not a Cause Penalty. The penalty for transferring assets depends upon:

- The date the transfer occurred,
- To whom the assets were transferred, and
- How much the assets were worth at the time of the transfer.

The transfer of assets penalty affects Medicaid coverage of certain long-term care services. See Penalties for Transferring Assets.

Transfer of Assets Flow Chart



Transfers That Cause a Medicaid Penalty

Legal reference: 441 IAC 75.23(249A), P. L. 100-360

Transfers that currently may result in a Medicaid penalty being applied are:

- Transfers by an applicant or an applicant's spouse to someone other than a spouse that are made on or after February 8, 2006, and within 60 months before the Medicaid application is filed or on or after the date of application. This includes:
  - The disclaimer of an inheritance, and
  - Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") if the value received by taking against the will would exceed the inheritance received under the will
- Transfers by an applicant or an applicant's spouse involving funds in a trust that are made after August 10, 1993, and during the 60 months before the Medicaid application is filed and after institutionalization.

Purchases Considered Transfers for Less Than Fair Market Value

Legal reference: 441 IAC 75.23(9), (10), and (11)

A transfer of assets for less than fair market value includes, but is not limited to, the following actions:

- Purchase of an annuity **before** February 8, 2006, if the expected return on the annuity is not commensurate with a reasonable estimate of life expectancy, also referred to as "actuarially sound."

  When an annuity purchased before February 8, 2006, is "actuarially sound," then it is not considered a transfer of assets for less than fair market value. The annuitant has just converted the resources to income.

  To determine whether the annuity is "actuarially sound," use the life expectancy tables compiled from information published by the Office of the Chief Actuary of the Social Security Administration. These tables may be accessed at http://www.ssa.gov/OACT/STATS/table4c6.html.

  The average number of years of expected life remaining for the annuitant must coincide with the life of the annuity. If the annuitant is not reasonably expected to live as long as or longer than the guarantee period of the annuity, the annuitant will not receive fair market value for the annuity based on the projected return.

In that case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place. The penalty is assessed based on a transfer of assets that is considered to have occurred at the time the annuity was purchased or the date the annuity became available as a countable resource, whichever is later.

1. Mr. W, at age 65, purchases a $10,000 annuity to be paid over the course of ten years. His life expectancy according to the table is 17.19 years. Thus, the annuity is actuarially sound.
2. Mr. A, at the age of 80, purchases a $10,000 annuity to be paid over the course of ten years. His life expectancy is only 7.9 years. Thus, a payout of the annuity for approximately three years is considered a transfer of assets for less than fair market value and the amount is subject to penalty.

- Purchase of an annuity on or after February 8, 2006, by a **Medicaid applicant or member as the annuitant**, unless the annuity also meets **one** of first three conditions **and** the fourth condition described below:
  - The annuity is an annuity described in subsection (b) or (q) of section 408 of the United States Internal Revenue Code of 1986, or
  - The annuity is purchased with proceeds from:
    - An account or trust described in subsection (a), (c), or (p) of section 408 of the United States Internal Revenue Code of 1986;
    - A simplified employee pension (within the meaning of section 408(k) of the United States Internal Revenue Code of 1986); or
    - A Roth IRA described in section 408A of the United States Internal Revenue Code of 1986; or
  - The annuity:
    - Is irrevocable and nonassignable;
    - Is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration (see Annuities); and
    - Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made; **and**

- The annuity has the state of Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is currently institutionalized. Iowa may be named as either:
  - The remainder beneficiary in the first position, **or**
  - The remainder beneficiary in the second position, after the community spouse, minor child or disabled child, and in the first position if the spouse or a representative of the child does dispose of the remainder for less than fair market value.

  NOTE: When an annuity has the state of Iowa named as a remainder beneficiary, complete form 470-4382, *Notification Regarding Annuity Benefits*, and send it to the annuity company.

- Purchase of an annuity on or after February 8, 2006, **with the spouse of a Medicaid applicant or member as the annuitant**, unless the annuity has the state of Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is currently institutionalized. Iowa may be named as either:
  - The remainder beneficiary in the first position, **or**
  - The remainder beneficiary in the second position, after the community spouse, minor child or disabled child, and in the first position if the spouse or a representative of the child does dispose of the remainder for less than fair market value.

  NOTE: When an annuity has the state of Iowa named as a remainder beneficiary, complete form 470-4382, *Notification Regarding Annuity Benefits*, and send it to the annuity company.

- Any purchase of a promissory note, loan, or mortgage made before February 8, 2006; or any purchase of a promissory note, loan, or mortgage made on or after February 8, 2006, unless the note, loan, or mortgage meets all of the following criteria:
  - It has a repayment term that is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration (see Loans and Promissory Notes);
  - It provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
  - It prohibits the cancellation of the balance upon the death of the lender.

- Purchase of a life estate in another person's home for more than its fair market value, regardless of whether the life estate was:
  - Purchased before February 8, 2006; or
  - Purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

Transfers That Do Not Cause a Penalty

Legal reference: 441 IAC 75.23(5)

In the following situations, the transfer is exempt and does not cause a penalty:

- A joint account is divided into separate accounts that reflect separate ownership, as long as the funds are divided equally in proportion of ownership. Funds not equally divided in proportion of ownership may be considered transferred and subject to penalty.

  Mr. J and Ms. H have $8,000 in a joint account (A) and $3,000 in another joint account (B) that they cannot separate. Ms. H also has an account of $500 in her name alone.

  Mr. J enters a nursing home and applies for Medicaid. Ms. H has spent $5,000 from account A and $1,000 from account B on Mr. J's nursing home care. At that point, she removes Mr. J's name from the accounts.

  Since Ms. H spent more than half of the accounts on Mr. J's care ($6,000 out of $11,000), she has rebutted the presumption of divesting. The account owned by Ms. H does not enter into the rebuttal of divesting.

- A transfer is made to the institutionalized person's child or adult child who is disabled as defined by Social Security Administration. The child is considered disabled if the child is:
  - Receiving SSI, Social Security disability benefits, or Railroad Retirement benefits as a disabled child, or
  - Declared disabled by a Department disability determination. See 8-C, *When the Department Determines Disability*.

Ms. E applies for Medicaid while living in a skilled nursing facility. She has transferred $10,000 to her son. She says her son is disabled, but he is not receiving any disability benefits. The Department refers the son to apply for SSI, because he has no income.

Ms. E's application is approved for other medical services but is pended for facility payments due to the need to determine her son's disability. If the son does not apply for SSI, the Department determines disability. If the son is not determined to be disabled, transfer of asset penalties are applied.

- The applicant or member or the applicant or member's spouse transfers an asset that would have been exempt as a resource at the time of transfer.

Mr. and Mrs. D have $11,000 in total assets in March. On April 14, they gave away $5,000 in certificates of deposit to their daughter. Mrs. D enters a medical institution to stay on April 30.

Since the Ds owned total assets of less than $31,584, the minimum protected amount for the community spouse in the month before the month of entry and attribution, the transfer is not for the purpose of qualifying for Medicaid.

EXCEPTION: Transfers of a home and surrounding property (including the transfer of a life estate interest only) are not exempt from transfer penalties.

- A transfer was made into a trust established solely for the benefit of:
  - The person's child or adult child who is blind or disabled, as defined by the Social Security Administration.
  - A person under 65 years of age who is disabled, as defined by the Social Security Administration.
- A transfer made between spouses or to another person for the sole benefit and support of the community spouse.

1. Mr. Q transfers his half of a $25,000 certificate of deposit to his daughter on May 14, 2005, for Mrs. Q's benefit. Mr. Q then applies for Medicaid on May 20, 2005. On June 1, 2005, he enters a skilled nursing facility. Mr. Q furnishes a statement that the money was transferred because Mrs. Q is handicapped, and the daughter will be handling Mrs. Q's finances.

   This transfer does not disqualify Mr. Q for payment of nursing facility services because the transfer was for the benefit of his spouse.

2. Mr. W transfers his car, valued at $25,000, to Mrs. W while living at home. Mr. W applies for Medicaid. This is not a disqualifying transfer, since the car was transferred to the spouse, and the spouse did not transfer it.

- A transfer is made in response to a court order that the institutionalized spouse provide support for the community spouse, and the assets are transferred for:
  - The support of the community spouse, or
  - The support of a minor or dependent child, dependent parent, or dependent sibling of the institutionalized spouse or community spouse who lives with the community spouse.

When Mr. P enters a nursing facility, there is a court order stating that Mr. P should transfer $10,000 to First National Bank for the support of his son, Pat, who lives with Mrs. P. Since Pat lives with Mrs. P, and there is a court order requiring this transfer, it is not a disqualifying transfer. Mr. P is eligible for payment for nursing facility services.

- The transfer results in denial of eligibility that causes an undue hardship to the applicant or member. Undue hardship exists only when all of the following conditions are met:
  - Application of the transfer of asset penalty would deprive the applicant or member of food, clothing, shelter, medical care, or other necessities of life, such that the applicant's or member's health or life would be endangered.
  - The client who transferred the resource or the client's spouse has exhausted all means to recover the resource, including legal remedies and consultation with an attorney.
  - The client's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:
    - The home, if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.
    - Household goods.
    - A vehicle required by the applicant or member for transportation.
    - Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for nursing facility services.

> Mr. C transfers his home, with an equity value of $75,000, to his nephew and applies for Medicaid payments in a nursing home. The IM worker determines that Mr. C is ineligible for Medicaid for 30 months.
>
> Mr. C replies that he does not have the money to pay for care. He goes to his lawyer, who writes to the nephew requesting that the nephew return the home. The nephew refuses to return the home, and the attorney advises that no further legal recourse is available.
>
> Mr. C has met the requirement of exhausting legal means. Mr. C has the following assets: $500 cash and a burial fund of $1,500. The $500 is countable because it is available. Since the $1,500 is earmarked for burial and under $4,000, it is not available.
>
> Because Mr. C's available assets are less than the average statewide cost of nursing facility services, he also meets the second requirement and a hardship exception is granted.
>
> Because the transfer of asset penalty will not be applied and Mr. C is otherwise eligible, Medicaid nursing facility payments are approved from the date of entry.

- The applicant or member who transferred the asset makes a satisfactory showing that the applicant or member intended to dispose of the asset either at fair market value or for other valuable consideration equal to the fair market value. The client must verify the attempts to sell the asset for fair market value through an independent source.
- The applicant or member who transferred the asset makes a satisfactory showing that the asset was transferred exclusively for another purpose other than to establish eligibility for Medicaid. See Rebuttal of Transfer of Assets.
- The applicant or member who transferred the asset makes a satisfactory showing that all assets transferred for less than fair market value have been returned to the applicant or member.

- The applicant's or member's home is transferred to one of the following:
  - The spouse of the institutionalized applicant or member.
  - A child of the institutionalized person who is under age 21, or who is blind or totally disabled as defined by the Social Security Administration. The child is considered disabled if the child is:
    - Receiving SSI or Social Security benefits or Railroad Retirement benefits as a blind or disabled person, or
    - Declared disabled by a Department disability determination. See 8-C, *When the Department Determines Disability*.
  - A sibling of the institutionalized applicant or member who has an equity interest in the home and who lived in the home at least one year immediately before the applicant or member became institutionalized or eligible for HCBS waiver or PACE services.

    Verify that the sibling has an equity interest and lived in the home for the required period of time.
  - A son or daughter who was living in the parent's home for at least two years immediately before the date the parent became institutionalized, and who provided care to the parent that allowed the parent to live at home rather than in a medical institution. The parent can be either a biological parent or stepparent.

    Verify with a third party the length of time that the parent was able to stay home due to the care of the son or daughter.

1. On September 17, while Mr. W is living at home on his farm, he transfers his farm to his son, age 51. Mr. W enters a nursing facility on September 29. His son is not disabled, and did not provide care to Mr. W while Mr. W was at home.

   The worker determines Mr. W is subject to a penalty, because the son to whom the farm was transferred did not meet the criteria for exempting the transfer.

2. Ms. O has a 32-year-old daughter who has always lived with her, but does not provide care to Ms. O to enable her to stay at home rather than in a medical institution. She wants her daughter to have the home and transfers it after her entry to the skilled nursing facility.

   The daughter does not receive SSI, Social Security, or Railroad Retirement, but alleges a disability. Disability Determination Services determines that the daughter is disabled. The transfer of the home is not a disqualifying transfer.

3. Mr. E, who lives in a skilled nursing facility, transfers his share of his home to his brother. They inherited the home from their father and had lived there together for 20 years.

   This transfer does not disqualify Mr. E for payment of nursing facility services, since the brother had an equity interest and they had lived together more than one year before Mr. E's entry to a nursing facility.

Rebuttal of Transfer of Assets

Legal reference: 20 CFR 416.1246, IAC 75.23(5)"c"(249A)

Assume all applicants or members who transfer assets do so to become eligible for Medicaid unless the applicant or member proves otherwise. The burden of proof is on the applicant or member to prove assets were **not** transferred to meet eligibility requirements. The applicant or member must:

- Explain why the asset was transferred.
- Explain the applicant's or member's relationship to the person who received the transferred asset.
- Establish the fair market value and the equity value of the resource.
- Verify an attempt to dispose of the asset for a fair market value.
- Explain why less than the fair market value was accepted.
- Establish that an agreement, contract, or expectation was created at the time of transfer stating the applicant or member received or will receive compensation for the value of the transfer. Compensation is money, real or personal property, food, shelter, or services received by an owner in exchange for an asset.
- Explain how the applicant or member planned for self-support after the asset was transferred.

Include in the case record documents or letters made at the time of the transfer as evidence to verify that a transfer was not done to qualify for Medicaid.

Certain factors **may** indicate that a transfer was done for some reason other than to obtain Medicaid eligibility, such as:

- The transfer was made before the applicant or member was diagnosed with a previously undetected disabling condition or became suddenly traumatically disabled (for example, due to a car accident).
- The transfer that would have prevented eligibility was made before the applicant or member unexpectedly lost other assets or income. For example, at the time the assets were transferred, the applicant or member had enough income or assets to meet the applicant's or member's own needs without the use of Medicaid but then unexpectedly lost that income or asset.

In July, Mr. J sells property valued at $8,000 for $5,000. He applies for Medicaid in October. Mr. J explains that he sold the property to pay medical bills of $3,900 incurred by his recently deceased wife. Although he was asking $8,000 for the property, he accepted less than fair market value because he needed the money quickly.

At the time of the sale, Mr. J was receiving $1,500 in Social Security, $200 from a private pension, $200 in dividends from a company in which he owned stock, and $1,000 monthly cash support from his son.

But in August, Mr. J's son died and the cash support payments ceased. In September, the company from which he had been drawing dividends went bankrupt, rendering his stock worthless, and removing that source of income.

Mr. J presents as evidence copies of paid medical bills, a March agreement with a realtor to sell the property, copies of canceled checks showing monthly $1,000 payments to Mr. J, a copy of his son's death certificate, and newspaper clippings regarding the bankruptcy of the dividend-paying company.

Mr. J has established that he sold the property exclusively for some other purpose than establishing Medicaid eligibility. The transfer does not affect Medicaid eligibility.

The rationale for this determination is that Mr. J attempted to sell the property at fair market value and at the time of the sale had income that would have made him ineligible to receive Medicaid. He could not reasonably have expected to become entitled to Medicaid as a result of the sale.

- The transfer was of an asset that was excluded on the date of transfer and would continue to be excluded even if retained. Property that was excluded as a homestead property is considered an asset for this purpose.

  If an excluded home is transferred for less than fair market value, the fact that it was excluded on the date of transfer and would continue to be excluded even if retained is not sufficient to establish that the transfer was done for some reason other than to obtain Medicaid eligibility.

- The transfer was a gift and a pattern has been established of giving gifts or contributing to a charity.

  > Mr. Z applies for Medicaid on November 6. He has given his son $500 for Christmas every year since the son was born. Mr. Z shows convincing evidence that he made such gifts to his son every year at Christmas. The presumption that the assets were transferred to qualify for Medicaid is rebutted.

- The transfer was in exchange for support, maintenance, or services provided to the applicant or member as part of a binding agreement at the time of transfer. Determine the fair market value of the services received and the length of time the services will be provided.

  > Mrs. H transferred her savings account of $5,000 to her son in July 1996, pursuant to a written agreement they made in October 1995 for him to provide her care until she went in the nursing home.
  >
  > The $5,000 was determined by the son charging $500 a month for 10 months of care. She rebutted the presumption that the transfer was made to attain eligibility.

  If services will be provided for the client's lifetime, use the table of Average Number of Years of Life Remaining under Purchases Considered Transfers for Less Than Fair Market Value to determine if the resources were transferred for less than they are worth. This table comes from the Social Security Administration Office of the Actuary.

  To determine the total value of support and maintenance for the client, multiply the current market value of the support and maintenance by the figure for average years of life remaining opposite the client's age. If the client's age is not on the chart, use the next lowest age on the chart.

  If the value of the service is equal to or more than the asset, there is no transfer of assets.

Penalties for Transferring Assets

Legal reference: 441 IAC 75.23(1)

Transfer of assets after August 10, 1993, for less than fair market value by either a Medicaid applicant or member or the applicant or member's spouse disqualifies the applicant or member for Medicaid payment for:

- Nursing facility services.
- Level of care in a medical institution equivalent to that of nursing facility services.
- Home- and community-based (HCBS) waiver services. (A person receiving HCBS waiver services is considered as an institutionalized person.)
- Program for All-Inclusive Care for the Elderly (PACE) services. (A person receiving PACE services is considered as an institutionalized person.)
- Home health care services.
- Home and community care for functionally disabled elderly people.
- Personal care services.
- Other long-term care services.

The penalty period for transferring assets depends on when the assets were transferred and how much the assets were worth at the time the transfer occurred.

The value of the assets transferred is divided by the statewide average cost of nursing facility services at the time of application.

Time of Application	Average Monthly Statewide Cost of Nursing Facility Services	Average Daily Cost of Nursing Facility Services
July 1, 2024 – June 20, 2025	$8,842.75	$290.88
July 1, 2023 – June 30, 2024	$8,581.61	$282.29
July 1, 2022 – June 30, 2023	$7,786.35	$256.13
July 1, 2021 – June 30, 2022	$7,710.66	$253.64
July 1, 2020 – June 30, 2021	$7,205.40	$237.02
July 1, 2019 – June 30, 2020	$6,799.88	$223.68
July 1, 2018 – June 30, 2019	$6,447.54	$212.09
July 1, 2017 – June 30, 2018	$6,269.63	$206.24
July 1, 2016 – June 30, 2017	$5,809.13	$191.09
July 1, 2015 – June 30, 2016	$5,407.24	$177.87
July 1, 2014 – June 30, 2015	$5,103.24	$167.87
July 1, 2013 – June 30, 2014	$5,057.65	$166.37
July 1, 2012 – June 30, 2013	$5,131.82	$168.81
July 1, 2011 – June 30, 2012	$4,853.36	$159.65
July 1, 2010 – June 30, 2011	$4,842.72	$159.30
July 1, 2009 – June 30, 2010	$4,598.61	$151.27
July 1, 2008 – June 30, 2009	$4,342.03	$142.83
July 1, 2007 – June 30, 2008	$4,173.92	$137.30
July 1, 2006 – June 30, 2007	$4,021.31	$132.28
July 1, 2005 – June 30, 2006	$3,697.55	$121.63

To establish the penalty period for transfers made **before** February 8, 2006:

1. Determine the equity value of all assets transferred in the 36 months before the client applied for Medicaid, other than those transferred to or by a trust.
2. Determine the equity value of all assets transferred into or by a trust in the 60 months before the client applied for Medicaid.
3. Divide the total equity value of the transferred assets by the average monthly cost of nursing services at the time of application to determine the number of months of penalty. Drop any fraction remaining, so the result is in whole months.
4. Start the penalty on the first day of the month assets were transferred.

1. Mr. T transfers $100,000 to his next-door neighbor on April 11, 2005. He enters a nursing facility and applies for Medicaid on June 3, 2006. The worker determines that the transfer was made to qualify for Medicaid. The penalty period is figured by dividing $100,000 by $3,697.55, with a result of 27.05 months.

   Since the transfer was made before February 8, 2006, the partial month of ineligibility is rounded down to 27 months. Also, the penalty period begins on the first day of the month the transfer was made. Mr. T's period of ineligibility begins April 1, 2005, and lasts through June 30, 2007. He can reapply for Medicaid nursing facility payment and, if he is otherwise eligible, be approved on July 1, 2007.
2. Mrs. A transfers $3,000 to her daughter on January 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid payment of her nursing facility care on June 9, 2006.

   The worker determines that the transfer was made in order to qualify for Medicaid. The penalty period is figured by dividing $3,000 by $3,697.55, with a result of 0.811. Since the transfer was made before February 8, 2006, the result is rounded down and there is no period of ineligibility.

To establish the penalty period for transfers made **on or after** February 8, 2006:

1. Determine the equity value of all assets transferred in the 60 months before the client applied for Medicaid.
2. Divide the amount from step 1 above by the average monthly statewide cost of nursing facility services.

3. Multiply the full number of months from step 2 by the average monthly statewide cost of nursing facility services to determine the amount of the transfer that would be used to cover the full months.
4. Subtract (result of step 3) from the total assets transferred (amount in step 1) to determine the balance or partial month amount.
5. Divide the partial month amount (result from step 4) by the daily average statewide cost of nursing facility services to come up with the number of additional days for the partial month penalty.
6. Start the penalty on:
   - The date the applicant or member would otherwise be eligible for Medicaid payment of long-term care services, or
   - The level of care effective date for Medicaid HCBS waiver applicants, or
   - The level of care effective date for PACE enrollees, or
   - The first day of the month assets were transferred, whichever is later.

1. Mr. Z transfers $95,000 to his best friend on February 11, 2006. He enters a nursing facility on March 3, 2006, and applies for Medicaid nursing facility payment on June 9, 2006. The worker determines that the transfer was made in order to qualify for Medicaid.

   Since the transfer took place after February 8, 2006, the partial month of ineligibility is not rounded down. The penalty period is figured as follows:

   a. Divide the total transferred by the statewide monthly cost of nursing facility services ($95,000 ÷ $3,697.55 = 25.69).
   b. Figure the amount used in the full 25 months of penalty (25 months × $3,697.55 = $92,438.75).
   c. Subtract this from the total transferred to come up with the partial month balance ($95,000 – $92,438.75 = $2,561.25).
   d. Take the partial month balance and divide by the statewide daily average cost of nursing facility services ($2,561.25 ÷ $121.63 = 21 days).

   The penalty period is 25 months and 21 days.

If there were no penalty for transferring his assets for less than fair market value, Mr. Z could have been eligible for Medicaid payment of his facility care effective March 3, 2006. Since this date is later than the date he made the transfer, Mr. Z's period of ineligibility begins March 3, 2006, and lasts through April 23, 2008. He can reapply for Medicaid nursing facility payment and, if he is otherwise eligible, be approved on May 24, 2008.

2. Mrs. G transfers $3,000 to her daughter on February 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid nursing facility payment on June 9, 2006. The worker determines that the transfer was made to qualify for Medicaid. The transfer was made after February 8, 2006, so the partial month of ineligibility is not rounded down.

   The penalty period is figured and results in a penalty for 24 days ($3,000 ÷ 121.63 = 24.66). If there were no penalty for transferring her assets for less than fair market value, Mrs. G would have been eligible for Medicaid payment of her facility care effective March 3, 2006.

   Since this date is later than the date she made the transfer, Mrs. G's period of ineligibility begins March 3, 2006, and lasts through March 26, 2006. If she is otherwise eligible, she can be approved effective March 27, 2006.

If the transfer period is determined and the community spouse later becomes eligible for Medicaid payment of facility care, divide the remaining period of ineligibility in half and apply one-half of the penalty period to each spouse. When the transfer was made before February 8, 2006, combine the two partial months of ineligibility to equal one month and apply that month to the spouse that initiated the transfer.

If one spouse dies before the penalty period is completed, apply the remaining period of ineligibility to the living spouse.

1. Mrs. L transfers $71,000 in January 2005. Mr. L enters a nursing facility in March 2006, and files an application for nursing facility care. A 19-month period of ineligibility is determined ($71,000 ÷ $3,697.55 = 19.2). Since the transfer was made before February 8, 2006, the period of ineligibility begins on the first day of the month the transfer was made. Mr. L is ineligible from January 1, 2005, through July 31, 2006.

   Mrs. L enters the facility on April 3, 2006. Sixteen months of the period of ineligibility have passed. The worker divides the remaining three months between the couple (3 months ÷ 2 = 1.5). Because Mrs. L initiated the transfer, she is ineligible for two months and Mr. L is ineligible for one month. Mrs. L is ineligible for nursing facility care beginning April 1, 2006, through May 31, 2006. Mr. L's period of ineligibility is shortened to end May 31, 2006.

2. Mrs. S transfers $71,000 on March 2, 2006. Both enter a nursing facility on April 1, 2006, and file an application for nursing facility care in June 2006. A 19-month period of ineligibility is determined ($71,000 ÷ $3,697.55 = 19.2, or 19 months + 6 days). The total period of ineligibility is divided between Mr. and Mrs. S (19 months + 6 days ÷ 2 = 9 months + 18 days each).

   Since the transfer was made after February 8, 2006, the period of ineligibility begins on the first day that both would otherwise have been eligible for Medicaid payment of their facility care. The partial month of ineligibility is not rounded down. A period of ineligibility is imposed for both Mr. and Mrs. S beginning on March 1, 2006, through December 18, 2006.

   Mrs. S passed away on April 3, 2006. One month and 2 days of her period of ineligibility have passed. The remaining 8 months and 16 days of ineligibility are imposed on Mr. S's period of ineligibility and is now extended to September 2, 2007.

Do not put a penalized member in a facility aid type. If the member has been receiving Medicaid under another coverage group, leave the aid type the same as it was before the member entered the facility. If the person is a Medicaid applicant who is eligible under a coverage group not contingent on living in a medical institution, use the nonfacility aid type for that coverage group.

Code the COPAY field on TD03 to reflect the penalty period. (See instructions in 14-B-Appendix.) Set a reminder in the system for the month before the end of the penalty period, and redetermine eligibility at that time.

Multiple Transfers

Transfers Before February 8, 2006

When an applicant or member makes more than one transfer of assets for less than fair market value before February 8, 2006, determine ineligibility as follows:

- If the penalty periods would not overlap, consider each transfer separately. Drop the partial month of ineligibility and begin each period of ineligibility on the first day of the month when the transfer was made.
- If the penalty periods would overlap, consider the total uncompensated value as one transfer. Drop the partial month of ineligibility and begin the period of ineligibility on the first day of the month when the first transfer was made.

Transfers on or After February 8, 2006

When there are multiple transfers made on or after February 8, 2006, total all of the transfers made on or after February 8, 2006, and within the 60 months before application. Consider the total uncompensated value as one transfer.

Begin the period of ineligibility in the month of the first transfer or in the month the person would otherwise have been eligible for Medicaid payment of facility care, whichever is later.

- When the date the applicant or member would otherwise have been eligible for Medicaid facility payment is later than the date the transfer was made, the period of ineligibility begins on the date the applicant or member would have been eligible.
- When the date the applicant or member would otherwise have been eligible for Medicaid facility payment is earlier than the date the first transfer was made, the period of ineligibility begins on the date the first transfer was made.

1. Mrs. B transfers $3,000 to her daughter on November 25, 2005, and another $3,500 to her son on January 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid payment of her nursing facility care on March 9, 2006.

   The worker determines that the transfers were made in order to qualify for Medicaid. Since the transfers were made before February 8, 2006, partial months of ineligibility are rounded down. No penalty is imposed because the amounts transferred are less than the statewide average cost of nursing facility services and the penalty is less than one month.

2. Mrs. M gave her granddaughter $60,000 in January 2005 and another $60,000 in January 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid in June 2006.

   The penalty period is figured by dividing $60,000 by $3,697.55, with a result of 16.23. The 16-month-period of ineligibility for the transfer made in 2005 would overlap the date of the next transfer made in 2006. The transfers were made before February 8, 2006. Total the two transfers and treat them as one transfer.

   The penalty period is figured by dividing $120,000 by $3697.55, with a result of 32.45. The partial month of ineligibility is rounded down and the period of ineligibility is started on the first day of the month of the first transfer. The period of ineligibility begins on January 1, 2005, and runs through August 31, 2007. Mrs. M can reapply and, if otherwise eligible, be approved effective September 1, 2007.

3. Mrs. D gave her daughter $6,000 on February 1, 2006, and another $6,000 in March 2006. Mrs. D entered a nursing facility on March 3, 2006, and applied for Medicaid in June 2006. The worker determined the transfers were made in order to qualify for Medicaid. The first transfer was made before February 8, 2006, and the second one was made after February 8, 2006.

   The penalty period for the first transfer is one month. The partial month of ineligibility is rounded down ($6,000 ÷ $3,697.55 = 1.62 or 1 month). This period of ineligibility is started on the first day of the month of the transfer (February 2006).

   Mrs. D's period of ineligibility for the second transfer is determined to be 1 month and 19 days. It is started on March 3, 2006, and runs through April 20, 2006. If otherwise eligible, Mrs. D can be approved effective April 21, 2006.

4. Mrs. C transfers $3,000 to her daughter on February 25, 2006. She enters a nursing facility on March 3, 2006. On April 3, 2006, Mrs. C inherits $3,500 and transfers it to her son. On June 10, 2006, she applies for Medicaid payment of her nursing facility care.

   The worker determines that the transfers were made in order to qualify for Medicaid. Since the transfers were made after February 8, 2006, the worker totals the two transfers and treats them as one transfer.

   The penalty period is figured by dividing the total of $6,500 by $3,697.55, with a result of 1.76 months or 1 month and 23 days. If there were no penalty for transferring her assets, Mrs. C would have been eligible for Medicaid payment of her facility care effective March 3, 2006.

   Since the date the first transfer was made is earlier than the date she would otherwise have been eligible, Mrs. C's period of ineligibility begins on March 3, 2006 (the day she would have been eligible). The penalty period lasts through April 25, 2006. If Mrs. C is otherwise eligible, she can be approved effective April 26, 2006.

Return or Partial Return of the Transferred Asset

Legal reference: 20 CFR 416.1246(a)(2), 441 IAC 75.23(5)"c"

If the transferred asset is returned, there is a change in the period that the uncompensated value of the asset affects eligibility. If the asset is returned in its entirety, the transfer penalty is expunged as of the first moment of the first day of the month after the return.

If the asset is partly returned, the period of ineligibility is determined by the difference in the value of the property transferred and the value of the property returned. Determine the changed period of ineligibility and apply it beginning the first month the transfer penalty was imposed.

The increase or decrease in value of the property transferred that may have occurred due to inflation or deflation from the time of transfer to the time of return does not affect the length of the period of ineligibility.

Changing the disqualification period does not necessarily establish eligibility.

Assets returned are not considered income but are a countable resource if retained in the month following the month they were returned.

Trusts

Legal reference: 20 CFR 416.1201, 441 IAC 75.24(249A)

Treatment of resources in a trust depends on:

- When the trust was established.
- Whether the trust was established with the member's assets or with someone else's assets.
- What use of the trust income and principal is allowed by the terms of the trust.
- The member's role in relation to the trust.
- Whether the trust is revocable or irrevocable.
- The coverage group under which eligibility is being explored or established when a child is the grantor or beneficiary of the trust. (See Resource Eligibility of Non-MAGI Children later in this chapter and 8-F, *Coverage Groups* for more information.)

A person is considered to have "established" a trust if:

- The person's assets were used to form all or part of the principal of the trust, **and**
- The trust was set up by any of the following:
  - That person,
  - That person's spouse, or
  - A person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of that person or that person's spouse.

"Assets" means all income and resources of the person and the person's spouse. This includes any income or resources that the person or the person's spouse is entitled to but does not receive, because of action taken by:

- The person or the person's spouse.
- Another person, court, or administrative body acting at the direction or upon the request of the person or the person's spouse.
- Another person, court or administrative body with legal authority to act in place of or on behalf of the person or the person's spouse.

Trusts established with assets not owned by the beneficiary include testamentary trusts (established by a will) and inter vivos trusts (established by one living person to another).

Policy on trusts is organized as follows:

- Definitions of the basic terms used in describing trusts.
- How to evaluate a trust, depending on a client's roles in relation to the trust.
- Treatment of assets in a trust, including a comparison of the major kinds of trusts.
- More information on specific kinds of trusts.

Trusts established with assets owned by the beneficiary are treated differently depending on whether they are revocable or irrevocable and whether they were established after August 10, 1993. Irrevocable trusts established on or before August 10, 1993, are known as "Medicaid qualifying trusts."

Certain kinds of irrevocable trusts established after August 10, 1993, provide that the assets go to reimburse the state for the member's Medicaid expenses after the member's death. Trusts that are subject to different treatment because of these provisions are:

- Medical assistance income (MAIT) trusts.
- Special needs trusts for persons under 65.
- Special needs trusts with no age limit.

Trust Definitions

A **trust** is an arrangement whereby one or more persons (the trustees) hold property for the benefit of one or more others (the beneficiaries). Trusts include two types of assets:

- **Trust principal** is the property placed in trust by the grantor that the trustee holds, subject to the rights of the beneficiary, plus any trust earnings paid into the trust and left to accumulate the month following the month of receipt.
- **Trust earnings or income** are amounts earned by trust principal, such as interest, dividends, royalties, or rents. These amounts are unearned income to the beneficiary if the beneficiary is legally able to use them for personal support and maintenance.

A trust can be established by a written document, including a will. A trust can also be established by a verbal understanding between the grantor and the trustee when the property has been transferred to the trustee.

No court involvement is necessary to establish a trust. The grantor and the beneficiary can be the same person, and the grantor can be the trustee, but the trustee and the beneficiary cannot be identical. If the trustee and the beneficiary are identical, the trustee/beneficiary owns the property outright.

NOTE: The trustee and the beneficiary are not identical if the state is a residuary beneficiary. The trustee and the life-time beneficiary may be the same person on a qualifying special needs or MAIT trust where the state is a residuary beneficiary.

A **grantor** is a person who sets up a trust. A person may be a grantor if an agent or someone legally empowered to act on behalf of the person or the person's spouse (such as a legal guardian, representative payee, person acting under a power of attorney, or conservator) establishes the trust with the person's funds or property. The terms grantor, trustor, and settlor may be used interchangeably.

A **trustee** is a person or entity who holds legal title to property for the use or benefit of another person. In most instances, the trustee has no legal right to revoke the trust or use the property for the trustee's own benefit. However, if the member is a trustee and has the legal ability to revoke the trust and use the money for the member's own benefit, the trust is a resource to the member.

A **beneficiary** is a person who benefits from the principal or income. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it. A trust may have more than one beneficiary.

A **residual or residuary beneficiary** benefits from the income and principal after the primary beneficiary is no longer involved, for example, due to the death of the primary beneficiary. The residuary beneficiary receives no benefit from the trust until certain conditions are met.

A **Totten trust** is a tentative trust in which a grantor makes himself or herself trustee of the grantor's own funds for the benefit of another. The trustee can revoke a Totten trust at any time. Therefore, consider the principal and income of a Totten trust available to the member. Should the trustee die without revoking the trust, ownership of the money passes to the beneficiary.

A **conservatorship** is similar to a trust. A conservatorship is always established by a court, which explicitly appoints a conservator to act on the ward's behalf for the ward's financial affairs. Treat a conservatorship established on or after February 9, 1994, as a trust. See Revocable Trusts and Irrevocable Trusts to determine availability and whether transfer of asset policies apply.

Evaluating a Trust

The following charts provide a guide to understanding trusts. Use the appropriate chart depending on whether the member is the grantor, the trustee, or the beneficiary. The member may occupy more than one role.

1. Mr. J is the grantor and also the beneficiary of a trust. Use the grantor and the beneficiary trust charts to determine availability and accessibility of the trust principal and income when determining Medicaid eligibility.
2. Mr. D is the grantor and trustee of a trust that names his niece as the beneficiary. Use the grantor and trustee charts to determine the availability of the trust principal and income when determining Mr. D's Medicaid eligibility.
3. Ms. M is the beneficiary of a trust. Use the beneficiary chart to determine the availability of the trust principal and income when determining her eligibility.

Grantor Chart

Use this chart if the member created the trust, or an agent or someone else legally empowered to act on the member's behalf established the trust with funds or property belonging to the client. (The member is the grantor.)

Is the trust revocable?

- NO → **Is the member a beneficiary?**
  - NO → This is a transfer of assets. The trust is not available and therefore is not a countable resource.
  - YES → **Is the member the sole beneficiary?**
    - NO → Possible transfer of assets. See the beneficiary chart.
    - YES → See the beneficiary chart.
- YES → The trust is available and countable.

Trustee Chart

Use this chart if the member holds legal title to property for the use or benefit of another. (The member is the trustee.)

Does the trustee have power to revoke and use the trust principal and income for the trustee's own benefit?

NO

YES
The trust is available to the trustee. The trust principal and income are countable as income and resources to the trustee.

Is the trustee also a beneficiary?

NO
The trust principal and income are not available. Look for trustee fees.

YES

Is the member both sole trustee and sole beneficiary (or are all trustees also all beneficiaries)?

NO
See the beneficiary chart. Refer the trust to the Medicaid trust program at: trust@dhs.state.ia.us.

YES
The principal and income are available to the client or to all trustees as a joint asset. Refer the trust to the Medicaid trust program at: trust@dhs.state.ia.us.

Beneficiary Chart

Use this chart if a trust exists for the benefit of the member. (The member is the beneficiary.) The member does not hold legal title to the trust property but does have an equitable ownership interest in it.

Is the beneficiary also the grantor?

NO

Apply appropriate Non-MAGI-related or MAGI-related policy.

YES

Was the trust established after August 10, 1993?

NO

For trusts established on or before August 10, 1993, apply Medicaid qualifying trust policies.

YES

For trusts established after August 10, 1993, evaluate the trust under the revocable or irrevocable policies unless it is:

- A special needs trust for persons under 65 years old,
- A medical assistance income trust, or
- A special needs trust (no age limit).

Treat according to the policies found in this chapter.

Treatment of Resources in a Trust

When determining eligibility, first review the trust to see if it is accessible. If the principal and income are accessible, count the amounts toward the resource limits and use them when determining eligibility, client participation, and spenddown.

For eligibility purposes, there is no requirement that the beneficiary of a trust take legal action to attempt to gain access to the trust principal.

	Testamentary and Inter Vivos Trusts	Medicaid Qualifying Trust (set up before 8/10/93)	Irrevocable Trust (set up after 8/10/93)	Revocable Trust (set up after 8/10/93)
Established by:	Someone other than the member is the grantor of the trust.	Member or someone acting on member's behalf is the grantor of the trust.	Member or someone acting on member's behalf is the grantor of the trust.	Member or someone acting on member's behalf is the grantor of the trust.
Established with:	Funds not owned by the beneficiary before trust was established.	Funds owned by the grantor or funds that the grantor is entitled to.	Funds owned by the grantor or funds that the grantor is entitled to.	Funds owned by the grantor or funds that the grantor is entitled to.

	Testamentary and Inter Vivos Trusts	Medicaid Qualifying Trust (set up before 8/10/93)	Irrevocable Trust (set up after 8/10/93)	Revocable Trust (set up after 8/10/93)
Availability of principal and income	Discretionary: Principal and income are not necessarily available to the beneficiary. Principal and income available to the beneficiary for basic needs is countable as resources and income when determining eligibility, client participation, and spenddown. Principal and income available for nonbasic needs only are not countable as resources and income.	Discretionary: The maximum amount that may be made available by the trustee under the terms of the trust, assuming the trustee exercises full discretion in the distribution of the income and principal is countable in determining eligibility, client participation, and spenddown. See Transfer of Assets for any principal or income not available to the grantor.	The principal and income are considered available and countable to the extent they could be made available, under any circumstances or for any purpose, according to the terms of the trust. See Transfer of Assets for any principal or income not available to the grantor.	Principal and income are available and countable to the beneficiary when determining eligibility, client participation, and spenddown. See Transfer of Assets Any payments from the trust not for the benefit of the client are assets transferred for less than fair market value.

	Testamentary and Inter Vivos Trusts	Medicaid Qualifying Trust (set up before 8/10/93)	Irrevocable Trust (set up after 8/10/93)	Revocable Trust (set up after 8/10/93)
Use in Medicaid and State Supplemen-tary Assistance	Count amounts available according to the terms of the trust.	Amounts that count toward FIP, SSI, or SSA cash payments are not used in determining Medicaid eligibility.	Any available principal or income counts toward resource and income limits. If not available, see transfer of asset policy.	Count principle and income as available.

Procedure: Refer trusts and conservatorships, including MAITS, for review by the Medicaid Trust Program. Even if clarification is not needed for Medicaid eligibility purposes, the referral is needed for proper tracking of Medicaid payback trusts. A referral should also be made when requested by Trust Program staff even if there is no Medicaid case.

Referring trusts and conservatorships is also needed to:

- Clarify how the terms of the trust impact eligibility;
- Make Trust Program staff aware when an inaccessible trust is held by an active member, a trustee is not abiding by the terms of the trust, or the trustee has the authority to use the principal of the trust for medical expenses but has not done so.

Make the referral for initial review by sending form 470-5132, *Clarification Request* (located in WISE) to trust@dhs.state.ia.us.

In the clarification request:

- Identify the client by name (if the trust beneficiary is a child, provide the child's name, not the case name), social security number, date of birth and state identification number. (This information is essential because program staff do not have access to the ABC system, Online Narrative, or electronic case files.)
- Provide all the case numbers of the files where you want the response placed.
- Identify relationship of client to the grantor or trustor.

- Identify marital status.
- Indicate what program the client is applying for or is eligible under (MAGI, Non-MAGI, Food Assistance, or FIP).
- Indicate whether this referral concerns a trust for third-party liability for medical expenses.
- Attach a copy of the legal document or trust agreement to the request.

Trust Program staff will first review each submitted document to determine whether it is a "pay-back" trust (defined as a special needs trust, an income trust, or a pooled trust).

- Trusts that are not "pay-back" trusts are returned to the eligibility policy staff for review. (See procedures below.)
- "Pay-back" trusts are kept for review by trust program staff. Of these, income trusts will be the priority for review.

Review procedure for income trusts:

1. The Trust Program will:
   - Determine whether the document meets the criteria for a medical assistance income trust; and
   - Send a response indicating whether the trust was approved or denied directly to the scanning center indicated on the *Clarification Request*. (If the request does not contain a case number, the response will be emailed to the requesting worker.)
2. When the trust is **approved**, the worker issues form 470-4488, *Medical Assistance Income Trust***,** to the client or the payee.
3. When the trust is **denied**, the Trust Program will:
   - Prepare a checklist indicating why the trust does not meet the criteria; and
   - Email the checklist to the scanning center indicated on the *Clarification Request*, where it will be received in the electronic case file process list.

Review procedure for other "pay-back" trusts:

When the trust has been **approved**:

1. The Trust Program will:
   - Forward the request to eligibility policy staff for eligibility review; and
   - Email a status update to alert the worker that the trust is now at central office.
2. The worker should make a note in the on-line narrative in case another worker has questions.
3. Eligibility policy staff will:
   - Review the trust for eligibility;
   - Respond to the *Clarification Request* indicating how the trust will affect eligibility; and
   - Upload the response to the electronic case file indicated on the *Clarification Request*, where it will be received in the case file process list.

When the trust has been **denied**, the Trust Program will:

1. Send a letter to the attorney or trustee explaining that the trust does not meet the criteria; and
2. Email a copy of the letter to the scanning center indicated on the *Clarification Request*, where it will be received in the electronic case file process list. (If the request does not contain a case number, the response will be emailed to the requesting worker.)

Review procedure for non-"pay-back" trusts:

1. The Trust Program will:
   - Forward the request to the eligibility policy staff for review; and
   - Email a status update to alert the worker that the trust is now at central office.
2. The worker should make a note in the on-line narrative in case another worker has questions.

3. Eligibility policy staff will:
    - Review the trust for eligibility;
    - Respond to the *Clarification Request* indicating how the trust will affect eligibility; and
    - Upload the response to the electronic case file indicated on the *Clarification Request*, where it will be received in the case file process list.

Trusts Established with Assets Not Owned by Beneficiary

Legal reference: 441 IAC 75 (Rules in Process)

If the applicant or member is the beneficiary but not the grantor of a trust, Medicaid eligibility is determined by the terms of the trust. These trusts may be testamentary trusts or inter vivos trusts.

Examine the terms of the trust to determine if it is countable. Under both Non-MAGI and MAGI-related policy, income and resources **are** available to an applicant or member who is the beneficiary as follows:

- Trust principal and income are countable resources and income to the beneficiary when the terms of the trust **require the trustee** to pay or to make available to the beneficiary trust principal and income for the beneficiary's basic needs. (EXCEPTION: Do not count resources for MAGI-related Medicaid.)
- Trust principal and income are countable income, but not a countable resource, to the beneficiary when the terms of the trust allow the trustee to make income or principal available to the beneficiary for basic needs, and the trustee makes either trust principal or income available to the beneficiary for basic needs.
- Trust principal and income are countable resources and income to the beneficiary when the terms of the trust **allow the beneficiary** to withdraw trust principal and income for basic needs. (EXCEPTION: Do not count resources for MAGI-related Medicaid.)

Income and resources are **not** available to the beneficiary under both Non-MAGI-related and MAGI-related policy if:

- The terms of the trust **prohibit** the trustee from making either trust principal or income available for the beneficiary's basic needs.
- The terms of the trust allow the trustee, at the trustee's discretion, to make income or principal available to the beneficiary for basic needs, but the trustee does not make either income or resources available for basic needs.

In both cases, any payments from either trust principal or trust income that are made to the applicant or member or made for the applicant's or member's basic needs are countable income in the period of intended use and a resource thereafter. (EXCEPTION: Do not count resources for MAGI-related Medicaid.) If payments are made to vendors for basic needs, see policies in 8-E, *Non-MAGI-Related In-Kind Income* or *In-Kind Unearned Income*.

Medicaid Qualifying Trusts

Legal reference: 441 IAC 75 (Rules in Process), P. L. 99-272, P. L. 99-509, section 9435(c)

A Medicaid qualifying trust is a trust or similar legal device which:

- Was established on or before August 10, 1993.
- Is not established by a last will and testament.
- Is established by an applicant or member, the applicant's or member's spouse, or someone acting for them.
- Is established from funds belonging to the applicant or member or the spouse.
- Allows or names the applicant or member to be the beneficiary of payments from the trust.
- Has one or more trustees determine the distribution of payments.
- Permits the trustees to exercise discretion with respect to the distribution of trust principal and income to the beneficiary.

When someone with power of attorney, a conservator, a guardian, a lawyer, or a court acts on behalf of the applicant or member to set up the trust, treat it as though the applicant or member set up the trust.

The amount of income and principal from a Medicaid qualifying trust that is considered available is the maximum amount that may be permitted under the terms of the trust, assuming the trustees exercise full discretion in the distribution of the income and principal.

EXCEPTION: Trusts or initial trust decrees established before April 7, 1986, solely for the benefit of a person with an intellectual disability who lives in an intermediate care facility for persons with an intellectual disability are exempt.

Evaluate an irrevocable trust established on or before August 10, 1993, under this policy. The terms of the trust that specify the available income and principal determine the amount counted as available to the applicant or member, regardless of whether any payments are actually being made. Treat a trust established for medical payments as a third-party resource.

1. Miss T established a trust in July 1985 as the result of a settlement of a malpractice suit. Since she has an intellectual disability and lives in an intermediate care facility for persons with an intellectual disability (ICF/ID), and since the trust was established before April 7, 1986, this is not a Medicaid qualifying trust.
2. Mr. D established a trust for himself and his wife in 1972. Mrs. D applies for Medicaid and she is a co-beneficiary of the trust. This is a Medicaid qualifying trust.

A trust established by the last will and testament of a spouse is not a Medicaid qualifying trust. Trusts set up with funds not owned by the member or spouse are not Medicaid qualifying trusts. Burial trusts set up by a member or spouse, are not Medicaid qualifying trusts when the funds are available only upon death, and the member is not the beneficiary of the trust.

Trusts set up by charity or a fund raising activity are not Medicaid qualifying trusts unless the money is given to the member, who then creates the trust. NOTE: If the charity or fund raising present the proceeds to the person and the receiver sets up a trust on or before August 10, 1993, this is a Medicaid qualifying trust.

Counting Income or Resources

Legal reference: 441 IAC 75 (Rules in Process)

Consider trust income available as specified by the terms of the trust, even if the trustees do not actually pay the income according to the terms of the trust.

Count trust principal (including accumulated income) available to the member as a resource. (EXCEPTION: Do not count resources for MAGI-related Medicaid.)

EXCEPTION: If the terms of the trust explicitly limit the amount of principal that is made available on an annual (or specified less frequent) basis, the principal is countable income beginning the month it becomes available. Prorate it for the period of accessibility and intended use.

Trusts established for medical payments are a third-party resource. Do not count trust principal and income if the terms of the trust specify that they are available only for medical care. The principal and income for these trusts are not countable as income and resources in determining eligibility.

Compare the total countable resources, including the amount from the trust, to the resource limit of the coverage group under which the applicant seeks assistance. (EXCEPTION: Do not count resources for MAGI-related Medicaid.)

If the applicant is ineligible by counting income and resources of a Medicaid qualifying trust according to the policies of the coverage group, determine whether the applicant is eligible under any other coverage group.

1. Ms. P receives SSI. She has a Medicaid qualifying trust that provides for "care and keep." Any of the principal of $12,000 can be used to meet her living expenses, but no money is currently provided for her.

   $12,000 is added to Ms. P's other countable resources. Ms. P is not eligible for Medicaid since $12,000 is greater than any resource limit.

2. Ms. W, a Non-MAGI applicant, has a Medicaid qualifying trust set up as the result of a malpractice suit. The trust pays only for medical care. There is $100,000 in the trust. Since the trust provides for medical care only, it is not a resource. It is a third party medical resource.

   Ms. W is evaluated for resources based on her other resources of $500. She is income- and resource-eligible for Medicaid, based on the Non-MAGI coverage group. The worker prepares and sends a memo to TPL stating the basic trust provisions and the name and address of the trustees.

3. Mr. N, a 503 applicant, has a Medicaid qualifying trust that provides payments of $100 a month from trust income. No principal can be used. The trustee has not made the income available.

   The worker determines whether Mr. N would qualify for SSI by adding all income together, including the $100 a month, and disregarding his COLAs. His social security income at time of cancellation was $230. He has no other income. $230 + $100 - $20 = $310. He is eligible under the 503 group.

4. Mr. O is living in a nursing facility. He applies for Non-MAGI-related Medicaid on May 6, 1993. His gross social security and VA income is $965.30 monthly. He has $1,700 in savings and checking accounts as of April 30, 1993, at midnight.

   He also has a trust that he set up when he went into the nursing facility in May 1990. The trust was set up over 60 months ago, so divesting is not considered. According to the trust, money is available if he needs it, but he can have no more than one-third of the principal of the trust each year.

   The trustee verifies the principal as of the first of the year to be $99,000. Mr. O has used $1,000 of the trust this year.

   His resource from the trust is: $99,000 divided by 3 = $33,000 that can be withdrawn minus $1,000 used = $32,000 remainder.

   Therefore $32,000 plus his other resources of $1,700 is counted toward the resource limit. He is not eligible.

5. Ms. J, an SSI recipient in a residential care facility, has a Medicaid qualifying trust for educational benefits that she set up with inheritance funds. Each year she receives $2,500 for tuition, books, and living expenses.

   Since SSI policy provides that the income for living expenses counts for eligibility and is included as income for SSI, there is no more income to count from the Medicaid qualifying trust.

   Also since the only amount available from the trust is for education, the trust is not counted as a resource.

Client Participation

Legal reference: 441 IAC 75 (Rules in Process)

Consider all income, including countable income from the Medicaid qualifying trust, as available when determining client participation in a medical institution, unless the income is expressly exempt income, as listed in 8-E.

Mrs. P, an NF resident, has social security income of $245. She also has civil service income of $310. She has a Medicaid qualifying trust that could pay $120 a month for expenses if she needed the money.

Eligibility for Medicaid is determined as follows:

$120.00	Trust income
245.00	Social Security Income
+310.00	Civil Service income
$675.00	To compare to the 300% income limit (Medicaid cap)

Her income used to determine client participation is $675.00.

Trusts Established After August 10, 1993

When the client or someone acting on the client's behalf created a trust using the client's assets after August 10, 1993, determine whether the client is a beneficiary of the trust. If the client is not a beneficiary, investigate the trust as a transfer of assets.

If the client is a beneficiary, treatment of the trust depends on whether the trust is revocable or irrevocable. Three special kinds of irrevocable trusts (Medical Assistance Income Trusts (MAITs) and two special needs trusts) also receive different treatment.

Revocable Trusts

Legal reference: 441 IAC 75.24(2)"a"

When an applicant or member establishes a revocable trust established after August 10, 1993, the **principal** of the trust is an available **resource**. **Payments** from the trust to or for the benefit of the applicant or member (as beneficiary) are countable **income** to the applicant or member in the period of intended use when determining income eligibility for Medicaid.

Any payments from the trust other than those made to or for the benefit of the applicant or member (beneficiary) are assets transferred for less than fair market value.

Irrevocable Trusts

Legal reference: 441 IAC 75.24(2)“b”

If the applicant or member or that person’s spouse establishes an irrevocable trust after August 10, 1993, which names the applicant or member as a beneficiary, determine what payments are allowed from the trust.

If payment could be made to or for the benefit of the applicant or member (as beneficiary) for any purpose, count the portion of the **principal** from which that payment could be made as a **resource**. Also count any income earned on the principal from which payment could be made.

Payments from the trust principal or income to or for the benefit of the applicant or member (beneficiary) are countable **income** in the period of intended use and a countable resource the following month.

Payments from trust principal or income for any other purpose are a transfer of assets for less than fair market value. Determine the period of ineligibility according to Penalties for Transferring Assets.

Any portion of the trust or any income on the principal from which no payment could be made to the applicant or member (beneficiary) under any circumstances is a transfer of assets for less than fair market value. The transfer occurred on the later of the date the trust was established or the date on which payment to the beneficiary was no longer available.

Determine the value of the transfer by including the amount of any payments made from the trust after the date of foreclosure. Determine a period of ineligibility according to Penalties for Transferring Assets.

Payments made on behalf of the beneficiary are countable income in the month the payment is made despite the purpose of the payment. FIP and SSI rules do not apply to irrevocable trusts established with an applicant’s or a member’s own assets after August 10, 1993.

Special Needs Trust for Persons Under 65 Years Old

Legal reference: 441 IAC 75.24(3)“a,” Iowa Code 633C.1, 633C.2

A special needs trust for persons under 65 years old must meet the following conditions:

- The trust is an irrevocable trust.
- The trust is established after August 10, 1993.
- The trust is created with the assets of a person who is under the age of 65 and is disabled as defined by the Social Security Administration.
- The trust is established for the benefit of the beneficiary by a parent, grandparent, legal guardian of the beneficiary, or a court.
- The trust provides that the state of Iowa will receive all amounts remaining in the trust upon the death of the beneficiary, up to an amount equal to the total Medicaid paid on behalf of the beneficiary.

When the Social Security Administration or the Railroad Retirement Board has not determined a person disabled, the Department must determine disability for this policy to apply. Send a referral to the Disability Determination Services Bureau. See 8-C, *When the Department Determines Disability*.

The principal of a special needs trust is not a countable resource. Income paid into the trust is not countable. Count only the income paid from the trust or made available to the member as income. Payments from the trust follow the same rules as described in 8-E, *Medical Assistance Income Trusts (MAITs)*.

When a member with a special needs trust reaches age 65, the trust retains its exempt status. However, any additions to the trust after the member reaches age 65 (other than those generated by the preexisting trust assets) are countable assets. Also:

- The income generated by any such additions is countable income.
- These additions will be considered a transfer of assets for less than fair market value.

Medical Assistance Income Trust (MAIT)

Legal reference: 441 IAC 75.24(3)"b," Iowa Code 633C.1, 633C.3

A medical assistance income trust (MAIT) must meet the following conditions:

- The trust is an irrevocable trust established after August 10, 1993.
- Only the beneficiary's earned and unearned income is deposited into the trust.
- The state will receive the remaining balance in the trust upon the death of the beneficiary, up to the amount Medicaid paid out for the beneficiary.
- The trust may be revocable, if a clause is added that upon revocation or termination, the trust and income will be paid back to the state up to the amount of medical assistance paid on behalf of the beneficiary.

The principal of a medical assistance income trust is not a countable resource. Determine available income as directed in 8-I, *Members With a Medical Assistance Income Trust* and 8-E, *Medical Assistance Income Trusts (MAIT)*.

Special Needs Trust (Pooled Trust)

Legal reference: 441 IAC 75.24(3)"c," Iowa Code 633C.1, 633C.2

A special needs trust or pooled trust for persons under 65 years of age is a trust that meets the following conditions:

- The trust is established after August 10, 1993, and provides that the state will receive the remainder of the trust principal and income upon the death of the beneficiary.
- The trust contains the assets of a person who is disabled as defined by Social Security Administration.
- The trust is established and managed by a nonprofit association.
- The association maintains a separate account for each beneficiary of the trust, but pools these accounts for purposes of investment and management of funds.
- Accounts in the trust are established solely for the benefit of people who are disabled (as defined by Social Security Administration).
- Accounts are established by the parent, grandparent, or legal guardian of the beneficiary, by the beneficiary, or by a court.

- Upon death of the beneficiary, all amounts remaining in the beneficiary's account not retained by the trust are paid to the state of Iowa up to the amount of medical assistance paid on behalf of the beneficiary.

For this policy to apply to a person who has not been determined disabled by the Social Security Administration, the Department must determine disability. See 8-C, *When the Department Determines Disability*.

When a trust qualifies as a special needs trust, count the principal and income as available according to the terms of the trust.

Any additions made to the trust after the trust beneficiary reaches age 65 will be considered a transfer of assets for less than fair market value.

Resource Eligibility of Non-MAGI-Related Children

Legal reference: 441 IAC 75 (Rules in Process)

Disregard the resources of all household members when determining eligibility for children in certain coverage groups. Continue to count resources when determining eligibility for children in all other coverage groups according to the policies in this chapter.

The age limit for determining if a person is a child or an adult is the age limit for the coverage group under which Medicaid is being received or under which eligibility is being explored or established. See 8-F, *Coverage Groups* for more information.

The following chart lists all coverage groups under which children can establish eligibility and whether household resources are disregarded or counted in determining children's eligibility.

Coverage Group Name	Are Resources An Eligibility Factor For Children?
SSI recipients in their own homes and recipients of mandatory supplements	Yes
SSI recipients in medical institutions	Yes
People eligible for SSI benefits but not receiving them	No
Essential persons	Not applicable. A child cannot be an essential person.
Ineligible for SSI or SSA due to requirements that do not apply to Medicaid	Yes
Ineligible for SSI or SSA due to Social Security COLAs (503 medical only)	Yes
Ineligible for SSI or SSA due to Social Security benefits paid from a parent's account	Yes
Ineligible for SSI or SSA due to Social Security increase of October 1972	Yes
Ineligible for SSI due to substantial gainful Activity (1619b)	Yes
Ineligible for SSI or SSA due to actuarial change for widowed persons	Yes
Ineligible for SSI or SSA due to receipt of widow's social security benefits	Yes
Ineligible for SSI due to residence in a medical institution	Yes
People in medical institutions under 300% income level	No
Medicaid for Kids with Special Needs	No
Medically Needy	No
Qualified disabled and working persons (QDWP)	Yes
Qualified Medicare beneficiaries (QMB)	Yes
Specified low-income Medicare beneficiaries (SLMB)	Yes
Expanded specified low-income Medicare beneficiaries (expanded SLMB)	Yes
Medicaid for employed people with disabilities	Yes

1. The C family applies for the HCBS ID waiver for Child C. Child C is the grantor and beneficiary of a trust with a countable value of $197,345. Income produced by the trust is countable, not excluded. If all other eligibility factors are met, Child C is eligible under the 300% group, since household resources are disregarded in determining children's eligibility under this group.
2. Child B, age 15, lives in an ICF/ID and is eligible for Medicaid and facility care under the coverage group for people who are ineligible for SSI due to residence in a medical institution. Child B has countable monthly income of $100 and countable resources of $1,800.

   At the annual review, the worker determines that Child B's countable resources now total $2,100. Since Child B is no longer eligible under this coverage group, the worker completes an automatic redetermination. Child B can be determined eligible under the 300% group, since resources are not an eligibility factor for children in the 300% group and because Child B's income exceeds the SSI maximum for a person in a medical institution ($30).

General Non-MAGI-Related Resource Policies

The following sections describe SSI-related policies on:

- Resource limits.
- What resources to count.
- Joint ownership of real property.
- Disputed ownership.
- Determining the value of a resource.
- Deeming resources from a spouse or parent.
- Eligibility while trying to sell a nonliquid resource.
- Long-term care asset protection.
- Resources exempt for Medicaid for Employed People with Disabilities.

Non-MAGI-Related Resource Limits

Legal reference: 20 CFR 416.1205, 441 IAC 50.2(1), 75 (Rules in Process)

For SSI-related Medicaid eligibility, the resource limit is:

- $2,000 for an individual, and
- $3,000 for a married couple living together.

The resources of the ineligible spouse must be deemed to the eligible spouse. See Deeming from a Spouse. Determine which resource limit to use, based on whether or not the ineligible spouse has income to deem to the eligible spouse (according to procedures in 8-E).

- Use the resource limit for an individual when no income is deemed from the ineligible spouse.
- Use the resource limit for a couple when income is deemed from the ineligible spouse.

EXCEPTIONS:

- The resource limit is $4,000 for an individual eligible as a qualified disabled and working person.
- The resource limit is $6,000 for a married couple living together who are eligible as qualified disabled and working persons.
- The resource limit is $9,660 for an individual eligible under one of the following coverage groups:
  - Qualified Medicare beneficiaries
  - Specified low-income Medicare beneficiaries
  - Expanded specified low-income Medicare beneficiaries
- The resource limit is $14,470 for a couple eligible under one of the following coverage groups:
  - Qualified Medicare beneficiaries
  - Specified low-income Medicare beneficiaries
  - Expanded specified low-income Medicare beneficiaries
- The resource limit is $10,000 for an individual or couple in the SSI-related Medically Needy coverage group.
- The resource limit is $12,000 for an individual in the Medicaid for employed people with disabilities coverage group.
- The resource limit is $13,000 for a couple in the Medicaid for employed people with disabilities coverage group.
- All household resources are disregarded in the eligibility determination of children in certain coverage groups. See Resource Eligibility of Children.

What Resources to Count

Legal reference: 20 CFR 416.1201, 20 CFR 416.1208

"Resources" are liquid and nonliquid assets owned by a person that the person is not legally restricted from using for support and maintenance, and that could be converted to cash to use for support and maintenance. Unless specifically exempt, all resources are considered countable.

Guardianship, conservatorship, and power of attorney are not legal restrictions on a resource. Continue to count an adult's resources if the person has (or is waiting for) a guardian, conservator, or person with power of attorney.

An applicant or a member is not required to start a lawsuit to access or sell a resource. However, a resource is counted if they (or their conservator) have to petition the court to request access, because this action is not a lawsuit. (See Trust Definitions for more information on conservatorships.)

Include the resources of everyone who is considered part of the Non-MAGI-related household. See 8-C, *Nonfinancial Non-MAGI-Related Eligibility*, when establishing the Non-MAGI-related household. Determine countable resources and resource eligibility as of the first moment of the first day of each month, including the retroactive period if the individual meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. If resource values change during the month, eligibility will not be affected until the next month.

Nonliquid Resources

"Nonliquid resources" are assets that cannot be converted to cash within 20 days. Examples are:

- Homes and homesteads. See Property in a Homestead.
- Nonhomestead property.
- Personal property, such as household goods, personal effects, tractors, motor vehicles, machinery, and livestock.

Liquid Resources

"Liquid resources" are assets that can be converted to cash within 20 days. Following are examples of liquid resources.

- **Annuities**. Count the salable value of an annuity or the amount the company will pay back to the applicant or member if the annuity is cashed in. Ask the client to obtain a statement from the company regarding the lump sum and the cash-in amount.

  If the annuity cannot be cashed in but is assignable or can be transferred, ask three knowledgeable sources what its value is. Average the three values.

  Most annuities allow benefits to be assigned or ownership sold. An applicant or a member who claims that an annuity cannot be sold or transferred must obtain verification.

- **Bonds**. The countable value of the bond is its redemptive value on the first moment of the first day of the month.
- **Cash**, unless it was counted as income for the month or specifically excluded as a resource, such as a retroactive SSI lump sum.
- **Checking and savings accounts**. Subtract verified outstanding checks and any funds included in the accounts that are specifically excluded as a resource.

  If funds intended for the following month are direct deposited or deposited by the applicant or member before the intended month, do not count the funds as a resource in the month they were intended to cover. Remember to count the funds as income.

  > Mrs. J has $2,000 in checking as of midnight on May 31. She receives her social security check of $700 June 1. This check is not a factor in determining resources, because $2,000 was countable as of the first moment of the first day of the month.

  For co-owned accounts, if two or more account holders are either Medicaid applicants or members or are people whose income and resources must be considered for Medicaid eligibility (such as spouses or parents of minor children), count an equal share of the account for each.

If only one of the account holders is a Medicaid applicant or member or a person whose income and resources must be considered for Medicaid eligibility, count the entire amount in a co-owned account unless the applicant or member can establish that they (or the deemer) cannot access the funds. See Disputed Ownership.

> Ms. G has $3,000 in a joint checking account with her sister, Ms. H, and their mother, Mrs. I. Ms. G and Ms. H are both over the age of 21 and are both receiving Non-MAGI-related Medicaid. Mrs. I has not applied for and does not receive Medicaid. Countable amounts are $1,500 for Ms. G and $1,500 for Ms. H, unless either can establish that they do not have access to the account.

- **Individual Retirement Accounts** (IRA). Use the value of the IRA if cashed in minus any penalties for early withdrawal. NOTE: The 10% tax penalty for early withdrawal would not be allowed as a deduction, since it is an additional tax on the income portion of the withdrawal.
- **Mutual funds**. Count the value for which the shares can be sold.
- **Oil leases**. The value must be established by a knowledgeable source, such as a brokerage firm or bank. The lease value can be excluded if it is under $6,000 and the land earns a net income of 6% of equity, or if the land is being sold. The leasehold is the right to use the property for a specified period. It does not convey ownership of the property.
- **Promissory notes** that can be sold or discounted.
- **Stocks**. Use the closing price of the stock on the first moment of the first day of the month.

Do not count resources that have no cash value, that cannot be liquidated, or that the applicant or member does not have the right to liquidate and use for support and maintenance. NOTE: Do not count property jointly owned by spouses involved in a divorce when the property is unavailable until a decision on distribution has been made. Do not consider the terms of a prenuptial agreement when determining Medicaid eligibility.

Do not count a resource until ownership is known to the applicant or member. An applicant or a member who is not aware of owning a resource must prove that it was reasonable not to know about it. Forgetting a resource is not evidence. Count the value of the resource plus any interest as income in the month of discovery. Count it as a resource the next month.

Mr. N's grandfather had transferred land to Mr. N in October but had not told him. Mr. N was told the following May. Mr. N provides verification with a letter from his uncle establishing that there was no prior knowledge. The $5,000 value of the land is income to Mr. N in May. The land is a resource in June unless it is sold.

If the applicant or member has the legal ability to convert a resource to cash, it is not necessary that they have possession of the resource for it to be counted. EXCEPTION: An applicant or a member must possess a savings bond for it to be counted. Savings bonds have no resource value for six months from the issue date.

Joint Ownership of Real Property

Legal reference: 20 CFR 416.1201, 20 CFR 416.1201(a), 20 CFR 416.1245(a)

If real property is owned by more than one person, assume all persons have equal shares, unless you are able to determine differently. If a client does not own an equal share in a resource, count only the portion owned by the client.

If the client jointly owns real property, evaluate the details of ownership and the particulars of the situation to determine how shared ownership affects the value of the property as a resource.

In Iowa, people who jointly own property and wish to dispose of their interest in the property may do so. The refusal of one owner does not preclude any other owners from selling their ownership interest. (After the sale of the property, the new owners can petition the court for a partition action.) So, joint ownership does not preclude the property from being a countable resource, but it may affect the countable value of the seller's interest.

If a client jointly owns real property in another state, state law there may require the co-owner to move if the property is sold. If so, exclude it as a resource if the disposal of this property would cause undue hardship to the co-owner due to lack of housing. Obtain verification of the joint ownership and the applicable state law. The co-owner must use the property as the principal place of residence and have no other housing readily available.

Mr. J owns 40% of a 100 acre farm as tenant in common with his brother. The interest is referred to as "undivided." Specific acres are not identified as belonging to Mr. J, but he could sell his 40% interest. If Mr. J dies, his ownership passes to his heirs.

"Joint tenancy" means that two or more persons own an interest in and possession of the entire property. An owner's portion can be sold. If an owner dies, the ownership passes **to the other owner**.

Mr. J owns 40% of the 100 acre farm with Mr. T in joint tenancy. His interest is undivided but he could sell his 40% interest. If Mr. J dies, his ownership interest passes to Mr. T.

"Leasehold" means the lessee has the right to the use of the property for a specified period of time. A lessee may sell that right. Verify the countable value with a statement from a knowledgeable source.

Disputed Ownership

Legal reference: 20 CFR 416.1201, 20 CFR 416.1208

Count jointly owned resources unless the client rebuts ownership. Allow the client to rebut ownership of all or part of jointly owned liquid and nonliquid resources. To do this, the client must establish:

- That the client's money is not deposited in the resource, or the proportion of money deposited by the client in relation to the total money deposited.
- The reason for the joint ownership.
- Whether the client made any withdrawals from the resource for the client's own use, or made withdrawals proportional to the client's share of the money.
- Whether the resource was altered to reflect true ownership interest.

If the client successfully shows either no ownership or partial ownership and changes the resource to reflect this, the ownership is then established at the beginning of the financial arrangement. Count only the part that the client could not prove belonged to another person. See Liquid Resources for countable amounts of co-owned checking and savings accounts.

Mrs. N and Mr. F, who are brother and sister, jointly own a bank account. Mrs. N has her name on the account to handle Mr. F's business, since he is not able to do so. Mr. F is not a Medicaid applicant or recipient.

Mrs. N applies for Medicaid on October 11. She lists the account, which has $6,000 as of October 1. She proves that all the deposits were Mr. F's and she did not use any of the withdrawals. She changes the name on the account to show the true ownership. This account is not countable to Mrs. N.

Determining the Value of a Resource

Legal reference: 20 CFR 416.1201

Policy: The **countable value** of a resource is the equity value. The **equity value** is the current fair market value minus any legal debt on the item. To be considered a debt against the resource, the debt must be legally recognized as binding on the resource's owner. The **current fair market value** is the amount an item can be sold for on the open market.

Procedure: If a client is trying to sell property:

- The client should provide verification of the fair market value of the property.
- If the client provides verification that the client has tried to sell the property at the fair market value and it did not sell, consider a lower amount to be fair market value as long as it seems reasonable.
- Use the prudent-person concept when determining if the lesser fair market value amount is reasonable.

When property is sold at an auction, the current fair market value is considered to be the highest bid, as long as the client has provided verification that both:

- Attempts to sell the property at fair market value have been unsuccessful; **and**
- The auction was advertised to the public.

If either of these criteria has not been met, assess a transfer of assets penalty for the difference between the fair market value and what the property sold for.

1. Mr. M applies for nursing facility assistance. He has listed his home on the market in January at the assessed value of $125,000. By May, he has not had an offer. Mr. M then lowers the price of his home to $120,000. In July there are still no offers on the home. In August, he again lowers the asking price to $116, 000. In September, the home sells for $112,000.

   As long as Mr. M can provide verification of the listings, sale of the home is not considered to be a transfer of assets, because Mr. M tried to sell the home for fair market value. The fair market value is considered to be the amount that the home sold for.

2. Ms. J applies for Medicaid. She has a home with a current assessed value of $95,000. She lists her home for $95,000 and after two months has not yet had an offer. Ms. J drops the listing on her home to $45,000 and sells her home two weeks later.

   The sale is considered to be a transfer of assets for less than fair market value.

When determining the equity value of a resource:

- Deduct from the current market value only the principal amount of the debt and any prepayment penalties required. Do not consider any future interest owed.
- Determine the ownership of jointly held resources, such as joint checking or savings accounts and jointly held real estate, according to the intent of the parties who created the joint interests upon the creation of the joint interest.

  If the document creating the joint interests, such as a deed to real estate or a bank account signature card, specifies the shares of the parties, divide the fair market value of the entire resource between the joint owners according to the shares specified.

  If the shares of the joint owners are not specified, assume equal shares for all joint owners, unless evidence of intent shows unequal shares. Examples of evidence of intent showing unequal shares include:

  - The source of the funds used to purchase or create the joint resource.
  - The use made of the joint resource.
  - The inclusion of one of the joint owners as a caretaker for the convenience of the other, etc.

- If excluded funds are combined with countable resources, assume the countable resources are spent first.

- Consider the sale or transfer of a resource as a change in the form of the resource. Do not consider the transfer or sale of a resource as income.
- A court restriction may make all or part of the resource unavailable to the client. Consult your supervisor if you have questions about the legal restrictions. Legal restrictions on resources can be included in:
  - Liens.
  - Qualified domestic orders.
  - Divorce decrees.
  - Probate matters.
  - Bankruptcy proceedings.

Deeming Resources

Legal reference: 20 CFR 416.1160, 20 CFR 416.1163, 20 CFR 416.1202

Deeming is the process of assigning a specified amount of resources of an ineligible spouse, parent, or sponsor when determining Medicaid eligibility. An "ineligible spouse" is a spouse who is not receiving Non-MAGI-related Medicaid. See 8-L, *Aliens* when deeming resources from a sponsor to an alien.

Do not apply deeming policies if the applicant's or couple's resources alone are over the resource limits after including all appropriate disregards and exclusions.

Deem resources as of the first moment of the first day of the month of eligibility.

Deeming From a Spouse

Legal reference: 20 CFR 416.1202

To determine eligibility, include resources of an ineligible spouse when:

- An eligible person was living in the same household with the ineligible spouse at any time during the month, or
- An SSI eligible person was living with an SSI eligible spouse during the last six months unless:
  - The spouses have divorced,
  - One of them has died, or
  - One of them moved to a medical facility.

When an applicant is living in the same household with an ineligible spouse, include the resources of the ineligible spouse in determining the application's eligibility. Do not, however, deem pension funds controlled by an employer or union, or IRA or Keogh accounts.

See 8-D, *Non-MAGI-Related Resource Limits* to determine which resource limit to apply.

If spouses who are both eligible for Medicaid separate, including when one spouse enters a medical facility, discontinue deeming the month after the month of the separation. Separation means that the spouses are not expected to be living together for a full calendar month.

Before entering a nursing facility, Mrs. L was living at home with her spouse. She will be in the facility for less than 30 days. Their countable resources are as follows:

$1,800	Savings account in Mr. L's name only
+ 500	Vacant lot owned by Mr. L
$2,300	Total resources of Mr. and Mrs. L
-3,000	Limit for a couple
$ .00	Excess resources

Since resources deemed to Mrs. L do not exceed the resource limit for a couple, eligibility exists.

Deeming From a Parent to a Child

Legal reference: 20 CFR 416.1856, 20 CFR 416.1202

Before deeming resources from a parent to a child, see 8-D, *Resource Eligibility of Children*. If the child's eligibility is determined under a coverage group where resources are exempt, there is no need to deem resources from the parents.

A "child" is a person who is:

- Not married,
- Not the head of the household, and
- Either under age 18 or under age 22, if a student regularly attending a school, college, university, or course of vocational or technical training to prepare for gainful employment.

When an eligible child is living in the household with an ineligible parent or stepparent, include the parent's and stepparent's resources when determining the child's eligibility unless the stepparent is the only person living with the child. If the child lives with the stepparent and not the biological parent, there is no deeming.

Do not deem a parent's resources to other ineligible children. Do not count or deem resources of ineligible children to the eligible child.

The child's resources are any resources the child owns plus any resources deemed from the parents. Determine the child's resources independently of the parents' resources. Consider household goods and personal effects owned by the child separately from those owned by the parents. Do not exclude more than one home and one vehicle for the family.

To deem the parents' resources to a child:

1. Allow the parents all the exclusions for which they would be eligible if they were eligible for Medicaid. Do not deem an ineligible parent's pension funds if they are controlled by the employer or by the union or are in an IRA or Keogh account.
2. Deduct $2,000 for an individual (if one parent) or $3,000 for a couple (if two parents) before deeming to the child.
3. Deem the remaining countable resources to the child.

A child is not eligible if the child's own resources plus the value of the resources deemed from the parents exceeds the $2,000 resource limit unless the child is eligible under QMB, SLMB, or Medically Needy. See 8-F.

Sam, age 17, was living with his parents and two brothers before entering a residential care facility (RCF). Sam has a $50 savings account in his own name. The parent's resources are as follows:

$ 30,000	Value of home they live in
$ 3,200	Parent's joint savings account

The home is excluded. $200 resources are available for deeming. ($3,200 minus $3,000 SSI exclusion for a couple.)

$ 200	Deemed from parents
+ 50	Sam's own resources
$ 250	Total resources

Since resources deemed to Sam plus Sam's own resources do not exceed the resource limit for an individual, Sam meets the resource standard.

Do not deem parents' income or resources to a child the month following the month of entry into a medical institution or RCF.

Eligibility While Trying to Sell a Nonliquid Resource

Legal reference: 20 CFR 416.1240-416.1245, 441 IAC 50.5(249A)

Applicants or members who have countable nonliquid resources that exceed the applicable resource limit may not receive Medicaid under a "Medicaid only" coverage group while they are attempting to sell the resource.

However, such applicants or members may be able to receive State Supplementary Assistance (SSA) or Supplemental Security Income (SSI) benefits until the resource is sold. These benefits are called "conditional benefits." Persons who are conditionally eligible for SSI are not eligible for Medicaid but persons who are conditionally eligible for SSA may receive Medicaid in the same manner as any other SSA recipient.

If the person has been approved for conditional SSI or federally administered State Supplementary Assistance benefits, there will be a "C" code in the COND PAY CODE field on the State Data Exchange (SDX).

There is usually no retroactive Medicaid eligibility for a recipient who has been approved for conditional SSI or State Supplementary Assistance benefits. However, the recipient's countable resources, including the excess resources, may have been under the Medically Needy limits. Also, some resources may not have been countable in the retroactive period, e.g., a house in which the recipient was living.

Ms. A, a six-month-old child, is approved for SSI effective August 1, 2018. Her parents receive 10 acres of land on August 6 as an anniversary gift. The land has a value of $6,000. In October, her parents sign an agreement to sell the land and repay SSI.

The IM worker evaluates resources of Ms. A and her family for the Medicaid retroactive period of May, June, and July, to determine if resources were under the limit. Since they did not own the land before August, retroactive eligibility is not affected by the 10 acres. The conditional benefits period begins in November (the month after the agreement was signed). For the months of September and October, the land value of $6,000 is a countable asset.

Long-Term Care Asset Preservation

Legal reference: 441 IAC 75 (Rules in Process), Iowa Code Chapter 514H

Policy: A person may be eligible for Medicaid when the person meets **all** of the following conditions:

- The person is aged 65 or older.
- The person:
  - Is the beneficiary of a qualified long-term-care insurance policy, or
  - Is enrolled in a prepaid health care delivery plan that provides long-term-care services.
- The person is eligible for Medicaid under one of the following coverage groups except for excess resources:
  - Ineligible for SSI or SSA due to residence in a medical institution,
  - In the 300% group, or
  - Receiving home- and community-based waiver services.
- The excess resources do not exceed the amount of long-term-care insurance benefits paid out under the person's qualified long-term-care insurance policy. (This amount is called the asset adjustment.)

The asset adjustment is exempt from estate recovery for the member and the member's spouse.

Comment: The Long-Term Care (LTC) Partnership program is a cooperative effort between private insurers and state government to encourage people to plan ahead and provide for their long-term health needs. An LTC partnership policy:

- Must meet the minimum standards established for long-term care insurance policies and certificates as established by the Iowa Insurance Division.
- Has identifying information included in the policy or attached to the policy to indicate that it is a qualifying long-term insurance policy.

The insurer provides the beneficiary a quarterly report which includes the amount paid in the last quarter and total amount paid on behalf of the insured.

In addition, the insurer is required to report data on each partnership policy sold under the Long-Term Care Partnership program to a national database. The national database then reports this information to each state's insurance department. The information reported includes:

- Notice of when benefits are paid under the policy,
- The amount of those benefits, and
- Notice of termination of the policy.

Iowa participates in a national reciprocity agreement with other states. If a person moves to Iowa and has a partnership policy that was purchased in another state, the policy can carry over to Iowa for the person to be eligible for an asset adjustment if the person applies for Medicaid in Iowa.

Procedure: The amount of the disregard is equal to the amount of the insurance benefits paid to or on the behalf of the person. The insurance benefits do not have to be fully exhausted before the disregard can be applied. If the person is approved for Medicaid and the policy continues to pay benefits, the asset adjustment can continue to increase.

Subtract the total amount the policy has paid on the person's behalf from the person's total resources. Compare the remaining resources to the resource limit to determine Medicaid resource eligibility. If the person's remaining resources exceed the resource limit, issue a *Notice of Decision* denying or canceling Medicaid.

1. Mr. J buys a long-term-care partnership policy. The policy provides for $100,000 in long-term-care coverage. Several years later, Mr. J needs nursing home care. His partnership policy covers most of the costs for three years before the $100,000 benefits are exhausted by payment for his care.

   Mr. J applies for Medicaid. He is able to protect $100,000 for his resources and still qualify for Medicaid to help pay for his long-term care if he meets the other eligibility criteria.

2. Mr. S buys a long-term care partnership policy that provides $100,000 in coverage. Several years later, Mr. S needs long-term care services and his policy begins to pay him a monthly benefit. Eventually, Mr. S applies for Medicaid home- and community-based waiver services.

   At the time of application, Mr. S has $90,000 in countable resources. His long-term care policy has paid out $88,000 in benefits with $12,000 remaining. The worker calculates his resources for Medicaid as:

$	90,000	Mr. S's resources
-	88,000	Benefits paid out under the LTC policy
-	2,000	Medicaid resource limit
$	0	Remaining countable resources

   Mr. S is eligible for Medicaid because the amount paid under his partnership policy ($88,000) combined with the Medicaid resource limit ($2,000) equals his total countable resources ($90,000). If his partnership policy continues to pay benefits, Mr. S can protect additional resources.

Exempt Resources for Medicaid for Employed People With Disabilities

Legal reference: 441 IAC 75 (Rules in Process)

Additional resources are exempt for persons who qualify for Medicaid eligibility under Medicaid for employed people with disabilities. They are:

- **Assistive technology accounts**: Assistive technology accounts include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value that are set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology services or assistive technology devices.

  These accounts must be held separate from other accounts. Funds must be used to purchase, lease, or otherwise acquire assistive technology, assistive technology services, or assistive technology devices for the working person with a disability.

"Assistive technology" is defined as the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by people with disabilities in areas such as education, rehabilitation, technology devices, and assistive technology services.

An **"assistive technology device"** is any item, piece of equipment, product system, or component part (whether acquired commercially, modified, or customized), that is used to increase, maintain, or improve functional capabilities or to address or eliminate architectural, communication, or other barriers confronted by people with disabilities.

"Assistive technology service" means any service that directly assists a person with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

Require the member to provide written verification from a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist that the technology being saved for is medically necessary and that the technology, device, or service can reasonably be expected to enhance the client's employment. Also require verification of an estimated cost for the technology.

- **Medical savings accounts.** These are accounts 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 such an account will have documentation from the bank or other financial institution that set it up.
- **Retirement accounts.** This includes any retirement or pension fund or account listed in Iowa Code section 627.6(8)"f" as exemption from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account. The following are exempt under this provision:
  - Pension or retirement plans authorized under federal law, as follows:
    - Retirement plans qualified under the Employee Retirement Income Security Act of 1974 ("ERISA-qualified plans").
    - Simplified employee pension plans.
    - Self-employed pension plans.
    - Keogh plans (also known as "H.R. 10 plans").
    - Individual retirement accounts.

- Roth individual retirement accounts.
- Savings incentive matched plans for employees.
- Salary reduction simplified employee pension plans (also known as "SARSEPs").
- Similar plans for retirement investments authorized under federal law after May 17, 1999.

- Retirement plans established pursuant to a "qualified domestic relations order" as defined by federal law (26 U.S.C. section 414).

If the type of plan is unclear from the documentation provided, verify it with the plan administrator or send a clarification request to central office.

Specific Non-MAGI-Related Resources

This section lists specific types of resources that are countable or excluded, in total or in part, when determining initial or ongoing eligibility for Non-MAGI-related coverage groups. Some countable resources require calculations to determine the countable value to the applicant or member. Some resources are excluded only up to a certain limit, after which the remainder is countable.

And finally, some resources are exempt in the month of receipt and in some cases, the month following the month of receipt. Examples include:

- Death benefits
- Earned income credit
- Income tax refunds
- Retroactive cash payments
- Social services expenses
- Third party medical payments

See individual items for more information.

ABLE Account

The Achieving a Better Life Experience (ABLE) Act of 2013 was signed into law in December 2014. The ABLE Act amends Section 529 of the Internal Revenue Service Code of 1986 to create tax-free savings accounts for individuals with disabilities. These savings accounts are called ABLE accounts

ABLE Account (Cont.)

Assets in an ABLE account and distributions from the account for qualified disability expenses would be disregarded when determining the designated beneficiary's eligibility for Medicaid.

SSI excludes up to and including $100,000 of the balance of funds in an ABLE account from resources of the designated beneficiary. If an ABLE account exceeds $100,000, SSI will not terminate the recipient, however they will suspend them.

For Medicaid, a beneficiary will not lose eligibility for Medicaid based on the assets held in their ABLE account, even during the time that SSI benefits are suspended (as described above for the account with over $100,000).

A distribution from an ABLE account is not income but is a conversion of resource from one form to another. Do not count distributions from an ABLE account as income to the designated beneficiary.

AIDS/HIV Settlement Payments

Exempt settlement payments from any fund established pursuant to the class action settlement of Susan Walker v. Bayer Corporation et al, 96 C5024(N.D. Ill.), as a resource. Some settlement payments were made in lieu of the class action settlement. These payments are also exempt as a resource. These settlements were signed on or before December 31, 1997. These funds must be kept in a separate, identifiable account.

Payments from the original settlement or the Ricky Ray Hemophilia Relief Act of 1998 are exempt as a resource.

Annuities
20 CFR 416.1201

An annuity is a contract in which a person receives fixed payments for a specified time period. The person who receives the payments is referred to as the annuitant. The term of the annuity contract can be for either:

- The lifetime of the buyer;
- The lifetime of the buyer, with a minimum return of principal to a residual beneficiary if a specified portion of the principal is not returned before the buyer's death; or
- A certain number of years, with a guaranteed payment amount if the annuitant dies before the specified period has expired.

Review a copy of each annuity to determine the terms of the contract. Annuity contracts may be assigned, transferred, or cashed in for a lump sum. Or the contract may state that once payments are being made to the annuitant, the contract cannot be assigned, transferred, or cashed in for a lump sum.

- If the annuity can be assigned, transferred, or cashed in for a lump sum, the loan value or the amount the company will pay back to the annuitant is a countable resource.
- If the annuity may be assigned or transferred, but not cashed in, the annuitant must verify the amount that the annuity can be assigned or transferred for. The annuitant should obtain three estimates from knowledgeable sources. Use the average of these to determine the countable resource value of the annuity.
- If the annuity is counted as a resource and the annuitant is eligible for Medicaid, obtain verification of the portion of the payment that is interest and the portion of the payment that is principal.

  Count the interest portion of the annuity payments as income to the annuitant when determining eligibility, spenddown, and client participation. Do not count the principal portion of the payment; this is already counted as a resource.

Annuities (Cont.)

- If the annuity cannot be assigned, transferred, or cashed in and the annuitant verifies that the annuity has no cash value, the annuity is not a countable resource. Count the total annuity payment as income to the annuitant when determining eligibility, spenddown, and client participation.

Annuities must also be reviewed to determine if the purchase of the annuity constitutes a transfer of assets for less than fair market value. See Transfers That Cause a Medicaid Penalty.

Request a copy of the contract and use the *Annuity Release of Information*, form 470-4699, to gather information on the annuity. If you need help interpreting the information provided on the form or the contract, send the form and contract to the DHS, SPIRS Help Desk.

Burial Contracts
20 CFR 416.1201,
20 CFR 416.1231 (See also Transfer of Assets.
20 CFR 416.1246,
42 USC 1396p(d))

Exclude a prepaid burial contract as a resource if it meets one of the following conditions:

- The contract is irrevocable and the applicant or member can't access the funds.
- Mutual consent of the applicant or member and the contract seller is required to revoke or access the contract, and the seller's consent can't be obtained.
- Liquidation of the contract would create a significant hardship to the applicant or member. Usually, the only hardship considered significant is requiring the applicant or member to move out of Iowa to access the funds.

Unless the contract clearly indicates that the burial contract is irrevocable, obtain a written statement from the contract seller that the funds committed to the contract are unavailable to the applicant or member.

Investigate a contract drawn up in another state to determine whether the law in that state permits irrevocable burial contracts and whether the contract is irrevocable under that law.

Burial Contracts (Cont.)

If a certificate of deposit or another form of funds is tied to the irrevocable contract, only the amount specified in the irrevocable contract is excluded.

If the burial contract is set up by purchasing a life insurance policy, check if the funeral home either owns the policy or is the irrevocable beneficiary.

If the funeral home owns the policy, both the whole cash value and the dividends are unavailable. However, if the funeral home is the beneficiary, only the cash value is unavailable. Count dividends that are available to the applicant or member.

Since there is no limit on the amount of money in the burial contract, some applicants or members may use prepaid burial contracts to protect assets. If the amount of the burial contract exceeds $13,125, which is the average cost of a funeral in Iowa, ask for an itemized list of funeral costs.

If the amount is less than or equal to the cost of the funeral, exclude the contract from resource consideration. If the amount in the burial contract exceeds the itemized listing, consider the excess deposits or payments as a transfer of assets for less than fair market value. See Transfer of Assets.

The amount of money considered transferred is the amount designated for the contract minus the specified cost of the burial. Determine whether transferring has occurred rather than determining how much of the irrevocable burial contract is a countable resource.

If a relative changes the selection of services in the burial contract at the time of the funeral, this is not a transfer of resources.

The following charts provide a guide to understanding burial contracts and how to count as a resource or consider as a transfer of asset.

Burial Contracts (Cont.)

Burial Contracts		
If the client has…	Countable resource?	Transfer of asset?
Paid cash and burial contract is: ▪ **Revocable**	Yes. See below on how to count.	No
▪ **Irrevocable**	No	No
No burial contract and burial funds are: ▪ **Revocable**	Yes	No
▪ **Irrevocable**	No	Yes. See transfer of asset chart.
Revocable burial contract funded by: ▪ **Revocable** burial funds	Yes. See below on how to count.	No
▪ **Irrevocable** burial funds	No	Yes. See transfer of asset chart.
▪ Life insurance policy with funeral home as the beneficiary	Yes, unless otherwise excluded.	No
▪ Life insurance policy **irrevocably** assigned to funeral home	No	Yes. See transfer of asset chart.

Burial Contracts (Cont.)

Burial Contracts		
If the client has…	Countable resource?	Transfer of asset?
Irrevocable burial contract funded by:		
▪ **Revocable** burial funds	Yes	No
▪ **Irrevocable** burial funds	No	See transfer of asset chart.
▪ Life insurance policy with funeral home as the beneficiary	Do not count cash value, but count any accessible dividends as a resource.	See transfer of asset chart.
▪ Life insurance policy **irrevocably** assigned to funeral home	No	See transfer of asset chart.

Burial funds may include annuity proceeds, a certificate of deposit, a bank account, or a trust at a financial institution.

If a countable resource: Exclude up to $1,500 for the client and up to $1,500 for the client's spouse when funds are held in a separate account designated for burial purposes.

Burial Contracts – Transfer of Assets		
Transfer of Asset	**Penalty**	**Amount**
Irrevocable burial funds not in a burial contract	Yes	Penalty is the amount of the irrevocable burial funds. If the client sets up an irrevocable burial contract, the transfer of assets penalty can be expunged as of the first of the following month.

Burial Contracts (Cont.)

Burial Contracts – Transfer of Assets		
Transfer of Asset	**Penalty**	**Amount**
Revocable burial contract funded by **irrevocable** burial funds	Yes	Penalty is the amount of the irrevocable burial funds. If client changes the revocable burial contract to irrevocable, the transfer of assets penalty can be expunged as of the first of the following month.
Revocable burial contract funded by life insurance policy **irrevocably** assigned to funeral home (either ownership or beneficiary)	Yes	Penalty is the amount of cash value and dividends of the life insurance policy. If client changes the revocable burial contract to irrevocable, the transfer of assets penalty can be expunged as of the first of the following month.
Irrevocable burial contract funded with **irrevocable** burial funds OR assigned life insurance policy (either ownership or beneficiary) If the amount of contract is:		
▪ **Less than** average cost of funeral in Iowa.	No	None

Burial Contracts (Cont.)

Burial Contracts – Transfer of Assets		
Transfer of Asset	**Penalty**	**Amount**
▪ **More than** the average Iowa funeral cost, ask for an itemized list of funeral costs.		
• If burial contract amount is **less than or equal to** itemized list.	No	None
• If amount **exceeds** the itemized list.	Yes	Penalty is the amount in excess of the burial contract.

Burial Funds
20 CFR 416.1231
(See also Transfer of Assets.
20 CFR 416.1246,
42 USC 1396p(d))

Exclude up to $1,500 for the client and up to $1,500 for the client's spouse when funds are held in a separate account designated for burial purposes. Examples of funds set aside for burial are:

- Revocable burial contracts.
- Trusts.
- Cash value of any life insurance policies.
- Any account or resource designated by the applicant or member for burial, cremation, or other funeral arrangements. An account or resource designated for burial could be bank accounts, CDs, etc.

Burial funds must be in separately identifiable accounts. If funds are combined with other funds that are not for burial purposes, the client must separate the funds.

The client must sign a statement designating the funds for burial purposes. File a copy of the statement in the case record and give a copy to the applicant or member. Exclude the fund as of the first of the month in which the fund is separated and designated as a burial fund.

Burial Funds (Cont.)

Reduce the amount the client set aside for burial by any excluded whole life, term life, and irrevocable burial contracts. For policies on burial space, see Burial Space. To determine the amount of burial funds that can be applied under this exclusion:

1. Obtain copies of irrevocable burial arrangements and life insurance policies to determine what burial funds the applicant or member owns.
2. If the irrevocable contract is over $1,500, no other burial funds can be excluded. (The irrevocable burial contract is an excluded resource, but it does have an effect on whether any other funds can be set aside for burial.)
3. If the burial contract is less than $1,500, determine the face value of any **excluded** whole life and term life insurance policies designated for burial funds. (Life insurance with a face value of $1,500 or less is excluded. Life insurance with a face value of more than $1,500 is not excluded.)
4. Add together the face value of excluded life insurance and the burial contract. Subtract this amount from the $1,500 set-aside amount. If there is no remainder, no additional funds can be set aside for burial.

   If the total amount set aside in the burial contract and excluded life insurance is under $1,500, the client can designate additional funds for burial to make up the difference. The total cannot exceed $1,500.

1. Mr. N has $2,500 in a burial fund that is revocable. He has no other burial funds. The maximum excluded from resource consideration is $1,500. $1,000 is a countable resource.
2. Mrs. B has life insurance with a face value of $3,000. The cash value is $1,800. This policy is not exempt and she has no other funds set aside for burial. Mrs. B has no funds set aside for burial and provides a written statement designating this policy for burial. The worker excludes $1,500 of the $1,800 cash value for burial. $300 is a countable resource.

Burial Funds (Cont.)

3. Mrs. H has a $2,000 burial fund that is revocable. She has life insurance with a face value of $800. $700 of the burial fund that can be excluded and the interest earned on this $700 are exempt as income and a resource.

   The remaining $1,300 is countable as a resource. The interest on the $1,300 is also counted, subject to policies on infrequent and irregular income.

4. Mrs. P has $1,000 in a savings account that she has designated for burial. She also has a $1,000 face value life insurance policy.

$1,500	Maximum exclusion
- 1,000	Life insurance
$ 500	Can be excluded for burial
$1,000	Designated burial account
- 500	Remaining exclusion
$ 500	Countable resource

5. Mr. Q has a $1,600 life insurance policy and a $1,000 irrevocable burial contract. The cash value of the life insurance policy is $1,975. Mr. Q designated the cash surrender value of his life insurance as funds set aside for burial.

$1,500	Maximum potential exemption
- 1,000	Burial contract
$ 500	Remaining potential exemption
$1,975	Cash surrender value of life insurance
- 500	Remaining exemption
$1,475	Countable resource

   Mr. Q's worker informs him that he could irrevocably assign the life insurance ownership to the irrevocable burial contract, at which point it would no longer count as a resource.

If the client spends any of the burial fund, count the amount spent as income during the period it was spent.

Burial Funds (Cont.)

A client in a nursing home has $1,400 in a burial fund, but spends $1,000 in June. This $1,000 is used for June eligibility, and client participation is adjusted for June.

Burial Funds' Increase in Value
20 CFR 416.1124(9),
20 CFR 416.1231(7)

Burial funds may increase in value due to interest income or to appreciation in the value of the burial arrangement. Do not count interest on or increases in the value of burial funds that are **excluded** as a resource.

Count interest on and increases in value of the **countable** portion of burial funds. To do this, determine the percentage of the burial funds that is countable based on the value of the burial funds at the time they were gathered and apply that percentage to the increase in value.

When a Non-MAGI-related Medicaid member has excluded funds set aside for burial at the time of cancellation of SSI:

- Exclude increased funds at the time of cancellation if the member becomes eligible for Non-MAGI-related Medicaid coverage within 12 months of cancellation.
- However, if the member loses SSI because the member is no longer disabled, allow the increased funds to be excluded only if the member becomes eligible for a Non-MAGI-related Medicaid program within three months.
- Allow only the same percentage increase in funds that was allowed before cancellation if the burial fund account is only partially excluded because the member has other burial funds. This is subject to the same 12-month period.

Contact the SSI representative at the district Social Security office to determine the amount of funds excluded at the time of cancellation when an SSI person becomes ineligible and then goes to another Non-MAGI-related Medicaid coverage group.

Burial Space
20 CFR 416.1231(a)

Do not count the value of a burial space that is **owned** by the client and is intended for the client, the client's spouse, or any other member of the client's immediate family.

The "immediate family" includes a client's:

- Children, stepchildren, adopted children
- Brothers, sisters
- Parents, adoptive parents, and
- Spouses of the above

The "immediate family" does not include members of an ineligible spouse's family. If a space is not intended for the use of an immediate family member, count it as a resource.

Exclude only one space for each person. Document in the case record for whom each space is intended.

A "burial space" includes:

- A conventional grave site, including opening and closing the grave.
- A crypt, vault, or mausoleum.
- The casket, urn, burial containers, and items traditionally used for the remains of a deceased person.
- Headstones, markers, or plaques.

A space can be all items that traditionally go with the burial space. For example, a space can include both a lot and a casket, but not an urn in addition to the lot and casket.

Child Tax Credit
20 CFR 416.1235

Exclude the child tax credit as a resource for nine months following the month of receipt.

Continuing Care Retirement and Life Care Community Entrance Fees
441 IAC 75 (Rules in Process)

Entrance fees paid by persons residing in continuing care retirement communities or life care communities that collect an entrance fee on admission are considered a resource available to the person if:

- The person has the ability to use the entrance fee, or the contract between the person and the community provides that the entrance fee may be used to pay for care;
- The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the community contract; and
- The entrance fee does not confer an ownership interest in the community.

Dedicated Accounts
20 CFR 416.546,
20 CFR 416.640,
20 CFR 416.1247

Exclude the funds in a dedicated account as a resource for people receiving SSI. When past-due benefit payments are paid for an eligible person under age 18, the Social Security Administration requires the representative payee to establish a dedicated account.

The dedicated account may be used only for:

- Medical treatment, education, and job skills training.
- Personal needs assistance, special equipment, housing modification, and therapy or rehabilitation if related to the child's impairment.
- Other items and services related to the child's impairment approved by the Social Security Administration.

Stop excluding the funds in a dedicated account when the person loses SSI eligibility, even if the person later reapplies and is approved.

Disaster Assistance
20 CFR 416.1201,
20 CFR 416.1210,
20 CFR 416.1237;
P. L. 101-508

Exclude disaster assistance from a state, federal or local programs as a resource.

Earned Income Credit
Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P. L. 111-312)

Exclude the earned income credit in the month it was received as well as in the following month. Funds remaining are countable resources after the end of the second month.

NOTE: Exclude for 12 months from the date of receipt all EITC payments as part of a federal tax refund between January 1, 2010, and December 31, 2012.

Educational Assistance
20 CFR 416.1236(7), 20 CFR 416.1236(14), 20 CFR 416.1250

All student financial assistance received under Higher Education Act (HEA) or under Bureau of Indian Affairs (BIA) student assistance programs is excluded as a resource, regardless of use and regardless of how long the assistance is held. Examples of HEA (Title IV) programs are:

- PELL grants
- State Student Incentives
- Academic Achievement Incentive Scholarships
- Byrd Scholars
- Federal Supplemental Educational Opportunities Grants (FSEOG)
- Federal education loans (Federal PLUS Loans, Perkins Loans, Stafford Loans, Ford Loans, etc.)
- Upward Bound
- Gear Up (Gaining Early Awareness and Readiness for Undergraduate Programs)
- LEAP (Leveraging Educational Assistance Partnership)
- SLEAP (Special Leveraging Educational Assistance Partnership)
- Work-study programs

Educational Assistance (Cont.)

- Other grants, scholarships, fellowships, or gifts used or intended to be used to pay the cost of tuition, fees, or other necessary educational expenses at any educational institution, including vocational and technical education, are excluded from resources for nine months beginning the month after the month the assistance was received.

  This exclusion does not apply to any portion set aside or actually used for food, clothing, or shelter.

"Necessary educational expenses" include the following:

- Laboratory fees
- Student activity fees
- Transportation
- Stationery supplies
- Books
- Technology fees
- Impairment-related expenses necessary to attend school or perform schoolwork (special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment, etc.)

Grants, scholarships, fellowships, and gifts that are retained after the nine-month exclusion are countable resources beginning the month after the exclusion period ends. Excluded educational assistance becomes countable as income in the earliest of:

- The month any portion of the excluded assistance is used for something other than tuition, fees, or other necessary educational expenses, or
- The month the member no longer intends to use the funds to pay educational expenses.

Emergency Energy Conservation Assistance
20 CFR 416.1124(b)

Exclude any cash or in-kind assistance provided under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program, including:

- Winterization of old or substandard dwellings. (Neither the cost of the materials nor the cost of labor is counted.)

Emergency Energy Conservation Assistance (Cont.)	▪ Insulation. ▪ Emergency loans and grants to install energy conservation devices. ▪ Alternative fuel supplies and special fuel vouchers or stamps. ▪ Alternative transportation activities designed to save fuel and guarantee continued access to training, education, and employment. ▪ Legal or technical training relating to the energy crisis. ▪ Fuel to operate food preparation appliances, or meals provided because utilities have been shut off.
Food Programs 20 CFR 416, Subpart K Appendix	Exclude the value of: ▪ Allotment paid under the Food Stamp Act ▪ Food provided under WIC ▪ School lunches or breakfasts ▪ Congregate meals ▪ Federally donated food Verification is not required.
Gifts Made Under Uniform Gift Act 20 CFR 416.1201	A gift given to a child under 21 is not considered an available resource under the Uniform Gift Act. When the child turns 21, the gift becomes a countable resource. Verify the amount of the gift before excluding it. See 8-E for how to treat all other types of gifts.
Household Goods and Personal Effects 20 CFR 416.1216	Household goods and personal effects are excluded as a resource. “Household goods” are items used to maintain the home as well as to accommodate, comfort and entertain the occupants. “Personal effects” are belongings of family members, including clothing, books, and grooming aids. Do not count one set of a client’s wedding and engagement rings.

Household Goods and Personal Effects (Cont.)	Exclude items required by any household member because of the person's medical or physical condition, regardless of value. For example, exclude prosthetic devices, dialysis machines, wheelchairs, and hospital beds. Exclude household goods and personal effects that were excluded in the attribution of resources. In spousal impoverishment cases, the household goods and personal effects retained by the community spouse are excluded as resources to the institutionalized spouse when determining Medicaid eligibility.
Housing Assistance Provided by HUD or FMHA 20 CFR 416.1124(b); U.S. Housing Act of 1937, Section 8; U.S. Housing Act of 1959, Section 202(h); National Housing Act; Housing Act of 1949, Title V; Housing and Urban Development Act of 1965, Section 101; (Section 1701 of 12 USC, section 1451 of 42 USC)	Do not count rent subsidies, cash toward utilities, or indirect assistance (guaranteed loans, mortgages, and mortgage insurance) provided to homebuyers by the Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture/World Development. Do not count any rent reduction to a person in low-income housing when the assistance is under the U.S. Housing Act of 1937, as amended. Verify the authority for the client's federal or federally assisted housing. If the client cannot get verification, contact the local public housing authority. If HUD and a private owner have entered into a contract directly, contact the owner or manager of the project to verify the nature and authority for the housing assistance payments. Record the findings in the client's case record.
Income Tax Refunds Public Law 111-312 Public Law 112-240	Federal income tax refunds are excluded for 12 months from the date of receipt. Exclude state income tax refunds as a resource for the month of receipt and the month following the month of receipt.

Individual Development Accounts 20 CFR 416.1201, 20 CFR 416.1210, 20 CFR 416.1236; P. L. 105-285, Section 415, P. L. 106-554	Contributions that are deposited in a Demonstration Project IDA are excluded from resources. Any matching funds that are deposited in a Demonstration Project IDA and interest earned are excluded from resources.
Indian Assistance 20 CFR 416.1201, 20 CFR 416.1210, 20 CFR 416.1236; P. L. 101-508, P. L. 92-254, P. L. 94-114, P. L. 103-66	Exclude judgment funds distributed to members of Indian tribes and payments that were received from certain lands and subsurface mineral rights, then distributed to tribal members. Exclude up to $2,000 of income per year received by a Native American from interests of Indian trusts or restricted lands. Exclude any land that the client or spouse cannot dispose without the consent of the tribe, a federal government agency, or other persons.
Insurance (Death Benefits) 20 CFR 416.1201, 20 CFR 416.1210, 20 CFR 416.1230; P. L. 101-508	Exclude in the month of receipt and the following month life insurance or death benefits not spent on the insured's last illness or burial. If the money is reimbursement for expenses of the last illness or burial, exclude it only for the month of receipt.
Insurance (Life) 20 CFR 416.1230	Exclude the cash surrender value of life insurance policies with a combined face value totaling $1,500 or less per owner. If the total face value of life insurance owned by the applicant or member is more than $1,500, count the cash surrender value toward the resource limit. Exclude the face value all life insurance that has no cash surrender value, such as term insurance. For purposes of this comparison, the countable face value of a life insurance policy is the total face value minus any face value purchased with dividends from the policy.

Insurance (Life) (Cont.)

If the face value of the policy increases in other ways, use the adjusted face value. Do not include additional sums payable if the member dies in an accident. The **cash surrender value** is the amount that the insurance company will pay if the policy is canceled before death (this value usually increases with the age of the policy). The cash surrender value may include dividends and may decrease with loans.

Funds paid as accelerated payments from the policy do not change the value of the resource. These payments, called **accelerated death benefits**, are counted as income.

1. Mr. X owns two life insurance policies, one with a face value of $750 and the other with a face value of $500. Since the total face value of life insurance is $1,250, the policies are exempt from resource consideration.
2. Mr. Y owns three life insurance policies with face values of $1,000, $750, and $500, totaling $2,250. Mrs. Y owns one life insurance policy with a face value of $1,000.

   Mrs. Y's policy is ignored in the computation because its face value is less than $1,500 per owner. Since Mr. Y's policies total $2,250, the cash surrender value of each policy must be determined.
3. Mr. and Mrs. Q and their child have life insurance with a face value of $4,000. Mr. Q owns the policy. The cash value is counted towards the resource limit.

Count accumulated dividends that are not used to purchase additional insurance as a resource in the same manner as money in a bank account. Count the accumulated dividends even if the countable face value of the policy is less than $1,500 and the cash value of the life insurance is excluded.

Do not include the face value of dividend additions in determining whether a policy is a countable or excludable resource. If the policy is a countable resource, include the cash surrender value of dividend additions in determining the resource value of the policy.

Insurance (Life) (Cont.)

Mr. B has a $1,000 whole life policy that he purchased in 1942. His dividends purchased an extra $3,000 in face value in 1976. Now, the total face value of the policy is $4,000, the cash value is $2,800, and dividends are $800.

Because the policy's face value, (not including the face value due to insurance purchased with dividends) is less than $1,500, the cash value is excluded. However, the $800 in dividends that were not used to buy additional insurance are countable resources.

Dividend accumulations may be considered as cash set aside for burial if all burial fund criteria are met. Do not automatically assume that the dividends are set aside for burial because the cash value of the life insurance is designated for burial.

If the life insurance policy is assigned to the funeral home in an irrevocable burial contract, do not count the cash value or the dividends as a resource.

If the funeral home is the beneficiary, the cash value of the policy may still be counted as a resource unless otherwise excluded. If the funeral home is the beneficiary and the client has an irrevocable burial contract, do not count the cash value of the policy, but count any accessible dividends as a resource to the client.

At the time of application, send form 470-0444, *Insurance Report*, to verify the:

- Total face value of the whole life insurance policy not including dividend additions.
- Amount of accumulated dividends not used to purchase additional insurance.
- Interest earned on accumulated dividends.

Insurance (Life) (Cont.)

At annual reviews, send 470-0444 unless the total face value of all policies is $1,500 or less and the last report indicated that the face values will not change. See 6-Appendix, for instructions on form 470-0444, *Insurance Report*.

Insurance (VA Term Life)

People who are age 70 or older and have National Service Life Insurance (VA) term policies earn cash value when the term policy lapses or is canceled at their request.

When the policy lapses or is canceled, the cash value will be used to buy a limited amount of paid-up additional (PUA) insurance. With PUA insurance, the policyholder may:

- Receive insurance coverage without paying premiums.
- Borrow against the cash value.
- Surrender it for cash.
- Receive annual dividends that may be used to buy more PUA.

The VA term insurance policies will remain excluded as a resource after the policyholder reaches age 70, as long as the policyholder:

- Continues to pay the policy premiums and does not allow the policy to lapse; and
- Does not request cancellation of the policy.

If the policy lapses or if the policyholder requests cancellation, how the policy is subsequently treated depends on what the policyholder does with the PUA insurance. If the policyholder:

- Receives insurance coverage without a premium, the cash value of the insurance is countable as a resource the month after the change takes place.
- Surrenders the policy for cash, the cash is countable income in the month received.

Life Estates or Remainderman Interest
20 CFR 416.1201, IAC 75 (Rules in Process)

Policy: Property can be divided into two parts, the life estate and the remainder interest. This applies whether the property is real estate or personal property or is liquid or nonliquid.

The value of a life estate or remainder interest depends on the value of the underlying property and the life expectancy of the person whose life controls it (the original holder of the life estate).

Comment: Life estates and remainder interests generally count as resources for eligibility purposes. However, if the underlying property would be exempt, the life estate or remainder interest is also exempt.

For example, exclude real property in a life estate as a homestead if the owner of the life estate lives in the dwelling, or if the other exclusion policies for a homestead apply. See Property in a Homestead.

People who receive or retain **a life estate** ("life tenants") have the right to use the property during their lifetime, including the right to any income generated by the property during their life. Count income generated according to policy. See 8-E, *Lump-Sum Income*.

This right has a value and can be sold to someone else. If the original owner of the life estate transfers or sells the life estate to someone else, the recipient of the life estate gets the right to use the property during the life of the original holder. The "life" that determines the life estate does not change with the transfer.

The owner of a **remainder interest**, the remainderman, has the right to receive the property when the life estate ends. Before the life estate ends, the owner of the remainder interest has no right to use the property or to receive any income from it.

Life Estates or Remainderman Interest (Cont.)

The right to receive the property when the life estate ends also has value and can be sold. As with a transfer of the life estate, the transfer of the remainder interest does not change the life that controls the life estate. When the life estate ends, the remainderman then owns the entire property. It is no longer divided into a life estate and remainder interest.

> Mrs. A, a nursing facility resident, has a life estate. She reports that the property held in the life estate was sold. Request documentation to determine if both the life estate and the remainder interest were sold, or if just the life estate or the remainder interest was sold.
>
> If just the remainder interest was sold, Mrs. A continues to hold a life estate in the property. If both the life estate and the remainder interest were sold, Mrs. A is entitled to that portion of the sale proceeds that represent the value of the life estate. If only the life estate was sold, Mrs. A is entitled to all of the proceeds.

The owner of the entire, undivided property can divide the property into the two parts and can:

- Keep the life estate and transfer the remainder interest;
- Transfer the life estate and keep the remainder interest;
- Transfer both the remainder interest and the life estate to two different people.

If the life controlling the life estate is likely to be short, the value of the life estate is smaller and the value of the remainder interest greater. Conversely, if the life controlling the life estate is likely to be long, the value of the life estate is greater and the value of the remainder interest smaller.

Procedure: Request verification of:

- What portion of the life estate the client owns,
- Which portion has been sold or transferred, and
- The date of the transaction.

Life Estates or Remainderman Interest (Cont.)

To determine the value of a life estate or remainder interest, first determine the fair market value of the entire underlying property as if it was not divided into a life estate and remainder interest.

Obtain verification of the fair market value of the underlying property from a disinterested, knowledgeable source, in the same way as for any other undivided property. This could be an appraisal, a real estate fair market analysis, or an offer on the property from a disinterested knowledgeable source.

For **real estate**, the fair market value of the underlying property is the amount it could be sold for on the open market. A disinterested, knowledgeable source can be a real estate broker, Farmer's Home Administration, bank, mortgage company, or other lending institution.

For **farm land**, obtain the average value of an acre of land in the area from the Iowa State University Extension office.

For **liquid** resources such as a certificate of deposit or bank account, the fair market value is the amount that would be received if the resource were cashed in.

To determine the value of the **life estate** when the applicant or member is the life estate holder:

1. Determine the fair market value of the entire underlying property (as if it was not divided into a life estate and a remainder interest).
2. Find the line on the life estate column corresponding with the age of the person whose life controls the life estate (the original holder of the life estate) as of the date for which a value is being determined. (If a couple owns the life estate, use the age of the younger spouse.)
3. Multiply the fair market value by the figure in the life estate column.

Life Estates or Remainderman Interest (Cont.)

To determine the value of the **remainder interest** when the client is the remainderman of a life estate:

1. Determine the fair market value the entire underlying property (as if it was not divided into a life estate and a remainder interest).
2. Find the line on the remainder column corresponding with age of the person whose life controls the life estate (the original holder of the life estate) as of the date for which a value is being determined.
3. Multiply the fair market value by the figure in the remainder column.

If the client maintains that the life estate or remainder interest cannot be sold for the amount determined using the table, the client must present other evidence to support this claim.

You may also use the table for mortality, life estates, and remainder published by the Iowa Department of Revenue at http://www.iowa.gov/tax/forms/60059.pdf. This table may be used as a second source in determining the fair market value of a life estate, along with the table in this chapter.

The client must obtain a statement from a disinterested, knowledgeable third party stating the value of the life estate or remainder interest.

A disinterested third party is someone who is free of bias and self-interest that can determine the value of the property. Use the “prudent person” concept in determining whether the party stating the value of the life estate has anything to gain by making the offer.

A disinterested, knowledgeable source may establish that a life estate or remainder interest has no value if it could not be sold at any price.

Life Estates or Remainderman Interest (Cont.)

Age	Life Estate	Remainder
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.51441	.49559
77	.48742	.51258

Life Estates or Remainderman Interest (Cont.)

Age	Life Estate	Remainder	Age	Life Estate	Remainder
78	.47049	.52951	79	.45357	.54643
80	.43569	.56341	95	.22887	.77113
81	.41967	.58033	96	.22181	.77819
82	.40295	.59705	97	.21550	.78450
83	.38642	.61358	98	.21000	.79000
84	.36998	.63002	99	.20486	.79514
85	.35359	.64641	100	.19975	.80025
86	.33764	.66236	101	.19532	.80468
87	.32262	.67738	102	.19054	.80946
88	.30859	.69141	103	.18437	.81563
89	.29526	.70474	104	.17856	.82144
90	.28221	.71779	105	.16962	.83038
91	.26955	.73045	106	.15488	.84512
92	.25771	.74229	107	.13409	.86591
93	.24692	.75308	108	.10068	.89932
94	.23728	.76272	109	.04545	.95455

Source: 49 Federal Register/Vol. 49 No. 93/5-11-84
Table -- Unisex Life Estate or Remainder Table.

Loans and Promissory Notes
20 CFR 416.1207

Any amount that is borrowed through a loan is a resource if it is retained into the month following the month the loan is received.

When an applicant or member makes a loan to another person, determine the resource value of the loan or promissory note. The loan or promissory note can be sold or transferred from one person to another. The resource value is the amount a disinterested third party would pay to receive the balance of the payments on the loan or promissory note.

Loans and promissory notes must also be reviewed to determine if use of the funds to purchase or make the loan constitutes a transfer of assets for less than fair market value. See Transfers That Cause a Medicaid Penalty.

Mortgages and Contracts
20 CFR 416.1201

Count mortgages and contracts as resources. The countable value of a mortgage or contract is:

- The remaining balance on the contract; or
- The gross price for which it can be sold or discounted on the open market minus any legal debts, claims, or liens against the property.

Offer the applicant or member the opportunity to:

- Show that a contract is not legally transferable; or
- Establish the fair market value of the contract.

The fair market value of a mortgage or contract is the amount that the buyer would pay the seller for the mortgage or contract. To establish the fair market value of the contract, tell the applicant or member to obtain three written estimates of the mortgage or contract value.

Inform the applicant or member that obtaining outside estimates of the market value could increase or decrease the countable value of the resource. The institutions from which the estimates are obtained do not need to be in the area where the property is located.

The fair market value must be determined as the contract or mortgage stands, without any modification or conditions. However, the following conditions to a valuation are acceptable and do not prevent it from being a bona fide estimate of fair market value:

- Establishment of ownership.
- Production of abstract.
- Payment of filing fees. Deduct filing fees from the value of the contract.

Average the estimates provided by the applicant or member. If you receive only one unbiased estimate, use that value.

Mortgages and Contracts (Cont.)

Make sure the financial institution is stating the actual worth of the contract and not an opinion on whether it wishes to buy the contract. Do not use the contract valuation to determine eligibility if it contains conditions such as:

- Credit approval of the buyer (unless there has been a recent credit approval of the buyer known to the client).
- Changes in the terms of the contract.
- Appraisal of the property at or above a particular value (unless there has been a recent appraisal at or above the stated value).

If a contract is jointly owned, the client's interest may be sold without the consent of the other owner. In Iowa, real property mortgages and contracts are usually legally transferable, even if the terms of the contract or mortgage prevent it. Although such terms are not legally enforceable, a nontransferable clause or an uncooperative co-owner may affect the fair market value.

If the contract is a countable resource, the portion of a mortgage or contract payment that represents interest, minus any interest used to purchase the property, is counted as unearned income. The principal portion of the payment is treated as a resource.

Mortgages and Contracts (Cont.)

If the contract is not a resource and the principal is not treated as a resource, count the total payment on the contract as income.

> Mr. H bought a property on contract that he is selling on contract. The value of the second contract is established at $1,500. He has a checking account that had $100 the first moment of the first day of the month, and no other resources. Mr. H is within resource limits.
>
> Mr. H receives $150 per month payment from the contract. Of this $150 payment, $40 a month is interest.
>
> He pays $12 a month interest in his payment for the property. The countable interest income for eligibility and client participation is $28 per month. ($40-$12=$28) The remaining $110, if retained is counted as a resource.

Mortgages and contracts must be reviewed to determine if the purchase constitutes a transfer of assets for less than fair market value. See Purchases Considered Transfers for Less Than Fair Market Value.

Other Excluded Federal Payments
20 CFR 416.1124,
20 CFR 416.1236,
P. L. 101-239,
P. L. 101-426,
P. L. 101-510
P. L. 106-398

Exclude the following federal payments:

- Compensation provided to volunteers by the Corporation for National and Community Services (CNCS) (previously referred to as ACTION), unless CNCS determines that the hourly rate is equal to or over the minimum wage. (So far, CNCS has never made this determination. Central Office will contact staff if that happens.) Programs under CNCS include:
  - University Year of Action (UYA).
  - Volunteers in Service to America (VISTA).
  - Foster Grandparents.
  - Retired Senior Volunteer Program (RSVP).
  - Senior Companion Program.
  - Special and Demonstration Volunteer Program.

Other Excluded Federal Payments (Cont.)

- **Agent Orange Settlement Fund** payments or payments from any other fund established because of the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y).

  NOTE: This settlement fund is now closed as all funds have been distributed.

- Dividend payments on shares of the **Alaska Native Fund**, and other revenue originated from the fund. The Alaska Native Fund was created by the Alaska Native Claims Settlement Act (Public Law 92-203), enacted on December 19, 1971.

- **Austrian Social Insurance** payments based partly or completely on wage credits granted under paragraphs 500-506 of the Austrian General Social Insurance Act. Use the award letter to determine how to count the payments.

- **Energy Employees' Occupational Illness Compensation Program** payments made to former employees or their families. Beneficiaries will receive one or two lump sum payments, which are excluded as income and as a resource. Award letters sent to the recipient from the Department of Labor should verify the amount and source of the payments.

- **German Reparations** payments made to survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution, whether they are paid periodically or in a lump sum.

- **Japanese-American (or their survivors) and Aleut restitution** payments made by the U.S. Government to people who were interned or relocated during World War II.

- **Japanese-Canadian** restitution payments from the Canadian Government to Japanese-Canadians who were interned or relocated during World War II. Use documents from the client to identify or verify the nature of the payments.

Other Excluded Federal Payments (Cont.)	If the applicant or member has no documents, ask if they were imprisoned, relocated, deported, or deprived of other rights in Canada during the period of December 1941 to March 1949 because of Japanese ancestry. If yes, exclude the payment. If no, count the payment as a resource. ▪ **Radiation Exposure Compensation Act** payments that compensate persons for injuries or death resulting from exposure to radiation from nuclear testing and uranium mining. After the affected person's death, payments are made to the surviving spouse, children, or grandchildren. Any interest on these funds is counted as income. ▪ **Relocation Assistance** payments provided to owners, tenants, or occupants who were displaced when property was acquired by a federal, state, or local government-assisted project.
Plan for Achieving Self-Support (PASS) 20 CFR 416.1180, 20 CFR 416.1181, 20 CFR 416.1225, 20 CFR 416.1226	Exclude resources of a blind or disabled member under the age of 65 if they are needed to fulfill a plan for achieving self-support (PASS). People 65 or over get this exclusion only if they were receiving SSI payments because of blindness or disability in the month before they turned 65. Check the SDX when an SSI recipient states that a plan for achieving self-support exists.
Property Necessary for Employment 20 CFR 416.1224	Exclude any tools, equipment, and uniforms necessary for a client's employment. The applicant or member must give you a signed statement listing the items required. If necessary, contact the employer for verification.
Property in a Homestead 20 CFR 416.1212	Exclude a homestead as a resource regardless of value. A homestead is any shelter used as the principal place of residence by the member, spouse, or dependent (including a child under age 18 or the disabled adult child of the member or spouse). It includes surrounding contiguous land and any buildings on this land. It may be fixed or mobile and located on land or water.

Property in a Homestead (Cont.)

Mr. K owns and operates the 80-acre farm on which he lives. The house, farm buildings, and farmland are exempt from consideration as a resource.

Mrs. Z owns 20 acres that is considered a homestead. Mrs. Z builds a second house and rents out the first house. Both houses are exempt as a resource because they sit on one contiguous homestead property.

Exclude the proceeds from the **sale** of the homestead (including homesteads sold on contract) for up to three months if the member intends to purchase another home. Ask the member to sign a statement such as the following:

"On ___(*date*)___ I received $_____ net proceeds from the sale of my home. I plan to use that money to replace that home with another home within three months, by ___(*date*)___."

The member must report the date the new home is purchased and the purchase price. Count any excess proceeds from the sale of the old homestead that are not used to purchase the new homestead.

The homestead is sold for $45,000 on December 2. A new home is purchased on February 16 for $35,000. The $10,000 difference is a countable resource on March 1.

If the proceeds are **not** used within three months to buy another homestead, count the proceeds as a resource at the end of the three-month period.

Also exclude a homestead as a resource if:

- It is not occupied by the member due to a **temporary absence**, such as a trip, visit, or stay in a residential care facility or medical institution. To be excluded, the member must intend to return to the home. If the member does not intend to return, the home becomes a nonhomestead property, and is countable as a resource.

Property in a Homestead (Cont.)

Obtain a signed statement from the member or the member's representative that the member intends to return home. Place the statement in the case record.

If the statement contradicts previous statements by the member or the member's representative regarding intent to return home, obtain additional verification from a knowledgeable source.

- It is **occupied by the member's spouse or dependent relative** while the member is absent due to being institutionalized. "Dependent relative" includes:
  - Child, grandchild, stepchild.
  - Mother, stepmother, father, stepfather.
  - Sister, stepsister, brother, stepbrother.
  - Aunt, uncle, niece, nephew.
  - Grandmother, grandfather.
  - In-laws.

  The dependency can be emotional, financial, or medical. If the dependent receives FIP assistance, the person can still be considered financially dependent on the member. Accept the member's statement that the relative is dependent unless you have reason to question it.
- It is not occupied by the member because the member is a victim of **domestic abuse** fleeing an abusive situation. Continue to exempt the home until the member establishes a new principal place of residence or otherwise takes action that makes the home no longer excludable.

Property in a Homestead for People Requesting Long-Term Care
441 IAC 75 (Rules in Process)

A person is not eligible for payment of nursing facility services or other long-term care services, if the person has substantial equity interest in their homestead. This limit does not apply:

- If the spouse, or child who is under age 21, or the person's child who is blind or disabled, as defined by Social Security, resides in the home; or
- To people approved based on an application or request for payment of long-term care services filed before January 1, 2006.
- Use the following chart to determine the correct maximum equity amount based on the date of application.

Application filed on or after:	Equity interest cannot exceed
January 1, 2014	$543,000
January 1, 2015	$552,000
January 1, 2017	$560,000
January 1, 2018	$572,000
January 1, 2019	$585,000
January 1, 2020	$595,000
January 1, 2021	$603,000
January 1, 2022	$636,000
January 1, 2023	$688,000
January 1, 2024	$713,000
January 1, 2025	$730,000

Property Earning Six Percent of Equity
20 CFR 416.1222

Exclude real property as a resource if its equity value does not exceed $6,000 and the net annual return earned on the property is at least 6% of the equity value. **Equity** is the current market value of the property minus any legal debt on the property. **Market value** is the amount an item can be sold for on the open market.

To determine if the property is earning 6% of equity, multiply the net monthly income by 12 months. This amount is the net annual return earned on the property. Then multiply the equity value by 6%. Compare the net annual return amount to the 6% of equity amount.

Property Earning Six Percent of Equity (Cont.)

If the net annual return is higher than 6% of the client's equity in the property, exclude the property if the equity value does not exceed $6,000.

If the client's equity in the property exceeds $6,000 and the property is earning at least 6% of equity, count only the amount of equity over $6,000 as a resource.

> Ms. T owns her home and rents it out for $700 a month. The fair market value of the home is $80,000 and she still owes $50,000 on it. Ms. T's equity value is $30,000. She files an application for medical assistance. Determine if the property is earning 6% of equity as follows:
>
> $700 x 12 = $8,400 net annual return
>
> $30,000 x 6% = $1,800
>
> Since Ms. T's equity amount exceeds $6,000 and the property is earning at least 6% of equity, count only the amount of equity over $6,000 as a resource.
>
> $30,000 - $6,000 = $24,000 countable resource value

If a property is not producing 6% of equity due to a client's illness, exclude the property as a resource for up to 24 months as long as the client plans to resume the business after the illness ends.

Property Used for Self-Support
20 CFR 416.1224

Exclude equity in non-income-producing real property that is valued under $6,000 and produces goods and services necessary to the applicant's or member's daily living. Liquid resources used for self-support are **not** excluded.

Resource Replacement
20 CFR 416.1232,
P. L. 101-508

Exclude cash received for the replacement or repair of an excluded resource. Do not count the cash or the interest earned on the cash for nine months from the date it is received.

Resource Replacement (Cont.)

If the replacement or repair takes longer because of circumstances beyond the control of the member, exclude the cash for an additional nine-month period. Count it as a resource the first moment of the next month after the second nine-month period expires.

Retirement Funds

20 CFR 416.1201,
20 CFR 416.1210,
20 CFR 416.1244;
P. L. 101-508

Exclude retirement funds if the member has to quit a job to withdraw the funds.

If the retirement funds are not excluded:

- Count the verified net proceeds after penalties in the attribution and the eligibility process if the fund is owned by the member.
- Count the verified net proceeds after penalties in the attribution process if the fund is owned by the community spouse.
- Do not count retirement funds owned by the ineligible spouse in the deeming process when spouses live together.

NOTE: Taxes are not an allowable expense when determining net proceeds of retirement funds. The 10% early withdrawal penalty on an individual retirement account (IRA) is an additional tax.

A member who has a choice to withdraw retirement funds as a lump sum or as an annuity must choose the annuity.

Types of retirement plans include:

- **Defined benefit plan**: The employer promises the employee a specific monetary benefit at a specific age, based on factors such as salary and length of service. The employee cannot draw a pension until the employee meets certain requirements, such as being a certain age or being retired.

Retirement Funds (Cont.)

- **Defined contribution plan**: The employer and employee makes specific contributions to an employee's pension fund. The amount of the benefit depends on the amount saved and how well the employee's fund investments perform.

  Most of these plans are 401(k) plans. Typically these plans can be accessed at age 59½ without a tax penalty or earlier with a tax penalty. Other withdrawal restrictions may apply depending on the plan.

- **Individual Retirement Account (IRA)**: The employee establishes and funds these accounts. The employee can liquidate these funds at any time.

Retroactive Cash Payments
P. L. 101-508

Exclude any retroactive cash payments paid to ineligible spouses or parents for providing in-home supportive services to the applicant or member. Exclude the payments in the month of receipt and the following month.

Retroactive SSI and Social Security Lump-Sum Payments
20 CFR 416.1233

Exclude SSI and Social Security retroactive lump-sum income as a resource for nine months after receipt, as long as the funds are not combined with other funds and can be identified as the lump-sum funds. (See 8-E, *Lump-Sum Income* for income guidelines.

Verify that the funds are separate and represent a retroactive lump sum. Before the ninth month, the member must again verify resources. If resources exceed the limit, cancel the member, giving timely notice.

An unmarried member receives a social security lump sum of $4,500 on October 12. The worker sets a reminder for June 1. On June 19, the worker verifies the resources are $2,600.

On July 30, the member is canceled and is ineligible for Non-MAGI-related coverage groups that have a $2,000 resource limit. The worker completes a redetermination. Effective August 1, the member is eligible under Medically Needy.

Self-Employment Property and Resources
20 CFR 416.1220, P.L. 101-239 SEC 8014

Exclude self-employment resources of the applicant or member, spouse, parent, or alien sponsor. Examples of self-employment resources are:

- Real property, buildings.
- Inventory, tools, equipment, machinery.
- Farm equipment and livestock.
- Motor vehicles.

If the homestead is used as the place of self-employment, exclude it as a home, if applicable; otherwise exclude it as a self-employment resource.

If you question whether a resource is used for self-employment or is the client's personal property, ask the client to sign a statement stating whether the resource is necessary for the self-employment. Allow the exclusion if client states the resource is necessary.

Exclude liquid resources that are essential for self-support and are used in the operation of self-employment. Obtain a signed statement that the liquid resources are used for self-employment.

Continue to allow the exclusion if:

- The business is operating at a loss.
- An illness or disability prevents the continuation of the self-employment business. This exclusion cannot exceed two years.
- The business is seasonal and the client is not currently working but is expected to return within one year after the last day of use.

1. Before Mrs. B entered a nursing facility, she and her husband farmed together. Mr. B continues to farm. Their animals, a truck, and farm machinery are necessary for farming and are not countable resources for attribution or eligibility determination. They are exempt as resources owned by the spouse necessary for self-employment.

Self-Employment Property and Resources (Cont.)

2. Mr. and Mrs. W are farmers. They apply for Medically Needy and list livestock, a tractor, a combine, a car, two trucks, and a bank account as necessary for self-employment. All of the resources are determined to be necessary for self-employment, and are not counted.

Social Services
20 CFR 416.1201,
P. L. 101-508

Exclude payments for social service expenses for the month of receipt and the month after the month of receipt. If the funds are a reimbursement for bills previously paid by the applicant or member, count them as a resource in the month after receipt.

Third-Party Medical Payments
20 CFR 416.1201,
20 CFR 416.1210,
P. L. 101-508

Do not count funds received to pay for a medical service, such as Veterans unusual medical expense payments. These funds are exempt as a resource in the month of receipt and the month after the month of receipt. If the funds are repayment for bills the client already paid, count the funds as a resource the month after receipt.

Vehicles
20 CFR 416.1218

A vehicle is any device used to provide transportation, such as cars, trucks, motorcycles, boats, animals, animal-drawn devices, mopeds, etc. Vehicles can be unregistered or in need of repair, as long as the vehicle is used for transportation. Treat vehicles as follows:

1. Exclude one vehicle as a resource regardless of value if it is used for transportation of the individual or a member of the individual's household.
2. If the individual owns more than one automobile, apply the exclusion as follows:
    a. Apply the exclusion in the manner most beneficial to the individual.
    b. Apply the total exclusion to the vehicle with the greatest equity value if the eligible individual owns more than one vehicle used for transportation of the individual or a member of the individual's household.

Vehicles (Cont.)

c. The equity value of any vehicle, other than the one wholly excluded, is a resource when it:
   - Is owned by the individual; **and**
   - Cannot be excluded under another reason (e.g., property essential to self-support, plan to achieve self-support).

3. Count the equity value of any other vehicles.
4. Count the equity value of any vehicles used solely for purposes other than transportation, such as racing cars or antiques toward the resource limit. These vehicles are personal property, not household goods.

Do not count any vehicle that the applicant or member sold, even if the buyer has not recorded the title transfer with the appropriate authority.

To determine the value of vehicles, use a "blue book," such as the National Automobile Dealers Association (NADA) *Used Car Guide Book*.

Find the amount listed in the column for "average trade-in value." To find the specific value of the vehicle, use the value corresponding to the options that the vehicle has. If the vehicle is not listed in the "blue book," contact a motor vehicle dealer or knowledgeable source in the community.

Victim's Compensation Funds
20 CFR 416.1201,
20 CFR 416.1210,
20 CFR 416.1229

Exclude for nine months funds paid through the Crime Victim Reparation program. The Iowa Department of Justice administers this program, which compensates victims of crime for expenses incurred or losses suffered as a result of a crime. The funds should be separate and identifiable. Expenses paid by the Crime Victim Reparation Program include:

- Medical bills.
- Lost wages.
- Loss of support.
- Clothing held in evidence.
- Counseling.
- Burial.

Worker's Compensation Medicare Set-Aside Arrangements

Treat a worker's compensation Medicare set-aside arrangement (WCMSA) as a trust created by a third party (the defendant in the worker's compensation claim). Exclude it as a resource when determining eligibility if the member does not have a legal authority to revoke it or to direct the use of the assets for the member's basic needs.

The funds in the WCMSA are available only to pay medical providers for future medical costs related to the work injury that would otherwise be paid by Medicaid. Therefore, the funds set aside in the account and any income generated by those funds are not available or countable as resources or income in determining Non-MAGI-related Medicaid eligibility or benefits, unless they are actually used for basic needs.

If the trustee makes the trust principal or trust income available to the member for basic needs (in violation of the terms of the WCMSA), count the available funds as income in the month of receipt and as a resource the month after.

Refer the WCMSA to the Third Party Liability Unit.

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Medicaid Income

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Overview

This chapter contains income policy information for both Non-MAGI-related and MAGI-related Medicaid coverage groups. General income policies regarding verification of income and income limits for Non-MAGI follow this overview.

Next, you will find the income policies for the Non-MAGI-related coverage groups. This section begins with an explanation of projecting income, joint ownership, and deeming.

The following section gives instructions on how to treat each type of income for Non-MAGI-related coverage groups, alphabetized by types. In-kind income, self-employment income, and veteran's affairs payments are described in separate sections because they are longer and more detailed. The last Non-MAGI-related section covers deductions.

The balance of the chapter contains the income policies for the MAGI-related coverage groups. This part begins with a section explaining the income limits and what income is considered. It also explains MAGI-related self-attested income, income exclusions, income verification, and budgeting procedures.

Verification of Income

Legal reference: 441 IAC 76 (Rules in Process)

For Non-MAGI-related Medicaid, any countable income received during the period of time for which income is being considered needs verified. See Projecting Future Income.

The client must provide requested verification. A client who provides a signed release to a specific individual or organization for specific information has met the requirement for supplying requested information or verification. The general release does not meet this requirement unless the client asks for help.

Verify all earned and unearned income. Require verification of income when it begins, changes, ends, is questionable, or when otherwise specifically required. A self-employed person must keep any records necessary to establish eligibility.

For MAGI-related Medicaid, refer to Income Verification under Income Policies for MAGI-Related Coverage Groups, later in this chapter.

Non-MAGI-Related Income Limits

Legal reference: 42 CFR 435, 20 CFR 416 Subpart D; 441 IAC 75 (Rules in Process)

The monthly countable income limits based on SSI are:

Single Person	Couple	300% of SSI Maximum Benefit
$967	$1,450	$2,901

Current poverty levels used for Medicaid coverage groups are:

Family Size	100%	120%	135%	200%
Individual	$1.305	$1,565	$1,791	$2,609
Couple	$1,763	$2,115	$2,380	$3,525

These amounts apply to coverage groups as follows:

- For qualified Medicare beneficiaries (QMB), the income limit is 100% of the poverty level.
- For specified low-income Medicare beneficiaries (SLMB), the income range is over 100% of the poverty level but less than 120% of the poverty level.
- For expanded specified low-income Medicare beneficiaries (E-SLMB), the income range is 120% of the poverty level but less than 135% of the poverty level.
- For qualified disabled and working people (QDWP), the income limit is 200% of the poverty level.

For Medicaid for Employed People with Disabilities (MEPD), net income for the family size is compared to 250% of poverty. (See 8-F, Medicaid for Employed People With Disabilities: Family Income Less Than 250% of Federal Poverty Level for extended listing of 250% levels and family size. See 8-C, Household Size for additional information about family size under MEPD.)

The Medically Needy coverage group does not have an income limit, although the applicant may have to meet a spenddown before eligibility exists. See 8-J.

State Supplementary Assistance Income Limits

Legal reference: 441 IAC 50.2(1), 441 IAC 51.3(3), 441 IAC 51.4(1), 441 IAC 52.1(1), 441 IAC 177.4(7), 441 IAC 177.4(8)

For State Supplementary Assistance, the person's income after allowable deductions must fall within the payment schedule limits for the category under which the person qualifies:

- Residential care facility. (See 6-B, Income (RCF).)
- Dependent person. (See 6-B, Income (DP).)
- Family-life home. (See 6-B, Income (FLH).)
- In-home health-related care. (See 6-B, Income (IHHRC).)
- Blind allowance. (See 6-B, Income (Blind Supplement).)
- Medicare and Medicaid eligibles. (See 6-B, Income (SMME).)

Income Policies for Non-MAGI-Related Coverage Groups

The following sections explain:

- What is defined as income for SSI.
- What is not considered income for SSI.
- How to project future income.
- Determining joint ownership of income.
- Deeming income from an ineligible spouse or parent.

What Is Income

Legal reference: 20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123, and 20 CFR 416.1167

Under SSI, "income" is anything a person receives either in cash or in kind that can be used to meet the person's basic needs of food or shelter. This includes any income deemed from a parent, spouse, or sponsor. See Deeming Non-MAGI-Related Income.

Determine the countable amount of earned and unearned income prospectively. For the retroactive period, as defined in 8-A, Definitions, use actual income received.

When determining eligibility, consider all gross income unless it is specifically excluded. See Recouped Benefits Paid in Error for an exception to this policy.

See Types of Non-MAGI-Related Income for a list of various types of income and information on whether the income is earned, unearned, counted, or not considered as income for Non-MAGI-related coverage groups.

What Is Not Considered Income

Legal reference: 20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123; P. L. 103-60

Some types of payments do not meet the definition of income and are not considered income. Items that do not meet the definition of income include:

- Income benefit payments made in error.
- Employer's benefits.
- Tax refunds.
- Third-party payments other than those for food or shelter.
- Veterans $90 pension exclusion for certain residents of medical institutions. See Pension Payments.
- Veterans aid and attendance and housebound allowance.
- Veterans benefits attributable to unusual medical expenses, except as noted under Payment Adjustment for Unusual Medical Expenses.

Each of these items, as well as other types of payments that are not considered income, are described under Types of Non-MAGI-Related Income, arranged alphabetically.

Projecting Future Income

Legal reference: 20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123; 42 CFR 435.725(e)(2)

Except when determining eligibility for the retroactive period, as defined in 8-A, Definitions, consider the income received in the 30 days before the application or review month to project future income when that income is an accurate indicator of future income.

If income fluctuates to the extent that a 30-day period alone cannot provide an accurate indicator, use an average over a longer past period if it will provide a more accurate indication of future income.

If income has changed and previous months' income is not an accurate indicator of future income, use the best information available to project future income. For example, the interest earned in the previous month on a savings account that has substantially increased or decreased would not be an indicator of future income.

When projecting income for cases that have fluctuating income and client participation, reevaluate the income at least every six months. Set a reminder at the eligibility review to request verification of actual income received. This includes earnings and interest income. Update client participation to reflect actual income in the month it was received.

Convert weekly income to monthly income by multiplying by 4.3. Convert biweekly income to monthly income by multiplying by 2.15.

See Determining Income from Self-Employment when projecting income for a self-employed client.

Determining Joint Ownership of Income

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

When there is income from property other than a trust, consider income paid in the name of one person as available only to that person, unless the document providing income states otherwise.

If the income-producing property is in the name of several people, consider each person's income to be in proportion to that person's ownership interest in the resource.

If the income is in the name of two people, count half to each person.

If the income is a joint payment to both spouses, count half to each person. If the client or the client's spouse can prove different ownership by a preponderance of evidence, divide the income in proportion to the ownership.

If there is trust property, follow the provisions of the trust regarding ownership.

See 8-D, Joint Ownership, for information about determining ownership of a resource.

1. Mr. and Mrs. P jointly own a CD. One-half of the interest is income to each spouse.
2. Mr. and Mrs. W jointly own a farm. One-half of the earnings is income to each spouse.

Deeming Non-MAGI-Related Income

Legal reference: 20 CFR 416.1160, 20 CFR 416.1163, 20 CFR 416.1202, 441 IAC 75 (Rules in Process)

Deeming of income is the determination of a specific portion of an ineligible parent's or ineligible spouse's income used to calculate the benefits of the eligible spouse or child. Determine deemed income for Non-MAGI-related Medicaid and State Supplementary Assistance coverage groups according to SSI policies except for the following coverage groups:

- Medically Needy. See 8-J, Households with Ineligible Spouse or Children.
- In-home health-related care. See 6-B, Eligibility for Children.
- Dependent person. See 6-B, Ineligible Spouse.
- Medicaid for employed people with disabilities (MEPD). See 8-F, Family Income Less Than 250% of Federal Poverty Level.

When determining eligibility, apply deeming policies to the income of an ineligible spouse or parent if either:

- An eligible person was living for any part of a month in the same household with an ineligible spouse, or
- The eligible person was a child living in the same household with a parent (or the spouse of a parent).

For all coverage groups except Medically Needy, do not apply the deeming procedure if the applicant's income alone, after appropriate exclusions and deductions, is over income limits. Allow the ineligible parent to deem income to an ineligible child in the household until the ineligible child reaches age 18 (or 21, if the child is a student). However, do not allow deeming to a child receiving FIP.

When determining the income of the ineligible spouse, parent, spouse of a parent, or ineligible children, do not include:

- Any excluded income.
- FIP payments or Veteran Affairs payments based on need.
- Any income that was counted in calculating the amounts of those payments.

- Court-ordered support or alimony payments. Deduct support payments from the income of the ineligible spouse or parent before determining the amount of income deemed. Deduct support payments first from unearned income. Any balance remaining then reduces gross earned income.

For income not based on need, allow the $20 general income deduction and the $65 plus one-half deduction per household. For example, apply the $20 general income deduction to veteran's compensation income, but not to a veteran's pension that is based on need.

The following sections explain:

- Deeming from an ineligible spouse.
- Deeming from an ineligible parent to an eligible child.

Deeming from an Ineligible Spouse

Legal reference: 20 CFR 416.1160, 20 CFR 416.1163

If the applicant's income is within program guidelines and an ineligible spouse lives in the same household, also consider the ineligible spouse's income to determine eligibility through the deeming process. An ineligible spouse is a spouse who is not eligible for SSI or Non-MAGI-related Medicaid, or State Supplementary Assistance.

When deeming income from an ineligible spouse:

1. Verify the ineligible spouse's unearned income. Subtract from the ineligible spouse's unearned income an allocation for each ineligible child. The allocation is $483 (the difference between the payment standard for a couple and the payment standard for one person), minus the child's income.
2. Verify the ineligible spouse's earned income. Subtract from the ineligible spouse's earned income any remaining balance of the ineligible child's allocation not subtracted from the ineligible spouse's unearned income.
3. Add the remaining unearned income and the remaining earned income of the ineligible spouse.

   If the total of the ineligible spouse's income is equal to or less than $483, there is no income available to be deemed to the applicant. Process as a one-person household.

   If the ineligible spouse's total remaining income is over $483, continue as follows.

4. Combine the applicant's unearned income and the ineligible spouse's remaining unearned income.
5. Combine the applicant's earned income and the ineligible spouse's remaining earned income.
6. If a $20 general income deduction is applicable to the coverage group being examined, subtract it first from the total countable unearned income. If the total countable unearned income is less than $20, subtract any unused portion of the $20 deduction from the total countable earned income, if any.
7. From the remaining earned income, subtract the impairment-related work expenses, the $65 work expense, and one-half of the remainder.
8. Add the earned and unearned income together to get the total countable income.

If the total countable income is less than the payment standard for a couple when at home, the applicant is eligible.

The applicant's SSI benefit will be the lesser of:

- The SSI benefit rate for an individual minus the applicant's own income, or
- The SSI benefit rate for a couple minus the couple's income.

Mr. M has applied for Medicaid. He receives $1,000 in Social Security disability benefits and Medicare. Mrs. M receives a Social Security benefit of $400. They have two children, Y and Z. Each child receives $150 Social Security benefits.

If Mr. M's own income makes him ineligible for SSI, it's not necessary to consider Mrs. M's income, except for Medically Needy, QMB, SLMB, E-SLMB, or QDWP.

$	Mr. M's unearned income
1,000.00	General income deduction
- 20.00	
$ 980.00	
$ 967.00	SSI benefit for one person
- 980.00	Mr. M's countable income
$ .00	

Mr. M's income creates ineligibility for SSI. The worker moves to the deeming process for SSI-related Medically Needy:

$ 400.00	Mrs. M's unearned income
- 333.00	Allocation for ineligible child X ($483 - $150 = $333)
- 333.00	Allocation for ineligible child Y ($483 - $150 = $333)
$ .00	Mrs. M's countable unearned income

$0 does not exceed $483. There is no income available to deem to Mr. M.

Mr. M's countable income of $980 ($1,000 - 20) is compared to the Medically Needy income level (MNIL) for a household size of one to determine the spenddown amount, and to 100% of the federal poverty level for a household size of one to determine QMB eligibility.

Deeming from an Ineligible Parent to an Eligible Child

Legal reference: 20 CFR 416.1160, 20 CFR 416.1165

When a child applicant is living in the same household with an ineligible parent, deem the ineligible parent's income when determining eligibility. Deem a stepparent's income to the child if the natural parent lives in the house with the stepparent and child.

If the child lives with a stepparent only, do not deem the stepparent's income to the child, but consider any food and shelter the stepparent provides to the child as in-kind support and maintenance. See In-Kind Support and Maintenance (ISM).

When deeming income from an ineligible parent or the spouse of an ineligible parent to a child:

1. Verify the ineligible person's unearned income. Subtract from the ineligible person's unearned income an allocation for each ineligible child. The allocation is $483 (the difference between the payment standard for a couple and the payment standard for one person), minus the child's income.
2. Subtract the $20 general income deduction from the unearned income.
3. Verify the ineligible person's earned income. Subtract from the ineligible person's earned income any remaining portion of the ineligible child's allocation that was not used to offset the ineligible person's unearned income.
4. Subtract from the earned income any balance of the $20 general income deduction that was not used to offset the unearned income.
5. Subtract the $65 standard work expense deduction and one-half of the remainder from the balance.
6. Combine the remaining earned income with the remaining unearned income.
7. Subtract an allocation for the ineligible parents or stepparent in the household. The remaining amount is the income available for deeming to the child.
   - For one ineligible parent, the allocation is equal to the SSI payment standard for one person.
   - For two ineligible parents or an ineligible parent with a spouse, the allocation is equal to the SSI payment standard for a couple.
8. Treat the income as unearned income for the child and, if applicable to the coverage group being examined, apply the $20 general income deduction.
9. Add any remaining countable earned income of the child.
10. Compare this amount with the payment standard for an individual to determine eligibility for the child.

NOTE: If there is more than one applicant child in the household, divide the parental income to be deemed equally among the children.

Client S, age 17, was living with her parents and two brothers before entering an RCF. She has no income of her own. Her father has earnings of $1,270 per month. Her brothers and mother have no income. The computation is as follows:

$1,270.00	Father's earned income
- 966.00	Allocation for ineligible children (2 x 483)
$ 304.00	
- 20.00	General income deduction
$ 284.00	
- 65.00	Work expense deduction
$ 219.00	
- 109.50	1/2 remainder
$ 109.50	
- 1,450.00	Parental exclusion
$ .00	Deemed income to Client S

Countable income of zero is less than the SSI payment standard for one person. As Client S has no income of her own, income eligibility exists for the retroactive period if she meets a category of eligibility for the retroactive period, as defined in 8-A, Definitions.

Types of Non-MAGI-Related Income

Income is either countable or excluded from consideration. "Countable income," which is the gross income expected to be received for the month under consideration, is either earned or unearned.

The following section is an alphabetical listing of various types of payments that explains how these payments are used in determining eligibility for Non-MAGI-related coverage groups.

AIDS/HIV Settlement Payments

Exempt settlement payments from any fund established pursuant to the class action settlement of Susan Walker v. Bayer Corporation, et. al., 96 C5024(N.D. Ill.) as income.

Some settlement payments were made in lieu of the class action settlement. These payments are also exempt as income. These settlements were made on or before December 31, 1997. These funds must be kept in a separate, identifiable account.

Adoption Assistance Subsidy

There isn't a single policy that covers subsidized adoption payments. It will depend on the source, type, and purpose of the subsidized adoption payment and how those circumstance fit under other income policies.

- Count as income to the child any payments for the maintenance needs of the child that are IV-E funded. (See federally funded assistance payments under **Assistance Payments** later in this chapter).
- Exempt payments that are for social services and involve funds provided under title IV-B of the Social Security Act. (See **Social Services** later in this chapter).
- Exempt payments that are completely state or privately funded, are for the maintenance needs of the child, and are based on need. (See state assistance based on need under **Assistance Payments** later in this chapter). If the payments are state or privately funded assistance that isn't based on need, then the payments are counted as income.
- Exempt payments that are completely state or privately funded and aren't intended to meet the child's maintenance needs at all (e.g. if they are being made to the parents to cover travel expenses and lodging). In this situation, the payment would be reimbursement to the parents and not considered income at all.

(NOTE: Refer to NJA0094, Income for the process to enter this type of income in ELIAS.)

Annuities
20 CFR 416.1121

An annuity is a contract in which a person receives fixed payments for a specified period. See 8-D, Annuities, for information on how to count the annuity payments.

AmeriCorps Payments
POMS SI00830.537

Effective with benefits payable on or after September 1, 2008, cash or in-kind payments provided by AmeriCorps State and National or AmeriCorps NCCC are excluded from income even if they meet the definition of wages.

Such payments include, but are not limited to:

- Living allowance payments
- Stipends
- Food and shelter
- Clothing allowance
- Educational awards
- Payments in lieu of educational awards

Assistance Payments
20 CFR 416.1124(c)(2)

Exclude state or local general assistance cash payments to the recipient that are based on the need of the recipient (e.g., State Supplementary Assistance, General Relief, Rent Reimbursement, Energy Assistance).

Unless specifically excluded, count assistance payments that are funded in whole or in part from federal monies. For exceptions to this policy, see Indian Assistance and Third-Party Payments. Verify the amount and source of the payment either with evidence provided by the client or by contacting the paying agency.

Benefit and Other Payments Made in Error
20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123;
P. L. 103-60

If the person receives a benefit or other payment in error and returns it by the end of the following month, the payment is **not considered income**.

If the person has a valid reason for not returning the payment by the end of the following month (such as a lengthy hospital stay), the payment is still not considered income. However, if the payment is not returned and the client has no good reason for not returning it, count the payment as income in the month of receipt.

Benefit and Other Payments Made in Error (Cont.)	An SSI eligible person enters a nursing home and informs the Social Security Administration. Social Security continues to make SSI payments, even though the person should not be eligible for SSI after entry to the nursing home. The client returns the checks when they are received. The erroneous SSI payments are not considered income.
Blood Plasma 20 CFR 416.1102	Count income from selling blood plasma as unearned income.
Census Income 20 CFR 416.1110	Count as earned income any wages from either temporary or permanent census employment, including wages received while in training. See Wages for more information.
Child Student's Earnings 20 CFR 416.1112(c)(3), 20 CFR 416.1861	Exclude up to $2,350 per month of a student child's earnings, but not more than $9,460 per calendar year. When the income exceeds $2,350 per month or $9,460 per calendar year, count the excess, subject to the work expense deduction of $65 + 1/2. See $65 Plus One-Half Deduction for coverage groups that do not receive the work expense deduction. To qualify, the student must meet all of the following criteria: ▪ Under age 22. ▪ Not married. ▪ Not the head of the household. ▪ Regularly attending a school, college, or university or taking a course of technical training designed to prepare the student for employment. "Regularly attending school" means: • 12 hours a week for grades 7-12. • 8 hours a week for college or university studies. • 12 hours a week for technical training courses. • 15 hours a week for technical training courses with shop practice.

Child Student's Earnings (Cont.)

A child can attend school less than the amount of time indicated above if reasons beyond the child's control justify the child's reduced credit load or attendance.

> Client M, a disabled child, is forced to limit vocational school attendance to one day a week due to the unavailability of transportation. Although he is enrolled for attendance of less than 12 hours per week, Client M qualifies as regularly attending school because the lack of transportation is a circumstance beyond his control.

Consider that a child who is a homebound student because of a disability is regularly attending school if the child is studying a course or courses given by a school (grades 7-12), college, university, or government agency at home, and a home visitor or tutor directs the studies.

Consider a child to be attending school during periods when school is not in session (such as summer vacation) when the child was regularly attending school before the break and intends on regularly attending when classes resume.

Count payments from Neighborhood Youth Corps, work-study, and similar programs as earned income.

Note: Refer to NJA0094, Income for the process to enter this type of income in ELIAS.

Child Support
20 CFR 416.1124(c)(11)

The annual $25 child support collection fee withheld by Child Support Services (CSS) is not considered income.

Exclude one-third of support payments for minor children. Count the remainder as unearned income. Count the full amount of child support payments for a child aged 18 or older.

The following are income to the child whether or not the child lives with the parent receiving the money or receives the money from the parent:

Child Support (Cont.)

- Child support payments received by a member of the child's family on behalf of a minor child, including back child support.
- Current child support payments received by a member of the child's family on behalf of a child age 18 or older.

Back child support payments received by a member of the child's family on behalf of a child aged 18 or older are income to the child when the child:

- Lives with the person who receives the money, or
- Receives the money from the person (when the child does not live with the person).

Back child support payments received by a member of the child's family on behalf of a child aged 18 or older are income to the person receiving the payment if the child does not live with that person and does not receive the money.

When the client receives irregular child support payments, use an estimated amount based on the absent parent's payment history for the last three quarters. Verify the amount using court records, canceled checks, IRS records, or CSS.

Note: Refer to NJA0094, Income for the process to enter this type of income in ELIAS.

Civil Service Annuity

Count the gross amount of Civil Service Annuity whether the payment is taxable or not taxable.

Note: Refer to NJA0094, Income for the process to enter this type of income in ELIAS.

Dedicated Accounts
20 CFR 416.546, 20 CFR 416.640(e), 20 CFR 416.1247

Exclude the interest and other income earned on funds in a dedicated account as countable income for SSI participants. When past-due benefits are paid for eligible people under age 18, the representative payee is required to establish a dedicated account. The dedicated account may be used only for:

Dedicated Accounts (Cont.)

- Medical treatment, education, and job skills training.
- Personal needs assistance, special equipment, housing modification and therapy or rehabilitation that is related to the child's impairment.
- Other items and services related to the child's impairment approved by the Social Security Administration.

Do not exclude the funds in a dedicated account when the person is terminated from the SSI program or is terminated and later reapplies and is approved.

Make a referral using form **470-2826, Insurance Questionnaire** and send to Iowa Medicaid Enterprise (IME) Revenue Collection Unit.

Disaster Assistance
20 CFR 416.1124(c)(5), 20 CFR 416.1150

Exclude:

- Assistance provided under any federal statute when the United States President declares a catastrophe to be a major disaster.
- Interest earned on the assistance.
- Unemployment benefits from FEMA that Iowa Workforce Development has identified as paid because of the disaster.
- In-kind support and maintenance if the client's circumstances meet the following conditions:
  - The client was living in a household maintained as the client's home when the disaster occurred.
  - The President declared the catastrophe to be a major disaster for the purposes of the Disaster Relief Act of 1974 and the Emergency Assistance Act.
  - The client stops living in the home because of the catastrophe and begins to receive support and maintenance within 30 days after the catastrophe.
  - The client receives support and maintenance while living in a residential facility (including a private household) maintained by another person.

Disaster Assistance (Cont.)

Record the date the disaster occurred and the date assistance is received (or support and maintenance begins) in the case record.

Dividends
20 CFR 416.1103, 20 CFR 416.1121(c), and 20 CFR 416.1124(c)(22)

Dividends earned on countable resources are excluded income when determining eligibility.

Dividends earned on excluded resources are excluded income except for the following:

- Dividends earned on unspent tax refunds related to an Earned Income Tax Credit or a Child Tax Credit are countable unearned income.
- Dividends earned on gifts to children under age 18 who have a life-threatening condition are countable unearned income. The gift must be from an organization that is described in Section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under Section 501(a).
- Dividends earned on the proceeds from the sale of a homestead that was excluded for up to three months when the client intends to purchase another home are countable unearned income.
- Dividends earned on unspent relocation assistance payments are countable unearned income.
- Dividends earned by funds that are SSI or Social Security Disability benefits excluded from resources for nine calendar months after receipt are countable unearned income.
- Dividends earned on unspent victims' compensation payments are countable unearned income.
- Dividends earned as a retirement benefit, such as IPERS, are countable if the resource is no longer available after the recipient chooses to receive monthly benefits instead of a lump sum.

Note: Refer to NJA0094, Income for the process to enter this type of income in ELIAS.

Earned Income Credit
P.L. 101-508

Exclude a federal or state earned income credit whether received as a part of earned income included with regular paychecks or as a lump sum included with the income tax refund. Also see 8-D, *Resources*.

Educational Assistance
20 CFR 416.1124“c”(3)

Exclude the following educational assistance except for any part the recipient uses for general living expenses (food or shelter):

- Any impairment-related expenses necessary for school.
- Any portion of a grant, scholarship, fellowship, or gift received by or for a recipient to pay for tuition, transportation to and from school, books, or fees at any educational institution. Exclude only the amounts billed by the institution. Count any excess funds as income and prorate them over the period of intended use.

Any portion of such educational assistance that is not used to pay current tuition, fees, or other necessary educational expenses but will be used for paying this type of educational expense at a future date is excluded from income in the month of receipt. This exclusion does not apply to any portion set aside or actually used for food or shelter.

Count as income any portion of grants, scholarships, fellowships, and gifts that is excluded from resources because it is set aside to pay for tuition, fees, or other necessary educational expenses but is used for some other purpose. The funds are income in the month that they are spent or in the month when the person no longer intends to use the funds to pay tuition, fees, or other necessary educational expenses.

- If funds are not spent after the ninth month, they are countable resources as of the tenth month following the month of receipt.
- Veterans educational benefits such as:
  - Any VA educational grants or scholarships for tuition, transportation to and from school, books, and fees at any educational institution.

Educational Assistance (Cont.)

- Payments made as part of the veterans vocational rehabilitation program.
- Any portion of a VA educational benefit that is a withdrawal of the veteran's own contribution. This is a conversion of a resource and is not income.

- Grants made or insured under a program administered by the Secretary of Education under Title IV, such as:
  - PELL or Basic Educational Opportunity Grants (BEOG).
  - Presidential Access Scholarships (Super PELL).
  - Federal Family Education Loan Program (formerly GSL).
  - Perkins Loans (formerly NDSL).
  - Federal Work Study funds.
  - Robert C. Byrd Honors Scholarship Program.
  - College Assistance Migrant Program (CAMP).
  - High School Equivalency Program (HEP).
  - TRIO Grants for disadvantaged students such as Upward Bound, Student Support Services, Robert E. McNair Post-Baccalaureate Achievement.

Count as unearned income any part that the recipient uses for general living, or any purpose other than education. Prorate it over the period of time it was intended to cover.

Count payments and allowances that are **not** grants, such as:

- Any amount received as a gift from a relative, friend, or other individual.
- Allowances to members of the United States armed forces.
- Allowances or retainer payments to students under ROTC.
- Grants with a requirement that work must be performed during or after study before receiving the grant, unless received under Title IV program which is listed previously.

Emergency Energy Conservation Services Assistance
20 CFR 416.1124(b)

Exclude any cash or in-kind assistance provided under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program, including:

- Winterization of old or substandard dwellings (neither the cost of the materials, nor the cost of labor is counted).
- Insulation.
- Emergency loans or grants to install energy conservation devices.
- Alternative fuel supplies and special fuel vouchers or stamps.
- Alternative transportation activities designed to save fuel and guarantee continued access to training, education, and employment.
- Legal or technical training relating to the energy crisis.
- Fuel to operate food preparation appliances, or meals provided because utilities have been shut off.

Employer's Benefits
20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123;
P. L. 103-60

Employer payments made on behalf of employees are **not considered income** when the payments are not earnings, and not available to meet the employee's needs of food or shelter. For example, the contributions by an employer in a health insurance fund and an employer's payment of FICA and unemployment compensation taxes are not income to the employee.

Expenses of Obtaining Income
20 CFR 416.1123(b)(3)

When a client incurred expenses that were essential in obtaining an unearned income payment, deduct the amount of the expenses to determine the amount of the payment to consider as income. The amount deducted is **not considered income**.

Essential expenses of obtaining unearned income may include legal, medical, and other expenses connected with an accident settlement or legal expenses connected with a claim for a benefit program such as Social Security benefits.

Expenses of Obtaining Income (Cont.)	When a client receives payment for damages in connection with an accident settlement, subtract legal fees, unmet medical expenses that will not be reimbursed, and other essential expenses connected with the accident. When a client receives a retroactive check from a benefit program such as Social Security, subtract legal fees connected with the claim. Deduct essential expenses from the first and subsequent payments received until the expenses are completely offset. A guardianship or conservatorship fee is an essential expense only if the presence of a guardian is a requirement for receiving the income. Guardianship fees are never an essential expense for obtaining Social Security or SSI benefits because the Social Security Administration never requires appointment of a legal guardian.
Experience Works Income 20 CFR 416.1124(b)	Exclude assistance, except wages or salaries, provided under the Experience Works program (formerly Green Thumb). Count wages and salaries as **earned** income. Experience Works is funded through Chapter 35 of Title 42 U.S. Code, Programs for Older Americans. Note: Refer to NJA0094, Income for the process to enter this type of income in ELIAS.
Federal Department of Labor Payments 20 CFR 416.1103 and 20 CFR 416.1104	Exclude cash or in-kind support service payments made by the U.S. Department of Labor payments. Support services are payments such as child care, transportation, medical care, and meals. Count cash or in-kind financial payments made by the U.S. Department of Labor payments for training. Financial payments include payments for tuition, on-the-job training, stipends, and work experience.

Food and Shelter Received During a Medical Confinement
20 CFR 416.1102, 20 CFR 416.1103; P. L. 103-60

Food and shelter received during a medical confinement are **not considered income**. Medical confinement occurs when a person receives inpatient medical services in a medical facility.

Food Programs (Federal)
20 CFR 416, Subpart K Appendix

Exclude the value of:

- Food Assistance benefits.
- Food provided under the WIC program.
- Free school lunches or breakfasts.
- Congregate meals.
- Federally donated food.

Verification is not required.

Foster Care Payments
20 CFR 416.1124

Exclude foster care payments from a public or private nonprofit child-placing agency to a foster family.

Garnishments and Other Withholdings
20 CFR 416.1102, 20 CFR 416.1110, 20 CFR 416.1123(b)(1)

A debt that a client is required to pay or that is withheld from the client's income (such as child support, alimony or garnishment) continues to be considered income received by the client. Use the gross amount of income before these deductions.

1. Mr. S, who has Social Security income of $700, is ordered by the court to pay alimony of $200 per month to his former spouse. His countable monthly income continues to be $700, regardless of his legal obligation.
2. Mr. Q has Social Security income of $300 and earnings of $400 per month. However, $100 per month of Mr. Q's earnings is garnished to pay a debt. Mr. Q's total earnings of $400 are considered to be received and are considered as income.

General Assistance Payments
20 CFR 416.1124(c)(2)

Exclude county general assistance cash payments based on the need of the recipient. See Assistance Payments for information about other types of state or federal assistance payments. Do not count assistance that is lent to the client.

Gifts
20 CFR 416.1124(c)(6) and 20 CFR 416.1121(g)

Count cash gifts as income in the month received. Exclude gifts that qualify as infrequent or irregular income. See Infrequent or Irregular Income. For gifts used to pay educational expenses, see Educational Assistance.

Count noncash gifts as income in the month received. Determine the value according to the amount the client would get if the gift were sold. Refer to In-Kind Unearned Income.

Exception: The value of any noncash item (other than food or shelter) is **not** considered income if it will be partially or totally excluded as a resource the month after it is received.

Green Thumb Income
20 CFR 416.1124(6)

See Experience Works Income.

Home Equity Conversion Plans
20 CFR 416.1103(f)

Home equity conversion plans are arrangements designed to allow homeowners (commonly elderly people) to convert the equity value of their homes into cash without having to leave the home.

Under these plans, the home is either mortgaged or sold to a financial institution or an individual in exchange for a regular cash payment or a line of credit, which the homeowner receives as long as the homeowner lives in the home. Common arrangements and the income policies that apply are explained below. The actual terms of specific contracts may vary.

Home Equity Conversion Plans

If you need help to understand the contract or the correct income policy to apply, submit your questions, along with the contract, through the DHS, SPIRS Help Desk.

- Reverse Mortgage

  Reverse mortgages allow a homeowner to borrow some percentage of the appraised value of the home. The homeowner then receives regular periodic payments (or a line of credit), which commonly does not have to be repaid as long as the borrower lives in the home.

  The payments the homeowner receives from the arrangement are considered as loan proceeds and are **not considered income**. However, if the loan proceeds are retained into the following month, they become a countable resource.

- Sale-Leaseback

  Under a sale-leaseback arrangement, the homeowner transfers the title of the home to a buyer in exchange for regular periodic payments. The buyer then allows the former homeowner to remain in the home for life (or some other agreed-upon time period) in exchange for rent. In some instances, the payment made to the former homeowner includes interest.

  Consider the noninterest portion of the payments the former homeowner receives as a conversion of a resource, **not as income**. Consider any portion of the payment that is due to interest as unearned income. If the interest portion of the payment is retained into the following month, it becomes a countable resource.

- Time Sale

  Under a time sale arrangement, the homeowner signs a contract to sell the home at death but maintains the title and continues to live in the home. The buyer then pays a monthly cash payment to the homeowner.

Home Equity Conversion Plans (Cont.)	The payments the homeowner receives from a time sale contract are considered as a conversion of a resource and are **not considered income**. If the payments are retained into the following month, they become a countable resource.
Home Produce for Personal Consumption Section 1612(b)(8) of the Social Security Act; 20 CFR 416.1124(c)(4)	Exclude home produce used for personal consumption and produce that is traded. When produce is sold, consider net earnings as earned income. When the client is engaged in commercial farming, see Non-MAGI-Related Self-Employment Income.
Housing Assistance 20 CFR 416.1124(b); U.S. Housing Act of 1937, Section 8; U.S. Housing Act of 1959, Section 202(h); National Housing Act; Housing Act of 1949, Title V; Housing and Urban Development Act of 1965, Section 101 (12 USC Section 1701, 42 USC Section 1451)	Exclude rent subsidies, cash toward utilities, and indirect assistance (guaranteed loans, mortgages, and mortgage insurance) provided to home buyers by the Department of Housing and Urban Development (HUD) and the Farmer's Home Administration (FMHA). Exclude any rent reduction to a person in low-income housing when the assistance is under the U.S. Housing Act of 1937, as amended. Verify the authority for the client's federal or federally assisted housing. If the client cannot get verification, contact the local public housing authority. If HUD and a private owner have entered into a contract directly, contact the owner or manager of the project to verify the nature and authority for the housing assistance payments. Document the findings in the client's case record.
Income Replacement 20 CFR 416.1102, 20 CFR 416.1103; P. L. 130-60	If a person's income is lost, stolen, or destroyed, then is replaced, the replacement is **not considered income**. For example, if the person loses a January paycheck and receives a replacement check in March, the pay is considered as income only for January.

Income Tax Refunds
20 CFR 416.1102, 20 CFR 416.1103;
P. L. 130-60

Income tax refunds are **not considered income**. An Earned Income Tax Credit is not a refund and is considered income but is excluded as income. See Earned Income Credit in this chapter.

Indian Assistance
20 CFR 416.1124(b) and (c)(2), 20 CFR 416.1102, 20 CFR 416.1103;
P.L. 103-66

Count as unearned income payments made through the Bureau of Indian Affairs (BIA) General Assistance program. These payments are federally funded and administered by the BIA through its local agency (usually the tribe). Payments made by the BIA for adult custodial care are excluded.

Some Native Americans may receive other types of funds, such as distribution payments from judgment funds, mineral rights, or tribal trust funds. Numerous types of payments may be made and numerous exclusions may apply to these payments.

If the client has a tribal distribution payment, find out as much as you can about the payment and send the information to the DHS, SPIRS Help Desk for instructions on how to count it. Applicable information might include:

- The name of the Indian tribe or group.
- The name and location of the reservation.
- The reason for the payment.
- A description and location of land if payment involves land conveyance.

Up to $2,000 per year of income received by a Native American from interests of individual trusts or restricted lands **is not** considered income.

Note: Refer to NJA0094, Income under Native American Payments for the process to enter this type of income in ELIAS.

Infrequent or Irregular Income
20 CFR 416.1112(c)(2), 20 CFR 416.1124(c)(6)

Exclude infrequent or irregular income if the quarterly amount does not exceed $30 for earned income or $60 for unearned income.

"Infrequent income" is income that is received (or available on demand) no more than once in a calendar quarter.

"Irregular income" is income that the client cannot reasonably expect to receive. "Irregular income" is unpredictable and cannot be scheduled, so that the client cannot count on it or budget for it.

Income from work performed on an "as-needed" basis for the same employer (not the same as regular part-time work) meets the definition of irregularly received income.

However, if the person works on one or more days each week for the same employer, count the income as regular and frequent, even when that income is less than $30 per month.

If both members of a couple have infrequent or irregular income, add all the income together before applying this exclusion. See Projecting Future Income for determining the amount of income to project.

Inheritance Income
20 CFR 416.1121

Exclude the part of a cash inheritance that is spent on the deceased's last illness and burial. Count any remaining cash inheritances as income in the month of receipt. Refer to Lump-Sum Income.

Count inheritances not received in the form of cash, as in kind income. See In-Kind Unearned Income.

The value of an asset that is not owned, in part, by the client and is received as inheritance is income in the month of receipt. If there is an estate opened, the asset may be available before the estate is closed. Count the inheritance as a resource the month after the month of receipt.

Inheritance Income (Cont.)

Do not count as income inherited items that were a result of the death of a spouse and that were already counted as a resource.

In Iowa, real and personal property passes to the person who inherits it immediately at the time of death and is not dependent on settlement of the estate unless the terms of the will are being contested.

Insurance
20 CFR 416.1102

- Accelerated Life Insurance Payments

  Count as income any payments made by a life insurance company or privately owned and operated business that are an early payout of some of the proceeds of a life insurance policy.

  Under this arrangement, the life insurance company or private business pays the owner of a life insurance policy money that would ordinarily go to the beneficiary after the owner's death (e.g., during a terminal illness).

  The payments may be in one lump sum or monthly. (Any payments not spent in the month of receipt become a resource in the following month.)

20 CFR 416.1103(e)

- Credit Life or Credit Disability Insurance Payments

  Payments issued to or on behalf of borrowers to cover payments on loans or mortgages in case of death or disability are **not considered income**.

  The payments are made directly to the loan or mortgage company, so the money is not available to the person. Although a payment might be used for food or shelter (for example, when an insurance company makes a mortgage payment), do not count the payment as income.

Insurance (Cont.)
20 CFR 416.1123(a),
Youngberg vs. Iowa DHS,
Polk Co. District Court
No. AA3294
(June 12, 2000)

- Income Insurance Policy

  Count the proceeds from income insurance policies as income in the month that proceeds are received, regardless of the period they were meant to cover. An income insurance policy is one that pays a flat-rate benefit without regard to the actual charges or expenses incurred. Examples are:

  - Indemnity policies that pay a per diem amount without regard to charges or expenses.
  - Disability insurance that pays a flat-rate benefit intended to replace lost income.
  - Cancer or dismemberment policies that pay a flat benefit.

  NOTE: Benefits from insurance policies that pay a flat rate to an individual are not considered income if:

  - The policy was purchased to pay for medical care and with regard to anticipated charges,
  - The benefit is payable only if the policy holder actually receives the type of medical care for which the policy was purchased, and
  - The benefit is actually used to pay for medical care for which the policy was purchased.

  See Third-Party Payments.

20 CFR 416.1121

- Death Benefits

  The part of life insurance and death benefits from Social Security, Veterans Administration, or Railroad Retirement that the beneficiary spends to pay expenses of the insured's last illness and burial that will not be reimbursed by a third party is **not** considered income. Count any remaining proceeds as income. Examples of last illness and burial expenses include:

  - Hospital and medical expenses remaining after health insurance payments.
  - Funeral expenses.

Insurance (Cont.)

- Funeral-related expenses, such as clothing to wear to the funeral or food for relatives.
- Burial plot.
- Interment.

If death benefits are received in more than one month, assume that the funds first received are the first spent on the deceased's last illness and burial. **Note:** Amounts not spent in the month of receipt become countable resources in the next month.

> Mr. B receives death benefits of $1,000 in April and $1,000 in May. Funeral expenses are $1,500. $500 is counted as income in May.

Interest Income
20 CFR 416.1103, 20 CFR 416.1121(c), and 20 CFR 416.1124(c)(9)

Interest earned on **countable** resources is excluded income when determining eligibility. Interest earned on **excluded** resources is excluded income except for the following, which are countable unearned income:

- Interest earned on unspent tax refunds related to an Earned Income Tax Credit or a Child Tax Credit.
- Interest earned on gifts to children under age 18 who have a life-threatening condition. The gift must be from an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986 and be exempt from taxation under Section 501(a).
- Interest earned on the proceeds from the sale of the homestead that was excluded for up to three months when the client intends to purchase another home.
- Interest earned on unspent relocation assistance payments.
- Interest earned by SSI or Social Security Disability benefits that are excluded from resources for nine months after receipt.
- Interest earned on unspent victim's compensation payments.

Interest Income (Cont.)

Consider interest income when the interest becomes available to the account holder. Interest on bank accounts (savings, CDs, etc.) is available to the account holder when the interest is actually recorded on the account. The frequency with which interest is computed is immaterial. Do not deduct bank service charges when determining countable income.

> Interest recorded on an account monthly is countable. Interest that is computed daily but recorded on the account only quarterly is excluded, unless the total amount exceeds $60 per month.

See Projecting Future Income for determining the amount of interest to project. If there has been a permanent change in the balance, compute the interest using the current account balance.

Note: Refer to NJA0094, Income for the process to enter this type of income in ELIAS.

Jury Duty Pay
20 CFR 416.1102

Count jury duty pay as unearned income.

Loans
20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123; P. L. 103-60

Money that is borrowed is **not considered income**. If a client has loaned another person money and receives repayment, the principal repayment on the loan is **not considered income**. However, any interest received is considered income.

Low-Income Home Energy Assistance Payments (LIHEAP)
20 CFR 416.1124

Exempt as income and as a resource energy assistance benefits paid to eligible households under the Low-Income Home Energy Assistance Act of 1981. This program is administered through the Department of Human Rights, Division of Community Action Agencies, and covers costs such as:

- Insulation.
- Home energy assistance.
- Emergency lodging because utilities have been shut off.

Low-Income Home Energy Assistance Payments (LIHEAP) (Cont.)

- Winterizing old or substandard dwellings (neither the cost of the materials nor the cost of labor is counted as income).

Lump-Sum Income
20 CFR 416.1121,

Do not count any lump-sum income received before the month Medicaid eligibility is granted. **Exception:** A lump sum that is self-employment income must be annualized.

- Nonrecurring Lump Sum

  Lump-sum payments received on a one-time basis include inheritance and retroactive benefits from Social Security, SSI, certain types of Veterans Administration income (see Non-MAGI-Related Veterans Affairs Payments), and Railroad Retirement.

  If the client receives a lump-sum payment, count it as income in the month of receipt, unless the lump sum is a retroactive SSI payment made while the Medicaid application is pending. If the application is pending the SSI decision, then see Retroactive SSI Payments.

  For retroactive lump-sum payments of Social Security or SSI, see 8-D, Retroactive SSI and Social Security Lump-Sum Payments, for treatment as a resource. For all other nonrecurring lump sums, count the lump sum as a resource after the month of receipt.

  Note: If the lump sum is unearned and is less than $60 or is earned and is less than $30, it may be excluded as infrequent or irregular income. See Infrequent or Irregular Income.

  Do not count corrective social security payments as income when the income was previously considered for eligibility and client participation. Count lump sums received in the retroactive period as income.

- Recurring Lump Sum

  Count recurring lump-sum payments as income and prorate them over the period of time they cover. The prorated amount may be excluded if the exclusion for infrequent or irregular income applies.

Lump-Sum Income (Cont.)

Lump-sum payments received annually, semiannually, or quarterly on a recurring basis include annual crop-sharing payments and quarterly Medicare reimbursements from a former employer.

Medical Assistance Income Trusts (MAIT)
441 IAC 75.24(3)"b"

A medical assistance income trust or MAIT is an irrevocable trust established for the benefit of an individual on or after August 10, 1993. It is a trust where:

- Only the beneficiary's income (both earned and unearned) is assigned to and deposited into the trust, and
- The state is the residuary beneficiary of the trust and will receive all amounts remaining in the trust at the beneficiary's death, up to the amount of Medicaid paid for the beneficiary.

If the trust meets these requirements, exempt the gross monthly income paid **into** the trust when determining eligibility and client participation. Count only the income to be paid **from** the trust or otherwise made available to the client.

Do not count the direct payments to the nursing facility or other medical provider as income to the client when determining eligibility. See 8-I, Trust Payments for payments to be made from medical assistance income trusts.

Military Pay
20 CFR 416.1111

The service branches issue a single pay slip each month on or after the first of the month. That pay slip shows the gross amount due for the full calendar month and the net amount issued on each payday of the month. Military personnel can access pay slips using the Internet.

Only basic pay and Continental United States (CONUS) cost of living allowance (COLA) constitute wages. All special pay and allowances, except hostile fire pay, imminent danger pay, and, in deeming situations, other kinds of additional pay that may be received by military personnel serving in a combat zone are chargeable unearned income to the service member.

Military Pay (Cont.)

Whenever possible, use the Leave and Earnings Statement to verify the gross pay for a month, including both earned and unearned income. The total base pay shown is earned income for that month. The total allowances shown are unearned income for that month (unless otherwise excluded, such as hostile fire pay).

Noncash Items
20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123; P. L. 103-60

The value of any noncash item (other than food or shelter) is **not considered income** if it will be partially or totally excluded as a resource the month after the month of receipt.

> Mr. A receives a car worth $6,000 as a gift from his daughter. He had no car before the gift. Because $4,500 of value of the car is excluded the month after receipt, the car will be an excluded resource in the month following the month of receipt. Therefore, the gift of the car is not income to Mr. A.

Other Excluded Federal Payments
20 CFR 416.1124, P. L. 92-203, P. L. 106-398

- Exclude income from any of the programs established under Public Law 93-103 through the Corporation for National and Community Service (CNCS), unless the director of CNCS determines that the hourly rate is equal to or over the minimum wage.

  (The director has never yet made this determination. Central Office will contact workers if that determination is ever made.)

  Programs under CNCS include University Year of Action (UYA), Volunteers in Service to America (VISTA), Foster Grandparents, Retired Senior Volunteer Program (RSVP), Senior Companion Program, and the Special and Demonstration Volunteer Program.

- Exclude dividend payments on shares of the **Alaska Native Fund**, and other revenue that originated with the fund. This fund was created by the Alaska Native Claims Settlement Act (Public Law 92-203), enacted on December 19, 1971.

- Exclude **Austrian Social Insurance** payments based partly or completely on wage credits granted under paragraphs 500-506 of the Austrian General Social Insurance Act. Use the award letter to determine how to count the payments.
- Exclude **Department of Defense (DOD)** payments to certain persons captured and interned by North Vietnam as a result of participating in DOD operations (known as OPLAN 34A (or its predecessor) or OPLAN35). Do **not** exclude interest earned on unspent payments.
- Exclude **Department of Defense (DOD)** payments made to or on behalf of certain Vietnam veterans' children, regardless of their age or marital status, for any disability resulting from spina bifida suffered by such children. Do **not** exclude interest earned on unspent payments.
- Exclude **Energy Employees Occupational Illness Compensation Program** payments made to former employees or their families. Beneficiaries will receive one or two lump-sum payments, which are excluded as income and as a resource.

  Award letters sent to the recipient from the Department of Labor should verify the amount and source of the payments.
- Exclude **German Reparations** payments made to survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution, whether they are paid periodically or in a lump sum.
- Exclude **Japanese-American and Aleutian restitution payments** made by the U.S. Government to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during World War II.

- Exclude **Japanese-Canadian restitution payments** from the Canadian Government to individual Japanese-Canadians who were interned or relocated during World War II. Use documents from the client to identify or verify the nature of the payments.

  If the client has no documents, ask if the client was imprisoned, relocated, deported, or deprived of other rights in Canada during the period of December 1941 to March 1949 because of Japanese ancestry. If yes, exclude the payment. If no, count the payment as income.

- Exclude assistance except wages or salaries provided under Chapter 35 of Title 42 U.S. Code, **Programs for Older Americans**. Count wages and salaries as earned income. Examples of programs offered include community service employment and the Green Thumb employment services program.

- Exclude as income and as a resource payments made under the **Radiation Exposure Compensation Act Trust Fund payment**. This program compensates people for injuries or death resulting from exposure to radiation from nuclear testing and uranium mining.

  After the affected person's death, payments are made to the surviving spouse, children, or grandchildren. Any interest on these funds is counted as income.

Personal Services
20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123; P. L. 103-60

Personal services performed for a client, such as lawn mowing, house cleaning, and grocery shopping, are **not considered income**.

Property Tax Refunds
20 CFR 416.1124(c)(1)

Exclude any amount a client receives from any public agency as a return or refund of taxes paid on real property. Verify the amount using the tax statement, or contact the state or local taxing authority. File the statement or a copy of the statement in the case record.

Rebates and Refunds
20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123; P. L. 103-60

If a person gets back money the person has already paid (e.g., a property tax rebate), the returned money is **not considered income**. If a rebate is not returning the person's own money, however, it is income.

Recouped Benefits Paid in Error
20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123

Do not count the portion of an unearned benefit that is being recouped if:

- The client received Medicaid under Medically Needy, Medicaid for Employed People with Disabilities (MEPD), HCBS waiver, or nursing facility assistance or received State Supplementary Assistance payments when the overpayment occurred, and
- The income that created the overpayment was included in figuring the amount of the Medicaid or State Supplementary Assistance benefit at the time it was incorrectly paid.

Relocation Assistance
20 CFR 416.1124(b)

Exclude relocation assistance provided to owners, tenants, or occupants who were displaced when real property was acquired by a federal, state, or local government-assisted project. Do not count:

- Moving expenses.
- Losses of tangible property.
- Expenses of looking for replacement business or farm.
- Displacement allowances.
- Amounts required to replace a dwelling.
- Compensation for increased interest costs.
- Closing costs on a replacement dwelling.
- Rental expenses for displaced tenants.
- Amounts for down payments on replacement housing.
- Mortgage insurance through federal programs, waiving requirements such as age, physical condition, or personal characteristics that borrowers must usually meet.

Rent Reimbursement Payments
20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123; P. L. 103-60

Payments received under the Department's Rent Reimbursement Program under Iowa Code Chapter 425 **are not considered income**. These payments are considered a refund of money the client has already paid.

The Department may also make rent reimbursement payments to residents of residential care facilities and nursing facilities. Do not consider the payments for either eligibility or client participation.

Rental Property or Life Estate Income
20 CFR 416.1110(b), 20 CFR 416.1121(d)

Count as unearned income the net income from a life estate, or rental of real property (including a homestead) **unless the client has a business of renting properties**. If the client is in the business of renting property, see Non-MAGI-Related Self-Employment Income.

If more than one person owns the property, count the income based on the ownership interest.

Use the most recent income tax return to determine net income from real property. Appropriate tax forms are:

- Schedule C, Profit or Loss Statement.
- Schedule E, Supplemental Income and Loss.
- Form 4562, Depreciation and Amortization.
- Form 1065, Partnership Return on Income.

Deduct from the gross income any necessary and reasonable expenses needed to produce the income. Examples of deductible expenses are real estate taxes, repairs and maintenance, the cost of advertising for tenants, and interest paid on a mortgage.

Do **not** deduct:

- The cost of capital equipment.
- Depreciation.
- Any portion of a mortgage payment that is attributed to the principal.

Rental Property or Life Estate Income (Cont.)

- Any purely personal expenses not associated with production of the income. If the expenses are both personal expenses and business expenses, prorate the expense following IRS policies used on the tax return.

  If a tax return is not available, deduct the same expenses that would be used on the tax return, as long as the expenses are reasonable as defined by IRS. The expenses of income are reasonable as long as the expense is ordinary and necessary as defined in the industry. You may need to contact a disinterested real estate agent, banker, farm manager, or other knowledgeable person in the particular industry.

Examples of allowable expenses:	**Examples of expenses that are not allowed:**
Repair of roof shingles	Replacement of the roof
Replacement of broken light	Replacement of wiring
Replacement of faucet	Replacement of plumbing

NOTE: Refer to NJA0094, Income under Rental Income or Losses for the process to enter this type of income in ELIAS.

Resource Conversion or Sale
20 CFR 416.1102, 20 CFR 416.1103; P. L. 103-60

Consider the conversion or sale to be a change in the form of a resource.

The increase in value of a resource is **not considered income**. An example of a resource value increasing when the value of stock increases from $100 to $110 in a six-month period.

Resource Replacement
20 CFR 416.1102, 20 CFR 416.1103; P. L. 103-60

Any payment to a client to replace a resource that was lost, damaged, or stolen is **not considered income**. Examples include insurance payments and private or public fund payments.

Retirement Funds
20 CFR 416.1121

Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or retirement plans administered by an employer or union).

A retirement fund owned by an eligible person is a resource if the person has the option of withdrawing a lump sum, even though the person is not eligible for periodic payments. See 8-D, Retirement Funds.

If the person can't withdraw the funds but is eligible for periodic payments, the payments are considered income.

Note: Refer to NJA0094, Income under Pension for the process to enter pension income in ELIAS.

Retroactive SSI Payments
20 CFR 416.1123

When the application is held pending a Social Security determination for SSI benefits, count the retroactive SSI benefits for the period that the payments are intended to cover.

When calculating client participation, do not count any part of a retroactive SSI payment that covers a period before the month of eligibility for State Supplementary Assistance or medical institution care, or that is withheld for interim assistance.

January 3	Client applies for SSI.
February 3	Client enters RCF.
June 5	Client applies for State Supplementary Assistance.
August 16	Client approved for SSI. Receives SSI payment for the months of January through August.
August 17	Client approved for State Supplementary Assistance effective June 5.

The amount of the SSI lump sum intended for January through May is not considered in computing client participation for June through August. The amounts for June, July, and August are considered income in determining client participation for each of those months.

Retroactive SSI Payments (Cont.)	When a lump sum of retroactive SSI benefits is received on an ongoing Medicaid case, see Lump-Sum Income for treatment of income and see 8-D, Retroactive SSI and Social Security Lump-Sum Payments, for treatment as a resource.
Sheltered Workshop Earnings 20 CFR 416.1110	Count the income a handicapped person earns at a sheltered workshop as earned income.
Sick Pay 20 CFR 416.1110	Sick pay is payment made to an employee by an employer or third party for sickness or accident disability. (Payments to an employee under a workers' compensation law are not sick pay.) Verify the period of time that sick pay has been paid. Count sick pay as earned income in the first six months of receipt unless the employer considers the income as unearned income. Contact the employer to determine how to consider sick pay. After six months, count sick pay as unearned income.
Social Security Payments	Count the gross amount of Social Security as unearned income. If the person is paying for Medicare Part B, the gross amount of the Social Security payment has been adjusted to allow for an even dollar net amount. For eligibility, count the gross amount of the Social Security that will be received when Medicare buy-in takes place. Round up to the next dollar amount only when buy-in would affect eligibility for a program. For client participation, Medically Needy spenddown calculation, and MEPD premium calculations, count the gross amount of the Social Security as verified by the Social Security Administration. (Do not round.)

Social Security Payments (Cont.)

Mr. A is an applicant for Medicaid. His gross Social Security benefit is $1,182.00. His Medicare premium is $185.00, so Mr. A's net check is $997.00.

If Mr. A is approved, the state will "buy in" and pay his Medicare premium. Once buy-in occurs, Mr. A's check will increase to $1,182. ($997.00 + $185.00 = $1,182.00).

In determining Medicaid eligibility for Mr. A, the worker considers income of $1,182, so that Mr. A's eligibility is determined based on the amount of income he will receive once buy-in occurs.

In determining client participation, Medically Needy spenddown, or an MEPD premium, the worker uses Mr. A's income of $1,182.00 to calculate his benefits until after buy-in takes place.

Social Services
20 CFR 416.1102, 20 CFR 416.1103, 20 CFR 416.1123; P. L. 103-60

Social services are **not considered income**. They include services to assist handicapped or disadvantaged people to function in society to the level of a person without the handicap, e.g., vocational rehabilitation. The training allowance issued by the Department of the Blind is considered a social service and is not counted as income.

The following items are **not** social services:

- Income from a sheltered workshop (see Sheltered Workshop Earnings).
- Financial aid for education and training (see Educational Assistance).
- FIP, SSI, Veterans assistance, or general assistance payments (see Assistance Payments).

Strike Pay
20 CFR 416.1102

Count strike pay as earned income if a union member is involved in the strike and the duties involve strike activity. Count all other strike pay as unearned income.

Third-Party Payments
20 CFR 416.1102, 20 CFR 416.1103;
P. L. 103-60;
Youngberg vs. Iowa DHS, Polk Co. District Court
No. AA3294
(June 12, 2000)

Direct payment of a person's bills by a third party is **not** considered income, unless the bills are for food or shelter. (See Non-MAGI-Related In-Kind Income for how to treat third-party payments for food or shelter.)

Third-party payments include medical services payments, such as:

- Medical insurance premiums paid directly to the insurance company by someone other than the client.
- Insurance company payments for medical care if the payments are equal to or less than the actual cost of the care.
- Room and board paid by a third party to a medical institution while a person is institutionalized.
- Accident settlement payments to cover medical expenses.
- Benefits from insurance policies that pay a flat rate to an individual if:
  - The policy was purchased to pay for medical care and with regard to anticipated charges,
  - The benefit is payable only if the policy holder actually receives the type of medical care of which the policy was purchased, and
  - The benefit is actually used to pay for the medical care for which the policy was purchased.

When the reason the third party is making a payment is for a cost that SSA or Medicaid may be meeting (i.e., nursing facility or in-home health related care), deduct the third party payment before the Medicaid or SSA payment.

Vacation Pay
20 CFR 416.1110(a)

Count vacation pay as earned income.

Victims' Compensation Payments
20 CFR 416.1124, P. L. 101-508

Exclude assistance paid through the Crime Victim Reparation Program. The Iowa Department of Justice administers this program, which compensates victims of crime for expenses incurred or losses suffered as a result of a crime. Expenses paid by the Crime Victim Reparation Program include:

- Medical bills.
- Lost wages.
- Loss of support.
- Clothing held in evidence.
- Counseling.
- Burial.

Wages
20 CFR 416.1110

Count the gross amount of wages prospectively. See Projecting Future Income. See also Non-MAGI-Related Deductions for deductions that are applied to wages. **Note:** Consider vacation pay as wages, even if paid in a lump sum after the client's employment has terminated.

Winnings
SI 0830.525

Count as unearned income any winnings from a contest, lottery, or game of chance. **Note:** Gambling losses are not subtracted from gambling winnings to determine countable income.

Workers' Compensation
20 CFR 416.1121

Count as unearned income any workers' compensation from state or federal employment that is paid to disabled workers.

Exclude any portion of the income that was paid or deducted for legal or related expenses, if the recipient did not have control of the money before distribution. This information is given in the award letter.

Note: Refer to NJA0094, Income for the process to enter this type of income in ELIAS.

Mr. O is injured at work in March. He begins receiving workers' compensation of $500 per month in August. This income is considered unearned and is counted for the time it is intended to cover.

Non-MAGI-Related In-Kind Income

Legal reference: 20 CFR 416.1102

In-kind income is not cash, but is food or shelter, or the receipt of something that can be sold or converted to obtain food, or shelter. EXCEPTION: Food is not included in the calculations of in-kind support and maintenance (ISM), which is a type of unearned income that we have special rules for valuing.

If the noncash item is given to the person by that person's spouse, minor child, or parent (if the recipient is a minor child), do not consider it in-kind income to the person.

The three types of in-kind income are:

- In-Kind Earned Income.
- In-Kind Unearned Income Other Than Food or Shelter.
- In-Kind Support and Maintenance (Unearned Income Received In the Form of Shelter).

In-Kind Earned Income

Legal reference: 20 CFR 416.1110-416.1111

In-kind earned income is a noncash payment a person receives in place of wages or money from self-employment. In-kind earned income can be food or shelter, or noncash items that could be sold or converted to obtain food or shelter.

An SSI recipient's in-kind earned income is reflected on the SDX in the same way as cash earned income.

Count the full market value of in-kind earned income in the same way as earned income received as cash. If the person is in a coverage group where the $65 or $65 and one-half work expense deductions apply for earned income, apply the deduction to the in-kind earned income as well.

Exception: If an in-kind item that is not in the form of food or shelter will be partially or totally excluded as a resource in the month after the month it is received, do not count it as income.

1. Mr. A receives a monthly wage of $500 to manage an apartment complex and also is provided an apartment to live in at no cost. The apartment that Mr. A lives in would otherwise rent for $300 per month.

   Mr. A receives a noncash item in the form of shelter (free rent) and therefore, receives in-kind income. Because Mr. A receives this in-kind income in place of wages, it is considered earned income. The market value of Mr. A's in-kind earned income ($300) is considered in the same manner as if Mr. A had been paid $300 in the form of cash (i.e., if applicable for the coverage group, $65 plus one-half is deducted). Mr. A's total earned income is $800 ($500 + $300).

2. Mr. B is an employee of an auto dealer. In lieu of wages, Mr. B is given a car worth $4,000. Mr. B has no other car. Because the car he receives is an excluded resource in the month following the month of receipt, the value of the car is not considered as income to Mr. B.

In-Kind Unearned Income

Legal reference: 20 CFR 416.1123

In-kind unearned income is in-kind income that a person receives that is not in place of wages or self-employment monies. In-kind unearned income can be either:

- Food or shelter. See In-Kind Support and Maintenance (ISM).
- Any item that can be sold or converted to buy food or shelter.

Count the full market value of in-kind unearned income that is not in the form of food or shelter in the same way as unearned cash income. Market value is how much money the item can be sold for, not the retail purchase price. Accept the recipient's estimate of the market value of the gift, unless you have reason to doubt the estimate.

Exception: If a client receives a noncash item (not food or shelter) and that item will be a partially or totally excluded resource in the month after the month it was received, do not consider it as income.

> Mr. T received a gift of a boat with a value of $1,000. The boat may be sold or converted to cash that may then be used to obtain food or shelter. It will not be an excluded resource in the month following receipt. Therefore, the receipt of the boat is in-kind unearned income. The boat's market value of $1,000 is considered as unearned income to Mr. T.

The income exclusion for infrequent or irregular income may apply to in-kind income. See Infrequent or Irregular Income.

An SSI recipient's in-kind unearned income that is not in the form of food or shelter is reflected on the SDX as unearned income type "S" (other income).

In-Kind Support and Maintenance (ISM)

Legal reference: 20 CFR 416.1130, 20 CFR 416.1132-416.1133

In-kind support and maintenance is in-kind unearned income in the form of shelter. Shelter includes:

- Room rent and mortgage payments.
- Real property taxes.
- Heating fuel, gas, electricity, water, and sewage.
- Garbage collection service.

ISM is valued according to either the value of one-third reduction (VTR) or presumed maximum value (PMV) rule. The VTR rule applies only when a client lives in another person's household.

Note: Food expenses are omitted from ISM calculations. Food expenses would not be included in the actual calculation; they will only be considered in determining whether to apply the VTR or PMV rule.

Determining the Client's Living Arrangement

To determine which rule to use, first establish if the client is living in the client's own household or in the household of another. See Living in Another Person's Household. If a client is living in the household of another, then decide if the person is paying a pro rata share. See Paying a Pro Rata Share.

Living in Another Person's Household

Legal reference: 20 CFR 416.1132-416.1133

A client is **not** living in another person's household if:

- The client has an ownership interest or a life estate interest in the home.
- The client (or any person in the household who could have income deemed to the client) is liable to the landlord for paying any part of the rent. In this context, a landlord and tenant cannot be members of the same household.
- The client pays at least a pro rata share of household and operating expenses.
- All members of the household receive public assistance income-maintenance payments, such as FIP or SSI.
- The client lives in an institution (an establishment which provides food, shelter, and some treatment or services to four or more people). An institution is not a household, and a household cannot exist within an institution.
- The client lives in a noninstitutional care situation, such as a family-life home or a foster care home.

A household must be a personal place of residence. A commercial establishment, such as a hotel or boarding house, is not a household. However, a household can exist within a commercial establishment if the client lives in the household as a roomer or boarder within the hotel or boarding house.

1. Mr. A lives in a boarding house and pays $200 per month to the owner for room and board. Several other people also live in the boarding house. Mr. A is not considered to be living in another person's household.
2. Mr. B lives with Mr. A. Mr. B does not have rental liability to the boarding household owner and does not pay a pro rata share of the expenses. Mr. B is considered to be living in the household of another (Mr. A).

Paying a Pro Rata Share

Legal reference: 20 CFR 416.1132-416.1133

If the client pays a pro rata share of household operating expenses, consider the client to be living in his or her own home and not receiving in-kind support and maintenance from anyone else in the household.

The pro rata share of household operating expenses is the average monthly household operating expenses (based on a reasonable estimate, if exact figures are not available) divided by the number of people in the household, regardless of age.

The household operating expenses are the total monthly expenditures for rent, mortgage, property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection service.

When to Apply the Value of One-Third Reduction (VTR) Rule

Legal reference: 20 CFR 416.1131

Apply the “value of one-third reduction” (VTR) rule to in-kind support and maintenance received when a client lives the whole month in another person’s household and others within the household pay for or provide them with all their meals. If the client is living in the client’s own household, use the “presumed maximum value rule.”

Under the VTR rule, the value of in-kind support and maintenance is one-third of the SSI benefit rate (currently $322.33). If a married couple lives in another person’s household, use one-third of the SSI benefit rate for a couple ($483.33).

The VTR amount always applies in full. Count this amount in the same way as if it were unearned income received in cash. Do not apply the $20 general income exclusion to in-kind support and maintenance valued according to the VTR rule.

An SSI recipient who receives in-kind support and maintenance valued according to the VTR method will have that income reflected on the SDX as income type “J.”

1. Mr. G, a Medicaid member, lives with his friend, Mr. F, in a home owned by Mr. F. Mr. G has Social Security income of $500 but does not contribute any of his income towards the household's operating expenses. Mr. F provides Mr. G with all of his meals.

   Mr. G is not paying a pro rata share of the monthly household operating expenses, so he is considered to be living in the home of another. Since Mr. F provides all Mr. G's meals, he is receiving ISM income that should be valued according to the VTR method. The IM worker determines that Mr. G has countable in-kind support and maintenance income of $322.33 (one-third of the SSI benefit rate).

2. Mr. S, a Medicaid member, lives with his adult son in a home owned by his son. Mr. S's pro rata share of the household's operating expenses is $200. However, Mr. S contributes only $100 per month towards the household's operating expenses.

   Although Mr. S is contributing towards the household expenses, he is not paying a pro rata share. Therefore, he is considered to be living in another person's household. His son also provides Mr. S's meals.

   Mr. S is receiving the in-kind support and maintenance that is valued according to the VTR method. This means that he has countable in-kind support and maintenance income of $322.33.

3. Same as Example 2, except that Mr. S's son **does not** provide his meals Because his son is not providing his meals, the VTR method does not apply. Mr. S's in-kind support and maintenance is valued according to the PMV method.

When to Apply the Presumed Maximum Value Rule (PMV)

Legal reference: 20 CFR 416.1140

Whenever a person receives in-kind support and maintenance that must be counted, but the one-third-reduction rule does not apply, use the presumed maximum value (PMV) rule. Under the PMV method, the maximum in-kind support and maintenance amount is presumed to be $342.33 (one-third of the SSI benefit rate plus $20).

Situations in which the PMV method is used include:

- A client living in another person's household, but the household does not pay for or provide all their meals.
- A client living in the client's own household and receiving in-kind support and maintenance.

Give clients an opportunity to show that the actual market value of their support and maintenance is less than the presumed maximum value. The actual market value is the client's pro rata share of household expenses minus the client's actual contribution. If the client verifies that the actual market value is less than $342.33, use the actual market value as the monthly income.

In-kind support and maintenance received by an SSI recipient that is valued according to the PMV rule is reflected under unearned income as income type "H."

1. Mr. G, a Medicaid member, lives with his friend, Mr. F. Mr. G has Social Security income of $700 but does not contribute any of his income towards the household's operating expenses. Mr. F provides Mr. G with shelter, but Mr. G provides his own food. The household's expenses, other than food, total $700.

   Because Mr. F does not pay for or provide all of Mr. G's meals, the in-kind support and maintenance income received is valued according to the PMV method and not the VTR method. (Mr. G's pro rata share of the household's operating expenses (not including food) is $350.)

   The difference between Mr. G's pro rata share ($350) and his contribution ($0) is greater than the presumed maximum value amount of $342.33. The IM worker uses countable in-kind support and maintenance income of $342.33 (one-third of the SSI benefit rate + $20) to determine Mr. G's Medicaid eligibility.

2. Mr. S, a Medicaid member, lives with his adult son in a home owned by his son. Mr. S purchases and eats his meals separately from his son. Mr. S's pro rata share of the household's $400 operating expenses is $200. Mr. S's actual contribution towards the household's operating expenses is $75 per month.

   Although Mr. S is not paying a pro rata share of the household expenses, his son is not paying for or providing his meals. Therefore, Mr. S's ISM is valued according to the PMV method. The actual value of Mr. S's ISM is $125 ($200 minus $75). Because this is less than the presumed maximum value, the countable ISM income is $125.

3. Ms. L, a Medicaid member, lives alone in her own home. Her father helps her by paying her gas and electric bill of $80 per month. (Payments are made directly to the utility company.)

   Because Ms. L lives in her own home, the PMV method of determining in-kind income (for the payment of utilities) is used. Because the actual value of the in-kind support and maintenance received is less than the presumed maximum value, the countable in-kind support and maintenance income is $80.

Non-MAGI-Related Self-Employment Income

This section describes:

- How to determine whether a client's employment is self-employment.
- How to consider income from self-employment.

Determining if a Client is Self-Employed

Legal reference: 20 CFR 416.1110, 20 CFR 416.1111

"Self-employment" is defined as providing income directly from one's own business, trade, or profession.

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** or if the person is subject to a self-employment tax.

If the person files form SE or is subject to self-employment tax, consider the person's self-employment verified, unless the situation has changed.

If the person does **not** file form SE, but claims to be self-employed, determine if the person would be subject to the self-employment tax if the person filed an income tax return. Consult the IRS or another knowledgeable source to determine if the person is self-employed. Ask if the person materially participates in the management decisions. If the person does, this may be self-employment.

Renting out one or two properties or leasing farmland to someone is not necessarily self-employment. In such cases, determine whether the person's business is renting those properties by requesting a complete copy of the person's federal tax return. See also Rental Property or Life Estate Income.

1. Mr. X rents out his life estate on the farm that he previously owned. He does not manage a business. Therefore, Mr. X does not engage in self-employment.
2. Mr. J files a Medicaid application for his daughter. He states that he is a self-employed salesman. The IM worker gets a release of information and contacts his distributor, who confirms that Mr. J is self-employed.
3. Ms. E babysits in her home. She does not file an income tax return. She is responsible for all expenses and makes her own management decisions. She is self-employed.

Determining Income from Self-Employment

Legal reference: 20 CFR 416.1110, 20 CFR 416.1111

"Self-employment income" is the gross income from a trade or business minus allowable deductions for that trade or business.

Annualize self-employment income on a taxable year basis by totaling all self-employment income received or projected to be received in the calendar year, then dividing the total by 12 to determine the monthly amount.

Divide the entire taxable year's self-employment income equally among the number of months in the taxable year, even if the business:

- Is seasonal.
- Starts during the year.
- Stops operating before the end of the taxable year.
- Stops operating before the application for assistance.

Use the person's federal income tax return from the previous year to project self-employment earnings in the following tax year. The following schedules may be used:

- Schedule SE, *Computation of Social Security Self-Employment*. For net earnings, use Section A, line 4 or Section B, line 4.C. For net loss, use Section A, line 3, or Section B, line 4.C.
- Schedule C, *Profit or Loss from Business or Profession*. Use the line entitled "Net Profit or Loss."
- Schedule F, *Farm Income and Expenses*. Use the line entitled "Net Profit or Loss."

If the client indicates that the last tax return is not an accurate indicator of future income, or if a change occurs, project self-employment income for the taxable year based on the best available information.

If the business has not been in operation long enough to have income tax records, project income based on the client's records. If the client's records are not available and no other evidence can be obtained, ask the client to provide a signed statement of projected self-employment earnings. Make a new determination of net income when a more accurate projection can be made, but no later than six months from the determination of eligibility.

Apply a 15.3% deduction to net profit to determine countable self-employment earnings if:

- The net profit exceeds or is expected to exceed $400, and
- The client has filed or expects to file a federal income tax return and therefore will pay the self-employed social security tax.

This deduction recognizes a portion of the additional Social Security taxes that a self-employed person must pay as a business expense. If the Social Security tax will be paid, multiply the net profit by 15.3% then subtract this amount from the net profit to determine countable self-employment income.

If the profit is expected to be less the $400, or the client does not anticipate filing a federal income tax return, do not allow the 15.3% deduction.

If you are making a self-employment income projection based on a client's business records, assume that any deductions taken on the business records are allowable by the IRS, absent evidence to the contrary. However, do not allow the following:

- Deduction for purchases of capital equipment. Capital equipment usually has a life span in excess of one year.
- Payment for a mortgage to buy capital resources used in self-employment. The portion of the payment applied toward the principal is not an allowable deduction, but the portion that is interest is an allowable deduction.

When an expense is for both personal and self-employment purposes, such as expenses of a home that is also used for self-employment, divide the expense according to the percentage that the client uses the item for self-employment.

Mr. O operates a self-employment business from his home. He deducts one-third of the home rent and one-third of the utilities on his income tax return as a business expense. One-third of the rent and utilities is an allowable deduction from gross self-employment income.

Calculate self-employment income as follows:

Gross self-employment earnings
- Allowable business expenses
= Net profit

- 15.3% Social Security deduction (net profit x 0.153) if applicable
= Countable self-employment income

Divide any verified loss from self-employment over the taxable year in the same way as net earnings. Deduct a verified loss from self-employment from income of other self-employment businesses or from earnings of the client or the client's spouse.

Consider changes in self-employment income when they occur. Continue annualized income from self-employment throughout the year, even if the person does not expect to earn any more income from self-employment.

> Mr. A earned $3,000 in self-employment income from January through June. Mr. A does not expect to earn any self-employment income from July through December. Mr. A's countable self-employment income for July through December is $250 per month ($3,000 divided by 12 months).

Note: Refer to NJA0094, Income under Rental Income or Losses for the process to enter this type of income in ELIAS.

Non-MAGI-Related Veterans Affairs Payments

Legal reference: 20 CFR 416.1121

The Veterans Administration (VA) makes many types of payments to clients and their families. The chart that follows is a summary of VA benefits and treatment of benefits. After the chart is a more detailed explanation of each type of benefit.

Type of VA Benefits	Treatment of VA Benefit
Compensation	Countable unearned income.
Pension	Countable unearned income.
Aid and Attendance	Third-party medical payment, count for client participation only. Do not divert to community spouse.
Housebound Allowance	Third-party medical payment, count for client participation only. Do not divert to community spouse.
Clothing Allowance	Not considered income.
Dependent Allowance (Augmented Benefit)	Countable income to the dependent unless the exception under Payments for Dependents applies.
Educational Benefit	Countable unearned income. **Exception:** Do not count the portion that is the veteran's contribution or the portion for social services such as vocational rehabilitation. Exclude the cost of tuition and educational expenses and fees.
Adjustments for Unusual Medical Expenses	Not considered income. Do not divert to community spouse.

Use Authorization for Release of Information, form 470-0461 or 470-0461(S) to request income verification from the VA. Include the following on the form:

- What type(s) of benefits is the person receiving?
- What is the gross monthly amount?

- What is the net monthly amount?
- Are there any deductions? If so, list type and amount.
- Are dependent benefits included? If so, how much?
- What portion is attributed to Aid and Attendance?
- What would the benefit be with Unusual Medical Expenses (UME)?
- What would the benefit be without UME?

Note: Refer to NJA0094, Income for the process to enter VA income in ELIAS.

Compensation Payment

Legal reference: 20 CFR 416.1121

A VA compensation payment is based on a service-connected disability or death and may be based on need. Count as unearned income any portion not attributable to aid and attendance or unusual medical expenses. The portion of a VA compensation payment that is for VA aid and attendance and housebound allowance or is attributable to unusual medical expenses is not considered income. See Aid and Attendance and Housebound Allowance and Payment Adjustment for Unusual Medical Expenses.

The portion of VA compensation that is due to a dependent's needs is called an augmented payment and is usually counted as income to the dependent. See Payments for Dependents.

A VA compensation or pension payment may also contain any of the other VA benefit types. Make sure to verify what is included in the VA compensation or pension payment. Verify what types of benefits are included in the VA payment.

Pension Payments

Legal reference: 20 CFR 416.1121

A Veterans Affairs (VA) pension payment is a combination of service and non-service-connected disability or death payment and is commonly based on need. Count as unearned income any portion of the VA pension payment that is not attributable to aid and attendance or unusual medical expenses.

Exception: A veteran (or the surviving spouse of a veteran) who does not have a spouse or dependent and is entitled to a VA pension may receive a $90 income exclusion after entering a medical institution.

Exclude $90 of the VA pension as income when determining eligibility and client participation, beginning the month after the month of entry into the institution. See **8-I, Veterans or Surviving Spouses of Veterans** and **Residents of Iowa Veterans Home**.

Any portion of the pension attributable to aid and attendance or housebound allowance is not considered income. In most cases, the portion of the VA pension attributable to unusual medical expenses is not considered income. See Aid and Attendance and Housebound Allowance and Payment Adjustment for Unusual Medical Expenses.

The portion of a VA pension that is attributable to a dependent's needs is called augmented payment and is usually counted as income to the dependent. See Payments for Dependents.

A VA compensation or pension payment may also contain any of the other VA benefit types. Make sure to verify what is included in the VA compensation or pension payment.

Aid and Attendance and Housebound Allowance

Legal reference: 20 CFR 416.1103, 20 CFR 416.1121

VA pays an allowance to some veterans, spouses of disabled veterans, and surviving spouses who are in regular need of the aid and attendance of another person or who are housebound. This allowance is combined with the person's pension or compensation payment and is paid while the person is at home, in a medical institution, or (in rare circumstance) in a residential care facility.

A payment for aid and attendance or housebound allowance **is not income** but is a third-party medical resource.

When the reason an applicant receives aid and attendance or housebound allowance is for costs which the Medicaid program or State Supplementary Assistance program will be meeting (such as nursing facility or in-home health related care), deduct the aid and attendance or housebound allowance to determine the amount of the Medicaid or State Supplementary Assistance payment.

If a member is in a nursing facility, add the aid and attendance or housebound allowance to the client participation to determine the total client participation owed. If a member receives in-home health-related care to meet the same need for which the member gets aid and attendance or housebound allowance, add the aid and attendance or housebound allowance to the client participation to determine the total client participation owed.

If a member is on two or more programs where aid and attendance is considered, such as waiver and in-home health-related care, allow the member to choose the program to which the VA aid and attendance payment would be applied.

If the client cannot verify the amount for aid and attendance or housebound allowance, request verification from the Department of Veterans Affairs. A client who provides a signed release to the Department of Veterans Affairs has met the requirement for supplying requested information or verification. The general release does not meet this requirement unless the client asks for help. Add the VA file number to a specific release.

Clothing Allowance

Legal reference: 20 CFR 416.1103, 20 CFR 416.1121

A lump-sum allowance is payable in August of each year to a veteran with a service connected disability who has a prosthetic or orthopedic appliance, including a wheelchair. This VA clothing allowance is to defray the increased cost of clothing due to wear and tear caused by these appliances and **is not income**.

Payments for Dependents

Legal reference: 20 CFR 416.1121

In some instances, the VA considers the number of dependents to determine the amount of the veteran’s or surviving spouse’s benefit. Payments for dependents are augmented payments. The augmented payment may be included in the same payment made to the veteran or widow or may be made in a separate payment to the dependent.

The portion of a VA payment that is augmented because of a dependent is income to the dependent, not the veteran. **Exception:** Count an augmented payment as income of the veteran or surviving spouse if **all** the following criteria are met:

- The dependent lives apart from the veteran or surviving spouse, and
- The dependent applies to have the augmented payment paid to the dependent separately from the veterans payment (apportionment), and
- The VA denies the dependent's request for separate payment, and
- The veteran or surviving spouse does not send the augmented benefit to the dependent.

If the VA denies apportionment and the veteran makes no payment to the dependent, count the augmented benefit as the veteran's income the month following the month of the VA's response.

If the client is a veteran or surviving spouse receiving a VA payment, and the client has a living spouse, dependent parent, child, or disabled adult child, verify whether any of the VA benefit is augmented. If the client indicates that the VA payment is not augmented (or does not know) and alleges no living spouse, dependent parent, child, or disabled adult child, assume that the benefit is not augmented.

If the client is a child or spouse living with a veteran receiving a VA payment, determine whether any of the VA payment is augmented and is income to the client.

If the client is a child or spouse living apart from a veteran who receives VA payments, determine whether any of the VA payment is augmented and is income to the client. Ask if the client receives any payments directly from the VA (i.e., by apportionment) or through the veteran.

If a surviving spouse or a child or spouse living apart from the veteran alleges that the augmentation amount was not given, ask if apportionment has been requested. If the dependent has already requested apportionment, obtain a copy of the VA response.

If the dependent has not applied for apportionment, refer the dependent to the appropriate VA office. Explain that the augmentation amount will continue to be considered the dependent's income unless the VA refuses to make the payment to the dependent by apportionment.

If the VA denies apportionment and the veteran makes no payment to the client, do not consider the augmentation amount as the client's income in the month following the month of the VA's response date.

Educational Benefits

Legal reference: 20 CFR 416.1121

Count a VA educational benefit as unearned income, unless it is for a rehabilitation payment or a withdrawal of the veteran's own contribution. The portion of a VA educational benefit that is a withdrawal of the veteran's contribution is a conversion of a resource and is not income.

Some VA educational benefits are for vocational rehabilitation, which is considered a social service and not counted as income. Training for a specific job skill or trade (vocational training) is not a social service; however if it is part of the vocational rehabilitation, treat it as a social service and do not count as income.

VA educational benefits that are counted as unearned income can be excluded if they are used to pay the cost of tuition, fees, or other necessary educational expenses. See Educational Assistance.

Payment Adjustment for Unusual Medical Expenses

Legal reference: 20 CFR 416.1103(a)(7)

VA defines "unusual medical expense" as unreimbursed medical expenditures that exceed five percent of the person's annual applicable maximum VA payment rate. If the person receives a needs-based VA pension or compensation payment, the unusual medical expenses are deducted from the countable income used to compute the VA benefit amount. This may result in a higher VA payment amount.

The portion of a VA payment that is attributable to unusual medical expenses (UME) is **not considered as income** in determining eligibility or client participation.

EXCEPTION**:** The portion of a VA payment that is attributable to UME **is** considered as income in determining client participation for veterans or surviving spouses of veterans who do not have a spouse or dependents and reside in the Iowa Veteran's Home.

A person with no countable income for VA purposes is already receiving the maximum VA benefit, so none of that person's VA benefit is attributable to unusual medical expenses.

To determine the amount of VA benefits attributable to UME, contact the Department of Veterans Affairs or use the VA award letter. When sending a release to the VA, specify on the release that the information needed is the amount of the VA benefit that is attributable to UME (difference in what the benefit would be with and without UME) and not merely the amount of UME.

To determine the amount of VA benefits attributable to UME from an award letter, calculate the benefit amount with and without consideration of the UME deduction.

1. Mr. A receives a veteran's pension of $500 and has social security income of $300. The IM worker sends a release form to the Department of Veterans Affairs. The VA indicates that $100 of the $500 VA benefit is attributable to UME. Only $400 of the VA benefit is considered to determine SSA and Medicaid benefits.

2. Mr. B receives a monthly veteran's pension of $698.00. Mr. B provides the IM worker with a copy of his VA benefit award letter. The letter indicates that the computation of Mr. B's VA benefit amount used the annual social security income of $5,497, annual "other" income of $353.00, and annual medical expenses of $9,700.00.

   The IM worker determines that $488.00 of the $698.00 VA pension is attributable to UME. Only $210.00 of the VA pension is considered to determine SSA and Medicaid benefits.

$	Maximum annual VA payment rate for Mr. B's pension type
8,376.00	Annual Social Security income used to compute VA benefit
- 5,497.00	Annual "other" income used to compute VA benefit
- 353.00	Annual VA benefit without UME deduction
$ 2,526.00	

   $2,526 divided by 12 months = $210.00 monthly benefit (rounded down to the nearest dollar) without UME deduction. This is the countable VA benefit amount for Medicaid and SSA purposes.

$ 698.00	Monthly VA benefit with UME income deduction (actual benefit
- 210.00	amount)
$ 488.00	Monthly VA benefit without UME income deduction
	Monthly VA benefit attributable to UME

Non-MAGI-Related Deductions

Legal reference: 20 CFR 416.1112, 20 CFR 416.1124

After determining countable nonexcludable income, apply the following deductions (except as noted) in the order listed. Some deductions do not apply for all coverage groups and all income types. See the corresponding subsection for a complete explanation of when to apply the deduction.

1. From unearned income, subtract a general income deduction of up to $20. See $20 General Income Deduction.
2. From earned income, subtract any remaining balance of the $20 general income deduction that was not used for unearned income. See $20 General Income Deduction.
3. From earned income, subtract a work expense deduction of $65. See $65 Plus One-Half Deduction.
4. From earned income, subtract any impairment-related work expenses. See Deduction for Impairment-Related Work Expenses.
5. From remaining earned income (after the $65 deduction), subtract one-half. See $65 Plus One-Half Deduction.
6. From earned income, subtract any work expenses of the blind. See Deduction for Work Expenses for the Blind.
7. From earned or unearned income, subtract any income that is to be used for the Plan for Achieving Self Support. See Deduction for Plan for Achieving Self-Support.

$20 General Income Deduction

Legal reference: 20 CFR 416.1124(c)(12) and 20 CFR 416.1112(c)(4)

When determining eligibility for SSI-related programs, allow a $20 general income deduction per eligible unit, except as listed below. Apply the deduction first to unearned income, then to earned income if unearned income is less than $20.

> Mr. and Mrs. W live at home with total unearned income of $800. Countable income is: $800 - $20 deduction = $780 countable income

Do **not** apply the $20 general income deduction for the following coverage groups:

- 300% group.
- State Supplementary Assistance recipients applying for or receiving in-home health-related care, or residential care facility services.
- Home- and community-based services waiver recipients.

Do **not** apply the $20 deduction to:

- Income based on need, such as unearned income for support and maintenance (veteran's compensation, for example).
- Income of an applicant in a medical institution. **Exception:** Allow the $20 deduction when determining eligibility for QMB, SLMB, or Medically Needy.
- In-kind support and maintenance valued according to the value of one-third reduction rule.

$65 Plus One-Half Deduction

Legal reference: 20 CFR 416.1112

Deduct $65 plus one-half of the balance from a person's earned income, except as listed below. Apply the deduction of impairment-related work expenses **before** deducting the one-half of the balance.

When both spouses are employed, add together their total earned income then subtract the earned income deduction of $65 plus one-half from the total. If the recipient is a child who has earned income, give the $65 plus one-half deduction to the child's earnings also.

Do **not** apply the $65 plus one-half deduction for the following coverage groups:

- 300% group in a facility or home- and community-based waivers.
- Dependent person. Deduct only $65 for the dependent. The aged, blind, or disabled client gets $65 plus one-half.

Deduction for Impairment-Related Work Expenses

Legal reference: P.L. 100-508, 20 CFR 416.976

Deduct impairment-related work expenses from the earned income of clients who are disabled (**but not blind**) and under age 65, or were determined to be disabled before age 65. If the client is blind, see Deduction for Work Expenses for the Blind.

Deduct expenses for items or services that enable the impaired person to work, and that are incurred by the person because of a physical or mental impairment. Examples include a one-handed typewriter, typing aids such as page-turning devices, and telecommunications devices for the deaf.

Deduct payments for residential modifications for a person employed outside the home that permit the person to get to work. This deduction also applies to residential modifications for a person who works at home to create a work space that accommodates the person's impairment and to provide access to that work space. Other changes in the home are not deductible as impairment-related work expenses.

Expenses may involve payment for the purchase, installation, maintenance, and repair of an impairment-related item or payment for an impairment-related service. In order for an impairment-related expense to be deducted, the following criteria must be met:

- The type of expense and the charge must be verified.
- The client must pay for the item. Payment can be cash, check or credit card, installment payments, or rentals or leases.
- The item cannot be reimbursable or payable through another source.
- The cost of the expense must be the reasonable cost based on going rates in the community.
- The cost cannot be a deductible self-employment expense.
- The expense would not be incurred by someone without the impairment. For example, everyone must have clothing but the client may need a certain type of shoes solely because of employment and the client's disability.

Impairment-related work expenses are not deductible in determining client participation for people in medical facilities.

Deduct impairment-related payments according to one of the following methods:

- **Down payment**. A person may make a down payment on an impairment-related item or service, then make regular monthly payments. Either deduct the down payment entirely in one month, or allocate it over a 12-consecutive-month period beginning with the month of purchase. The client chooses the method.

- **Annualized payment**. The down payment and the monthly payment must be divided into uniform monthly payments if:
  - The monthly payments do not begin immediately after the month in which the down payment is made, or
  - The regular monthly payments extend for less than 12 months.

  To calculate uniform monthly payments:
  - Establish the 12-month proration period beginning with the month of purchase.
  - Add together the down payment and all the monthly payments that will be paid in the 12-month proration period.
  - Divide the sum by 12.

  Mr. G purchases a deductible item in July 1994, paying $1,450 down. However, the first monthly payment of $125 is not due until September. The worker calculates a uniform monthly deduction as follows:

  Step 1. Establish the 12-month proration period as July 1994 through June 1995 (12-months beginning with month of purchase)

  Step 2. Add the down payment and monthly payments

  $ 1,450 Down payment in 7/94
  + 1,250 ($125 x 10)
  $ 2,700 Sum of monthly payments during proration period (July 1994 - July 1995)

  Step 3. Divides $2,700 by 12 = $225

  In this situation, a $225 monthly deduction, the down payment prorated amount plus the regular monthly payment, is allowed beginning in July 1994, and ending in June 1995. After June 1995, the deduction amount would be the regular monthly payment of $125.

- **Nonrecurring payment**. If the impaired person pays the full amount all at once, either deduct it entirely in one month, or prorate it over a 12-consecutive-month period, beginning with the month of purchase. The client chooses the method.
- **Recurring payments**. Some impairment-related work expenses are paid on a recurring basis. When durable equipment is purchased by installment over a period of time, the cost of the item, interest, and sales tax are deductible. Prorate the payments over the time period between payments.

- **Rentals or leases**. Deduct the actual monthly rental or lease charge.

When a person has impairment-related work expenses, and the IABC system is determining the eligibility and client participation, subtract the impairment-related expenses before entering the earned income onto the system for eligibility.

Attendant Care Services

Legal reference: 20 CFR 416.976(c)(1)

Deduct payments made for attendant care services if those services are needed in the work setting or to help the impaired person travel to and from work. “Attendant care services” are types of physical assistance that help an impaired person meet essential personal needs at home or at work.

Deduct the payments made for attendant care services in the home only when the services relate to preparations for going to or returning from work. Examples include services relating to bathing, dressing, cooking, eating, administering medications, or arranging medical devices right before or after the impaired person’s workday. The services generally require no more than one or two hours each morning or evening.

Do **not** deduct payments made to family members for attendant care services unless:

- The client can show that the family member has suffered economic loss by reducing or terminating employment to provide the care, and
- The payment to the family member is made in cash.

A family member is anyone related by blood, marriage, or adoption, whether or not the person lives with the impaired person.

An attendant assists a client in getting ready and traveling to work for approximately one hour per day and assists the client with laundry, housecleaning, and other non-work-related services for approximately three hours per day. The worker deducts only one-fourth of the total payment to the attendant as an impairment-related work expense.

Routine Drugs and Medical Supplies and Services

Legal reference: 20 CFR 416.976(c)(5)

Deduct payments for routine drugs, medical supplies, and services if they are necessary for controlling the disabling condition and are not payable by Medicaid or another source. Examples include payments for physical therapy and medical supplies such as incontinence pads, catheter, bandages, elastic stockings, face masks, irrigating kits, and disposable sheets and bags.

Durable Medical Equipment and Prostheses

Legal reference: 20 CFR 416.976(c)(2) and (3)

Deduct the costs of durable medical equipment and prostheses that are not payable by Medicaid or another source. The prostheses must be used primarily for functional, rather than cosmetic purposes in order to be a deduction.

"Durable" medical equipment is medical equipment that:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose.
- Is generally not useful to a person who does not have the illness or injury.

The following types of equipment are **not** deductible unless a physician verifies that the equipment is necessary to control the disabling condition:

- Portable room heater.
- Air conditioner.
- Humidifier or dehumidifier.
- Electric air cleaner.
- Posture chair.
- Physical fitness equipment, such as an exercise bicycle.

If the expense was incurred within 11 months before receiving the earned income (i.e., because of a different job) and has not already been deducted as an impairment-related work expense, the client can choose either to:

- Prorate the expense over 12 months after receiving earned income, or
- Use the deduction in the first month of earned income.

Modified Vehicles

Legal reference: 20 CFR 416.976(c)(6)

Deduct the cost of modifying an impaired person's vehicle. A physician must verify that the person is unable to use public transportation and requires the special modifications in order to get to and from work. Also, the person must pay the cost of the modification before it can be deducted.

Deduct the actual cost paid to make structural or operational modifications to a vehicle in order to drive it, or be driven in it, to work. Do not deduct the cost of the vehicle.

Deduct mileage allowance for operating costs based on the weight of the empty vehicle according to the chart below. Operating cost includes gas and oil, maintenance, parts, tires, tolls, parking, insurance, and state and federal taxes.

Cost of Owning and Operating Automobiles, Vans, and Light Trucks - 2001
Cents Per Mile *

Size	Cost **	Characteristics ***
Subcompact	32.2	4 cylinder, Avg MPG = 32
Compact	42.3	4 cylinder, Avg MPG = 23
Intermediate	46.9	6 cylinder, Avg MPG = 20
Full-Size Vehicle	51.1	6 cylinder, Avg MPG = 19
Compact Pickup	40.2	4 cylinder, Avg MPG = 18
Full-Size Pickup	47.7	8 cylinder, Avg MPG = 13
Compact Utility	45.6	4 cylinder, Avg MPG = 15
Intermediate Utility	51.4	6 cylinder, Avg MPG = 15
Full-size Utility	52.9	8 cylinder, Avg MPG = 13
Mini-Van	50.7	6 cylinder, Avg MPG = 17
Full-Size Van	52.0	6 cylinder, Avg MPG = 13

* Total costs over 5 years, based on 70,000 miles.

** Includes depreciation, financing, insurance, registration fees, taxes, fuel maintenance, and repairs.

*** Average MPG reflect city, excluding highway. Source: Federal Highway Administration estimates based on the 2001 editions of **The Complete Car Cost Guide** and **Complete Small Truck Guide** from Intellichoice, Inc., and sales figures from **Automotive News**.

Multiply the number of round trip miles to work by the rate per mile. Multiply that times the number of trips per month to determine the monthly deduction.

A person who uses a modified vehicle to get to work may be entitled to a mileage allowance and modification cost allowance even if the person is able to use public transportation to get to work.

Driver Assistance, Taxicab or Other Hired Vehicles

Legal reference: 20 CFR 416.976(c)(6)

If a person's impairment requires the person to use driver assistance, taxicabs, or other hired vehicles in order to get to and from work, deduct the fee paid to the driver. If the impaired person's own vehicle is used, allow a deduction for both the driver cost and the vehicle operating costs. Use the same mileage allowance rates for vehicles operating costs that are used for Modified Vehicles.

A deduction for driver assistance, taxicabs, or other hired vehicles is allowable only if:

- Public transportation is not available in the person's community or if
- Public transportation is available but the person is unable to use it because of the person's impairment.

Ms. S is employed as a computer technician. She cannot take public transportation. The cost of a driver of $70 per month and the rate allowed for her type of vehicle are deducted. The rate is $.295 per mile because her car is a 1989 compact.

The worker allows the charge for the driver and the mileage to and from Ms. S's home. The round-trip mileage is 5 miles per day. In a month with 20 working days, Ms. S is allowed $99.50 in transportation expenses [$70 for the driver and $29.50 for mileage ($.295 x 5 x 20)].

Own Unmodified Vehicles

Legal reference: 20 CFR 416.976(6)

Allow a deduction for vehicle operating costs if:

- The impaired person drives the person's own unmodified vehicles to and from work and

- Public transportation is unavailable in the person's community or the impaired person is unable to use public transportation because of the person's impairment.

Use the same mileage allowance rates for vehicle operating costs that are used for Modified Vehicles.

Deduction for Work Expenses for the Blind

Legal reference: 20 CFR 415.1112(c)(8)

A person who qualifies for SSI because of blindness is **not eligible** for the deduction for impairment-related expenses but may deduct the ordinary and necessary expenses of earning income. If the blind person's spouse is also eligible because of blindness, each spouse is eligible for this deduction.

Blind people who are 65 or over are **not** eligible for this exclusion unless they were either:

- Receiving SSI payments because of blindness in the month before they turned 65, or
- Converted to SSI from the Aid to the Blind program in effect in 1974.

Examples of ordinary and necessary work expenses include those related to:

- Transportation to and from work such as the actual cost of bus or cab fare, cane travel instructions, a seeing eye dog and the dog's expenses, or private automobile (15¢ per mile).
- Actual cost of job improvement training such as computer programming training.
- Job performance items such as:
  - Braille instruction and translation of material into Braille, readers.
  - Child care costs (if not otherwise provided).
  - Equipment needed on the job or tools used in the trade (e.g., for homebound work) due to blindness.
  - Instructions in grammar.
  - Meals.
  - Professional association dues that are work-related, licenses, union dues.
  - Prostheses needed for work even though not related to blindness.
  - Optical aids.

- Safety shoes and uniforms and the care of them.
- Income taxes (federal, state, local) and FICA self-employment taxes.
- A wheelchair if necessary due to other disabilities.

The amount deducted cannot be more than the amount of earned income for the period. Do not carry unused deductions over to another quarter.

The client must keep records of work expenses and verify the expenses. If transportation and meal expenses appear reasonable, accept them without verification.

Deduction for Plan for Achieving Self-Support

Legal reference: 20 CFR 416.1112, 20 CFR 416.1180, 20 CFR 416.1181,

Deduct the income of a blind or disabled client under the age of 65 if that income is needed to fulfill a Plan for Achieving Self-Support (PASS). People 65 or over get this deduction only if they were receiving SSI-related eligibility because of blindness or disability in the month before they turned 65.

Check the SDX when a client states that a plan for achieving self-support exists. When other clients have a plan, it is verified by the social worker.

Subtract the income deduction for a PASS from a client's countable income after all other applicable deductions, such as the $20 general income deduction and the $65 and 1/2 deduction.

Income Policies for MAGI-Related Coverage Groups

Legal reference: 42 CFR 435.603, 441 IAC 75 (Rules in Process)

Definitions

Legal reference: 441 IAC 75 (Rules in Process)

"Modified Adjusted Gross Income" means the tax-based methodology to determine income eligibility and household size for family-related and other coverage groups. It is also known under the acronym "MAGI."

"Reasonable Compatibility" means the standard by which the total attested countable income for each person's household size is compared with the total amount from available Electronic Data Sources used by DHS. In order for attested income to meet the standards for 'reasonable compatibility' it must meet one of three criteria:

- Both the total attested income and the total income from the Electronic Data Sources are above, at, or below the applicable income limit for Medicaid or HAWK-I, or
- The total attested income is within 10% of the total income from Electronic Data Sources, or
- The total attested income exceeds the total income from electronic data sources.

If the attested income meets any of the reasonable compatibility criteria, the income is considered to be verified. "Reasonably compatible" is another term used in place of "reasonable compatibility" and carries the same meaning as "reasonable compatibility".

MAGI-Related Income Limits

Legal reference: 441 IAC 75 (Rules in Process)

Effective January 1, 2014, the following income limits apply to the MAGI-related Medicaid coverage groups specified below, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
Family Medical Assistance Program	441 IAC 75.3(1); 42 C.F.R. Part 435.110 and 435.118; Title XIX of the Social Security Act, Section 1931	1	$447
		2	$716
		3	$872
		4	$1,033
		5	$1,177
		6	$1,330
		7	$1,481
		8	$1,633
		9	$1,784
		10	$1,950
		over 10	$1,950 plus $178 for each additional person
Mothers and Children, for pregnant women	441 IAC 75.3(2); 42 C.F.R. Part 435.116 and 435.118; Title XIX of the Social Security Act, Section 1902	215% of the federal poverty level for the household	
Mothers and Children, for infants under one year of age		300% of the federal poverty level for the household	
Mothers and Children, for children aged 1 through 18 year	441 IAC 75.3(2); 42 C.F.R. Part 435.118; Title XIX of the Social Security Act, Section 1902	167% of the federal poverty level for the household	

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
Medicaid for Independent Young Adults	441 IAC 75.3(13); Title XIX of the Social Security Act, Section 1902(a)(10)(A)(ii)(VII)	254% of the federal poverty level for the household	
Iowa Health and Wellness Plan (IHAWP)	441 IAC 74.4	133% of the federal poverty level for the household size, as of the date of a decision on initial or ongoing eligibility	

Self-Attested Income

Legal reference: 42 CFR 435.603(h)(3), 42 CFR 435.945

Enter all self-attested income, earned and unearned, using the amount and frequency as reported by the client, unless otherwise directed.

Deductions that are not allowed:

Add back the following income to determine countable income:

- Non-taxable Social Security benefits
- Tax-exempt interest
- Foreign earned income & housing expenses for Americans living abroad

View the Income Verification Detail page to see if Title II income verification results were returned from EDS. The worker will need to enter the amount of Title II income returned from EDS, if different then the self-attested amount. The Title II income from EDS is considered verified. Title II income must be entered on a separate income record for each person receiving it. Do not combine multiple individual's Title II income amounts under one person. If one person receives more than one type of Title II income, they should be combined and entered on one income record.

For long term disability, the income that is equal to the percentage of the premium paid by the employer is countable for MAGI and Non-MAGI. The income equal to the percentage of the premium paid by the employee is not countable for MAGI but will be counted for Non-MAGI.

Income verification received that was not requested by the IM worker needs to be processed as a reported change.

After running EDBC for all available eligibility months and an over income denial is received for any applicant or household member for the month of application or the first month of a new review period, workers need to review the entered income for subsequent months. If eligibility may potentially occur due to a lower income amount, rescind the first month as ineligible and run EDBC.

When income verification is received in a frequency other than monthly, add all income in the time period being used together and divide by the number of pay periods in the time period

For both applications and reviews:

- If the client does not complete any part of an income section, assume there is no income of that type.
- When the client provides a monthly amount but the rest of this section is left blank, you can use this as the self-attested amount.
- When the client states they work a certain number of hours a week at a certain rate of pay, they have provided a self-attested amount.
- If the client leaves the income section blank and provides verification of that income type, you can use the verification provided as a self-attested amount.

When information provided at application, review or when a change is reported is not enough to reasonably determine a self–attested amount, clarification is needed. Clarification will need to be requested when:

- The client states they work a range of hours a week (e.g. 20-30 hours per week) and make a certain rate of pay per hour and does not provide a gross amount.
- The client states they work a certain number or a range of hours a week and the hourly rate varies based on job type (e.g. $7.50 an hour when hosting, $4.50 an hour when serving) and does not provide a gross amount.
- The client reports beginning employment and is unsure of the hours and rate of pay.
- The client provides the employers name and does not complete the rest of the income section.

- The client states they are receiving a type of unearned income (e.g. Unemployment, Social Security etc.) and does not list an amount.

When self-attested income cannot be determined based on information provided at application, review, or when a change is reported and the requested information is not provided, a non-compliance of 'failure to provide information' will be used to complete the negative action.

For clients attesting to Tips/Commissions via an e-App, assume the amount provided is consistent with the pay frequency listed for earnings, unless questionable.

When self-attested income is questionable and prudent person concept does not apply, reach out to the client for verification. Clearly document if prudent person was used.

When an application from the FFM lists an income frequency as irregular or infrequent, the worker must contact the household to obtain a self-attested income.

When the client has filled out the income/employment section on an application or review, or has submitted a change report and has self-attested income that cannot be determined, attempt to call the client to resolve/clarify a self-attested income amount that is indicative of future months. Document in WISE the reason for the call and the outcome. If the self-attested income is not indicative of future income, the income may need to be flattened. (See Flattening Income later in this chapter.)

Income Considered

Legal reference: 441 IAC 75.70, 441 IAC 75 (Rules in Process)

Income eligibility under MAGI-related Medicaid shall be determined using "modified adjusted gross income" (MAGI) for a coverage group that is subject to MAGI methodology, including the imposition of any premiums or cost sharing.

The total countable earned and unearned income of the applicant or member household shall be considered when determining initial and ongoing Medicaid eligibility for coverage groups that are subject to MAGI methodology. For eligibility to exist, the total countable monthly income of the applicant's or member's household must be at or below the income limit for the applicable coverage group.

MAGI-Related Household Member Income Exclusions

Legal reference: 441 IAC 75 (Rules in Process)

The income of a household member that meets the requirements of paragraph (a) or (b) below is excluded from the household's total countable income.

a. Income of children under age 19.

(1) The income of a child under age 19 who are:

- Included in the household of his or her parent (natural, adopted or step), and
- Not expected to be required to file a federal tax return for the taxable year in which Medicaid is being determined, whether or not the child files a tax return.

(2) Income of a child under age 19 with income of less than the threshold determined annually by the Internal Revenue Service is considered not to be expected to file.

b. Income of tax dependent other than spouse or child.

(1) The income of a tax dependent other than a spouse or a child (natural, adopted or step) who is not expected to be required to file a federal tax return for the taxable year in which Medicaid is being determined is not included whether or not the dependent files a tax return.

(2) A dependent with income of less than the threshold determined annually by the Internal Revenue Service is considered not to be expected to file.

(3) Any cash support provided to the claimed dependent by the tax-filer.

Countable Income Under MAGI

Legal reference: 441 IAC 75 (Rules in Process)

For the purpose of determining initial and ongoing MAGI-related Medicaid eligibility, countable income is the amount that remains after allowable expenses and deductions have been subtracted from gross countable income.

The worker will not make this calculation outside of the system. When the self-attested income, allowable expenses, and deductions are entered into the system, the system will calculate the countable income.

Gross Countable Income

Gross countable income under MAGI includes income types that are considered as gross income for federal tax purposes except as specified under Income Types Excluded from Gross Income below. Gross income for the purpose of Medicaid eligibility under MAGI includes but is not limited to the following income types:

- Earned income, including salaries, wages, tips and other compensation for services, including fees, bonuses, commissions, fringe benefits such as sick pay, vacation pay, severance pay, and similar items. Also includes AmeriCorps income used for living expenses*, census earnings, child student earnings*, foreign earned income and housing expenses of a U.S. citizen or resident who lives abroad even though these types of income may not be taxable.
- Gross profit derived from a self-employment trade or business;
- Capital gains derived from dealings in assets or property;
- Interest (taxable and non-taxable);
- Rental income*, including room and board;
- Royalties, residuals;
- Taxable Dividends;
- Alimony and separate maintenance payments;
- Taxable annuities, pensions*, IRA distributions or withdrawals;
- Income from life insurance and endowment contracts;
- Retirement – Military, IPERS;
- Income from discharge of indebtedness;
- Distributive share of partnership or S-corporation gross income;
- Income in respect of a deceased person;
- Income from an interest in an estate or trust;
- Deemed sponsor income;
- Social security benefits (taxable and non-taxable);
- Disability payments, including government, private, temporary and permanent payments;
- Unemployment Insurance Benefits (UIB);
- Gambling winnings;

- Survivor's benefits;
- Strike pay;
- Blood/Plasma;
- Educational assistance used for general living expenses;
- Deferred comp;
- Court awards;
- Job Corps;
- Jury duty;
- Railroad retirement, disability, or survivors benefits;
- Senior Community Service Employment Program (SCSEP);
- Tribal gaming distributions;
- College work study;
- Youth Corps;
- Civil Service annuity or pension.*

*Refer to NJA0094, Income for additional process information.

Income Types Excluded from Gross Income

Income that meets the following criteria is not considered when determining countable gross income under MAGI-related Medicaid despite the fact that the income may be considered for federal tax purposes.

- An amount received as a non-recurring lump sum from a source that is considered in determining adjusted gross income for federal tax purposes (See **Countable Gross Income** above) is counted only in the month received for determining MAGI-related Medicaid eligibility. A non-recurring lump sum received from a source that is not considered in determining adjusted gross income for federal tax purposes is entirely excluded.
- Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.
- American Indian/Alaska Native distributions.
- Student financial assistance provided under the Bureau of Indian Affairs education programs are excluded from income.
- Any other type of income that is not identified as countable (See Gross Countable Income above) and is not otherwise included in "adjusted gross income" for federal tax purposes.

Allowable Expenses

Expenses that are allowed as deductions from gross income when determining a person's adjusted gross income for federal tax purposes are subtracted from gross income as defined in Gross Countable Income and Income Types Excluded From Gross Income when determining countable income under MAGI-related Medicaid. These expenses can be claimed by individuals whether or not they plan to file a tax return.

Allowable expenses include:

- Educator expenses;
- Certain business expenses of reservists, performing artists, and fee-based government officials;
- Health savings account contributions;
- Moving expenses;
- Deductible part of self-employment tax;
- Contributions to self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees of Small Employers (SIMPLE) and Qualified Plans;
- Self-employed health insurance contributions;
- Amount of penalty for early withdrawal of savings;
- Alimony payments;
- Certain Individual Retirement Account (IRA) contributions;
- Student loan interest expense;
- Qualified domestic production activities deduction;
- Expenses directly related with the conduct of a self-employment trade or business, including but not limited to depreciation and capital losses;
- Pre-tax contributions.

MAGI Income Deduction

An amount equal to 5 percent of the federal poverty level for the applicable household size shall be subtracted from the total monthly countable MAGI income amount when:

- An applicant's monthly MAGI income exceeds the highest income limit of all of the MAGI-related Medicaid coverage groups for which the applicant meets the categorical requirements, **and**
- Deducting the 5 percent results in the applicant's income being within the income limit of this MAGI-related Medicaid coverage group.

MAGI-Related Self-Employment

A person is considered self-employed if:

- The person carries on a trade or business with the goal of making a profit and the person is the sole proprietor of the trade or business, or
- The person is an independent contractor and the person paying for the work has the right to control or to direct only the result of the work and not how the work will be done.

Reported income losses allowable by the IRS must be subtracted from other income if indicative of current income. These losses can be used to offset any other type of income such as wages or pensions. Self-employment losses are allowable for both tax filers and non-filers.

ELIAS will not accept a negative amount on the Income page. If there is a loss, enter the self-employment amount as zero on the Income page and enter the loss on the Expense page as MAGI Moving Expenses. Make a Journal entry stating that the client has an allowable income loss of $XX.XX from (allowable type of loss).

If tax forms are provided, enter the business income or loss found on the tax form. **Note**: Also consider capital gains or losses and other gains or losses. If using ledgers to determine the business income or loss, use the net amount of income or losses provided.

If the self-employment has been in existence for less than a year, the net profit shall be averaged over the period of time the self-employment has been in existence and the monthly amount projected for ongoing eligibility.

If the self-employment has been in existence for such a short time that there is very little income information, the worker shall work with the household to establish a reasonable estimate that will be projected for ongoing eligibility.

When there is a change in the nature of the self-employment business or a permanent change in operating expenses, net profit must be recalculated based on the change.

Income Verification

Legal reference: 441 IAC 75 (Rules in Process)

The department shall consider an applicant's or member's attestation of their income as verified and use the attested income to determine eligibility when the attested amount is reasonably compatible with electronic data sources.

The department will not require the applicant or member to provide verification when attested income is reasonably compatible with electronic data sources or verification is available to the department from other sources.

When attested income is not reasonably compatible with electronic data sources, the applicant or member must provide verification of the income or provide a statement that reasonably explains the discrepancy between the attested income and electronic data sources.

Whether the income is self-employment or another income source, an attempt to verify self-attested through Electronic Data Sources is always done before using documentation provided by the applicant/member to verify income.

When Eligibility Determination and Benefits Calculation (EDBC) results require verification of income or expenses follow the applicable income verification process:

- No aid code verifications means the individual's self-attested income did not result in eligibility when running EDBC. The income must be worker verified.
- Deferred verifications means the individuals reported change in income or expenses did not result in eligibility when running EDBC. The income must be worker verified.
- When EDBC results in all household members being 'Denied Over Income' and there are **NO** expenses with a Not Verified status, accept the EDBC results and Save & Continue.

- When EDBC results in all household members being 'Denied Over Income' and there are expenses with a Not Verified Status, **do not** accept the EDBC results and cancel out prior to attempting to verify the expenses.
- Complete WAGE/DBRO/WISE Look Ups to assist you in determining what income sources require verification when an individual on the case is denied/discontinued for No Aid Code - Verification or Deferred Verifications. A look up is not to be completed before EDS and EDBC is completed.
- Electronic Data Look Up functionality available in ELIAS is only to be used as listed below under WAGE, DBRO, and WISE-SSA/SSI benefits when attempting to verify income for Medicaid ONLY.
- When an individual self-attests to zero income and income is found when completing WAGE/DBRO/WISE Look Ups, follow up with the individual to clear up the discrepancy. If the individual continues to self-attest to zero income the worker must verify and run EDBC. If the individual self-attests to an amount other than zero income, attempt to verify the new amount by running electronic data sources (EDS).
- When requesting self-employment income information, provide the client with examples of acceptable types of verification. Some examples are ledgers or income statements. A Federal Tax Return may be suggested along with another type of acceptable verification. Since providing a Federal Tax Return is only a suggestion, a client **cannot** be denied or discontinued if the form is not returned.
- When EDBC results require verification of income or expenses, complete the following look ups to complete the MAGI Income Verification process:
- WAGE – earned income. WAGE provides gross wages for an individual. The information found on this screen is not considered verified information. The information should be used only as an indicator that an individual may have wages that may require verification.
- DBRO – unemployment insurance benefits (UIB). DBRO provides information on unemployment insurance benefits. The information found on this screen is considered verified information. The countable monthly amount is determined by taking the remaining balance as of the 1st day of the month of application and new certification period or the first day of the month that the change can be acted on, if reported timely and acted on timely, and dividing by 12.

When UIB is received in retroactive months, the remaining balance as of the first month of application is considered indicative for all months when UIB is received. Use it as of the month UIB began if in the retroactive period. Request actual income for retroactive months where UIB was not received.

Review payments to determine issued UIB payments that should be included in the remaining balance. To determine the date of receipt of a UIB payment for the individual, if the Pay Code column displays an issuance code of:

- W – Warrant; add 2 workdays to the number of calendar days listed in the 'P'
- D – Direct Deposit; add 4 workdays to the Issue Date
- DC – Debit Card; add 3 workdays to the Issue Date

When UIB ends in the month of application, the first month of a new certification period, or in the month of change, use the balance divided by 12 for the first month of the application, new certification period, or the month the change becomes effective (i.e. The first month change can be acted on if reported timely and acted on timely) and $0 UIB for ongoing months.

- WISE – SSA/SSI benefits. Completing a look up in WISE provides SSA/SSI information, if available, for an individual and includes the amount of disability or retirement benefits or Supplemental Security Income. The SSA/SSI benefit amount information returned from a WISE look up is considered verified.

  Refer to the WISE User Guide found on the Field IM SharePoint for more information on completing look ups.

UIB or SSA/SSI

Use this option when UIB or SSA/SSI has been worker verified using DBRO or completing a WISE look up.

Client Self-Attests to Zero Income

Use this option whenever zero income is self-attested.

Other Income – Options 1-4

Other Income – Option 1

Use this option only if acceptable income verification is submitted with the application, review, or change report.

- "Acceptable" means it is consistent with other information provided by the client and indicative of future income.
- Use the prudent person concept to determine if the verification is acceptable.

Other Income – Option 2

Use this option only if income verification is not submitted with the application, review, or change report or is not acceptable and a Generic Release is on file.

NOTE: The Generic Release is not required when completing an Electronic Data Look Up in WISE.

If the Generic Release is not on file, see **Other Income - Option 3**.

Other Income – Option 3

Use this option only if income verification is not submitted with the application, review, or change report, or submitted information is not acceptable, or a Generic Release is not on file, or Electronic Data Look Up was not successful, or 3rd party did not verify.

Other Income – Option 4

If none of the three previous Other Income options result in verification of income or apply to your situation, as a last resort, request income verification from the individual as follows:

- Create and send a request for information using WISE Forms. Prior to creating the request for information, determine if expenses need to be included in the request.
- Upload the request for information to catalog.
- Narrate and track in WISE.

- Reassign case in ELIAS, if applicable.
- Upload and catalog any documents.
- End.

Refer to NJA0069, Verifying Income and Expenses for the steps on how to enter each source of Other Income.

MAGI-Related Budgeting Procedures for Determining Financial Eligibility

Legal reference: 441 IAC 75 (Rules in Process)

Initial and ongoing financial eligibility under MAGI-related Medicaid is based on current monthly household income and family size with consideration given to any anticipated changes or fluctuation in income or expenses. Total countable earned and unearned income of all persons in the applicant or member household after applicable expenses and deductions is considered in determining financial eligibility under MAGI-related Medicaid.

Current Monthly Household Income

Both initial and ongoing eligibility shall be based on current monthly income when current income and any applicable expenses is a good indicator of future income except when the income is unemployment insurance benefits as described below.

Change in Current Month's income

If the household indicates that current countable income is not indicative of future income due to a change that is reasonably expected to occur in the current or next month, the amount of monthly income used for initial and ongoing eligibility shall be calculated based on the change. When the anticipated change is with unemployment insurance benefits, income shall be budgeted as described below.

Unemployment Insurance Benefits (UIB)

When current income includes unemployment insurance benefits (UIB), the monthly amount of UIB income used for initial and ongoing eligibility shall be determined by annualizing the remaining balance according to the applicable item below:

- For applicants, the monthly amount is determined by using the remaining balance as of the 1st day of the month in which the application was filed and dividing the balance by 12. If the UIB will end in the application month, the annualized amount will be used for the application month only and no UIB income will be used for months thereafter.
- For members in the review process, the monthly amount is determined by using the remaining balance as of the 1st day of the month of the new certification period and dividing the balance by 12. If the UIB will end in the first month of the new certification period, the annualized amount will be used for the first month and no UIB income will be used for months thereafter.
- For members reporting a change and not due for review, the monthly amount is determined by using the remaining balance as of the 1st day of the month in which the change can be acted upon.

Recurring Lump-Sum Income

Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

- Income received by an individual employed under a contract shall be prorated over the period of the contract.
- Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described in **Self-employment income** below.
- Applicable expenses and deductions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

Projecting Future Income

When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

Change in Circumstances

When a change in circumstances that is required to be timely reported by the client is not reported as required, eligibility shall be re-determined beginning with the month following the month in which the change occurred. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

Adding/Removing a Person

In any month for which a person is determined eligible to be added to a currently active MAGI-related Medicaid household, the person's needs and income shall be considered as of the date the change is reported. When it is reported that a person is anticipated to enter the home, the date to add the person shall be no earlier than the date the person actually begins to live in the household or the date of report, whichever is later.

A person who is a member of a Medicaid household and who is determined to be ineligible for Medicaid shall be discontinued prospectively effective the first of the next month in which the timely notice requirements can be met.

Self-Employment Income

Countable self-employment income is the gross income less allowable expenses. Apply the policies in the following paragraphs when self-employment income is received before the month of decision and is expected to continue after Medical assistance is approved.

Countable income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents a person's annual income shall be annualized to arrive at the monthly amount to be used to determine eligibility. Countable self-employment income is the gross income less allowable expenses.

When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence to arrive at a projected monthly amount to be used to determine eligibility. If the enterprise has been in existence for such a short time that there is very little income information or income in the period of time is not a good indicator of future income, the worker shall establish, with the cooperation of the applicant or member, a reasonable estimate of the projected monthly income to be used for eligibility.

Self-employment income and/or the cost of producing self-employment income (expenses) may change. A change in self-employment income and expenses are defined as follows:

- Change in self-employment income is a change that will result in a significant change in the person's annual income.
- Change in self-employment expenses is an established, permanent, ongoing change in the operating expenses of a self-employment enterprise that will result in a significant change in the person's annual net income.

When an applicant or member reports that a change in self-employment income or expenses has occurred and the person's self-employment income has been annualized, the department shall recalculate the countable self-employment income on the basis of the change.

A change in operating expenses or income that occurs as a result of seasonal business fluctuations is not considered a change for this purpose.

Rounding Procedures

The following rounding procedures apply when determining countable MAGI income.

- In any calculation of income, drop to the nearest cent.
- When the monthly countable income is converted to a percentage of the federal poverty level and the resulting percentage is not a whole number, the federal poverty level percentage is always rounded up to the nearest percentage if the remainder is greater than zero.

Shared Living Arrangements

When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member exclusively for the applicant's or member's needs are considered income except any cash support provided to the claimed dependent by the tax-filer.

Flattening Income

When point-in-time income is not a good indicator of future income due to fluctuations in income or expenses, adjust the monthly self-attested income to a flattened/annualized amount.

This would include any countable income such as self-employment, wages, etc. Handle fluctuating income and expenses as follows:

- Annual income shall be prorated over 12 months.
- Income that fluctuates, such as income that is seasonal, shall be flattened by averaging the anticipated annual amount over 12 months.
- Self-employment income may be annualized using the flattening income process.
- In order to use an anticipated tax expense for self-employment to determine MAGI countable income, the applicant/participant will need to provide verification of the anticipated expense.

Prudent person can be used to determine if the verification is sufficient. Tax expenses can be claimed by individuals whether or not they plan to file a tax return.

- Allowable tax expenses include:
  - Car and truck expenses (for travel during workday, not commuting)
  - Depreciation
  - Employee wage and fringe benefits
  - Property, liability, or business interruption insurance
  - Interest (including mortgage paid to bank, etc.)
  - Legal and professional services
  - Rent or lease of business property or utilities
  - Commissions, licenses, taxes, and fees
  - Advertising
  - Contract labor
  - Repairs and maintenance
  - Certain business travel and meals
  - Deductible self-employment taxes
  - Cost of self-employed health insurance
  - Contributions to self-employed SEP, SIMPLE, or qualified retirement plan

Give the client the opportunity to clarify why income is not a good indicator of future income. Document in WISE the reason for the call and the response. Send a request for information if no response from the client. The request should also inform the client that they may also provide verification of anticipated income. However, verification cannot be required at this point.

If clarification of income is requested but not provided a non-compliance of ‘failure to provide information’ will be used to complete the negative action.

IOWA Health and Human Services

Employees' Manual
Title 8, Chapter F

Revised February 28, 2025

Medicaid
Coverage Groups

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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.

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8, Chapter G

Revised November 4, 2022

Medicaid
Case Maintenance

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Overview

This chapter covers policies relating to how to handle changes involving active Medicaid cases.

The first section deals with the client's responsibility to report changes in household circumstances and worker actions based on the information received about changes. Reported changes may result in reinstatement or automatic redetermination, which are topics that follow the discussion on changes.

The next two sections relate to specific MAGI-related and Non-MAGI-related case maintenance issues. Reporting fraud or misuse of Medicaid services by clients or providers comprises the final section of the chapter.

Client Reporting Requirements

Client reporting requirements include:

- Supplying requested information or verification.
- Reporting changes.

NOTE: "Clients" include applicants, members, people who are conditionally eligible, and people whose income or assets are considered in determining eligibility for an applicant or member.

All clients are responsible for reporting changes timely as they occur. However, the specific changes required to be reported and the time frames within which they must be reported may differ depending on whether the member receives Non-MAGI-related or MAGI-related Medicaid.

The following sections explain requirements for:

- Supplying information and verification
- Reporting changes
- Interviews due to questionable information

Supplying Information and Verification

Legal reference: 42 CFR 435.916, 435.952(c)-(d), 441 IAC 75 (Rules in Process) 441 IAC 76 (Rules in Process), 76.8(2)-(3), 86.3(7)(c)

Policy: For MAGI-related Medicaid, the client shall not be required to provide additional verification if attested income meets the Department's standards for 'reasonable compatibility' as defined in 8-A, *Definitions*, and if the Department can verify all other required information through an Electronic Data Source. If attested income does not meet the Department's standards for 'reasonable compatibility' or if the Department is not able to verify other required information through an Electronic Data Source, send a written request for the additional information or verification.

Before terminating or reducing benefits, a request must be sent to members for information that cannot be obtained electronically or is obtained electronically but is not reasonably compatible with information provided by or on behalf of the individual.

For non-MAGI-related Medicaid, the client must supply complete and accurate information needed to establish ongoing eligibility.

Procedure: If you need additional information, give, mail, or fax a written request to the client. Inform the client in writing of the date the information is due and the consequences for failure to supply the information or verification.

The client must supply the information within ten calendar days of the day you give or mail a written request to the client. The ten-day period begins with the day after you issue the written request. When the tenth day falls on a nonworking day or a legal holiday, extend the due date to the next working day for which there is regular mail service.

"Supply" means the Department receives the requested information or verification by the specified date. You can allow additional time when the client is making every effort to obtain the information but is unable to do so in ten days and notifies you about the problem.

See 1-C-Appendix for a list of release forms to use when obtaining information from a third party. Explain the following to the member, in writing:

- When the client must obtain information from a third party, it is the client's responsibility to return the information timely. It is not the responsibility of the third party.
- It is the client's responsibility to follow up with the third party before the due date to make sure the third party will have the information ready to pick up or has mailed the information in time to be received by the Department by the due date.
- The client may ask for more time to get the information to the Department if the third party does not have the information ready or it will not arrive by the due date.

Although it is the client's responsibility to provide information, do not cancel assistance if the client is unable to get the information because of a disability, lack of education, or lack of knowledge. If requested, assist the client in getting information to establish continuing eligibility.

A client who provides a signed release to a specific individual or organization for specific information has met the requirement for supplying requested information or verification. The general release does not meet this requirement unless the client asks for help.

Cancel or deny Medicaid if the client fails to supply the information or refuses to authorize you to obtain it from other sources when the client is unable to obtain the information.

If the client is unable to get information from a spouse who is no longer in the household, do not cancel the case. Contact the client to obtain the best information available. Ask the client about bank accounts, records showing deposits of the spouse's income, information from the divorce proceedings, and tax returns.

Ask the client to provide information that would help to verify what the client is telling you about the spouse who is no longer in the home. Determine eligibility from the information provided. If the member fails to provide the requested information, cancel the case.

Reporting Changes

Legal reference: 42 CFR 435.916(c); 441 IAC 75 (Rules in Process) and 76.15

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

- Income from all sources.
- Changes in household membership.
- Health insurance premiums or coverage, including Medicare and buy-in.
- A change in mailing or living address. Remember to offer *Voter Registration* forms when a client reports a change of address, either in person or by phone. Ask clients reporting an address change, "If you are not registered to vote where you live now, would you like to apply today to register to vote?" Send the *Voter Registration* form if the client wants to register.
- Receipt of a social security number.
- Filing of an insurance claim against a possible liable third party with the expectation of seeking restitution or payment of medical expenses that resulted from an injury and were paid by Medicaid.
- Retaining an attorney with the expectation of seeking restitution for an injury from a possible liable third party when Medicaid has paid the resulting medical expenses.
- The receipt of a partial or total settlement for payment from a liable third party of medical expenses due to an injury which were paid by Medicaid.
- Alien or citizenship status.

MAGI-related clients must also report the following:

- School attendance.
- Federal income tax filing status on claimed dependents for federal tax purposes.

IHAWP clients must also report:

- Entitlement or enrollment in Medicare Part A or Part B, or both.
- Entry into a nonmedical institution, but not limited to a penal institution.
- Childern under the age of 21 living with the client who lose minimum essential coverage, if the client 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.

Non-MAGI-related clients (except individuals receiving SSI benefits) must also report:

- Unmet medical bills.
- Resources.
- Recovery from disability.
- Gross income of the community spouse or of the dependent children, parents, or siblings of the institutionalized or community spouse who are living with a community spouse when a diversion is made to the community spouse or family.
- Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation, or spenddown.
- Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

Individuals in the **breast and cervical cancer** coverage group are required to report changes in their health insurance coverage and changes in their living or mailing address.

Individuals receiving Medicaid based on the **receipt of Title IV-E funded foster care or based on an adoption assistance agreement** are required to report changes in health insurance coverage, when their living or mailing address changes, upon receipt of a social security number, and upon termination of the adoption assistance agreement.

Individuals receiving **state-only funded Medicaid** are required to report any changes in the following:

- Income from all sources.
- Mailing or living address.
- Receipt of a social security number.
- Health insurance coverage.
- Alien or citizenship status.

Clients may report changes in person, by telephone, by mail, or online using the DHS Services Portal. Give clients form 470-5590, *Ten-Day Report of Change for Medicaid/Hawki* when requested by the client.

Members and people being added to the existing household must report changes within ten calendar days of the day the change occurred. If the last day to report a change is a nonworking day, the person must report the change by the next working day.

Act on changes and complete a redetermination within ten days of when you become aware of a change or when you verified the change, if verification is appropriate, unless using the automatic redetermination policy for information received and verified after the tenth of the month.

If the change is adding someone to the household or results in an application, follow application policies regarding effective dates.

If the change results in cancellation from the current coverage group, follow the automatic redetermination policy on whether the information was received by or after the tenth of the month.

When the client reports changes in health insurance, send form 470-2826, *Insurance Questionnaire*, to the client to fill out and return. When the client reports filing an insurance claim, retaining an attorney, or receipt of a settlement, notify the Iowa Medicaid Enterprise Lien Recovery Unit at 1-888-543-6742.

When a probable change affects eligibility, act on the change if you have all information you need to establish eligibility, and the best information available indicates that the change will actually take place as reported. See 8-A, *Notification*, for timely notice requirements. See Automatic Redetermination.

Establish a claim for any medical assistance that was incorrectly paid when a change affecting eligibility was not reported timely.

Interviews Due to Questionable Information

Legal reference: 42 CFR 435.907(d), 441 IAC 76 (Rules in Process)

Procedure: For MAGI-related Medicaid, an interview shall not be required.

For non-MAGI-related Medicaid, a face-to-face or phone interview may be required at application or review, if needed, to clarify information or resolve discrepancies.

Changes In Household Circumstances

Legal reference: 42 CFR 435.916(d), 441 IAC 76.16 and 76.16(1)

Policy: After assistance has been approved, changes occurring during a month are effective the first day of the next calendar month, provided timely notice can be given. When timely notice is required and cannot be given, the effective date is the first day of the second month following the month the change was reported. For exceptions to this policy, see 8-F, *Transitional Medicaid*.

When a change is reported or comes to the attention of the Department, eligibility shall be redetermined regardless of whether the change was required to be reported.

Procedure: The following sections explain procedures that apply to all Medicaid households for acting on:

- Changes received through IEVS.
- Changes received from other sources.
- The death of a member.

When you become aware of unreported information, the date you receive a signed release for specific information from the member or the date the member otherwise acknowledges the previously unreported information is the date the member reports the change.

Do not cancel or deny anyone's Medicaid due to a failure to supply information about a change in circumstances that does not affect a person's eligibility.

Comment:

Mrs. R and her three children receive Medicaid under a MAGI-related Medicaid coverage group. The youngest is receiving Medicaid as a newborn child of a Medicaid-eligible mother. Mr. R, the father of all three children, returns home and has earnings.
The worker requests income verification, but the information is not returned by the due date. The worker cancels the Medicaid for the parents for failure to return requested information. The children remain on Medicaid due to continuous eligibility.

See also Additional MAGI-Related Case Maintenance: Adding a New Member to an Existing MAGI-Related Case and Other Changes in the Household, for additional procedures specific to MAGI-related households.

Moving and Returned Mail

Legal reference: 441 IAC 75.10(249A) and 76.15

Policy: A member must remain an Iowa resident for Medicaid eligibility purposes; however, a move within Iowa is not required to be reported.

Comment: Reporting a change in a mailing or living address within Iowa is always desired and is beneficial to the household in order to continue proper communication with the Department.

Procedure: When mail is returned to the Department, handle the mail according to the following:

- When the Post Office has attached a forwarding address and it is in Iowa:
  - Use this address and update the DHS systems.
  - It is not necessary to contact the member.
  - Send any returned mail to the member at the correct address and keep a copy in the case record.
  - Transfer the case to the correct county, if appropriate.
- When the Post Office has attached a forwarding address and it is out-of-state, contact the member to ensure the member is no longer an Iowa resident.
- When there is no forwarding address (i.e., address unknown, undeliverable), cancel the case because we are unable to find the member using the only address we have on file.
- When there is hand-writing on the returned mail, attempt to contact the member to resolve the issue. If you are unable to contact the member, cancel the case because we are unable to find the member.

Changes Reported From IEVS and Other Automated Sources on Alerts

Legal reference: 42 CFR 435.945, 435.948, 441 IAC 75 (Rules in Process), and 76.14(2)

In addition to changes reported by the household, information that might affect eligibility is also available through alerts that are issued to the worker through the WISE system.

When you receive an alert, act on it as follows:

1. Determine if the client reported the information and if you have already acted on it. If so, notate in WISE and file alert as "no action required".
2. Act on information received from the alert that was not previously reported by the household within 30 days from the date printed on the alert. Check the description of each alert to see whether the information must be verified or is already considered verified.

   If the new information requires verification, contact the household in writing and obtain a specific release of information, if necessary. You may delay action beyond 30 days when a third party causes the delay by not providing requested verification. It may be necessary to reduce or cancel future benefits and to establish a claim.
3. If the income does not affect past, current, or future eligibility, notate in WISE and file alert as "no action required".
4. If the alert information affects eligibility, complete a redetermination and adjust future benefits. Do a claim if necessary.

IEVS Wage Report

Legal reference: 42 CFR 435.945(g), 435.948(a)(1), 441 IAC 75 (Rules in Process)

Use information provided by Iowa Workforce Development on the *Wage Report*, S470X225-A, to determine if the household reported earnings. If the *Wage Report* indicates earnings that were not reported or were underreported, contact the client to verify information. Do not take any case action based solely on data taken from this report.

IEVS Unemployment Compensation Report

Legal reference: 42 CFR 435.945, 435.948, 441 IAC 75 (Rules in Process)

The *Unemployment Compensation Report*, S470X160-A, is a monthly list of all Medicaid cases that contain a household member whose social security number matches with the social security number of a person to whom Iowa Workforce Development (IWD) issued unemployment benefits for the previous month.

Consider benefits received on the second day after IWD mailed the check. The column entitled "Date Received" shows this date. When the second day falls on a Sunday or legal federal holiday, the IEVS system extends the time to the next mail delivery date.

The report lists the amount withheld for child support. Consider this amount verified. This amount is considered income and must be added to the net amount received by the client. However, allow it as an income deduction or diversion if the child for whom the support is intended is not living in the home. See 8-E, *Income*.

The amount listed as withheld for unemployment insurance recoupment is not considered income.

Consider the benefit amounts on this report to be verified income. Act on the unemployment benefit information before the next benefit month.

Allow the household to verify the amount of benefits actually received when the household indicates the amount of unemployment benefits provided through IEVS is wrong. Use the verified amount from the household instead of the amount shown on the printout.

The household must report the discrepancy before the first month affected by the discrepancy or ten days after the date of the *Notice of Decision* (whichever is later) to have medical eligibility redetermined for the first month affected by the discrepancy.

IEVS Bendex and State Data Exchange

Legal reference: 42 CFR 435.948, 441 IAC 9.10(4)"c"

Use the information provided by the Social Security Administration on the Bendex and State Data Exchange to verify social security numbers and Social Security, Black Lung, and SSI benefits. This data is in WISE as lookups and alerts.

IEVS Earnings and Pension Report (IRS)

Legal reference: 42 CFR 435.948, 441 IAC 9.10(4)"c"

Use the information as an indicator of the wages and pensions. Consider the information unverified. This data is in WISE as lookups and alerts.

IEVS Internal Revenue Service Report (IRS)

Legal reference: 42 CFR 435.948(a)(1), 441 IAC 9.10(4)"c"

Use the information as an indication of earned and unearned income. Consider this information unverified. This data is in WISE as lookups and alerts.

Acting On IEVS Information On a Community Spouse

IEVS reports are sent for all people whose names and identifying information have been pended on the ABC system, including a community spouse. Do not delay processing eligibility if the IEVS report is not received within the 30-day-processing period.

If Medicaid is approved for the institutionalized spouse, leave the community spouse pended. You should receive an IEVS report on the community spouse as well as on the applicant.

If the Medicaid case is denied for the institutionalized spouse, or only an attribution is completed, leave both cases pending for Medicaid. Manually issue the *Notice of Attribution*. If the Medicaid case is denied, manually issue a notice denying the Medicaid.

An IEVS report should be issued for all pending cases. If there is no IEVS report within 60 days, close the pended case. There is no match for IEVS. If you believe that an IEVS report will not be forthcoming for either the applicant or the community spouse, document this in the case record.

When you receive the IEVS report, compare the resources that are made known with reported resources. If the attribution needs to be corrected, manually issue a *Notice of Decision* to correct the attributed amounts.

Acting on Changes Received From Other Sources

Legal reference: 42 CFR 435.952(a), 441 IAC 76.14(2)

When you receive a report from sources other than the client indicating that there may be unreported income or resources that may affect eligibility, contact the client to ascertain the facts and then determine the effect on eligibility.

If the subject of the report is an SSI-eligible person, forward the information to the Social Security Administration. Investigate only when the client is an institutionalized spouse with a community spouse.

The client must provide requested verification. See Supplying Information and Verification.

You may also receive notification from the Iowa Medicaid Enterprise that a Medicaid member is eligible for Medicare Part A and B when this is not reflected on the current eligibility file. Verify the coverage with the Social Security Administration or with Bendex.

If an update is needed in the "Medicaid Resource Section" of the eligibility file, complete form 470-0397, *Request for Special Update*, according to the instructions in 6-Appendix.

Death of a Member

Legal reference: 42 CFR 431.213(a), 441 IAC 7.7(2)

Policy: Eligibility for Medicaid ends when the member dies.

Procedures: Verify the date of the member's death using a reliable source, such as a funeral director, hospital, courthouse record, newspaper obituary, or SDX. Send a *Notice of Decision* to the member's family, conservator, or guardian, as appropriate. See also 8-D, *Estate Recovery*.

Reinstatement

Legal reference: 441 IAC 7.7(249A), 7.7(6), and 76 (Rules in Process)

Policy: Eligibility shall be reinstated without a new application when eligibility can be reestablished:

- Before the effective date of cancellation, or
- After the effective date of cancellation as allowed under Grace Period.

Comment: If you can process the information and make all necessary computer entries before the effective date of cancellation, the case can be reinstated even if the system does not process the information until after the effective date of cancellation.

Procedure: Issue adequate and (if appropriate) timely notice whenever an attempt at reinstatement is made. See 8-A, *Notification*, for notification requirements.

When a notice to cancel is issued and the member resolves the issue but should be canceled for another reason or should be reinstated with higher client participation, send timely and adequate notice of the new action, unless listed under 8-A, *When Timely Notice Is Not Required*.

If the additional timely notice required for a second reason cannot be issued in time to be effective the first day of the immediately following month, reinstate the case with the former client participation amount.

Then, issue the second timely notice to cancel the case or increase client participation effective the first day of the second following month. You cannot increase client participation on a canceled case during the reinstatement process unless you give timely notice.

The fact that you have already issued a *Notice of Decision* or *Notice of Action* to cancel a case does not stop you from manually issuing a second notice when a new reason for cancellation occurs. The member then must resolve both issues before assistance can be reinstated.

Grace Period

Legal reference: 441 IAC 76 (Rules in Process)

Policy: A "grace period" is a specific period of time during which a member has the opportunity to "cure" the reason for cancellation. The grace period is defined as the 14 calendar days immediately following the effective date of cancellation. If the fourteenth day falls on a weekend or state holiday, the fourteenth day is extended to the next business day for which there is regular mail service.

Eligibility on a canceled case shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the effective date of cancellation. Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

If the member is eligible, the effective date of assistance shall be the first day of the month following the month of cancellation. See Effect of Nonpayment of Premiums for MEPD. See 8-A, *Notification*, for notification requirements.

Comment: The grace period does not apply to late payment of premiums or to noncooperation actions. Cancellation reasons for which a grace period may apply include, but are not limited to, failure to provide information necessary to determine eligibility and inability to find the member.

If the case was closed because mail was returned or the Department was unable to find the member, a new application is not required if the household contacts the Department within the 14 days to provide a current Iowa address and eligibility can otherwise be established.

When cancellation is due to no review form and the review form is received during the 14-day grace period, first follow the 14-day grace period policy to determine if the case can be reinstated. If the case cannot be reinstated during the 14-day grace period, process the review as an application under the 90-day reconsideration period. Only send a request for information after the 14-day grace period has expired. If the information is not returned, deny the application.

Procedure: Based on the circumstances of your case, take the appropriate action as follows:

- **No information provided**: When no information is provided by the 14th day after the effective date of cancellaton, no further action is required.
- **Partial information provided**: When some of the information is returned, but there is still information needed to determine eligibility:
  - Attempt to contact the household to let the household know what is needed and that if the information is not received by the end of the grace period, the household will have to reapply. Document the contact. A written request for the previously requested information is not required.
  - If the information is not provided by the end of the grace period, no further action is necessary.
- **Requested information provided and a change has occurred**: If the original requested information is provided, but the household also reports a change for which verification is necessary:
  - Make every effort to verify the information and inform the member that you cannot make an eligibility determination unless the change is verified by the end of the grace period. Document the contact. A written request for the new information is not required.

- If the new information is not verified by the end of the 14-day grace period, send a manual "Remain Canceled" notice (See below for language). This is because the original reason for cancellation has been cured, but you cannot determine eligibility due to a change in circumstances that is required to be verified. Document your decision. (Your Medicaid is still cancelled because you did not give us the information we asked for. We cannot determine if (insert person's name) (is/are) eligible. 441 IAC 74.7, 76.14(2), 76.16 (249A))

- **Unable to verify change within grace period**: When an additional change is reported and it is unlikely the information can be verified by the end of the 14-day grace period, attempt to notify the member to file a new applicaiton. Document the contact.

NOTE: If a generic release is on file, it should be utilized.

1. Ms. B, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice is issued to cancel the case effective May 1 for failure to provide requested information. Ms. B provides two of the items on April 17 and the third item on May 5. There have been no other changes in the household circumstances. Medicaid is reinstated for Ms. B effective May 1.
2. Ms. C, a Medicaid member, fails to provide two pieces of information requested by the Department. A notice to cancel the case is issued effective June 1 for failure to provide requested information. Ms. C provides the two items on July 17. The household is not eligible to be reinstated and no additional notice is issued. Ms. C must reapply.
3. Mr. D, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice to cancel the case is issued effective July 1 for failure to provide requested information. Mr. D provides two of the items on June 21 and the third item on July 10. On July 10, Mr. D also reports that he has changed jobs. The IM worker explains to Mr. D that he has until July 14 to provide verification of the old job ending and the beginning of the new job or he will have to reapply for Medicaid.

   Mr. D does not provide verification of the end of the old job or the beginning of the new job. The household is not eligible to be reinstated. The IM worker issues a "remain canceled" notice to the household, since Mr. D had provided the original requested information but did not provide the new verification. Mr. D will have to reapply.
4. Ms. E, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice to cancel the case is issued effective April 1 for failure to provide requested information. Ms. E provides two of the items on March 21 and the third item on April 5. On April 5, Ms. E also reports that she has changed jobs. The IM worker explains to Ms. E that she has until April 14 to provide verification of the old job ending and the beginning of the new job or she will have to reapply for Medicaid.

   On April 14, Ms. E provides verification of the end of the old job but does not provide verification of the beginning of the new job. An eligibility determination cannot be made. The IM worker issues a "remain canceled" notice to the household since Ms. E had provided the original requested information but did not provide the new verification. Ms. E will have to reapply.

5. Mr. F, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice to cancel the case is issued effective July 1 for failure to provide requested information. Mr. F provides two of the items on June 21 and the third item on July 6. On July 6, Mr. F also reports that he has changed jobs. The IM worker explains to Mr. F that he has until July 14 to provide verification of the old job ending and the beginning of the new job or he will have to reapply for Medicaid.

   Mr. F provides verification of the end of the old job and the beginning of the new job on July 14. The IM worker processes the new information and, if eligible, benefits will be reinstated effective July 1.

6. Ms. G, a Medicaid member, fails to provide all the information requested by the Department within the ten days. A notice of cancellation is issued effective February 1, for failure to provide requested information. On March 10, all the information is returned in order to determine eligibility. The information is entered into the system but Ms. G is not eligible. A "remain canceled" notice is issued to Ms. G.

90-Day Reconsideration Period

Legal reference: 42 CFR 435.916, 441 IAC 76.14 (Rules in Process)

The reconsideration period is the 90-day period following the Medicaid cancellation date due to failure to submit a Medicaid review form or other information needed to determine continued eligibility at the time of review.

Eligibility shall be reconsidered back to the date of cancellation without a new application when the following conditions apply:

- Medicaid was canceled for failure to return a completed Medicaid review form or other information needed to review eligibility, and
- A completed Medicaid review form is received within 90 days following the effective date of cancellation.

If the 90th day falls on a weekend or state holiday, the member shall have until the next business day to provide the review form.

The eligibility effective date shall go back to the first day of the first month of ineligibility only if all other eligibility criteria are met for that month. Eligibility for subsequent months within the reconsideration period can still be determined even if the applicant remains ineligible for the initial reconsideration month(s), but eligibility shall not be granted any earlier than the month in which all eligibility criteria are met.

For the Qualified Medicare Beneficiaries (QMB), the Home- and Community-Based (HCBS) Waiver groups, and the Program for All-Inclusive Care for the Elderly (PACE), apply the 90-day reconsideration period policy, but treat the review form like an application when establishing the eligibility effective date for these specified groups.

Automatic Redetermination

Legal reference: 42 CFR 435.916(f)(1), 435.930(b), 441 IAC 76.17(249A)

Whenever a member no longer meets the eligibility requirements of the current coverage group, an automatic redetermination of eligibility for other Medicaid coverage groups will be made.

EXCEPTION: An automatic redetermination will not be made if the reason the client is ineligible under the current coverage group relates to a condition of eligibility that applies to all coverage groups. Examples include refusal to provide verification and failure to assign a third-party benefit.

For MAGI-related and Non-MAGI-related cases, the redetermination process is built in the ELIAS hierarchy when Eligibility Determination and Benefit Calculation (EDBC) is completed. However, when the person is an SSI recipient, you will first need to gather additional verification of income and resources before the redetermination process can be completed.

If a non-MAGI-related person is no longer disabled, look for eligibility under MAGI-related Medicaid. If a MAGI-related person loses eligibility, check to see if the person is disabled for non-MAGI-related Medicaid. "Disabled for non-MAGI-related Medicaid" means that the person:

- Is currently receiving social security disability payments; or
- Has previously been determined disabled by the Department; or
- Is a child who lost SSI due to reevaluation of disability but who remains eligible for non-MAGI-related Medicaid under the Balanced Budget Act of 1997.

The effective date of cancellation from the current coverage depends upon when you receive information that causes ineligibility.

Information Received:	Time Frames to Complete Automatic Redetermination	Effective Date of Cancellation
By the tenth of the month	Complete the redetermination by the end of month.	First day of the month following the month the information was received. Issue timely notice.
After the tenth of the month	Complete the redetermination no later than the end of the following month.	No earlier than the first day of the first month following the month the information was received, but no later than the second month following the month the information was received. Issue timely notice.

During the redetermination period, provide Medicaid only to people who were receiving Medicaid in the eligible group when eligibility under the initial coverage group ceased. This applies only to situations where the information causing ineligibility was received after the tenth of the month.

When an SSI recipient loses SSI and additional verification is needed, send form 470-3152 or 470-3152(S), *Notice of Cancellation/Redetermination*, and request the verification. Allow the client ten calendar days from the date of notification to return the requested verification.

- If the client returns verification by the due date on the *Notice of Cancellation/ Redetermination*, complete the redetermination and issue a *Notice of Action*.
- If the client does not return verification but has a legitimate reason not to supply verification by the due date, you can grant an extension but the cancellation remains in effect. If verification is received by the second due date, treat it as though it was received timely. Complete the redetermination and issue a *Notice of Action*.
- If the client does not return verification and you have not granted an extension, do not do anything further. Do not send a *Notice of Action*, because the client already received a *Notice of Cancellation/Redetermination*.

If you receive an SDX from the Social Security Administration and the payment status is N01, use the SDX as income verification when completing the automatic redetermination. NOTE: Some people in an N01 payment status may be eligible for the 1619b coverage group. See 8-F, *People Ineligible for SSI (or SSA): Due to Earnings Too High for an SSI Cash Payment (1619b Group)*.

If the client is canceled from SSI for being over resources, status N04, call the Social Security Administration to determine the amount of resources. If resources are within Medicaid limits, document the contact and complete the redetermination process. Use the SDX for resource verification. If resources are **not** within Medicaid limits, contact the client and request verification of resources.

Keep adequate documentation in the case record to show that a redetermination was completed. Document what steps were taken to complete the process and the results of that process.

If a client files a timely appeal and reinstatement of eligibility is required, reinstate to the coverage group under appeal until a final decision is reached.

Additional Information for Non-MAGI-Related Redeterminations

For SSI-related redeterminations, eligibility under a new coverage group is usually apparent. The only time it should be necessary to use the automatic redetermination aid type is when you need additional information to make a redetermination. This affects mainly:

- SSI recipients living in their own homes who lose SSI eligibility due to excess income.
- People in the 300% group who return to their own homes from a medical facility.
- People returning home from a residential care facility.

Additional MAGI-Related Case Maintenance

This section contains information on additional procedures for ongoing maintenance of MAGI-related cases, including:

Passive Renewal

Passive renewal is a system-driven process that intends to speed up the annual renewal process of the state by eliminating more worker-driven actions during the renewal period. The intent is to determine eligibility based on an individual's case information which is verified from data sources and notifies the individual of the outcome without worker interaction.

Not all cases qualify for the passive renewal process. If the case does not qualify, a pre-populated review form is generated and sent to the individual.

When the individual has a successful passive renewal, narrative records are sent to WISE to inform the worker of the outcome. The worker will need to refer to the *Notice of Action* for more information and to see the individuals who are passively reviewed.

Act on any changes that are reported during or after the passive renewal process.

Form 470-5168 or 470-5168(S), *Medicaid/Hawki Review* will be generated to households that did not meet the criteria for passive renewal or households who were not successfully passively renewed.

Passive renewal will not occur for more than three consecutive years. The issuance of a pre-populated review form will begin a new three year period.

Review Process

Legal reference: 42 CFR 435.916, 441 IAC 76.14

A review of eligibility for MAGI-related Medicaid households will be conducted once every 12 months and no more frequently. Except for individuals who are passively renewed, a pre-populated form 470-5168 or 470-5168(S) will be generated and mailed. The client will have at least 30 days from the date the form is mailed to complete necessary information, sign, and return the completed review form.

Requirements for a Complete Report

Legal reference: 441 IAC 75 (Rules in Process)

For a report to be considered complete:

- All questions must be answered.
  - Questions with a "yes or no" response must have either "yes" or "no" marked.
  - If the answer is "yes," all requested information must be completed.
  - The question is considered answered if the member does not answer on the form but sends verification of the information.
- The member must sign the form. See 8-B, *Who Must Sign the Application*.
  - When both parents or a parent and stepparent are in the home, **either** may sign for the household, even if temporarily absent.
  - Forms that are signed and then faxed or sent electronically, such as scanned and e-mailed, do not have to be resigned. A faxed report shall be considered an original report.
- All nonexempt income must be verified. EXCEPTION: Members do not need to verify prorated or annualized income that remains unchanged, as long as you and the member have established a set schedule for verifying the income.

Procedure: Verification of earned income does not always mean that the household has submitted every pay stub. If a pay stub is missing but you can calculate the gross income from the missing pay stub by using the year-to-date figures on the pay stubs submitted, the earned income is verified.

Changes reported on a report form in the sections "Other Changes" and "Expected Changes" do not have to include verification for the report form to be complete. Give the household ten calendar days to provide any needed verification.

Inform self-employed people that income and expense records must be supplied at the time of the annual review. This is a requirement for the report to be considered complete.

Send a request for information to obtain any information that was not provided.

Allow the client ten calendar days to provide any additional records. If the records are still not provided, cancel Medicaid for failure to cooperate in providing information needed to establish eligibility.

If the requested information is returned within 14 calendar days and eligibility is determined, reinstate the case. See Reinstatement earlier in this chapter for more information. Also see Grace Period.

MAGI-Related Eligibility Reviews

Legal reference: 42 CFR 435.916, 441 IAC 76.14(249A)

Policy: Review each MAGI-related case at least every 12 months. Interviews are not required. Children approved for Mothers and Children through express-lane eligibility will not be reviewed for Medicaid eligibility under express-lane procedures.

Procedure: Follow standard Medicaid eligibility review procedures for children approved through express-lane eligibility. See 8-F, *Express-Lane Eligibility For MAC*.

Supply a *Voter Registration* form at the time of review.

Voter Registration Procedures

Legal reference: National Voter Registration Act of 1993, Iowa Code 48A.19, 721 IAC Ch. 23

Policy: The voter registration form and the declination form shall be given to every person who receives an application, recertification, or review form for medical assistance, or who reports an address change.

Procedure: The *Voter Registration* form is given to clients at the time of the annual review.

When a client moves, ask if the client would like to register to vote at the new address. If yes, mail or give the client the *Voter Registration* form. No follow-up is necessary to track the return of the *Voter Registration* form.

When a client returns a completed *Voter Registration* form, keep the declination section and return the voter registration information section to the member. Follow your local procedure for handling the form after completion.

When the member returns an incomplete *Voter Registration* form, contact the member to get a completed form. If the member chooses not to check "yes" or "no," leave the section blank and accept that the member has chosen not to register to vote. If the member chooses not to sign the form, print the member's name and the date where indicated, and initial the form.

If the member requests help with registering to vote, be careful not to influence the member's voter registration options in any way.

See 6-Appendix for office procedures regarding processing the forms.

Adding a New Member to an Existing MAGI-Related Case

Legal reference: 441 IAC 76.12(249A)

A new application is not required to add a person to an **existing** MAGI-related eligible group. This includes:

- New household members.
- Other caretakers.
- Newborn children of Medicaid-eligible mothers.
- Ineligible household members

1. Ms. C's two children are receiving MAC. Ms. C is having some medical problems and has asked that she be added to the Medicaid case. Because there is no decrease in income, a paper application is required to determine eligibility under Medically Needy.
2. Same as Example 1 above, except that Ms. C's income has decreased. She calls her worker to request Medicaid. Due to the decrease in income, Ms. C is determined eligible for MAGI-related Medicaid along with her children. No paper application is necessary, because Ms. C is being added to an existing MAGI-related household. The application date is the date she requested Medicaid.

Because a paper application is not needed to add a person to an existing case, it is especially important to document contacts with the client. Detailed case record documentation is crucial to provide pertinent information that would substantiate your actions in the event of a Quality Control (QC) review or an appeal.

There is a difference between an **inquiry** and a **report** as far as what you do with the information:

- An **inquiry** occurs when the client contacts you to find out about the impact on the client's case if another person should join the household, but the client is not sure if or when the person may actually join.

  In this situation, give the client the necessary information, and remind the client to contact you within ten days of when the change occurs or if possible, a week before the change is expected to occur. Document the client contact and your response in the case record. Do not issue a *Notice of Decision* (NOD).

- A **report** occurs when the client (or the client's authorized representative) contacts you with an approximate or specific date that the person is expected to join the household. (See 8-F, *Newborn Children of Medicaid-Eligible Mothers* for information on adding newborns.)

NOTE: A parent returning to the home may not be added to the eligible group if the parent was previously sanctioned and the sanction has not been cured. See Other Changes in the Household for more information.

The following sections give more information on:

- Acting on a client's report of future changes.
- Establishing the date of application and eligibility.
- Determining the income of people added.

Acting on a Client's Report of a Future Change

When a client has reported to you that a new person will be joining the household at some time in the future, the client still has a responsibility to timely report when the person actually joins the household.

Contact the client in writing within one or two days after the person was expected to enter the household. Ask for updated information about the anticipated change and any needed information about the person. The client has ten calendar days to provide the information.

If the client reports that the person will be joining the household **within 30 days** of the report, and you receive the information by the due date you gave the client, process the application to add the person.

If you do **not** receive the information by the due date, cancel the existing MAGI-related case for failure to provide the information and deny the application to add a person to the household. Issue timely notice. Reinstate the case if the information is received before the effective date of cancellation. The date you receive the information is the new date of application to add the person.

If the client reports that the person will **not** be joining the household within 30 days of the report, issue a *Notice of Action* denying the application to add the person. Follow up with the client at the time the person was expected to enter the household, as described above. Remember to document your contacts with the client.

Establishing the Date of Application and Eligibility

Legal reference: 441 IAC 76.12(249A)

The date of application and the effective date of eligibility depend upon the client's situation.

The date of application to add a new person to an existing eligible group is usually the date the household reports the new person in the home. However, circumstances of the client's situation may affect the date of application.

When the household requests to add a new person to the eligible group and that person meets eligibility requirements, the effective date is the first day of the month in which the request is made.

Person Being Added	Date of Application	Effective Date of Eligibility
Household member who is in the home	Date of report.	Add the person effective as of the first day of the month in which eligibility is established.
	1. On May 4, Mrs. A reports that Mr. A, the father of her children, returned home on May 3. The date of application to add Mr. A is May 4. The effective date of eligibility is May 1. 2. On May 5, Ms. B reports that she got married to Mr. C on April 2. Mr. C is not the father of the child. On May 5, Mrs. C (formerly Ms. B) requests to add Mr. C to her case. The date of application is May 5. The effective date is May 1.	
Person who will join the household (anticipated)	Date of report.	No earlier than the first day of the month in which the person enters the household or the first day of the month in which entry is reported, whichever is later.
	Ms. D and her child receive MAGI-related Medicaid. On May 20, she reports that another child will come to live with her within the next couple of weeks. On June 1, she reports that the child actually returned on May 25. The child is added to the eligible group May 1.	
Person who lost their Medicaid eligibility because they failed to cooperate	Date the person indicates willingness to cooperate (e.g., cooperate with Third Party Liability or HIPP).	No earlier than the first day of the month in which the person indicates willingness to cooperate, which is the month of application. Do not take action to add the person until cooperation has actually occurred.
Person previously sanctioned due to failure to cooperate with CSRU	Date the person indicates willingness to cooperate.	No earlier than the first day of the month in which the person indicates willingness to cooperate. Contact CSRU for this date if the client does not contact you directly. Do not take action to add the person until cooperation has actually occurred per CSRU.
	Ms. G has not received Medicaid for several months because she failed to cooperate with CSRU. On May 10, she contacts her worker to indicate her willingness to cooperate with CSRU. On June 2, CSRU notifies IM that Ms. G has cooperated. She is approved for Medicaid effective May 1.	

Person Being Added	Date of Application	Effective Date of Eligibility
Person ineligible for failure to provide a social security number or proof of application	Date the number or proof of application is provided.	No earlier than the first day of the month in which the number or proof of application is provided.
	Ms. T and her two children receive MAGI-related Medicaid. A third child is ineligible due to lack of a social security number. On May 5, Ms. T provides proof of application for the child's number. The child is approved for Medicaid effective May 1.	

When the household fails to timely report a new person in the home, the date of application to add the person to the eligible group is still the date of report. In addition, determine the affect of the person's presence on eligibility as of the date the person entered the home.

Determining the Income of People Added

Legal reference: 441 IAC 75 (Rules in Process)

The income of people added to the eligible group is counted prospectively. See Budgeting for Ongoing Eligibility for MAGI-Related Households in this chapter and also 8-E, *MAGI-Related Budgeting Procedures for Determining Financial Eligibility* for more information.

When the person being added was a Medicaid member for the immediately preceding month, obtain a new self-attested income. Do not use the previous self-attested income for months before the person is added to the existing household.

Mrs. A receives FMAP for herself and two children. They have no income. On May 2, Mr. A, who had been a Medicaid member in another household in April, returns to the home. Mrs. A reports his return on May 5.

Although Mr. A's income was projected at $300 per month in the other household, his new self-attended income is $250 per month. The new self-attested income is expected to continue.

The $250 per month for Mr. A is entered into the system and used when checking electronic date sources.

Other Changes In the Household

The following sections contain more information on what to do when:

- A parent returns but is not added to the eligible group.
- A person on an active case becomes ineligible.
- A child goes into foster care.

Returning Parent Not Eligible for Medicaid

Legal reference: 441 IAC 75 (Rules in Process)

Count the income of a returning parent who is not eligible for Medicaid (e.g., a sanctioned parent or an ineligible adult alien) when determining eligibility unless it is specifically excluded or an allowable expense. Also count the returning parent in the household size. Project income of the returning parent.

See 8-E for *Projecting Future Income*. See Determining the Income of People Added when the returning parent is added to the MAGI-related Medicaid household.

Person Becomes Ineligible for Medicaid

Legal reference: 441 IAC 75 (Rules in Process)

If a Medicaid eligible person is determined to be ineligible for Medicaid, cancel the person's Medicaid effective the first of the following month allowing a 10-day notice.

Household size will be determined according to the tax filing status.

If the person is a parent of a child in the household and the parent continues to reside with the household, the parent continues to be counted in the household size. If the person is not a parent of a child in the household, the person may continue to be counted in the household size, based on tax filing status.

1. Child A leaves the household and is removed effective January 1. Child A's unearned income of $40 per month is not counted when determining eligibility for the remaining members of the household beginning with the month of January.
2. Mr. and Mrs. D receive Medicaid under MAGI-related for themselves and their two children. Mr. D has failed to cooperate with Third Party liability. The worker is notified and Mr. D's Medicaid is canceled effective the first of the next month, allowing a ten-day notice.

   Although Mr. D is sanctioned, the household remains a four-member group and Mr. D's income is used in determining eligibility for Mrs. D and the children.

3. Mr. and Mrs. Q receive Medicaid under MAGI-related for themselves and their two children, Bob, age 12 and Gary, age 17. Gary is not in school and has been employed for quite some time. Mrs. Q reports that Gary lost his job. The worker instructs Gary to apply for Unemployment benefits. Gary refuses to apply.
   Gary's Medicaid is canceled effective the first of the next month, allowing a ten-day notice. The household size remains the same. Any income Gary receives would be counted in determining eligibility for Mr. and Mrs. Q and Bob.

Child Goes into Foster Care

Legal reference: 441 IAC 76 (Rules in Process)

When a child leaves the home to enter foster care, remove the child's needs from the eligible group effective the first day of the following month. System requirements may delay the effective date until the first day of the second month after the month in which the child left the home.

However, if the child returns to the home before the effective date of cancellation, reinstate the child or case without a new application.

When a child leaves the home to enter foster care, but returns to the household in the same month and has not yet been canceled from the case, do not remove the child from the household.

1. Mrs. A receives Medicaid under MAGI-related for herself and one child. The child is placed in foster care July 2. Notice is issued to cancel the child from the case effective August 1, and eligibility for Mrs. A is redetermined under a MAGI-related Medicaid coverage group.

   The worker establishes a foster care Medicaid case for the child with an effective date of August 1. On July 19, the child returns to the home. The foster care case is canceled and the child is reinstated on Mrs. A's case.

2. Mrs. B receives Medicaid under MAGI-related for herself and one child. The child is placed in foster care July 25. Since it is too late to cancel for August, the child is canceled effective September 1. Eligibility for Mrs. B is redetermined under a MAGI-related Medicaid coverage group effective September 1.

   The worker establishes a foster care Medicaid case for the child with an effective date of September 1. The child returns to the home August 4. The foster care case is canceled and the child is reinstated on Mrs. B's case.

3. Mrs. C receives Medicaid under MAGI-related for herself and one child. The child is placed in foster care July 17. The child is canceled effective August 1. Eligibility for Mrs. C is redetermined under a MAGI-related Medicaid coverage group effective August 1.

   The child returns to the home August 8. An automatic redetermination of eligibility is completed for the child when leaving foster care. The child is reinstated to Mrs. C's case effective September 1.

Budgeting For Ongoing Eligibility For MAGI-Related Households

Legal reference: 441 IAC 75 (Rules in Process)

When a change in income is reported, act on it regardless of whether the change was required to be reported or not. First, determine if the change being reported is indicative of future income.

If the change is not indicative of future income, document in the case that the change was reported but a new projection of income was not completed because the change is not indicative of future income.

If the change is indicative of future income, request a new self-attestation from the client. Accept the client's statement as to whether the change is indicative of future income, unless questionable.

1. Mr. H receives Medicaid for himself and his son under MAGI-related. On November 20, Mr. H reports that he will be working ten additional hours per week in December. He states that the additional hours will only occur in December, due to the holidays, and that he cannot anticipate working any overtime in the future.

   The worker documents the reported change in Mr. H's case file. The worker further documents that the reported change is a one-time change and is not representative of future income. Verification of the change is not requested, and a new projection of income is not completed.

2. Ms. I receives Medicaid for her children under MAC. She does not receive Medicaid for herself. On August 27, Ms. I reports that she began working the evening shift on August 25. The evening shift pays an additional $.50 per hour. Ms. I states that her employer was unclear as to whether this change was temporary or permanent.

   The worker requests verification from the employer, which is received September 3. It indicates that Ms. I will be working the evening shift only until September 15, at which time she will return to her usual shift and her usual hourly rate. The worker documents this in the case file and does not complete a new projection of income, since the change is not representative of future income.

3. Same as Example 2, except that the verification from the employer indicates that Ms. I will be working the evening shift until at least November 1 and perhaps longer. The worker requests a new self-attestation of income based on the increase in Ms. I's hourly rate. The new self-attested income is used beginning with the month of October.

Income Changes Reported on Review Forms from Other Programs

Some MAGI-related Medicaid members may also receive benefits from other programs. The other programs' reporting requirements may affect Medicaid eligibility.

When income reported on a review form differs in the amount that was projected for MAGI-related Medicaid, act on the new amounts as a reported change if it is indicative of future income.

When the change is **only** due to a third or fifth check, do not enter the income for MAGI-related Medicaid. Allow the income used for eligibility the previous month to roll forward.

1. Mr. and Mrs. J apply for Medicaid and SNAP on May 3. They request SNAP for the entire family and Medicaid for just their two children. The application is approved for both programs. Mr. J's earnings are the only income for the family. At application, the projection was $1,500 gross per month.

   At recertification for SNAP, the J family reports that Mr. J now has monthly gross earned income of $1,700. The worker enters the same income into the computer system for both programs.

2. Mrs. K and her two children receive Medicaid under MAGI-related in addition to FIP and SNAP. Mrs. K has earned income of $515 bi-weekly. $1,030 per month is entered into the computer system for all three programs.

   At the next FIP review, Mrs. K reports income of $1,545 due to a third paycheck. Since this income is not a good indicator of future income, the income of $1,030 is allowed to roll forward for MAGI-related Medicaid.

   At the next FIP review, Mrs. K reports an increase in income to $530 bi-weekly. Since this income did not include a third check and is indicative of future income, $1,060 is entered into the computer system for MAGI-related Medicaid.

Acting on Changes

Legal reference: 42 CFR 435.911(b) & (c), 435.916(1) and (2), 435.930, 435.948, 435.952, 441 IAC 76 (Rules in Process), and 75 (Rules in Process)

Act on the change as soon as possible, but no later than ten working days from the date you become aware of the change, unless using the automatic redetermination policy for information received and verified after the 10th of the month.

Complete an automatic redetermination when changes are reported or become known. See Automatic Redetermination. Verification requirements apply before acting on changes. See 8-A, *Notification*, for timely notice requirements.

When a probable change affects eligibility, act on the change if you have all information you need to establish eligibility, and the best information available indicates that the change will actually take place as reported.

Change Reported	Effect on Eligibility	Effective Date	Do a Recoupment or Adjustment?
Timely reporting for members is within ten days after the change occurred.			
Timely	Positive	The month following the month the change is **reported**. Timely notice is not required.	No, if the Department acted timely.
	Negative	The month following the month change is **reported**. Timely notice is required.	No, if the Department acted timely.
Timely reporting for members is within ten days after the change occurred.			
Not Timely (or not at all)	Positive	The month following the month the change is **reported** or became known. (Do not adjust benefits back to when the change occurred.)	No, if the Department acted timely.
	Negative	The month following the month the change **occurred**, regardless of when the change occurred or became known.	Yes, if benefits were received incorrectly. Redetermine eligibility beginning with the month following the month of the change..
Not Required to be Reported Until Annual Review	Positive	The month following the month the change is reported.	No, if the Department acted timely.
	Negative	The month following a timely notice.	No, if the Department acted timely.

NOTES:

- If the change is adding someone to the eligible group or results in an application, follow application policies regarding effective dates. See 8-B, *Application Processing*.
- If the change results in cancellation from the current coverage group, follow the automatic redetermination policy on whether the information was received by or after the 10th of the month. See Automatic Redetermination.

- If the household would have been eligible under the Medically Needy program, determine the spenddown amount for each certification period. See 8-J, *Income Policies*.
- See 8-A, *When Timely Notice Is Not Required*, for more information on when timely notice is not required.

1. **Positive Change Timely Reported:**

   Mr. and Mrs. X receive Medicaid under MAGI-related for themselves and their children. Mr. X is the only one with income. Mrs. X reports on August 3 that Mr. X has left the home July 25.

   Although the loss of a household member is negative, this change is positive because Mr. X is the only one with income. Since this change was reported timely in August, Mr. X is canceled effective September 1 and his income is no longer used for eligibility purposes. No claim is established for August.

   Had this same change been reported untimely, a claim for Mr. X would have been completed for the month of August and any months thereafter, since the change occurred in July and was not reported timely.

2. **Negative Change Timely Reported:**

   Mr. B receives Medicaid for himself and his children under MAGI-related. On July 23, he timely reports beginning unearned income that will make him and his children only conditionally eligible under Medically Needy (MN) with a spenddown. He provides verification timely on August 5.

   The effect of the change on eligibility is adverse and requires a timely notice. The effective date of the change is September 1. The MN certification period is September/October. No claim is established for August, since the change was reported timely.

   The children remain continuously eligible under MAGI-related Medicaid until the annual review. If the children are no longer eligible at the annual review due to income, they will be considered for Hawki.

3. **Negative Change Timely Reported:**

   Ms. G and her children receive Medicaid under MAGI-related. Ms. G starts a new job and receives her first paycheck on May 23. Ms. G reports the change timely by June 2. The worker requests verification and it is returned timely by June 15.

   The effective date of the change is July 1 if the worker acts on the change by timely notice in June. The effective date of the change is August 1 if the worker acts on the change after timely notice in June but before timely notice in July.

   No claim is established in either situation because the verification was received after August 10.

   If Ms. G and her children go over income for FMAP and are otherwise eligible for transitional Medicaid (TM), TM begins the first of the month after MAGI-related ends.

   The children remain continuously eligible until the annual review. If the children are no longer eligible at the annual review due to income, and TM does not apply, they are considered for Hawki.

4. **Positive Change Not Timely Reported but Required to Be Reported:**

   Mr. F's children receive Medicaid under MAGI-related. In June, Mr. F reports that he got a new job the previous December with a new company and had a decrease in income.

   Due to this change, Mr. F is eligible for Medicaid under MAGI-related. The effective date of the income change is July 1, since he reported the job in June.

   The worker explains to Mr. F that it appears he would now be eligible for Medicaid. Mr. F states he has health insurance and doesn't want Medicaid.

   In August, Mr. F calls his worker and requests Medicaid. He says he has medical bills that his health insurance didn't cover for the past six months.

   Mr. F's request for Medicaid is treated as an application. The worker explores whether Mr. F is eligible for August and ongoing. Mr. F is not eligible for Medicaid for February through July because this application for Medicaid was in August.

5. **Negative Change Not Timely Reported but Required to Be Reported:**

   Ms. C and her children receive Medicaid under MAGI-related. On September 3, it is discovered that Ms. C failed to timely report beginning earned income. Ms. C received her first paycheck on July 23. Since the change was not reported timely, the effective date of the change is August 1. The worker redetermines Medicaid eligibility for August, September, and ongoing.

   If a change in eligibility occurs, a timely notice must be issued. If appropriate, a claim is established for Ms. C.

   If eligibility is only under Medically Needy with a spenddown, the certification period is August and September.

   The children remain continuously eligible under MAGI-related Medicaid until the annual review. If they are over income for MAGI-related Medicaid at the annual review, they are considered for Hawki.

6. **Required to Be Reported:**

   Mr. G and his children are approved for Medicaid under FMAP in November. In December, Mr. G goes from part-time employment to full-time employment at the same company. Mr. G reports this to his worker the following February. The increase in income makes the family over income for FMAP.

   The worker acts on the report and the family is eligible for transitional Medicaid (TM) beginning March 1.

   It is not a negative action to change coverage from FMAP to TM since they are both full Medicaid programs. Therefore, a ten-day negative action is not sent for FMAP.

7. **Addition of Household Member Reported Timely; Cancellation and Automatic Redetermination; Information Received by 10th of Month:**

   Ms. K and her children receive Medicaid under FMAP. On April 20, Mr. K joins the household and the change is timely reported to the Department. Mr. K requests Medicaid and has unearned income. The worker requests necessary information and it is timely provided May 10.

   The unearned income makes the family over income for MAGI-related Medicaid. The children are continuously eligible until the annual review when eligibility is examined.

The worker completes an automatic redetermination to MN for the parents in May, effective June 1. An April/May MN certification period is set up for Mr. K and a June/July MN certification period is set up for Mr. And Mrs. K

8. **Addition of Household Member Reported Timely; Cancellation and Automatic Redetermination; Information Received after 10th of Month:**

   Mr. Q and his children receive Medicaid under FMAP. On April 20, Mrs. Q joins the household and the change is timely reported to the Department. Mrs. Q requests Medicaid and has unearned income. The worker requests necessary information and it is timely provided May 11.

   The unearned income makes the family over income for MAGI-related Medicaid. If time permits, the worker completes an automatic redetermination to MN for the parents in May, effective June 1. However, a redetermination **must** be completed no later than timely notice in June effective July 1. No claim is established in either situation.

   The children remain continuously eligible under MAGI-related Medicaid until the annual review. If they are over income for MAGI-related Medicaid at the annual review, they are considered for Hawki.

   Alternative Scenario: If the information is not provided by the due date, a Notice of Cancellation is sent canceling Medicaid effective June 1.

   If the information is received after timely notice in May, June benefits are reopened and a redetermination would be completed effective July 1. No claim is established.

9. **Addition of Household Member Not Reported Timely; Cancellation and Automatic Redetermination; Information Received after 10th of Month:**

   Mr. S and his children receive Medicaid under FMAP. On April 20, Mrs. S joins the household and the change is reported to the Department untimely on June 30. Mrs. S requests Medicaid and has unearned income. The worker requests necessary information and it is timely provided July 19.

   The unearned income makes the family over income for MAGI-related Medicaid. An automatic redetermination must be completed no later than August effective September 1 for Mr. and Mrs. S. If appropriate, a claim is established beginning in May for Mr. S.

   If eligibility is only under Medically Needy with a spenddown, the certification periods are May/June and July/August.

   The children remain continuously eligible under MAGI-related Medicaid until the annual review. If they are over income for MAGI-related Medicaid at the annual review, they are considered for Hawki.

   NOTE: If the annual review is due in April, May or June, continuous eligibility may not apply and an overpayment may have occurred on the children.

The effective date of a change that is either reported untimely or not reported at all, is the month following the month in which the change occurred, regardless of when in the month the change occurred and regardless of the effect the change has on eligibility.

Ms. C and her children receive Medicaid under FMAP. On September 3, it is determined that Ms. C failed to timely report beginning earned income. Ms. C received her first paycheck on July 23. The effective date of the change is August 1. The worker redetermines Medicaid eligibility for August and September and establishes recoupment, if appropriate.

The effective date of a change that was timely reported but was not acted upon depends on when the change occurred, regardless of whether the change was required to be reported or not.

1. Mr. and Mrs. D receive Medicaid under MAC for their children. Mr. and Mrs. D do not receive Medicaid. On October 18, Mrs. D timely reports beginning income. In December, it is determined that the worker failed to act on the reported change.

   The worker requests verification, which Mrs. D provides on December 10. Because the change was timely reported after October 10, the effective date of the change is December 1.

2. Same as Example 1, except that the change was timely reported October 3. Because the change was timely reported on or before October 10, the effective date of the change is November 1.

3. Ms. E receives Medicaid for herself and her son under FMAP. On May 5, she reports a permanent increase in her hourly rate, which is effective with the paycheck she will receive May 12.

   In September, it is determined that the worker failed to act on the reported change. The worker requests verification, which Ms. E provides on September 22. Even through Ms. E was not required to report the change, because it was reported, it is acted upon like any other reported change. Since the change was reported on or before May 10, the effective date of the change is November 1.

Additional Non-MAGI-Related Case Maintenance

This section contains information for Non-MAGI-related cases on:

- Eligibility review
- MEPD case maintenance
- New members in Non-MAGI-related households

Non-MAGI-Related Eligibility Reviews

Legal reference: 441 IAC 76.14(249A)

Policy: Eligibility shall be reviewed at least once every 12 months for all Non-MAGI-related members **except** when a member receives SSI or only a blind or mandatory State Supplementary Assistance payment

The member shall complete form 470-5482, 470-5482(S), 470-5482(M), or 470-5482(MS), *Medicaid/State Supp Review*, for the annual review.

Procedure: Evaluate the information on the *Medicaid/State Supp Review* to determine if the member remains eligible for Medicaid under the current coverage group. Complete a redetermination when changes are reported that result in the member no longer being eligible under the current coverage group. See Automatic Redetermination.

Comment: An interview is not required as part of the annual eligibility review process, however an individual must attend a face-to-face or telephone interview if requested to do so by the Department. Do not require an interview for cases on which only children receive Medicaid.

MEPD Case Maintenance

Legal reference: 441 IAC 75 (Rules in Process)

MEPD Reviews

Policy: Premiums for Medicaid for employed people with disabilities (MEPD) are established at a fixed monthly rate for a 12-month enrollment period. The MEPD premium may increase or decrease at the time of the eligibility review. However, the premium may increase or decrease during a 12-month enrollment period in specific situations. See Premium Change for Current or Past System Months.

Procedure: The ELIAS system issues a *Medicaid/State Supp Review*, form 470-5482 or 470-5482(S) to the member 60 days prior to the end of the premium period. After the *Medicaid/State Supp Review* is returned, process eligibility in ELIAS and issue the *Notice of Action*.

In order to have the correct premium in the system for billing for the new 12-month enrollment period, the review must be processed and the review entries made in the ELIAS system before timely notice of the twelfth month of the current 12-month enrollment period.

Review entries made by the 15th of the month will be reflected on the next monthly *MEPD Billing Statement.* A revised *MEPD Billing Statement* will be issued when the premium is changed after the 15th but before system cutoff.

Review entries made after cutoff will not update the MEPD billing system and a revised *MEPD Billing Statement* will not be issued until the next regular monthly bill. Premium changes entered in the ELIAS system after cutoff require MEPC entries to revise the premium for the next month.

Effect of Nonpayment of Premiums

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Members who are assessed premiums do not have Medicaid eligibility for a month until a premium payment is applied to that month. Although the due date of a premium payment is generally the 14th of the month for which a premium is assessed, a premium payment may be applied to a month up to three months after the due date.

In other words, to become Medicaid-eligible for a month, the client must pay the premium no later than:

- Three months after the due date of the premium, **or**
- By the premium due date for retroactive months that were initially billed with a due date three months after the month the *MEPD Billing Statement* was issued.

There is no provision to request a hardship waiver for MEPD.

Procedure: When a premium is not received by the due date, a batch will run to discontinue the MEPD case for failure to pay the premium. Standard procedures are as follows:

- When payments are recorded after the due date, an alert is issued to notify the worker to:
  - Reinstate the MEPD case when a payment is received before the effective date of cancellation.
  - Reopen the MEPD case when a payment is received in the month following the month it was due.
  - Leave the MEPD case closed when a payment is received after the month following the month when it was due. The member must file a new application to determine eligibility for MEPD.

1. Mr. B applies for MEPD on January 30. Approval entries are made on March 10 (before system cutoff). Mr. B receives an *MEPD Billing Statement* showing that::
   - The premium for January is due by June 14.
   - The premium for February is due by June 14.
   - The premium for March is due by April 14.

   Mr. B does not pay the March premium by April 14. The system cancels the case with timely notice.

   Mr. B pays all three premiums on June 10. After the payments are posted in June, the worker receives an alert saying that the payments were received. Medicaid eligibility is granted for January, February, and March because:
   - March premium was paid within three months of the billing month, and
   - January and February premiums were paid before the due date of June 14.

   It is too late to reopen the case for ongoing benefits because the March payment was received later than the month following the month it was due. Mr. B must reapply if he wants to get MEPD again.
2. Mr. Z applies for MEPD on January 5 and is approved on January 28 (after system cutoff). His first *MEPD Billing Statement* shows:
   - The premium for January is due by February 14.
   - The premium for February is due by February 14.

   Mr. Z doesn't pay the premiums by February 14. The system cancels the case with timely notice.

   Due to the MEPD reopening policy, the worker waits to complete the automatic redetermination to Medically Needy until the end of the month following the month the payment was to cover.

   Mr. Z pays both premiums on March 27. An alert is issued to the worker stating that the premiums have been paid. Mr. Z is eligible for Medicaid in January and February because the premium payments were received during the three-month period to accept payments. The MEPD case is reopened because the premium payments were applied before the last day of the month following the month they were due.

Reinstating a Case Canceled for Failure to Pay Premium

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Reinstatement is allowed when an MEPD case was canceled because a premium payment was not received by the 14th of the month it was intended to cover.

Reopening a Case Canceled for Failure to Pay Premium

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Reopening an MEPD case is allowed when the case was canceled because a premium payment was not received by the end of the month it was due. To qualify for a reopening, payment must be received by the last day of the month following the month it is to cover.

NOTE: Using the CREATE STMT entry on the MEPD STMT screen issues an *MEPD Billing Statement* that is up to date with payments and premiums assessed. The REPRINT (client or worker) a statement selection sends a duplicate copy of an *MEPD Billing Statement.* The REPRINT selection allows the choice of the statement by the date it had been issued.

Premium Change for Current or Past System Months

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Monthly MEPD premiums can be reduced for the remainder of a 12-month enrollment period due to a change in income that results in a lower premium.

Premiums should not be increased during the 12-month enrollment period due to an increase in income. Premiums may be increased only when an error has been made in the calculation and the case is being corrected. The error may be due to:

- The member underreporting the income.
- Incorrect income entries in the system, or
- How income was determined.

Decrease a Premium

Procedure: Reduce MEPD premiums effective the month following the month the lower income is reported. Send a *Notice of Action* with the new premium amount and the month the decrease is effective.

To decrease a premium that has **already been paid** for the **current** or a **past month:**

1. Make entries in the MEPC screen to decrease the premium amount. See 14-B(9), *Using MEPC*.
2. The MEPC changes will update overnight to the MEPD system, which will calculate the difference between the original, paid premium and the new, lower premium to show a credit.

3. The balance of overpaid premiums will be:
   - Applied to unpaid months, or
   - Held as a credit to be applied to future assessed premiums.

To decrease a premium for the **next calendar month:**

1. Income entries made in ELIAS before system cutoff will update the MEPD billing system. A new *MEPD Billing Statement* will be issued with the revised premium amount.
2. Income entries made in ELIAS after system cutoff will not update the MEPD billing system. A revised *MEPD Billing Statement* will not be issued until the next regular monthly bill. Changes entered in ELIAS after system cutoff require MEPC entries

1 An *MEPD Billing Statement* for a $110 premium is issued to Mrs. B on March 16. On March 23, Mrs. B reports on the *MedicalState Supp Review* form that her earned income has decreased.

On March 30, the worker makes MEPD review entries in ELIAS with the lower earned income and the unearned income. The lower income causes her premium to decrease to $80. Since the entries are made **after** March system cutoff, the MEPD billing system does **not** automatically update and issue a revised *MEPD Billing Statement* for April.

On March 31, the worker makes MEPC entries to change the premium amount for April to $80. After the premium amount updates to $80 in the MEPD billing system, a revised *MEPD Billing Statement* for $80 is issued for April.

2. An *MEPD Billing Statement* for a $53 premium is issued on March 16 to Mr. K. On March 18, Mr. K reports that he is searching for a new job and sends form 470-4856, *MEPD Intent to Return to Work*, showing he lost his job on March 10.

On March 19, the worker enters zero earned income and unearned income in ELIAS, which decreases Mr. K's premium to $29 for April. Since the change is entered before March system cutoff, the MEPD billing system is updated with the lower premium and a revised *MEPD Billing Statement* for April is automatically issued with a $29 premium.

Increase a Premium

Procedure: When an MEPD premium needs to be increased for past months, contact the member to report that the premium was incorrect and give the member the choice of either:

- Having the premium corrected to a higher amount for past months, or
- Referring the underpayment to collections.

When the member agrees to pay the higher premiums without timely notice:

1. Ask the member for a signed and dated statement giving permission to increase the premium for past months without timely notice.
2. Send a manually issued *Notice of Action* stating the corrected premium amount and the months involved.

3. Make entries in the MEPC screen to increase the premium for current or past months. See 14-B(9), *Change to MEPD Premium*. ELIAS will update ongoing months.

4. The billing system will issue a revised *MEPD Billing Statement* for the months corrected.

Refunds

Legal reference: 441 IAC 75 (Rules in Process)

Policy: When the member has paid in more than is owed, refunds are automatically issued if there are funds in the MEPD premium account and:

- The premium has been reduced to zero for two consecutive months, or
- There have been two consecutive months of inactivity on the MEPD case.

The Department will also issue a refund upon the member's request.

Procedure: To request a refund on behalf of an MEPD member, send an e-mail to DHS, SPIRS Help Desk. Include the member's name, state identification number, the amount to be refunded, and the reason for the refund. Do not tell the member to call IME Member Services, as IME staff cannot request MEPD premium refunds.

New Members in Non-MAGI-Related Households

Legal reference: 441 IAC 76.1

For Non-MAGI-related Medicaid purposes, the "household" concept and "adding a new member to a household" do not apply in the same way as for MAGI-related cases. Rather, except for eligible married couples, non-MAGI-related cases are based on an individual's eligibility.

Non-MAGI-related Medicaid eligibility for unmarried persons is determined individually rather than as a "household." Therefore, a new member may not be added to an unmarried person's Non-MAGI-related Medicaid case. **NOTE:** A newborn child of a Non-MAGI-related Medicaid-eligible mother may be eligible on the newborn's own case under the coverage group in which the mother received Medicaid at the time of birth.

Non-MAGI-related eligibility for married couples in which both spouses are aged, blind, or disabled is determined together (as a couple) when both spouses are receiving or have applied for Non-MAGI-related Medicaid. When two Non-MAGI-related members marry, determine their ongoing eligibility as a couple in the month following the month of marriage.

When a Non-MAGI-related Medicaid member marries a person who is aged, blind, or disabled but is not receiving Medicaid, the spouse must file an application to begin receiving Non-MAGI-related Medicaid.

When a Non-MAGI-related member is living with a spouse who turns 65 or becomes blind or disabled, the spouse must file an application to begin receiving Non-MAGI-related Medicaid.

Treat an aged, blind, or disabled spouse who has not applied for Medicaid as an ineligible spouse when determining the member's ongoing Medicaid eligibility (i.e., apply income deeming policies).

When a Non-MAGI-related member marries and the spouse is not Medicaid-eligible, determine the effect on the Medicaid member for the next month. If the new spouse applies for Medicaid when the other spouse is already eligible, determine their eligibility as a couple and, when they are eligible, grant Medicaid for the month of application to the spouse who has applied. Then, put the couple together the next month.

When parents or stepparents are also in the home, treat them as considered persons.

Fraud and Overuse of Medicaid Services

Legal reference: 441 IAC 79.2

If you become aware of a situation where it appears that Medicaid services are being overused or excessive or inappropriate Medicaid services are being provided, email the details to FWAReports@dhs.state.ia.us.

If you become aware of any situation that indicates potential fraud by a medical provider, report the circumstances to the IME Program Integrity Unit at 1-877-446-3787 or in Des Moines at 515-256-4615. Examples of such situations include:

- Billing for services, supplies, or equipment that were not rendered to or used for members.
- Billing for supplies or equipment that is clearly unsuitable for the member's needs or so lacking in quality or sufficiency for the purpose as to be virtually worthless.
- Flagrant and persistent overutilization of medical or paramedical services with little or no regard for results, the member's ailment, conditions, medical needs, or the doctor's orders.
- Claiming of costs for noncovered or nonchargeable services, supplies, or equipment disguised as covered items.
- Material misrepresentations of dates and descriptions of services rendered or of the identity of the member or the person who rendered the services.
- Duplicate billing that appears to be deliberate, e.g., billing twice for the same services.
- Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the Medicaid program using various devices to siphon off or conceal illegal payments.
- Charging to the Medicaid program by subterfuge costs that were not incurred or that were attributable to nonprogram activities, other enterprises, or personal expenses.

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8, Chapter H

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Foster Care, Adoption, and Guardianship Subsidy

Page

Overview

This chapter explains Medicaid coverage for children in a foster care, presubsidy, subsidized adoption or subsidized guardianship placement. Medicaid eligibility determinations for these children differ because:

- The service unit often initiates the application instead of the family.
- An additional federal coverage group is available for these children through the Foster Care and Adoption Assistance Act (Title IV-E of the Social Security Act). See 13-B, *Determining Title IV-E Eligibility*.
- Each child is considered as a household size of one and all income is disregarded in the Medicaid determination.
- With one exception, state rules guarantee medical coverage for children for whom Iowa has financial responsibility, even if the child does not meet eligibility requirements for a federally funded coverage group.

Medicaid benefits available to the children are the same, regardless of coverage group.

Establishing benefits for children who are in a foster care, presubsidy, subsidized adoption, or subsidized guardianship placement is a cooperative effort between the service worker and the income maintenance (IM) worker.

- The IM worker is responsible for determining the proper maintenance funding source, administrative cost source, and Medicaid coverage group.
- The service worker (or the juvenile court officer) provides the information necessary to make those determinations, calculates the amount of the maintenance payment, and makes the child support referral.

This chapter addresses program policies and procedures determining the appropriate medical coverage group for children in foster care, subsidized adoption, or subsidized guardianship. This first section of the chapter gives definitions, a summary of IM and service duties, a summary of the applicable Medicaid coverage groups, and application processing policies and procedures for all types of placements.

The requirements specific to foster care, adoption, and guardianship placements are explained in the sections that follow. Case maintenance procedures common to all types of placements are described in the final section.

Definitions

Legal reference: 441 IAC 156.1(234), 201.2(600), 202.1(234), and 204; Section 473(b)(3) of the Social Security Act

"FBU" means "family budget unit." The FBU is a two-digit portion of the Automated Benefit Calculation (ABC) system case number that follows the serial number. It is used to distinguish certain kinds of cases. FBUs 18 and 19 are used only for Medicaid cases related to foster care, subsidized adoption, subsidized guardianship, or psychiatric medical institutions for children.

"Financial responsibility" means that the Department is legally required to pay a foster care maintenance payment or has an adoption assistance agreement or a court-approved subsidized guardianship agreement for the child. Financial responsibility can be imposed on the Department through juvenile court action, or assumed through a voluntary agreement with the child's parents, adoptive parents, or legal guardian (or with the child, if aged 18 or over).

"Foster care placement" means 24-hour substitute care provided by a licensed foster care provider to an eligible child for whom the Department has financial responsibility. Foster care placements include, but are not limited to, foster family homes, group homes, shelter care facilities, group care facilities, supervised apartment living, and psychiatric medical institutions for children. (See Placement Types for more information.)

"Maintenance payment" means a monthly payment to help cover the basic expenses of an eligible child, including the cost of food, shelter, clothing, transportation, and recreation.

"Presubsidy placement" means placement in the home of an adoptive family before the adoption is finalized, with the child receiving assistance through a maintenance subsidy payment, a special services subsidy payment, or both, based on the special needs of the child. The presubsidy payment is a foster care payment.

"Subsidized adoption placement" means a permanent placement for a special needs child who legally becomes a member of the adoptive family, with the child receiving assistance under an adoption assistance agreement. This assistance may include a maintenance subsidy payment, a special services subsidy payment, or both. A child in a subsidized adoption placement is eligible for Medicaid under the terms of their adoption assistance agreement even if the child is not receiving an adoption subsidy maintenance payment.

"Subsidized guardianship placement" means a court-approved placement of an eligible child with a guardian who is assisted financially through a maintenance subsidy payment. A child in a subsidized guardianship placement is eligible for Medicaid under the terms of their guardianship assistance agreement even if the child is not receiving a guardianship subsidy maintenance payment.

IM Responsibilities

The IM worker for a child in a foster care, presubsidy, subsidized adoption, or subsidized guardianship placement is responsible for:

- Determining Medicaid eligibility. Grant state-only medical assistance if there is no eligibility for any other coverage group. For non-IV-E subsidized guardianship cases, see the EXCEPTION under State-Only Medical Assistance.
- Opening a Medicaid case on the ABC system, using an FBU of 19 in the case number. EXCEPTIONS: Use an FBU of 18 for:
  - An Iowa child who is placed out of state but remains on Iowa Medicaid.
  - A child who is placed in Iowa from another state and qualifies for Iowa Medicaid.

- Linking the ABC Medicaid case to the referral the service worker has made to the Iowa Collections and Recovery (ICAR) system to facilitate support recovery.
- Acting on changes reported by the service worker and others.
- Completing Medicaid eligibility reviews.

For additional information about responsibilities related to children in foster care, presubsidy, subsidized adoption, or subsidized guardianship placements see 13-B, *Determining Title IV-E Eligibility.*

Service Responsibilities

The service worker for a child in a foster care, presubsidy, subsidized adoption, or subsidized guardianship placement is responsible for:

- Sending a Medicaid application to the parents of the child or to the person responsible for the child with a request to return it within ten calendar days. (A new application is not required when the child is already receiving Medicaid or is IV-E-eligible. For more information, see 13-B, *Determining Title Iv-E Eligibility*.)
- Completing the Medicaid application if the parents fail to cooperate and there is no other person representing the child. (Not applicable in subsidized guardianship cases.)
- Forwarding the application to the appropriate IM worker within two working days of receipt.
- Reporting changes to the IM worker (changes in placement, maintenance payment, etc.).
- Making FACS entries as needed to correctly reflect the child's circumstances. This includes opening a new FACS case when one FACS case is closed (e.g. when a child terminates foster care but begins subsidized guardianship or subsidized adoption) to ensure there is no interruption in medical coverage for the child.
- Assisting the IM worker with reviews of eligibility when necessary.
- Handling EPSDT activities. (Not applicable in subsidized guardianship cases.)
- Handling payments for court-ordered care and treatment and for services received that are not Medicaid-covered services or that were delivered when the child was not Medicaid-eligible.
- Notifying the IM worker of a child leaving a foster care, subsidized adoption, or subsidized guardianship placement no later than ten calendar days after the exit.

See 18-C(1), *Handoff to Case Management*, 18-F(2), *Subsidized Guardianship*, and 18-F(1), *Permanent Placement Procedures*, for more information on service responsibilities. Additional detail on service responsibilities specific to subsidized guardianship placement is covered later in this chapter.

Categories of Medicaid Eligibility

Legal reference: 441 IAC 75 (Rules in Process)

The Department receives federal financial participation for Medicaid for children in these coverage groups:

- Supplemental Security Income (SSI)
- Title IV-E (meets requirements of Title IV-E of the Social Security Act)
- Child Medical Assistance Program (CMAP)
- Medically Needy

Determining Medicaid eligibility for a child in a foster care, presubsidy, subsidized adoption, or subsidized guardianship placement is the same as for other children, with the following exceptions:

- Each child is considered as a household size of one, and all income is disregarded in the Medicaid determination.
- If a child for whom Iowa has financial responsibility qualifies for no federally funded coverage group, the child is eligible for state-only medical assistance. For non-IV-E subsidized guardianship cases, see the EXCEPTION under State-Only Medical Assistance.

SSI

Legal reference: 20 CFR 416.1160, 416.1165, 441 IAC 75 (Rules in Process)

Medicaid is provided to children in foster care, presubsidy, subsidized adoption, or subsidized guardianship placements who receive or are eligible for benefits through the Supplemental Security Income (SSI) program. Children who are both IV-E-eligible and receive SSI shall have their Medicaid provided under the SSI coverage group.

Consider each child as a household size of one.

Title IV-E

Legal reference: P.L. 96-272; 42 CFR 435.145; Section 473(b)(3) of the Social Security Act as amended by P.L. 110-351; 441 IAC 75 (Rules in Process)

Medicaid must be provided to children for whom any of the following is provided under Title IV-E of the Social Security Act:

- Foster care maintenance payments.
- Guardianship assistance (regardless of whether or not the agreement provides for guardianship subsidy maintenance payments).
- Adoption assistance (regardless of whether or not the agreement provides for adoption subsidy maintenance payments).

IV-E Medicaid eligibility exists when all IV-E service, maintenance, and financial requirements are met according to 13-B, *Determining Title IV-E Eligibility*.

Consider each child as a household size of one.

Make IV-E-eligible children eligible for Medicaid automatically without requiring a separate application or annual Medicaid review. However, an application or review form may be requested to gather information needed to determine whether the child is IV-E-eligible and to facilitate the child's Medicaid enrollment.

When an Iowa IV-E-eligible child is placed in or moves to another state, the state where the child is living provides Medicaid coverage, even though Iowa retains financial responsibility for the child.

When a child is placed in or moves to Iowa, the placing state determines the child's eligibility for IV-E maintenance payments or if an adoption or guardianship assistance agreement is in effect for a IV-E-eligible child.

Iowa will provide Medicaid to IV-E-eligible children living in Iowa. If a child receives IV-E foster care maintenance payments, or has a IV-E adoption assistance or guardianship agreement in effect from another state, the child is Medicaid-eligible in Iowa without an application, review, or further verification.

CMAP

Legal reference: 42 CFR 435.222; 441 IAC 75 (Rules in Process)

Medicaid is available through the Child Medical Assistance Program (CMAP) to children in foster care, presubsidy, or subsidized adoption for whom Iowa has financial responsibility and who:

- Are not eligible for SSI or IV-E and
- Are under age 21.

Consider each child as a household size of one and disregard all income.

Refer also to Medicaid Reciprocity for Subsidized Adoption.

> Karen, age 10, and her sister, Katrina, age 12, are placed together in foster care. The children do not meet SSI or IV-E criteria. CMAP eligibility is granted separately for each child using a household size of one.

Medically Needy

Legal reference: 441 IAC 75 (Rules in Process), 42 CFR 435.308(b)

Medicaid is available under the Medically Needy program to children in subsidized guardianship for whom Iowa has financial responsibility and who:

- Are not eligible for SSI or IV-E and
- Are under age 21.

Consider each child as a household size of one and disregard all income.

Medically Needy will not pay for facility care. If the subsidized guardianship child resides in a facility (ICF-ID, PMIC, or any other institutional care), the child will need to qualify for a different federally funded coverage group that considers the income of the MAGI household or meets the requirements of the 300% group which has a 30-day stay requirement. Refer to 8-D, *People in a Medical Institution Within the 300% Income Limit*.

> John is a child living in a private home pursuant to a court-approved subsidized guardianship agreement. John is not SSI-eligible and is not IV-E eligible. His Medicaid eligibility is established through the Medically Needy program as a household of one and any income is disregarded.

State-Only Medical Assistance

Legal reference: 441 IAC 75 (Rules in Process)

If a child in a foster care, presubsidy, subsidized adoption, or subsidized guardianship placement for whom Iowa has financial responsibility does not qualify for federally funded Medicaid, state-only medical assistance shall be provided.

Consider each child as a household size of one and disregard all income.

EXCEPTIONS: Eligibility for state-only medical assistance does not exist in non-IV-E subsidized guardianship cases when:

- A guardian fails to provide necessary information or comply with procedural requirements; or
- The subsidized guardianship child resides in a facility (ICF-ID, PMIC, or any other institutional care).

NOTE: A child who is placed in Iowa from another state or who is receiving guardianship subsidy payment from another state **is not** eligible under this coverage group. This child's medical assistance must be provided by the other state if the child is not eligible for federally funded Medicaid.

Application Processing

Legal reference: 441 IAC 76.1(249A), 76.2(249A), 76 (Rules in Process), 76.16(3), 76.17

Procedures related to application processing depend on whether the child is IV-E eligible and whether the child is already receiving Medicaid when the foster care, subsidized adoption, or subsidized guardianship begins. Refer to 8-F, *Continuous Eligibility for Children*, to determine if continuous eligibility applies.

When the child is receiving Medicaid at the time that foster care, subsidized adoption, or subsidized guardianship placement begins, contact the IM worker responsible for the case where the child is currently eligible to have the child removed from the existing case. Obtain from the existing case file a copy of the most recent application or review form and any other documents (e.g. SDX for an SSI-eligible child) needed to establish eligibility.

IV-E-eligible children must be made automatically eligible for Medicaid without requiring a separate application. However, an application may be requested to gather information needed to determine whether the child is IV-E eligible and to facilitate the child's Medicaid enrollment.

Request an *Application for Foster Care and Subsidized Adoption Medicaid*, form 470-5535 or 470-5535(S), for a foster child or subsidized adoption child who is not receiving Medicaid at the time of placement. Use the *Application for Health Coverage and Help Paying Costs*, forms 470-5170 or 470-5170(S) for children in subsidized guardianship. The child's parents, guardian, or someone acting on the child's behalf should complete the application.

NOTE: Foster care-related Medicaid cannot begin until the month of foster care placement. Send a referral to the local office to determine coverage for any month(s) a child needs coverage prior to placement in a foster care setting (e.g. a child, including but not limited to a newborn or a deemed newborn, who is hospitalized prior to the start of the foster care placement). Send this referral to the same email address used for continuous eligibility referrals; include the placement address, who has custody, the date of foster care-related Medicaid approval (if approved), and placement dates. The local office will then determine Medicaid as directed in NJA0110, *Referrals from IV-E Unit*.

Foster Care

The service worker provides the family with the application at the time a *Voluntary Foster Care Placement Agreement*, form 470-0715 or 470-0715(S), is signed. For all other placements, the service worker or juvenile court officer sends the application to the child's parents within three working days after the child is placed.

When a parent or other responsible person cannot be located or fails to cooperate, the child's service worker or juvenile court officer completes the application on behalf of the child. The child may assist in the application process if the child is old enough to provide information. When the child is in a supervised apartment living foster care placement, the child completes the application.

The family, or child if applicable, is instructed to return the completed application to IM staff within ten calendar days. A service worker or juvenile court officer who receives the completed application shall forward it to the IM worker within two working days of its return.

If you have received a FACS *Foster Care and/or Subsidized Adoption Information Exchange* indicating a child has been placed in foster care, but after ten days you have not received a Medicaid application, contact the service worker or juvenile court officer about the status of the application.

If you still do not receive an application after contacting the service worker or juvenile court officer, contact your supervisor, who will contact the service supervisor to resolve the discrepancy.

Follow normal application processing timeframes for children in placement. Refer to 8-B, *Application Processing*.

You may allow additional time when you are attempting to obtain information necessary to establish eligibility. Determine the case to be state-funded if the information is not received after **60 days** of repeated attempts to obtain necessary eligibility information. Continue to pursue the missing information and when it is received, adjust the Medicaid eligibility accordingly.

Subsidized Guardianship

When an Iowa subsidized guardianship placement begins and the service worker enters the placement into the FACS system, FACS will generate a *Foster Care and/or Subsidized Adoption Exchange* report to the IM worker indicating a placement exit from foster care and into a subsidized guardianship placement. In addition, the IV-E IM will receive alerts via JARVIS/IV-E Tracking, and the SW will complete the *IV-E Changes*, form 470-3918 and provide guardianship paperwork.

The child's guardian is responsible for completing the application. When a guardian fails to return necessary information, such as an application form, eligibility under a Medicaid coverage group cannot be determined. In this situation, the child is not eligible under the state-only coverage group.

Iowa Subsidized Adoption

When an Iowa subsidized adoption becomes final and the service worker enters the finalization into the FACS system, FACS will generate a *Foster Care and/or Subsidized Adoption Information Exchange* to the IM worker indicating 'placement exit.' This action will cause the ABC system to close the foster care (presubsidy) Medicaid case and send the IM worker a message/alert indicating that the case has been closed.

The adoption worker will open a new subsidized adoption case in FACS with the child's new name, new state identification number, and possibly a new social security number. FACS will generate a *Foster Care and/or Subsidized Adoption Information Exchange* to the IM worker that indicates 'subsidy adoption placement.' In addition, the IV-E IM will receive adoption paperwork needed to complete the IV-E determination.

Complete an automatic redetermination of Medicaid eligibility when a child is already a Medicaid member when the adoption is finalized. To maintain the confidentiality of the biological identity of the child and the child's biological parents, do not place any identifying information from the pre-adoption record (e.g. redacted copies of applications or other materials, copies marked "confidential", or any references to the child's pre-adoptive name) in the adoption Medicaid record.

A IV-E-eligible child with an adoption assistance agreement is eligible under the IV-E Medicaid coverage group. The child will remain IV-E eligible as long as the child remains in the adoptive home and an adoption assistance agreement is in effect. See 13-B, *Overview of IV-E Adoption Requirements*, for more information on IV-E policies. EXCEPTION: Children who are both IV-E-eligible and receive SSI shall have their Medicaid provided under the SSI coverage group.

For a child who is not either receiving SSI, IV-E eligible, or already receiving Medicaid at the time the adoption is finalized, request an *Application for Foster Care and Subsidized Adoption Medicaid*, form 470-5535 or 470-5535(S). The child's adoptive parents are responsible for filing the Medicaid application.

If SSI or IV-E eligibility does not exist, determine if Medicaid eligibility exists under CMAP.

If the Iowa child is not eligible under CMAP, determine if the child is eligible on the basis of policies at 8-F, *Continuous Eligibility for Children*. If so, document in the adoption Medicaid case record that the child's pre-adoption Medicaid case was reviewed, the pre-adoption Medicaid case number, and the date through which the child is continuously eligible. Do not place any identifying information from the pre-adoption record in the adoption Medicaid record.

NOTE: Although a child in deemed "newborn" status is not continuously eligible, the above process also applies to these children. Document in the adoption Medicaid case record that the child's pre-adoption Medicaid case was reviewed, the pre-adoption Medicaid case number, and the date through which the child is eligible due to deemed newborn status. Do not place any identifying information from the pre-adoption record in the adoption Medicaid record.

If Medicaid eligibility does not exist under any of the above provisions, approve under state-only. If the adoptive child is only eligible for state-only medical assistance due to an issue that can be corrected (e.g. by obtaining an SSN, by resolving a non-cooperation, etc.), encourage the adoptive family to take any actions needed to establish Medicaid for the child under a federally funded coverage group.

Out-of-State Subsidized Adoption

Legal reference: 441 IAC 75 (Rules in Process)

When a child with an out-of-state adoption assistance agreement moves to Iowa, the adoption program manager in the Division of Adult, Children, and Family Services is notified by the other state with form ICAMA 7.0, *ICAMA Notice of Medicaid Eligibility/Case Activation*. The other state attaches a copy of their adoption assistance agreement.

NOTE: If the child with an out-of-state adoption assistance agreement is already receiving Iowa Medicaid when the adoption is finalized, follow the procedures under Iowa Subsidized Adoption for opening a new Medicaid case while protecting the child's pre-adoptive identity.

The adoption program manager will forward a copy of form ICAMA 7.0 and the adoption assistance agreement to the IV-E unit for processing. Form ICAMA 7.0 includes the following information:

- Name, date of birth, and social security numbers for each adopted child and the parents.
- The family's address and phone number in the other state.
- The family's new address and phone number in Iowa.
- Whether the child is eligible for IV-E or state-funded subsidy assistance.
- Whether the other state provides Medicaid reciprocity for children with an adoption assistance agreement from another state.
- Whether the child remains eligible for Medicaid from the state where the child has an adoption assistance agreement (which may or may not be the state the child is moving from).
- Information about other health insurance and eligibility for SSI or Social Security.

When form ICAMA 7.0 is received, review the information and request additional information if needed. If form ICAMA 7.0 is fully completed, no additional information should be required to process eligibility for Medicaid.

A child who is eligible for IV-E adoption assistance is eligible under the IV-E coverage group. The child will remain IV-E-eligible as long as the child remains in the adoptive home and an adoption assistance agreement is in effect. See 13-B, *Overview of IV-E Adoption Requirements*, for more information on IV-E policies. EXCEPTION: Children who are both IV-E-eligible and receive SSI shall have their Medicaid provided under the SSI coverage group.

A child who is eligible for non-IV-E adoption assistance from a state that has a Medicaid reciprocity agreement is eligible for the CMAP coverage group. (See Medicaid Reciprocity for Subsidized Adoption for a list of states.)

The non-IV-E reciprocity child will remain eligible for Medicaid as long as all of the following are true:

- The child is under age 21;
- The child has been placed and is living with a family in Iowa or has moved with the adoptive family to Iowa;
- Another state has a state-funded adoption assistance agreement for the child;
- That state is a member of the Interstate Compact on Adoption and Medical Assistance (ICAMA); and
- That state also provides Medicaid to children with Iowa subsidized adoption cases who move to that state.

Use a 18 FBU, a 37-2 aid type, and a TD03 FACS indicator code of "R" when setting up a case for reciprocity Medicaid. No case will be open in FACS, but the TD03 coding is used to claim federal funding, since a unique aid type is not available. The system will convert the aid type for SSNI.

A child who is not IV-E-eligible and whose adoption assistance agreement is with a state that does not have a Medicaid reciprocity agreement must file an *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), if assistance is desired. The child may be eligible under a MAGI-related or Non-MAGI related Medicaid coverage group if the rest of the family is included in the eligibility determination regardless of whether the rest of the family wants Medicaid coverage.

There is no state-only Medicaid eligibility for children with out-of-state adoption assistance agreements from non-reciprocity states. If there is no eligibility for Iowa Medicaid for the child, the state with the adoption assistance agreement will remain responsible for the child's medical expenses.

Determining Eligibility for the Retroactive Period

Legal reference: 42 CFR 435.915, 441 IAC 76.13(3)

Medicaid benefits may be available for any or all of the three months preceding the month in which the application is filed as long as the individual meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. Consider the retroactive period for all newly filed applications.

If a child was in foster care more than three months before the month the application is filed, federally funded Medicaid cannot cover those months. Provide state-only Medicaid coverage in this situation.

NOTE: Policies related to determining the retroactive period do not apply to IV-E-eligible children because IV-E-eligible children must be made automatically eligible for Medicaid without requiring an application to be filed.

Foster Care and Presubsidy Placements

Legal reference: 441 IAC 202, 441 IAC 201

The following sections explain Medicaid eligibility determination for children residing in a presubsidy or foster care placement. (Medicaid eligibility for the presubsidy period is the same as for a foster care placement.)

- Who is eligible
- Defining the eligible group
- Referral for support recovery

Who Is Eligible

Legal reference: 441 IAC 75 (Rules in Process), 234.1

Medicaid is available to children for whom the Department has financial responsibility and who are living in one of the placements listed under Placement Types. See Definitions for additional information.

The Department provides foster care only to persons meeting the definition of a child. "Child" means either a person less than 18 years of age or a person 18 or 19 years of age who meets any of the following conditions:

- Is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma.
- Is attending an instructional program leading to a high school equivalency diploma.
- Has been identified by a director of special education of the area education agency as a child requiring special education.

A person over 18 years of age who has received a high school diploma or a high school equivalency diploma is not a child within this definition.

A child who is placed into foster care for a very short period is eligible for Medicaid for the months that the child was in foster care. Sometimes a child can be placed in foster care for less than a week or even overnight, but since the child is in foster care, the child is eligible for Medicaid. Medicaid covers the whole calendar month when a person is in foster care for any part of the month.

Children who were in subsidized adoption and go into foster care shall have their eligibility determined as a foster child.

The FACS system will generate Report S472N111-01, *Foster Care and/or Subsidized Adoption Information Exchange*, to the IM worker identifying the type of foster care placement where a child is residing. In addition, the IV-E IM will receive alerts via JARVIS/IV-E Tracking, and the SW will complete *IV-E Initial Placement Information*, form 470-3839 and *IV-E Changes*, form 470-3918.

Placement Types

Legal reference: Section 472 of the Social Security Act, P.L. 115-123, 441 IAC 156.1(234), 201.2(600), 202.1(234), and 85.21(249A)

Foster family care is provided in a single-family home licensed for foster care, in which an individual or a couple provides room, board, and care to the child. The maintenance payment for a child in a foster family home is continued if the child is absent from the foster home for two weeks or less with the knowledge and consent of the service worker.

Since the maintenance payment continues during the absence, Medicaid coverage also continues under foster care. If the maintenance payment and foster care Medicaid eligibility end, see 8-F, *Continuous Eligibility for Children*, to determine if continuous eligibility applies.

Group care is a group setting for children who are socially, emotionally, or physically unable to live in a family setting. Prior to July 1, 2020, the levels of group care were differentiated by the intensity and frequency of treatment services and the supervision and structure needed by the child. These levels were:

- Community residential group treatment
- Comprehensive residential treatment
- Enhanced residential treatment

Starting July 1, 2020, pursuant to the Family First Prevention Services Act (FFPSA), all prior levels of group care began to be collapsed into the single category of group care referred to as Qualified Residential Treatment Program.

Occasionally, children will be absent from a group care placement for short periods due to visits or hospitalization. As long as the maintenance payment continues, the child is still considered to be living in a foster care placement and is eligible for Medicaid on that basis. If the maintenance payment and foster care Medicaid eligibility end, see 8-F, *Continuous Eligibility for Children*, to determine if continuous eligibility applies.

Shelter care is a group facility for the temporary care of children. Approval standards for shelter care facilities require that children be discharged to a permanent placement at the earliest possible time, preferably within 30 days.

Supervised apartment living foster care, formerly called "independent living", is a supervised foster care placement for children who are at least 16 years old but less than 20 years old, living on their own, and employed. Foster children in supervised apartment living placements are not eligible under the IV-E coverage group.

Presubsidy placement is placement in the home of the adoptive family before the adoption is finalized. The presubsidy payment is a foster care payment.

PMIC (psychiatric medical institution for children) is a medical institution that provides continuous care and diagnostic or long-term psychiatric services to children under the age of 21. PMICs must be licensed as health care facilities and must also have a license as either a foster care facility or a substance abuse treatment facility.

Children in a PMIC are not eligible under the IV-E coverage group. When a child enters a PMIC from foster care or subsidized adoption, refer the case to the IM worker assigned to the PMIC to determine eligibility. In addition, children in a PMIC for whom the Department does not have custody are not considered to be in foster care, and Medicaid eligibility is not established on that basis.

Placements Not Considered Foster Care

The following are examples of placements where a child could be living but Medicaid does not recognize as a foster care placement:

- Locked juvenile detention facilities
- Training school in Eldora (except for 30-day evaluations)
- Glenwood and Woodward Resource Centers
- Children in PMICs for whom the Department does not have custody
- Children living with a relative who:
  - Is not a licensed foster care provider, or
  - Is licensed but is not receiving a foster care maintenance payment

Juvenile detention facilities, Eldora State Training School, and Glenwood/Woodward Resource Centers are temporary placements similar to shelter care, but they are public facilities for youth who have pending criminal charges and are not considered foster care facilities. Children placed in these settings are not eligible for full Medicaid because they are residents of a public institution but should have their Medicaid benefits limited to inpatient hospital claims only if they continue to meet other Medicaid eligibility requirements while incarcerated. Refer also to 8-C, *Residents of Public Nonmedical Institutions* for procedures when the report of incarceration is received via a data match.

Exception: Youth who are only at Eldora for a 30-day evaluation are not considered to be residing at the institution, so if they are already receiving Medicaid, eligibility can continue through the temporary absence during the evaluation period as long as other eligibility requirements are met.

Iowa Child Placed Outside Iowa

Legal reference: 441 IAC 75 (Rules in Process)

Iowa provides Medicaid for a child placed outside the state if the child is not IV-E-eligible. Due to system constraints, the FBU for these cases must be 18.

When Iowa places a IV-E-eligible child in another state, Medicaid shall be provided by the other state. Timely cancel a IV-E-eligible child's Iowa Medicaid when the child is placed out-of-state and the placement meets IV-E requirements. Refer to 18-D(6), *Medical Services* for service procedures involved in securing Medicaid coverage for these children.

Out-of-State Child Placed in Iowa Foster Care Placement

Legal reference: Section 473(b)(3) of the Social Security Act; 441 IAC 75 (Rules in Process)

Iowa provides Medicaid coverage to IV-E-eligible children placed in Iowa by another state when the other state is making a IV-E foster care maintenance payment. These IV-E-eligible children must be made automatically eligible for Medicaid without a separate application or further verification.

NOTE: If the other state opts to extend IV-E foster care maintenance payments up to age 19, 20, or 21, Iowa must provide Medicaid without regard to Iowa's foster care age limits. Refer to 18-D(6), *Placement of Out-of-State Children in Iowa* for procedures involved in identifying children placed in Iowa by another state.

Establish this case with an 18 FBU when the required IV-E documentation is provided.

If the foster child from another state loses IV-E eligibility or leaves a IV-E placement, cancel the Medicaid. The child must get non-IV-E foster care-related Medicaid from the placing state. Note: If the new placement is not foster care (e.g. is instead a relative or other suitable adult), determine if the child instead remains eligible under continuous eligibility policies.

Child Hospitalized Before Entering Foster Care

A child who is removed from the home by court order may require hospitalization before going to the foster care placement. Until the child is actually placed in licensed foster care, the child is not a foster child, and Medicaid eligibility cannot be established on that basis.

There is no maintenance payment for children placed in a hospital upon removal from the home. In these situations Medicaid eligibility must be established under a non-foster care-related coverage group without regard to the pending foster care placement.

If there is **no court order** removing the child from the parental home, consider the child a household of one only if the child will be hospitalized more than 12 months. If the child will be hospitalized less than 12 months, the child is considered with their family at home. See 8-C, *Absence in a Medical Institution*. If the child is not eligible for a federally funded coverage group, do not establish a case providing state-only Medicaid in this situation.

Send a referral to the local office to determine coverage for any month(s) a child needs coverage prior to placement in a foster care setting. Send this referral to the same email address used for continuous eligibility referrals; include the placement address, who has custody, the date of foster care-related Medicaid approval (if approved), and placement dates. The local office will then determine Medicaid as directed in NJA0110, *Referrals from IV-E Unit*.

1. Kelly, age 3, was removed from her home by court order due to reported child abuse. Since she required hospitalization for treatment of her injuries, Kelly did not immediately enter a foster care placement.

   The local office IM worker establishes that Kelly meets MAGI- or Non-MAGI-related eligibility requirements and opens the case in ELIAS. When Kelly actually enters foster care, the IV-E IM opens foster care Medicaid on a 19 FBU case and notifies the local office IM worker to close their case.

2. Same as Example 1, except Kelly has income that exceeds applicable income limits. The local office IM worker determines if eligibility exists under another coverage group. State-only medical assistance cannot be provided, since Kelly is not in a foster care placement.

3. Susie, a newborn, was relinquished to a hospital by a birth parent under Iowa's Safe Haven law. The Department has enough information to determine that Susie's birth mother was on Medicaid for the birth month. The local office opens a "deemed newborn" Medicaid case for Susie, narrating in the case file that her birth mother was verified to be on Medicaid for the birth month but that no identifying information about the mother can be placed in the child's case due to confidentiality.

4. Same as Example 3, except there is not enough information to determine if Susie meets "deemed newborn" criteria. A court order for placement is sought quickly when a Safe Haven case is identified, usually before the child leaves the hospital. The court typically places the child in foster care, so a foster care-related Medicaid case is established. If, however, the court orders the child placed into a home licensed for adoption only, this "suitable other" placement requires the local office to consider eligibility for the child and any other applicants in the household using regular MAGI or Non-MAGI-related policies and procedures.

Defining the Eligible Group

When determining eligibility for siblings who are placed in foster care together, establish Medicaid eligibility for each child separately from other siblings. Each child is considered as a household size of one and set up on their own case.

1. Todd, age 5, and his sister Nancy, age 3, are placed in the same foster family home. Todd is eligible under the IV-E coverage group while Nancy is eligible under the CMAP coverage group. A separate Medicaid case is established for each child.
2. Same as Example 1, except Todd and Nancy are both eligible under the CMAP coverage group A separate Medicaid case is still established for each child.

When a Foster Child Is a Minor Parent

Legal reference: 441 IAC 75 (Rules in Process)

When a minor parent is in foster care placement and has their own child living with them, who is also in foster care placement, set up separate Medicaid cases for the minor parent and their child.

If the minor parent is in foster care placement and their child is not (e.g., as in the case with supervised apartment living when only the minor parent's needs are included in the foster care maintenance payment), only the minor parent is placed on a foster care medical case. The minor parent's child's case must be handled by the local office following regular Medicaid policy. Refer to 8-F, *Coverage Groups*.

An infant born to a Medicaid-eligible mother shall be granted deemed newborn status; see 8-F, Deemed *Newborn Children of Medicaid-Eligible Mothers*.

Referral for Support Recovery

Legal reference: 441 IAC 75.14(249A) and 156.2(234)

The Department collects child support and medical support on behalf of children in foster care. Where applicable, the Department also recovers the cost of foster care from the unearned income of the child.

The Foster Care Recovery Unit (FCRU), a part of the Division of Field Operations, is responsible for enforcing child support orders and for medical support for referrals received through the FACS system.

When the Medicaid application is approved:

- Both parents of children under age 18 who are in foster care should be referred to FCRU. FCRU defines foster care as children who are in family foster care, group care, shelter care, or supervised apartment living.
- Subsidized adoption parents should be referred only if all of the following apply:
  - The parent has left the adoptive home,
  - There is an existing child support order, and
  - The child covered by the order is in foster care.

  FCRU will enforce an assignment of support due to the state. New establishment action will not be taken on subsidized adoption cases.
- Parents of a child in a PMIC should not be referred for support recovery when the Department does not have custody.

Service workers are responsible for making the referral on the FACS system. In order for FCRU to receive the referral, the IM worker must link the referral to the ABC medical case.

Linking of referrals is completed through the ICSC linking screen between the ABC system and ICAR, the CSRU computer system. The ICSC screen will not display the FACS referral when called up by the ABC case number.

Find the FACS referral and its ICAR case number by changing the ICSC display to a SID# display. Do this by entering "3 ICSC" from the ICSC screen along with the client's state identification number and pressing ENTER. See the example below:

```
ICSC                                IOWA DHS SYSTEM              DATE: 05 14 03
IABC #: 000003-19-0-8
      CHILD SUPPORT      ABSENT PARENT        CASE NUMBER          PAYEE/CHILD 0000010B
STATE ID/NAME          REFER  ROLE  A/D/R     CASE NUMBER          ICAR NUM          DATE
FIRST    LAST          TI  (Y,N)
0000010B ----------
SUSAN EXAMPLE
*1=STOP 2=FRWD 3=NEXT SCRN 4=MORE DATA 6=UPDT 7=SRCH 8=EDIT CD/SCRN: 3 ICSC
SID: 0000010B                IABC:                    FACS:                ICAR:
```

The screen example below shows all referrals for this state ID number. You can identify a FACS referral by seeing under the ROLE column a code of "F" and under the CASE NUMBER column an "F" followed by the child's state ID number.

```
ICSC                                IOWA DHS SYSTEM              DATE: 05 14 03
SID #: 0000010B
      CHILD SUPPORT      ABSENT PARENT        CASE NUMBER          PAYEE/CHILD 0000010B
STATE ID/NAME          REFER  ROLE  A/D/R     CASE NUMBER          ICAR NUM          DATE
FIRST    LAST          TI  (Y,N)
0000010B                     Y       F         F00000-10-B          0121217          03/13/03
SUSAN EXAMPLE                Y       F         F00000-10-B          0121218          03/13/03
                             N                 M00021-00-0                           09/07/97
                             Y       I         C02000-00-0          0098888          12/12/00
*1=STOP 2=FRWD 3=NEXT SCRN 4=MORE DATA 6=UPDT 7=SRCH 8=EDIT CD/SCRN: 3 ICSC
SID:           IABC: 000003-19-0              FACS:                ICAR:
```

The two ICAR cases to review are 0121217 and 0121218. Look up both ICAR case numbers to verify that one or both list "Foster Care State of Iowa" as payee with account type of 10 or 13 and the payor is a parent to the foster child.

If so, change the display back to the ABC case number by entering "3 ICSC" and the ABC case number and pressing ENTER. After the ICSC display changes to the ABC case number, you can continue with the referral process. Link the matched ICAR cases to the Medicaid case as follows:

```
ICSC                                IOWA DHS SYSTEM              DATE: 05 14 03
IABC #: 000003-19-0-8
      CHILD SUPPORT      ABSENT PARENT        CASE NUMBER          PAYEE/CHILD 0000010B
STATE ID/NAME          REFER ROLE A/D/R       CASE NUMBER          ICAR NUM          DATE
FIRST LAST TI (Y,N)
0000010B                     Y       I    A    F00000-10-B          0121217          03/13/03
SUSAN EXAMPLE

*1=STOP 2=FRWD 3=NEXT SCRN 4=MORE DATA 6=UPDT 7=SRCH 8=EDIT CD/SCRN:
 SID         IABC:  FACS: ICAR: 0121217
```

Use the PF6 key to update the screen. Link both parents to ICAR. After both links are made, the ICSC screen should look like this:

```
ICSC                                IOWA DHS SYSTEM              DATE: 05 14 03
IABC #: 000003-19-0-8
      CHILD SUPPORT      ABSENT PARENT        CASE NUMBER          PAYEE/CHILD 0000010B
STATE ID/NAME          REFER ROLE A/D/R       CASE NUMBER          ICAR NUM          DATE
FIRST LAST TI      (Y,N)
0000010B                     Y       I    A    000003-19-0-8        0121217          05/14/03
SUSAN EXAMPLE                Y       I    A    000003-19-0-8        0121218          05/14/03

*1=STOP 2=FRWD 3=NEXT SCRN 4=MORE DATA 6=UPDT 7=SRCH 8=EDIT CD/SCRN:
 SID:
 IABC:  FACS: ICAR:
```

Subsidized Guardianship Placements

Legal reference: 441 IAC 75 (Rules in Process) and 204; P.L. 110-351

This section pertains to Medicaid eligibility for a child who has been placed in a subsidized guardianship home approved by an Iowa court and has a *Guardianship Subsidy Agreement*, form 470-3631, in effect. It also contains information about children receiving IV-E funded subsidized guardianship payments from other states.

The requirements for this program are found in 18-F(2), *Subsidized Guardianship*.

The purpose of the subsidized guardianship program is to provide financial assistance to guardians of eligible children who are not able to return home or be adopted. This allows children a more permanent living arrangement than they have in foster care. It also provides Medicaid for children in a subsidized guardianship arrangement.

Eligibility for Medicaid for children in subsidized guardianship arrangements differs from children in foster care and subsidized adoption placements because:

- The subsidized guardianship home is not a foster care placement and does not require supervision by the Department. The Department's service worker's responsibilities are limited to payment-only.
- The guardian is responsible for providing applications needed to determine the child's Medicaid eligibility. (Applications are not required if the guardianship is IV-E funded.)
- If the guardian fails to provide information needed to determine eligibility or comply with procedural requirements under a Medicaid coverage group, the child is **not** eligible under state-only coverage. (Applications and reviews are not required if the guardianship is IV-E funded.)

The following sections address:

Who Is Eligible for Subsidized Guardianship Placements

Legal reference: 441 IAC 75 (Rules in Process), P.L. 110-351, Section 473(b) of the Social Security Act

Medicaid is available to children for whom the Department has financial responsibility and who are living in a court-approved subsidized guardianship home. See Definitions for additional information.

In Iowa's subsidized guardianship program, a subsidy payment may be made until the child reaches the age of 18, unless the Department determines that the subsidy may continue until the child reaches the age of 21 due to the child's physical, intellectual, or mental health disability.

In addition, children receiving IV-E funded subsidized guardianship payments from Iowa or another state are automatically eligible for Medicaid under the IV-E coverage group without a separate application, annual review, or further verification.

NOTE: Iowa must provide Medicaid without regard to Iowa's subsidized guardianship age limits to a child receiving a IV-E subsidized guardianship payment from another state if that state opts to extend IV-E subsidized guardianship payments up to age 19, 20, or 21.

A child with a non-IV-E-funded subsidized guardianship agreement-from another state may receive Medicaid in Iowa. However, the child must meet the financial and categorical eligibility requirements, including state residency requirements, of a Non-MAGI or MAGI-related Medicaid coverage group. Iowa's Medically Needy coverage group for subsidized guardianship children and state-only coverage group are **not** available to these children.

See 18-D(6), *Interstate Compact on the Placement of Children*, and 18-F(2), *Subsidized Guardianship* for procedures on identifying children receiving a guardianship subsidy from another state and whether they are IV-E eligible.

Children who were in subsidized guardianship and go into foster care shall have their Medicaid eligibility established as a foster child. See 8-F, *Continuous Eligibility for Children*, to determine if continuous eligibility applies.

Nonfinancial Criteria

To be eligible for Medicaid, children receiving subsidized guardianship must meet certain nonfinancial eligibility requirements. See 8-C, *Nonfinancial Eligibility*, for general rules. Exceptions to 8-C are explained in the following sections:

- Eligible group
- Residence outside Iowa
- Referral to support recovery

Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

When determining eligibility for a subsidized guardianship child living in the same home with siblings, establish Medicaid eligibility for each subsidized guardianship child separately from the other siblings. Each child in subsidized guardianship is considered a household of one and set up on their own case.

Subsidized Guardianship Child Is a Minor Parent

When a child in subsidized guardianship is a minor parent and has a child who resides with the minor parent, that child is not included in the minor parent's eligibility group. Medicaid eligibility for the minor parent's child is determined separately. Refer to 8-F, *Coverage Groups*.

An infant born to a Medicaid-eligible mother shall be granted deemed newborn status; see 8-F, *Deemed Newborn Children of Medicaid-Eligible Mothers*.

Parent Enters the Subsidized Guardianship Household

If the parent of a child in subsidized guardianship enters the household, the presence of the parent has no effect on the child's Medicaid eligibility and the child remains eligible for Medicaid on the basis of subsidized guardianship as long as the guardianship subsidy agreement remains in effect. The parent's parental liability also continues until the court terminates the order.

If the parent requests Medicaid, the parent's case must be handled by the local office following regular Medicaid policy. Refer to 8-F, *Coverage Groups*.

Note: In this situation, if the guardian fails to provide necessary information or comply with procedural requirements, the child is **not** eligible under the state-only Medicaid coverage group.

When the guardianship subsidy agreement is terminated, reexamine eligibility under other coverage groups. See 8-F, *Continuous Eligibility for Children*, to determine if continuous eligibility applies. The state-only coverage group is **not** available once the guardianship subsidy agreement is terminated.

Residence Outside Iowa

Legal reference: 441 IAC 75.10(2) and 204.9(234); Section 473(b)(3) of the Social Security Act

When a child in a IV-E funded Iowa court-approved subsidized guardianship home moves with the guardian or is placed with a guardian out of state, the other state must provide Medicaid. A separate application, review form, or further verification is not required.

When a child in a IV-E funded Iowa subsidized guardianship home moves with the guardian or is placed with a guardian out of state, see 18-D(6), *Interstate Compacts on the Placement of Children*, and 18-F(2), *Subsidized Guardianship* for procedures on notifying the other state. Cancel the Iowa Medicaid case effective the month following the move unless additional time is necessary to provide a timely notice of decision.

When a child in a non-IV-E-funded Iowa subsidized guardianship moves with the guardian or is placed with a guardian out of state, the guardian must apply for Medicaid coverage for the child in the new state of residence. Cancel the Iowa Medicaid case effective the month following the move unless additional time is necessary to provide a timely notice of decision.

If a child with a non-IV-E guardianship subsidy agreement does not meet the other state's eligibility requirements due to no fault of the guardian, the guardian must provide official notification of Medicaid ineligibility from the other state. The child's Medicaid will then be reopened under Iowa's state-only coverage group. Due to system constraints, the FBU for these cases must be 18.

Referral for Support Recovery

Legal reference: 441 IAC 204.5(234)

The Department will collect child and medical support on behalf of a child in a subsidized guardianship placement. If these children come directly from a foster care placement, a new referral is not needed.

Subsidized Adoption Placements

Legal reference: 441 IAC 201, Public Law 101-508

This section pertains to Medicaid eligibility for a child who has been adopted and has an adoption assistance agreement in effect. In Iowa, adoption assistance agreements are made on the *Adoption Subsidy Agreement*, form 470-0749 or 470-0749(S).

"Subsidized adoption" means a permanent placement and assistance for parents for a special needs child who legally becomes a member of the adoptive family. "Special needs" means a child who is physically or mentally disabled, older, or otherwise hard to place. The service worker negotiates the amount of the subsidy with the adoptive parents.

The following sections address:

- Medicaid reciprocity for subsidized adoption
- Who is eligible for subsidized adoption placements
- Defining the eligible group

Medicaid Reciprocity for Subsidized Adoption

Legal reference: 441 IAC 75 (Rules in Process), 441 IAC 201.11(2)

"Medicaid reciprocity" is an agreement among certain states to provide Medicaid to children who are placed in or move to each other's state when the child was receiving Medicaid under specified conditions in the home state. Medicaid must be provided to non-IV-E-eligible children with an adoption subsidy agreement in a state with a Medicaid reciprocity agreement.

When a non-IV-E child with an adoption subsidy agreement from another state is placed in or moves to Iowa, Iowa provides Medicaid coverage if the state with the adoption subsidy agreement has a Medicaid reciprocity agreement, regardless of whether the child meets the eligibility requirements for Medicaid in Iowa.

Make these children automatically eligible for Medicaid without requiring a separate application. However, an application may be requested to gather information to facilitate the child's Medicaid enrollment.

When a non-IV-E-eligible Iowa child with an Iowa adoption subsidy agreement moves to another state that has a Medicaid reciprocity agreement with Iowa, that state provides Medicaid coverage regardless of whether the child meets the eligibility requirements for Medicaid in that state.

If a child has an adoption subsidy agreement from a state that has a Medicaid reciprocity agreement with Iowa, the child is Medicaid-eligible in Iowa without further verification. See Application Processing for Out-of-State Subsidized Adoption later in this chapter for additional information about establishing the Medicaid case.

A non-IV-E-eligible child with an adoption subsidy agreement who moves into a state that does not have a reciprocity agreement must qualify for Medicaid according to the policies of the state where the child lives. If the child does not qualify, the state that made the adoption subsidy agreement must maintain Medicaid coverage.

Use the following list to determine which states have subsidized adoption Medicaid reciprocity agreements:

Alabama	Montana
Alaska	Nebraska
Arizona	New Hampshire
Arkansas	New Jersey
California	New York
Colorado	North Carolina
Connecticut	North Dakota
Delaware	Ohio
Florida	Oklahoma
Georgia	Oregon
Idaho	Pennsylvania
Indiana	Rhode Island
Iowa	South Carolina
Kansas	South Dakota
Kentucky	Tennessee
Louisiana	Texas
Maine	Utah
Maryland	Vermont
Massachusetts	Virginia
Michigan	Washington
Minnesota	West Virginia
Mississippi	Wisconsin
Missouri	Wyoming

Who Is Eligible For Subsidized Adoption Placements

Legal reference: 441 IAC 201.2(600), 75 (Rules in Process), Section 473(b)(3) of the Social Security Act

A child in an Iowa subsidized adoption placement is eligible for Medicaid. The child is eligible for Medicaid regardless of whether or not the adoptive parents choose to accept an adoption subsidy payment.

A IV-E-eligible child with an adoption assistance agreement is automatically eligible for Medicaid under the IV-E coverage group without a separate application, annual review, or further verification.

In Iowa's subsidized adoption program, a "child" is defined as either a person under age 18 or a person under age 21 with a physical or mental disability.

Adoption Assistance Agreement From Another State

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

Iowa Medicaid is provided to a IV-E-eligible child with an adoption assistance agreement from another state. See 18-F(1), *Permanent Placement Procedures*.

A IV-E-eligible child with an adoption assistance agreement is automatically eligible for Medicaid under the IV-E coverage group without a separate application, annual review, or further verification.

NOTE: Iowa must provide Medicaid without regard to Iowa's adoption subsidy age limits to a IV-E-eligible child with an adoption assistance agreement from another state if that state opts to extend IV-E adoption assistance agreements up to age 19, 20, or 21.

Iowa Medicaid is also provided to a non-IV-E-eligible child with an adoption assistance agreement from a state with a Medicaid reciprocity agreement. These children are eligible under the CMAP coverage group without a separate application.

A non-IV-E-eligible child with an adoption assistance agreement from another state **is not** eligible under the state-only coverage group. If Medicaid eligibility does not exist under another coverage group, the child is not eligible for Iowa Medicaid.

1. Lily, age 7, is in subsidized adoption placement in Texas. She is not eligible for IV-E. Lily and her adoptive family move to Iowa and meet Iowa residency requirements.

   The IM worker receives form ICAMA 7.0, *Notice of Medicaid Eligibility/Case Activation,* indicating Lily is living in Iowa and is eligible for a state-funded adoption subsidy from Texas.

   The IM worker determines that Lily is eligible for CMAP, considering only the fact that Lily receives a subsidy payment and that Texas has a Medicaid reciprocity agreement.

   Since the adoption service is not open in FACS, Medicaid cannot be approved with a 19 FBU. The IM worker opens a Medicaid case with an 18 FBU.

2. Richard is not IV-E-eligible. Richard's adoption subsidy is paid by Illinois. Illinois does not have a Medicaid reciprocity agreement, so Richard's Medicaid eligibility will need to be determined for a MAGI or Non-MAGI-related coverage group.

   Iowa **will not** provide state-only Medicaid for Richard.

Iowa Child Living Outside Iowa

When a IV-E-eligible child with an Iowa *Adoption Subsidy Agreement*, form 470-0749 or 470-0749(S), moves out of Iowa, the other state is responsible for the Medicaid.

Similarly, the other state is responsible for the Medicaid when a non-IV-E-eligible child moves to a state with a reciprocity agreement. A non-IV-E-eligible child with an Iowa adoption assistance agreement who is residing in a state that does not provide Medicaid reciprocity remains eligible under Iowa Medicaid. See 18-F(1), *Permanent Placement Procedures*.

Write to the parents of the child and ask that they apply for Medicaid in that state. Ask the parents to provide a copy of the official notification from the other state about the status of Medicaid eligibility.

If the parents do not comply with your request that they apply for Medicaid in the other state, inform the child's service worker and ask for help in the application process.

Eligible Group for Subsidized Adoption Placements

Legal reference: 42 CFR 435.100

Consider all biological siblings adopted by the same family separately. Open a separate case for each child with a household size of one.

If the family of the adopted child also wants Medicaid, the local office must determine their Medicaid eligibility according to MAGI or Non-MAGI Medicaid policies and procedures. Refer to 8-F, *Coverage Groups*.

Case Maintenance

The following sections address case maintenance issues that are treated the same way for foster care, subsidized guardianship and subsidized adoption cases:

- Managed care organization (MCO)
- Home- and community-based waivers
- Eligibility reviews
- Automatic redetermination

Managed Care Organization (MCO)

Medicaid received by children in foster care, presubsidy, subsidized guardianship, and subsidized adoption will be handled by the managed care organization (MCO) unless the child also has a status that is exempt from MCO management.

Home- and Community-Based Waivers

A child who receives Medicaid home- and community-based waiver services while in a foster care, presubsidy, subsidized adoption, or subsidized guardianship placement shall have waiver eligibility established on a separate case. Do not use a 19 FBU for the waiver case.

Reviews

Medicaid annual reviews for the foster care, subsidized adoption and subsidized guardianship child populations are handled passively/administratively without a review form.

For SSI eligible children, Medicaid reviews are not required.

For IV-E eligible children, Medicaid reviews are not required. However, IM must enter the review on TD05 so the review does not show as overdue, and to set the correct continuous eligibility period if the child leaves foster care, subsidized adoption or subsidized guardianship, or becomes ineligible due to age.

For all other children (CMAP, Medically Needy, and State-Only), Medicaid policy requires a review; however, since there is no income or resource criteria for eligibility, the review will be handled passively/administratively without a review form.

The IV-E IM will confirm the foster care, subsidized adoption, or subsidized guardianship placement for ongoing cases. In addition, the IV-E IM will receive alerts for each child turning 17 and one-half years of age.

Since reciprocity for subsidized adoption cases are not in FACS, the IM will send a letter to the family to verify that the adoption agreement is still in effect and the child continues to live in Iowa

Review the foster care case every time there is a court order or change in placement.

Automatic Redetermination

Legal reference: 441 IAC 76.17(249A)

Refer to 8-F, *Continuous Eligibility for Children*, to determine if continuous eligibility applies.

If continuous eligibility for children policies do **not** apply, complete an automatic redetermination of eligibility when:

- A child in foster care, subsidized adoption, or subsidized guardianship enters or leaves a PMIC.
- A child leaves the subsidized adoption home and enters foster care.
- A child leaves foster care. (See 8-F, *Expanded Medicaid for Independent Young Adults (EMIYA)* and *Medicaid for Independent Young Adults (MIYA)*, when redetermining Medicaid for a child who was in foster care, including court-ordered PMIC placement, at age 18.)
- Subsidized guardianship terminates or eligibility no longer exists.
- IV-E status changes.
- Other changes occur that affect Medicaid eligibility.

When a child leaves foster care, subsidized adoption, or subsidized guardianship, determine eligibility for Medicaid under another coverage group based on the child's new residence and household circumstances. A new application form **cannot** be required, but an application may be requested to gather information to facilitate the child's Medicaid enrollment.

When completing an automatic redetermination, close the 19 FBU case and reopen Medicaid with a different FBU.

If information creating ineligibility is received **by the tenth of the month**, complete the automatic redetermination by the end of that month.

If you cannot immediately determine eligibility under another coverage group, reopen Medicaid under the automatic redetermination aid type and request any additional information using form 470-3152, *Notice of Cancellation/ Redetermination*. Allow the client ten calendar days from the date of notification to return the requested information.

Refer to 8-G, *Automatic Redeterminations*, for more information about the automatic redetermination process. Refer to 8-F, *Continuous Eligibility for Children*, to determine when continuous eligibility applies to children leaving placement.

The following chart lists various changes in placement and effect of the change.

Change in Placement	Effect of the Change
Foster child returns home to family currently receiving Medicaid	Close the 19 FBU case. Add child to family's case using continuous eligibility procedures.
Foster child returns home to family not receiving Medicaid	Determine if continuous eligibility for children applies, or redetermine Medicaid eligibility under another coverage group. Establish a non-19 FBU case.
SSI child leaves foster care	Establish a non-19 FBU case and place the child on SSI Medicaid in ELIAS.
Foster child moves to a supervised apartment living placement	Determine if continuous eligibility for children applies, or redetermine Medicaid eligibility under another coverage group.
Child is canceled from foster care (includes court-ordered PMIC placement), subsidized adoption, or subsidized guardianship due to age	Determine if continuous eligibility for children applies, or redetermine Medicaid eligibility under another coverage group. Establish a non-19 FBU case. See 8-F, *Expanded Medicaid for Independent Young Adults (EMIYA)* and *Medicaid for Independent Young Adults (MIYA)*, when redetermining Medicaid for a child who was in foster care at age 18.

Change in Placement	Effect of the Change
Child no longer meets federal Medicaid eligibility requirements but remains in foster care, subsidized adoption, or subsidized guardianship	Change the aid type to 40-9, state-only medical assistance. See EXCEPTION related to subsidized guardianship.
Child loses SSI due to subsidized adoption	Determine if child meets IV-E requirements. (See 13-B.) If not, determine if continuous eligibility for children applies, or redetermine Medicaid eligibility under another coverage group.
Child enters a PMIC	Determine if continuous eligibility for children applies, or redetermine Medicaid eligibility under another coverage group. CFEU must determine eligibility for facility Medicaid coverage. Use a 19 FBU on the PMIC case.
Child enters a nursing facility or RCF	Determine if continuous eligibility for children applies, or redetermine Medicaid eligibility under another coverage group. Establish a non-19 FBU case.
Child runs away and cannot be located	Cancel Medicaid.
IV-E-eligible foster child is placed out-of-state	Cancel Medicaid after confirmation of approval in the other state.
Child with IV-E adoption assistance moves out of state	Cancel Medicaid after confirmation of approval in the other state.
Child with non-IV-E adoption assistance moves out-of-state	You will receive form ICAMA 7.5 or an e-mail from the adoption program manager. If the other state has a reciprocity agreement, cancel Medicaid after confirmation of approval in the other state.
Child with out-of-state non-IV-E adoption assistance moves to Iowa	You will receive form ICAMA 7.0 from the adoption program manager.
Out-of-state IV-E foster child moves to an Iowa placement that is not IV-E eligible	If the new placement is still foster care, cancel Medicaid; the child must get non-IV-E foster care-related Medicaid from the placing state. If the new placement is not foster care (e.g. is instead a relative or other suitable adult), determine if the child remains eligible under continuous eligibility policies. If not, cancel Iowa Medicaid.

Medical Institutions

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Overview

This chapter explains the eligibility, income, and resource policies that are unique for people in medical institutions. Following an explanation of how Medicare pays for people in medical institutions, there is a section on who is and is not eligible for Medicaid payment of medical institution care. Also included in this section is information about how institutionalization may affect a person's eligibility for other benefits.

Because income and resource policies are different for married people, these policies are outlined in the next section. Once the member is determined eligible, client participation is then calculated using the policies and procedures listed in the section that follows.

The balance of the chapter is devoted to administrative issues, such as billing, that are used when handling cases involving Medicaid members in medical institutions.

The section on billing and payment includes information about using the Institutional and Waiver Authorization and Narrative System (IoWANS) for authorization of facility payments.

Medicare Coverage for Institutional Care

To receive Medicare reimbursement for institutional care, a facility must be certified to provide:

- Care in an acute hospital setting,
- Care in a psychiatric hospital for patients age 65 and older, or
- Skilled nursing care.

Nursing facilities that provide the skilled level of care must also be certified to participate in the Medicare program. Because of this requirement, many Medicaid members' skilled nursing care is first paid by Medicare. (Other resources, including Medicare, must be used before any Medicaid payment is made.)

Medicare coverage limits are based on a "benefit period." Medicare defines a benefit period as beginning the day the person enters the hospital as an inpatient and ending after the person has **not** been in a hospital or skilled nursing facility for 60 days. If the person returns to the hospital or skilled care in less than 60 days, this is not a new benefit period. Any remaining days in the current benefit period are used.

Medicare coverage of **hospital care** is as follows:

- For the first 60 days of each benefit period, full payment is made after the beneficiary pays a deductible.
- For days 61 through 90, beneficiaries pay a daily coinsurance.

- After 90 days in the hospital for a single benefit period, beneficiaries may draw on their "lifetime reserve." The lifetime reserve is 60 days and is nonrenewable. Beneficiaries must pay a coinsurance.
- After 150 days (or 90 days if the lifetime reserve has been exhausted), Medicare makes no further payment.

At the **skilled** level of care, Medicare covers 100 days per benefit period if the person has been hospitalized for at least three days within 30 days of entering skilled care. Medicare pays the full cost for days 1 through 20. For days 21 through 100, Medicare pays the full cost except for a daily coinsurance, which is paid by the beneficiary. After 100 days, Medicare skilled care payment stops until the next benefit period begins.

> Mr. B enters the hospital on January 5. After being hospitalized for four days, he returns home. He enters skilled care on February 1 and stays there until May 15. He is eligible for 100 days of Medicare skilled nursing coverage (20 days of full coverage and 80 days of coinsurance). Medicare coverage ends May 11.
>
> On July 1, Mr. B returns to the hospital. After three days in the hospital, he reenters skilled care. Mr. B is not eligible for any more Medicare skilled nursing coverage, because he has not been outside of a hospital or skilled care long enough to begin a new benefit period.

Medicare coverage of care in a **psychiatric hospital** is as follows:

- There is a lifetime payment limit of 150 days for people who entered a mental health institute (MHI) before January 1, 1989, and did not have a break in their benefit period. (A patient breaks the benefit period by returning home or being placed in a hospital.)
- For a person who entered an MHI after January 1, 1989, the lifetime limit is 190 days.

Medicare does **not** cover the cost of care in a nursing facility for people with mental illness, an intermediate care facility for people with an intellectual disability (ICF/ID), or a psychiatric medical institution for children (PMIC).

Eligibility

Legal reference: 42 CFR 435.911, 441 IAC 76 (Rules in Process)

Unless otherwise specified in this chapter, application policies and general eligibility requirements are the same for people living in a medical institution as for any other applicant. Follow processing procedures described in 8-B, *Application Processing* and eligibility requirements in 8-C, *Nonfinancial Eligibility*, 8-D, *Resources*, 8-E, *Income*, and 8-F, *Coverage Groups*.

A person who is not currently a Medicaid member must file an application as defined in 8-B, *Which Application Form to Use*.

Residents of medical institutions must also:

- Meet specific income and resource guidelines for single and married couples.
- Need the level of care provided by the medical institution. See Medical Necessity.
- Have lived in an institution for 30 consecutive days if in the 300% eligibility group.

Reassess eligibility for a Medicaid member who enters a medical institution to determine if the member meets these additional eligibility requirements. (You do not need to reassess eligibility when a member enters an acute-care hospital unless the member expects to stay or stays more than 30 days.) A new application is not required, unless the person is at the end of a Medically Needy certification period, or the certification period will end within the 30-day stay requirement.

> Mr. W is eligible for Medically Needy with a certification period of May and June. He enters the nursing home on June 5. He is not eligible for nursing facility payment until he meets the requirements of the 300% group because he is over income. Mr. W must file an application.

Even if an application is not needed, evaluate income and resources of the client as well as the other requirements for facility payment. Entering a facility can change the household unit, deeming policies, and countable resources and income. See Effect of Institutionalization on SSI and FIP Eligibility.

A Non-MAGI member who is eligible for full Medicaid before entering the facility does not need to meet the 30-day-stay requirement for nursing facility approval in the month of entry. However, a redetermination is required before facility eligibility can be approved for ongoing months. A member, who is redetermined to the 300% group, must meet the 30-day-stay requirement before ongoing eligibility is approved.

MAGI-related members are not eligible for payment of long term care services. Exception: Children under the age of 21 who meet eligibility under the 300% group. In the month of entry, the income of the parents is counted. If the child continues to be institutionalized in the month after the month of admission, the child is considered as an individual. The income of the parents is not counted or deemed to the child.

Newborns who do not leave the hospital or who are transferred to another medical institution are considered as individuals. When a newborn is not discharged home but goes directly to another medical facility, the income of the parents is not counted or deemed to the child.

Newborns who are discharged home but return to the hospital or some other medical institution are considered part of the household in the month of admission. The income of the parents is counted or deemed in the month of entry. If the child continues to be institutionalized in the month after the month of admission, the child is considered as an individual. The income of the parents is not counted or deemed to the child.

Count resources according to 8-D, Resource Eligibility of Children.

The 30-day stay requirement applies to people in the 300% group only. Medicaid members who are automatically redetermined to another coverage group to cover the cost of facility care do not need to meet the 30-day-stay requirement unless they are redetermined to the 300% group.

> A MEPD member enters a nursing facility on April 15. The member is eligible for nursing facility assistance in the month of entry. The IM worker redetermines eligibility for ongoing months and finds that the member meets level of care requirements, is over the 300% limit, but continues to be eligible for MEPD. The member is eligible for nursing facility assistance for ongoing months because the member meets level-of-care requirements and remains eligible for Medicaid in a full coverage group.

Assess client participation as specified in Client Participation for all members.

For ICF/ID, see 6-Appendix for instructions on completing the required form, *ICF/ID Residential Care Agreement*, form 470-0374.

Medicaid eligibility may be established for a person who lives in a medical institution that does not participate in the Medicaid program, even though no Medicaid payment will be made to the facility. Determine income, resources, and level of care as though the institution were participating in Medicaid.

The Iowa Medicaid (IM) Medical Services Unit will do a level of care determination for a person in a facility that is not Medicaid-certified. If the person does not meet the facility's level of care, determine eligibility as if the person lived at home.

The following sections give more information on:

- Who is not eligible for Medicaid payment of institutional care
- Eligibility under the 300% coverage group
- Determination of medical necessity for institutional care
- The effect of institutionalization on SSI and FIP eligibility

Who Is Not Eligible

Legal reference: 441 IAC 75 (Rules in Process)

Eligibility under most coverage groups includes eligibility for Medicaid medical institution payment if the medical necessity requirements are met. Exceptions are as follows:

- The Medically Needy coverage group does not provide for payment for nursing care, skilled care, ICF/ID or NF/MI care, or care in psychiatric institutions.
- The qualified Medicare beneficiary (QMB) coverage group provides limited coverage for hospital and skilled nursing care and no coverage for nursing care or ICF/ID care. Only Medicare premiums, coinsurance, and deductible are covered.
- The qualified disabled and working persons (QDWP) coverage group provides Medicaid payment only for Medicare Part A premiums.
- The specified low-income Medicare beneficiary (SLMB) and the expanded specified low-income Medicare beneficiary (E-SLMB) coverage groups provide Medicaid payment only for Medicare Part B premiums.

Examine such cases to determine if the members would be eligible for institutional care payment if in another coverage group. Obtain a new application only if a Medically Needy certification is about to end.

Eligibility for the 300% Group

Legal reference: 441 IAC 75 (Rules in Process)

The 300% group is an eligibility group used for a person in a medical institution who meets all the following requirements:

- Has countable income less than or equal to 300% of the SSI benefit amount.
- Meets level of care requirements as determined by the Iowa Medicaid (IM). See Medical Necessity.
- Receives care in a hospital, nursing facility, psychiatric medical institution, or ICF/ID for 30 consecutive days.
- The person 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.

For more information about the 300% group, see 8-F, People in Medical Institutions: 300% Income Level.

Do not approve eligibility until after the applicant has lived in an institution for at least 30 **consecutive** days. Eligibility begins no earlier than the first day of the month in which the 30-day period began. The period begins at 12 a.m. on the day of admission and ends no earlier than 12 midnight of the thirtieth day following the beginning of the period.

Only one 30-day period is required to establish eligibility. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month, regardless of whether the eligibility determination was completed before discharge.

If the person dies before completing the 30-day period, consider the person to have met the 30-day requirement.

The 30-day stay requirement applies to the 300% group only. Medicaid members who are automatically redetermined to another coverage group to cover the cost of facility care do not need to meet the 30-day-stay requirement unless they are redetermined to the 300% group.

A temporary absence of not more than 14 full consecutive days does not interrupt the 30-day period if the person remains under the jurisdiction of the institution. The person must first have been physically admitted to the institution.

Do not wait until after the 30-day period is over to verify other eligibility factors such as income and resources.

1. The client enters a nursing facility at 4:00 p.m. on September 5 and remains there. An application for Medicaid is received on September 12. The 30-day period of residency is met on October 4. Eligibility can be established on October 4, effective September 1, assuming all other eligibility factors are met. There is no eligibility for a prior period under the 300% coverage group.
2. The client enters a hospital at noon on August 1, transfers to a nursing facility August 15, and remains there until October 15. An application is received September 15. Eligibility can be established effective August 1 for the 300% group, assuming all other eligibility factors are met.
3. The client enters the hospital on August 15 and leaves September 15. The client is eligible for Medicaid under the 300% group effective August 1. Eligibility for the 300% group ends September 30, providing timely notice is given.
4. The client has been a private-pay patient at a nursing facility for several years. An application for Medicaid is received August 10. Eligibility can be established retroactive to May 1, assuming all other eligibility factors are met.
5. The client enters a nursing facility on July 31 and is discharged September 10. Eligibility can be established for July, August, and September, assuming all other eligibility factors are met.

6. The client enters the hospital March 31, leaves the hospital on April 14, and returns to the hospital April 16. The client is **not** eligible, since the client was not in the hospital for 30 consecutive days. The client must establish the 30-day period in the medical institution starting April 16 up to and including May 15 to be eligible for the 300% group.

People with income in excess of 300% of the SSI benefit for one person may qualify for Medicaid payment for institutional care using a medical assistance income trust. See Members with a Medical Assistance Income Trust (MAIT).

Eligibility of Blind or Disabled Children in Medical Institutions

Legal reference: 42 CFR 435.725, 441 IAC 75 (Rules in Process)

A blind or disabled child under age 18 (or under age 22 if a student) may be eligible for institutional care. The child is eligible for the month of birth if all other eligibility factors are met.

Count the income of the parents for the month the child entered the institution if the child lived with the parents for part of that month. See 8-E, *Deeming SSI-Related Income* for a description of the deeming process between parents and children.

Effective with the first full calendar month of institutionalization, consider only the income and resources of the child when determining Medicaid eligibility. A child who is born in a medical institution and does not leave the institution during the month of birth is considered a resident of the institution for a full calendar month. Count only the child's income when determining eligibility.

For treatment of resources, see 8-D, *Resource Eligibility of Children*.

The income and resources of the parents are not deemed to the child until the month following the month of discharge.

3-20-03 Child is born in hospital
4-10-03 Child leaves hospital for parent's home

The parents' income is not considered in determining eligibility for March and April.

Preadmission and Resident Review (PASRR)

All individuals entering a Medicaid-certified nursing facility must have a Preadmission Screening and Resident Review (PASRR) completed. PASRR is a federally required process to ensure that individuals with intellectual disabilities or mental illness are appropriately screened, evaluated, placed in nursing facilities when appropriate; and if placed in a nursing facility, are receiving all services necessary to meet the resident's needs. A PASSR must be completed prior to an individual being admitted into a nursing facility.

All nursing facilities in Iowa are required to use the PathTracker system to enter resident admissions, transfers, and discharges. PathTracker data is used to generate form 470-5386, PASRR Case Activity Report.

Medical Necessity

Legal reference: 441 IAC 78.3(249A), 441 IAC 81.3(249A), 441 IAC 81.7(249A), 441 IAC 82.7(249A), 441 IAC 82.8(249A), 441 IAC 85.7(2)

A person is eligible for Medicaid payment for care in a long term care facility or psychiatric institution only if the level of care provided is determined to be reasonable, medically necessary, and appropriate.

A level of care determination is required when a person enters a facility or moves to a different level of care. Use the Case Activity Report to determine who will be making the level of care determination. Review the form to verify the date of the member's admission to the facility and Medicare coverage.

The Iowa Medicaid (IM) Medical Services Unit or the MCO determine whether the person needs the level of care provided by a medical institution. However, when a person is eligible for Medicare and admits into a facility using their Medicare skilled nursing benefit, the Medicare intermediary makes the determination. Accept a level of care determination completed for Medicare purposes for determining Medicaid eligibility. A person who has been approved for Medicare at a particular level of care is eligible for the same level of care under Medicaid. The facility should submit a new Case Activity Report when Medicare benefits are exhausted. To begin the process, make entries to pend the facility program in ELIAS. This initiates the level of care determination.

The Iowa Medicaid (IM) Medical Services Unit nurse reviewer or the MCO makes a level of care determination based on the information provided and enters the decision in IoWANS. IoWANS documents the level of care approval and effective date.

If a member has requested retroactive eligibility to cover cost of medical institution care, check to see if the Iowa Medicaid (IM) Medical Services Unit has made a retroactive determination. A person may have needed institutional care in the retroactive period even if such care is not medically necessary now.

If the member meets all other eligibility requirements and the level of care is medically necessary, complete ELIAS entries for an eligibility determination. For more information, see 14-M, IoWANS User Guide for specific enrollment processes.

See If Level of Care Is Denied for procedures when the Iowa Medicaid (IM) Medical Services Unit finds that the person does not need the level of care requested.

NOTE: When a person requests Medicaid payment for skilled nursing care in an out-of-state facility, refer the facility to the Bureau of Medical and Long Term Services and Supports for approval of payment. Also discuss the waivers and programs for all-inclusive care for the elderly (PACE) with these applicants and request waiver slots if appropriate. (A person receiving Iowa Medicaid payment in an out-of-state facility is still considered an Iowa resident and can be put on waiver waiting lists.)

Continued Stay Reviews

Legal reference: 441 IAC 78.3(249A), 441 IAC 81.3(1), 441 IAC 81.7(249A), 441 IAC 82.8(249A), 441 IAC 85.7(2)

An initial medical necessity determination does not ensure continued eligibility. The Iowa Medicaid (IM) Medical Services Unit or the MCO will review the member's level of care within 90 days after admission. A member must continue to need the level of institutionalized care provided in order to ensure continued eligibility.

Assume that the level of care continues to be approved as long as the member stays at the same level of care. The Iowa Medicaid (IM) Medical Services Unit will notify you of any change in the level of care.

See If Level of Care Is Denied for procedures when the Iowa Medicaid (IM) Medical Services Unit finds that the member does not need the level of care received. If a continued-stay review denies the current level of care, but the member continues to need care in a medical institution, eligibility can continue with payment at the lower level of care. See Approval at a Lower Level of Care.

If Level of Care Is Denied

Legal reference: 441 IAC 81.3(1)

If the applicant does not need a level of medical institution care or needs a lower level than requested, the Iowa Medicaid (IM) Medical Services Unit or the MCO issues a denial letter to the applicant, the physician, the facility, and the Bureau of Medical and Long Term Services and Supports. IoWANS will notify you if level of care is denied.

The client may file an appeal if the client disagrees with the Iowa Medicaid (IM) decision. Appeal requests should be sent to the Department's Appeals Section following the normal appeal procedure in 1-E, Appeals and Hearings. Iowa Medicaid (IM) staff will review the previous denial and complete an internal reconsideration in preparation for the appeal.

When level of care is denied, the application for payment of nursing facility care should be denied. People in the 300% group must need institutional care as a condition of eligibility. People who qualify under other coverage groups may be eligible for general Medicaid services even if they are not eligible for Medicaid payment for their institutional care.

1. Mr. P has lived in a nursing facility for four years and has gross income of $700 monthly. He applies for Medicaid March 1. Iowa Medicaid (IM) determines that Mr. P does not need care in a medical institution. He is not eligible for Medicaid payment for nursing care. Medicaid eligibility under other coverage groups is examined.
2. Mrs. W has been receiving skilled care for three months when she applies for Medicaid November 5. Iowa Medicaid (IM) determines that Mrs. W does not need skilled care, but does need nursing care. Ms. W meets all other eligibility factors. The application is approved for medical institution care at the nursing care level.

If a person files a timely appeal of a level of care denial in a continued stay review, continue assistance pending the decision.

If the appeal decision upholds the Iowa Medicaid (IM) denial, examine the case to determine if the client is eligible for another Medicaid coverage group that does not depend on institutional residence (e.g. Medically Needy or qualified Medicare beneficiary). If so, payment will be made for other services. No payment will be made for facility care. Enter the aid type the person would have if living at home.

Ms. A is a Medicaid member in a nursing facility. She is in the 300% group and has income of $900 per month. She is denied nursing level of care and receives the final decision June 3 that she no longer needs care in a medical institution. Her case is canceled effective July 1 for the 300% group. She is automatically determined eligible for the Medically Needy coverage group.

Approval at a Lower Level of Care

Legal reference: 441 IAC 81.10(4)“g,” 441 IAC 78.3(6), 441 IAC 78.3(14)

If the Iowa Medicaid (IM) Medical Services Unit or the MCO determines that a person needs a lower level of care, the client must seek placement in the correct level of care. The social worker at the facility is responsible for finding another placement if the current facility does not offer the lower level of care.

If an alternative placement is not available, payment may be made at the lower level if the facility agrees to accept it. When the facility agrees to accept payment at the rate for the certified lower level of care, continue to use the same aid type entered for the original level of care.

Mr. N is initially approved for nursing level of care. At the continued stay review, he is determined to need residential level of care. Payment can continue at the residential care facility rate. The case continues under the nursing facility aid type and vendor number used before the denial of level of care.

If the facility will not accept the lower payment rate, approve Medicaid in the aid type the person would be in if living at home.

NOTE: ICFs/ID and PMICs offer care that is not primarily nursing care. Iowa Medicaid (IM) does not usually certify a lower level of care for people in these facilities.

Effect of Institutionalization on SSI and FIP Eligibility

How SSI Eligibility Is Affected

Legal reference: 20 CFR 416.211, 20 CFR 416.414

Entry into a medical institution may affect SSI eligibility including the benefit amount and deeming policies. When an SSI recipient enters a medical institution, notify the Social Security Administration district office using form 470-0641, *Report of Change in Circumstances - SSI-Related Programs*. This allows Social Security to review the payment.

When an SSI recipient enters a public or private medical institution in which Medicaid pays more than 50% of the cost of care, different SSI benefits rates apply. The person is entitled to the full SSI benefit rate for any month in which the person is out of the institution for part of the month.

The SSI benefit rate drops to $30 effective with the first full calendar month that the person is in the institution. For many people in institutions, this policy results in loss of SSI benefits. If SSI benefits continue, then Medicaid eligibility can continue without completing a review.

Recipients who lose SSI eligibility because they enter the institution must complete an application. This form is for purposes of review and is not an application. Complete an automatic redetermination to see if the person meets the requirements of another Medicaid coverage group.

When Medicaid is **not** paying at least 50% of the cost of **private** institutional care for an SSI recipient, the person continues to receive full SSI benefits as though the person were in an independent living arrangement. The Social Security Administration determines who is paying 50% of the cost of care. When SSI continues, the person retains Medicaid eligibility by virtue of the receipt of SSI benefits.

When an SSI recipient enters a **public** medical institution, such as a state mental health institute, SSI benefits end effective with the first full calendar month the person lives in the institution, unless Medicaid is paying at least 50% of the cost.
EXCEPTIONS:

- Full SSI benefits continue for up to three months, even if Medicaid pays 50% of the cost of care, when a doctor verifies that the stay will be less than three months.
- People who perform substantial gainful activity receive the full SSI benefit for two full months after entry to a medical institution.

When SSI recipients aged 22 through 64 enter a mental health institution, they lose SSI eligibility after being in the institution for a full calendar month.

The Social Security Administration stops deeming income and resources from ineligible parents to an eligible child effective the month after the month the child enters a medical institution.

When both members of a married couple receive SSI and one enters a medical institution, the Social Security Administration considers them a couple for the month of entry. They are considered separately the next month for SSI. Medicaid policy considers each member of the couple for attribution even though one or both members may be on SSI.

1. Mr. W, age 65, enters a mental health institute and applies for Medicaid. His income is $100 per month. He would be eligible for SSI outside the institution, but the SSI benefit level changes to $30 since Medicaid is expected to pay more than 50% of the care, and his income is in excess of that amount. He is eligible under the coverage group "eligible for SSI but for living in a medical institution."
2. Mr. J, an SSI recipient, age 32, enters a county hospital in its swing-bed unit. There is an initial level-of-care denial. Mr. J has insurance that pays the swing-bed. Since Medicaid does not pay 50% of the cost of care, Mr. J is canceled from SSI. However, Medicaid continues under the coverage group for persons ineligible for SSI because of requirements that do not apply to Medicaid, because Mr. J meets all other SSI requirements.

How FIP Eligibility Is Affected

Legal reference: 441 IAC 41.23(3)"b"

Entry into a medical institution may affect Family Investment Program (FIP) eligibility. Examine eligibility to determine if the person who enters the medical institution continues to meet the FIP definition of "living with." See *4-C, Temporary Absence in a Medical Institution*.

The person is not a part of the FIP eligible group at home if the person is not expected to return within one year from either:

- The date of application, if the person is not a current member, or
- The date of entry to a medical institution, if the person is a current member.

If the person is not "living with" the family at home, determine eligibility of the person in a medical facility separately.

If a MAGI-related person loses eligibility under the previous coverage group, examine eligibility under a Non-MAGI-related coverage group. Examine eligibility under the 300% group for a child under 21.

If a parent is 21 or older, determine if the family would be eligible for FIP if the person were to live at home.

Income and Resources of Married Persons

Legal reference: 441 IAC 75 (Rules in Process)

If a spouse in an institution is expected to stay at least 30 consecutive days, some eligibility factors are considered differently. These include:

- Determining income from property.
- Division of income for Non-MAGI-related groups.
- Attribution of resources to an institutionalized spouse and a community spouse. (There is no attribution for single persons.)
- Different income and resource policies for spouses who entered an institution before September 30, 1989, and those who entered on or after that date.

Determine the anticipated length of institutionalization for new applicants. Verify with a physician that the stay is expected to last at least 30 consecutive days if the client is unsure or the information is questionable.

Eligibility factors are also different depending upon whether one or both spouses are in an institution and whether they share a room. This section deals with the different requirements based on length of stay and living arrangements.

When one spouse is in an institution, treatment of income and resources depends upon the spouse's situation, as explained in the following chart:

WHEN ONE SPOUSE IS IN AN INSTITUTION	
Expected stay of less than 30 days:	
Income: Compare household income to SSI limit for couple when determining eligibility.	**Resources:** Compare household resources to SSI limit for a couple when determining eligibility.
Mrs. M enters skilled care after a hip injury, expecting to stay about 20 days. Mr. M, her spouse, is at home. Mr. and Mrs. M have gross income of $600 monthly and countable resources of $6,000. Mrs. M's eligibility is determined with Mr. M, since she is not expected to remain in a medical institution 30 consecutive days. They may be eligible under the Qualified Medicare Beneficiary group or Medically Needy (for services other than skilled care).	

Expected stay of less than 30 days, but stay exceeds 30 days:	
Income: Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to minimum monthly maintenance needs allowance (MMMNA).	**Resources:** Complete an attribution.
In an institution on or after September 30, 1989, for 30 days or more:	
Income: Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	**Resources:** Complete an attribution.
Institutionalized spouse returns home, but community spouse enters facility and expects to stay 30 days or more:	
Income: Count only the newly institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	**Resources:** Complete an attribution for new institutionalized spouse and new community spouse.
Marries a community spouse before eligibility is established:	
Income: Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	**Resources:** Complete an attribution for new institutionalized spouse and new community spouse as of the date of entry into the medical institution.
Marries a community spouse after eligibility is established:	
Income: Count only the institutionalized spouse's income to determine eligibility and client participation. May divert income to the community spouse to raise income to MMMNA.	**Resources:** Compare the institutionalized spouse's resources to the single-person limit. Do not count community spouse's resources to institutionalized spouse. Complete an attribution for the new institutionalized spouse and new community spouse only if the institutionalized spouse's assistance is canceled and reapplication is made.

Institutionalized person marries another institutionalized person:	
Income: Treat as individuals or a couple per client request and client advantage. If treated as a couple, compare total gross income to 2 x 300%. If treated as individuals, income limit of 300% for each person.	**Resources:** Treat as individuals or a couple per client request and client advantage. If treated as a couple, add resources, compare to $3,000 limit. If treated as individuals, resource limit is $2,000 for each person.

Determining If a Common-Law Marriage Exists

Legal reference: Legislative Guide to Marriage Law/Iowa Legislative Services Agency at https://www.legis.iowa.gov/docs/central/guides/marriage.pdf; IowaLegalAid.org at http://www.iowalegalaid.org/resource/common-law-marriage-in-iowa

When determining if someone has a spouse, there may be situations where a common-law marriage exists or the applicant or member claims a common-law marriage exists. Accept a couple's claim that a common-law marriage exists unless you have reason to question the claim. If you question the claim, a common-law marriage exists if **both** people:

- Mutually agree they are married (they are not free to marry someone else).
- Live together continuously or lived together continuously before one member entered a medical institution.
- Publicly declare and present themselves to be married.

The following items can further indicate that a common-law marriage exists:

- Joint income tax forms
- Joint purchase of property (house, car, etc.)
- Mortgages or loans
- Insurance policies
- School records
- Employment records
- Birth records
- Joint bank accounts
- Statements to friends or relatives
- Hotel or motel registrations
- Wear wedding bands

Evidence must represent the couple as married. One item is generally not enough evidence, but several items might indicate a common-law marriage.

A common-law marriage is a legal and valid marriage. When a common-law marriage exists, treat the adults the same as any other married couple.

1. Mr. Brown applies for nursing facility care. Mr. Brown and Ms. Smith have lived together for 25 years. They have purchased several properties together, including the home they live in. They have a joint bank account.

   Mr. Brown requests that an attribution be completed because he states they are common law. There is no evidence that they have publicly declared or presented themselves as married. They have always filed individual income tax returns.

   Since they have never publicly declared or presented themselves as married and never filed a joint return, evidence shows they are not common law. Do not complete an attribution.

2. Sally and John complete an application for facility care. John is listed as the spouse. Sally enters a medical institution on April 14.

   In a phone conversation with John, he states they have a common-law marriage. Sally and John have publicly declared they are husband and wife. John has Sally listed on his employment application as his wife. This creates a presumption that a common-law marriage exists.

   The worker completes an attribution of resources. When Sally is resource-eligible, John will be allowed a spousal diversion, if applicable.

When Both Spouses Are in an Institution

When both spouses are institutionalized and living in different facilities, treat each as a single individual. Do not count the income and resources of one spouse to determine the eligibility of the other spouse.

When both spouses are in the same institution, treatment of income and resources depends upon whether the spouses are living in the same room or in different rooms, as explained below.

Living in the Same Room

Legal reference: 441 IAC 75 (Rules in Process)

If spouses live in the same room in a medical institution, treat their income as a couple from the month the first spouse entered the medical institution until the last day of the sixth calendar month in which the first spouse continuously lived in the facility. The six-month period that the couple must be treated together begins with the month following the month of entry into the institution when both spouses enter in the same month. When spouses enter the same room at different times, see When a Spouse Moves into the Same Room.

To be eligible for Medicaid, the couple's combined income cannot be more than two times the 300% limit of the SSI benefit for a single person. Use the SSI resource limit for a married couple.

After Six Months

Effective the first day of the seventh calendar month, spouses can choose to be treated individually. If they chose to be separate, the income of each spouse cannot exceed 300% of the SSI benefit for one, and the resource limit is $2,000 for each person.

The couple can continue to be treated as a couple after six months if:

- They choose to be considered together, or
- One spouse would be ineligible for Medicaid or would receive reduced benefits by considering them separately.

People treated together as a couple for income and client participation must be treated as a couple for resources. People treated individually for income and client participation must be treated individually for resources.

1. Mr. and Mrs. J, a married couple, enter the same room in a nursing facility on June 13. Mr. J has gross income of $950, and Mrs. J has gross income of $675. Their combined income of $1,625 is compared to twice the 300% income limit for June through December. In January, they choose to be separate and their respective incomes are compared to the single-person gross income limit.

   They have countable resources of $3,000 in a joint checking account. For June through December, their resources are combined and compared to the couple limit. For January, half of their combined resources is compared to the single-person resource limit. (The jointly owned checking account is divided in half, since each spouse is a Medicaid member.)

2. Mr. and Mrs. Z enter the same room of a nursing facility in January. Mr. Z's income is $2,700 per month and Mrs. Z's income is $300 per month. Their combined income is $3,000; their combined resources are $2,900.

   As of July 1, eligibility for Mr. and Mrs. Z can be determined as separate individuals. Because this would make Mr. Z ineligible beginning July 1, the worker continues to determine the Zs' NF eligibility as a couple.

When a Spouse Moves Into the Same Room

Legal reference: 441 IAC 75 (Rules in Process)

If one spouse is in an institution and the second spouse later moves into the same room within six months of the first spouse's entry, the policies under Living in the Same Room apply to the eligibility of the second spouse. The eligibility and client participation of the spouse who has been in the institution does not change for the month of entry of the second spouse.

The initial eligibility of the second spouse to enter the institution is considered with the spouse already in the institution when they both live in the same room during the six-month period. In the **next month** after the second spouse's entry, combine the income of both spouses when determining each person's eligibility, until the six-month period has expired. The six-month period begins the month of entry of the first spouse.

Once the six months has elapsed, there is no second six-month period if the couple enters different rooms and then later reenters the same room. There is not a new six months' treatment for a couple's income and resources if the couple changes nursing homes. However, if both spouses return home and then reenter a medical facility, a new six months of treatment as a couple applies.

> Mr. Y entered a nursing facility in May and became eligible for Medicaid. Mrs. Y enters the same room in June. Their eligibility must be considered together from June through October 31. Her eligibility is determined by adding her income of $450 to Mr. Y's income of $575 and comparing the result of $1,025 to twice the 300% income limit. Her countable resources of $1,180 are added to his countable resources of $1,817. She is eligible.

Living in Different Rooms

Legal reference: 441 IAC 75 (Rules in Process)

If both spouses are institutionalized in the same facility but in different rooms:

- Treat their income and resources as a couple for the month of entry to the institution. Combined income may not exceed two times the 300% limit for an individual.
- Treat their income separately for eligibility purposes effective the month after the month of entry.

The spouses can be treated as a couple effective the first day of the seventh calendar month of continuous residency in the same facility if:

- One spouse would be ineligible or would receive reduced benefits if considered separately, or
- The spouses choose to be considered together.

If the spouses enter separate rooms at different times, treat income and resources as for an individual. After the spouse who entered the facility first has been in the facility for six months, the spouses may choose to be considered together for eligibility.

> Mr. W enters skilled nursing facility care and Mrs. W enters an NF care on November 7 (not in the same room). Their joint income is $897. They must remain in a medical facility 30 consecutive days for eligibility. They meet this requirement December 6.
>
> Mr. W's income is $497 monthly and Mrs. W's income is $400 monthly. Mr. W has $1,800 in a savings account and Mrs. W has $1,400 in checking.
>
> For November, the combined income of Mr. and Mrs. W is counted towards two times the 300% income limit for an individual. Their income ($897) is below this limit. The couple's joint resources ($1,800 + $1,400 = $3,200) are compared to the resource limit for a couple.
>
> Mr. and Mrs. W are both ineligible for the 300% group for November because their combined resources exceed the couple limit for the 300% group. They are conditionally eligible for Medically Needy.
>
> For December, each person's resources are compared to the resource limit for an individual. Mr. and Mrs. W each have resources below the 300% group limit, so they become eligible effective December 1.

When Applying for or Receiving Waiver or PACE Services

Legal reference: 441 IAC 83.2(1)"f," 441 IAC 83.3(5), 441 IAC 83.22(1)"c," 441 IAC 83.23(5), 441 IAC 83.42(1)"c," 441 IAC 83.43(5), 441 IAC 83.61(1)"b," 441 IAC 83.62(5), 441 IAC 83.82(1)"b," 441 IAC 83.83(4), 441 IAC 83.102(1)"e," 441 IAC 83.103(4)

hen one spouse is applying for or receiving home- and community-based service (HCBS) waiver or programs for all-inclusive care for the elderly (PACE) services and the other spouse lives in the home, treat income and resources according to policies under Income and Resources of Married Persons in the category "In an institution on or after September 30, 1989, for 30 days or more."

When both spouses are applying for or receiving HCBS waiver or PACE services, treat income and resources according to policies under When Both Spouses Are in an Institution: Living in the Same Room.

When one spouse is in a medical facility and the other spouse is applying for or receiving HCBS waiver or PACE services, treat each as an individual. Do not count the income and resources of one spouse to determine the eligibility of the other spouse.

Client Participation

Legal reference: 42 CFR 435.725, 441 IAC 75 (Rules in Process), 441 IAC 81.4(2), 441 IAC 82.9(2)

Medicaid members (except for members in acute hospital care or QMB recipients) are required to participate in the cost of medical institution care. The amount that a resident contributes is called “client participation.” Both client participation and third party payments, such as Medicare, must be paid before any Medicaid payment.

The facility is notified of the member’s client participation amount through the Iowa Medicaid Provider Access (IMPA) portal.

The facility makes arrangements directly with the resident to collect client participation. Generally, the facility will ask the member to pay client participation at the beginning of the month from income received during the month. If income is received periodically during the month, the member may be asked to pay the facility as income is received.

This section describes:

- Countable and exempt income in determining the client participation.
- Deductions.
- How client participation is calculated.

Enter gross income into the system to determine first-month and ongoing client participation.

Review the client participation determination at the time of the eligibility review. Verify:

- The member’s income and deductions.
- The income of the community spouse and dependents.
- The cost of unmet medical needs.

Income Available for Client Participation

Legal reference: 42 CFR 435.725, 441 IAC 75 (Rules in Process)

Use the member's total monthly income, including:

- The $30 benefit that SSI pays to people who remain eligible in a medical institution.
- Infrequent and irregular income disregarded during eligibility computation.
- All earned income and child support. (NOTE: The $25 annual fee paid to Child Support Services is not considered income.)
- The gross income before tax or social security withholding. (Members can write the income source to ask that federal tax not be withheld. Members should describe their living and financial circumstances in the request.)
- Veterans aid and attendance if included in the monthly VA check. Do not allow a deduction for amounts being recouped. Enter the aid and attendance amount as "income" for benefits if the system is determining client participation.
- Veterans payments for unusual medical expenses (UME) included in the monthly VA check, if the veteran or the surviving spouse of a veteran is residing in the Iowa Veterans Home (IVH) in Marshalltown **and** does not have a spouse or dependents. In these circumstances, the first $90 of the monthly VA check is not considered to be UME.

  Payments for UME are not considered as income in determining eligibility or client participation for veterans residing in other medical facilities or those residing at the IVH who have a spouse or other dependents.
- Deemed income from the parent for any month when a child spends part of the month in the parents' household (i.e., the child enters the facility on a day other than the first of the month).
- Benefits from insurance policies for institutional care that are paid to the policyholder but excluded as income for eligibility purposes. (See 8-E, What Is Not Considered Income and Types of SSI Related Income: Insurance and Third-Party Payments for a description of this type of income.)
- Interest and dividends that are excluded during the eligibility computation.

See 8-E, Projecting Income for instructions on calculating client participation correctly.

Do not allow the earned income deduction of $65 and 1/2 or the $20 disregard in computing gross income. See Ongoing Personal Needs Allowance regarding earned income.

Ms. J. has a gross monthly pension of $50.00. $5.80 is deducted from the pension for federal income tax. Also, she has infrequent interest income that prorates to $6.00 monthly. The $50.00 gross pension and $6.00 interest are counted as income in computing client participation.

If a client enters skilled care, check with the facility to determine if Medicare will share in the cost of care. Calculate client participation as if Medicare were not paying. The facility will refund any excess client participation to the client.

EXCEPTION: Client participation is not accessed when the combination of Medicare payments and Medicaid benefits available to qualified Medicare beneficiaries covers the cost of skilled care. For more information on client participation in skilled care, see Client Participation for QMBs Entering Skilled Care.

If there is a community spouse, consider only the institutionalized spouse's income when determining client participation.

If both spouses are in the same room and they chose to be considered as a couple, use the couple's combined income to determine eligibility. Determine client participation for each spouse based on half of the combined income.

If spouses are living in different rooms of the same medical institution or in different medical institutions, they are considered separately for eligibility. Consider each person's income separately for client participation.

Benefits insurance policies that are paid to the policyholder are considered available to pay for facility care. Add them to the client participation for the benefit calculation. These payments are not considered income for eligibility as long as they are applied to the member's cost of care. Any insurance payment retained by the member is considered income in the month of receipt and must be included in the eligibility determination.

When an insurance payment is based on a flat rate per day, convert the daily amount to a monthly amount by multiplying by 30.4. Add the monthly amount to the client participation after giving all allowable deductions. Do not complete form 470-2826, *Insurance Questionnaire*, when the insurance payments are added to the client participation. (See 8-E, *Third-Party Payments*.)

If the client participation plus the additional insurance benefits exceeds the maximum monthly Medicaid rate, follow policies under If Client Participation Exceeds the Facility's Medicaid Rate.

Mr. M enters a nursing facility. His income consists of $870 in social security and $200 private pension. He also has an insurance policy that he purchased to pay for nursing facility care. The policy pays $70 per day when Mr. M receives nursing facility care. He also has a Medicare supplement insurance policy with an $86 premium.

The premium on his nursing facility policy is waived while he is receiving care in a nursing facility. He is applying the benefits paid by this policy to his monthly nursing facility care charges.

Mr. M applies for Medicaid payment for nursing facility care. The worker calculates the average monthly insurance benefits by taking the $70.00 per day times 30.4, for a monthly average of $2,128.00 and adds this monthly nursing facility insurance benefit to the client participation after all deductions are allowed.

Eligibility Calculation

$ 870.00	Social security
+ 200.00	Private pension
$1,070.00	Total income

Client Participation Calculation

$ 870.00	Social security
+ 200.00	Private pension
$ 1,070.00	Total income
- 50.00	Personal needs
- 86.00	Health insurance
$ 934.00	Client participation
+ 2,128.00	Insurance benefit
$ 3,062.00	Mr. M's payment to the facility

Since Mr. M's payment to the facility is greater than the maximum Medicaid rate for nursing facility care, no Medicaid payment is made.

Veterans Affairs (VA) lump-sum payments are income in the month of receipt and a resource the month following the month of receipt, except that portion due to aid and attendance and unusual medical expenses.

A VA aid and attendance payment is a third-party liability. Count the aid and attendance for the month it was intended to cover. Recalculate client participation for those months and complete a vendor adjustment or overpayment, as appropriate.

The portion of a VA payment attributable to unusual medical expenses is not considered as income in determining eligibility or client participation. See 8-E, *Non-MAGI-Related Veterans Affairs Payments* for more information about aid and attendance and unusual medical expenses.

Deem parental income to a child in the month of entry to the facility using SSI income policies. See 8-E, *Deeming from an Ineligible Parent to an Eligible Child*.

Income Exempt from Client Participation

Legal reference: P.L. 99-643, 441 IAC 75 (Rules in Process)

For FIP recipients, do not calculate client participation using the income of the member or the family if the member has a parent, stepparent, or child at home who receives FIP and the family's income is considered together in determining FIP eligibility.

> Sam, age 17, enters a facility and is expected to stay less than 12 months. His Medicaid eligibility is determined under the 300% group. The family's income is below the FIP guidelines for their household size.
>
> Sam will need to meet the 30-day stay requirement for the 300% group. The family at home is approved for FIP and neither the family's income nor Sam's income is used to calculate client participation.

For State Supplementary Assistance recipients, exempt the State Supplementary Assistance payment and exempt any client participation that the member paid while in a State Supplementary Assistance living arrangement for the month of entry to the medical institution.

If the member enters a medical institution from foster care, do not count the amount of income paid for foster care when calculating client participation for that month. Check with the service worker for the amount of the member's income that was spent on the foster care maintenance payment, and use the remaining balance as income.

Non-MAGI-Related Members

Legal reference: 441 IAC 75 (Rules in Process)

For Non-MAGI-related members who are substantially gainfully employed, as determined by the Social Security Administration, exempt any SSI and mandatory State Supplementary Assistance payments for the first two full months after the resident enters the institution.

For Non-MAGI-related members expecting to return home within three months, exempt SSI or federally administered State Supplementary Assistance payments for the three months after entry to the institution if the Social Security Administration continues these payments.

To determine whether to exempt the income of an SSI or federally administered SSA recipient, ask how long the person expects to remain in the facility. Record the answer under "Comments" on form 470-0641, *Report of Change of Circumstances*, *SSI-Related Programs*, and send the form to the Social Security Administration district office.

If the expected stay is **more than three months**, assume that SSI and State Supplementary Assistance will end.

If the expected stay is **less than three months**, phone the Social Security Administration to report this. Ask staff to let you know if payments will continue. If payment continues, do not count it in determining client participation.

If the SSI worker does not call you within five days of your telephone call, call the SSI worker again. Act on the best information available from Social Security.

If you assume that SSI or State Supplementary Assistance payments will continue but later determine that the member was not eligible for payments, redetermine client participation based on the actual income for each month.

Ms. H, an SSI recipient, enters a nursing facility on June 10, expecting to stay two months. She informs her worker June 13. The IM worker sends form 470-0641 to the SS office informing them of the move and asking the SSI worker to notify the IM worker of the possibility of continued SSI.

On July 1, the SSI worker notifies the IM worker that the case is being developed. On July 27, the SSI worker says that the SSI will continue. The IM worker notifies Ms. H that the SSI does not count for client participation for July, August, or September. Her social security income and other income are counted.

Veterans or Surviving Spouses of Veterans

Legal reference: 441 IAC 75 (Rules in Process); 38 USC sec. 5503

Veterans Affairs (VA) “reduced/improved” pension payments are limited to $90 per month after a veteran or surviving spouse enters a medical institution unless the person has a spouse or dependent. Federal law requires that this $90 be excluded from client participation (in addition to the $50 personal needs allowance).

The VA considers a report of the changed living arrangement timely if made within 30 days of entry and gives a 60-day notice of benefit reduction. Pension recipients are not required to repay any excess assistance received between the time they report entry to a Medicaid institution and the time VA makes the change.

To determine whether to exempt the income of a veteran or surviving spouse of a veteran, you must:

- Determine the type of VA payment being received. Other types of VA benefits, such as compensation payments, aid and attendance, and unmet medical expenses are not subject to the reduction and do not qualify for the $90 income exclusion.
- Determine whether the person has a spouse or dependents. If the person **has** a spouse or dependent, the pension will not be reduced, and the person does not qualify for the $90 income exclusion.

Based on the person's situation:

- Use the entire VA pension amount to determine eligibility and client participation for the month of entry if the veteran or surviving spouse is entitled to full benefits for that month.
- If the VA pension has already been reduced because the person came from another institutional placement, exclude $90 pension as income when determining eligibility and client participation.
- If the client **does not have** a spouse or dependent, assume that the VA pension will be reduced to $90. Exclude $90 pension income when determining income and client participation beginning with the month after the month of entry to the institution.
- If the VA continues to pay full benefits to a member whose pension will be changed to $90:
  - Consider any pension or aid and attendance amount over $90 for eligibility and client participation,
  - Tell the member to report when the pension is reduced, and
  - Use the reduced amount to calculate client participation for the month of the reduction, even if the change is reported later.

NOTE: VA pension payments of certain residents of the Iowa Veterans Home are not subject to the $90 limitation but still qualify for the $90 income exclusion. See Residents of the Iowa Veterans Home.

When an application for a VA pension is approved, a lump sum is sent to the member. Exclude the portion of this lump sum that represents the $90 reduced/improved pension, based on federal requirements for eligibility and benefits. Consider any remaining amount of the lump sum as income in the month of receipt. Any amount of the lump sum retained in the following month is a countable resource.

Mr. V has a monthly pension of $600 and gross Social Security benefit of $800. He has no wife or dependent children. He enters a nursing facility from home in January. His full pension continues until April, when it is reduced to $90. Mr. V informs the worker in April of the reduction.

Mr. V's entire VA pension and gross Social Security benefit is used to determine eligibility and client participation for January, and he is allowed expenses of his home in the month of entry (up to the current SSI benefit amount) plus the $50 personal needs allowance.

$90 of Mr. V's VA pension is excluded for eligibility and client participation effective February 1, and ongoing. The remaining $510 VA pension plus the $800 Social Security benefit is countable income until April.

For April, the IM worker removes the $510 from countable income. If the worker is unable to change April client participation by timely notice, the worker must prepare a vendor adjustment to correct the payment.

Residents of the Iowa Veterans Home

Legal reference P.L. 105-33

A person whose Veteran Affairs (VA) pension would normally be limited to $90 after entry to a medical institution will continue to receive the full pension amount upon entry to the Iowa Veterans Home (IVH). However, the person is still entitled to exclude $90 of the pension in the determination of income and client participation.

To determine whether to exempt the income of a veteran or surviving spouse of a veteran who resides in the Iowa Veterans Home (IVH), you must determine:

- The type of VA payment received and
- If the client has a spouse or dependent.

If the client is entitled to a full VA pension for the month of entry to the IVH; then use the entire VA pension to determine eligibility and client participation in the month of entry.

If the client **has a spouse or dependent**, continue to count the full VA pension as income when determining eligibility and client participation. This will result in the client retaining only the $50 personal needs allowance.

If the client **does not have a spouse or dependent**, exclude $90 of the VA pension income beginning the month after the month of entry to the IVH, even though the pension will not be reduced. This will result in the client retaining $90 of the VA pension in addition to the $50 personal needs allowance.

Because of living at the IVH, the member is not subject to the normal $90 VA pension limitation.

NOTE: Persons receiving VA compensation payments are not entitled to the $90 veteran's income exclusion.

VA payments for unusual medical expenses are countable income when determining client participation for residents of the IVH who do not have a spouse or dependents.

Deductions from Client Participation

Members are allowed the following deductions from their income when client participation is calculated:

- Personal needs allowances, which are:
  - An ongoing personal needs allowance
  - Personal needs in the month of entry to the institution
  - Personal needs in the month of discharge from the institution
- Deduction for the maintenance needs of a spouse and dependents.
- Deduction for unmet medical needs.

Each of these deductions is explained in more detail in the next sections.

Ongoing Personal Needs Allowance

Legal reference: 441 IAC 75 (Rules in Process)

All members who have at least $50 in countable monthly income retain $50 for a personal needs allowance. Members who have less than $50 in countable monthly income retain all of their income for a personal needs allowance.

The personal needs allowance is for the member's use for items not provided by the facility, such as magazines, cigarettes, personal care items, etc. If not used, the personal needs allowance represents a countable resource in the month following the month the income was received and is subject to resource limits.

Veteran and surviving spouses of veterans who receive the $90 reduced/improved pension receive a $50 personal needs allowance in addition to the $90 income exclusion. See Veterans or Surviving Spouses of Veterans.

State-Funded Payment

When a member who resides in a nursing facility, ICF/ID, or NF/MI has countable income of less than $50 per month, a state-funded payment for the difference between that countable income and $50 is issued so that the member will have $50 for personal needs. (This state-funded payment is not available to residents of PMICs.)

When a facility application is approved with an effective date in the previous month, issue the appropriate state-funded payment for each month in a lump-sum payment.

Do not consider the lump sum as income in the month of receipt for purposes of determining eligibility or client participation. The state-funded payment is excluded as assistance based on need.

Direct Deposit for State-Funded Payment

Medicaid facility residents or their payees who receive a state-funded payment have the option to request that their payments be deposited directly to an active account at a financial institution.

The date the money is deposited into the account depends on when the payment is authorized, as follows:

- Ongoing monthly payments are deposited into the member's account on the first working day of the month.
- Reinstatements that occur too late in the month to be included with the monthly issuances are generally deposited into the member's account three to five days after the first working day of the month.

Members who choose direct deposit will receive a notification similar to a check stub. This notification is mailed so that the member should receive it close to the date the benefits are available in the account.

Remind members that there is a risk that creditors holding past-due bills could attempt to garnish the account.

When a member requests direct deposit, have the member complete form 470-0261, *Agreement for Automatic Deposit*. See 6-Appendix for the form and instructions for its use.

Use the Automated Direct Deposit (DIRD) system to enroll members in direct deposit. See 14-B(4), DIRD-Automated Direct Deposit for instructions in using the DIRD system. The beginning date for direct deposit is ten working days past the date you enter the direct deposit request in the DIRD, unless another, later beginning date is requested.

Benefits will continue to be credited to the account until the member requests a change and you make direct deposit stop entries in the DIRD system. Act promptly to terminate or change direct deposit when requested to do so by the member.

Remind members to report promptly if the account is closed or changed. Failure to report a closed or changed account can cause delays in getting the payment if the direct deposit is rejected.

If facility assistance is canceled and reinstated before system month end of the month of cancellation, direct deposit will continue. If the facility program is still canceled after system month end, DIRD system entries are required to start direct deposit again.

Earned Income

If the member has earned income, allow an additional $65 deduction from earned income only. The $65 deduction is intended for expenses in producing the income, like transportation, extra clothing, FICA, etc. This deduction is in addition to the $50 deduction for personal needs and the $90 VA pension income exemption for certain veterans and surviving spouses.

If the member has less than $65 of earned income, deduct only the earned amount. If the member has self-employment income, deduct the expenses of self-employment from gross self-employment income. The $65 personal needs allowance is automatically subtracted from the amount of earned income entered in the ELIAS system.

See 8-E, Projecting Income more information.

1. Mr. B, a Medicaid member residing in an ICF/ID, has income of $596. His client participation is $546 monthly ($596 - $50 personal needs).
2. Mrs. D, a Medicaid member residing in a nursing facility, has income of $596. Her client participation is $546 monthly ($596 - $50 personal needs).

3. Mrs. G, a Medicaid member residing in a nursing facility, has income of $30 SSI. Her client participation is $0 and a state-funded payment of $20 is issued to bring her total personal needs allowance up to $50.
4. Ms. M lives in a nursing facility and occasionally works for her former employer when needed. She has $450 a month unearned income and her earned income averages $50 a month. She is allowed a total personal needs deduction of up to $65 from earned income and $50 from unearned income.
5. Mr. H, an SSI recipient living in an ICF/ID, has net self-employment earnings of $18 a month from his hobby, carving wood. He is allowed a total of $48 personal needs allowance, $18 from his earned income and $30 from the SSI income. His client participation is $0. A state-funded payment of $20 is issued to bring his total personal needs allowance to $68.

Personal Needs Expenses in the Month of Entry

Legal reference: 42 CFR 435.725, 42 CFR 435.726, 441 IAC 75 (Rules in Process)

A person entering a medical institution can be given an allowance for stated living expenses during the month of entry unless the person has a community spouse. Allow this deduction in addition to the $50 personal needs allowance.

For a single person, the limit on the deduction for living expenses or the month of entry is the amount of the SSI benefit for one person. Use the following deduction guidelines for married couples:

- If both spouses enter a medical institution in the same month and live in the same room, combine their income in determining client participation for the month of entry. Deduct any claimed expenses from this amount up to the amount of the SSI benefit for a couple.
- If both spouses enter a medical institution in the same month but live in different rooms, deduct any claimed expenses up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than the deduction, give the remainder of the allowance to the other spouse.
- If the community spouse enters a medical institution in a later month, deduct claimed expenses for the month of entry when calculating client participation, up to the amount of the SSI benefit for one person.

Determine the prior living arrangement of the member. People living in a private living arrangement do not have to verify their living expenses unless questionable. Living alone or with friends or relatives is a “private living arrangement,” regardless of who owns the dwelling.

If the person was **not** in a private living arrangement, allow these deductions for personal needs expenses in the month of entry as follows:

- If the member enters a hospital and then enters a nursing facility in the next month, do not allow a personal needs expense deduction for the month of entry into the nursing facility. The month of entry to a medical institution was the month that the person entered the hospital, and client participation is not assessed for people in hospitals.
- If a waiver member or programs for all-inclusive care for the elderly (PACE) enrollee moves to a nursing facility, do not recalculate client participation. Apply any client participation that was not used for waiver services or PACE to the first partial month of facility care.
- If the member was in a residential care facility (RCF) and received State Supplementary Assistance, deduct the amount paid in client participation to the RCF. Follow these same guidelines for members of in-home health-related care.
- If the member was in a RCF but did not receive State Supplementary Assistance, allow a deduction for home-maintenance living expense up to the amount of the SSI benefit for a single person.
- If the member was in a family-life home, deduct the amount paid to the home for client participation.
- If the member was in foster care, deduct the amount of the income retained by the Department to recover foster care expenses.

In April, Mr. L enters skilled care and Mrs. L enters nursing care. Their gross monthly income is $272 for Mrs. L and $430 for Mr. L. They state that they have home maintenance expenses of $1,500 and are allowed a deduction equal to a couple's SSI benefit of $1,450 for the month of entry.

The Ls' combined gross income is $702. Each spouse is allowed a $50 personal needs allowance. The personal allowances and the deduction for living expenses for the month of entry are subtracted from that gross income. ($702 – 50 – 50 – 1,450 = 0)

Personal Needs in the Month of Discharge

Legal reference: 441 IAC 75 (Rules in Process)

The member is allowed an additional personal needs deduction in the month of discharge from a medical institution to a private living arrangement, unless the member has a community spouse. A member does not need to make any declaration of expenses to get this deduction. Deduct the SSI benefit for a single person (or the SSI benefit amount for a couple if both spouses are discharged in the same month).

If member moves from a nursing facility to a HCBS waiver program or programs for all-inclusive care for the elderly (PACE), recalculate the nursing facility client participation. Allow a home maintenance deduction for the month of discharge, even if the member is going to receive waiver or PACE services during the month.

If the member is discharged and returns home and the spouse at home is an HCBS waiver member or PACE enrollee, allow a diversion to the waiver or PACE spouse at home. (See Allowance for the Community Spouse.)

Allow the deduction even if you are informed about the discharge after the member left the facility or after client participation has been paid. Complete a vendor adjustment for the month of discharge if necessary.

1. Ms. M enters skilled care in February and returns home in October. She is allowed a deduction for expenses in October equal to the SSI benefit for one person.
2. Mr. and Mrs. P enter a nursing facility together and return home in the same month. They are given the SSI benefit for two as a deduction in the month of discharge.

Deduction for the Maintenance Needs of Spouse and Dependents

Legal reference: 42 CFR 435.725, 441 IAC 75 (Rules in Process)

Allow a deduction for the maintenance needs for:

- A community spouse and dependents living with the community spouse, including:
  - Children, regardless of age,
  - Parents and in-laws, and
  - Siblings of either spouse.

  NOTE: Consider children under age 22 who are away attending school but are under the control of the parents as living with the community spouse.
- Children under the age of 21 living at home when there is no community spouse.

If the institutionalized spouse has a community spouse with income less than the minimum monthly maintenance needs allowance (MMMNA), allow a deduction to provide an ongoing allowance for the maintenance needs of the community spouse. Also allow a deduction for minor or dependent children, stepchildren, dependent parents, or the dependent siblings of either spouse who live with the community spouse.

The community spouse and dependents must apply for every income benefit for which they are eligible, except they are not required to accept Supplemental Security Income (SSI), Family Investment Program (FIP), or State Supplementary Assistance (SSA) in place of the maintenance needs allowance.

Issue form 470-0383, *Notice Regarding Acceptance of Other Benefits*, to the community spouse and dependents. The community spouse and dependents must indicate whether the member or spouse intends to apply for the identified benefits.

If the community spouse or dependents refuse to apply for benefits, contact the benefit agency to determine benefit amounts for a person in the same financial circumstances as the spouse or dependent. Count the anticipated amount as income as if the spouse or dependents received the benefits. Reduce the maintenance needs allowance by the amount of the anticipated income from each income source.

Consider income prospectively. See 8-E, *Projecting Future Income*. If there is a change in income, consider the change when determining prospective income.

Use the verified gross income of the spouse and dependents when determining maintenance needs. Include all monthly earned and unearned income and assistance from the FIP, SSI, and SSA. Gross income also includes the proceeds of any annuity or contract for sale of real property. See 8-D, *Specific Non-MAGI-Related Resources: Annuities* on how to count annuities.

Consider income the same way the SSI program considers income. Do not allow the community spouse or dependents the earned income disregard or the general income disregard. Do not count any other income disregarded by policy.

If the community spouse is receiving FIP, the community spouse's share of the grant is based on whether the children for whom the FIP benefit is received are the children or the stepchildren of the institutionalized spouse.

- If the children receiving FIP are all stepchildren of the institutionalized spouse, use the standard of need for one as the portion of the FIP benefit to count as income for the community spouse.
- If the children receiving FIP are all children of the institutionalized spouse, consider the FIP grant as income to the community spouse. Divide the grant by the number of people in the household and count the result as income to each person when calculating deficits.
- If the institutionalized spouse has both stepchildren and legal children at home receiving FIP, use the procedure in 4-E, *Excluded Parent* to determine the FIP income of the community spouse.

If the community spouse or dependents receive SSI or federally administered SSA, use the State Data Exchange (SDX) amount labeled “SSI gross” or “SSA gross.”

If the community spouse or dependents receive SSA benefits for in-home health-related care, count all the SSA benefit for the spouse or dependent receiving this care. If both spouses receive in-home health-related care in the month of entry, ask the service worker the amount of the community spouse’s SSA benefit.

Allowance for the Community Spouse

Legal reference: 441 IAC 75 (Rules in Process)

To determine the maintenance needs of the community spouse, subtract the spouse’s gross income from the minimum monthly maintenance needs (MMMNA) allowance shown below. The allowance is indexed annually for inflation.

Minimum Monthly Maintenance Needs Allowance (MMMNA)			
Calendar Year	**Amount**	**Calendar Year**	**Amount**
2025	$3,948.00	2012	$2,841.00
2024	$3,853.50	2011	$2,739.00
2023	$3,715.50	2010	$2,739.00
2022	$3,435.00	2009	$2,739.00
2021	$3,259.50	2008	$2,610.00
2020	$3,216.00	2007	$2,541.00
2019	$3,160.50	2006	$2,488.50
2018	$3,090.00	2005	$2,377.50
2017	$3,022.50	2004	$2,319.00
2016	$2,980.50	2003	$2,266.50
2015	$2,980.50	2002	$2,232.00
2014	$2,931.00	2001	$2,175.00
2013	$2,898.00		

Mr. B enters a nursing facility for long-term care, leaving Mrs. B at home. Mr. B has $800 per month gross income and also receives $100 in aid and attendance payments. The income available from Mr. B to meet Mrs. B’s needs is determined as follows:

$ 800.00 Gross income
- 50.00 Personal needs allowance
$ 750.00 Available to meet Mrs. B’s needs

If the shortfall between Mrs. B’s income and the MMMNA is $750 or more, Mr. B’s client participation will be $100, the amount of his aid and attendance payments.

When one spouse lives in a facility and the other lives in the community and receives HCBS waiver or programs for all-inclusive care for the elderly (PACE) services, the spouses are treated as a married couple living in separate facilities for eligibility.

However, when determining client participation of the institutionalized spouse, a diversion to the community spouse can continue even when the community spouse is receiving waiver or PACE services.

If you divert income from the institutionalized spouse to the community spouse, inform the community spouse's income maintenance and SSI workers when the community spouse or dependents receive FIP, SSI, or SSA.

Either spouse may request an appeal if the spouse believes the community spouse needs income above this level because of significant financial duress. (If the income of the institutionalized spouse does not support a greater allowance for the community spouse, explain this to the client.)

The administrative law judge may substitute a higher allowance. If the appeal decision establishes a higher allowance, substitute this amount as the maintenance need. See 8-D, *If the Applicant Appeals the Attribution Amount.*

If any court orders a greater monthly income allowance against the institutionalized spouse to support the community spouse, use that amount as the minimum monthly maintenance needs allowance. Obtain from the applicant a copy of the court order to verify the amount of the court-ordered support.

If the community spouse indicates in writing that some or all of the diversion is not wanted, make the diversions in the lesser amount requested by the community spouse.

Assume that the community spouse is receiving the benefit of the income diverted from the institutionalized spouse. No further investigation is required unless there is evidence to the contrary. When the income is not made available, make a referral to the adult protective service worker at the request of the community spouse.

1. Mr. B is eligible for Medicaid payment in a nursing facility. His gross income is $650 a month, and Mrs. B's income is $350 a month. The only income that can be provided for a maintenance need for Mrs. B is $650 minus $50 personal needs, or $600 a month.

   This diversion allows a total income of only $950 a month for Mrs. B ($350 + $600). No more income can be diverted to Mrs. B, even if an appeal decision sets her maintenance needs at a higher amount.

2. Mrs. G is receiving skilled care and is eligible for Medicaid in the 300% group. Mr. G is at home. He has earned income of $4,750 per month. No diversion of Mrs. G's income can be made for Mr. G in determining her client participation, because his income exceeds the maintenance need of $3,948.00, and no greater amount has been ordered.

3. Mr. D receives skilled care and is eligible for Medicaid under the 300% group. Mrs. D is living in an RCF and receives SSI and SSA. Mrs. D's income consists of $533 social security, $454 SSI, and $276.30 SSA, for a total of $1,263.30 per month. Mr. D has gross income of $752. He is allowed a $50 personal needs allowance. The diversion is determined as follows:

Mr. D:		Mrs. D:	
$ 752.00	Gross income	$ 3,948.00	Maintenance
- 50.00	Personal needs	- 1,263.30	Income
$ 702.00	To divert	$ 2,684.70	Deficit

   Only $702 can be diverted to Mrs. D, because Mr. D must be allowed an ongoing personal needs allowance before a diversion is made to Mrs. D. Mrs. D's income with the diversion is $1,263.30 + $702.00 = $1,965.30. Mrs. D loses eligibility for State Supplementary Assistance.

4. Mr. O is in a nursing facility and eligible for Medicaid. Mrs. O and their three children are at home and receiving FIP. Mr. O has begun receiving veterans' income of $500 per month. Mrs. O's only income is the FIP grant.

   The amount of FIP to count for Mrs. O in the first month of diversion is the difference between the grant for four people and the grant for three people ($495 - $426 = $69). The diversion to Mrs. O is determined as follows:

Mr. O:		Mrs. O:	
$ 500.00	Income	$ 3,948.00	Maintenance
- 50.00	Personal needs	- 69.00	FIP income
$ 450.00	To divert	$ 3,879.00	Deficit

Mr. O can divert a maximum of $450 of his income to Mrs. O. With this diversion, Mrs. O and the children remain eligible for FIP.

Even though Mrs. O's income may decrease after the initial month, there will be no change in the diversion from Mr. O. He does not have enough income to meet the needs of his spouse.

5. Mrs. E is a community spouse with $500 gross monthly income. She is estranged from Mr. E and has obtained a court order for $4,000 per month in support. The court-ordered amount is substituted for the $3,948.00 maintenance needs. The diversion of income is determined as follows:

Mr. E:		Mrs. E:	
$1,100.00	Gross income	$ 4,000.00	Maintenance
- 50.00	Personal needs	- 500.00	Income
$1,050.00	To divert	$ 3,500.00	Deficit

Mr. E can divert only $1,050 because his income supports only this amount.

Allowance for Other Dependents

Legal reference: 441 IAC 75 (Rules in Process)

Determine the maintenance needs of the other dependents by subtracting **each** person's gross income from 150% of the monthly federal poverty level for a family of two (currently $2,644.00 per month) and dividing the result by three. Include SSI and FIP benefits as income.

The dependent's diversion does not need to be for the benefit of the dependent. That is a requirement for the community spouse diversion only.

1. Mr. T receives Medicaid payment for nursing care. His wife and mother live at home. Diversion for Mr. T's dependents is determined as follows:

Mr. T:		Mrs. T:	
$2,150.00	Gross income	$3,948.00	Maintenance needs
- 50.00	Personal needs	- 970.00	Income
$2,100.00	Available to divert	$2,978.00	Deficit

Mr. T's mother:

$2,644.00	150% FPL for 2
- 398.00	Income
$2,246.00	Divided by 3 = $748.67maintenance for dependent

The total need of the spouse and dependent is $2,978.00 + $748.67 or $3,726.67. Mr. T does not have enough income to meet all of his mother's needs. Mr. T's client participation is determined as follows:

$2,150.00	Gross income
- 50.00	Personal needs allowance
- 2,978.00	Diversion for spousal deficit
- 0.00	Diversion for mother's needs ($2,100.00 - $2,978)
$ 0.00	

2. Mrs. W lives in a nursing facility and is Medicaid-eligible. Mr. W lives at home with two children who do not receive FIP. Mr. W has earned income. Mrs. W has workers' compensation. The children have no income.

Mrs. W:

$ 700.00	Gross income
- 50.00	Personal needs allowance
$ 650.00	Income available to divert to spouse and dependents

The spousal and dependent allowances are determined as follows:

Mr. W:		Children:	
$3,948.00	Maintenance	$2,644.00	Poverty level
- 4,000.00	Gross	- 0.00	Income
$ 0.00	income	$2,644.00	Divided by 3 = $881.33 per child
	Unmet needs		

$881.33 x 2 children = $1,762.66

All of Mrs. W's income after deduction of her personal needs is diverted for the children. Mrs. W's client participation is determined as follows:

$ 700.00	Gross income
- 50.00	Personal needs
- 650.00	Diversion for dependents' needs ($700 – 50 = $650)
$ .00	Amount of client participation

3. Mr. P is in a nursing facility and is eligible for Medicaid. Mrs. P lives at home with her three children (Mr. P's stepchildren) who are eligible for FIP.

   The FIP grant for the children and Mrs. P is $495. The amount for the children is $426. The amount for Mrs. P is $69 ($495 - $426 = $69). Each child is credited with $142 as income ($426 divided by 3). The maintenance allowances are determined as follows:

Mr. P:		Mrs. P:	
$ 821.00	Gross income	$ 3,948.00	Maintenance
- 50.00	Personal needs	- 69.00	FIP income
$ 771.00	Available to divert	3,879.00	Deficit

   All of Mr. P's income is diverted to Mrs. P. There is no more income remaining for a diversion to the dependents.

If the institutionalized person does not have a spouse but does have children under age 21 at home, allow a deduction from the institutionalized person's income to meet the children's maintenance needs. Do not allow a deduction if the children receive FIP.

Count the children's income and a parent's income if living in the home in determining maintenance needs. Use gross income less disregards allowed in the FIP program. Child support is considered income of the child.

Calculate the children's maintenance needs by subtracting the children's income from the FIP standard for that number of children.

1. Mr. G is eligible for Medicaid while living in a nursing facility. He has $700 per month gross income. He has a child aged 20 at home who has no income. The FIP payment standard for one is considered as the need. The determination of the dependent's allowance is as follows:

Mr. G:		Child G:	
$ 700.00	Gross income	$ 183.00	Need for one
- 50.00	Personal needs	- 0.00	Income
$ 650.00	Available to divert	183.00	Deficit

2. Mrs. F is Medicaid-eligible in a nursing facility. She has $350 gross monthly income. She has two children at home who are under 21. One child has unearned income of $105 per month. The determination of the dependents' allowance is as follows:

Mrs. F:		Both children:	
$ 350.00	Gross income	$ 361.00	Payment standard
- 50.00	Personal needs	- 105.00	Unearned income
$ 300.00	Available to divert	$ 256.00	Deficit

$256 can be diverted to meet the needs of the children.

Deduction for Unmet Medical Needs

Legal reference: 42 CFR 435.725, 441 IAC 75 (Rules in Process)

Allow a deduction for expenses a person incurs for medical or remedial care that is not payable by a third party, including the following:

- The member's Medicare premiums, other health insurance premiums (including dental and vision), deductibles, and coinsurance.
  - There should be no Medicare Part A or Part B deductibles or coinsurance once Medicaid eligibility is established. The portion of the premium that remains the member's responsibility is an allowable unmet medical deduction.
  - Members who are enrolled in Part D plans or who qualify for Part D but were not enrolled may continue to be responsible for premiums, deductibles, drug costs, or coinsurance. The length of time the member remains responsible and the amount of expense varies greatly between plans.

    Allow verified expenses as an unmet medical deduction. If a deduction is allowed and expenses are later reimbursed, consider the reimbursement as income in the month of receipt and adjust the client participation accordingly.
- Health insurance premiums for coverage of other persons of the family when the insurance is a family policy that covers the member.
- Expenses for necessary medical or remedial care recognized under state law that are not covered by Medicaid and were not incurred during a transfer of assets penalty period.
- Medical bills for the month of eligibility that the member paid before being determined eligible, unless Medicaid will later pay the bill. For example, a member may have paid a medical bill incurred before eligibility was determined.

  If those bills were incurred during the period that retroactive eligibility is granted or during the month of application, allow the bills to be deducted as long as Medicaid does not later pay the bill.

- Client participation paid in another medical facility and “private pay” payments made by residents of medical institutions.
- Client participation paid for in-home health-related care, home- and community-based waiver services, or programs for all-inclusive care for the elderly (PACE).

1. Mr. S was approved for Medicaid and nursing facility payments effective May 1. He was ineligible for Medicaid before the month of May. Mr. S did not have enough resources to pay all the private-pay charges for the month of April. He still owes the facility $900 for April charges.

   Mr. S arranges with the facility to pay off the $900 by paying $300 in June, $300 in July, and $300 in August. He provides the IM worker with verification of this agreement. An unmet medical deduction of $300 can be allowed for the months of June, July, and August when calculating the client participation for those months.

2. Mrs. A is approved for Medicaid and nursing facility payments effective May 1. She has client participation of $200 but she fails to pay the May client participation during the month of May. In June, Mrs. A pays both the May and the June client participation.

   The IM worker cannot allow an unmet medical deduction in the month of June for the $200 May client participation that was paid late, as it is not a private-pay expense.

Do not allow a deduction for payment of:

- A bank service charge made for handling medical insurance payments.
- Insurance premiums if the benefit paid is counted as income for eligibility.
- Adult day care services from a source not certified as a Medicaid provider. This is not medical care.

If the agent is unable to tell you if the insurance is indemnity or health, ask if an established amount is paid if the member is ill or injured, regardless of the amount of the medical bill. If yes, treat it as an indemnity policy. If benefits are paid only to cover incurred expenses of illness or injury, treat it as a health insurance policy.

If Client Participation Exceeds the Facility’s Medicaid Rate

Legal reference: 441 IAC 81.22(1)

The member is required to pay only the amount charged to the Medicaid program. (When the Department retroactively increases the maximum daily rate, the facility can charge the client the increased amount retroactively.) After computing client participation, if client participation exceeds the facility’s Medicaid rate on IoWANS, the ELIAS system will generate a notice telling the member that the

facility can't charge client participation in excess of the approved Medicaid daily rate for the number of days the member received services in the facility. If eligibility and client participation were calculated manually, add the following words to the notice:

> "This is the most you will have to pay for your care, based on your income. The facility can charge you this amount or their daily rate whichever is less, for the days you are in the facility. If the facility rate changes for the past months, you may have to pay more based on the new rate."

When the client participation equals or exceeds the maximum Medicaid monthly reimbursement rate, no Medicaid payment is made. The member retains any difference between the Medicaid rate charged by the facility and the client participation.

This situation occurs most often when the member has veterans' aid and attendance payments but can also occur when the member has nursing facility insurance.

Mr. C is in a nursing facility. He does not have a wife or dependents. He receives:

$ 900.00	Social security
$ 400.00	Private pension
$ 500.00	VA pension
$1,000.00	VA aid and attendance allowance (disregarded for eligibility)

His income exclusive of the A & A allowance is $1,800, and he is eligible for Medicaid. The total amount available to him is $2,800. Mr. C has no unmet medical expenses or private health insurance, so his potential client participation is $2,660 ($2,800 - $50 personal needs allowance - $90 VA pension exemption).

Mr. C's client participation exceeds the maximum Medicaid reimbursement rate for the facility where he lives. Since his client participation exceeds the Department's maximum payment for nursing care, Medicaid makes no payment for Mr. C's care, although he is eligible for all other Medicaid services.

Client Participation for Skilled Care

Legal reference: 441 IAC 81.6(20)"b"

Do not split or zero out client participation just because Medicare covered some of the skilled stay at the facility. The facility provider will report Medicare-covered days on the *Case Activity Report*. In most cases, the Medicare payment amount will exceed or equal the Medicaid-allowed payment amount.

If this is the case for the skilled days, Medicare will pay the cost of care. Medicaid will not participate, and the facility will not require the member to pay client participation. Payment of any skilled care days will be handled by the facility in the way it submits the claim.

Facility providers have received an informational letter explaining the procedure for these claims.

Providers are to submit a Medicare claim for the Medicare-covered days. The provider should also submit one Medicaid care claim for the full month, even when the resident's status changes to a Medicare-payable level of care during the month. The Medicare days are to be shown on the Medicaid claim as noncovered days to avoid duplicate payment by Medicare and Medicaid.

> A Medicaid member was in a nursing facility from May 1 to May 7. She was in the hospital on May 7 through May 12 and then returned to the nursing facility with Medicare coverage from May 13 through May 16. Medicare coverage ended May 17. The member's care was covered only by Medicaid from May 17 to May 31.
>
> The worker determines one client participation amount for the entire month. The facility bills Medicare for the four Medicare-covered days of May 13 to May 16. The facility submits a Medicaid claim for May 1 through May 31 (the entire month) showing four noncovered days (the four days that Medicare covered).
>
> The claim for May 1 through May 31 is processed and the facility receives Medicaid payment for 27 of the 31 days. The Medicaid payment is reduced by the amount of the full monthly client participation. The four Medicare-covered days are not paid on this claim. If Medicare does not pay at 100%, a crossover claim is received and processed. Medicaid payment is made only when the rate for Medicare didn't equal or exceed the Medicaid rate.

When the Medicare rate equals or exceeds the Medicaid rate, no Medicaid payment is made to the facility for the Medicare-covered days. Most of these situations, there is no Medicaid payment on the Medicare crossover claim. In a rare case where the Medicaid rate is higher, you will need to adjust the client participation.

If a facility reports that the client participation has been used twice, once on the crossover claim and once on the long-term care claim, then the stay will need to be split in IoWANS to correct the doubled client participation.

If the facility reports that the client participation has been used twice and the client is a qualified Medicare beneficiary (QMB), then the stay will need to be split in IoWANS to show that client participation was zero for the Medicare-covered days. Change the client participation to zero during Medicare-covered days when:

- A QMB-eligible facility client is receiving skilled care, and
- The Medicaid rate is higher than the Medicare rate for this stay.

For more information on QMB eligibles, see Client Participation for QMBs Entering Skilled Care.

Members With a Medical Assistance Income Trust (MAIT)

Legal reference: 441 IAC 75.24(249A)

People with income in excess of 300 percent of the SSI benefit for one person may qualify for Medicaid payment for institutional care using a medical assistance income trust. A person with such a trust qualifies for facility payment only if the person's total gross monthly income does not exceed 125 percent of the statewide average charge for the type of facility or level of care the person meets.

If the person's total income is less than 125 percent of the statewide average charge for care, the trust makes payments to raise the person's countable income up to but not above the 300% limit. This allows the person to be income-eligible for Medicaid payment for facility care. See 125 Percent of the Statewide Average Charge for Care.

Unless the trust document provides otherwise, the trust is effective as of the date the document is executed and the trust is funded. If the trust document is signed but not funded, the trust becomes effective the first month that income is assigned to the trust.

For example, if the trust document is signed after the first of the month, and the income for the month is assigned to that trust, then only income that the trustee makes available to the member is counted for eligibility during that month.

See 8-D, *Trusts* for more information about requirements for medical assistance income trusts. Iowa law requires certain deductions be allowed from the trust beneficiary's gross income when determining client participation.

The following sections explain:

- 125 Percent of the statewide average charges for care
- Trust payments
- Determination of client participation

125 Percent of the Statewide Average Charge for Care

Legal reference: 441 IAC 75.24(3)"b"

Charge for care figures are:

Type of Care	Charge for Care	
	July 1, 2023 – June 30, 2024	July 1, 2024 – June 30, 2025
Nursing facility	$10,467.50	$10,653.75
PMIC	$21,477.50	$26,477.50
MHI	$35,152.50	$36,416.25
ICF/ID	54,781.25	$85,026.25

Substitute a higher amount for 125 percent of the average statewide charge for nursing facility care in the following situations:

If the trust beneficiary meets the level of care requirements for…	**Then use this amount in the income comparison:**
Nursing facility care and receives some type of specialized care (e.g., care in a Medicare-certified hospital-based nursing facility or a nursing facility providing care to special populations such as an Alzheimer's unit, pediatric skilled care, or skilled care for brain injury)	The cost of the type of specialized care being received. In general, use the rate charged by the facility.
Skilled nursing care and is eligible for **HCBS** waiver or programs for all-inclusive care for the elderly (PACE) services except for income	The costs in a facility providing the type of care being received
Services in a **PMIC** and resides in a PMIC	The 125 percent of the statewide average charge to private-pay patients for PMIC care
Services in an **MHI** and resides in a state MHI	The 125 percent of the statewide average charge for state MHI care
Services in an **MHI** and is eligible for **HCBS** waiver or PACE services except for income	The 125 percent of the statewide average charge for state MHI care
Services in an **ICF/ID** and resides in an ICF/ID	The 125 percent of the maximum monthly Medicaid payment rate for services in an ICF/ID

Trust Payments

Legal reference: Iowa Code Section 633C.3

If the total income received by the beneficiary of a medical assistance income trust, including income received or generated by the trust, is **less** than 125 percent of the applicable statewide average charge for care, Iowa law allows the following deductions (trust payments) from gross income to determine client participation:

1. A reasonable amount may be paid or set aside for trust administration fee not to exceed $10 per month without court approval. This payment is not considered income to the client.
2. An amount for the needs of the beneficiary:
   - A personal needs allowance of $50 for a medical facility resident plus additional amounts for personal needs in the month of entry or discharge, as appropriate. NOTE: Exclude $90 of VA pension income per Income Exempt from Client Participation.

- A maintenance allowance of 300% of the current SSI income limit for a waiver member or a PACE enrollee.

3. An amount for the needs of dependents:
   - An amount diverted to the community spouse to raise the spouse's income to the minimum monthly maintenance needs allowance.
   - A deduction for minor or dependent children, dependent parents, or the dependent siblings of either spouse living at home.

   Determine the deduction according to Deduction for the Maintenance Needs of Spouse and Dependents.
4. An amount for unmet medical needs, determined according to Deduction for Unmet Medical Needs.
5. Any amount of income remaining, up to the Medicaid rate, is paid directly to the medical facility, a waiver service provider, or the PACE provider. This payment is not considered income to the client.
6. At the trustee's option, payment may be paid directly to other medical providers that would otherwise be covered by Medicaid or may be paid to reimburse Medicaid. This payment is not considered income to the client.
7. Any remaining income must be retained in the trust until the beneficiary's death, or, if the trust is abolished, must be paid to the state of Iowa.

1. Mrs. S is in a nursing facility at nursing facility level of care. She has social security benefits of $974 and a pension of $780, for total gross monthly income of $1,754. Mrs. S did not really need a medical assistance income trust but is paying all of her income to the trust.

   Mrs. S's total income is less than 125 percent of the average charge for nursing facility level of care. The trust will pay her all of the available income. Count the payment from the trust to Mrs. S as income. She is income-eligible for Medicaid payment of nursing facility care using the medical assistance income trust.
2. Mr. T is in a nursing facility at the nursing facility level of care. He has social security benefits of $1,500 and a monthly pension of $1,138 per month. Only his social security check is deposited into his medical assistance income trust.

   Mr. T's total income is less than 125 percent of the average charge for nursing facility care. The trust may set aside $10 per month for administration. The trust will pay Mr. T the $50 personal needs allowance each month Mr. T is income-eligible for Medicaid payment of nursing facility care using the medical assistance income trust.

3. Mr. W is in the Alzheimer's unit of a nursing facility. He meets the nursing facility level of care. He has social security benefits of $2,825, an annuity payment of $5,450, and a monthly private pension of $3,400.

   Mr. W's total income is $11,675. His total income is higher than $10,653.75, 125 percent of the average charge for nursing facility care. However, since Mr. W is receiving specialized care, the cost of his Alzheimer's care can be substituted for the average nursing facility charge.

   Mr. W provides a statement from the nursing facility that he pays $400 per day for his care. The average monthly cost would be $12,160 ($400 X 30.4 = $12,160). The cost of $12,160 can be substituted in place of 125 percent of the statewide average charge for nursing facility care. Mr. W is income-eligible for Medicaid payment of nursing care using the medical assistance income trust.

If the total income received by the beneficiary (including income received by or generated by the trust) **equals** or is **greater** than 125 percent of the applicable statewide average charge for care, Iowa law directs the trust to make the following payments, in the following order:

1. A reasonable amount may be paid or set aside for trust administration fee, not to exceed $10 per month without court approval. This payment is not considered income to the client.
2. All remaining amounts paid into the trust or retained from prior months must then be paid out to the beneficiary. This payment is considered as income to the beneficiary for Medicaid eligibility purposes. (Use this income to calculate eligibility.)

Mr. Y is a resident of a nursing facility at nursing facility level of care. His gross monthly income consists of social security benefits of $2,877, a civil service pension of $4,500, and income from his farm (homestead) of $3,500. His total gross monthly income of $10,877 is deposited into a medical assistance income trust.

Mr. Y's total income is greater than 125 percent of the average charge for nursing facility care. The trust will take $10 in administration fees and pay the remaining as income to Mr. Y. Mr. Y is not income-eligible for Medicaid payment of nursing facility care because his income still exceeds program limits.

NOTE: Use form 470-4678, *MAIT Facility Worksheet*, to calculate client participation for members who reside in a medical institution and have a MAIT. Use form 470-4679, *MAIT Waiver Worksheet,* to calculate client participation for members who are eligible for a home- and community-based services (HCBS) waiver and also have a MAIT.

Determination of Client Participation

When determining client participation for a person with a medical assistance income trust, count only the income to be paid from the trust or otherwise made available to the member as income to the member. Do **not** count as income to the member:

- The gross monthly income paid into the trust.
- Direct client participation payments the trust makes to the facility or waiver service provider or programs for all-inclusive care for the elderly (PACE) provider.

When the member's gross monthly income is **less than** 125 percent of the statewide charge for the care the member receives (see 125 Percent of the Statewide Average Charge for Care):

Mr. R is a single person in a nursing facility. His income consists of $1,377 gross social security benefits and $2,200 in pension, for a total of $3,577 per month. He has Medicare and a supplemental health insurance. The Medicare premium of $185 is withheld from his social security check. The supplemental policy premium of $200 per month is withheld from his pension check.

Mr. R's nursing facility costs are $3,500 per month. He contacts an attorney and establishes a medical assistance income trust. His $1,192 net social security check ($1,377- $185 = $1,192) and $2,000 net pension check ($2,200 less $200 private insurance premium) are deposited to the trust.

The total income that is deposited into the trust account is $3,192. The additional $385 withheld from his checks is countable income that is not deposited to the trust. Calculate the amount of income left in trust after trust administration fees by subtracting the fee from the total deposited into the trust.

$3,192.00	Total net amount deposited into trust
- 10.00	Trustee retains $10 trust administrative fee
$3,182.00	Income remaining in trust

Of the remaining $3,182, the trustee makes $50 available to Mr. R for his personal needs. The trustee pays the remaining $3,132 in the trust directly to the nursing facility up to the Medicaid rate.

- When the member's gross monthly income is **equal to** or **greater than** 125 percent of the statewide charge for the care the member receives (see 125 Percent of the Statewide Average Charge for Care):
  - Process the case for other coverage groups, including Medically Needy, to pay for other medical costs, unless the household has requested otherwise.

1. Mr. Z is a resident of a nursing facility. He has social security benefits of $2,888, a civil service pension of $4,500, and $3,500 from a private person, for a total gross monthly income of $10,888.

   Mr. Z establishes a medical assistance income trust. His income is greater than 125 percent of the statewide average charge for care. The trust pays the $10 administration fee and pays the remaining $10,878 to Mr. Z. This payment is counted as income to Mr. Z when determining Medicaid eligibility and benefits.

2. Mr. G enters a nursing facility on July 1, 2017, leaving Mrs. G at home. His income consists of $2,200 in social security and $933 in civil service pension. Mrs. G's income consists of $210 social security. Mr. G applies for Medicaid payment for nursing facility care. The worker explains the income limit and Mr. G sets up a medical assistance income trust to receive all of his income.

   Spousal diversion calculation:

$3,948.00	Minimum monthly maintenance needs allowance
- 210.00	Mrs. G's income
$3,738.00	Deficit to be met by diversion from Mr. G's income to Mrs. G

   Client participation calculation:

$3,133.00	Total income deposited to the trust
- 10.00	Trust administrative fee
- 50.00	Personal needs allowance
$3,073.00	Total income available for diversion
-3,738.00	Diversion to Mrs. G
$ .00	Client participation

3. Mrs. C applies for waiver assistance. She lives with her husband and their child, age 10. Mrs. C's income consists of $2,600 in social security and $950 in pension. Mr. C has $2,000 in gross monthly earnings. A $250 monthly health insurance premium is deducted from his earnings. This policy covers the whole family. Mrs. C meets level of care for waiver assistance and establishes a MAIT that receives all of her income.

   Spousal diversion calculation:

$ 3,948.00	Minimum Monthly Maintenance Needs Allowance
- 2,000.00	Mr. C's countable income
$ 1,948.00	Amount of Mr. C's deficit from MMMNA

   Dependent diversion calculation:

$ 2,644.00	150% FPL for 2
- 0.00	Child's income
$ 2,644.00	Divided by 3 = $881.34 maintenance for dependent

   Client participation calculation:

$ 3,550.00	Mrs. C's gross income
- 10.00	Trust administration fee
- 2,901.00	Mrs. C's maintenance allowance
- 2,829.34	Spouse and Dependent diversion ($1,948.00 + $881.34)
- 250.00	Unmet medical-health insurance premium
$ 00.00	Waiver client participation

If the institutionalized spouse's income is above 125 percent of the statewide average charge, a medical assistance income trust alone may not be sufficient to gain eligibility.

> Mr. E enters a nursing facility at the NF level of care, leaving Mrs. E at home. He does not receive specialized care. He has monthly income of $2,500 in social security, $4,500 in IPERS benefits, and $4,000 from an annuity. Mrs. E's income consists of $220 social security. After Mr. E pays for nursing facility care and other medical bills, he has only $200 a month he can give to Mrs. E to live on.
>
> Mr. E applies for Medicaid payment for nursing facility care. The worker explains the income limit and that a medical assistance income trust will not help Mr. E qualify for Medicaid. Since his income exceeds 125 percent of the statewide average charge, state law requires that all income after the $10 trust administration fee is income to Mr. E, leaving him over income for Medicaid.
>
> The worker refers the couple to their attorney to determine if a qualified domestic relations order will offer relief. Once the qualified domestic relations order is complete, the ownership of some or all of the income will be changed to Mrs. E. Mr. E should file another application at this time.
>
> The worker obtains a copy of the order to determine which income sources changed to Mrs. E's ownership. Only the income owned by Mr. E is countable to him when determining Medicaid eligibility and client participation.

Beneficiaries who have a Medicare premium deducted from their social security check are considered to have received the premium amount. This is also true for people who have other withholdings, such as union dues, taxes, and private health insurance.

When buy-in occurs, recalculate the client participation without the deduction for the Medicare premium, effective with the month of buy-in. (See Effect of Buy-In, later in this chapter.) Eliminate the Medicare premium deduction when calculating client participation for future months.

1. Mr. J is a single person in a nursing facility. His income consists of $1,522 gross social security benefits and $2,500 in pension, for a total of $4,022 per month. He has Medicare and a supplemental health insurance with a premium of $123.40 per month. Mr. J's nursing facility costs are $9,500 per month. He contacts an attorney and establishes a medical assistance income trust.

   Income to the trust:

   $ 1,337.00 Net social security (gross of $1,522 less $185 Medicare equals net amount of $1,337 rounded down)
   + 2,500.00 Gross pension check
   $ 3,837.00 Total amount that is deposited into the trust

   Client participation calculation:

   $ 4,022.00 Gross income
   - 10.00 Trust administration fees
   - 50.00 Personal needs allowance
   - 185.00 Medicare premium
   - 123.40 Health insurance premium
   $ 3,653.60 Client participation

   Amount paid from the trust:

   $ 3,837.00 Total amount deposited into trust
   - 10.00 Trust administrative fees
   - 50.00 Personal needs allowance
   - 123.40 Health insurance premium
   $ 3,653.60 Client participation

   When buy-in occurs for Mr. J's Medicare premium, the worker recalculates client participation.

   Income to the trust:

   $1,522.00 Gross monthly social security
   + 555.00 Gross social security Medicare reimbursement check
   +2,500.00 Gross pension check
   $4,577.00 Total amount that is deposited into the trust account

   Client participation and amount paid from the trust:

   $4,577.00 Total amount deposited into trust
   - 10.00 Trust administrative fees
   - 50.00 Personal needs allowance
   - 123.40 Health insurance premium
   $4,393.60 Client participation in the month buy-in reimbursement is received

Ongoing client participation calculation:

$1,522.00	Gross social security
+2,500.00	Gross pension
$4,022.00	Gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- 123.40	Health insurance premium
$3,838.60	Client participation

2. Mr. K is a single person in a nursing facility. His income consists of $1,543 gross social security benefits and $2,000 in pension, for a total of $3543 per month. He has Medicare and a supplemental health insurance. The health insurance premium of $100 per month is withheld from his pension check. Mr. K's nursing facility costs are $9,500 per month.

   Mr. K contacts an attorney and establishes a medical assistance income trust. Income to the trust:

$1,358.00	Net social security (gross of $1,543 less $185 Medicare rounded down)
+1,900.00	Net pension check (gross $2,000.00 less $100 insurance premium)
$3,258.00	Total amount that is deposited into the trust account

   Client participation calculation:

$3,543.00	Gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
- 185.00	Medicare premium
- 100.00	Health insurance premium
$3,198.00	Client participation

   Amount paid from the trust:

$3,258.00	Total amount deposited into the trust
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
$3,198.00	Client participation

3. Mrs. D enters a nursing facility, leaving Mr. D at home. Mrs. D's income consists of $1,234 in social security and $1,940 in IPERS benefits. She has Medicare and a supplemental insurance policy. The monthly premium for the supplemental policy is $64. Mr. D's income consists of $1,300 social security.

   Mrs. D applies for Medicaid payment for nursing facility care. The worker explains the income limit. The couple contacts an attorney and sets up a medical assistance income trust to receive Mrs. D's income.

Spousal diversion calculation:

$3,948.00	Minimum monthly maintenance needs allowance
-1,300.00	Mr. D's income
$2,648.00	Deficit to be diverted from Mrs. D's income to Mr. D

Income to the trust:

$1,049.00	Net social security (Gross is $1,234 less $185 Medicare equals net amount of $1,049 rounded down)
+1,940.00	Gross IPERS
$2,989.00	Total income that is deposited into the trust

Client participation calculation:

$3,174.00	Mrs. D's gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
$3,114.00	
-2,648.00	Diversion to Mr. D
466.00	
- 249.00	Unmet medical expense ($185 Medicare premium and $64 health insurance)
$ 217.00	Client participation

Amount paid from the trust:

$3,989.00	Total amount deposited into trust
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
-2,648.00	Diversion to Mr. D
- 64.00	Health insurance premium
$ 217.00	Client participation

When buy-in occurs for Mrs. D, the worker recalculates her client participation, effective for the month of buy-in.

Income to the trust:

$1,234.00	Gross social security
555.00	Gross social security Medicare reimbursement check
+1,940.00	IPERS
$3,729.00	Total amount that is deposited into the trust account

Client participation and amount paid from the trust:

$3,729.00	Total amount deposited into trust
- 10.00	Trust administrative fees
- 50.00	Personal needs allowance
-2,648.00	Diversion to Mr. D
- 64.00	Health insurance premium
$ 957.00	Client participation in the month buy-in reimbursement is received

Ongoing client participation and amount paid from the trust:

$1,234.00	Gross social security
+1,940.00	IPERS
3,174.00	Income going into the trust
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
-2,648.00	Diversion to Mr. D
- 64.00	Unmet medical needs
$ 402.00	Client participation

No recalculation is needed for members whose spousal deduction equals the income after the personal needs allowance deduction, since no Medicare deduction was given.

Other Third-Party Payments

Veterans Affairs (VA) aid and attendance payments are a third-party liability. They do not count as income when determining eligibility, but do count in the client participation calculation.

Third-party liability or other non-income sources may be included in benefit payments. For example, veterans' payments for aid and attendance, housebound allowance, or unusual medical expenses are included with veterans' pensions. These amounts should not be deposited into the trust. If the check containing both payments is deposited into the trust account, the trustee should remove the non-income portion of the payment and pay it to the beneficiary.

Mrs. V is a single person in a nursing facility. Her income consists of $2,980 in social security benefits and $1,402 VA benefits. The payment from VA consists of $782 in VA pension and $620 in aid and attendance. Mrs. V has a Medicare premium.

Mrs. V contacts an attorney and establishes a medical assistance income trust. The income deposited into the trust is the $2,980 social security benefit and $782 VA pension, for a total of $3,762. The trustee removes the $620 aid and attendance and gives it to Mrs. V to pay the third-party liability portion of the client participation.

Income to the trust:

$2,980.00	Gross Social Security
+ 782.00	VA pension
$ 3, 762.00	Total income that is deposited into the trust

Client participation calculation:

$ 3,762.00	Mrs. V's gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
$3,702.00	
+ 620.00	VA aid and attendance
$4,322.00	Client participation

When there are income disregards for a community spouse as well as third-party liability, follow the same order as for a case that does not have a trust.

Mr. C enters a nursing facility. He has monthly income of $2,400 social security, $442 IPERS benefits, $731 VA pension, and $489 VA aid and attendance, none of which is attributable to unusual medical expenses. Mrs. C, at home, gets $500 in social security.

Mr. C files an application for Medicaid payment for nursing facility care. The worker explains the income limit, and Mr. C sets up a medical assistance income trust.

Spousal diversion calculation:

$3,948.00	Minimum monthly maintenance needs allowance
- 500.00	Mrs. C's income
$3,448.00	Deficit to be met by diversion from Mr. C's income to Mrs. C

Income to the trust:

$2,400.00	Gross Social Security
+ 442.00	IPERS pension
+ 731.00	VA pension
$3,573.00	Total income that is deposited into the trust

Client participation calculation:

$3,573.00	Mr. C's gross income
- 10.00	Trust administration fee
- 50.00	Personal needs allowance
$3,513.00	Income available for diversion
-3,448.00	Diversion to Mrs. C
$ 65.00	
+ 489.00	VA aid and attendance
$ 554.00	Client participation

Changes in Client Participation

Legal reference: 42 CFR 435.725, 441 IAC 76 (Rules in Process)

Process changes in client participation for future months within ten days after receiving information of errors in computation or changes in income or expenses. Consider all nonexempt income for client participation in the current month.

Issue timely and adequate notice when client participation increases. Client participation adjustments that cannot be made due to timely notice requirements may require vendor adjustments. The first step in completing a vendor adjustment is to determine the cause of the error or incorrect payment and calculate the correct amount of client participation.

If the income was not reported timely and Medicaid eligibility is affected, an overpayment has occurred and recoupment should be completed. (See 8-A, Recovery.)

When the member remains eligible, the member is still obligated to pay the increased client participation amount for the month that the client participation increases but timely notice could not be given. Complete the following steps:

1. Recalculate client participation, taking into consideration the additional income in the month received.
2. Manually issue a notice of decision telling the member to pay the additional client participation to the facility.
3. Complete changes to the client participation in IoWANS, either by:
   - Using the IoWANS Change Tool after completing the change for the current month in the ELIAS system; or
   - Completing and sending form 470-3924, Request for IoWANS Changes to the DHS, IoWANS-Facilities e-mail box.
4. If the facility reports that the member refused to pay the additional client participation, reverse the client participation amount and complete a recoupment.

On March 24, Mr. W, a nursing facility member, receives a retroactive veterans payment of $2,000 and an award of $600 monthly veterans income. He reports this April 2. The worker changes client participation on the system for May. Mr. W also owes **extra** client participation for March and April, but no more than the state would pay for the care.

For computation of March client participation, the worker adds $2,000 to March's income. For April, the worker adds the monthly veterans income ($600) to April's income. The worker notifies Mr. W and the facility of adjusted client participation for March and April. When Mr. W pays the facility, the worker corrects the amount on IoWANS for March and April.

When the member has paid too much client participation, prepare an adjustment to return the money to the medical institution. The member collects the excess client participation from the facility.

If Lower Level of Care Is Needed

Legal reference: 441 IAC 75 (Rules in Process), 441 IAC 78.3(6), 441 IAC 78.3(14), 441 IAC 81.10(4)"g"

As described in Medical Necessity, the Iowa Medicaid (IM) Medical Services Unit or the MCO may decide that a member needs a lower level of medical care than the level provided by the facility where the member lives. If the facility agrees to accept payment at the lower level, the member may stay in the facility temporarily until placement at the correct lower level is found.

Assess client participation based on the type of facility in which the member lives. For members in a hospital, do not assess client participation if the hospital is providing SNF or NF care in an acute-care bed. If the hospital is a swing-bed hospital, the member is considered to be in a skilled facility as long as the member needs skilled care. When the member does not need skilled care, the bed "swings" back to an acute-care bed.

If a member is eligible or potentially eligible for Medicaid only under the Medically Needy coverage group, there is no client participation, since Medicaid does not pay for institutional care under Medically Needy.

See Payment for Inpatient Hospitals Who Require a Lower Level of Care for how to handle payments to facilities when a member needs a lower level of care but an alternative placement cannot be found.

1. Mr. G is in a hospital at acute level of care and is eligible for Medicaid. It has just been determined that he no longer needs acute hospital care but needs skilled care. The hospital is not a skilled care provider, but provides skilled care for Mr. G until an appropriate placement is available.

   Mr. G's client participation for skilled care would normally be $695 per month but since Mr. G is receiving a lower level of care in a hospital, he does not owe any client participation.

2. Ms. F is Medicaid member in a nursing facility with $250 monthly income. The IM Medical Services Unit determines that she does not need care in a medical facility. She is seeking appropriate placement. She remains eligible for Medicaid nursing facility payment. Her client participation is determined by subtracting $50 personal needs and her $30 medical insurance payment from her gross income.

3. The IM Medical Services Unit determines that Mrs. M no longer needs nursing care but she does need residential care. The facility agrees to keep her at the lower level of care and accept the RCF rate. The Department agrees to pay the lower level of care amount while Mrs. M is looking for another placement. The worker keeps the case under the nursing facility aid type, with the nursing care MED CP code and the nursing facility vendor number.

Effect of Buy-In

Legal reference: 42 CFR 435.725(c)(4), 441 IAC 75 (Rules in Process)

Initially determine income for client participation based on the gross amount of social security or railroad retirement benefits. Consider any amounts withheld for overpayments as income.

After the Department completes the buy-in process to pay the cost of Medicare Part A or Part B, change the social security or railroad retirement income to indicate that the member no longer pays this cost. Do not allow the Medicare premium as a deduction. The ABC system may automatically reflect this adjustment.

The member is issued a refund check for the Medicare premium costs in the same month that the buy-in occurs. The social security check increases in the next month. You will receive a Bendex form to show completion of the buy-in when the social security income changes.

The Medicare premium refund check is counted as a nonrecurring lump sum. Count the refund as income in the month received.

1. Mr. B enters a nursing facility on January 15 and is approved for Medicaid as of his date of entry. Mr. B receives $811.00 gross Social Security before buy-in. Mrs. B remains at home and receives $605.00 gross monthly Social Security. Mr. B's client participation before buy-in is calculated as follows:

$ 3,948.00	Minimum monthly maintenance needs allowance
- 605.00	Mrs. B's social security
$ 3,343.00	Deficit to be diverted from Mr. B's income to Mrs. B
$ 811.00	Mr. B's social security
- 50.00	Personal needs allowance
$ 761.00	Mr. B's income available to divert to Mrs. B
- 761.00	Diversion to Mrs. B
$ 0.00	Mr. B's income available for unmet medical diversion and client participation

   Mr. B's gross social security is used to determine client participation, but Mr. B does not have enough income to divert the entire allowable spousal diversion to Mrs. B ($3,343 was the monthly shortfall but the actual amount will be $761.00, or all of Mr. B's income after deductions).

   Buy-in occurs in April. Mr. B receives a Medicare premium refund check on April 17 for $740. Since Mr. B's gross social security income was used to determine client participation and the entire allowable spousal diversion was not received, the Medicare premium refund check can be paid to Mrs. B.

2. Mr. D enters a nursing facility on March 21 and is approved for Medicaid as of his date of entry. Mr. D receives $1,951 gross social security before buy-in. Mrs. D remains at home and receives $908 gross Social Security and a $1,250 gross monthly pension. Mr. D's client participation before buy-in is calculated as follows:

$ 3,948.00	Minimum monthly maintenance needs allowance
- 2,158.00	Mrs. D's gross income
$ 1,790.00	Deficit to be diverted from Mr. D's income to Mrs. D
$ 1,951.00	Mr. D's social security
- 50.00	Personal needs allowance
$ 1,901.00	Mr. D's income available to divert to Mrs. D
- 1,790.00	Diversion to Mrs. D
$ 111.00	Mr. D's income available for unmet medical diversion and client participation

   Only $1,790 of Mr. D's income is available for the spousal diversion.

   Buy-in occurs in June. Mr. D receives a Medicare premium refund check on June 15 for $740. Since Mr. D was able to divert enough of his income back to Mrs. D to bring her to the MMMNA amount, Mr. D will need to pay $740 additional client participation to the facility.

Timely and adequate notice must be given when client participation increases. The member is still obligated to pay the increased client participation amount for the month that the payment was received.

Although the ELIAS system has been designed to complete buy-in automatically, there may be cases that the system cannot handle. To manually complete buy-in, please follow the steps below:

1. Calculate the correct amount of client participation for the current month that included the refund received due to buy-in.
2. Calculate the correct client participation for ongoing months.
3. Complete ELIAS entries according to **NJA0116 LTC – Medical Institutions.**
4. Send a manually prepared **Notice of Action, form 470-0485(M) or 470-0485(MS)**. Use the comments section of the notice to explain that member owes additional client participation for the current month due to receipt of the refund.
5. If a member does not pay the facility the additional client participation for the current month, complete form **470-3924, Request for IoWANS Changes**, to reduce the client participation back to the original amount.

If the Member Receives a Lump Sum

Count a nonrecurring lump-sum payment in the month the payment is received. Send a notice telling the member to pay the difference between the client participation already assessed and either the redetermined client participation or the maximum Medicaid reimbursement rate to the facility, whichever is less.

Prorate a recurring lump-sum payment over the period it is intended to cover. Do not count any lump-sum income received before the month Medicaid eligibility is granted.

If a member receives a lump-sum VA check, divide the check into pension and aid and attendance. The pension portion is income in the month of receipt, regardless of the months it is intended to cover. The aid and attendance portion is a medical payment for the months the lump-sum payment is intended to cover.

Send a notice showing the new client participation for ongoing months and the additional payment for the back months. The member pays the difference between the assessed client participation and either the Medicaid payment or the redetermined client participation, whichever is less.

Complete vendor adjustments for the pension portion and the VA aid and attendance after the member repays the facility.

Determine the maximum Medicaid reimbursement rate by multiplying the per diem rate of the facility (from the MMIS screen) by the number of days in the month. Adjust the per diem rate for any reserved bed days or days that Medicaid would not pay due to the member's absence from the facility exceeding reserved bed days.

When the payment is made to the facility, completes form 470-3924, Request for IoWANS Changes for each of the months involved.

1. In October, Mrs. Z receives a retroactive VA payment for $2,500. This amount is all pension money; no VA aid and attendance is included. Mrs. Z's client participation is $300 and she has paid this for the month of October. The maximum Medicaid reimbursement rate for the facility for October is $1,900.

   The worker considers the VA amount a lump sum in October and notifies Mrs. Z to pay $1,600 to bring the total payments by Mrs. Z to the maximum Medicaid reimbursement rate to the facility for the month of October. The worker completes a Request for IoWANS Changes for October.

2. Mrs. A receives a retroactive VA payment in December for $8,700. $2,500 is for VA aid and attendance for August through December. The remainder of this, $6,200, is pension.

   Mrs. A's client participation is $800 per month. The worker considers $6,200 pension and $500 VA aid and attendance when determining client participation for December. The maximum Medicaid reimbursement rate for the facility is $1,922. The worker sends a notice to Mrs. A to pay $1,122 to the facility to bring her total client participation for the month of December to the maximum Medicaid reimbursement rate.

   The worker completes a Request for IoWANS Changes for December.

   The worker recalculates client participation for the months of August through November using the VA aid and attendance, which equals $500 per month. The worker sends a notice to Mrs. A to pay $500 per month for each month August through November. The worker completes a Request for IoWANS Changes for August through November.

If the Member Leaves or Transfers Facilities

Legal reference: 42 CFR 435.725, 441 IAC 81.5(1), 441 IAC 81.13(6)“a,” 441 IAC 82.10(1), 441 IAC 85.6(249A)

A member who transfers from one medical institution to another in the same month must pay any unused client participation to the new institution.

If the member transfers from a medical institution to a residential care facility (RCF), the member pays unused client participation computed for the medical institution to the RCF.

If a member transfers from an RCF to a medical institution in the same month, the member pays the unused client participation computed for the RCF to the medical institution.

To determine the amount of unused client participation:

1. Find the per diem rate of the facility in which the member lived during the first part of the month. Multiple the rate times the number of days in that facility. Do not include the day of discharge, because Medicaid does not pay for the discharge day.
2. Subtract this amount from the member’s previously calculated total client participation. If any amount remains, this is the unused client participation and must be paid to the second facility.

If a member transfers from an RCF to a medical institution, do **not** make an adjustment to client participation to allow for the decreased personal needs allowance in a medical institution. The member is allowed to retain the higher personal needs allowance for the month of transfer, but client participation must be recomputed for the month following the month of transfer.

1. Mrs. M transfers January 6 from skilled care to regular nursing care. Her client participation is $540. Her client participation for each type of care is computed as follows:

   Per diem for skilled care = $90
   $90 x 5 = $450 owed for skilled care

$540.00	Ms. M’s client participation
- 450.00	Owed for the skilled care
$ 90.00	Available to pay for the nursing care

2. Mrs. Q transfers from an RCF to a nursing facility on July 5. Her client participation at the RCF is $500. The RCF rate is $19 per day. She owes $76 to the RCF for the month of July ($19 x 4 days). Her client participation to the nursing facility is $424 ($500 client participation - $76 for the RCF = $424).

If a member goes home and is approved for either Programs for All-Inclusive Care for the Elderly (PACE) or waiver services in the month of discharge from the facility, adjust the facility client participation to allow for the increased personal needs allowance in the month of discharge. Calculate waiver client participation according to 8-N, Client Participation and allow a deduction for client participation paid to the medical facility in the month of discharge.

1. Mrs. N has $1,100 social security income, is discharged from a nursing facility on June 5, and is approved for waiver services the same month.

   Nursing facility client participation calculation:

$	1,100.00	Social security
-	50.00	Personal needs allowance
-	967.00	Personal needs in month of discharge
$	83.00	Nursing facility client participation

   Waiver client participation calculation:

$	1,100.00	Social security
-	2,901.00	Waiver maintenance allowance
$	0.00	Waiver client participation

2. Mr. O, who has a MAIT and $3,000 gross monthly income, is discharged from nursing facility on June 15 and is approved for waiver services on June 28. The nursing facility per diem rate is $175.

   Nursing facility client participation calculation:

$	3,000.00	Gross income
-	10.00	Trust administration fee
-	50.00	Personal needs allowance
-	967.00	Personal needs in month of discharge
$	1,973.00	Nursing facility client participation (Actual cost of care is $2,450 ($175.00 per diem x 14 days))

Waiver client participation calculation:

$	3,000.00	Gross income
-	10.00	Trust administration fee
-	2,901.00	Waiver maintenance allowance
	89.00	Remaining income
-	1,973.00	Unmet medical deduction for nursing facility client participation paid
$	0.00	Waiver client participation

3. Same as Example 2, except that Mr. O's discharge date is June 2.

   Nursing facility client participation calculation:

$	3,000.00	Gross income
-	10.00	Trust administration fee
-	50.00	Personal needs allowance
-	967.00	Personal needs in month of discharge
$	1,973.00	Nursing facility client participation (Actual cost of care is $175 ($175.00 per diem x 1 day))

   Waiver client participation calculation:

$	3,000.00	Gross income
-	10.00	Trust administration fee
-	2,901.00	Waiver maintenance allowance
	89.00	Remaining income
-	175.00	Unmet medical deduction for nursing facility client participation paid
$	00.00	Waiver client participation

4. Mr. P is a PACE enrollee residing in an ICF/ID. He has $3,000 in gross monthly income which is deposited into a MAIT. He is discharged from the ICF/ID on July 10. He re-enters ICF/ID on August 25.

   July PACE client participation:

$	3,000.00	Gross trust income
-	10.00	Trust administration fee
-	50.00	Personal needs allowance
$	2,940.00	PACE client participation for institutionalized enrollee

   Adjusted PACE client participation for the month of ICF/ID discharge

$	3,000.00	Gross trust income
-	10.00	Trust administration fee
-	50.00	Personal needs allowance
-	967.00	Personal needs in month of discharge
$	1,973.00	Recalculated PACE client participation for July

August PACE client participation:

$	3,000.00	Gross trust income
-	10.00	Trust administration fee
-	2,901.00	Maintenance allowance
$	89.00	PACE client participation for August (no adjustment is made in the month of institutionalization)

Qualified Medicare Beneficiaries in Skilled Care

Legal reference: P.L. 100-360, 441 IAC 75 (Rules in Process), 441 IAC 76.13(1)“a”

For people whose only Medicaid eligibility is under the qualified Medicare beneficiary (QMB) coverage group, Medicaid pays only for the Medicare Part A and Part B premiums, coinsurance and deductibles. If a person is receiving skilled care or hospital care, Medicare pays the cost of care within certain limits. (See Medicare Coverage for Institutional Care for payment limits.)

Eligibility for QMB applicants begins the month **after** the month of decision. The person is not eligible for Medicaid payment until the month following the month of decision unless the worker determined Medicaid eligibility under another coverage group.

Some members may be concurrently eligible for QMB and another Medicaid coverage group. Examples of these members include:

- SSI recipients with Medicare
- People in the 300% group with Medicare
- FIP recipients with Medicare

When a person is concurrently eligible both for skilled care payments under a nursing facility aid type and for QMB benefits on the date of entry, the person has no client participation until Medicare is exhausted. Medicaid payment for skilled care stops for a person who is **only** QMB-eligible when the Medicare is exhausted.

A member who is eligible for SSI, FIP, or FMAP and has Medicare Part A has already been determined eligible as a QMB member. No QMB application is needed.

In order for Medicare to make skilled care payments, the member must be hospitalized for three days and enter skilled care within 30 days of leaving the hospital. If this requirement is not met, Medicare does not pay for skilled care and QMB also does not pay, because there is no coinsurance. Determine eligibility under another coverage group. The member does have client participation under the other coverage group.

If you are examining eligibility under both QMB and the 300% group for a person who is not a QMB member when the person enters skilled level of care, determine whether the 30-day stay or QMB eligibility happened first.

Initially approve eligibility for the coverage group under the eligibility that occurred first. If a client is eligible for QMB and the 300% group, approve eligibility for the 300% aid type and enter the percent of poverty in the poverty level indicator field. If the member wants QMB assistance only, do not approve 300% group coverage.

1. Mr. and Mrs. P are QMB-eligible in July. Mr. P enters a nursing facility (not receiving skilled level of care) where he is expecting to stay indefinitely. Mr. P is considered a single person for QMB eligibility for the month of July, or is evaluated under the program of his choice. Eligibility for Mrs. P must be reexamined after the resource determination is made for Mr. P.
2. Mr. C, age 83, enters a hospital February 1 and then enters a nursing facility at the skilled level of care and applies for Medicaid on February 4. He receives $385 monthly in social security benefits. He is eligible for and receiving Medicare benefits. Mr. C's countable resources are $3,800 as of February 1. He is not resource-eligible for any SSI-related coverage group except for QMB and Medically Needy.

   The IM worker explains that due to the amount of his countable resources, the only Medicaid coverage group for which he may be eligible that would pay for his cost of care is QMB. Mr. C is also eligible for Medically Needy. The Medically Needy program will pay for services other than the cost of facility care.

   The worker approves eligibility on February 28, with the Medically Needy program effective February 1 and a QMB effective date of March 1. The worker enters the approval with the Medically Needy aid type (37-E).

   The ELIAS system establishes QMB eligibility for March based on the coding and poverty level indicator and the date of entry. No client participation or any other facility entries are made on the ELIAS system, because they do not apply under QMB or under Medically Needy.

   Mr. C is responsible for paying the coinsurance for February 24-28, which is before the QMB effective date. If Mr. C's resources still remain in excess of Medicaid limits after Medicare pays for the 100 days, he is totally responsible for paying his own cost of care.
3. Mr. W, age 68, enters a hospital on February 1, and then enters a nursing facility at the skilled level of care on February 5. He applies for QMB on the same day. He is approved for QMB March 1, with an effective date of April 1.

   If Mr. W needs help with the cost of skilled care for February and March, he must be determined eligible under the 300% group or as a person who would be eligible for SSI or SSA, if not in a medical institution.

Client Participation for QMBs Entering Skilled Care

Legal reference: 441 IAC 75 (Rules in Process)

When an application is for QMB and skilled care payment, assess client participation until QMB eligibility becomes effective. When the person becomes QMB eligible, access zero client participation while Medicare is paying for the cost of the skilled care and Medicaid pays the copayment.

If Medicare coverage has not been exhausted, you may need to enter zeros in the first-month client participation and ongoing client participation fields. This prevents the facility from overcharging the member and provides the Iowa Medicaid (IM) with the correct payment amount. See Client Participation for Skilled Care.

You may contact the Medicare intermediary to verify the number of days to be paid by Medicare. You need a signed release of information to contact the intermediary.

The facility will complete the **Case Activity Report** to verify the number of days to be paid by Medicare.

Manually issue a notice to notify the applicant of the client participation amount for days 21 through 100 and to tell the applicant that client participation will not be charged until Medicare coverage is exhausted. Include the following wording:

> "Medicare and Medicaid will pay for the cost of care in the facility until Medicare coverage ends. If you remain at this level of care after Medicare coverage ends, you will be charged for part of the cost of care. The client participation amount on this notice is the amount you will be responsible for paying the facility each month after the Medicare payments end."

When the Medicare coverage has been exhausted and the client is concurrently eligible for payment at the skilled level of care under a facility aid type, enter client participation into the ELIAS system. Allow deductions, including personal needs in the month of entry to the facility.

Enter the first month and ongoing client participation on the ELIAS system effective the day after Medicare coverage ends. For this purpose, "first month" means the first month that the member has to pay client participation. This usually is not the month that the member entered the facility.

1. Ms. P, age 78, applies for Medicaid on March 5. She reports that she entered the hospital on March 1 and transferred to skilled care on March 5. The worker verifies that Ms. P began a new spell of illness as of March 1.

   The worker processes the application under the 300% group. The worker approves eligibility for QMB on March 22, effective April 1, and for the 300% group on April 4, effective March 1. The worker calculates client participation for March 5 (first month) and the ongoing months.

   Ms. P is issued a notice informing her of the client participation for March and ongoing months, and that she will not be responsible for paying client participation after March until Medicare is no longer paying the facility. On the 101st day, she must pay client participation.

2. Mr. B, a QMB Medicaid member, enters skilled level of care on January 15. Mr. B asks that the worker determine whether another coverage group would be more advantageous for his situation. Since Mr. B is still receiving skilled care on February 15, the IM worker determines that eligibility also could exist under the 300% group. He chooses the 300% group.

   Since Mr. B is QMB-eligible and was hospitalized for a week before entering skilled level of care, he has Medicare coverage for 100 days of skilled care. Medicaid pays the Medicare coinsurance for days 21 through 100.

   If the Medicaid rate is higher than the Medicare rate, the IM worker computes client participation for the first month and ongoing client participation. The poverty level indicator is also entered. The ongoing client participation amount is entered on the notice of decision.

   If Mr. B still lives in a nursing facility receiving skilled care after the 100-day period covered by Medicare, no change in aid type is required. **NOTE**: If this were a new applicant, there would be client participation charged for January.

3. Ms. L is currently receiving Medicaid as a Medically Needy member and is QMB eligible. There is no spenddown. On March 5, Ms. L reports that she entered the hospital on February 15 and entered a skilled level of care on March 1. Ms. L continues to be QMB-eligible.

   Eligibility can be established under the 300% group after the 30-day residency requirement is met. No facility entries are made until there is eligibility in a 300% aid type. After eligibility for the 300% group has been met on March 16, the IM worker closes the Medically Needy case on the ABC system and reopens the case with a 300% aid type.

   Zeros are entered for the first month and ongoing client participation fields **if** Medicare is paying for the cost of care and the Medicaid rate is higher than the Medicare rate.

   The IM worker computes client participation for the ongoing months and informs Ms. L on the notice when she will be required to pay client participation to the facility and the amount she will be charged.

4. Mrs. N is eligible for Medicaid as part of the 300% group and also has QMB eligibility. The nursing facility reports that Mrs. N no longer needs skilled level of care on June 4. On July 4, she again meets skilled level of care after having been hospitalized for three days. A new benefit period has not started for Mrs. N. The facility reports that Mrs. N has used all but ten days of Medicare entitlement for skilled level of care.

   No changes are needed unless the Medicaid rate is higher than the Medicare rate. In August, Mrs. N is required to pay the facility $350 in client participation per month.

5. Mr. G, age 79, enters a hospital on May 27, then transfers to a nursing facility on May 30 receiving skilled care. He applies for Medicaid for help to pay for the cost of care. On July 1, the IM worker determines that he is both eligible under the 300% group and QMB-eligible.

   Medicare pays for the cost of care from May 30 through June 18. Since QMB cannot be effective until August 1, Mr. G is responsible for paying client participation from June 1 through July 31. Medicaid will pay the Medicare coinsurance beginning August 1. If the Medicaid rate is higher than the Medicare rate, change the client participation to zero effective August 1.

   The IM worker enters the amount of client participation for May, June, and July, because these months are before QMB eligibility.

   The worker issues a manual notice to inform Mr. G that he is responsible for paying client participation for May, June, and July, and that he will be responsible for client participation when Medicare is no longer paying the facility after the 100th day.

Billing and Payment

Legal reference: 441 IAC 79.1(249A), 441 IAC 80.2(249A), 441 IAC 80.3(249A), 441 IAC 81.10(5), 441 IAC 81.11(1), 441 IAC 81.22(2), 441 IAC 82.14(4), 441 IAC 82.15(1)

When a resident becomes eligible for Medicaid payment for facility care, the facility must accept Medicaid or MCO contracted rates effective with the date the resident's Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

If the beginning Medicaid eligibility date is a future month, the facility must accept the Medicaid rate effective the first of that future month.

NOTE: When a resident enters skilled care in a facility outside the state of Iowa, refer the facility to the Bureau of Medical and Long Term Services and Supports to obtain approval of out-of-state skilled payments.

Nursing facility services can be paid for many Medicaid members who are nonfacility aid types in the month of entry into the facility and for short stays. A "short stay" means less than 30 days. Also, people in nursing facilities may go back and forth between facilities. If the worker is not informed of these changes, payment may be delayed or not made at all.

In both instances, an IoWANS file must be created or updated and transferred to the Iowa Medicaid (IM) before payment for the appropriate facility care can be made.

When a Medicaid member in a nonfacility aid-type is admitted to a medical institution and continues care at the medical facility the month following the month of admission, and you are informed **before** the discharge, close the regular Medicaid case. Complete an automatic redetermination and reopen the case beginning the date of admission under the applicable facility aid type.

When a Medicaid member in a nonfacility aid type is admitted to a medical institution and continues care the month following the month of admission, but you are informed **after** the discharge, do not close the regular Medicaid case. Complete an automatic redetermination for the applicable facility aid type.

Follow these steps to get authorization into IoWANS:

1. Complete a manual notice of decision showing the approval and the cancellation on the same notice.
2. Complete form 470-3924, *Request for IoWANS Changes*, and e-mail it to DHS, IoWANS-Facilities. The form must include:
   - The member's name, case number, and state identification number.
   - The facility name and vendor number.
   - The dates of service (admission and discharge dates).
   - The client participation amount (for each vendor and stay).

Remember that the 30 day stay requirement is for a person in the 300% group. Many Medicaid members in nonfacility aid types do not need to meet this requirement, unless they are redetermined to the 300% group.

When you are informed that a nursing facility member moved to a different facility (and is still there), complete an automatic redetermination for the new, appropriate aid type.

When a nursing facility member is admitted to a different facility but returns to the original facility, and you are informed of the moves after the member has returned, do not close the current case. Complete an automatic redetermination for the care the member received in the other facility.

If a significant amount of time has passed and you are unable to update ELIAS all the way back to the original admission date, follow these steps to get authorization into IoWANS:

1. Complete a manual notice of decision showing the approval and the cancellation to any facility stays that are in the past.
2. Complete form 470-3924, *Request for IoWANS Changes*, and e-mail it to DHS IoWANS-Facilities. The form must include:
   - The member's name, case number, and state ID number.
   - The facility name and vendor number.
   - The dates of service (admission and discharge dates).
   - The client participation amount (for each vendor and stay).

Provider Rates

Facilities have an established rate based on their cost report. The fee-for-service rate for each facility provider can be found by viewing the IoWANS My Reports screen. For client participation purposes, use the rate on IoWANS My Reports screen for the facility in which the member resides.

Billing Process

Legal reference: 441 IAC 81.11(1), 441 IAC 82.15(1)

The facility can view a member's client participation through Iowa Medicaid Provider Access (IMPA). IMPA allows the facility to view client participation that a member residing in their facility is required to pay.

Fee-for-service claims for medical institution care are submitted to the Iowa Medicaid (IM). The claims can be submitted any time after the end of the month of service. The facility is responsible for billing other payers before filing a Medicaid claim. Payments are mailed from the Iowa Medicaid (IM) after the claims are approved. Medicaid is the payer of last resort.

For members enrolled in managed care, providers submit claims to the appropriate MCO.

Payment is made only for those services or for the part of the cost of a service for which no other payer exists. Any health insurance, Medicare, client participation, or other payments made to the facility by the member, relatives, or other source is deducted before payment is made.

Payment for Reserve Bed Days

Legal reference: 441 IAC 81.10(4), 441 IAC 82.14(4)

Different limits apply to payments to reserve a bed in a nursing facility or an ICF/ID during a member's absence. No reserve-bed payments are allowed for nursing facilities, hospitals or MHIs.

Nursing Facilities

Legal reference: 441 IAC 81.10(4)"f"

Effective December 1, 2009, Medicaid no longer pays for reserved bed days in nursing facility for persons at the NF/ICF level of care.

Skilled care is a level of care received by residents of a nursing facility. The number of bed-hold days is the same when a resident is receiving skilled care. The resident is not required to receive skilled care for 90 days before the bed-hold days can be paid.

Reserve bed days stop when:

- The resident enters a different long-term care facility (whether for skilled care, nursing care, or ICF/ID care).

- The facility will not accept the client back from hospitalization due to care needs.

Payment for reserve bed days is at 42% of the facility's rate. No worker entries are required to stop or lower payments to a nursing facility for bed hold. Payments are adjusted based on claims submitted by the facility.

Facilities use the *Case Activity Report*, to notify you if the resident is discharged, including reserve bed information from the month of discharge. If reserve bed days run out before the person is discharged, remaining days are noncovered days, and are not paid by Medicaid.

Use the information from the *Case Activity Report* to recalculate client participation between facilities. When calculating the payment for reserved bed days, use the facility per diem listed on the IoWANS My Reports screen.

Mr. N leaves a nursing facility and goes to the hospital August 10. He stays 15 days in the hospital and is placed in skilled care. His total client participation is $1,500. The portion computed for each facility is as follows:

NF Medicaid per diem is $90.00
42% of $90.00 = $37.80
$37.80 x 10 days = $378.00

$ 810.00	$90.00 x 9 resident days
+ 378.00	$37.80 x 10 bed hold days
$1,188.00	CP owed for nursing care
$1,500.00	Total CP
- 1,188.00	CP paid for nursing care
$ 312.00	CP owed for skilled care beginning August 20

ICFs/ID

Legal reference: 441 IAC 82.14(4)"d," "e," and "f"

Payment will be made to reserve a bed in an ICF/ID as follows:

- For visits home, payment is made up to a maximum of 30 days annually.

  Additional days may be approved for special programs of evaluation, treatment, or habilitation outside the facility. A physician or qualified intellectual disability professional must sign documentation indicating the appropriateness and therapeutic value of the resident's visits and programming days.

  Visit days may be taken at any time. There is no restriction on the number of days taken in any month or any visit as long as the maximum number is not exceeded.

- For hospitalization, payment is made up to a maximum of ten days in any calendar month.

Reserve bed days stop if the resident enters a different long-term care facility, whether for skilled care, nursing care, or ICF/ID care.

An ICF/ID with 16 or more beds receives 80% of its actual per diem for reserve bed days. An ICF/ID with 15 or less beds receives 95% of its actual per diem for reserve bed days. No worker activity is required to correct reserve bed day payment.

When Reserve Bed Days Are Paid Privately

Legal reference: 441 IAC 81.10(5)"e", 441 IAC 82.14(5)

The resident, family, or friends may choose to pay reserve bed days when the resident has exhausted reserve bed days. If the resident is not discharged, the payment made by the resident must be consistent with the Department payment. These days paid by family or friends are not covered days for Medicaid.

If the facility plans to discharge a resident after Medicaid payment stops, the resident or the family may make an arrangement to hold the bed when the resident is discharged. The facility must follow normal discharge procedures (e.g., clothing and possession are returned to the family, the personal needs account is closed and all resident records are closed), and send a *Case Activity Report* to the local office.

No Supplementation of Payment Allowed

Legal reference: 441 IAC 80.3 (249A), 441 IAC 81.10(5), 441 IAC 82.14(5)

Only client participation can be billed to the member. The facility cannot require supplementation of a Medicaid payment. The facility must accept reimbursement based on the Department's methodology as payment in full. There are two exceptions:

- The member, family, or friends may pay to hold a bed when the member is absent over the limit for reserve bed days. See When Reserve Bed Days Are Paid Privately.
- Payment of the cost of care by the resident or resident's family is not supplementation when it is included in the calculation of client participation and does not exceed the payment made by the state.

Use form 470-0373, *Voluntary Contribution Agreement*, to document a voluntary contribution so that all parties are aware of the contribution and its effect on the Medicaid payment.

Voluntary contribution amounts should be entered in the ELIAS system as "Other" income benefits only.

Payment for items that the facility does not have to provide, such as a telephone or cable television, is not considered supplementation.

Payment for items or care required to be provided by the facility is supplementation. For example, payment for a private room is supplementation, since the facility must provide a room. If such payment is made, it must be included in the member's client participation.

Payment for Inpatient Hospitals Who Require a Lower Level of Care

Legal reference: 441 IAC 78.3, 441 IAC 78.3(13) and (14), 441 IAC 81.10(4)"g"

When the Iowa Medicaid (IM) Medical Services Unit or the MCO determine that a resident needs a lower level of care, the facility's social worker is responsible for finding alternative placement. When an alternative placement cannot be found, and the facility and the Department agree to this, Medicaid payment may continue.

Payment for Transferring a Resident by Ambulance

Legal reference: 441 IAC 78.11(249A)

Payment for transporting a resident by ambulance will be approved if medically necessary and the resident is:

- Transferred to the nearest hospital with appropriate facilities.
- Transferred to a hospital in the same locality.
- Transferred from one hospital to another.
- Transferred from a hospital to a nursing facility.

The Iowa Medicaid Enterprise or the MCO will deny a claim for ambulance transportation from a medical institution to a hospital if the transportation was not medically necessary.

When a nursing facility resident is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility in which the recipient lives, even if it is not the nearest nursing care facility.

If a resident needs to move to another facility because a facility is closing, the requirements regarding medical necessity and distance do not apply. Nor do these requirements apply to a resident moving from a nursing home to a residential care facility because the resident no longer required nursing care.

Billing and Payment for Hospice Members

Legal reference: 441 IAC 78.36(3)

Before providing hospice service to a Medicaid member in a nursing facility, the hospice agency must notify the member's IM worker that the member has chosen to receive hospice services, and to verify the amount of client participation. Determine eligibility and client participation as for other nursing facility member.

When a hospice member enters a nursing facility, the hospice is responsible for paying for the nursing facility care. Medicaid will pay the hospice for the care, and the hospice reimburses the nursing facility. The hospice collects client participation, unless the hospice and nursing facility jointly agree that the nursing facility will collect the client participation.

The hospice is responsible for obtaining the signature of the member or the member's representative on form 470-2618, *Election of Medicaid Hospice Benefit*, or a similar form as defined in the hospice provider manual.

The hospice is also responsible for entering into a written agreement with the nursing facility under which the hospice program takes responsibility for the professional management of the member's hospice care and the facility agrees to provide room and board to the member.

Use of IoWANS

IoWANS is the Iowa Department of Human Services' Institutional and Waiver Authorization and Narrative System. IoWANS (previously Individualized Services Information System (ISIS)) started supporting the facility programs in October of 2004. The purpose of IoWANS is to assist workers in both processing and tracking requests starting with entry from the ELIAS system through approval or denial.

Upon application, the consumer will be tracked through the eligibility determination process. Once the application is approved, IoWANS will provide the Iowa Medicaid Enterprise or the MCO with information and authority to make payments to or on behalf of a member. The member is tracked in IoWANS until that member is no longer accessing a facility or waiver program.

A case normally starts with the income maintenance (IM) worker entering information into the ELIAS system. Pertinent information is then passed to IoWANS. IoWANS identifies key tasks (called "milestones") for the IM worker and for other entities involved to complete approval of the member. The milestones form a workflow, taking a request for facility payment to denial or final approval.

For details on IoWANS work flows for facilities and on using IoWANS, see 14-M, *IoWANS User Guide*.

Different IoWANS work flows (sequences of key tasks presented on milestone screens) have been established for medical facility enrollment processes:

- NF, skilled, PMIC, MHI, and hospice
- ICF/ID

Important Facts About IoWANS for Facility Programs

While 14-M, *IoWANS User Guide* is a rich source of information about IoWANS, some of the important facts from that guide are repeated here for emphasis and convenience:

- IoWANS milestone screens present a question, instruction, or statement followed by choices for a response on two to five response buttons. Reaching a choice may take activity outside of IoWANS. Remember that while IoWANS tends to speed the process, it does not replace all the work that must be done, such as collection of verification.
- All milestones in the process of approving a facility case must be completed before the Iowa Medicaid Enterprise or the MCO can be authorized to start making payments.
- If you receive an IoWANS milestone and do not immediately know how to respond, clicking on the **CANCEL** button will leave the milestone task on the workload page so it can be postponed for a later response. You will be able to access the milestone screen again whenever you are ready to respond.
- If the person responsible for a milestone responds prematurely with insufficient or erroneous information, it may be possible to "undo" the milestone.

  To see if that is possible, navigate to the STATUS screen for the member by clicking on the **STATUS** subtab while the member is selected. If it is possible to undo the milestone, a **TRASH CAN** icon will be present in the last column of the milestone's record.

  If the "undo" is not permitted because "downstream" milestones have been accomplished, it will be necessary to contact people who have performed the downstream milestones to arrange for a series of "undo" actions or to contact the IoWANS Facilities Help Desk for assistance.
- The LOC (level of care) and LOC EFFECTIVE DATE fields (on the PROGRAM REQUEST screen) will be blank or show "unknown" when the pending application is first passed to IoWANS. During the workflow process, an LOC milestone is generated. Once the level of care is formally entered, the program request will display the correct level of care and the effective date.

- When entries are completed in the ELIAS system to move a consumer to a different facility, IoWANS will start a new program request. All of the workflow associated to a new member must be repeated before for the new facility can receive payment.
- IoWANS provides a screen that displays the current program request. This screen will eventually show three years of program request history. Information for programs older than three years will be archived. Reports will be available through the SPIRS Help Desk.

A request for facility payment is processed through the IoWANS workflow that ends with the milestone for the IM worker to give final approval. When you give a positive response to this milestone, it will authorize the Iowa Medicaid (IM) or the MCO to make payments to the provider.

IMPORTANT: Make sure that all actions necessary to establish eligibility, including those outside of IoWANS are complete and accurate before you respond to the final milestone and enter the approval on ELIAS.

Once the program request is authorized and a beginning date is passed from ELIAS, a facility provider can view the member's client participation amount using Iowa Medicaid Provider Access (IMPA).

For enrollment process details, see 14-M, IoWANS User Guide.

Facility Administrative Information

This section contains a brief overview of selected facility responsibilities. The facility provider manuals explain more fully all the responsibilities of facilities that participate in the Medicaid program. Included in this section are procedures relating to:

- Reporting changes in a resident's status
- Transfers and discharges
- How personal needs accounts are handled
- What happens when a facility closes
- What happens when ownership of a facility changes

Reporting Changes in a Resident's Status

Legal reference: 441 IAC 81.5(2), 441 IAC 82.10(2), 441 IAC 85.6(2), 441 IAC 85.24 (2), 441 IAC 85.45(2)

Medical institutions, except hospitals, are required to send the *Case Activity Report* to the office responsible for the placement when a Medicaid applicant or member:

- Enters the facility.
- Dies or is discharged.

- Is covered by Medicare for skilled level of care.
- Is no longer covered by Medicare for skilled level of care.

Transfers and Discharges

Legal reference: 441 IAC 81.5(1), 441 IAC 81.13(6)"a," 441 IAC 82.10(1),

The facility is not allowed to transfer or discharge the resident unless:

- A transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.
- The resident's health improves so that the resident no longer needs the facility's services.
- The safety of other residents in the facility is endangered.
- The health of other residents in the facility would be endangered.
- The resident has failed, after reasonable and appropriate notice, to pay for stay at the facility. If the resident became eligible for Medicaid after admission, the facility may charge only for those items allowed by Medicaid.
- The facility ceases operation.

If a facility plans to discharge a resident, facility staff must provide advance written notice and explain appeal rights. The facility must also send you form 470-0042, *Case Activity Report*, when the discharge is made.

A resident may be transferred or discharged from a facility upon the request of the resident or the resident's family, guardian or physician. The facility's social worker may help the resident by:

- Planning the move.
- Referring the resident to other resources for help.
- Coordinating the services of public health nursing, homemaker services and other agencies, and work with the resident's family.
- Performing follow-up visits.
- Involving family and friends in decision-making, planning, and the work of transfer or discharge.

Resident Trust Account

Legal reference: 441 IAC 81.4(3), 441 IAC 81.13(5)“c”, 441 IAC 82.9(3)

As described in Ongoing Personal Needs Allowance, residents may keep a portion of their monthly income for personal needs, to spend as the resident wishes. Resident trust accounts are set up by the facility to manage the personal needs funds for residents.

If the resident dies, the facility must release the balance in the account to the resident’s guardian or next of kin to pay funeral expenses. The facility must get a receipt when it releases funds.

If there are no relatives, funds in the account revert to the Department. The facility should turn the funds over to the Centralized Facility Eligibility Unit (CFEU). Forward the funds to the Department’s Bureau of Accounting Services. If an estate is opened, the Department will turn the funds over to the estate. The estate is responsible for paying claims to the Department under the estate recovery program.

If a Facility Closes

Legal reference: 441 IAC 81.12(249A), 441 IAC 82.16(249A)

If a facility plans to close, facility staff must notify the Department 60 days in advance. (In an emergency, this time may be shortened.) If the contract between the Department and a facility is terminated, the local office must help residents who wish to transfer to a certified facility.

If the Department terminates the Medicaid contract with a facility, the Iowa Medicaid (IM) sends a notice of cancellation to the facility by certified mail. Copies are sent to the local office, the service area manager or the MCO, the Division of Fiscal Management, and the Department of Inspection and Appeals.

Local office staff and the administrator of the facility must immediately notify the residents and their families of the closing, then plan for an orderly transfer of residents. Alternative placements must be investigated. The facility may make transfer plans independently with the residents and their families.

In certain cases the federal government will continue participation of Medicaid funds for residents of facilities that have lost certification. The extension cannot exceed 30 days beyond the date of contract cancellation, and is allowed **only** to cover the time necessary to ensure the orderly transfer of residents.

If a resident is transported by ambulance due to a facility closing, contact the Bureau of Medical and Long Term Services and Supports before the date of service with the following information:

- Name and case number of resident to be transferred.
- Date of transfer.
- The vendor used in the transfer.
- The facility from which the resident is being moved and the facility to which the resident is being moved.

This information is used to process the claim and authorize the Iowa Medicaid Enterprise to make payment.

If Facility Ownership Changes

If ownership of a facility changes, the facility is given a different provider number for the new owner. Payments will not be made until the provider number is changed from the old owner's number to the new owner's number. This change occurs in IoWANS through the following steps:

1. Department of Inspections, Appeals, and Licensing (DIAL) notifies the Iowa Medicaid (IM) Provider Services Unit of the ownership change.
2. The new facility owner submits an enrollment application to Iowa Medicaid (IM) Provider Services Unit.
3. The Iowa Medicaid (IM) Provider Services Unit:
    - Issues the facility a new provider number.
    - Enters the number into MMIS.
    - Verifies the reimbursement rate for the old provider number in MMIS.
    - Verifies that the new provider number is active in MMIS.
    - Sends a memo to Iowa Medicaid (IM) Data Warehouse to initiate the automatic change in IoWANS.
    - Sends a letter to inform the facility of the change, with copies to DIAL Health Facilities and Audits, the IM supervisor, and other Iowa Medicaid (IM) units.
4. The Iowa Medicaid (IM) Data Warehouse implements the "change of ownership" (CHOW) process for all members who are identified as receiving services from the old provider. Any member whose record has an open program request with the old provider number or has been closed with an end date that is later than the effective date of the new provider number will be processed as follows:
    - The program request is ended for the old provider on the date the new provider number is effective.
    - A new program request is started for the same date with the new provider number.

- The aid type, level of care, assessment date, county of residence, county of responsibility, program, case number, and “app date” fields on the newly created program request are the same as the program request that was closed.
- The change of ownership reason code of 077 will show on the new program request on IoWANS.

5. Review the program request to ensure that the change was processed correctly. If the change is effective the first day of the month, the approval is set. If the change is any day other than the first, you will receive a workflow notification that the change has been made in IoWANS, and you must respond to the workflow to set the approval.

   Check the calculation of client participation. If there were bed hold or hospital days, the CP 1ST MONTH entry should be lower and you need to send a request to DHS, SPIRS to correct this. Check the calculation of the CP 1ST MONTH entry as follows:

   - Determine the reimbursement rate of the facility in which the member lived during the first part of the month.
   - Multiply that rate by the number of days in the facility. This is the amount to be applied to the last partial month at the old vendor number, before the change of ownership. Do not include the last day, because Medicaid does not pay for that day. The last day will be paid under the new provider number.
   - Subtract this amount from the member’s previously calculated total client participation (found in the CP ONGOING field on the program request that is being closed).
   - The remainder is to be applied to the new vendor number for the remaining days in the month and should be entered in the CP 1ST MONTH field.

   The CP ONGOING entry should be the same as in the previous program request.

   Any subsequent program requests with **this same provider** number must also have the provider number changed. If there are subsequent program request with a different provider number, you must process the ownership change manually.

6. You will also be notified through IoWANS workflow to make ELIAS entries to change to the new provider number and effective date. If you don’t make the correct entries in ELIAS, this could cause errors or an incorrect vendor number to be passed with the next ELIAS activity.
7. Once approval is set on the new program request, the provider can submit claims to Iowa Medicaid (IM) CORE using the new provider number. The provider will need to check Iowa Medicaid Provider Access (IMPA) to determine if the approval to the new provider number has been completed.

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8, Chapter J

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Medically Needy

Page

Overview

This chapter provides information specific to the Medically Needy coverage group. Medically Needy provides Medicaid coverage to people who have too much income or resources to qualify for SSI cash assistance or for other medical coverage groups but not enough for medical care. These people must also meet categorical criteria for eligibility. That is, they must be:

- Aged, blind or disabled, or
- Members of families with children, or
- Pregnant women, or
- Children under age 19.

People eligible for the Medically Needy coverage group are eligible for payment for all services covered by Medicaid except:

- Care in a nursing facility, including a Medicare-certified skilled nursing facility or NF/MI.
- Care in an intermediate care facility for persons with an intellectual disability.
- Care in an institution for mental disease.
- Rehabilitative treatment services for children (specified services in the family preservation, family-centered services, family foster care treatment, and group care programs).

The Medically Needy coverage group is authorized in Title XIX of the Social Security Act and described in the Code of Federal Regulations, Title 42, Chapter 4, Part 435. State authorization for the program is Iowa Code Chapter 249A. The portion of the Iowa Administrative Code dealing specifically with the Medically Needy coverage group is 441 IAC Chapters 75 and 76.

This chapter contains definitions for terms unique to the Medically Needy coverage group. You will also find descriptions of how people become eligible, the services for which they are eligible and other factors unique to Medically Needy, such as verifying medical expenses and the spenddown process.

Use this chapter in combination with Chapters 8-A, 8-B, 8-C, 8-D, 8-E, and 8-G to determine eligibility for the Medically Needy coverage group.

Definitions

Legal reference: 441 IAC 75 (Rules in Process)

"Applicant" means a person for whom assistance is being requested, including at recertification.

"Break in assistance" means more than three months between the end of the last certification period and the beginning of the next certification period.

"Categorically eligible" means a person meets the broad guidelines for the categories of people to whom Medicaid eligibility is provided.

To be FMAP-related categorically eligible, a person would be a child under age 21, a parent living with a child under age 18, or a pregnant woman.

To be SSI-related categorically eligible, a person would be aged, blind or disabled.

"Certification period" is the time period for which a person may be determined eligible for Medically Needy. A conditionally eligible person is certified for a period of no more than two consecutive months. **Note:** Recipients with no spenddown have ongoing eligibility, instead of certification periods.

"Conditionally eligible recipient" is a person who is approved for Medically Needy with a spenddown but has not yet met the spenddown.

"Considered person" is a person whose needs, income, and resources are considered in the Medically Needy eligibility determination but who is not eligible to receive benefits.

"Dependent child" is a child who meets the non-financial eligibility requirements of the applicable FMAP-related coverage group.

"Eligible recipient" is a Medically Needy person with zero spenddown or who has met spenddown. This person has income at or less than the medically needy income level (MNIL) or has reduced income through the spenddown process to the MNIL.

"FMAP-related" means people who would be eligible for the Family Medical Assistance Program (FMAP) except for income or resources.

"Incurred medical expenses" are:

- Medical bills paid by a recipient, a responsible relative, or a state or by a political subdivision program (other than Medicaid) during the certification period or retroactive certification period, **or**
- Unpaid medical expenses for which the recipient or responsible relative remains obligated to pay.

"Medicaid-covered services" are medical services payable through the Medicaid program.

"Medically needy income level (MNIL)" is 133% of the FMAP schedule of basic needs (payment level) based on family size.

"Medically needy person" means a person who:

- Is FMAP-related or SSI-related,
- Has resources within the $10,000 limit, and
- Has income no more than the MNIL or has income reduced to the MNIL by spenddown.

"Medically Needy subsystem" is a subsystem of the Medicaid Management Information System (MMIS) managed by the Iowa Medicaid Enterprise (IME) that applies verified medical expenses against the unmet spenddown obligation and notifies the ABC system when spenddown has been met.

"Necessary medical and remedial services" are medical expenses recognized under state law that are currently covered by the Iowa Medicaid program.

"Obligated medical expenses" are expenses for which the recipient or responsible relative continues to be legally liable.

"Ongoing eligibility" means eligibility continues for people with a zero spenddown. There is no certification period.

"Recertification" means establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Responsible relative" means a spouse, parent, or stepparent living in the household of the medically needy person. Responsible relatives are "considered" people.

"Retroactive certification period" is the period of up to three calendar months before the month in which a person applies for Medicaid and who meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. The retroactive certification period begins with the first month Medicaid-covered services are received and continues to the end of the month immediately before the month of application.

"Specified relative" is a person defined by FMAP policies. The specified relative must have a dependent child in their care.

"Spenddown" is the process in which a medically needy person obligates excess income for allowable medical expenses in order to reduce income to the household's MNIL.

"SSI-related" means aged, blind or disabled people who would be eligible for Supplemental Security Income (SSI) benefits except for excess income or resources.

Policies for FMAP-Related Coverage Groups Prior to MAGI Methodology

Nonfinancial FMAP-Related Eligibility Prior to MAGI Methodology

Age of Children

Legal reference: 441 IAC 75 (Rules in Process)

Age requirements for children differ, depending whether eligibility is established under:

- Family Medical Assistance Program (FMAP)
- Mothers and Children (MAC) program

A child who meets the program's age requirement is eligible in the month of birth, unless their birthday is the first day of the month.

The following sections explain the requirements for each group.

Family Medical Assistance Program (FMAP)

Legal reference: 441 IAC 75 (Rules in Process)

A child can receive Medicaid under the Family Medical Assistance Program (FMAP) until the age of 18 without regard to school attendance when a parent or needy specified relative in the child's eligible group also receives Medicaid under FMAP.

An 18-year-old child can receive FMAP if the 18-year-old is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching age 19. See School Attendance later in this chapter.

A child can be determined eligible for a month if the child was eligible at any time during the month. For example, a child can be determined eligible if the child becomes 18 during the month, unless the birthday falls on the first day of that month. Refer to 8-F, *Family Medical Assistance Program (FMAP)*.

NOTE: Under FMAP, a child becomes an adult when the child gets married unless the marriage is annulled. The child remains an adult if divorced.

Mothers and Children (MAC) Program

Legal reference: 441 IAC 75 (Rules in Process)

Medicaid is available through the Mothers and Children (MAC) coverage group to people who have not reached the age of 19. Refer to 8-F, *Mothers and Children (MAC) Program*.

Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Certain people in a household *must* be in the FMAP-related eligible group; others *may* be included in the group.

- The people who must be included in the eligible group may vary depending upon the coverage group under which eligibility is being established.
- A single household may contain one or more eligible groups depending on the relationships of the household members.
- The household may voluntarily choose to exclude certain otherwise mandatory members of the eligible group when assistance is not wanted for them.

The following sections explain:

- Who must be in the FMAP eligible group
- Who may be in the FMAP eligible group
- Determining the number of eligible groups in a household
- Household composition examples

Procedure: Follow these steps to determine who to include in the FMAP-related eligible group:

STEP	ACTION
1	**Categorical eligibility:** Start with people for whom the household is requesting Medicaid. Identify the coverage groups for which each person is categorically eligible.
2	**Mandatory household members:** Include people in the eligible group according to the policies for the applicable coverage groups.
3	**Nonfinancial eligibility criteria:** If any person in the household is ineligible for nonfinancial reasons, determine if the person must still be included in the eligible group as a considered person.
4	**Voluntary exclusion:** Determine if there are any household members that the eligible group may voluntarily choose to exclude.
5	**Relationships:** Evaluate the effect that excluding the person has on the relationships of the remaining members of the eligible group.

Who Must Be in the FMAP Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

Policy: The FMAP eligible group consists of all eligible people living together. The FMAP eligible group is considered a separate and distinct group, regardless of other people in the home and the relationship of these other people to the eligible group.

SSI recipients are never included in the FMAP eligible group. See State Supplementary Assistance Recipient for details on how to treat SSA or SSI recipients in the same household.

An eligible group must have at least one dependent child and one eligible specified relative to meet eligibility requirements for FMAP. EXCEPTIONS: The parent, the incapacitated stepparent married to the parent, or the needy specified relative may be the only FMAP-related eligible group member receiving Medicaid if:

- The only eligible child receives SSI, or
- The dependent child is ineligible for Medicaid, or
- The parent or needy specified relative voluntarily chooses to exclude the child or children in order to receive coverage for the parent or needy relative.

Include the following household members in the eligible group:

- The dependent child.
- Any brother or sister of the dependent child (of whole, or half-blood, or adoptive) who:
  - Is not an SSI recipient, and
  - Meets requirements under Age of Children and School Attendance.
- Any natural or adoptive parent of the dependent child, regardless if the parents are married to each other.
- Any household member who:
  - Receives home- and community-based waiver services,
  - Is not an SSI recipient, and
  - Meets the family relationship requirements.

The unborn child, when the pregnant mother is counted in the household. If the only child in the family receives Medicaid as a newborn, the mother cannot establish eligibility under the FMAP coverage group unless she requests that the child be removed from newborn status and added to her eligible group. See Unborn Children.

- A parent who is not eligible for Medicaid due to a nonfinancial reason. The parent must remain a part of the household size as a "considered" person. The parent's income and resources are counted toward the eligible group. See Whose Resources to Count, for instructions on how to treat the resources of an ineligible parent.

1. Ms. C, Mr. D, and their common child, Child E, apply for Medicaid for all three of them. Child E has no social security number. The parents indicate that they are not going to apply for one.

   Child E is not eligible for Medicaid and is not a "considered" person on his parent's cases.

   However, if they are otherwise eligible, Ms. C and Mr. D are each eligible as a household of one because they both have a dependent child in the home. They are not part of the same eligible group because they are not married and their common child is not receiving Medicaid.

2. Mr. F applies for assistance for himself and his two children, a boy, age 5, and a girl, age 7. Each child has a different mother and neither mother is in the home.

   Mr. F has social security numbers for himself and his son. He has not been able to apply for a social security number for his daughter. Since the girl is ineligible for Medicaid, the eligible group consists of Mr. F and his son.

The following sections explain specific exceptions to FMAP eligible group policy for:

- People who are voluntarily excluded
- Unborn children
- Siblings
- SSI recipients

People Voluntarily Excluded from the Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

Policy: People who may be voluntarily excluded from the FMAP eligible group include:

- Self-supporting parents of an unmarried minor who are excluded by the minor parent in order to get Medicaid for the minor parent's child.
- The minor parent when the minor parent's self-supporting parents are voluntarily excluded. However, consider the minor parent's income and resources (if applicable) when determining eligibility for the minor parent's child.
- A stepparent.
- The biological parent and any common children when the stepparent is excluded in order to get Medicaid for a stepchild. Use the biological parent's income and resources when determining eligibility for the biological parent's child.

- An infant who is receiving Medicaid as a newborn child of a Medicaid-eligible mother.
- Whole, half, or adoptive siblings of eligible children.
- A person cannot receive Medicaid if that person is ineligible for a nonfinancial reason, such as no social security number, no verification of citizenship or identity, or a sanction.
    - When a **child** is not eligible for a nonfinancial reason, the child is **not** part of the household size. The child's income and resources are **not** counted toward the eligible group.
    - When a **parent** is not eligible for a nonfinancial reason, the parent must remain a part of the household size as a "considered" person. The parent's income and resources are counted toward the eligible group. See Whose Resources to Count, for instructions on how to treat the resources of an ineligible parent.

1. Mrs. X, a single parent, applies for Medicaid for herself. She has two children, Mary, age 6, who receives SSI, and Bobby, age 10. Bobby receives $375 a month social security benefits from his deceased father's account.

   Bobby may be voluntarily excluded from the eligible group, and Mrs. X may receive FMAP for herself only.

2. Ms. L, 36, has two children who receive social security benefits due to the death of their father. Ms. L was never married to her children's father and does not receive social security benefits. Ms. L has earned income from babysitting in her home.

   Ms. L does not want her children included in her eligible group, as their unearned income creates ineligibility. She voluntarily chooses to exclude the children. If her earned income does not exceed the FMAP standard for one person, Ms. L is eligible for FMAP.

3. When Mrs. E applies for FMAP, she has the following people living in her home: Bobby, a six-year-old child by a previous marriage; Mr. E, her husband; and Rick, their three-year-old common child.

   Mrs. E would like to apply for herself and Bobby only, but Rick must be included, since he is a half-brother to Bobby. Mrs. E may choose to exclude Rick voluntarily. If Rick is not voluntarily excluded, he is an eligible child and therefore, his father, Mr. E, must also be included in the eligible group.

4. Household composition:
   Ms. B, age 30, pregnant
   Unborn child
   Mr. R, age 32, unborn child's father
   Child T, age 10, Ms. B's child from a previous marriage

   Ms. B applies for Medicaid for herself because she is pregnant. Under MAC, the needs, income, and resources of the pregnant woman, the unborn child, the father of the unborn child, and any siblings of the unborn child are considered when determining eligibility for the pregnant woman.

   Ms. B states that she does not want to receive Medicaid for Child T because his resources create ineligibility for her. Therefore, Child T is voluntarily excluded, and eligibility for Ms. B is based on a three-member household. The worker refers Child T to the Hawki program.

Only the needs, income, and resources of Ms. B, the unborn child, and Mr. R are considered. Ms. B cannot voluntarily exclude the needs of her unborn child in order to avoid counting the income and resources of the Mr. R.

NOTE: If child T does not have resources and is not voluntarily excluded, eligibility should first be determined under the FMAP coverage group. If the unborn child is **not** included in the household size, Mr. R's needs, income, and resources are not considered toward Ms. B's eligibility.

5. Household composition:
   Mr. J and Mrs. J
   Child A, 17, married
   Baby A, Child A's child
   Child B, 17
   Child C, 15

   Mr. and Mrs. J apply for Medicaid coverage for their family. If the family income does not exceed FMAP limits for a four-member household, Mr. and Mrs. J, Child B, and Child C are eligible for Medicaid under FMAP. Since Child A is considered emancipated due to marriage, Child A and Baby A may be determined eligible for FMAP as their own eligible group.

6. Same as Example 5, except that Child A is not married. If the family's income does not exceed FMAP limits for a six-member household, the family is eligible under FMAP.

   Since Child A is not married, she must be included as part of the eligible group unless the household chooses to exclude her from the eligibility determination.

7. Same as Example 5, except Child A is 19 and is not in school. If the family's income does not exceed FMAP limits for a four-member household, Mr. and Mrs. J, Child B, and Child C are eligible for FMAP.

   Since Child A is 19 and cares for a child, she and Baby A may be determined eligible under FMAP as their own filing unit.

8. Household composition:
   Mrs. A, age 36
   Child, B, age 12, receives $600 per month Social Security
   Child C, age 8

   Child B's income exceeds the FMAP limit for a three-person household. Mrs. A chooses to exclude Child B from the eligible group in order to obtain Medicaid for herself and Child C.

   If the income and resources for Mrs. A and Child C do not exceed the FMAP limits for a two-member household, Mrs. A and Child C are eligible under FMAP.

9. Mr. J is severely injured in an auto accident and, as a result, lives in a nursing facility. Since Mr. J would be eligible for FMAP if not living in a medical institution, both the needs, income and resources of his family at home and of Mr. J are considered. They are compared to FMAP limits for a family size including Mr. J.

   If the family at home would be eligible for FMAP if Mr. J were included in the eligible group, Mr. J is entitled to receive Medicaid under the coverage group for people who would be eligible for FMAP if not in a medical institution.

Mr. J's three children each receive $150 per month in disability payments through his employer. By excluding two of the children, the household's income is below FMAP limits for three people (Mr. J, Mrs. J, and one remaining child). Therefore, Mr. J is eligible to receive Medicaid under this coverage group.

The determining factor in whether the family at home can actually receive Medicaid is whether the income and resources of the remaining household members meet FMAP limits.

10. Ms. N and her child Kelly apply for Medicaid. Kelly's absent father carries health insurance for her. Ms. N chooses not to apply for Medicaid for Kelly. Therefore, if all other eligibility factors are met, Ms. N can be eligible for FMAP or Medically Needy as a one-person household.

11. Household composition:
    Ms. Q, age 19, not pregnant
    Mr. B, Ms. Q's boyfriend, age 24
    Baby C, common child

    Mr. B has earnings of $3,000 per month. He carries health insurance for Baby C. Ms. Q has no health insurance and applies for Medicaid for herself.

    If Baby C is in newborn status, then Baby C is not considered part of Ms. Q's household and Ms. Q is not FMAP eligible. Ms. Q must establish eligibility in her own right without consideration of Baby C. Therefore, there is no relationship between Ms. Q and Mr. B and his income is not considered in her eligibility determination.

    If Baby C is not in "newborn" status, the household can voluntarily exclude Baby C. Since Ms. Q and Mr. B are not married, they are separate eligible groups of one because they both have a dependent child, Baby C.

    If all other eligibility requirements are met, Ms. Q is determined eligible under FMAP or FMAP-related Medically Needy, as a one-person household.

12. The household consists of Mrs. M and her four children, her husband, and their newborn common child. Mrs. M received Medicaid as a pregnant woman and her postpartum period has expired. She no longer wants Medicaid for herself.

    Even though Mrs. M no longer receives Medicaid, the common child continues to be eligible as a newborn child of a Medicaid-eligible mother.

    Mrs. M's four children also receive Medicaid. She does not want her husband's income to be used to determine Medicaid eligibility for them, so she voluntarily chooses to exclude him. Doing so also excludes Mrs. M's needs from her children's eligible group.

    Mrs. M will not receive Medicaid for herself, but Medicaid will continue for her four children. The four children are considered in the household size in determining eligibility for Medicaid. NOTE: Mrs. M's income is used to determine eligibility for the four children.

13. Same household composition as in Example 12, except that the newborn is now one-year-old. Mrs. M does not want her husband's income to be used to determine Medicaid eligibility for her children. Therefore, she chooses not to continue Medicaid for the one-year-old.

    The household size continues to be four. Mrs. M's income is used to determine eligibility for her four children in the eligible group.

14. Mr. and Mrs. Q have a 16-year-old daughter, Sally, who has a one-year-old child, Jason. Mr. and Mrs. Q's medical insurance covers Sally. They want Medicaid for Jason only. The household size is one. NOTE: Sally's income is used to determine eligibility for Jason.

Unborn Children

Legal reference: 441 IAC 75 (Rules in Process)

Policy: An unborn child may or may not be included in the FMAP-related eligibility group depending on the circumstances:

- If a pregnant woman is included in the household size (as an eligible, considered, or sanctioned person), the unborn child is also included in the household size unless the mother requests to exclude the unborn child. If the unborn child is included in the eligible group, use the income and resources of the unborn child's father.
- A pregnant woman whose Medicaid eligibility is not based on pregnancy may choose to exclude the unborn child from the household size.

Count the unborn child in the household size. (See 8-C, *Verification of Pregnancy*.) The pregnant mother may be an eligible, considered, or sanctioned person.

A woman whose Medicaid eligibility is not based on pregnancy may voluntarily exclude the unborn child from the household size. If the unborn child is included in the eligible group, you must also consider the income and resources of the unborn child's father.

Siblings

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Include in the household size all siblings that live together and meet the age criteria for the coverage group they are eligible under. Do not include siblings in the household size if they are:

- Emancipated due to marriage, unless the marriage is annulled;
- Voluntarily excluded; or
- In a "newborn status."

MAC and FMAP-Related Medically Needy Exception: Household members eligible under FMAP may be in a separate eligible group.

See Determining the Coverage Group, for more information on determining the eligible group.

SSI Recipient

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Exclude the needs of a person who receives Supplemental Security Income (SSI). For this policy, the term "SSI" also includes mandatory or optional State Supplementary Assistance payments.

Include the needs of the potential SSI recipient in the eligible group. Remove the person's needs prospectively when the Social Security Administration office notifies you that the SSI application is approved.

FMAP ineligibility for a person with continuing SSI eligibility begins the month in which the person receives the SSI payment. Remove the person's needs effective the first of the following month.

State Supplementary Assistance Recipient

Legal reference: 441 IAC 50.2(1)

Policy: The term "SSI" also includes State Supplementary Assistance payments. This program supplements the income of aged, blind, or disabled people who receive SSI or would be eligible for SSI except for their income and who have a special need that is not covered by SSI.

One special need covered by this program is the needs of a dependent family member, such as a spouse or child, who is living in the home of the aged, blind, or disabled person and who is financially needy. See 6-B, *Dependent Person Program* for eligibility criteria.

For Medicaid, the State Supplementary Assistance recipient is considered the same as an SSI recipient. However, the person who is the "dependent" is not considered as an SSI recipient.

> Mr. H receives SSDI income and qualifies to receive State Supplementary Assistance cash support for his dependent wife. The couple has four-year-old twins. The family applies for Medicaid.
>
> Mr. H is not considered to be a part of the FMAP household because he is a State Supplementary Assistance recipient. Mrs. H and the two children are considered together for FMAP-related Medicaid.

Who May Be in the FMAP Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

Stepparents and needy relatives may be included in the eligible group and receive FMAP coverage, depending on the circumstances. The following sections explain the policies that apply to:

Incapacitated Stepparent

Legal reference: 441 IAC 75 (Rules in Process)

An incapacitated stepparent **may** be included in the eligible group if the person:

- Is the legal spouse of the natural or adoptive parent by ceremonial or common-law marriage, **and**
- Does **not** have a child in the eligible group.

When the incapacitated stepparent has a child in the eligible group, treat the stepparent as a parent. This means that the incapacitated stepparent **must** be included in the eligible group, unless the incapacitated stepparent is receiving SSI or is ineligible for a nonfinancial reason.

A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has an obvious effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity must be expected to last for a period of at least 30 days from the date of application.

When a stepparent recovers from the incapacity, remove the recovered stepparent from the eligible group the first month after recovery allowing a ten-day notice. Complete an automatic redetermination of eligibility to determine if the stepparent is eligible for Medicaid on some other basis.

Verifying Incapacity

Receipt of Social Security or SSI payments based on disability or blindness is considered proof of incapacity.

All other determinations involving incapacity must be supported by medical or psychological evidence. Participation in vocational rehabilitation services is not considered proof of incapacity, but it indicates that a disability may exist.

Obtain medical evidence from a physician (including a chiropractor) or from the Division of Rehabilitation Services. Evidence can be submitted either by a letter from the physician or on form 470-0447, *Report on Incapacity*.

When an examination is required but medical resources, such as county hospitals or free clinics, are not available, you may authorize a physician to perform the examination. The examination must be limited to verification of the specific illness or physical or mental disability upon which the determination of incapacity will be considered.

Issue form 470-0502, *Authorization for Examination and Claim for Payment*, to the physician to submit for payment of the claim.

Nonincapacitated Stepparent

Legal reference: 441 IAC 75 (Rules in Process)

The nonincapacitated stepparent may be included in the eligible group if:

- The stepparent is the legal spouse of the dependent child's natural or adoptive parent by ceremonial or common-law marriage, **and**
- The stepparent is required in the home to care for a child in the eligible group while the child's parent works, if it would be necessary to allow child care as a deduction if the stepparent were not available.

When the stepparent has a child in the eligible group, treat the stepparent as a parent. This means that the stepparent **must** be included in the eligible group unless the stepparent is receiving SSI or is ineligible for a nonfinancial reason.

1. Mrs. A receives FMAP for herself and her two children. Also in the home is Mr. A, the children's stepfather. Mrs. A pays her mother $300 per month for child care while she works. Mr. A is not employed.

   Mr. A's needs may be added to the FMAP group if he provides care for the FMAP children, thereby eliminating child care costs.

2. Mrs. C and one child get FMAP. Also in the home is Mrs. C's other child, who is on SSI, and Mr. C, the children's stepfather. Mrs. C pays $200 per month in child care for the SSI child while she works.

   Even if Mr. C begins providing child care for the SSI child, his needs cannot be added to the eligible group, because Mrs. C's child care costs are incurred for a child not included in the FMAP-eligible group and, therefore, are not allowed as a deduction.

Needy Nonparental Specified Relative

Legal reference: 441 IAC 75 (Rules in Process)

A needy nonparental specified relative who assumes the role of parent may be included in the eligible group if the specified relative's:

- Resources are within the resource limits, and
- Income is below the FMAP income standards for one person.

Aunt M, 46, applies for FMAP for her two nieces. She has unearned income of $125 a month and no resources. The two nieces have no income. Aunt M elects to have her needs included in the eligible group, because her income is under FMAP standards for one person and she will receive Medicaid.

When the nonparental specified relative has a spouse, determine the fact that one of them is needy by establishing that their combined income and resources are within FMAP standards for two people.

1. A grandmother applies for FMAP for her grandchild. She has no income, and her spouse has $200 per month income from Social Security. They have no resources. One of them may be considered needy, because their income and resources are under FMAP standards for two people.

   Regardless of which grandparent chooses to be considered as the needy specified relative, the eligible group will consist of the grandchild and the needy specified relative.

2. A grandmother receives Medicaid for her two grandchildren. She has medical bills and requests to be added to the eligible group as a needy specified relative. Also in the home is the grandfather, who has $900 gross earnings.

   Step 1. The worker determines if the grandmother is needy. (Ignore the children in the household. Compare the grandparents' income to the FMAP limits for two people.)

$ 900.00	Test 1
× .80	20% earned income deduction
$ 720.00	
× .42	58% work incentive deduction
$ 302.40	Test 3 ($302)

   The worker does not apply the standard of need test when adding a person to an existing FMAP-related case. Since the income is less than the FMAP limits, the grandmother is considered "needy" and added to FMAP.

   Step 2. The worker determines how much of the grandfather's income must be attributed toward the FMAP eligible group for the grandmother and grandchildren.

$ 900.00	Gross earnings
- 180.00	20% earned income deduction
- 183.00	Diversion for grandfather's needs
- 311.46	58% work incentive deduction
$ 225.54	Countable income

   NOTE: The countable $225.54 plus any gross nonexempt income of the eligible group must pass the 185% gross income test (Test 1) for the eligible group. Additionally, the $225.54 plus any income of the eligible group after allowable deductions must pass the benefit standard test (Test 3).

Needy Specified Relative and Parent

Legal reference: 441 IAC 75 (Rules in Process)

A needy specified relative who acts as the child's caretaker may be included in the eligible group when the parent is in the household but the parent is unable to act as the caretaker. The Medicaid case is still considered as a parental case, rather than a nonparental caretaker case.

"Unable to act as caretaker" means that the parent is physically or mentally incapable of caring for the child. There is no time limit on how long the needy specified relative who acts as a caretaker may be included in the eligible group. The parent could be permanently unable to act as caretaker (e.g., severe intellectual disability) or temporarily unable (e.g., hospitalized due to a car accident).

> Ms. A and her child are on FMAP. Ms. A is in an auto accident and is hospitalized. She will be unable to care for her child until she has recovered. Ms. A's mother moves into the home to take care of her grandchild in the interim.
>
> Even though Ms. A remains in the eligible group as an FMAP member, Ms. A's mother, if needy, may be added to the eligible group for as long as she acts as the child's caretaker.

Defining the Number of Eligible Groups in a Household

Legal reference: 441 IAC 75 (Rules in Process)

After deciding who **must** be in the eligible group and who **may** be in the eligible group, there are additional considerations involved in determining the composition of each eligible group.

The unborn child is generally considered in determining household size. However, if the unborn child is the only child, the parents cannot establish their own eligibility based on the unborn child.

When a pregnant woman is establishing eligibility under MAC, the father of the unborn child must be a part of the eligible group if he is living with the pregnant woman.

If parents are no longer income-eligible for FMAP, they are considered self-supporting parents.

The following sections explain how the relationships affect the eligible group for:

- Parents and married couples
- Minor parents
- Nonparental specified relatives

Parents and Married Couples

Legal reference: 441 IAC 75 (Rules in Process)

Parents and their children are one eligible group. However, when unmarried parents choose to voluntarily exclude their common children, the unmarried parents can no longer be part of the same eligible group.

Ms. A and Mr. B and their common child all live together and apply for Medicaid. Because the common child has a $25,000 savings account, Ms. A and Mr. B choose to voluntarily exclude the child so that they can receive Medicaid.

The only factor requiring Ms. A and Mr. B to be in the same eligible group is the common child. Since the child has been voluntarily excluded, Ms. A and Mr. B are now considered unrelated adults and can no longer be in the same eligible group.

However, Ms. A and Mr. B can both be eligible under FMAP as separate one-member eligible groups, since each of them has a child (the common child) in their care. The common child would not be eligible for Medicaid under any coverage group.

Only the income and resources of Ms. A are considered in Ms. A's eligibility determination, and only the income and resources of Mr. B are considered in Mr. B's eligibility determination. If Ms. A, Mr. B, or both are over income or over resources for FMAP, potential eligibility under FMAP-related Medically Needy should be explored.

Unmarried adults, their respective own children, and common children are one eligible group. Unmarried adults with their respective own children but no common children are two eligible groups.

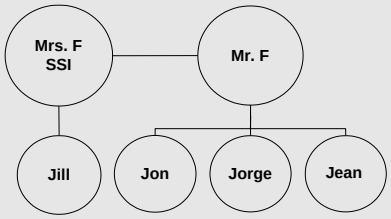
Ms. G has one child and Mr. S has one child. They are living together but are not married. FMAP eligibility is determined for two separate eligible groups.

A married couple and their respective own children are one eligible group if the parents both want Medicaid. A double stepparent household with no common children may request Medicaid for either the mother and her children or the father and his children.

1. Mr. B has two children by a previous relationship and Mrs. B has one child by a previous relationship. FMAP eligibility is determined for one five-member eligible group, since the parents are married.

   If only Mr. B and his two children want Medicaid, then Mr. B and his children would be one household and Mrs. B would be treated as a stepparent.

2. The household consists of:
   - Mrs. F, SSI recipient
   - Jill, Mrs. F's child from a previous relationship
   - Mr. F
   - John, Jorge, and Jean, Mr. F's children from a previous relationship



   a. Mrs. F requests Medicaid for Jill only. Because the F's have no common children, the eligible group can be a household of one for Jill. Mr. F is a stepparent and any income he has would first be diverted for his and his children's needs before being used for Jill's eligibility.

b. Mr. F requests Medicaid for himself, Jon, Jorge, and Jean only. Because the F's have no common children, the eligible group can be a household of four: Mr. F, Jon, Jorge, and Jean. Mrs. F's income is exempt since she's receiving SSI. Jill is not a required household member since she's not a sibling to Mr. F's children.

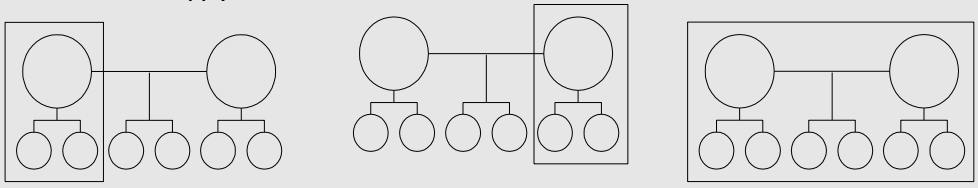
c. Mr. and Mrs. F request Medicaid for everyone in the household. Because everyone wants Medicaid and the parents are married, the family has two eligible groups. Mrs. F is a household of one, since she receives SSI. Mr. F, Jill, Jon, Jorge, and Jean are a household of five because they all want Medicaid.

d. The household size could be reduced if the Fs want to exclude any of Mr. F's children voluntarily. Those children would not be eligible for any other Medicaid coverage group. If the children were voluntarily excluded due to income or resources, they would be referred to Hawki.

A married couple, their respective own children, and their common children are one eligible group.

The household consists of a mother and her two children, a father and his two children, and two common children. The mother and father are married to each other. Possible groups are:

- The mother could apply for her two children if she excludes the common children.
- The father could apply for his two children, if he excludes the common children.
- Both could apply for the entire household.



3-member household Option 1 | 3-member household Option 2 | 8-member household Option 3

If Medicaid is requested for the common children, they must be in the same eligible group with their half-brothers and half-sisters.

Minor Parents

Legal reference: 441 IAC 75 (Rules in Process)

A minor parent and the dependent child in the minor parent's care are not required to live with the minor parent's adult parent or legal guardian to receive Medicaid.

A minor parent and the minor parent's children are one eligible group when living with self-supporting parents.

Ms. H, age 17, lives with her self-supporting parents. She has a baby and applies for FMAP. Ms. H and her baby comprise the eligible group.

A minor parent and children living with the adult parent who receives FMAP are in the same group with the adult FMAP parent.

Ms. X is 15 and lives with her mother, Mrs. X, who receives FMAP for Ms. X and her younger brother. In October, Ms. X has a baby. The baby is eligible as the newborn child of a Medicaid-eligible mother for one year.

If assistance is requested for the baby after the newborn period has expired, the eligible group will consist of Mrs. X, the brother, Ms. X, and her baby.

When the **minor parent turns 18**, **is in school**, and will complete the course of study before reaching age 19, the minor parent and the child remain in the adult parent's group until the course of study is completed.

Ms. W is a 17-year-old student who lives with her mother, who receives FMAP for herself, Ms. W, and Ms. W's baby. Ms. W will turn 18 in December. However, she is expected to complete her course of study in the following May, before she reaches age 19.

Ms. W and her baby remain in her mother's eligible group through May. Mrs. W loses FMAP eligibility effective June 1.

When the **minor parent turns 18**, and **is not in school**, or is in school but will **not** complete the course of study by age 19, the minor parent and the child are removed from the parent's FMAP eligible group and are set up as a separate FMAP eligible group. An application is **not** required.

Ms. Y is 17 and has a baby. They live with her mother, Mrs. Y, who receives FMAP for Ms. Y, Ms. Y's baby, and two of Ms. Y's siblings. The baby has been eligible as a newborn child of a Medicaid-eligible mother and is turning age one.

An automatic redetermination is completed for the baby as the newborn period expires. The eligible group will consist of Mrs. Y,
Ms. Y, Mrs. Y's two other children, and Ms. Y's baby.

Ms. Y will turn 18 on December 15. She is not in school. Since Ms. Y will not be eligible as a child past December, Ms. Y and her baby will be removed from Mrs. Y's eligible group effective January 1.

The worker completes an automatic redetermination and establishes that Ms. Y may receive FMAP for herself and her baby as a separate eligible group. An application is **not** required to be complete an automatic redetermination of eligibility.

When the minor parent is ineligible (e.g., subject to a sanction or an ineligible alien) cancel the minor parent's Medicaid. However, the minor parent will remain a part of the household size. See Who Must Be in the FMAP Eligible Group.

The minor parent remains ineligible for Medicaid until the sanction is fixed, if that is the reason the minor parent is ineligible.

> Ann is 16 years old. She has a baby and lives with her mother, Mrs. Z, who receives FMAP for Ann and the baby. In December, Ann fails to cooperate with CSRU.
>
> Ann is sanctioned and canceled from Medicaid. However, the household remains a three-member household.

When the minor parent is living with a nonparental specified relative or in an independent living arrangement, determine need in the same manner as if the minor parent had attained majority.

However, if the nonparental specified relative assumes a parental role over the minor parent, the nonparental specified relative may establish a caretaker case and may be included in the eligible group if needy.

See Minor Parents and Minor Pregnant Women.

Nonparental Specified Relative

Legal reference: 441 IAC 75 (Rules in Process)

Children in a nonparental home are one eligible group, whether or not they are siblings.

A needy nonparental specified **relative acting as caretaker** who has chosen to be included in the eligible group and the child are one eligible group. Once a nonparental specified relative is determined needy, the nonparental specified relative's needs are determined the same as a parental case. See Needy Nonparental Specified Relative.

When a nonparental caretaker has children on FMAP, this is a separate eligible group from the nonparental caretakers own children. The two groups are:

- The caretaker and the caretaker's own children.
- Children for whom the caretaker is responsible.

The parent, the needy nonparental specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker, and the children are one eligible group.

1. A sister, age 26, applies for her brother, age 15. She does not want her needs to be considered as a needy specified relative. The brother is eligible for FMAP if his income is within FMAP standards of a one-member eligible group.
2. An aunt applies for a niece and a nephew. She does not want her needs to be included. FMAP eligibility is granted if the niece's and nephew's income does not exceed the FMAP schedule of needs of $361 for a two-person household, whether or not they are siblings.
3. A grandmother who is needy applies for herself and two grandchildren. The IM worker determines that the grandmother is needy based on a household size of one.

   FMAP eligibility is granted if the income of the grandmother and her two grandchildren do not exceed the FMAP standard for a three-person eligible group. The grandmother must also be resource eligible based on the resources of the three household members.

When a minor nonparental specified relative is a caretaker and lives with self-supporting parents, the eligible group consists of only the child for whom the minor is caretaker.

When a minor nonparental specified relative is a caretaker and lives with an adult parent who receives FMAP, there are two eligible groups:

- The adult FMAP parent and children, including the minor nonparental specified relative who is a caretaker.
- The children for whom the minor caretaker is responsible. (The needs of the minor nonparental specified relative are not included in this eligible group.)

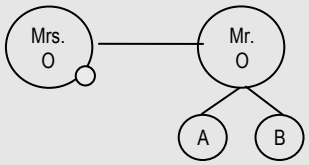
Do not include children in foster care in the eligible group with the family at home, regardless of the length of the foster child's absence. See 8-H, *Foster Care and Subsidized Adoption* when examining Medicaid eligibility for a foster child.

Children in subsidized adoption may be an eligible group of their own or may be included in the adoptive family's eligible group, whichever is most beneficial. See 8-H, *Foster Care and Subsidized Adoption*, when examining Medicaid eligibility for a child in subsidized adoption.

Include in the eligible group people who meet the definition of temporary absence, unless the people are voluntarily excluded. See 8-C, *Absence*. However, do not include adults or children confined to a penal institution, no matter how long they will be incarcerated.

Household Composition Examples

1. Household composition:



   - Mrs. O, aged 32, pregnant
   - Mr. O, aged 36, husband of Mrs. O and father of unborn
   - Child A, aged 12, Mr. O's child from previous relationship
   - Child B, aged 10, Mr. O's child from previous relationship

   The household applies for Medicaid for everyone.

   Mrs. O is a stepparent. She cannot be included in the FMAP eligible group because she is not incapacitated and has no born child living with her. Mr. O and his children are eligible under FMAP if countable income is within FMAP limits for a three-person eligible group and all other eligibility factors are met.

   Since Mrs. O is pregnant, she can be eligible under MAC if her countable income does not exceed 300% of poverty for a two-person eligible group (Mrs. O and unborn child), and all other eligibility factors are met.

   If Mr. O and his children are **over income** for FMAP, explore eligibility under MAC for the children and under Medically Needy for Mr. O. When determining eligibility under MAC and under Medically Needy, the eligible group includes all household members. Mrs. O and the children become part of the same MAC household.

   Mrs. O can be eligible under MAC if countable income does not exceed 300% of poverty for a five-person eligible group and all other eligibility factors are met. The children can be eligible under MAC if countable income does not exceed 133% of poverty for a five-person eligible group and all other eligibility factors are met.

   The Medically Needy spenddown is calculated for a five-person eligible group with Mr. O being the only potentially eligible person.

2. Same as Example 1, except that Mrs. O and Mr. O are not married. They apply for Medicaid for everyone.

   Mr. O and his children can be eligible under FMAP if countable income is within the FMAP limits for a three-person eligible group and all other eligibility factors are met.

   Since Mrs. O is pregnant, she can be eligible under MAC if her countable income does not exceed 300% of poverty for a two-person eligible group (Mrs. O and unborn child), and all other eligibility factors are met.

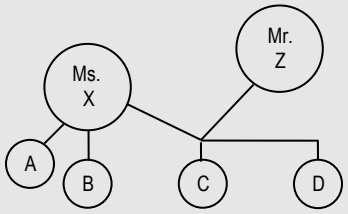
   If Mr. O and his children are over income for FMAP, eligibility under MAC should be explored for the children and eligibility under Medically Needy should be explored for Mr. O. When determining eligibility under MAC, the eligible group includes only Mr. O and his children.

   The fact that Mr. O and his children are over income for FMAP has an effect on Mrs. O's eligible group (Mrs. O, the unborn child and Mr. O), but not on Mrs. O's eligibility, because she is continuously eligible.

   Mr. O's children can be eligible under MAC if countable income does not exceed 133% of poverty for a three-person eligible group (Mr. O and his children) and all other eligibility factors are met.

   Mr. O can be potentially eligible under Medically Needy if all eligibility factors are met. The spenddown is calculated for a three-person eligible group with Mr. O being the only potentially eligible person.

3. Household composition:



Ms. X, age 35
Mr. Z, age 37
Child A, age 13, Ms. X's child from previous relationship
Child B, age 11, Ms. X's child from previous relationship
Child C, age 4, common child
Child D, age 2, common child

The household applies for Medicaid for everyone. All members are eligible under FMAP if countable income is within the FMAP limits for a six-person eligible group.

If the eligible group is over income for FMAP, eligibility under MAC should be explored for the children and under Medically Needy for the parents. When determining eligibility under both MAC and Medically Needy, the eligible group size is six.

The common children may be voluntarily excluded as a way to not count Mr. Z's income and resources in the eligibility determination for Ms. X, Child A, and Child B. The common children would not be eligible for Medicaid under any other coverage group.

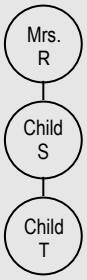
However, even if the common children are voluntarily excluded, Mr. Z may be eligible for Medicaid under FMAP or FMAP-related Medically Needy as a one-person eligible group.

4. Same as Example 3, except that Ms. X and Mr. Z are **married**. They apply for Medicaid for themselves and voluntarily choose to exclude the common children.

Ms. X and her two children can be eligible under FMAP if countable income is within FMAP limits for a three-member eligible group and all other eligibility factors are met. Mr. Z is a stepparent to this group and his income and resources are considered accordingly.

If the household voluntarily chooses to exclude Mr. Z's income from the eligibility determination of Ms. X's eligible group, Ms. X's needs are not included in the group.

5. Household composition:

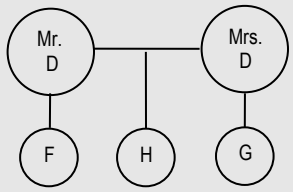


Mrs. R, self-supporting parent of Child S
Child S, turning age 18, minor parent of Child T
Child T, age 2

Child S and Child T are currently receiving Medicaid under MAC as a separate eligible group from Mrs. R. Mrs. R is allowed a diversion from her income. The remainder is being counted in the eligibility determination of Child S and Child T.

Child S turns 18 September 4. Beginning with the month of October, Mrs. R's income is not longer counted in the eligibility determination of Child S and Child T. Child S and Child T are still both under the age limit for children for MAC. They continue to be eligible under MAC if the income of the two-member eligible group does not exceed 133% of poverty level.

6. Household composition:
   Mr. D
   Mrs. D
   Child F, age 8, Mr. D's child from a previous relationship
   Child G, age 10, Mrs. D's child from a previous relationship
   Child H, age 5, common child

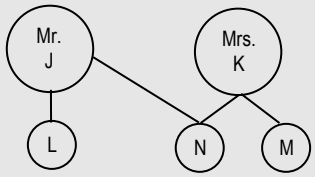


The household applies for Medicaid for everyone. In determining eligibility under FMAP, the eligible group size is five. If the eligible group is over income for FMAP, eligibility under MAC and Medically Needy should be explored and the eligible group size would continue to be five.

If the household chooses to exclude the common child, the eligible group size for FMAP, MAC and Medically Needy is four.

7. Household composition:

   Mr. J
   Ms. K
   Child L, age 8, Mr. J's child from a previous relationship
   Child M, age 10, Ms. K's child from a previous relationship
   Child N, age 5, common child



The household applies for Medicaid for everyone. The eligible group size for FMAP, MAC, and Medically Needy is five.

If the household chooses to exclude the common child, there are two separate eligible groups. One for Ms. K and Child M and the other for Mr. J and Child L. Child N is not eligible for Medicaid under any other coverage group.

School Attendance

Legal reference: 441 IAC 75 (Rules in Process)

A needy child can receive FMAP or FMAP-related Medically Needy until the age of 18 regardless of school attendance. FMAP is available to a needy 18-year-old child only if the child is:

- A full-time student (as defined below), and
- Reasonably expected to complete training before the child's nineteenth birthday or any time during the month of the nineteenth birthday, unless the birthday is on the first of the month. For example, a child turning 19 on May 2 and completing training on May 23 is eligible through May.

Obtain written verification from the school or institution of the date the student is expected to complete requirements for graduation. You need a signed release or form 470-1638, *Request for School Verification*, before contacting the school.

A person is in school full time if enrolled or accepted in a full-time elementary school, secondary school, or equivalent level of vocational, technical, or training school, including Job Corps. The school or program must lead to a certification or diploma. Do not allow correspondence school as a program of study.

Consider a person to be in school full time, regardless of any of the following:

- Official school vacation
- Training program vacation
- Illness
- Convalescence
- Family emergency

Consider a person to be attending school until officially dropped from the school record. Continue assistance for a reasonable period when a person's education is temporarily interrupted because of a change in the education or training program.

The school determines whether the student's hours of attendance are considered full time. Obtain a statement from school officials if there is a question about whether to consider a student full time who is:

- Working on a GED.
- Enrolled in a "drop-in" school.
- Enrolled in any other public educational program that has irregular or shortened hours.

Consider a child who receives home schooling the same as any other student, provided the home schooling arrangement is certified by the school system. Obtain any needed verification of student or attendance status from the school system that certified the arrangement. A signed release from the client is needed (the same as when a child is enrolled in a regular school setting).

NOTE: School attendance is not an eligibility factor for the MAC coverage groups.

Specified Relatives

Legal reference: 441 IAC 75 (Rules in Process)

For FMAP and FMAP-related Medically Needy coverage groups, a child must live with a specified relative. "Relative" includes persons related by blood or marriage. The child's home can be with either the specified relative or the spouse of the specified relative, even if the marriage is terminated by death or divorce.

The following is a list of persons who qualify as specified relatives:

- Father, adoptive father
- Mother, adoptive mother
- Grandfather, grandfather-in-law (the subsequent husband of the child's natural grandmother, i.e., step-grandfather), adoptive grandfather
- Grandmother, grandmother-in-law (the subsequent wife of the child's natural grandfather, i.e., step-grandmother), adoptive grandmother
- Great-grandfather, great-great-grandfather
- Great-grandmother, great-great-grandmother

- Stepfather, but not his parents
- Stepmother, but not her parents
- Brother, brother-of-half-blood, stepbrother
- Brother-in-law, adoptive brother
- Sister, sister-of-half-blood, stepsister
- Sister-in-law, adoptive sister
- Uncle, aunt (of whole or half blood)
- Uncle-in-law, aunt-in-law (the spouse of the child's natural uncle or aunt)
- Great uncle, great-great-uncle
- Great aunt, great-great-aunt
- First cousins, nephews, nieces

A relative of the "putative" father can qualify as a specified relative only after paternity has been established by the court or the putative father has acknowledged paternity with written evidence.

Written evidence can include an affidavit, a court document, a signed *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S). Use the prudent-person concept regarding written evidence. A favorable determination made by another government agency (e.g., the Social Security Administration, the Veteran's Administration) also constitutes reliable evidence of paternity.

The following sections give more information on:

- Determining who the natural father is.
- Determining if a child lives with a specified relative.

Determining the Natural Father

Legal reference: 441 IAC 75 (Rules in Process)

The term "natural father" refers to the male who can be considered the child's father for the purpose of determining eligibility. Consider a man as the natural father if he:

- Was married to the mother at the time of the child's conception or birth (unless the court has declared this man **not** to be the father), or
- Has been declared by the court to be the father, even though not married to the mother at the time of the child's conception or birth, or
- Claims to be the father, **unless** the child already has another legal father as described above.

When paternity has not been established through marriage or a court decision, allow a man claiming to be the natural father to be included in the eligible group if he:

- Signs a Medicaid application or provides a signed statement that he is the father of the child, and
- Attests to his citizenship on form 470-2549, *Statement of Citizenship Status*.

The "biological father" is the male responsible for the conception of the child. The "legal father" is the male considered the father under Iowa law. When the child's biological father is someone other than the child's legal father, consider the legal father to be the parent. Do so until the court establishes that the legal father is not the parent of the child. See also 8-B, *Referrals to CSRU*.

> Mrs. A, an FMAP member, is separated from Mr. A. She lives with Mr. K and has a child by him. Mr. A is considered the legal father of the child and must be referred to CSRU.
>
> Even though Mr. K is the child's biological father, he cannot be included in the eligible group until the court declares Mr. A not to be the child's father. Until such time, Mr. K's income and resources are not considered (other than any amounts he makes available to the eligible group).

Determining if Child Lives With a Specified Relative

Legal reference: 441 IAC 75 (Rules in Process)

When a specified relative accepts responsibility for the child's welfare and the child shares a household with the specified relative, the specified relative and child are considered "living with" each other.

A "home" is defined as an established family setting or a family setting that is in the process of being established. Evidence must show that the specified relative assumes and continues the responsibility for the child in this setting. This includes living together or sharing a household.

A "home" is considered suitable unless the court rules it unsuitable and removes the child. When you have reason to believe a home is unsuitable because of neglect, abuse, or exploitation of the child, refer the family to the Protective Service Unit for investigation. Make an oral report to the unit within 24 hours.

If the child or specified relative is **temporarily** absent from the household, the relationship continues to exist even **if** the specified relative temporarily loses responsibility for the care and control of the child.

A child may be under the jurisdiction of the court, or legal custody may be held by a person or agency, but the child does not **live** with the person or agency. There may be a court order specifying that public assistance should not be sought.

Regardless of existing legal documents, base eligibility on all factors in the child's current living arrangement. The child is considered to be "living with" the specified relative, as long as the child is either physically present or temporarily absent.

The following sections explain this policy in relation to:

- Adoption.
- Cases where parental rights are terminated.

Adoption

Legal reference: 441 IAC 75 (Rules in Process)

When a mother intends to place her child for adoption shortly after birth, the child is considered as living with the mother until the legal release of custody is signed and custody is actually relinquished. Iowa law requires that when a child is voluntarily placed for adoption, a release of custody cannot be signed less than 72 hours after the child's birth.

An adoption severs the legal relationship between the child who is adopted and that child's biological parents and biological siblings. However, the adoption does not sever their blood relationship.

Consequently, when a child who was adopted returns to the home of the biological parent, the biological parent is not considered the legal parent of the child but is still considered a specified relative to the child. Establish a nonparental case for the child, with the biological parent as caretaker. Treat the case like any other nonparental case.

If the biological parent requests assistance as well, include the biological parent on the case as a needy relative, if otherwise eligible. Treat the eligible group according to Needy Nonparental Specified Relative in this chapter.

If the biological parent's home also includes biological siblings of the child who was adopted out, and assistance is requested for everyone, establish two separate cases:

- A parental case for the biological parent and the biological siblings.
- A nonparental case for the child who was adopted.

Parental Rights Terminated

Legal reference: 441 IAC 75 (Rules in Process)

When parental rights have legally been terminated, but the child has *not* been adopted by another person, the parent is still considered a parent of the child for eligibility purposes. Therefore, establish a parental case when the child lives in the home of a parent whose parental rights were previously terminated.

FMAP-Related Resource Policies Prior to MAGI Methodology

Legal reference: 441 IAC 75 (Rules in Process)

Use FMAP-related policies regarding excluded resources, countable resources, and whose resources to consider when determining resource eligibility under FMAP-related programs.

Use FMAP-related policy to determine the value of the applicant's or member's property and consider the property for Medicaid eligibility. Exclude:

- Nonhomestead property that produces income that is consistent with its fair market value, and
- Nonhomestead property that is up for sale at a price that is consistent with its fair market value.

"Fair market value" is the gross price for which the property could be sold on the open market.

1. Ms. A and her children apply for Medicaid. Ms. A owns nonhomestead real property valued at $40,000. The worker explains to Ms. A that this property will be considered an accessible resource for her eligibility unless she either lists it for sale at a price that is consistent with the fair market value or it produces income which is consistent with the fair market value.

   Ms. A chooses to list the property for sale at a fair market value and is approved for Medically Needy, as she meets all other eligibility factors.

2. Mr. L and his children receive Medicaid through Medically Needy. Mr. L inherits nonhomestead real property valued at $25,000 and timely reports this to his worker. The property has been a rental property and currently has a tenant paying rent. The worker verifies that this property is producing income consistent with the fair market value. This property is exempt and Mr. L continues to receive Medicaid through Medically Needy.

3. Same as Example 2, except that this property is being rented to a relative and the income it is producing is not consistent with the fair market value. Mr. L chooses not to increase the rent.

   Mr. L's Medicaid assistance is canceled effective the first of the next month allowing a ten-day notice. However, Mr. L's children remain eligible since resources are not considered in determining Medically Needy eligibility for children.

Use general Medicaid policy on trusts. Even though a trust may not be considered for the FIP determination, persons eligible for FIP who have a trust may not be eligible for Medicaid.

Ms. C and her son apply for FIP and Medicaid. Ms. C reports she is the beneficiary of a trust with a current principle of $55,000. The trust principle is not countable as a resource for FIP and the trust is not paying out any income to Ms. C. However, the trust is a Medicaid qualifying trust and therefore, countable for Medicaid.

The application is approved for FIP, but, since Ms. C's countable resources exceed the resource limits of all Medicaid coverage groups, the application is denied for Medicaid for Ms. C. Ms. C's son would be eligible for Medicaid. It does not matter that Ms. C is a FIP participant.

A transfer of assets between persons who are not spouses results in ineligibility for Medicaid payment for all long-term-care services. See Transfer of Assets for more information about eligibility.

Since transfers between spouses do not result in a penalty, a transfer of assets made by the stepparent to the spouse in order to qualify the group for Medicaid does not disqualify the persons in the assistance unit from payment of nursing facility services.

A transfer of assets does not cause a period of ineligibility for specific Medicaid services for children when the children are eligible in a coverage group in which household resources are disregarded in determining children's eligibility.

Eligibility for Medicaid payment of nursing facility services for persons in the household is not affected by a transfer of assets made by self-supporting parents. The self-supporting parents' income is considered in determining Medicaid eligibility but their needs are not included in the eligibility determination. Remember, the resources of self-supporting parents are **not** included in the eligibility determination.

Parents who are not eligible for Medicaid, such as sanctioned parents, are included in the household size. Ineligible parent's assets are considered when determining Medicaid eligibility for adults. Therefore, if assets of ineligible parents are transferred to persons other than their spouse, the transfer affects the eligibility for certain Medicaid services, for adults in the assistance unit.

FMAP-Related Resource Limits

Legal reference: 441 IAC 75 (Rules in Process)

For FMAP-related Medically Needy, $10,000 in liquid resources is the resource limit.

When using the FMAP-related resource limits, apply the resource limit for each month of the retroactive period, as defined in 8-A, *Definitions*, and for the month of application (even if retroactive Medicaid eligibility is established).

The resource limits apply only to adults in the eligible group.

Countable Resources

Whose Resources to Count

Legal reference: 441 IAC 75 (Rules in Process)

Count the resources of all persons in the eligible group. Include the resources of a parent who is living in the home with the eligible children but who is not a member of the eligible group (e.g., excluded parent).

Do **not** consider the resources of:

- An ineligible stepparent living in the home.
- A Supplemental Security Income (SSI) recipient.
- A self-supporting parent when determining eligibility for the minor parent's child.
- An ineligible child living in the home. This means a child who is not included because the child receives subsidized adoption assistance.

What Resources to Count

Legal reference: 441 IAC 75 (Rules in Process)

Unless specifically exempt, all resources are considered countable. The following table lists examples of countable and exempt resources:

Resource	Medically Needy
Bank accounts used **solely** for a self-employment business	Exempt
Bonds (Use the redemptive value on date of decision or time of review.)	Countable
Cash on hand	Countable
Certificates of deposit	Countable
Checking or savings accounts	Countable
Employee's portion of a lump sum retirement fund payment when a client leaves employment, plus accumulated interest. (See 8-E, *Nonexempt Lump Sums* regarding the employer's share of the retirement fund.)	Exempt
Life insurance cash value (the amount the insurance company pays upon borrowing against or canceling the policy before death). Use form 470-0444, *Insurance Report*, to get authorization to verify the amount of cash value and that the client has ownership of or access to this cash value.	Exempt
Medicaid qualifying trust whether trustee makes it available or not. If principal can be made available under discretion of trustee.	Countable
Motor vehicles (see Vehicles)	Exempt
Mutual funds	Countable
Net market value of available nonhomestead real property (see Determining Net Market Value of a Countable Resource)	Exempt
Promissory notes, mortgages and contracts	Exempt
Retirement accounts (IRAs, Keoghs, 401(k)s, IPERS)	Exempt
Stocks (Use the closing price on the date of decision or time of review.)	Countable

Count a resource only when:

- The applicant or member owns the property in part or in full and has control over it (meaning it can be occupied, rented, sold, etc. at their discretion).
- The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available.

Determine the availability of a resource regardless of the equity (net market) value.

An applicant or member need not gain title and control of an unavailable resource. Consider a resource unavailable when they own it in part or in full but have no control over it.

Joint Ownership

Legal reference: 441 IAC 75 (Rules in Process)

When a resource is owned by more than one person, assume everyone has equal shares unless you have verification to determine that the shares are different.

If an applicant or member owns a resource with another person but indicates that ownership is not equal, get a release signed so you can ask the co-owner to provide a written statement specifying the intent, degree, and terms of the joint ownership.

The intent of the co-owner is important. If the co-owner does not intend to provide the client access, the resource is unavailable. Examples include:

- An elderly parent of an FMAP-related Medicaid member who has a joint account with the member in the event the parent becomes disabled.
- An adult child (an FMAP-related Medicaid member) who is added to the title of a parent's home for ease of transfer in the event the parent should die.

In cases such as these, ask the other owner to write a statement indicating whether or not the Medicaid member has access to the account. If the statement indicates no access to the resource, consider it unavailable. Periodically check the availability of the resource.

If the applicant or member has joint ownership or tenancy-in-common ownership:

1. Determine the equity (net market) value of the total resource. If the total value plus other resources owned by the client are less than resource limits, take no further action.
2. Determine the client's share of the total equity (net market) value of the jointly owned resource. If the client's share plus other resources owned by them are less than the resource limit, take no further action.
3. If the client's share of the equity value would affect eligibility, contact the co-owner to determine if the co-owner would be willing to sell the resource. If so, count the client's share of the total equity value.

4. If the co-owner refuses to cooperate in the sale of the property, determine the equity (net market) value of only the client's share. The applicant or member must provide a written estimate of the value from a knowledgeable source.

   The source must consider local market conditions as well as the condition and location of the resource. The source must also consider that the client has only a partial interest and that the co-owner refuses to sell.

   If the estimate provided by the client appears reasonable, accept it. If the estimate is questionable, get a signed release of information so that you can independently verify the estimate.

5. Approve assistance, if otherwise eligible, when the equity value of the client's share in combination with other resources does not exceed resource limits. Deny or cancel assistance if that equity value, in combination with other resources, exceeds resource limits.

If the client disagrees with your decision, ask the client to supply additional information regarding the availability or value of the property.

If you need assistance in determining availability, refer the case to the DHS, SPIRS Help Desk.

Determining Net Market Value of a Countable Resource

Legal reference: 441 IAC 75 (Rules in Process)

Determine the net market (equity) value of countable resources only. The net market value is the gross price for which an item or property can be sold on the open market, less any legal debts, claims, or liens against it.

Consider each resource separately. The value of one resource does not affect another. To determine the net market value:

1. Establish the gross sale price, called the "fair market value." Consider local market conditions and the condition and location of the property in determining the fair market value. For example:
   - A piece of real property may be worth less in one part of the state than a similar property is worth in another part of the state, due to a distressed local economy.
   - A piece of property may be worth less than it was previously because of depressed market conditions.
   - An item of real property may have a lower fair market value because of the location of that property (on a flood plain, remote location, etc.).

   Contact a source knowledgeable about similar property, such as a car dealer, stockbroker, realtor, or banker.

   If the client disagrees with the fair market value you determine, give the client an opportunity to provide written evidence of a different valuation.

2. Verify and subtract legal debts, claims, or liens, and document them in the case record. To be considered a lien or encumbrance against a resource, a loan or lien must give the creditor a legal right to satisfy the debt from the resource in question. In most cases, loans from family or friends do not meet this requirement.

   When there is a legal debt against a combination of exempt and nonexempt property, look at the terms of the loan to see if any of the debt is deductible.

   - When the terms of the loan require the proceeds from the sale of any part of the property to be applied to the balance of the loan, deduct the total legal debt from the fair market value of the nonexempt property.
   - When the terms of the loan place a lien against the exempt property only, there is no legal debt to apply in determining the net market value of the nonexempt property.

1. Mr. A owns a home on 80 acres of land outside a city plat. There is a lien of $20,000 on the **total** property. Proceeds from the sale of any part of the property must be used to reduce the balance of the loan. Deduct the entire $20,000 from the gross value of the nonexempt property.

2. Ms. B owns a home on **one** acre of land inside a city. There is a lien of $40,000 on the house and **one-half** acre. Do not deduct the $40,000 from the gross value of the non-exempt property.

The balance after subtracting debts from fair market value is the net market (equity) value. Count as "zero" a resource that has a negative net value (that is, the debt against the property is more than the fair market value). Do not assign a negative number to any resource.

Subtract the expenses in selling the property only after it is sold.

Contracts

Legal reference: 441 IAC 75 (Rules in Process)

The resource value of a mortgage or contract is the gross price for which it can be sold or discounted on the open market, minus any legal debts, claims, or liens against it.

In Iowa, mortgages and contracts are always legally transferable, even if the terms of the contract or mortgage prohibit it. Although such terms are not legally enforceable in Iowa, they may affect the current market value of the contract or mortgage.

If the mortgages or contracts have terms that, as a practical matter, prevent sale, do not count them as resources.

Ms. B owns a contract with her two sisters, Ms. C and Ms. D. The terms of the contract prohibit any transfer or sale of the contract without approval of all of the siblings. Neither Ms. C nor Ms. D is willing to sell her shares or to buy Ms. B's share.

In reviewing the contract, a knowledgeable source determines that the terms of the contract prevent the sale. Even though these terms are not legally enforceable, they affect the market value of the contract or mortgage. Therefore, the contract is considered to have a value of zero.

Consider any **principal** payments received on a mortgage or contract as a resource upon receipt. Consider the monthly interest portion of the payment as a resource effective the first of the month after the month of receipt. If the interest is prorated, exempt it for the number of months in which the interest is prorated.

Determining Contract Value

Ask the applicant or member for a written estimate of the mortgage or contract value. The estimate must be based on local market conditions and the condition and location of the property. If the estimate provided appears reasonable, accept that value.

If you have more than one valuation, average the values.

> Ms. A owns a contract. She obtained three written valuations: $925, $850, and $800. The worker averages the three evaluations ($925 + $850 + $800 = $2,575 divided by 3 = $858). The average value of $858 is considered the fair market value of the contract.

If you doubt the value of the estimate, or if the client cannot get one, ask the client to sign a release of information so that you can independently verify or obtain the estimate. Obtain one or more estimates of value from sources knowledgeable in the business of buying and selling contracts.

These sources do not need to be in the area where the property is located, but the source must consider local market conditions and the condition and location of the property when determining the value. Valuations must be based on the most complete information possible.

If the applicant or member disagrees with your estimate, allow them to provide additional information.

Vehicles

Legal reference: 441 IAC 75 (Rules in Process)

A vehicle is any motorized means of transportation that moves persons or articles from place to place. This includes automobiles, trucks, motorcycles, tractors, snowmobiles, recreational vehicles, campers, and motorized boats.

Vehicle Exemption

Legal reference: 441 IAC 75 (Rules in Process)

Exempt one motor vehicle without regard to its value. This exemption applies to each FMAP-related Medicaid eligible group. Count the value of any additional vehicles owned by the eligible group, as described in Equity Exclusion.

See Determining Net Market Value of a Countable Resource for instructions on how to calculate net market value of a vehicle. Use a current "blue book," such as *National Automobile Dealers Association* (NADA) *Used Car Guide Book* to determine value of a vehicle.

Find the amount listed in the left-hand column, entitled "Average Trade-In Value." Do not increase the value because of low mileage or optional equipment. This is the value to use unless the applicant or member can establish a lower value.

If the vehicle is not listed in the Blue Book, contact a motor vehicle dealer in the community. Ask the dealer what the cash value would be of the same make, model, size, material, or condition as the client's vehicle.

Special equipment that modifies a vehicle for a disabled person does not increase the value of the vehicle.

Equity Exclusion

Legal reference: 441 IAC 75 (Rules in Process)

Exclude the equity value up to $5,874 per vehicle of each adult (including a needy nonparental relative) and working teenaged child whose resources must be counted in determining eligibility. (The equity value limit changes each July 1 to reflect the latest increase in the consumer price index for used vehicles.)

The exclusion applies regardless of who owns the vehicle, as long as the owner is a person whose resources must be counted. Do not allow an exclusion for additional vehicles over and above the number of exclusions to which the eligible group is entitled.

When a person whose resources must be counted has multiple vehicles, apply the exclusion to the vehicle with the highest equity value. Allow the exclusion for a working teenager regardless of the teen's age, whether the teen has a driver's license or whether the car is needed for the teen to drive to work.

The exclusion for the teen continues when the teen is temporarily absent from the job for illness, vacation, between jobs or due to the nature of employment (for example, if the teenager works only during summer vacation). The exclusion does not apply to a teenager who is looking for work but has not been employed in the past.

Ms. A receives Medicaid for herself and three children. One teenaged daughter is employed. The family owns four vehicles; the equity values are $10,000, $8,000, $5,000, and $500. The family has no other resources.

	Vehicle 1	Vehicle 2	Vehicle 3	Vehicle 4
Equity value	$ 10,000	$ 8,000	$ 5,000	$ 500
Exemption/exclusion	- 10,000	5,874	- 5,874	- 0
Excess resources	$ 0	$ 2,126	$ 0	$ 500

- The motor vehicle with the highest equity value is exempt.
- The vehicle exclusion for Ms. A and the employed teen is deducted from the two vehicles with the next highest equity values.
- Count the equity value of the lowest valued vehicle since there is no exclusion.

Ms. A's countable resources are within the $10,000 limit for Medically Needy.

When the household has a vehicle that is used for a self-employment enterprise and also used for personal use, apply the one motor vehicle exemption policy, the $10,000 exemption for capital assets, and the vehicle exclusion. See Self-Employment Assets.

Ms. A receives Medicaid. She has the following resources: One camper valued at $12,000, one car valued at $6,000, $1,000 in savings, $200 cash value in a life insurance policy, and $5,000 equity in tools needed for her self-employment.

Countable Resources		Exempt Resources	
$ 1,000	Savings	$12,000	Camper (exempt one motor vehicle)
200	Cash value of insurance		
	Excess equity in car	$5,000	Equity in tools
+ 196	Countable resources	$ 5,874	Car equity exclusion
$ 1,396			

Ms. A is resource-eligible for Medicaid under FMAP-related Medically Needy.

Exempt Resources For FMAP

Legal reference: 441 IAC 75 (Rules in Process)

Some resources are always exempt under FMAP-related Medicaid. However, for other resources the exemption lasts only for the month of receipt and the month following. Any resources remaining are then counted towards the maximum resource limit.

The following resources are exempt in the month of receipt and perhaps in the following month of receipt. See individual sections for more information.

- Corrective payments
- Earned income credit (EIC) payments
- Property settlements
- Insurance settlements and damage judgments

A listing of exempt resources follows. These resources are **totally exempt** for FMAP-related Medicaid. Count any resources not on the exempt list as well as the value of any resources exceeding the excluded amounts toward the resource limit.

AIDS/HIV Settlement Payments 441 IAC 75 (Rules in Process)	Exempt settlement payments from any fund established pursuant to the class action settlement of Susan Walker v. Bayer Corporation et al, 96 C5024(N.D. Ill.), as a resource. Some settlement payments were made in lieu of the class action settlement. These payments are also exempt as a resource. These settlements were signed on or before December 31, 1997. These funds must be kept in a separate, identifiable account.

AmeriCorps
Public Law 103-82,
441 IAC 75 (Rules in Process)

Exempt as a resource the living allowance (stipend) payments made to participants in the AmeriCorps*VISTA program as long as the Director of ACTION determines that the value of all such payments is less than either the federal or state minimum wage when divided by the number of hours the volunteer is serving. To date, no AmeriCorps*VISTA payments have exceeded this standard.

Exempt the educational award as a resource, because the award is issued directly to the educational institution or the holder of the loan and is not considered available to the recipient.

Also exempt as a resource the health insurance, reasonable accommodations, supplies, and services made available for AmeriCorps participants who have disabilities.

Burial Plot
441 IAC 75 (Rules in Process)

Exempt one burial plot for each member of the eligible group. A burial plot is a gravesite, crypt, mausoleum, urn, or other repository customarily used for the deceased's remains.

When the client owns more than one plot for each member of the eligible group, count the net market value of the excess plots toward the resource limit. Also count the net market value of a burial plot for an ineligible person whose resources must be considered (e.g., an excluded parent).

Burial Trusts or Funeral Contracts
441 IAC 75 (Rules in Process)

Exempt equity not to exceed $1,500 in one burial trust or funeral contract for each member of the eligible group. Count any amount over $1,500 towards the resource limit, unless the contract or trust is irrevocable. ("Irrevocable" means that the contract or trust cannot be terminated or amended unless both parties to the contract or trust agree.)

Count burial trusts and funeral contracts held by an ineligible person whose resources must be considered (e.g., an excluded parent).

Child Support $50 Exemption
441 IAC 75 (Rules in Process)

Exempt the first $50 of a current monthly support obligation or a voluntary support payment from a parent of a child in the eligible group or from a person who is under court order to pay support for a member of the eligible group. (A parent of a child is considered legally responsible, whether or not that parent is ordered to pay support.)

The maximum exempt amount is the lowest of the following:

- $50.
- The amount paid.
- The monthly obligation.

Corrective Payments
441 IAC 75 (Rules in Process)

Exempt retroactive FIP payments in the month received and in the following month.

Current Month's Income
441 IAC 75 (Rules in Process)

Do not add current month's income to the total countable resource amount for that month. This includes situations when you prorate lump-sum or self-employment income and project it as future months' income. Exclude the prorated income from consideration as a resource during the period of months over which you prorate it and count it as income.

When you verify that a liquid resource amount includes current month's income, subtract the income from the resource amount you count for the month. Count any income remaining after the month of receipt as a resource.

Disaster and Emergency Assistance Payments
441 IAC 75 (Rules in Process)

Exempt disaster and emergency assistance payments as provided under the Disaster Relief Act of 1974, as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

This policy covers:

- Payments provided by the Federal Emergency Management Agency (FEMA), including payments from the Individual and Family Grant Program.
- Disaster unemployment benefits provided under the 1988 amendments to the Disaster Relief Act of 1974. Under this Act, unemployment benefits are provided to persons who are out of work due to a major disaster, including self-employed persons and others who are not covered under regular unemployment insurance benefits.
- Disaster and emergency assistance provided under the 1988 Amendments to the Disaster Relief and Emergency Assistance Act of 1974 and comparable assistance provided by states, local governments, and disaster assistance organizations.

Exempt vendor payments made under Iowa's Emergency Assistance program.

Before exempting the payments verify the source.

Domestic Volunteer Services Act
441 IAC 75 (Rules in Process)

Exempt payments from programs under Titles II and III of the Domestic Volunteer Services Act made to volunteers for support services or reimbursement of out-of-pocket expenses.

Programs under this act include:

- University Year for Action (UYA)
- Service Corps of Retired Executives (SCORE)
- Active Corps of Retired Executives (ACE)
- Foster Grandparents

Earned Income Credit (EIC) Payments
441 IAC 75 (Rule in Process); Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010, P. L. 111-31

Exempt Earned Income Credit (EIC) payments in the month received as well as in the following month. Exempt payments in these two months whether they are received with a regular paycheck or in a lump sum as part of a federal income tax refund. Funds remaining are countable resources after the end of the second month.

NOTE: Exclude for 12 months from the date of receipt all EITC payments received as part of federal tax refund between January 1, 2010, and December 31, 2012.

Education Assistance
441 IAC 75 (Rules in Process)

Exempt all earned and unearned financial assistance for education or training.

Energy Assistance Payments
441 IAC 75 (Rules in Process)

Exempt energy assistance payments made to eligible households through the Division of Community Action Agencies of the Department of Human Rights under the Low-Income Home Energy Assistance Act of 1981 (LIHEAP). LIHEAP covers costs such as:

- Insulation.
- Home energy assistance.
- Emergency lodging because utilities have been shut off.
- Winterizing old or substandard dwellings. (Neither the cost of the materials nor the cost of labor is counted as a resource.)

Exempt other support and maintenance energy assistance when the assistance is based on need and is furnished by a:

- Supplier of home heating gas or oil, whether in cash or in kind.
- Municipal utility providing home energy, whether in cash or in kind.
- Private nonprofit organization, but only if the assistance is in-kind.
- Rate-of-return entity providing home energy, whether in cash or in kind. "Rate-of-return" means that revenues are primarily received from charges to the public for goods or services, and the charges are based on rates regulated by a state or federal agency.

"Support and maintenance" assistance is any assistance designed to meet day-to-day living expenses. This includes assistance to pay for heating or cooling a home.

"Based on need" means that assistance is issued to or on behalf of a person according to income limits at or below 150 percent of the federal poverty level.

There may be other assistance for home energy costs provided to FMAP-related households. When other assistance meets the criteria above, that assistance is also exempt.

Family Support Subsidy Program 441 IAC 75 (Rules in Process)	Exempt Iowa Family Support Subsidy payments made to families with children who have special educational needs due to physical or mental disabilities. The purpose of the program is to reduce the need for out-of-home placements or to facilitate the return of the child from an out-of-home placement.
Federal Tax Refunds Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010, P.L. 111-312. P.L. 112-240	Federal tax refunds are excluded for 12 months from the date of receipt.
Food Programs 441 IAC 75 (Rules in Process)	Exempt the value of: ▪ Benefits received under the Food Assistance program. ▪ Commodities donated by the U.S. Department of Agriculture. ▪ Supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended, (Public Laws 92-433 and 93-150). ▪ Congregate meals or other benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act of 1965.
Grants 441 IAC 75 (Rules in Process)	Exempt grants obtained and used under conditions that preclude their use for current living costs.
Home Produce for Personal Consumption 441 IAC 75 (Rules in Process)	Exempt the value of home-produced garden products, orchards, animals, etc., that are eaten by the household. When home produce is raised for sale or exchange, consider it a business operation and treat it as self-employment income.
Homestead 441 IAC 75 (Rules in Process)	Exclude the applicant's or member's homestead without regard to its value. A homestead is any house, mobile home, or similar shelter used as the applicant's or member's home. It may contain one or more adjacent lots or tracts of land, including buildings and equipment.

A homestead may contain any type or number of buildings within the land limits described including:

- A duplex. (Exempt the entire duplex.)
- An apartment. (If the client lives in the building and does not sell any of the apartments, exempt the entire apartment house. Apartments include both standard buildings and single-family houses converted to apartments.)
- A family home containing a room or apartment. (If the client lives in one of the units, exempt the home.)
- A condominium or row house occupied by the client. (Exempt only the unit occupied by the client.)

There is a limit on the amount of land that may be exempted as part of the homestead:

- When outside a city plat, exclude no more than a total of 40 acres of land.
- Within the city plat, exclude no more than one-half acre of land.

To determine if the homestead within a city plat is within size limits, multiply the length of the property by the width to calculate the square footage. Compare this figure to 21,780 (the number of square feet in one-half acre). If necessary, obtain courthouse or tax records to find the legal descriptions of the property.

Property that exceeds the allowable limit is counted as a resource.

Exempt a homestead when an applicant or member temporarily leaves if they:

- Are absent for a defined purpose, **and**
- Lived in the home immediately before the absence, **and**
- Intend to return when the purpose of the absence has been accomplished.

Regularly document the client's intentions to return home. If the client does not intend to return home, the homestead becomes a countable resource.

Do not apply the homestead exemption to nonhomestead property which the household acquires intending to make the property its homestead in the future.

Homestead for People Requesting Long-Term Care Payments
441 IAC 75 (Rules in Process)

Effective January 1, 2006, a person is not eligible for payment of nursing facility services or other long-term care services if the person's equity interest in the person's home exceeds $500,000. For more information, see Property in a Homestead for People Requesting Long-Term Care.

Household Goods and Personal Effects
441 IAC 75 (Rules in Process)

Exempt household goods and personal effects without regard to their value. Household goods are items used in and about the house in connection with home occupancy. They are items used to maintain the home as well as to accommodate, comfort, and entertain the occupants.

"Personal effects" are the belongings of family members, including clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

Animals, pets, and collections are **not** excluded and must be counted.

Inaccessible Resources
441 IAC 75 (Rules in Process)

Exempt resources that are not available to the applicant or member. Examples of instances in which a resource is **not** available include:

- Property jointly owned by spouses involved in a divorce proceeding. The property is not available until a decision on property distribution has been made.
- Real or personal property in which the terms of the joint tenancy or tenancy in common make the property unavailable. See Joint Ownership.
- Nonhomestead property jointly owned by a FMAP-related Medicaid parent and a separated or divorced spouse or a deceased spouse's estate, when the parent is not able to have control of it. This may occur because the other owner has possession of the property or because it is in litigation.
- Nonhomestead property for so long as the property is publicly advertised for sale at an asking price consistent with its fair market value. To verify that the property is up for sale at fair market value, use collateral contacts and documentation, such as newspaper ads or real estate broker listings.

Income in Kind
441 IAC 75 (Rules in Process)

Exempt as a resource unearned income-in-kind such as money paid on an applicant's or member's behalf to a third party (vendor payments). Also exempt earned income in-kind, such as meals, reduced rent received in exchange for performing work or a service.

Indian Tribe Judgment Funds
441 IAC 75 (Rules in Process)

Exempt as a resource Indian tribe judgment funds that have been or will be distributed to each member or held in trust for members of any Indian tribe.

When all or part of the payment is converted to another type of resource, also exempt that resource. If this resource decreases in value, the exemption applies to the remaining value of the resource. If the resource appreciates in value, only the original amount is exempted.

Individual Development Accounts
441 IAC 75 (Rules in Process)

Individual Development Accounts (IDAs) are optional, interest-bearing accounts much like IRAs. IDAs encourage families to save and plan for the future, without the savings affecting eligibility for assistance. The accounts allow withdrawal without penalty for items such as educational expenses, business start-up, home ownership, and emergencies.

Exempt the balance in an IDA and any interest applied to the account.

Insurance Settlements and Damage Judgments
441 IAC 75 (Rules in Process)

Consider insurance settlements and damage judgments received for damage or destruction of an **exempt or nonexempt** resource as liquidating a resource and not as income.

When the applicant or member intends to repair or replace the resource, and signs a legal, binding commitment no later than the month after the payment is received, exempt the payments for the duration of the commitment (up to eight months following the commitment date).

For example, if a homestead is damaged by fire, the applicant or member must commit any settlement funds in excess of resource limits in a binding contract to rebuild or repair the home to avoid being over the resource limit.

Document the settlement and the legal commitment in the case record.

If the applicant or member does not intend to repair or replace the home, or the payments are for a **nonexempt** resource, count the amount of the settlement as a resource in the month following the month payment was received.

Life Estates
441 IAC 75 (Rules in Process)

Exclude a life estate of the life estate holder. A life estate is defined as the ownership of the right to live on, use, or receive income from a property in which the person does not have full rights of disposition. The life estate holder may use the property but may not alter or transfer it.

Exclude any interest in a property held by an applicant or member when another person holds the life estate until the holder dies or surrenders the life estate to the applicant or member.

Life Insurance With No Cash Surrender Value
441 IAC 75 (Rules in Process)

Exclude any types of life insurance that have no cash value, such as term insurance or group insurance. The owner of the life insurance policy is the person paying the premium who has the right to change the policy.

The cash surrender value of insurance is generally available to the premium payor, unless it is assigned or in some other manner actually transferred on the records of the insurance company to the insured or other named person. Do not automatically assume that the applicant or member does not own the policy simply because another person is paying the premium.

Loans
441 IAC 75 (Rules in Process)

Exempt bona fide loans. A bona fide loan is one that includes an agreement between the lender and the borrower that the money is a loan. This agreement may be oral or in writing, as long as it indicates an intent to repay the money.

Lump Sum (Nonrecurring)
441 IAC 75 (Rules in Process)

Exempt the amount of a nonrecurring lump sum that is reserved for current or future month's income. See FMAP-Related Lump Sum Income for more information about how to treat lump sums.

Medical Expense Settlement
441 IAC 75 (Rules in Process)

Exempt settlements for payment of medical expenses.

Other Excluded Federal Payments
441 IAC 75 (Rules in Process)
P.L. 106-398

Exclude the following federal payments:

- Payments received through the Agent Orange Settlement Fund or any other fund established because of the settlement in the "In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)." NOTE: This settlement fund is now closed as all funds have been distributed.
- Payments made by the U.S. government under Public Law 92-203, the Alaskan Native Claims Settlement Act. Exempt the tax-exempt portions.
- Payments made by the U.S. government to individual Japanese-Americans (or their survivors) who were interned or relocated during World War II.
- Payments made to eligible civilian Aleuts under section 206 of Public Law 100-383. This payment is available only to those Aleuts who were living on August 10, 1988, the date Public Law 100-383 was enacted.
- Payments made under the Radiation Exposure Compensation Act, Public Law 101-426 which compensates persons for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining. After the affected person's death, payments are made to the surviving spouse, children, or grandchildren.

- Payments received under the Energy Employees' Occupational Illness Compensation Program. Payments are made to former employees or their families. Members may receive one or two lump sum payments. Award letters are sent to the recipient from the Department of Labor.
- Payments from the Experimental Housing Allowance Program under annual contribution contracts entered into before January 1, 1975, under section 23 of the U.S. Housing Act of 1936, as amended.
- Payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968. The federal government makes these payments to persons displaced when the government acquires their property for a federal or federally assisted project. Local poverty agencies administer these programs.

Property Producing Income Consistent with Fair Market Value
441 IAC 75 (Rules in Process)

Exempt the resource value of nonhomestead property producing income consistent with the property's fair market value, such as when income from rental property is consistent with rental income for similar rental properties in the area. Allow the exemption even when the property produces the income on a seasonal basis.

If the property does not produce income consistent with its fair market value, count the net market (equity) value of the property toward the resource limit.

NOTE: If the household uses the real property for self-employment purposes, consider the exemptions as described under Tools of the Trade.

See Determining Net Market Value of a Countable Resource for information determining net as well as fair market (gross) value. Also see Inaccessible Resources to determine availability of the nonhomestead property.

Property Settlements
441 IAC 75 (Rules in Process)

Exempt property settlements that are part of a legal action in the dissolution of marriage or palimony suits, regardless if received as a lump sum or in periodic payments. Exempt settlements for the month of receipt and the following month.

Property Sold Under Installment Contract
441 IAC 75 (Rules in Process)

Exempt property sold under an installment contract or held as security in exchange for a price consistent with its fair market value. Also exempt the value of the installment contract.

If the price is not consistent with the fair market value, count the net market (equity) value of the installment contract (rather than the equity value of the property) toward the resource limit. See Determining Net Market Value of a Countable Resource for information on determining contract value.

Prorated Income
441 IAC 75 (Rules in Process)

Exempt prorated income during the period of months over which you prorate it. See Current Month's Income.

Self-Employment Assets
441 IAC 75 (Rules in Process)

See FMAP-Related Self-Employment Income for information on how to determine if an enterprise is considered self-employment.

Exempt **inventory** and **supplies** that are needed for self-employment.

"Inventory" is defined as all unsold items, whether raised or purchased, that are held for sale or use. Examples are:

- Merchandise
- Grain held in storage by a farmer
- Livestock raised for sale
- Antiques held by a dealer
- Cosmetics held by a beautician

> Mr. A is a self-employed toy maker. His unsold toys (his inventory), as well as his lumber, glue, varnish, and other supplies are exempt as inventory.

"Supplies" are items that are necessary for the operation of the business like lumber, paint, seed, and fertilizer.

Capital assets are not considered to be inventory or supplies. These are assets that, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. (See below.)

Capital gains result from sale of a resource and are a resource upon receipt.

Continue to exempt self-employment inventory or supplies if the self-employment is temporarily interrupted due to circumstances beyond the control of the household (such as illness). There must be a defined purpose for the interruption and an intent to return to the self-employment. Apply prudent-person guidelines to determine if this is a situation where you can expect the person to return.

Subsidized Guardianship Payments
441 IAC 75 (Rules in Process)

Payment made under a subsidized guardianship program are exempt as a resource.

Tools of the Trade
441 IAC 75 (Rules in Process)

Exempt up to a total of $10,000 in equity (net market) value for **tools of the trade or capital assets** for self-employed households. First deduct what the applicant or member owes on the tools. Then count any equity value over $10,000.

The $10,000 limit applies to the entire household, regardless of how many members are self-employed.

Tools of the trade and capital assets are those items that, if sold, could be used to claim gains or losses for federal income tax purposes. A capital asset usually has a life span of more than one year. It can include real as well as personal property.

Examples include:

- Farm equipment of a farmer
- Farm land
- Hair dryers of a beautician
- Tools of a mechanic
- Electric saw and sander of a toy maker
- Computer and other equipment of a word processor
- Stoves and ovens of a baker
- Photocopy machines in a copy center

Livestock used for breeding, show, or dairy purposes are capital assets if depreciated for federal income tax purposes. If not, the livestock is considered inventory and is entirely exempt.

When the household has a vehicle that is used for the self-employment enterprise and also for personal use, apply the motor vehicle exemption policy, the $10,000 exemption for capital assets, and the vehicle exclusion. See Vehicles.

The tools of the trade exemption also applies when:

- The household is in the process of setting up a business, and provides verification, or
- A member's self-employment is temporarily interrupted because of circumstances beyond the control of the household (for example, because of illness or training directly related to self-employment).

The $10,000 exemption no longer applies when the self-employment ends or when the applicant or member files Chapter 7 bankruptcy. The household loses this exemption beginning the month after the self-employment ends.

Transfers to Minors
Iowa Code 565B
441 IAC 75 (Rules in Process)

When a child has assets in an account set up under the Uniform Transfers to Minors Act (Iowa Code Chapter 565B), an adult is named as custodian of the account. The adult has discretion in withdrawing money from the account to give to the child (or spend for the child).

When the custodian of the account lives with the FMAP-related Medicaid household, consider the money in the account as a countable resource, regardless whether the custodian receives Medicaid with the other household members. If the custodian is a parent in the eligible group, count the money as available even if the parent is temporarily absent.

When the custodian is someone who does **not** live with the FMAP-related Medicaid household (other than a parent who is temporarily absent), count as an available resource only the amount the custodian is willing to make available to the household.

Obtain a signed statement from the custodian to determine the amount the custodian is willing to make available to the FMAP-related Medicaid household. Consider the remainder in the account as an unavailable resource.

The Act specifies that the custodianship terminates and the property is distributed when the minor turns 21.

VISTA Payments
441 IAC 75 (Rules in Process)

Exempt as a resource Title I VISTA volunteer payments, as long as the value of all payments is less than either the federal or state minimum wage when dividing the payments by the hours of service.

To date, no VISTA payments have been determined by the Director of ACTION to equal or exceed the minimum wage.

Women, Infants and Children (WIC) Nutrition Program
441 IAC 75 (Rules in Process)

Exempt the value of food assistance received through the Women, Infants, and Children Nutrition Program administered by the Department of Public Health through local health agencies.

Income Policies for FMAP-Related Coverage Groups Prior to MAGI Methodology

Legal reference: 441 IAC 75 (Rules in Process)

Income must be within FMAP-related program limits, unless otherwise specified by the coverage group under which the person is applying or eligible. Treat the income for people whose Medicaid eligibility is FMAP-related according to the policies in this chapter, except where noted.

The following sections explain:

- Income considered.
- Treatment of minor parents and minor pregnant women.
- Budgeting for FMAP-related households.
- The work transition period.

Income Considered

Legal reference: 441 IAC 75 (Rules in Process)

Consider all unearned and earned income when determining initial and continuing FMAP-related Medicaid eligibility except when the income is specifically:

- Exempted
- Disregarded
- Deducted
- Diverted

See Taxes.

Unearned income is any income in cash that is not gained by labor or service. Examples of unearned income are:

- Investment income, such as dividends from stocks or bonds.
- Alimony or child support.
- Nonrecurring lump-sum payments.
- Rent from property handled by an agent.
- Interest income.
- Worker's compensation.
- Extended disability payments paid by an insurance company. See Disability Benefits for more information.
- Benefits or rewards for service, or compensation for lack of employment, such as Social Security benefits, Railroad Retirement, VA pensions, unemployment insurance, and strike pay.

Earned income is income earned by the person's own efforts. Examples of earned income are:

- Net profit from self-employment. See FMAP-Related Self-Employment Income.
- Income from Job Corps.
- The total gross amount of salary, wages, tips, bonuses, or commissions earned as an employee, including vacation and sick-leave pay, regardless of any employment-related expenses.

Earned income includes income from managerial responsibilities, such as the management of capital investments in real estate. However, in a capital investment where the owner carries no responsibility (such as where rental properties are in the hands of rental agencies and the check is forwarded to the owner), the income is classified as unearned income.

Whose Income Is Not Counted

Legal reference: 441 IAC 75 (Rules in Process)

Do not count the income of the following people:

- SSI recipients.
- Ineligible or voluntarily excluded children. (Also exempt their resources.)
- Minor parents in foster care when determining FMAP-related eligibility of the minor's dependent child.
- Nonparental relatives who are not in the eligible group. (When the relative is needy and is included in the eligible group, treat the relative's income the same as the income of a parent.)

Income Under a Shared Living Arrangement

Legal reference: 441 IAC 75 (Rules in Process)

When an FMAP-related parent shares the responsibility for paying household expenses with another family or person, consider as income only the funds made available to the FMAP-related eligible group exclusively for their needs. Do not consider as income funds that are combined to meet mutual obligations for shelter and other basic needs.

Obtain a statement from the client that specifies the living arrangement, signed by both the person making the contribution (if possible) and by the client.

Minor Parents and Minor Pregnant Women

Legal reference: 441 IAC 75 (Rules in Process)

Treat a pregnant minor (under age 18, never married or marriage was annulled) in the same way as a minor parent. When a minor parent is living independently or with a nonparental relative, treat the minor parent's income as if that person has turned 18 years old.

When a parent under the age of 19 who is in high school and is expected to finish by age 19 lives with that person's adult parent, treatment of the household's income depends on whether the adult parent receives Medicaid under FMAP or is self-supporting. See Minor Parents for more information.

The following sections give more information on:

- Living with a parent who receives FMAP.
- Living with a self-supporting parent.
- Treatment of income of the self-supporting parent.
- Treatment of income of the spouse of the self-supporting parent.

Living with a Parent Who Receives FMAP

Legal reference: 441 IAC 75 (Rules in Process)

Treat the income of a parent under age 19 who is also receiving Medicaid under FMAP with their adult parent in the same way as the income of any other eligible child in the adult parent's eligible group. See Age of Children.

The same policy applies when the minor parent lives with a nonparental relative who assumes a parental role over the minor parent. If needy, the nonparental relative may be included in the eligible group. See Specified Relatives.

> Sue is 17 years old. She and her baby live with her mother, Mrs. Y, who receives Medicaid under FMAP. The needs of Sue and her baby are included in Mrs. Y's eligible group. The income of both Sue and the baby is given the same consideration as that of any other eligible child.
>
> This would also be true if Sue were 18, full time in secondary school or its equivalent, and expected to complete the program before turning 19.

Treat an ineligible minor parent in the same manner as any other ineligible parent:

- Treat the income of the minor parent the same as any other ineligible parent's income when you are determining eligibility for the baby.
- A sanctioned minor parent remains ineligible for Medicaid until the condition that caused the sanction is fixed.
- An ineligible minor parent continues to be counted in the household size as a "considered" person.

If there are no other eligible children in the home, the adult parent may remain eligible as the specified relative of a dependent child.

> Ann is 16 years old. She has a baby and lives with her mother, Mrs. Z, who receives Medicaid under FMAP for herself, Ann, and the baby. In December, Ann fails to cooperate with CSRU. Ann is sanctioned and becomes ineligible for Medicaid.
>
> Mrs. Z can continue to receive Medicaid under FMAP because she is the specified relative of a dependent child (Ann). Ann's income continues to be used in determining eligibility for Mrs. Z and Ann's baby. Ann is a "considered" person on the case and the household size remains three.

Living with a Self-Supporting Parent

Legal reference: 441 IAC 75 (Rules in Process)

When a minor parent lives with one or both self-supporting parents not receiving Medicaid under FMAP, consider the income of each self-supporting parent in the household to be available when determining eligibility for the minor parent and the minor's child. See Self-Supporting Parent's Income.

Treat the income of the minor parent in the same way as any other parent. Treat the income of the minor parent's child in the same way as the income of any other child receiving Medicaid under FMAP.

Exempt the self-supporting parent's income when the minor parent turns 18, marries, or a court determines the minor to be emancipated, regardless of the minor parent's school attendance.

> Ms. B is 17 years old and a full-time student. She lives with her self-supporting parents. Ms. B has a baby, aged 2. She is also employed and earns $400 a month.
>
> Because Ms. B is the parent of the dependent child, she is included in the eligible group with the baby. Ms. B's income is exempt because she is a full-time student. However, the income of her self-supporting parents is considered in determining eligibility for Ms. B and the baby.
>
> Ms. B turns 18 on September 8. Beginning with the month of October, the income of Ms. B's self-supporting parents is no longer considered.

Remember that restricted income (Social Security, Veteran benefits, etc.) paid to a self-supporting parent on behalf of the minor parent is considered unearned income to the minor parent, unless the representative payee is living outside the home. See Representative Payee Income.

1. Ms. X is a minor parent who lives with her self-supporting parents. Her parents receive Social Security retirement benefits that include $150 a month for Ms. X. The $150 paid to Ms. X's parents on her behalf is considered as income when determining eligibility for the eligible group, regardless of the amount actually made available to the eligible group.
2. Ms. Q is a minor parent who lives with her self-supporting father. Her mother, who is not in the home, receives Social Security benefits of $126 for Ms. Q. Ms. Q's mother gives $100 to Ms. Q each month. She puts the rest of the money in a bank account for Ms. Q's education. Ms. Q does not have access to the bank account.

   Because Ms. Q's mother is the representative payee and is living outside the home, only the amount of Social Security that she actually makes available ($100) is considered as income when determining eligibility for the eligible group.

Consider child support payments received by a self-supporting parent on behalf of the minor parent as unearned income of the minor parent, and subject to the $50 support exemption.

Ms. A is a 17-year-old parent who lives with her self-supporting mother. Ms. A's mother is the payee for child support for Ms. A. She receives $200 a month. Only $150 ($200 - $50) is counted as income to Ms. A.

The same would be true if Ms. A were 18 years old, because child support is income to the person for whom the support is paid, regardless of that person's age.

Self-Supporting Parent's Income

Legal reference: 441 IAC 75 (Rules in Process)

When a minor parent under age 18 lives with one or both self-supporting parents, treat the income of each self-supporting parent according to stepparent policies. See Treatment of Stepparent Income.

Apply the same deductions to the gross income that apply to stepparents' income, except as otherwise specified. Treat nonrecurring lump-sum income the same way as if received by a stepparent.

1. Zoe applies for FMAP. She is 17 years old and has a one-year-old baby. She lives with her self-supporting parents, Mr. and Mrs. Z, and her two younger brothers. Zoe and her brothers have no income. Mr. Z has projected gross earnings of $1,500 and Mrs. Z has projected gross earnings of $500. Mr. Z pays $250 in child support for a child not in the home.

$1,500.00	Mr. Z's projected gross earnings	$500.00	Mrs. Z's projected gross earnings
- 300.00		-100.00	
$1,200.00	20% earned income deduct.	$400.00	20% deduction Mrs. Z's projected net income

- 250.00	Child support deduction
$ 950.00	Mr. Z's projected net income
400.00	Mrs. Z's projected net income
$1,350.00	
- 986.00	Diversion for Mr. and Mrs. Z and their other two children
$ 364.00	
- 211.12	58% deduction
$ 152.88	Attribute as unearned income to the FMAP eligible group

NOTE: Mr. and Mrs. Z and their two sons constitute one unit. It is not appropriate to split the diversion for their needs. Thus, their respective income that remains before the diversion is combined, and the 58% deduction applied to the remainder.

2. The household consists of:

Mrs. G, age 43, self-supporting
Fanny, age 19, Mrs. G's daughter
Hannah, age 16, Mrs. G's daughter
Ben, age 1, Hannah's son

Mrs. G is employed and has gross earnings of $1,300 per month. The following shows the calculation if everyone wants Medicaid.

FMAP

$1,300.00	Gross earnings
- 260.00	20% earned income deduction
$1,040.00	
- 365.00	Diversion for Mrs. G
$ 675.00	
- 391.50	58% deduction
$ 283.50	Countable income <$361.00

Hannah and Ben are FMAP-eligible.

Medically Needy

$1,300.00	Gross earnings
- 260.00	20% earned income deduction
$1,040.00	
- 283.50	Diversion for the FMAP group
$756.50	
- 483.00	MNIL for one person
$ 273.50	
x 2	months
$ 547.00	Spenddown for Mrs. G and Fanny

Spouse of the Self-Supporting Parent

Legal reference: 441 IAC 75 (Rules in Process)

A self-supporting parent's self-supporting spouse is the stepparent of the minor parent. When the self-supporting spouse is also living in the home, treat the spouse's income in the same way as a stepparent's income for the eligible group.

Consider the self-supporting parent and any dependent of that parent as **one** unit. Consider the self-supporting spouse and any dependent of the spouse (other than the self-supporting parent) as **one** unit.

Attribute the spouse's income to the self-supporting parent in the same way that the income of a stepparent is determined for the eligible group. Allow the same deductions as for a stepparent.

Treat nonrecurring lump-sum income of the spouse in the same way as nonrecurring lump-sum income received by a stepparent.

Determine the unmet needs of the self-supporting spouse's ineligible dependents the same as you treat the dependents of a stepparent. Although the income of an ineligible dependent of the spouse is not attributable to the self-supporting parent, consider the income of the dependent in determining if the dependent has unmet needs.

Do not divert income of the spouse to meet the needs of the self-supporting parent. However, you may divert income of the self-supporting parent to the spouse, if the parent claims or could claim the spouse for federal income tax purposes.

Perform a double stepparent calculation to determine the income that is attributable to the eligible group.

Ms. B is 17 years old and applies for Medicaid for herself and one child. She lives with Mrs. Y, her self-supporting mother, Mr. Y, her stepfather and her two younger sisters and her stepbrother. Mr. Y has $1,150 projected gross monthly earnings. He pays $100 per month child support for a child not in the home. Mrs. Y has projected gross earnings of $1,080 per month.

Step 1. Determine the income of Mr. Y that is attributable to Mrs. Y.

$ 1,150.00	Mr. Y's projected gross income
- 230.00	20% deduction
$ 920.00	
- 100.00	Child support
$ 820.00	
- 719.00	Diversion for Mr. Y and his child
$ 101.00	
- 58.58	58% deduction
$ 42.42	Attribute as unearned income to Mrs. Y for the eligible group.

Step 2. Determine income of Mrs. Y to be attributed to the FMAP group.

$ 1,080.00	Mrs. Y's projected gross income
- 216.00	20% deduction
$ 864.00	
- 849.00	Diversion for Mrs. Y and her two children
$ 15.00	
- 8.70	58% deduction
$ 6.30	Mrs. Y's countable projected income
+ 42.42	Income attributed from Mr. Y
$ 48.72	Total unearned income attributed to the FMAP group.

Budgeting for FMAP-Related Households

Legal reference: 441 IAC 75 (Rules in Process)

Determine FMAP-related Medicaid eligibility for each month of the application period separately. Determine eligibility for the people who are in the home during each month of the application period. Determine eligibility for any retroactive months separately unless eligibility is being established under Medically Needy.

Base initial and ongoing FMAP-related eligibility on projected income. If the projected future income is not valid for the month of application, month of decision, or any months in between, use the actual income received in the month to determine eligibility for that month.

Projecting Income

Legal reference: 441 IAC 75 (Rules in Process)

For all FMAP-related coverage groups, always count income prospectively.

Use and project as future income all nonexempt earned and unearned income received by the eligible group. Any of the following may be used as a guideline:

- Income received in the 30 days before receipt of an application or review form.
- Income received in a different 30-day period that is indicative of future income.
- Income received in a longer period of time that is indicative of future income.
- One pay stub that is indicative of future income.
- Self-employment tax returns or books if indicative of future income. (This may include the past three years' average.)
- Income verification obtained from the income source.

1. Mr. and Mrs. B apply for Medicaid for their children on August 21. In order to project income, the worker requests verification of all income received by the eligible group in the 30 days before August 21, the date of application if it is indicative of future income.
2. Mr. C files an application for Medicaid on July 27. Most of the application is blank but it does list Mr. C and his children. Several unsuccessful attempts are made to contact Mr. C to gather information and determine if the application is for only the children or for all household members.

   Although an interview is not required, the worker decides to schedule an interview for August 9. In order to project income, the worker requests verification of all income received by the eligible group in the 30 days prior to the application date.

   At the interview, the worker and Mr. C decide that this 30-day time frame is not a good indicator of future income. They explore whether a different or longer time frame would be indicative of future income, or whether verification from Mr. C's employer would be the best information.
3. Ms. E applies for Medicaid for herself and her children on September 25. The worker requests information in order to process the application. When the information is received, the worker contacts Ms. E again to clarify some information.

   During this conversation, it is determined that the 30-day period before the application is not a good indication of future income. The worker sends another request to Ms. E to verify income based on their conversation and the time frame that Ms. E felt would be a good indication of future income.

Accept the statement of the client as to what time frame is representative of future income.

The decision on whether to use a longer period of time or to request verification of future income from the income source should primarily be the client's. However, when the client is unsure of which would be the best indicator of future income, request verification from the income source.

Also, if the client does not have proof of income, request verification from the income source.

1. Ms. E applies for Medicaid for only her children. The application date is September 21. The only income received by the eligible group is earned income from Ms. E's job. She states that the income she received in the 30 days before September 21 is indicative of future income. The worker requests Ms. E to provide verification for that period of time.
2. Mr. and Mrs. F and their children apply for Medicaid on July 16. The only income received by the eligible group is from Mrs. F's part time job.

   Mrs. F is unsure if her past income is indicative of future income, since her employer just informed her that she will likely be working fewer hours than she has in the past. The worker requests verification of future income from Mrs. F's employer.

When a third or fifth check occurs during the period being used to project income, do not ignore it. Instead, add all check amounts together, divide the total by the number of checks, and multiply that result by four, if the income occurs weekly, or by two, if the income occurs biweekly.

Ms. G applies for Medicaid for her children on September 1. Ms. G is employed and is paid biweekly. She says her income in the 30-day period before the application date is indicative of future income. During the 30 days before the application date, she received three paychecks. Her projected income is calculated as follows:

$	653.45	August 3 pay
	628.89	August 17 pay
+	637.44	August 31 pay
$	1,919.78	Total income for the 30-day period
÷	3	
$	639.92	Average biweekly pay
x	2	
$	1,279.84	Projected monthly income

The projection of $1,279.84 is used in determining the Medicaid eligibility for Ms. G's children beginning with the month of September.

Rounding Down

Legal reference: 441 IAC 75 (Rules in Process)

When the need standard or benefit amount is not a whole dollar, round down to the next whole dollar. Round down the Standard of Need in:

- The 185 percent test.
- The standard of need test.
- The allowance for the needs of a stepparent and dependents.
- The allowance for the needs of self-supporting parents and dependents when deeming income to unmarried parents under age 18.

- The allowance for the needs of an alien's sponsor and dependents when deeming income to the alien.
- Determining the period proration resulting from receipt of a nonrecurring lump sum.

Do not round down the Schedule of Basic Needs.

Dropping the Third Digit

Legal reference: 441 IAC 75 (Rules in Process)

Drop the third digit to the right of the decimal point in any computation of income, hours of employment, or work expenses for care costs. EXCEPTION: When an employer's rate of pay contains a third digit to the right of the decimal (e.g., hourly rate of $3.567), do not drop the third digit until a computation is performed (e.g., $3.567 x 36 hours = $128.412, which becomes $128.41).

Applying Income Tests for FMAP

Legal reference: 441 IAC 75 (Rules in Process)

When processing Medicaid applications under FMAP, it is critical to identify the proper relationship of the household members to each other, so that the system can apply the proper deductions, disregards, and diversion on the three income tests. This is true whether or not the people are included in the eligible group.

Determine the FMAP eligibility by subtracting the countable net income in the month of decision from the Benefit Standard for the eligible group.

Remember, the income tests apply to **each person** in a FMAP household whose income must be considered in order to determine total countable income for the entire household.

Use the schedule of basic needs to determine the basic needs of people whose needs are included in the eligible group. Also use the schedule of basic needs to determine the needs of certain people not included in the eligible group, such as an ineligible child of the FMAP parent (e.g., one who does not have a social security number).

The following sections explain:

- The 185% eligibility test
- The standard of need eligibility test
- The benefit standard eligibility test

Step 1: 185% Eligibility Test

Legal reference: 441 IAC 75 (Rules in Process)

Apply the 185% test on case applications and also when a new person whose income must be considered enters an existing FMAP household.

Determine the nonexempt gross earned and unearned income the eligible group has received and expects to receive in the month of decision.

Use **gross** nonexempt income of:

- People included in the eligible group.
- Parents who are not eligible for Medicaid due to sanction.
- Parents who are **not** sanctioned but who are ineligible for Medicaid, such as ineligible adult aliens and adults with no social security number.

For self-employed people, use the net profit figure.

For ineligible stepparents and self-supporting parents in minor parent cases, use income that remains after deducting the following, **if applicable**:

- 20 percent earned income deduction.
- Adult/child care expense.
- Diversion for people not in the home.
- Diversion for ineligible or voluntarily excluded people in the home.

Compare the countable gross income to the 185% of the standard of need **for the size of the eligible group**.

185% of Schedule of Living Costs	
Number of People in Eligible Group	Income Limit
1	$675.25
2	$1,330.15
3	$1,570.65
4	$1,824.10
5	$2,020.20
6	$2,249.60
7	$2,469.75
8	$2,695.45
9	$2,915.60
10	$3,189.40
Each Additional Person	$320.05

See Rounding Down for instructions on when rounding applies in this test.

When the countable gross income **exceeds** the 185% test, deny the application for that month. If the application is denied, there may be eligibility for Medicaid for a retroactive month, if the individual meets a category of eligibility for the retroactive period, as defined in 8-A, *Definitions*.

When the applicant household's gross nonexempt earned and unearned income is **below or equal to** the 185% eligibility test, determine the household's eligibility under the standard of need test.

Step 2: Standard of Need Eligibility Test

Legal reference: 441 IAC 75 (Rules in Process)

The standard of need test determines eligibility for the 58 percent work incentive deduction.

Apply the standard of need test (test 2) only to case applications and reapplications. On reapplications, apply the standard of need test regardless of how much time has passed since the previous period of eligibility.

Ms. B receives Medicaid under FMAP. She is employed and receives the 20 percent earned income deduction and the 58 percent work incentive deduction when the system calculates her Medicaid eligibility.

Ms. B's Medicaid is canceled effective March 1 for failure to return the January RRED. She reapplies March 3. Ms. B is subject to the standard of need test (test 2) without the 58 percent work incentive deduction in processing her reapplication.

Discontinue application of the standard of need test beginning with the month after the month of decision.

March 1	Date of application
March 1	Effective date of assistance
May 2	Date of decision

Apply the standard of need to the months of March, April, and May. Stop applying the test effective with the month of June.

Do not apply the test when determining initial eligibility for a new person who enters an existing Medicaid household.

Do not apply the standard of need test when **reopening** a case or when the time frames for reinstatement have lapsed when an application is not involved.

To apply the standard of need test:

1. Calculate the countable gross nonexempt earned and unearned income received or expected to be received in the month of decision by any person whose income must be considered.
2. Apply the following deductions, disregards, and diversions, **if applicable**:

   - 20% earned income deduction.
   - Adult/child care expense.
   - Diversions for people not in the home.
   - Diversions for ineligible or voluntarily excluded people in the home.

   Apply these first to the **earned** income of:

   - People included in the eligible group.
   - Parents who are not eligible for Medicaid due to sanction.
   - Parents who are not sanctioned but who are ineligible for Medicaid, such as ineligible adult aliens and adults with no social security number.
   - Ineligible stepparents and self-supporting parents in minor parent cases.
3. Determine the total countable income for each person whose income must be considered:

   - When a person has both earned and unearned income, and earnings are less than the allowable deductions and diversions, subtract any unused portion of the diversions for people in and outside the home from the unearned income. Consider the balance as countable income.
   - When a person has both earned and unearned income, and earnings remain after applying the allowable deductions and diversions, add the unearned income to the remaining earned income. Consider the total as countable income.
4. Compare the total countable income of the eligible group to the Standard of Need for an eligible group of that size, which is the total need of the eligible group as determined by the Schedule of Living Costs.

Schedule of Living Costs (Standard of Need)	
Number of People in Eligible Group	Income Limit
1	$365.00
2	$719.00
3	$849.00
4	$986.00
5	$1,092.00
6	$1,216.00
7	$1,335.00
8	$1,457.00
9	$1,576.00
10	$1,724.00
Each Additional Person	$173.00

See Rounding Down for instructions on when rounding applies in this test.

When the remaining income in the month of decision is **below** the standard of need **for the eligible group**, the applicant is eligible for the 58 percent work incentive deduction. Go on to determine the household's eligibility under the benefit standard test.

When the remaining income in the month of decision **equals or exceeds** the standard of need for the eligible group, deny the application for that month. There may be eligibility for a retroactive month if the individual meets a category of eligibility for the retroactive period, as defined in 8-A, *Definitions*.

Step 3: Benefit Standard Eligibility Test

Legal reference: 441 IAC 75 (Rules in Process)

When the applicant household is eligible under both the 185% test and the standard of need test, determine the household's eligibility under the benefit standard test. To determine eligibility under the benefit standard test:

1. Calculate the countable gross nonexempt earned and unearned income received or expected to be received in the month of decision by any person whose income must be considered.
2. Apply the following deductions, disregards, and diversions, **if applicable**:

   - 20% earned income deduction.
   - Adult/child care expense.
   - Diversion for people not in the home.
   - Diversion for ineligible or voluntarily excluded people in the home.
   - 58% work incentive deduction.

   Apply these first to the **earned** income of:

   - People included in the eligible group.
   - Parents who are not eligible for Medicaid due to sanction.
   - Ineligible stepparents.
   - Self-supporting parents in minor parent cases.
   - Parents who are not sanctioned but who are ineligible for Medicaid, such as ineligible adult aliens and adults with no social security number.
3. Determine the total countable income of each person whose income must be considered:

   - When a person has both nonexempt earned and unearned income, and the earnings are less than the allowable deductions and diversions, subtract any unused portion of the diversions (for people in or outside the home) from the unearned income. Consider the balance as countable income.

   - When a person has both nonexempt earned and unearned income, and earnings remain after applying the allowable deductions and diversions, add the unearned income to the remaining earned income. Consider the total as countable income.

4. Compare the total countable income of the eligible group to the Benefit Standard for a group of that size, which is the total need of the eligible group as determined by the Schedule of Basic Needs.

Schedule of Basic Needs (Benefit Standard)	
Number of People in Eligible Group	Income Limit
1	$183
2	$361
3	$426
4	$495
5	$548
6	$610
7	$670
8	$731
9	$791
10	$865
Each Additional Person	$87

Do not round down the Schedule of Basic Needs.

Approve the application if the countable net earned and unearned income in the month of decision is less than the benefit standard for the eligible group. Approve the application even in situations where information indicates the applicant may be ineligible the month following the month of decision.

Deny the application for the month if the countable net earned and unearned income in the month of decision is equal to or exceeds the benefit standard for the eligible group. There may be eligibility for a retroactive month if the individual meets a category of eligibility for the retroactive period, as defined in 8-A, *Definitions*.

Work Transition Period (WTP)

Legal reference: 441 IAC 75 (Rules in Process)

Exempt the earnings from new employment of any person whose income is considered when determining eligibility for the first four months of the new employment if all of the following criteria are met:

- The new job starts after the date of application.
- The new job is timely reported.
- The person with the new job has not already received the WTP in the past 12 months.
- The person with the new job had less than $1,200 in earnings in the 12 calendar months before the month in which the new job begins. The $1,200 limit applies to gross income, without any exemptions, disregards, work deductions, diversions, or allowances for the cost of doing business used in determining net profit from self-employment.

Do not allow the work transition period during the retroactive period.

1. Ms. R and her two children receive FMAP. In October, Ms. R begins a part-time job and is approved for the work transition period for FMAP for October through January.
2. Ms. J, age 18 and pregnant, applies for FMAP on January 11 for herself and her 13 month old child. She also requests retroactive Medicaid eligibility for October, November, and December. On October 22, Ms. J began a part-time job baby-sitting. She is not eligible for the work transition period because the job started during the retroactive period.

People eligible for the WTP may include members in the eligible group, as well as ineligible people whose income must be considered (ineligible stepparents, parents who are not eligible for Medicaid due to a sanction, ineligible aliens, etc.). The exemption continues when the person on a WTP is added to another Medicaid case.

If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

When a change results in considering the income of a person living in the home whose income was not considered previously, that person may qualify for the WTP. The person's new job must start after the date of the change that caused the person's income to be considered in order for that person to qualify for the exemption.

The following sections explain:

- Qualifying employment
- Verification of eligibility for WTP
- Exemption period

Qualifying Employment

Apply the WTP regardless if the new earnings are from an exempt source (e.g., exempt work study, exempt earnings of a student, etc.).

Promoting or switching to a different position with the same employer does not constitute a new job. This includes when a client changes jobs from one state agency to another. However, being laid off from a job and subsequently recalled by the same employer may be considered a new job, depending on the length of the layoff.

A leave of absence without pay (e.g., maternity leave, unpaid vacation or sick leave), with a subsequent return to the job may also be considered a new job, depending on the length of the absence. Consider a job to be "terminated" when income that was received on a monthly or more frequent basis will not be received again for the remainder of the month in which the job terminated or the following month.

Allow the WTP if the new employment or self-employment enterprise is considered intermittent in nature. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families.

However, a person is not considered as starting new employment or self-employment each time intermittent employment re-starts or changes, such as when the same temporary agency places the person in a new assignment, or a child care provider acquires another child care client.

Verification

If the information in the case record indicates that the client is not eligible for the WTP, there is no need to pursue eligibility for the WTP any further. Consider the new earnings in the usual manner. No additional notification to the client is required.

When it is not clear from the case record whether the person had earnings of less than $1,200 in the 12 months before the month the earnings from the new employment were received, the client must provide that information. Accept the client's statement with respect to the $1,200 earnings in the past 12 months unless there is other evidence to the contrary. If so, pursue verification in the usual manner.

Failure to provide information needed to determine eligibility for the WTP (i.e., not providing information on the amount of earnings in the previous 12 months when requested) results in ineligibility for the WTP only. However, failure to provide verification of the beginning date of employment or failure to provide the date self-employment began, results in ineligibility for Medicaid.

If information needed to determine eligibility for WTP is returned after the due date, grant WTP for the months remaining in the WTP period if there is eligibility.

Exemption Period

The exemption period begins on the first day of the month in which the client receives the first pay from the new employment. It continues through the next three benefit months, regardless if the job ends during the four-month period. Earnings from the new employment are exempt for the entire four-month period and are not considered in any income tests.

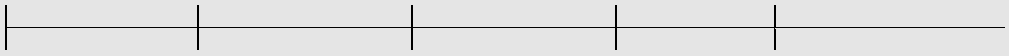
If another new job or self-employment enterprise starts while the WTP is in progress, the exemption also applies to earnings from the new source that are received during the original four-month period, provided that:

- The new job is timely reported, and
- The earnings were less than $1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

A person is allowed the four-month exemption period only once in a 12-month period. An additional four-month period shall not be granted until the month after the previous 12-month period has expired.

Ms. M receives FIP and FMAP for herself and three children. She timely reports her new job. The worker determines that Ms. M is prospectively ineligible for FIP and that she is eligible to receive the WTP for Medicaid. The family remains eligible for FMAP because income from the new employment is not considered for four months.

When the WTP ends, the family is over income for FMAP. Since FMAP eligibility ended due to earned income and they had received FMAP three out of the past six months, the family is eligible for Transitional Medicaid.



July	August	September	October	November
Ms. M reports new job began 7/8. First pay received 7/24.	FIP canceled effective 8/1 prospectively			Anticipated November income creates November ineligibility.
1st month WTP	2nd month WTP	3rd month WTP	4th month WTP	Transitional Medicaid begins

Types Of FMAP-Related Income

Adolescent Pregnancy Prevention Payments
441 IAC 75 (Rules in Process)

Exempt as income payment from state funded-adolescent pregnancy prevention programs, such as the "Dollar-A-Day" program. These programs focus on preventing subsequent pregnancies for mothers who are 18 or younger by providing a monetary incentive.

The recipients are required to attend weekly support meetings that concentrate on preventing another pregnancy during the adolescent years, as well as meeting the social and economic needs of the recipient. As long as the mother attends the weekly sessions and does not become pregnant, she receives an incentive payment.

Adoption Subsidy
441 IAC 75 (Rules in Process)

Do not count the income and resources of a child who is not included in the FMAP-related eligible group because the child receives subsidized adoption assistance.

Count subsidized adoption assistance as unearned income if the child is included in the eligible group.

A subsidized adoption payment for one person may be greater than the income limit for FMAP for one person. Consequently, in most cases, a child receiving subsidized adoption payments will not be included in the eligible group.

However, if this is the only eligible child in the home and the parents are requesting Medicaid for themselves, the parents and the child may be one eligible group or they may choose to be separate eligible groups.

If the parents choose to be a separate eligible group, establish eligibility for the parents in the same way as you would for parents who chose to voluntarily exclude their only child.

1. Mr. and Mrs. A receive an adoption subsidy payment of $198 for their only child, Mary. They have no income and apply for Medicaid. Mary is included in the eligible group. The parents are eligible for Medicaid under FMAP.

   Several months after the FMAP approval, Mr. A begins receiving unemployment of $125 a week. The $500 projected monthly income exceeds the FMAP income limit for a three-person eligible group. Mr. and Mrs. A's FMAP benefits are canceled, and Mary reverts to an eligible group of one.

   An automatic redetermination is completed for Mr. and Mrs. A. Eligibility for Medically Needy as a two-person eligible group is explored.

2. Mrs. C receives subsidy payments of $198 for her son Sam and $300 for her son Steven. Mrs. C is eligible for FMAP as a one-person eligible group because she has dependent children in her care. Neither Sam nor Steven must be included in Mrs. C's eligible group in order for her to be eligible under FMAP.

Alimony
441 IAC 75.14(249A), 441 IAC 75 (Rules in Process)

Although alimony is assigned to the Department, CSRU does not pursue enforcement of alimony. Do not allow the $50 exemption on alimony payments received directly by an FMAP-related applicant or recipient. However, exempt the first $50 when the direct support payment includes both child support and alimony.

AmeriCorps
Public Law 103-82, 441 IAC 75 (Rules in Process)

The National and Community Service Trust Act of 1993 amends the National and Community Service Act of 1990 and establishes a Corporation for National Community Service. The Corporation administers national service programs including AmeriCorps.

AmeriCorps is designed to engage Americans in a year or two of national service in exchange for an educational award for each year of completed service. It includes three programs:

- AmeriCorps*USA for participants 17 years and older
- AmeriCorps*VISTA for participants 18 years and older
- AmeriCorps*NCCC for participants 16 to 24 years of age

In addition to the educational award, payments to AmeriCorps participants may include a living allowance and a child care allowance, if child care is needed to participate in the program.

Participants may be provided health insurance if not otherwise covered by health insurance. People with disabilities are provided reasonable accommodations, supplies and services they may need to participate in AmeriCorps.

Exempt as income and as a resource the living allowance payments made to participants in the AmeriCorps VISTA program, as long as the Director of ACTION determines they do not exceed the minimum wage. See VISTA Payments.

Count payments made to participants in other AmeriCorps programs as follows:

- Treat the living allowance (stipend) as earned income. Apply all the usual income deductions and disregards. If the AmeriCorps participant is a child by FMAP-related Medicaid definition, treat the earnings as described in Child's Earnings.

- Do not consider the child care allowance as income, but also do not allow a deduction for child care, unless the allowance is less than the actual child care expense. Then allow the excess expense as a deduction, subject to the child care maximum.
- Exempt the educational award as income and as a resource.
- Exempt as income and as a resource the health insurance, reasonable accommodations, supplies and services made available for AmeriCorps participants who have disabilities. These are treated as unearned in-kind benefits, and therefore, exempt.

Blind Training Allowance
441 IAC 75 (Rules in Process)

Exempt as income a training allowance issued by the Department for the Blind to cover the cost of training, such as tuition, books, transportation, lodging away from home, and other related items.

Blood Plasma
441 IAC 75 (Rules in Process)

Count the sale of blood plasma as earned income. The plasma center is considered the employer.

Cafeteria or Flexible Benefit Plans
441 IAC 75 (Rules in Process)

Cafeteria or flexible benefit plans use either the employee's or employer's money to pay certain expenses, such as child care, medical expenses, health insurance, annual leave, or sick leave. (These benefits are not displayed in the same way on all pay stubs. The best source of information regarding them is the employer.)

Count as earned income the employee's gross wages, including any amount withheld for these plans, even if the employee loses any money left over at the end of the year.

Count as earned income any cash an employee receives of the employer's money because the employee did not use all of the money for benefits covered by the plan.

Car Pool Payments
441 IAC 75 (Rules in Process)

Exempt as income payments to FMAP-related Medicaid applicants or recipients from a passenger in a car pool.

Census Earnings
441 IAC 75 (Rules in Process)

Exempt as income for eligibility all census earnings received by temporary workers from the Bureau of Census.

Exempt as income reimbursements for travel expenses. See Reimbursements for more information.

Child's Earnings
441 IAC 75 (Rules in Process)

Earnings of a child who is not a full-time student are countable income, subject to applicable earned income exemptions, deductions, or diversions. Count the earnings when determining eligibility under all three tests. See Student Earnings for more information.

Corporation Income
441 IAC 75 (Rules in Process)

All corporations are separate legal entities. A closely-held corporation is one that has only a few shareholders. An owner or employee of a corporation is not a self-employed person. A person who receives a salary from a corporation is an employee of the corporation.

The corporation is responsible for its debts and obligations. The income and resources of a corporation belong to the corporation.

Crime Victim Compensation
Public Law 103-322

Exclude as income and as a resource payments received from a crime victim compensation program that is funded by the Crime Victim's fund under Public Law 103-322.

Department of Labor Payments
441 IAC 75 (Rules in Process)

Earnings or compensation paid instead of wages under a U.S. Department of Labor program is counted as earned income. Apply the policies under Student Earnings when a full-time student under age 20 receives this payment.

Exempt as income any training expenses issued through a U.S. Department of Labor program. They may help pay for child care, meals, and transportation.

Disability Benefits
441 IAC 75 (Rules in Process)

Count the amount of an employee's disability benefits as **unearned** income when the payment comes from an insurance company.

Count an employee's disability payments as **earned** income when the payment is paid out of the employer's funds.

Disaster and Emergency Assistance
441 IAC 75 (Rules in Process)

Exempt as income and as a resource disaster and emergency assistance payments as provided under the Disaster Relief Act of 1974, as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988. This exemption includes:

- Payments provided by the Federal Emergency Management Agency (FEMA), including payments from the Individual and Family Grant Program.
- Disaster and emergency assistance under the 1988 Amendments to the Disaster Relief and Emergency Assistance Act of 1974, and comparable assistance provided by states, local governments, and disaster assistance organizations.

Exempt as income and as a resource vendor payments made under Iowa's Emergency Assistance program. Verify the source of the payments before exempting them.

Diversion Programs
441 IAC 75 (Rules in Process)

Exempt as income financial assistance from the diversion programs operated in certain areas of the state, including cash payments to the family.

The diversion programs provide immediate, short-term financial assistance or services to enable families to become or remain self-sufficient by removing barriers to obtaining or retaining employment. The programs are intended to:

- Help families to avoid the need for ongoing FIP assistance.
- Allow FIP participants to leave the program sooner.
- Help families who are leaving FIP stabilize their employment status and reduce the likelihood of returning to FIP.

Participation in the diversion programs is voluntary. They are designed to divert families only from cash assistance under FIP. They are not designed to divert families from other types of benefits, such as Medicaid and Food Assistance.

However, **cash** assistance provided to a family from the program results in a period of ineligibility for FIP for the family. The local DHS office that provided the diversion cash assistance determines the period of ineligibility. But there is no period of ineligibility for Medicaid.

Dividend Income
441 IAC 75 (Rules in Process)

See Interest Income.

Domestic Volunteer Services Act
441 IAC 75 (Rules in Process)

Exempt as income and as a resource payment from programs under Titles II and III of the Domestic Volunteer Services Act made to volunteers for support services or reimbursement of out-of-pocket expenses. Programs under this act include:

- University Year for Action (UYA)
- Service Corps of Retired Executives (SCORE)
- Active Corps of Retired Executives (ACE)
- Foster Grandparents

Earned Income Credit
441 IAC 75 (Rules in Process)
Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P. L. 111-312)

Exempt as income an Earned Income Credit, whether received with regular paychecks or as a lump sum included with the federal income tax refund.

NOTE: Exclude for 12 months from the date of receipt all EITC payments received as part of a federal tax refund between January 1, 2010 and December 31, 2012.

Energy Assistance Support and Maintenance
441 IAC 75 (Rules in Process)

Exempt as income and as a resource energy assistance support and maintenance when the assistance is based on need and is furnished by a:

- Supplier of home heating gas or oil, whether in cash or in kind.
- Municipal utility providing home energy, whether in cash or in kind.
- Rate-of-return entity providing home energy, whether in cash or in kind. "Rate-of-return" means that revenues are primarily received from charges to the public for goods or services, and the charges are based on rates regulated by a state or federal governmental agency.
- Private nonprofit organization, but only if the assistance is in kind.

"Support and maintenance" assistance is any assistance designed to meet day-to-day living expenses. This includes home energy assistance to pay for heating or cooling a home.

"Based on need" means that assistance is issued to or on behalf of a person according to income limits at or below 150% of the federal poverty level.

There may be other assistance for home energy costs provided to FMAP-related Medicaid households. When other assistance meets the criteria above, that assistance is also exempt.

Family Investment Program Assistance
441 IAC 75 (Rules in Process)

Exempt as income any FIP cash assistance received by the FMAP-related Medicaid eligible group.

Family Self-Sufficiency Grants
441 IAC 75 (Rules in Process)

Exempt as income PROMISE JOBS payments through Family Self-Sufficiency Grants. These are intended to help PROMISE JOBS participants with employment-related expenses. Assistance is intended to enable recipients to overcome barriers to employment and become self-sufficient.

While the payments are not PROMISE JOBS expense allowance payments, they are considered in the same way. They are exempt as income, including when in the form of cash payments made directly to the family.

Family Support Subsidy
441 IAC 75 (Rules in Process)

Exempt as income and as a resource payments made through the Iowa Family Support Subsidy Program to families with children who have special educational needs due to physical or mental disabilities. The purpose of the program is to reduce the need for out-of-home placements or to facilitate the return of the child from an out-of-home placement.

Federal Payments

441 IAC 75 (Rules in Process);
P.L. 105-78 (H.R. 2264) Section 606, P.L. 106-398

Various specialized types of federal payments are excluded. Exempt as income and as a resource:

- Distributions by a Native Corporation established under the **Alaska Native Claims Settlement Act**, Public Law 92-203 when distributed to an Alaskan Native or a descendent of an Alaskan Native. The exemption applies to the following:
  - Cash payments up to $2,000 per year. Count any excess.
  - Stock (including stock issued or distributed by a Native Corporation as a dividend or distribution on stock).
  - A partnership interest.
  - Land or any interest in land (including land received by a Native Corporation as a dividend or distribution of stock).
  - An interest in a settlement trust.
- **Energy Employees Occupational Illness Compensation Program** payments. These payments are made to former employees or their families. Recipients may receive one or two lump sum payments. Award letters are sent to the recipient from the Department of Labor.
- **Experimental Housing Allowance Program** payments under annual contribution contracts entered into before January 1, 1975, under Section 23 of the U.S. Housing Act of 1936, as amended.
- **Wartime Relocation of Civilians** payments made under Public Law 100-383 to:
  - Certain United States citizens of Japanese ancestry (Section 105)
  - Certain eligible Aleuts (Section 206)
- **Radiation Exposure Compensation Act** payments made under Public Law 101-426. The program compensates people for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining. After the affected person's death, payments are made to the surviving spouse, children, or grandchildren.
- **Relocation Assistance** payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.
- **Vietnamese Commando Compensation** payments. The Secretary of Defense under the National Defense Authorization Act makes these payments for Fiscal Year 1997 (Public Law 104-201).

Federal Tax Refunds
Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P. L. 111-312)

Federal tax refunds received between January 1, 2010, and December 31, 2012, are excluded for 12 months from the date of receipt.

Financial Assistance for Education or Training
441 IAC 75 (Rules in Process)

Exempt as income and as a resource all earned and unearned financial assistance received for education or training including work-study income. Apply the exemption to educational assistance of an undergraduate, graduate student, or person in training.

Any extended social security or veterans benefits received by a parent or nonparental relative, conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

Focus Group, Survey or Study Income
441 IAC 75 (Rules in Process)

- Count as income payments received for participating in a focus group, survey, or study unless the payment is a reimbursement or a gift certificate. Whether it is considered earned or unearned income depends on how the payment is described by the entity providing it. Also see Welfare Reform Evaluation Payments.

Food Programs
441 IAC 75 (Rules in Process)

Exempt as income and as a resource the value of:

- Food Assistance.
- Commodities donated by the U.S. Department of Agriculture.
- Supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended (Public Laws 92-433 and 93-150).
- Benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act of 1965, such as the Congregate Meals Program administered through the Iowa Department of Elder Affairs.

Food Stamp Employment and Training Allowance
441 IAC 75 (Rules in Process)

Exempt as income the Food Stamp Employment and Training (FSET) component allowances.

Foster Care Payments
441 IAC 75 (Rules in Process)

Exempt as income foster care payments, including therapeutic foster care payments, made to an FMAP-related family operating a licensed foster family home. "Therapeutic foster care" payments are higher payments made on behalf of special needs foster children.

Gambling Winnings
441 IAC 75 (Rules in Process)

Count recurring winnings from gambling (such as winnings from casino gambling) as unearned income in the budget month received. Do not offset the winnings with any amount lost.
(See Nonrecurring Lump Sum for treatment of one-time winnings, such as lottery winnings.)

General Assistance
441 IAC 75 (Rules in Process)

Exempt as income general assistance from county funds if:

- Does not duplicate any basic need under FMAP-related, or
- Is a duplication of an FMAP-related basic need but is made on an emergency basis, not as ongoing supplementation.

Gifts
441 IAC 75 (Rules in Process)

Exempt as income a nonrecurring monetary gift (for Christmas, birthdays, etc.) not to exceed $30 per person per calendar quarter. A calendar quarter is a period of three consecutive months, ending on March 31, June 30, September 30, or December 31.

When a gift from a single source exceeds $30, count the entire amount as unearned income. When monetary gifts from several sources are each $30 or less, but the total of all gifts exceeds $30, count only the amount in excess of $30 as unearned income.

When a gift is given to the entire eligible group, it may be divided among the members of the group in the most advantageous way to the client. When a gift is given to one member of the group, the gift may be divided among the members of the group if the participant claims the gift is intended for the entire group.

Verify gifts over $30 per person per calendar quarter. Allow the $30 exemption for any person whose income must be counted, even if that person is not actually receiving medical assistance (e.g., ineligible parents, and ineligible stepparents).

1. Ms. A receives $50 from her mother in December as a Christmas gift. Since this exceeds $30 from a single source, the entire $50 is considered unearned income to Ms. A.
2. Bobby, an FMAP child, receives $25 in October for his birthday and $25 in December as a Christmas gift. The $25 that Bobby received in October is exempt. Since $25 had already been exempted for Bobby for the quarter ending December 31, only $5 of the gift he received in December is exempt. $20 is considered unearned income to Bobby in December.
3. Ms. C and her three children received a Christmas gift of $100. As the gift was intended for the entire family of four, $25 is considered to be a gift to each person. If no other gifts were received during the quarter, the entire gift is exempt.

Grants Precluded From Use for Current Living Costs
441 IAC 75 (Rules in Process)

Exempt as income and as a resource grants obtained and used under conditions that preclude their use for current living costs.

Home Produce for Personal Consumption
441 IAC 75 (Rules in Process)

Exempt as income and as a resource the value of home-produced garden products, orchards, domestic animals, etc., which are eaten by the household. When home produce is raised for sale or exchange, consider it a business operation and treat it as self-employment income.

Housing Supplements
441 IAC 75 (Rules in Process)

Exempt as income housing supplements received as a result of an urban renewal or low-cost housing project from any governmental agency (federal, state or local).

Housing supplement payments or subsidies may be issued to help meet the costs of both shelter and utilities. Those payments are exempt as income regardless of whether they are paid to a vendor or directly to the client. The most common housing supplement payments are issued by Low Rent Housing or HUD.

Income Tax Refunds
441 IAC 75 (Rules in Process)

Income tax refunds are considered a nonrecurring lump sum, and are exempt as income.

Indian Tribe Judgment Funds
441 IAC 75 (Rules in Process)
CFR 233.20(a)(4)(ii)(n) and (o)

Exempt as income and as a resource Indian Tribe Judgment funds that have been or will be distributed to each member or held in trust for members of any Indian tribe.

Individual Development Accounts
441 IAC 75 (Rules in Process)

Exempt as income and as a resource regular monthly deposits to an Individual Development Account (IDA) when determining FMAP-related Medicaid eligibility.

An IDA is an optional, interest-bearing account much like an IRA (but it is not a pension plan). FIP encourages clients to start IDAs to save for long term goals without the savings affecting eligibility or benefit amount. The client may keep the IDA and continue to contribute to it after FIP eligibility ends.

IDAs are established and managed by DHS-approved organizations. IDAs are opened in financial institutions and are set up in an individual's name. Any Iowan whose family income is below 200% of the federal poverty level and who lives in an area where there is an IDA project can open an IDA.

Withdrawals are allowed for approved purposes only and must be authorized by the operating organization. "Approved purposes" are post-secondary education or job training, starting a small business, buying a home or home improvement, or medical emergencies.

Withdrawals may be in the form of a two-party check (in the name of the vendor and the client) or solely in the vendor's name. Either way, consider the withdrawals as an unavailable resource (not income).

The account holder, another household member (regardless of the person's FIP or Medicaid status), or a source outside the household can make deposits. Deposits can be from earned or unearned income.

Allow a deduction to income only when the deposit is made from income of the particular household member who is the account holder and whose income must be counted. EXCEPTIONS: Do not deduct the deposit from:

- Income that is exempt.
- FIP grant.
- The client's *assigned* child support.

However, allow a deduction from child support received while the application is pending, when an assignment is not yet in effect.

Ask the client to provide verification of the amount and date of the first deposit. Do not require verification of each regular monthly deposit. Accept the client's word that the deposits will be made monthly, unless questionable.

To allow the deduction, the county office must receive verification of the deposit by the end of the month after the month in which the first deposit was made or by the extended filing date, whichever is later.

Accept the client's word with respect to whose income was deposited. If the client's statement appears questionable, obtain further information or verification. If the client fails to provide needed information or verification, do not allow a deduction.

Deduct the deposit from nonexempt earned or unearned income or the net profit from self-employment when projecting income for the months in which the deposit is anticipated to be made. If the client has both nonexempt earned and unearned income, subtract the deposit from the nonexempt unearned income first.

IABC cannot make this deduction. You must manually subtract the deposit **before** you enter the remaining income on BCW2.

Mrs. A, an FMAP recipient, begins depositing $200 per month into her IDA in March. She has $850 projected gross earnings, $50 of projected in-kind income, and $100 projected unearned income in March.

The worker first subtracts $100 of the IDA deposit from the unearned income and then subtracts the remaining $100 from the earnings. Income entered on BCW2 is $750 earnings. (The IDA deposit is not subtracted from the in-kind income, because it is exempt income.)

Allow applicable earned income deductions to the client's nonexempt earnings from employment or net profit from self-employment that remains after subtracting the amount of the deposit.

Apply allowable deductions to any nonexempt unearned income that remains after subtracting the amount of the deposit. See FMAP-Related Deductions and Diversions.

If the client receives a deduction for a deposit in error, redetermine Medicaid eligibility and recoup if ineligible.

1. Mr. and Mrs. A and their children receive Medicaid under FMAP. Mrs. A has an IDA. Mr. A is employed, and Mrs. A has no income. In March, Mr. A begins depositing $200 per month into his wife's IDA. Mrs. A states she also will begin making monthly deposits of $50.

   Mr. A is not allowed a deduction from his earnings, because he is not the account holder. Mrs. A is not allowed a deduction, as she has no income.

2. Ms. B and her son receive Medicaid under FMAP. Ms. B is employed. Her son has an IDA, and he receives social security benefits from a deceased parent. In April, Ms. B begins depositing $100 per month from her earnings plus $20 from her son's social security benefits into her son's IDA.

   The $20 deposits are allowed as a deduction, because they come from income of the account holder. The $100 deposits are not allowed as a deduction, because they come from Ms. B's income and she is not the account holder.

3. Mr. and Mrs. G receive Medicaid under FMAP. Mr. G receives social security disability income and has an IDA. In March, he receives a $5,000 nonrecurring social security lump sum and deposits all of it into his IDA. The entire $5,000 is exempt.

4. Mrs. E and her children receive FIP and FMAP. Mrs. E has an IDA. In March, she receives $110 direct child support from the absent parent. Rather than refunding the support, she deposits the $110 into her IDA.

   A deduction is not allowed for FMAP, since the child support is assigned to DHS while Mrs. E is on FIP. (The same would be true if the absent parent had properly sent the support payment to CSRU but CSRU released the payment to Mrs. E in error.)

   If Mrs. E was receiving only FMAP and not FIP, the child support would not be assigned. She would be allowed a $60 deduction. (The first $50 of child support is exempt.)

5. Mrs. T and her child receive FMAP. Also in the home is Mr. T, a stepparent. He is employed and has an IDA. In April, he begins depositing $300 into his IDA. He is allowed a $300 deduction from his earnings. If Mrs. T were the account holder, Mr. T would not be allowed a deduction.

6. Mr. D, an FMAP recipient, is employed and has an IDA. In April, the children's grandmother begins depositing $100 into Mr. D's IDA. The deposit is exempt as income. Mr. D does not get a deduction for the deposits, because they were not made from his income.

In-Kind Earned Income
441 IAC 75 (Rules in Process)

Exempt earnings in kind as income and as a resource. "In-kind" earnings means:

- The client performs a service and, in exchange, receives something the client would normally have to pay for, and
- The person for whom the service is provided would normally have to pay for the service.

1. Mrs. T works in a restaurant and receives meals as part of her salary. Her paycheck stub lists the value of the meals as $10 per week. Exempt the $10 as earned income in kind.
2. Mr. K receives reduced rent in exchange for managing an apartment building. His apartment would normally rent for $350, but Mr. K pays only $200. Exempt the difference of $150 as earned income in kind.

In-Kind Unearned Income
441 IAC 75 (Rules in Process)

Exempt unearned income in kind as income and as a resource. Consider monies paid to a third party on the client's behalf as unearned income in kind.

1. Ms. A's mother pays Ms. A's rent directly to Ms. A's landlord. This is unearned income in-kind and is not considered in determining eligibility for Ms. A.
2. Ms. B's mother, who does not live with Ms. B, gives Ms. B $200 to use to pay her rent. Ms. B pays this money to her landlord. However, since this money passed through Ms. B's hands, count it as a gift when determining her eligibility.

Interest Income
441 IAC 75 (Rules in Process)

Exempt as income interest and dividend income such as:

- Interest from savings.
- Interest on payments from property sold on contract.
- Interest payments from conservatorships and trusts.

1. Ms. A has a savings account that pays $5 interest per month. This interest is exempt as income.
2. Ms. B receives $400 each month from property sold on contract. Of the payment, $250 is interest income. The remaining $150 is payment on the principal. Both the principal and the interest part of the payment are exempt as income (but not as a resource).

   NOTE: The contract itself must still be evaluated for its resource value. See Determining Net Market Value of a Countable Resource for more information.

Exempt any amount that is **identifiable** as interest or dividend income. If the interest portion is not identified separately, but the client indicates that the payment includes interest, ask the client to provide necessary verification to exempt the interest portion. Unless the interest portion is identified, count the entire payment as income.

Job Corps
441 IAC 75 (Rules in Process)

Job Corps participants may work toward a GED or high school diploma or be involved in postsecondary education or vocational pursuits.

Participants receive room and board, and a monthly salary. Part of the salary is received when it is earned, and part of it withheld until the participant completes or otherwise leaves the program after at least a six-month stay. In addition, participants may receive a bonus based on their performance in the program.

Exempt the value of the room and board. Count the ongoing part of the salary as earned income and project forward if it is indicative of future income.

Count both the lump-sum salary payout and the performance bonus as earned income in the month in which the payments are received. (See Recurring Lump Sum for details.)

Job Corps participants also receive a clothing allowance. However, Job Corps makes payment directly to the stores. Thus, exempt the clothing allowance as a vendor payment.

NOTE: Job Corps participants are considered full-time students. However, participants may be in high school or post-secondary education. Accept the client's word as to which it is.

If the client's statement is questionable, require the client to obtain verification from Job Corps. Exempt only the earnings of participants 19 or younger who are in high school education. See Student Earnings for more details.

Jury Duty Pay
441 IAC 75 (Rules in Process)

Count compensation for jury duty as earned income.

Lien Recovery Payments
441 IAC 75 (Rules in Process)

The Iowa Medicaid Enterprise (IME) will notify you on form 470-4309, *Notice of Lien Settlement Payment to Medicaid Member*, when a member receives a lien recovery payment. The IME Revenue Collections Unit has verified the information reported with the third party insurer.

Treat the lien recovery funds received according to the terms of the settlement as reported on form 470-4309. Obtain any additional information needed from the sources listed on the form.

Loans
441 IAC 75 (Rules in Process)

Exempt as income bona fide loans from any source, including undergraduate and graduate student loans. Check that the loan is from an institution or person engaged in the business of making loans and that there is a written agreement to repay the money within a specified time.

When the loan is from a person not normally engaged in the business of making loans, use at least one of the following criteria to establish that the loan is legitimate or bona fide:

- There is a borrower's acknowledgment of obligation to repay (with or without interest).
- The borrower expresses intent to repay the loan when funds become available.
- There is a timetable and a plan for repaying the loan.

For money received to be considered a bona fide loan, there must be an agreement between the person making the loan and the borrower that the money is a loan. This agreement may be oral or in writing, but there must be an intent to repay the money.

Low Income Home Energy Assistance Payments (LIHEAP)
441 IAC 75 (Rules in Process)

Exempt as income and as a resource energy assistance benefits paid to eligible households under the Low-Income Home Energy Assistance Act of 1981. This program is administered through the Department of Human Rights, Division of Community Action Agencies. It covers costs such as:

- Insulation
- Home energy assistance
- Emergency lodging because utilities have been shut off
- Winterizing old or substandard dwellings (neither the cost of the materials nor the cost of labor is counted as income)

Medical Expense Settlement
441 IAC 75 (Rules in Process)

Exempt as income and as a resource settlements for payment of medical expenses. Some insurance settlements may also include amounts for the repair or replacement of a resource or for pain and suffering.

When a specific amount for a pain and suffering settlement is not designated, only the amount of the settlement actually spent for medical expenses or repair or replacement of a resource is exempt as income. See also Nonrecurring Lump Sum.

When a specific amount is identified for the replacement of a resource, also exempt that portion of the settlement, whether or not it is actually used to replace the resource.

Mortgages
441 IAC 75 (Rules in Process)

Exempt as income mortgage or contract payments. The part of any payment received that represents principal is a resource upon receipt. The interest portion of the payment is a resource the month following the month of receipt. For more information, see:

- Property Producing Income Consistent with Fair Market Value
- Property Sold Under Installment Contract, and
- Determining Net Market Value of a Countable Resource

Preparation for Adult Living (PAL) Stipend
441 IAC 75 (Rules in Process)

Exempt as income payments from the preparation for adult living (PAL) program. PAL provides additional financial support to youth who:

- Are no longer eligible for voluntary foster care placement;
- Have left state-paid foster care on or after their eighteenth birthday and have been in foster care for at least 6 of the previous 12 months;
- Attend school, job training, or work full-time at least 30 hours per week;
- Live in an approved living arrangement, other than the parental home; and
- Participate in aftercare services.

PROMISE JOBS Payments
441 IAC 75(Rules in Process)

Exempt as income payments from the PROMISE JOBS program for child care or transportation expenses that are incurred as a result of participating in PROMISE JOBS.

However, PROMISE JOBS payments paid to a Medicaid recipient who provides child-care services for a PROMISE JOBS participant are considered self-employment earned income to the child care provider. See the *PROMISE JOBS Provider Manual* for a description of the payments made by this program.

Property Sold on Contract
441 IAC 75 (Rules in Process)

See Mortgages.

Refunds from Rent or Utility Deposits
441 IAC 75 (Rules in Process)

Exempt as income refunds of security deposits on rental property or utilities.

Reimbursements
441 IAC 75 (Rules in Process)

- **Job-Related:** Exempt as income reimbursements from the employer for job-related expenses, including travel expenses, food, and uniform allowances.
- **Third Party:** Exempt as income third-party reimbursements when the payment is to pay or repay the client for an expense that was billed to the client, but owed by the third party.

  The payments are exempt whether the third party is living in the home or out of the home. Examples include reimbursement for long distance calls made by a friend using the client's phone, and payments on utilities by a person in a shared living arrangement.

  Exempt as income payments received from other public and private assistance programs when the payments represent reimbursement for expenses incurred for participating in these programs. Reimbursable expenses may include rent reimbursement, travel, child care, meals, and lodging.

  Verify the purpose of the program with the source of the payments before applying the exemption. Document your action in the case record.

Representative Payee Income
441 IAC 75 (Rules in Process)

Exempt any income restricted by law or regulation that is paid to a representative payee living outside the home (other than a parent who is the applicant or recipient), unless the representative payee actually makes the income available to the client.

Social Security and other federal benefits are sometimes required by law or regulation to be paid to a representative payee (for example, when the beneficiary is a minor).

The representative payee is to use the funds in the best interest of the beneficiary. The payee may decide to save the money for future use or may make only a part of the funds available for the current needs of the eligible group.

When such income is paid to a representative payee who lives outside the home, consider only the amount actually made available to the applicant or recipient. Obtain a signed statement from both parties to verify the amount of income the payee makes available.

When the representative payee is a parent, count the total income, even if the parent is temporarily absent from the home. If the representative payee is living with the FMAP-related Medicaid household, count the total income when determining eligibility.

If the source of the income is child support, apply the $50 support exemption.

1. Ms. A, who is 15 and lives with her aunt, applies for FMAP for herself and a baby. The aunt receives a $250 monthly Social Security payment for Ms. A. She keeps $150 each month in an emergency account in the aunt's name and gives Ms. A $100.

   Because Ms. A is living with her representative payee, consider the total $250 Social Security per month as available to Ms. A.

2. Ms. B, who is 17 and lives alone, applies for FMAP for herself and a baby. Ms. B's grandmother receives $200 a month Social Security for Ms. B. The grandmother keeps $100 each month in an account for Ms. B's college education and gives Ms. B $100. This $100 is countable income to Ms. B.

3. Ms. C is 18 years old. She and her child live with her self-supporting mother, who is the payee for child support for Ms. C. Ms. C's mother receives $200 child support for Ms. C. Only $150 ($200 - $50) is counted as income to Ms. C. (The same would hold true if Ms. C were under age 18.)

Retirement Benefits
441 IAC 75 (Rules in Process)

Treat retirement payments received on a monthly or more frequent basis as unearned income to determine eligibility. See 8-C, *Benefits From Other Sources*, for information on client responsibility to apply for and accept benefits.

Medicare premiums are withheld from Black Lung and Railroad Retirement benefits. However, Medicare premiums are not taken out of civil service pensions. These benefits may be further reduced due to recovery of an overpayment. Count only the actual income received (plus the Medicare premium, if applicable).

When the client receives an early lump-sum payment from a retirement fund, determine which portion of the payment represents the client's contribution plus accumulated interest, and which portion represents the employer's contribution.

Consider the employer's portion as nonexempt nonrecurring lump-sum income. See Nonrecurring Lump Sum.

When a client who is under age 55 leaves public employment covered by IPERS, the *employer's* contribution to the IPERS fund reverts to the employer when the employee requests an early withdrawal of the benefits.

When a client who is age 55 or over leaves public employment covered by IPERS and has 4 years or more of service, the person **must** apply for early retirement to be eligible for FMAP (unless the funds have been withdrawn).

Retroactive Corrective Payments
441 IAC 75 (Rules in Process)

Exempt as income retroactive corrective FIP payments.

Retroactive SSI Payments
441 IAC 75 (Rules in Process)

A retroactive SSI payment is considered a nonrecurring lump sum. It is exempt as income and as a resource, whether or not the client is an SSI recipient when the lump sum is received.

Severance Pay
441 IAC 75 (Rules in Process)

Count severance pay as a non-exempt unearned lump sum payment. Depending on how it is paid out, it could be a recurring or non-recurring lump sum payment.

Sick Pay
441 IAC 75 (Rules in Process)

Count sick pay as earned income if the person gets it while employed. See Recurring Lump Sum for treatment of unused sick leave payout after employment has ended.

When coworkers donate their sick leave time, count the payment the same as if it was the person's own sick pay when determining eligibility of the person to whom the sick pay was donated.

Social Security Income
441 IAC 75 (Rules in Process)

Count social security benefits as unearned income when determining eligibility.

Consider social security benefit amounts reported on the Bendex as verified. (You must enter the correct social security claim number into the system to get a Bendex report.)

When a social security recipient is enrolled in Medicare Part B, the premium is deducted from the person's entitlement. Use the gross amount of the entitlement before a Medicare premium is withheld.

If the Department pays the Medicare premium ("buys in"), the recipient receives the full social security entitlement and a refund for the months the participant paid the premium while included in the FMAP eligible group. Do not count the refund as income.

> Mr. Z's Social Security payment decreased when he enrolled in Medicare, Part B. However, the amount before the decrease is used to determine Medicaid eligibility while the buy-in procedure is in process.
>
> When the buy-in takes place, Mr. Z's Social Security check increases, and he receives a refund for the number of months he was in the eligible group and paid his own premium. The refund is not considered as income, since the amount before the decrease was used to determine Medicaid eligibility during the buy-in process.

If the Social Security Administration is recouping for a prior overpayment, count only the amount the client actually receives (plus the Medicare premium, if applicable).

Amounts may be deducted from social security payments for a child support arrearage. The gross and net social security payment amounts on IEVS reports may not reflect the correct social security payments in these cases. Count the gross social security income and allow a deduction, if appropriate.

See Diversion for People Not in the Home and 14-G, *BENDEX* for more information.

Social Security Benefits Extended for Education
441 IAC 75 (Rules in Process)

A person aged 18 can receive extended Social Security benefits based on disability or death of a parent if attending high school full time.

The benefits stop at the end of the fourth month after the month the person turns 19 or completes high school, whichever occurs first. If the person's birthday falls on the first day of the month, the person is considered to have reached age 19 in the previous month.

When a child in the eligible group receives extended Social Security benefits, consider the entire amount of the benefits as unearned income available to meet the needs of the eligible group.

When the person aged 19 or younger receiving the extended Social Security benefits is also a parent, the extended Social Security amount is exempt as income.

> 1. Bob is an 18-year-old child receiving FMAP. He receives $95 a month in extended social security benefits while in high school. Because he is a child, the $95 is counted against the needs of the entire eligible group.

2. Susan, an 18-year-old, has a child and is receiving FMAP as a parent. She is receiving $150 a month in extended Social Security benefits while she attends high school. The entire $150 is exempt.
3. Mary, an FMAP parent with two children, receives $200 per month in extended social security benefits while attending college. The entire $200 is exempt.

Strike Benefits or Picket Pay
441 IAC 75 (Rules in Process)

Count strike benefits as unearned income.

If a union on strike considers picket pay to be payment for work performed (such as walking the picket line), count the income as earned. If the union does not consider the picket pay to be payment for work performed, it is a strike benefit and is unearned.

Student Earnings
441 IAC 75 (Rules in Process)

Exempt earnings of a person aged 19 or younger who is a full-time student in high school or in an equivalent program. **Note:** A person who has completed high school and is a student in postsecondary education is not eligible for this exemption.

Exempt the earnings when determining eligibility under all three income tests. Exempt the earnings when the student is a child or a parent, regardless of the student's living arrangement. See Minor Parents and Minor Pregnant Women for more information.

Employment does not alter a student's status. The person may be employed during school vacation periods. If the person qualified as a full-time student in the term preceding the vacation period, exempt the earnings. This exemption does not apply if the student has completed the program and will not return to school.

When a full-time student completes high school or an equivalent curriculum, drops out of school, or begins attending less than full time, consider the person a student for that entire month. Exempt the earnings through the month in which the person completes high school, drops out, or decreases attendance.

Likewise, when a person under age 20 who has earnings **becomes** a full-time student, exempt the earnings beginning with the first month after the person becomes a full-time student.

Apply the student exemption for the entire month of the person's twentieth birthday unless it falls on the first day of the month.

The particular school defines "full-time" student status. See School Attendance, for more information.

Subsidized Guardianship Payments
441 IAC 75 (Rules in Process)

Exempt payments made under a subsidized guardianship program of Iowa or another state.

Taxes
441 IAC 75 (Rules in Process)

Do not count taxes (FICA, state, and federal income taxes) that are actually withheld from unearned income. Count the net amount of income after the taxes were withheld. Do not count taxes when determining eligibility.

Some types of unearned income may be taxable but do not have taxes withheld. Do not allow a deduction for this type of tax.

Tip Income
441 IAC 75 (Rules in Process)

Count the amount of tips an applicant or recipient anticipates receiving.

Any reasonable form of verification is acceptable. Examples of documents verifying tip income include:

- Pay stubs
- Employee's statement
- Employer's statement

Verify tip income at the time of the annual review, even if the anticipated amount has not changed.

Trust Payments
441 IAC 75 (Rules in Process)

Count payments from trusts or conservatorships that are available for basic or special needs as unearned income in the month received.

Unemployment Insurance Benefits
441 IAC 75 (Rules in Process)

Count unemployment insurance benefits as unearned income as noted below. If unemployment benefits are reduced due to recoupment, count the actual amount the person receives.

- Unemployment Insurance Benefits (UIB) or UIB extension: count for eligibility.
- Trade Readjustment Act (TRA): count for eligibility.
- Training Extension Benefit (TEB): exempt as financial aid.
- $25 stimulus: exempt as income.

Vacation Pay 441 IAC 75 (Rules in Process)	Count pay for vacation taken while the person is employed as earned income in the month received. See Recurring Lump Sum for information on vacation payout in lieu of taking vacation or payout of unused vacation after employment has ended.
Vendor Payments 441 IAC 75 (Rules in Process)	Exempt as income and as a resource vendor payments made to a third party on the client's behalf.
Veterans' Benefits 441 IAC 75 (Rules in Process)	Count veteran's benefits as unearned income. If a VA benefit is reduced due to recoupment, count only the actual amount the client receives. However, exempt as income payments made under the Aid and Attendance program or the housebound allowance, or the amount attributable to unusual medical expenses.
Veterans' Benefits for Education or Training 441 IAC 75 (Rules in Process)	A person eligible for financial assistance under the GI Bill may also receive additional assistance for each dependent. Exempt the amount designated for the veteran's education. Count the amount for the dependents who are included in the FMAP-related Medicaid eligible group as nonexempt, unearned income to determine eligibility.
VISTA Payments 441 IAC 75 (Rules in Process)	Exempt Title I VISTA volunteer payments, as income and as a resource as long as the Director of ACTION determines the value of all such payments is less than the federal or state minimum wage when dividing payment by the hours of service. To date, the Director of ACTION has determined no VISTA payments to equal or exceed the minimum wage. Central office will notify county offices when these payments are no longer exempt. VISTA payments are considered as unearned income. This is because recipients are considered volunteers rather than employees. When VISTA payments exceed the minimum wage limit, count the entire amount.
Vocational Rehabilitation Training Allowance 441 IAC 75 (Rules in Process)	Exempt as income a training allowance issued by the Division of Vocational Rehabilitation Services of the Department of Education. The vocational rehabilitation counselor establishes an allowance amount that meets the client's needs for items relating to the rehabilitation program, such as tuition, books, transportation, lodging away from home, and similar items.

Wages
441 IAC 75 (Rules in Process)

Count all wages and salaries as earned income. Consider earnings received on the date the employer distributes payroll.

When the employer distributes payroll to the employees on a date other than the regular payday, consider the date distributed as the date of receipt. For example, regular payday is on January 1. The employer distributes payroll on December 31 because January 1 is a holiday. Consider December 31 as receipt date.

If the employer merely grants an exception for a particular employee to pick up the paycheck early, consider the regular payday as the date of receipt.

When an employer **holds** wages at the employee's request, count the wages as income in the month the wages would normally be paid by the employer. However, when the employer holds wages as a general practice, count the wages as income in the month the household actually receives them.

Count wage **advances** as income only if the wage advance is anticipated to continue and is representative of future income.

Welfare Reform Evaluation Payments
441 IAC 75 (Rules in Process)

Exempt as income any payments made to FMAP-related Medicaid households for participating in the Iowa welfare reform evaluation conducted by Mathematica Policy Research, Inc. Randomly selected people who agree to participate may be interviewed, participate in focus groups and complete surveys.

Welfare to Work Payments
441 IAC 75 (Rules in Process)

Welfare-to-Work are federally funded grants made available to states and local communities by the U.S. Department of Labor.

The purpose of the grants is to create additional job opportunities for the hardest-to-employ welfare recipients, such as long-term welfare recipients, school drop-outs, teen parents, people with a poor work history, or those who are within 12 months of reaching the state's time limit for assistance. (In Iowa, this is the 60-month limit of FIP assistance.)

The grants can be used for a number of activities, such as community service and work experience programs, job creation through wage subsidies, on-the-job training, contracts, and vouchers for services for job readiness, placement, job retention, and other services.

As in any other situation, to determine treatment of Welfare-to-Work payments that FMAP recipients who are also FIP participants may receive, first find out the source of the payment and what the payment represents.

- For example, exempt the payment if it:
- Represents a reimbursement (for child care, transportation, meals and other miscellaneous expenses the client has).
- Is provided in the form of a gift certificate or gift card.

If the payment does not represent a reimbursement or is not in the form of a gift certificate, count the payment as income unless the payment is exempt under another program policy. (For example, earnings of a person under age 20 and in high school or equivalent program full-time are exempt.)

Whether to consider the payment as earned or unearned income depends on program policy and how the payment is described **by the entity issuing it**.

FMAP-related Medicaid recipients who are also FIP participants may be in the Welfare-to-Work experience program and be paid or reimbursed through the U.S. Department of Labor. In that case, consider the payments as earned income (unless the student exemption above applies).

Whether or not the payments are exempt, FMAP-related Medicaid recipients are required to report the payments.

Work Force Investment Project Incentive Allowance Payments
441 IAC 75 (Rules in Process)

Exempt as income incentive allowance payments received from the Work Force Investment Project, a state-funded program administered by the Department of Economic Development.

The purpose of the program is to provide support services to pregnant teens and teen parents. It serves people who are traditionally underrepresented in the labor force, and people who usually have great difficulty entering the labor force. Recipients attend high school, GED classes, workshops, and training at program work experience sites.

When recipients successfully achieve the objectives of their training program, they receive an incentive allowance. For example, a recipient can receive an incentive allowance for perfect attendance at school and program workshops during a 15-day period.

Worker's Compensation
441 IAC 75 (Rules in Process)

Count workers compensation payments as unearned income.

See Nonexempt Lump Sums for information on retroactive payments.

Child Support for Composite FIP and FMAP Households

Legal reference: 441 IAC 41.27(1)"h", 441 IAC 41.27(6)"o", and 441 IAC 75 (Rules in Process)

"Child support" means money that a legally responsible person pays for the support of a child. "Legally responsible person" means either:

- A legal parent of the child whether or not ordered to pay support, or
- Any other person who is ordered to pay support for the child.

A person may pay child support voluntarily or may be obligated to pay support under an order established through a judicial process or through an administrative process by the Child Support Recovery Unit. The monthly amount payable according to the terms of either an administrative order or a court order is usually referred to as the "monthly obligation."

When an absent parent makes payments to a third party for a family's current basic or special needs, the payments are exempt as unearned income in kind. The payments are exempt even when made in compliance with a court order for support. See In-Kind Earned Income. Treat payments made to the eligible group by friends or other relatives as a gift and not as child support. See Gifts in this chapter.

FMAP-related Medicaid recipients who also are FIP participants have assigned to the Department their rights to support payments made for members of the eligible group. The assignment remains effective for the entire period for which FIP assistance is paid. See 8-C, *Assignment of Medical Support*.

Support that is assigned to the Department is collected by the Collection Services Center (CSC). Contact the Child Support Recovery Unit if you have questions about the amount of support ordered.

Consider support assigned as of the date the local office successfully enters the FIP eligibility into the ABC system.

The following sections give more information on:

- The $50 exemption for cash support income
- Treatment of support for applicants
- Treatment of support for recipients
- Support for the first month of ineligibility
- Support for an ineligible or excluded child

$50 Exemption

Legal reference: 441 IAC 75 (Rules in Process)

Exempt as income and as a resource the first $50 of a current monthly support obligation or a voluntary support payment paid by a legally responsible person for a child in the eligible group. Apply the exemption only when an applicant or recipient anticipates **receiving and keeping** cash support.

The maximum exempt amount is either $50 or the amount paid or the monthly obligation, whichever is less, regardless of how many absent parents pay support.

Ms. Z and her three children are FMAP recipients. Each child has a different father, and each father has been paying $100 per month court-ordered support for his child. Ms. Z anticipates the support to continue. Ms. Z is allowed only one $50 exemption.

If the anticipated direct support payments represent a delinquent support obligation, the $50 exemption does not apply. When a responsible person is anticipated to pay for the current month plus past months all in the same month, allow an exemption up to $50 only from the support applied to the current month.

1. $200 is the monthly obligation
   $100 is anticipated to be paid to the client for the current month
   $50 is exempt
2. $40 is the monthly obligation
   $50 is anticipated to be paid to the client, including $10 for delinquent support
   $40 is exempt
3. $200 is the monthly obligation
   $45 is anticipated to be paid to the client for the current month
   $45 is exempt

When a legally responsible person is anticipated to be pay support for dependents who are in different FMAP-related Medicaid eligible groups, each eligible group is entitled to an exemption up to $50 of the monthly support payments the group receives and keeps.

1. The monthly obligation for two children is $200. One child lives with the mother and the other child lives with the grandmother. Both the mother and the grandmother apply for Medicaid for the children on separate cases. The father is anticipated to pay $100 support each to the mother and the grandmother. Each eligible group is entitled to a $50 exemption.
2. Same as Example 1, except the father is ordered to pay $50 per month support for both children. It is anticipated that he will pay $25 support each to the mother and the grandmother. Each eligible group is entitled to a $25 exemption.

Treatment of Support for Applicants

Legal reference: 441 IAC 75 (Rules in Process)

When determining Medicaid eligibility for applicants, count as unearned income any nonexempt cash support payment for a member of the eligible group that is made or anticipated to be made while the application is pending.

Count the entire nonexempt support payment received or anticipated to be received up through the date of the eligibility decision, regardless whether the support payment:

- Is for current or past support or a combination of the two, or
- Exceeds the monthly obligation.

Apply the $50 exemption to the month in which the applicant receives or is anticipated to receive the support. (See Establishing the Date of Receipt for details.) Manually deduct the exempt amount before entering the countable support on the system.

> Mr. G files an FMAP-related Medicaid application on September 1. On August 28, CSC received a $100 child support payment, which was mailed to Mr. G. He receives the payment on September 3.
>
> Although the $100 represents an August payment, $50 is exempted for September because this is the month in which Mr. G received the payment. The remaining $50 is counted as income in determining September FMAP-related eligibility.

Do not count as income, nor enter onto the system, support expected to be received after the date of decision for a composite FMAP/FIP household. This is because support is assigned to the Department when the person is approved. Any cash support payment the **recipient** receives after the date of decision must be refunded to CSC.

> Mrs. D applies for FIP and FMAP-related Medicaid on February 2. Mr. D is ordered to pay $50 support per week, which Mrs. D receives every Friday. It is anticipated that Mr. D will pay the total $200 in February.
>
> On February 23, the IM worker approves the application with an effective date of February 1 for FMAP-related Medicaid and February 9 for FIP. Up to the date of decision, Mrs. D had received $50 support payments on February 6, 13, and 20. Therefore, the worker enters $100 income ($150 received - $50 exemption) for eligibility for February.
>
> Ms. D is required to refund the entire amount of any support she receives after February 23. Any support received after February 23 will not be entered onto the system for eligibility, because support is assigned as of February 23.

If the amount received up through the date of decision includes ordered support for **prior** months, treat the retroactive amount as a nonrecurring lump sum. To determine the retroactive portion, deduct the amount of the current support obligation from the total support payment the applicant received.

The $50 exemption applies only to **current** support. If there is no court order, consider the **entire** support payment the applicant receives as **current** support, subject to the $50 exemption.

If there is a court order, consider only up to the amount of the obligation as current support, subject to the $50 exemption. Consider any amount that exceeds the ordered amount as **past** support and treat it as a nonrecurring lump sum. Do **not** apply the $50 exemption to that portion.

> 1. An FMAP-related Medicaid applicant gets a $350 support payment. There is no court order. Thus, the entire payment is considered as voluntary support. The first $50 is exempt. The remaining $300 is counted as unearned income in the month the applicant receives the payment.
> 2. An FMAP-related Medicaid applicant gets a $650 support payment. There is a court order for $200 monthly support. Therefore, $200 of the $650 payment is considered as **current** support, and the $50 exemption is applied to that portion. The remaining $450 is considered as past support and treated as a nonrecurring lump sum.

If support the applicant **receives or is anticipated to receive** represents future court-ordered support, prorate the payment over those future months the payment is intended to cover. Use the nonexempt portion to determine FMAP-related Medicaid eligibility for each month. Apply the $50 exemption to each future month when the future month arrives.

Establishing the Date of Receipt

When support payments are made to CSC, which, in turn, forwards the payments to the applicant, check the dates recorded under the DISTR DATE column on the ICAR PAYHIST screen.

Consider the payment as income in the month in which the **applicant** receives the payment. The date under DISTR DATE reflects the date CSC received and processed the payment (and is **not** the date the applicant received it).

The payment is mailed two working days after the DISTR DATE on ICAR. Allow two additional days for mailing, excluding days when there is no mail delivery, such as holidays or Sundays. In other words, add a minimum of four days to the DISTR DATE on ICAR to determine when the applicant may have received the payment.

If the applicant disputes your calculated date, accept the applicant's statement as to the date of receipt, if that date appears plausible.

1. A $400 payment shows on PAYHIST with a 5/28 DISTR DATE. Unless the applicant states otherwise, the payment is considered to have been received in June. The payment is considered as June income to the applicant regardless of what month CSC applies the payment.
2. Same as Example 1, except that the DISTR DATE shows 5/20. The payment is considered to have been received in May, unless the applicant states otherwise. The payment is considered as May income to the applicant, regardless of what month CSC applies the payment.

When the applicant receives support payments from another source, e.g., directly from the absent parent or from a clerk of court, ask the applicant for verification of receipt dates and amounts.

If payments were mailed to the applicant, allow at least two mailing days to arrive at a possible receipt date. If the applicant disputes your calculated receipt date, accept the applicant's statement, if plausible.

Treatment of Support for Recipients

Legal reference: 441 IAC 75 (Rules in Process)

Exempt as income assigned support that is collected and retained by the Department. Do not use any part of the support amount collected and kept by the Department when determining FMAP-related Medicaid eligibility for recipients.

1. Mrs. K. is employed and has $400 projected monthly countable earnings. She receives FIP and FMAP-related Medicaid for herself and her two children. In March, the children's father starts to pay $150 per month child support to CSC. The entire $150 retained by CSC is exempt and is not used to determine Mrs. K's FMAP-related Medicaid eligibility.
2. Mr. T receives FIP and FMAP-related Medicaid for himself and one child. The child's mother pays $200 child support per month to CSC. Mr. T gets a new job, and his projected monthly countable income is $350. The $200 support amount retained by CSC is exempt and is not used to determine Mr. T's FMAP-related Medicaid eligibility.

See Direct Support Not Refunded by the Client for instructions when a recipient receives direct support and fails to refund it.

At the point that the collected support exceeds the entire amount of FIP assistance paid out to the family, CSC will release the overage to the family the following month. If the absent parent has been paying support to CSC regularly, it can be expected that support collections will continue to exceed the total FIP paid out. Since overage payments to the recipient are expected to continue, use the overage as projected income.

However, if the absent parent has a history of paying support only sporadically, and overage payments are not likely to continue, do not use the overage as income in the month received. Do not use the overage as projected income.

Ms. B has received $1,500 FIP benefits over the past several months. The absent parent does not pay support regularly. When CSC receives the February child support payment from the absent parent, the total support collected comes to $1,600. In March, CSC sends the $100 overage to Ms. B. The $100 is not used to complete a new projection of income, since it represents a one-time payment.

Consider any **countable** support payment as income in the month in which the recipient receives or anticipates receiving the payment. See Establishing the Date of Receipt for information on how to determine when the recipient may have received a support payment from CSC (or from another source).

Other circumstances that can result in CSC releasing child support to a FMAP/FIP recipient include:

- Support is collected for a child who is not in the eligible group.
- Release of the payment could not be prevented due to the timing of the FMAP/FIP approval or reinstatement.

To determine how to treat the payment, it is important to know the reason CSC released the payment. If the payment represents support for an ineligible child, consider the policies under Support for an Ineligible or Voluntarily Excluded Child. Confer with the child support recovery officer if you have questions on the reason CSC released the support to the recipient.

Direct Support Not Refunded by the Client

Legal reference: 441 IAC 75 (Rules in Process)

FMAP/FIP recipients must report and refund to the Department **the entire amount of** direct support payments received from the absent parent or any other source. If the client returns the support payment to you, forward the payment to CSC.

Use actual countable support payments received in a past month for which eligibility is being determined. Use support payments anticipated to be received in future months to determine eligibility for future months.

When support payments stop before the eligibility decision on an application, use the support payments received (or anticipated to be received) in each month to determine FMAP-related Medicaid eligibility for the month of decision and any prior months.

Manually deduct the exempt amount and count as unearned income any remaining direct support that the client refuses or fails to refund.

If the direct support can be anticipated to continue, use the nonexempt portion of the direct support payment as unearned income in the month received to determine eligibility.

When determining whether direct support can be anticipated to continue, consider the past payment history, the statement of the recipient, and when available, the statement of the absent parent. However, do not **require** a statement from the absent parent.

> An FMAP/FIP recipient receives $100 direct support that is released by CSC in error. The recipient fails to refund the support. The IM worker does not use the direct support for FMAP-related Medicaid, since it cannot be anticipated to continue.

Support for the First Month of Ineligibility

Legal reference: 441 IAC 75 (Rules in Process)

When the support assignment is not terminated at the same time as the family's FIP eligibility is canceled, support payments may be made to CSC in error. CSC must refund these payments to the client.

Exempt as income for FMAP-related Medicaid eligibility support refunded for the first month of FIP ineligibility, if the family remains off FIP for the entire month. The refunds are exempt as income regardless of when the family receives the support, as long as the family remains off FIP assistance for the month.

1. Ms. A's FIP assistance is canceled effective July 1. CSC receives support payments of $15 on July 10 and $25 on July 25. Ms. A reapplies for FIP on August 5. She receives the $40 July support refund on August 10. This $40 is exempt as income.
2. Ms. B is canceled from FMAP and FIP effective July 1. CSC continues to receive support payments in July ($60) and August ($120). Ms. B reapplies for FMAP and FIP September 7. She receives an abstract from CSC for $180 on September 12. The $60 portion for July is exempt as income, but the $120 portion for August is countable income.

This exemption applies only to cases that are canceled from FIP. It does not apply to families still considered FIP participants who do not get a grant due to rounding down or due to the restriction on payments of less than $10.

This exemption does not apply when the family reapplies and is found eligible for the first month following the termination.

Support for an Ineligible or Voluntarily Excluded Child

Legal reference: 441 IAC 75 (Rules in Process)

For FMAP-related Medicaid purposes, child support is considered income of the child. The income and resources of an ineligible or voluntarily excluded child are exempt for FMAP-related Medicaid.

When an FMAP-related parent receives child support for a child who is not in the FMAP-related eligible group, consider the support payment as follows:

- If the ineligible or voluntarily excluded child **lives in the home** with the eligible group, do not count the support payment as income or as a resource toward the eligible group, even if the FMAP-related parent has access to the payment. As long as the FMAP-related parent provides care and support for the ineligible or voluntarily excluded child, it is reasonable for the parent to use the support payment to do so.
- If the child is **not living in the home** with the eligible group and the FMAP-related parent uses the support for the needs of the eligible group, then count the support as unearned income to the eligible group. Do not allow the $50 support exemption, because the exemption applies only to current support paid **for a member of the eligible group**.

If the FMAP-related parent claims to make the support payment available to the intended person, obtain written verification from both the FMAP-related parent and the intended person, or a responsible person with whom the intended person lives.

FMAP-Related Lump-Sum Income

Discussion of lump sums is divided into:

- Recurring lump sums, which may be earned or unearned income
- Nonrecurring (one-time) lump sums, which are always unearned income, in the nature of a windfall or a retroactive payment of benefits.

Recurring Lump Sum

Legal reference: 441 IAC 75 (Rules in Process)

Examples of **recurring** lump-sum income are:

- Vacation pay instead of taking vacation, or payout for unused vacation when employment ends.
- Sales commission.
- A bonus.
- Profit sharing based on the employer's profits, when received while the client is employed with the company. NOTE: Profit sharing received after termination of employment is considered a nonexempt, nonrecurring lump sum.
- Past due wages (if the wages cover more than one month).

Consider recurring lump-sum income if it is received or is anticipated to be received at any of the following times:

- Any time during the receipt of assistance.
- In the month of application or any subsequent month, before the date of decision.
- Before the month of application when the income is anticipated to recur. (If it is not anticipated to recur, do not consider any lump sum received before the month of application.)

Except for self-employment income, prorate recurring lump sum earned and unearned income over the number of months for which the income is received. If the lump sum is earned income, apply applicable disregards, deductions, and diversions.

Consider the prorated amount when projecting future income for both applicants and recipients. Use the prorated amount to determine eligibility for the same number of months as the recurring lump sum covers.

For applicants, the month in which the lump sum was received is the first month for which a prorated amount will count.

For ongoing cases, if the lump sum is reported timely, the first month in which a prorated amount will be used is the first month following a ten-day notice. If the lump sum is not reported timely, redetermine eligibility using the prorated amount beginning with the month following the month of receipt.

1. Mr. and Mrs. G apply for Medicaid for their children on January 30. The worker is processing the application March 3. Mr. G reports and verifies he received a quarterly bonus of $300 on January 28. Since it is expected to continue, the recurring lump sum is prorated over the months it is intended to cover. $100 is counted when projecting future income, beginning in January.

2. Same as Example 1, except that Mr. G's employer has discontinued the bonuses and the one received in January is the last one. The bonus is prorated and counted when projecting income for the months of January, February, and March. No recurring lump-sum income is counted any month following March.

3. An active case consists of Mrs. B and her five children. Mrs. B receives sales commission income in the amount of $300 every quarter. The worker applies $100 to the needs of the family on a monthly basis.

4. Same as Example 3, except Mrs. B applies for FMAP on October 3. The worker is determining eligibility October 28. Mrs. B received her $300 quarterly sales commissions in September, the month before the month of application. If commissions are anticipated to continue, the worker counts $100 in October and subsequent months.

5. Ms. A is a current recipient. At her annual review in December, Ms. A reports that she will begin receiving sales commissions in a lump sum every four months, in addition to her base pay. Ms. A's employer estimates the lump-sum amounts to be approximately $240. She will receive the first commission check in January.

   In projecting Ms. A's future income, $60 per month ($240 ÷ 4 months) is counted as earned income in addition to her base pay, beginning with the month of January.

6. Mr. Z reports on June 18 that he received two paychecks June 10. One paycheck was his regular weekly earnings and the other was two weeks of vacation pay in lieu of taking annual vacation. The vacation pay is lump-sum income.

   The total lump sum is not added with other June earnings, but is prorated over the 12 months it represents and is added to the projected income used to determine eligibility. If timely notice can be given, the prorated amount will be used beginning in July.

7. Mrs. T, an applicant, receives her annual profit-sharing bonus on October 1. She applies for Medicaid on October 12. The date of decision is November 2, with an October 1 effective date. The bonus is prorated over 12 months and included in the income projection.

8. Ms. Q receives Medicaid. On July 16, she begins receiving quarterly bonuses of $60 in addition to her regular earnings. Ms. Q reports the quarterly bonus on July 18. The worker requests verification, which Ms. Q provides on July 23.

   The worker completes a new projection of monthly income using $20 monthly bonus income ($60 ÷ 3 months). The first month for which the new projected monthly income is considered is September, the first month following the ten-day notice.

9. Same as Example 8, except that Ms. Q does not report receipt of the quarterly bonuses until at her annual review in November. Ms. Q also reports she received a 50-cent-per-hour raise in August. The worker requests verification of both the quarterly bonuses and the rate of pay increase, which Ms. Q provides on November 22.

   The worker recalculates the projected income for August (the month after the month of receipt) through November by adding $20 ($60 ÷ 3 months) to the projected income used for those months. Recoupment is established, if appropriate, since starting to receive recurring lump-sum income is considered to be beginning income.

   The worker also completes a new projection of income for the months of December through November, using the prorated amount of the bonus along with the new rate of pay. No recoupment is established for failure to report the rate of pay increase at the time it occurred. Since the rate-of-pay increase is not considered beginning income, it is only required to be reported at the annual review.

When the recurring lump-sum income is **expected to continue at the same rate**, the prorated amount will continue to be part of the projection of future income until the client reports a change.

When the recurring lump-sum income is **expected to continue but at an unknown rate**, the client will be required to timely report the receipt of each lump sum payment.

When the recurring lump-sum income is **ending and not expected to continue**, the lump sum will be prorated and used in the projection of future income for only the same number of months that the final lump sum covers.

Income from Contract Employment

Legal reference: 441 IAC 75 (Rules in Process)

If income from contract employment is received on a recurring lump-sum basis, determine the period covered by the contract. Calculate the total amount payable under the contract and prorate it over the number of months the contract covers.

Count the prorated monthly amount as part of the income projection. If the contract income is timely reported, begin using the prorated amount in the month following a ten-day notice. If the income is not reported timely, begin using the prorated amount in the month after the month in which the lump sum is received.

1. Ms. A, is a Medicaid recipient. In April, Ms. A timely reports that she began contract employment in March and that she received $300 in April that covers the months of March, April, and May. $100 prorated income ($300 ÷ 3 months) is counted for the months of May, June, and July.
2. Mr. B is employed under contract and receives $600 in January. The contract period is January through June. On April 5, Mr. B applies for Medicaid. On April 26, the Medicaid application is approved. $100 prorated income ($600 ÷ 6) is counted in the income projection for the months of April, May, and June.

Treat income from contractual employment received on a regular basis (weekly, biweekly, etc.) in the same manner as the earnings of a noncontractual employee.

Periodic or Intermittent Income

Legal reference: 441 IAC 75 (Rules in Process)

Prorate income received at periodic intervals or intermittently over the period covered by the income, and apply the prorated amount to the eligibility determination for the same number of months. (Do not apply this policy to income from self-employment.)

> Ms. A applies for Medicaid. She works part-time for a small company. She keeps her own time sheet and is paid when she turns it in. On May 15, Ms. A turns in a time sheet covering the preceding four months. She timely reports income of $240 received in May. The worker divides this income by four and includes $60 monthly income in the projection for four months, beginning with May.

Nonrecurring Lump Sum

Legal reference: 441 IAC 75 (Rules in Process)

Give pamphlet Comm. 24 or Comm. 24(S), *One-Time Payments*, to each applicant. Also issue the pamphlet to each member who reports receipt or possible receipt of a nonrecurring lump sum, or when you believe the member may receive such sums.

When a client reports receipt of a lump sum, document in the case record:

- The date you issued the pamphlet.
- The date the lump sum was received.
- How it was reported.
- The amount of the sum.
- The source of verification.
- How it was determined that it is a lump sum.
- That the client was informed of the effect of receiving the lump sum.

Count the nonrecurring lump-sum income if received by:

- Any person in the eligible group.
- A parent who is in the home but is not eligible for Medicaid due to sanction.
- A parent in the home who is otherwise ineligible for Medicaid (e.g., ineligible alien).

Do **not** count the lump-sum income of a person who is receiving SSI or is voluntarily excluded.

NOTE: When an SSI recipient or voluntarily excluded person acts as a representative payee for another person in the home, the income received for the other person is considered to be income of that person, not income of the representative payee. If the other person is a member of the Medicaid eligible group, count the income as appropriate.

1. Ms. A receives SSI for herself and FMAP for her child. Ms. A is in an accident and receives a lump sum insurance settlement as a result. The lump sum is exempt in determining the child's Medicaid eligibility because Ms. A is an SSI recipient.
2. The same situation as Example 1, except it is Ms. A's child who is in an accident, and Ms. A receives a lump sum insurance settlement for the child. The lump sum is countable in determining the child's Medicaid eligibility. Although Ms. A receives the lump sum as representative payee for her child, the lump sum is intended for the child's needs.

Consider nonrecurring lump sums received by the following people as income in the month of receipt only.

- An ineligible stepparent.
- A self-supporting parent.
- A spouse of a self-supporting parent.

Refer to Treatment of Stepparent Income and Minor Parents and Minor Pregnant Women for more information.

The following sections give more information on:

Exempt Lump Sums

Legal reference: 441 IAC 75 (Rules in Process)

Exempt as income the following types of nonrecurring lump sums:

- State or federal income tax refunds (including earned income credit).
- Retroactive SSI benefits.
- Settlements for payment of medical expenses (also exempt as a resource).
- Refunds of security deposits on rental property or utilities.
- The part of the lump-sum payment that is both received and spent on funeral and burial expenses.
- The part of the lump-sum payment that is considered a reasonable income producing cost (such as attorney fees that have been paid).
- That part of the lump-sum payment that is both received and expended for a replacement of a resource. When a part of a lump sum is designated for the repair or replacement of a resource, that part of the payment is exempt as income whether or not the client actually uses it to repair or replace the resource.

When the amount of the damage and pain and suffering settlements are not designated, only the amount actually expended for repair or replacement of the resource is exempt as income. See Insurance Settlements and Damage Judgments.

- Sums received by people whose income is not considered (such as nonparental specified relatives not in the eligible group and SSI recipients).
- The employee's share of a lump-sum retirement payout. (If the sum was produced by payroll deduction, consider it a resource upon receipt.)
- Cash payments from the DHS diversion programs.

See Lump Sum (Nonrecurring), for treatment of these nonrecurring lump sums as a resource. Also see Property Settlements, for treatment of property settlements as a resource rather than income.

Nonexempt Lump Sums

Legal reference: 441 IAC 75 (Rules in Process)

Nonrecurring lump sums that are **not** exempt include:

- Inheritances.
- Insurance settlements for pain and suffering.
- Insurance death benefits.
- Lawsuit settlements.
- Countable gifts.
- One-time winnings (such as lottery winnings). Deduct the cost of the ticket, bingo card, etc., but do not deduct prior losses.
- Retroactive payments of benefits such as Social Security, veterans' benefits, workers' compensation, job insurance, and child support.
- Severance pay (unearned income is amount received).
- The employer's share of a lump-sum retirement fund which is paid to the employee.

When to Count the Lump Sum

Legal reference: 441 IAC 75 (Rules in Process)

Policy: The date a nonrecurring lump sum is received determines whether the lump sum is considered. The lump sum does not affect eligibility if:

- It was received while the person receiving it was living in another state. (Check on resources due to receipt of the lump sum.)
- It is received **before** the month of application and the applicant does not request retroactive Medicaid eligibility.
- The assistance issued for the month the lump sum is received is subject to recoupment because the person receiving the lump sum is ineligible for other reasons. Consider the lump sum if at least one person was eligible in the month of receipt and the ineligible person is a parent remaining in the home.

- The recipient requests cancellation before the first day of the month that the lump sum will be received. However, once the lump sum is received, the household cannot later voluntarily exclude the member of the eligibility group who received the lump sum to refigure and reduce the lump-sum proration.

Procedure: When the amount of the lump sum was reported before the month of receipt and the cancellation of the coverage was completed before timely notice, no recoupment will be needed.

When receipt of the lump sum was not reported timely or the cancellation of the coverage was not completed before timely notice, begin recoupment of Medicaid claims with the month of receipt of the nonrecurring lump sum.

Budgeting the Lump Sum

Legal reference: 441 IAC 75 (Rules in Process)

Consider a nonrecurring lump sum as unearned income in the month received and count it in determining eligibility during the period of proration. (See Exempt Lump Sums and Gifts for more information.)

Reduce the lump sum by the cost of producing the income, such as attorney fees, taxes, etc.

Mr. W receives a $5,000 nonrecurring lump sum directly. He provides verification that his attorney fees were $1,000. Mr. W paid his attorney $700 and still owes him $300. Only the $700 actually paid is allowed as a deduction. When Mr. W provides proof that he has paid the other $300, the period of proration is recalculated.

1. Ms. A is receiving FMAP. On June 14, she timely reports that she received a nonexempt, nonrecurring, lump-sum payment on June 8. The first month of the period of proration is June. Eligibility is determined using a prorated portion of the lump sum beginning with the month following a notice of adverse action.
2. Ms. B applies for Medicaid on June 8. On June 17, she receives a nonrecurring lump-sum payment of $5,000. On July 1, the worker determines Ms. B eligible for FMAP effective June 1. On July 6, Ms. B reports the lump-sum payment. The worker must determine the period of proration, refigure the projection of income, and redetermine Medicaid eligibility beginning with June.
3. Ms. C applies for Medicaid on November 20 for herself and her son. Ms. C receives a $2,500 nonrecurring lump sum on November 27, and timely reports it on December 2. The worker processes the application on December 10. The worker determines the period of proration to be four months ($2,500 ÷ 719).

   Eligibility for both Ms. C, under Medically Needy and Ms. C's son, under MAC, will be determined using the prorated amount beginning with November. In February, the remainder of $343 will be used.

For purposes of the lump-sum policy, the "eligible group" is defined as all eligible people and any other person whose income is considered in determining Medicaid eligibility. If the unborn child is being counted in the household size at the time of receipt of the lump sum, the unborn child is also counted in determining the appropriate standard of need to prorate the lump sum.

If an ineligible parent receives the nonrecurring lump sum, count the lump sum, since the parent is included in the eligible group as a "considered" person.

1. Ms. A has two children for whom she receives Medicaid. Ms. A is not receiving Medicaid because she failed to cooperate with CSRU. Ms. A receives a $5,000 nonrecurring lump sum. The worker divides $5,000 by the three-person FMAP Standard of Need amount to prorate the lump sum.
2. Same as Example 1, except the lump sum is received by one of Ms. A's children. Prorate the lump sum using a three-person Standard of Need amount.
3. Mr. and Mrs. T receive Medicaid for their three children. Mr. and Mrs. T are not eligible for Medicaid because they are ineligible aliens. Mr. T receives a nonrecurring lump sum. Because Mr. and Mrs. T are considered persons on the Medicaid case, the worker uses the five-member FMAP Standard of Need in prorating the lump sum.

If a person who is voluntarily excluded receives the lump sum, the lump sum is not counted toward the eligible group.

Ms. M has three children. She voluntarily chooses to exclude Child C because Child C receives child support and is covered under the father's health insurance. Ms. M is approved for Medicaid effective October 1 for FMAP for herself, Child A, and Child B.

Child C receives a nonrecurring lump sum on November 20. The lump sum is not used in determining eligibility for the FMAP household.

When, due to the untimely report of a nonrecurring lump sum, Medicaid eligibility is being redetermined for the first month of the period of proration, only use the prorated amount of the lump sum. This is because all countable monthly income was added to the nonrecurring lump sum before the proration calculation.

When Medicaid eligibility is being redetermined for any month of the period of proration other than the first month, use the prorated amount of the lump sum plus any projected monthly income.

Period of Proration

Legal reference: 441 IAC 75 (Rules in Process)

The months in which any prorated portion of the lump sum will be counted are called the period of proration.

To determine the months in which the lump-sum income will be counted, divide the total countable income in the month of receipt including the countable lump-sum income, by the FMAP Standard of Need (Test 2) for the eligible group.

Ms. X receives Medicaid under FMAP for herself and her two children. She receives a $1,704 nonrecurring lump sum in February, which she timely reports. The worker is currently using a monthly projection of $200 in other unearned income.

$1,704 + $200 = $1,904 divided by $849 (the three-person FMAP Standard of Need) = 3 months of proration

If the applicant withdraws an application (or is denied assistance for a reason other than the lump sum), establish a period of proration if the lump sum is received in the **same** month as the withdrawal or denial, even if that month is the application month.

To determine the number of months in which lump-sum income will be counted:

- For applications, divide the total of the countable lump-sum income and other countable income received for the same month by the Standard of Need (Test 2). Do not consider assigned support collected and retained by the Department for the month the lump sum is received.
- For ongoing cases, divide the total of the countable lump-sum income and other countable income projected for the same month by the Standard of Need (Test 2).

1. Ms. A applies for Medicaid on April 3 for herself and her three children. On April 10, Ms. A reports receiving a $3,000 nonrecurring lump sum on April 8. The only other income Ms. A or her children have is Ms. A's earned income.

   Ms. A states that the 30-day period before the date of application is indicative of her future income. In that 30-day period, Ms. A received four weekly paychecks for a gross monthly income of $801.54. So, $801.54 will be the projected gross earned income.

   First, determine the countable projected earned income.

$	801.54	Gross earned income received in the 30 days before April 10
-	160.30	(20% earned income deduction)
$	641.24	
-	250.00	Child care
$	391.24	Countable projected earned income

   Prorate the lump sum as follows:

$	3,000.00	Nonrecurring lump sum
+	391.24	Countable April income
$	3,391.24	
÷	986.00	FMAP Test 2 for four people
$	3.44	Months of proration

The following income is used to determine eligibility:

April	May	June	July	August and on
$986.00	$1,377.24 ($986.00 + $391.24)	$1,377.24 ($986.00 + $391.24)	$824.48 ($433.24 lump sum remainder + $391.24)	$391.24

2. Mrs. B applies for Medicaid on May 21 for her two children. She does not request Medicaid for herself. On June 2, Mrs. B receives a $1,800 nonrecurring lump sum, which she reports on June 3. The application is processed June 6. The only other income Mrs. B and her children have is Mrs. B's earned income.

   Mrs. B states that the 30-day period before May 21 is indicative of her future income. In that 30-day period, Mrs. B received two biweekly paychecks, for a total of $1,126.74 gross monthly income.

   First, determine the countable projected earned income.

$ 1,126.74	Gross earned income received in the 30 days before May 21
- 225.34	20% earned income deduction
901.40	
- 300.00	Child care
601.40	Countable projected earned income

   Prorate the lump sum as follows:

$ 1,800.00	Nonrecurring lump sum
+ 601.40	Countable June income
2,401.40	
÷ 849.00	FMAP Test 2 for three people
2.82	Months of proration

   The following income is used to determine eligibility:

May	June	July	August	September on
$601.40	$849.00	$1,450.40 ($849.00 + $601.40)	$1,304.80 ($703.40 lump sum remainder + $601.40)	$601.40

3. Mr. C receives Medicaid for himself and his son. On May 16, Mr. C receives a $1,500 nonrecurring lump sum, which he reports May 23. Current Medicaid eligibility is being determined using $306 in countable projected earned income. The first month of the period of proration will be May.

   Prorate the lump sum as follows:

$ 1,500.00	Nonrecurring lump sum
+ 306.00	Countable projected May earned income
1,806.00	
÷ 719.00	FMAP Test 2 for two people
2.51	Months of proration

Timely notice is sent May 25 effective July 1. May and June are included in the period of proration. However, because the lump sum was timely reported, no recoupment is established for either month. This leaves a $368 remainder to be counted in determining eligibility for July in addition to the monthly projected earned income.

NOTE: The change in income for July is **not** treated as a one-time change in income because it is part of a period of proration.

If countable income, including the countable lump-sum income, is **less** than the Test 2 income limit of the eligible group, consider the lump sum as a one-time change in income. Remember that a one-time change in income is not used in the projection of income since it is not representative of future income.

A $100 lump-sum payment is received in August and is timely reported. The $100 lump sum, combined with other countable income received in August, does not exceed the income limit of the eligible group. Since the $100 nonrecurring lump sum is a one-time change in income and is not indicative of future income, it does not affect the projected amount of monthly income.

If countable income is **equal** to or **more** than the Test 2 income limit of the eligible group, determine the number of months the lump-sum income will be prorated.

Ms. C receives Medicaid for her two children under MAC. Ms. C is a considered person on the MAC case. She does not receive Medicaid for herself. Ms. C receives a $300 nonrecurring lump sum in September and timely reports it. Countable projected September income is $549.

In order to determine if there will be a period of proration, the nonrecurring lump sum and other countable income are added together. $300 + $549 = $849. The Test 2 limit for a three-member eligible group is $849. Since the countable income, including the nonrecurring lump sum is equal to the Test 2 limit, the period of proration will be one month.

The first month of the period of proration is always the month in which the lump sum is received.

If the nonrecurring lump sum was reported timely, do not establish recoupment for the months of the period of proration in which a portion of the lump sum could not be used due to timely notice requirements.

Ms. T receives Medicaid for her three children. Ms. T does not receive Medicaid for herself. Ms. T receives a $3,000 nonrecurring lump sum October 9. Ms. T timely reports receipt of the lump sum October 14. The worker requests additional information and Ms. T supplies it by the due date of October 24.

The first month of the period of proration is October. Timely notice is issued October 26 effective December 1. Because the lump sum was timely reported, no recoupment will be established for October or November. The first month in which a prorated portion of the lump sum will be used to determine eligibility will be December, the third month of the period of proration.

If the nonrecurring lump sum was reported **untimely**, establish recoupment for the months of the period of proration in which the portion of the lump sum could not be used due to timely notice requirements.

Ms. T receives Medicaid for her three children. Ms. T does not receive Medicaid for herself. Ms. T receives a $3,000 nonrecurring lump sum May 9. Ms. T reports receipt of the lump sum May 21. The worker requests additional information and Ms. T supplies it by the due date of May 31.

The first month of the period of proration is May. Timely notice is issued June 2 effective July 1. Because the lump sum was **not** timely reported, Medicaid eligibility will be redetermined for the months of May and June. If any of the children were only conditionally eligible for Medically Needy with a spenddown, recoupment will be established for May or June.

NOTE: Any of Ms. T's children who are only conditionally eligible for Medically Needy with a spenddown should be considered for Hawki.

Do not establish a period of proration if the application is withdrawn (or denied for another reason) before the first of the month in which the lump sum is (to be) received.

1. Mrs. A applies for Medicaid on April 14. She expects to receive a nonrecurring lump sum on April 27 and requests withdrawal of her application on April 20. A period of proration is still established, because the request did not occur before the first day of the month in which Mrs. A expects to receive the lump sum.
2. Ms. B applies for Medicaid on April 14. She expects to receive a nonrecurring lump sum on May 8. On May 2, she requests withdrawal of her application. A period of proration is still established, because the request did not occur before the first day of the month in which Ms. B expects to receive the lump sum.
3. Mr. H applies for Medicaid on April 14. He expects to receive a nonrecurring lump sum on May 2. On April 28, he withdraws his application. A period of proration is **not** established, because the request occurred before the first day of the month in which Mr. H expects to receive the lump sum.

   If the worker has all needed information to approve the application on April 28, the worker should inform Mr. H that Medicaid can be approved for April only and canceled for May. In either case, a period of proration is not established.

Assistance may be denied or canceled for another reason, delaying the lump sum period of proration. When enough information is available, send a letter specifying the period of proration. If there is insufficient information available because the lump-sum income was not verified, send a letter to inform the client about the period of proration due to receipt of lump-sum income.

When either letter is sent, enclose Comm. 24 or Comm. 24(S), *One-Time Payments*. Document in the case record that you sent the letter and the pamphlet. In addition, make an entry in the ABC system (the TD01 screen's, Info line) to flag the prior receipt of lump-sum income if the client reapplies.

Receipt of Another Lump Sum During a Period of a Proration

Legal reference: 441 IAC 75 (Rules in Process)

When a household receives another nonrecurring lump sum during a period of proration, establish a separate period of proration.

Count the new lump sum in the month it is received and add it to that month's income, including the initial lump sum prorated amount. Divide the total by the FMAP Standard of Need for the household size. The period of proration for the second lump sum runs concurrently with the period of proration for the first lump sum.

Ms. R receives FMAP for herself and her two children. She is employed and has projected countable earned income of $400 per month. Ms. R receives a $7,500 nonrecurring lump sum in March, which she timely reports and verifies March 8.

To determine the period of proration, the $7,500 is added to her countable earned income of $400 and divided by the FMAP Standard of Need for a three-person eligible group. ($7,500 + $400 = $7,900 ÷ $849 = 10 months) The period of proration will be March through December, with $259 being considered for December. Timely notice is issued March 15. The first month in which a prorated amount of the lump sum will be used is April, the second month of the period of proration.

In August, Ms. R receives a $10,000 inheritance from her grandmother's estate which she timely reports and verifies August 10.

The $10,000 is added to the $400 countable monthly income and the $849 prorated lump sum and divided by the FMAP Standard of Need. ($10,000 + $400 + $849 = $11,249 ÷ $849 = 14 months) The period of proration for this second lump sum will be August through September of the following year, with $212 remaining for September. Timely notice is issued August 17. The first month in which a prorated amount of the second lump sum will be used is September, the second month of the period of proration.

In September through November, $849 from the first lump sum and $849 from the second lump sum are used in addition to any other monthly income. In December, the remaining $259 from the first lump sum and $849 from the second lump sum will be used. Beginning in January, only the $849 from the second lump sum will be used.

Members Entering the Household During a Period of Proration

Legal reference: 441 IAC 75 (Rules in Process)

When new members who were not in the eligible group when the lump-sum income was received enter the household during the period of proration, they may be eligible for Medicaid as a separate eligible group. The new members must meet all program requirements.

Count the nonexempt income of the new members. Allow all applicable deductions, disregards, and diversions. People who were in the eligible group when the lump sum was received, including any unborn children, remain subject to the period of proration.

1. Ms. B is receiving FMAP for her daughter, Sue, and herself. Ms. B is employed. She receives a nonrecurring lump sum in September, which she timely reports. It creates a period of proration for ten months beginning in September. In November, she applies for Medicaid for her son, Johnny, who has come to live with her.

   Ms. B's earnings (but not the prorated amount of the lump sum) are considered available to Johnny and used in determining Johnny's Medicaid eligibility as a household size of one. There is no diversion of income to meet Ms. B's needs, because the lump sum is for this purpose.

2. Ms. C is pregnant and receives FMAP for herself and her child, Jill. The unborn child is included in the household size because Ms. C reported her pregnancy.

   Ms. C receives a nonrecurring lump sum in April which she timely reports and verifies April 25. The lump sum is divided by the FMAP Standard of Need for a household of three and is prorated for 12 months beginning in April. Ms. C is granted continuous eligibility under MAC. Eligibility under MAC or Medically Needy is explored for Jill with a household size of three.

   In September the baby is born. The baby can be granted Medicaid as either a newborn child of a Medicaid-eligible mother or as part of the existing eligible group.

   In granting newborn status, Ms. C's household size is reduced to two. However, the prorated income remains the same. This could cause Jill to lose MAC eligibility or increase the amount of spenddown. It may be to the household's advantage to continue to include the newborn in the household size and explore eligibility under MAC.

   Regardless of the household's decision, the newborn cannot be granted Medicaid eligibility as a new member entering the household during the period of proration, because the newborn was included in the original Medicaid eligible group when the lump sum was received.

3. Ms. D is pregnant and receives FMAP for herself and her child, Ann. The unborn child is <u>not</u> included in the household size, because Ms. D did not report her pregnancy to her worker.

   Ms. D receives a lump sum in April, which she timely reports and verifies April 10. The lump sum is divided by the FMAP Standard of Need for a household size of two and is prorated for 15 months beginning in April. Ms. D's eligibility is explored under Medically Needy and Ann's eligibility is explored under MAC or Medically Needy, both as households of two.

In July the baby is born. If Ms. D is receiving Medicaid when the baby is born, the baby may receive Medicaid as a newborn child of a Medicaid-eligible mother.

However, if Ms. D is not receiving Medicaid, the baby is a new member entering the home and may receive MAC as a household of one. Ms. D's income (not counting the lump sum) is used to determine the baby's eligibility. There is no diversion of income to meet Ms. D's needs. The lump sum is for this purpose.

4. Mrs. E is receiving Medicaid under FMAP for herself and one child. She receives a nonrecurring lump sum that creates a period of proration of 12 months beginning in October. Mr. E, the child's father, enters the home in December and applies for Medicaid.

   The worker determines that Mr. E meets all eligibility requirements of the FMAP coverage group. Even though there is no child in Mr. E's eligible group, he can receive FMAP as a separate one-person eligible group because he has a dependent child in his care.

   When determining Mr. E's eligibility, the worker considers his income and any income Mrs. E has other than the lump sum. There is no diversion for Mrs. E's needs, because the lump sum is for this purpose.

Conditions for Shortening the Period of Proration

Legal reference: 441 IAC 75 (Rules in Process)

The period of proration can be shortened when:

- The FMAP Standard of Need increases. Recalculate based on the new amounts.
- All or a part of the lump sum is lost or stolen. The client must provide documentation of the loss or theft. Filing a report with law enforcement officials is acceptable documentation.

  Ms. B and her child were receiving FMAP when Ms. B received a $3,595 lump sum. The lump sum was prorated and will be used for six months. An automatic redetermination is completed. Ms. B's child is eligible under MAC. Ms. B declines Medically Needy.

  Ms. B reports and documents that $1,200 of the lump sum was stolen. The period of proration is recalculated as follows ($3,595 - $1,200 = $2,395; $2,395 divided by $719 = 4 months).

- The person controlling the lump sum no longer lives with the eligible group, and the lump sum is no longer available to the group. Recalculate the period of proration and disregard any amount taken by the person who left the home. However, use the same standard of need figure for the recalculation that was used to calculate the original period of proration.

1. Mr. and Mrs. C and their two children were FMAP recipients in May when they received a lump-sum payment of $4,032. The lump sum was timely reported and verified May 15. The lump sum was prorated for five months, May through September ($4,032 divided by 986 = 4 with a remainder of $88).

   In July, Mrs. C left the home and took $800 of the lump sum with her. The period of proration is shortened by subtracting $800 from $4,032.

   The remaining $3,232 is divided by $986 to determine the new period of proration ($3,232 divided by 986 = 3 months with a remainder of $274). The new period of proration is May through August. $274 will be applied against the August eligibility.

2. Same as Example 1, except that Mrs. C did not take any of the lump sum with her when she left because it was all spent before she left home. The period of proration remains unchanged.

- The client uses the lump sum for one of the following expenditures (unless there is insurance to cover the expense):
  - To pay for medical services for the eligible group or their dependents that are allowable under Medicaid at the time the expense is reported. ("Dependents" are people who could be claimed as such for federal income tax purposes.)
  - To pay the cost of repairs to the homestead exceeding $25 per incident which are necessary to keep the house habitable.
  - To replace exempt resources due to fire, tornado or other natural disasters.
  - To pay funeral or burial expenses. (Allow the expenditure whether or not the expenditure is for a person who could be claimed as a dependent.)

Verify these expenditures. "Expenditures" means the amount actually spent on the items, rather than the amount owed.

Document in the case record the calculation of the new period of proration. Obtain and record your supervisor's approval of the expenditures and the new period of proration. Determine availability of insurance. Insurance must be used before applying the prorated funds.

1. A two-member eligible group (with no other income) receives a $4,050 lump sum. ($4,050 divided by 719 = 5 months with $455 to apply to the sixth month) Allowing a medical expense of $850 results in the proration period being reduced to four months with $324 left over to apply to the fifth month. ($4,050 - $850 = $3,200 divided by $719 = 4 months with a remainder of $324).
2. Same as Example 1, except there is insurance available to pay $200 of the expense. The insurance is used to reduce the cost of the medical expense to $650. ($4,050 - $650 = $3,400; $3,400 divided by $719 = 4 months with a remainder of $524 to apply to the fifth month).

FMAP-Related Self-Employment Income

Legal reference: 441 IAC 75 (Rules in Process)

Treat countable income (net profit) from self-employment the same way as earnings of an employee. After establishing that the client is self-employed (see Determination of Self-Employment), calculate net profit based on the type of self-employment enterprise (see Determination of Net Profit).

How you apply the net profit depends upon when the income is received and when allowable expenses are incurred. (See How to Treat Self-Employment Income.) Do not offset the loss from one self-employment enterprise against the profit of another one.

FMAP-related Medicaid policy differentiates between home-based and non-home-based self-employment enterprises. A client who provides a service in the client's home or whose business office is in the home is involved in a home-based enterprise.

The office does **not** need to be a separate room to meet this qualification. Also, a client can be allowed the appropriate deduction for a home-based business regardless of whether or not the client is actually required to pay shelter costs.

Determination of Self-Employment

Legal reference: 441 IAC 75 (Rules in Process)

The federal and state revenue departments use the following guidelines. Consider a person to be self-employed when that person:

- Is not required to report to the office regularly except for specific purposes, such as sales training meetings, administrative meetings, or evaluation sessions.
- Establishes the person's own working hours, territory, and methods of work.
- Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

If it is difficult to identify whether a person is an employee or self-employed, ask the client to provide a written statement from the person or agency for whom the client works. If the person or agency considers the client to be self-employed, compute the income as self-employment income. You can also contact the IRS to determine if the IRS would consider the individual to be self-employed or an employee.

If a person has income from self-employment other than farming, complete form 470-0313, *Work Sheet Determining Income of Self-Employed Business*. When a person is self-employed as a farmer, complete form 470-0312, *Work Sheet Determining Income of Farm Operators*. Also evaluate all self-employment enterprises in terms of resource limits.

Frequently a new employee is considered to be in an employee-employer relationship until that employee gains sufficient experience and knowledge of the company's mode of operation. The employee may then move to the status of a self-employed person.

A self-employed person may not file quarterly reports or an income tax return, but that does not change the person's self-employed status. For example, people who baby-sit in their own home are considered self-employed, even though they may not file any reports.

Determination of Net Profit

"Net profit" means gross earnings minus allowable business expenses. Determine the net profit of self-employment income through a review of past books or through records of the previous year's federal income tax report. If neither books nor tax records are available, do not allow expenses related to the production of self-employment income. Document the method used to determine the net profit in the case record.

NOTE: The FMAP-related Medicaid program does not follow all IRS regulations in determining whether a given expense is deducted as an expense in the production of self-employment income.

After you have determined the net profit, enter the figure into the system as appropriate, showing the applicable disregards and work expenses. Apply allowable earned income deductions to the net profit figure. Do not deduct a loss from self-employment from other income or a separate self-employment business.

Net profit is determined differently for home-based and non-home-based operations. Discussion of home-based operations is further divided into the following sections:

- Renting apartments in the client's home
- Providing room and board, family-life home care, or nursing care
- Providing child care in the client's home
- Other types of businesses operated from the home

Renting Apartments in the Client's Home

Legal reference: 441 IAC 75 (Rules in Process)

When the client is renting out apartments in the client's own home, determine the net profit by deducting the following from the gross rentals received:

- The shelter expense over the amount listed on the *Schedule of Needs, Chart of Basic Needs Components*, RC-0002 (in 6-Appendix) for the eligible group.

  The part of the expense for utilities furnished to tenants that is over the amount listed on the *Chart of Basic Needs Components* for the eligible group. The utility expense in excess of the amount of utilities is an allowable deduction, even when the client pays only a portion of the utility costs for the tenant.

- 10% of gross rentals to cover the costs of upkeep.

The eligible group consists of a mother and two children. The client rents out two apartments in her home. The monthly gross rentals for the apartments (including utilities) total $400.

Mortgage payment	$ 175.00
Shelter expense for 3 (3 x $47.10)	- 141.30
	$ 33.70
Actual utility cost	$ 110.00
Utilities for 3 (3 x $11.77)	- 35.31
	$ 74.69
10% of gross rentals ($400 x .10)	$ 40.00
Gross rentals	$ 400.00
Total deductions ($33.70 + $74.69 + $40)	- 148.39
Profit	$ 251.61

The $251.61 is subject to the appropriate earned income expenses and deductions.

Providing Room and Board, Family-Life, or Nursing Care

Legal reference: 441 IAC 75 (Rules in Process)

When a client furnishes room and board for compensation, operates a family-life home, or provides nursing care, deduct the following amounts from the payments received:

- $41 plus the amount equal to the maximum monthly Food Assistance allotment for a one-member household for each boarder and roomer (a person to whom the client provides **both** meals and lodging) **or** each person in the home to receive nursing care.
- $41 for a roomer (a person to whom the client furnishes only lodging, but not meals). The person lives in a room of the home and usually has privileges in the rest of the home.
- An amount equal to the maximum monthly Food Assistance allotment for a one-member household for a boarder (a person to whom the client furnishes only meals, not lodging).
- 10% of the total payment to cover the costs of upkeep for people receiving a room or nursing care. (Do not allow the 10% deduction for upkeep for boarders.)

Providing Child Care in Own Home

Legal reference: 441 IAC 75 (Rules in Process)

When the client provides child care services in the client's own home, determine net profit by deducting 40% of the total gross income received to cover the cost of upkeep of the home and producing the income.

Gross income from providing child care in the client's own home includes the total payment received for the service, plus any payment received under the Child Nutrition Amendments of 1978 for the cost of providing meals to children. However, exempt as income and as a resource any portion of the payment for the client's cost of providing meals to the client's own children in the home.

When the client claims to have expenses in excess of the 40% and asks to have actual expenses considered, determine net profit in the same manner as outlined in Other Home-Based Operations.

NOTE: Use actual expenses **only** at the client's request and only when they exceed 40% of the gross income. This may require a computation of net income using both methods to determine which is to the client's advantage. When you use the 40% deduction, do not allow 10% deduction for upkeep.

Income received from the Child Nutrition Amendments of 1978 must be reported and verified. Tell the client about this responsibility.

Other Home-Based Operations

Legal reference: 441 IAC 75 (Rules in Process)

Other home-based self-employment operations may include party sales, mechanic, painter, craftsperson, and beauty operator.

When the client operates a self-employment enterprise in the home (other than providing room and board, renting apartments, or providing child care services in the home), deduct the following expenses from the income received:

- The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.
- Wages, commissions, and costs (including cost for health insurance) relating to the wages for employees of the self-employed person. When the employee is a member of the eligible group, allow the person's wages as a deduction for the self-employed person but also count the employed person's wages as income.
- The cost of machinery and equipment in the form of rent, interest on a mortgage or contract payment, and any insurance on such machinery and equipment.
- 10% of the total gross income to cover the costs of upkeep when the work is performed in the home.
- Any other direct cost involved in the production of the income.

Do not allow a deduction for the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods, or any cost of depreciation.

Non-Home-Based Operations

Legal reference: 441 IAC 75 (Rules in Process)

Determine the net profit from self-employment income in a business that is not based in the client's home by deducting only the following expenses that directly relate to the production of such income:

- The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption, and raw materials.

- Wages, commissions, and costs (including cost for health insurance) relating to the wages for employees of the self-employed person. When the employee is a member of the eligible group, allow the person's wages paid as a deduction for the self-employed person, but also count the employed person's wages as income.
- The cost of shelter in the form of rent, the interest on mortgage or contract payments, taxes, and utilities.
- The cost of machinery and equipment in the form of rent, or the interest on mortgage or contract payments.
- Insurance on the real or personal property involved.
- The cost of any needed repairs.
- The cost of any required travel (other than the cost of travel from the home to the business).
- Any other expense that is directly related to producing income for the client.

Do not allow a deduction for:

- The purchase of capital equipment.
- Payment on the principal of loans for capital assets and durable goods.
- Any cost of depreciation on equipment, vehicles, or property.

How to Treat Self-Employment Income

The treatment of self-employment income differs depending on whether the income and expenses are received regularly or irregularly, and whether irregular income has been received for less than a year.

Income and Expenses Received Regularly

Legal reference: 441 IAC 75 (Rules in Process)

Treat countable income (net profit) received on a regular basis from self-employment in the same way as the earnings of an employee.

Expenses must be incurred on the same regular basis as the income; that is, if the income is received monthly, the expenses must also be incurred monthly. If expenses are incurred less often than the income (for example, insurance, license fees, etc.), annualize the self-employment income.

Self-employment received on a regular basis is any income that is anticipated to be received on a daily, weekly, biweekly, semimonthly, or monthly basis. Some types of self-employment income that may be received on a regular basis are income from:

- Baby-sitting in the client's home
- Renting apartments in the client's home
- Providing room and board
- Collecting bottles and cans for deposit refunds
- Sporadic spot labor (such as mowing lawns, shoveling snow, etc.)

Annualizing Income Received Irregularly

Legal reference: 45 CFR 233.20(a)(3)(iii), 441 IAC 75 (Rules in Process)

Average annual self-employment income that is received on an irregular basis over a 12-month period of time, even if the income is received only within a short period in that 12 months. Apply this policy when the income is received:

- Before the month of decision and expected to continue. (If it is not expected to continue, do **not** consider any self-employment income received before the month of application.)
- In the month of decision.
- After assistance is approved.

Annualize self-employment income over 12 months, even if income is received from other sources in addition to self-employment. The annualized self-employment income is used for a specific 12-month period of time that is called the annualized period. To determine the annualized income:

- Average the past 12 months of income, ending with the month before the month of decision or the month of annual review, **or**
- Use the client's income tax return, if the return covers a full year of self-employment and covers the calendar year before the year in which the computation is being done.

If you use the income tax form, establish the annualized period to coincide with the filing of the tax return. Filing of a tax return is not a change as defined in earned income. It is your responsibility to follow up and request a copy of the new tax return when the previously determined annualized period is about to expire.

For an **applicant**, an annualized period can be established to begin before the application. When a **recipient** becomes subject to annualizing, you can make the initial "annualized period" for less than a full tax year, so that, from then on, the end of the annualized period coincides with the filing of the tax return.

If the household experiences a significant increase or decrease in the self-employment business income that is subject to annualization, the tax return will not provide a good projection. In these cases, work with the household to arrive at the best estimate of future income.

1. Mr. X has been a farmer for the last two years. He applies for Medicaid in July. The eligible group is within resource limits. The worker uses the income tax return covering the previous year to determine the income to be considered for the month of decision and prior months of eligibility (if applicable) and to establish ongoing eligibility for Mr. X and his children.

   Mr. X's income tax form was filed in February, and this is the month he anticipates filing each year. There are several options for establishing the annualized period, such as February through January of the next year, March through February of the next year, or beginning with a later month. If Mr. X is eligible, the monthly amount established is considered accurate until the annualized period ends.

2. Mr. Y ends his self-employment on October 15 due to a lack of business and applies for Medicaid on October 28. The worker processes the application on November 4. No income from self-employment is counted in determining Mr. Y's Medicaid for November.

   If Mr. Y requests Medicaid for October, and if Mr. Y's self-employment experienced a significant decrease in business income preceding the termination, use the best information available to arrive at the net profit for October.

Income Received Irregularly for Less Than a Year

Legal reference: 441 IAC 75 (Rules in Process)

If a client is self-employed in a business that does not produce a regular income, and the business has been in existence for less than a year, average the income over the period the business has been in existence. Project the monthly amount for the same period of time that the business has been in existence.

If the business has been in existence for only a short time and there is little income information, establish a reasonable estimate of income and expenses with the client's help. Use this estimate for the first three months.

Average the actual income from the first three months, and use that amount for the second three months. Use this method regardless of the day of the month the enterprise started, or when the first income was received.

Average the actual income from the first six months, and use that amount for the next six months. Then start annualizing for the next year. Use the projected monthly income to determine initial and ongoing eligibility.

Self-employment begins in November for an active Medicaid case. The projected income is used to determine eligibility for November, December, and January.

Change in the Cost or Nature of Self-Employment

Legal reference: 441 IAC 75 (Rules in Process)

Recalculate expenses when there is an established, permanent, ongoing change in operating expenses, such as an increase or decrease in rent payments, or in the cost of supplies.

When the cost for supplies increases, recalculate only if the client does not increase the cost of the service or product, thereby experiencing a loss in profit. There is no need to recalculate if the client increases the cost of the product or service because of the increased costs of supplies.

Recalculate income and expenses when there is a change in the nature of the business, such as a salesman switching from selling one company's product to selling another company's product, or an insurance salesman decreasing or increasing the types of policies offered.

FMAP-Related Deductions and Diversions

Legal reference: 441 IAC 75 (Rules in Process)

Allowable deductions under FMAP-related coverage groups include:

- The cost of producing unearned income.
- 20% deduction from earned income.
- Adult or child care expenses.
- Applicable diversions for people not in the home.
- Diversions for an ineligible or voluntarily excluded person's needs, if appropriate.
- 58% work incentive deduction (except for MAC or Medically Needy cases).

Project deductions as you project income. Subtract these deductions in the order listed from earned income first.

1. 20% earned income deduction.
2. Adult or child care expenses. (Allow the deduction from earnings of ineligible stepparents or self supporting parents in minor parent cases.)
3. Applicable diversions for people not in the home (for example, child support and alimony payments).
4. Diversions for an ineligible or voluntarily excluded person's needs, if appropriate.
5. 58% work incentive deduction. NOTE: Do not allow the 58% deduction when determining initial eligibility under the Standard of Need test (test 2).

When the person whose income must be considered has both nonexempt earned and unearned income, and earnings remain after applying the allowable deductions, add the unearned income to the remaining earned income. Consider the total as countable income.

NOTE: Diversions for people not in the home (such as child support and alimony payments) and diversions for an ineligible or excluded person's needs are allowable for either earned or unearned income. When a person has both nonexempt earned and unearned income, and the earnings are less than the allowable deduction, subtract any unused portion of either diversion from unearned income. Consider the balance to be countable income.

Income Subject to Comparison to the Three Income Tests

Test 1 (applicants and members):
Gross income (Include nonexempt earnings of a child who is less than a full-time student. If the person is self-employed, use the net profit figure. For income of stepparents, see Treatment of Stepparent Income. For income of self-supporting parents, see Self-Supporting Parent's Income.)

Test 2 (applicant cases):
Gross earnings (Include earnings of a child who is less than a full-time student.)
Minus the 20% earned income deduction
Minus the child/adult care deduction
Minus applicable diversions for people **not** in the home
Minus applicable diversions for people **in** the home
Plus any unearned income
Do not allow the 58% work incentive deduction

Test 3 (applicants and members):

Gross earnings (Include earnings of a child who is less than a full-time student.)
Minus the 20% earned income deduction
Minus the child/adult care deduction
Minus applicable diversions for people **not** in the home
Minus applicable diversions for people **in** the home
Minus the 58% work incentive deduction
Plus any unearned income

If eligible for these deductions, people in FMAP-related coverage groups may have these deductions applied when their retroactive eligibility is examined.

1. Household consists of:
   Mrs. Z, 32
   Child A, Mrs. Z's child
   Mr. Z, 39
   Child C, common child

   The family applies for Medicaid for Mrs. Z and Child A. Mrs. Z has no income. Mr. Z has earnings of $1,230 per month. The worker explains who must be in the eligible group and who may be voluntarily excluded. Eligibility is determined as a household of four. The worker determines eligibility as follows:

$	1,230.00	Mr. Z's earnings
-	246.00	20% earned income deduction
$	984.00	
-	570.72	58% work incentive deduction
$	413.28	Net countable income.

   If all other eligibility factors are met, the family is eligible for FMAP.

2. The household consists of Mr. W and his two children who receive Medicaid under FMAP. Mr. W has $300 per month in earned income. Each child has unearned income of $100, for a total of $200. Mr. W fails to cooperate with the Third-Party Liability Unit, and he is sanctioned and not eligible for Medicaid effective first of the next month allowing a ten day notice. Mr. W will be a "considered" person.

   The worker determines Medicaid eligibility for the children as follows:

$	300.00	Mr. W's gross earnings
-	60.00	20% earned income deduction
$	240.00	
-	139.20	58% work incentive deduction
$	100.80	Mr. W's income used towards the eligible group
+	200.00	Unearned income of children
$	300.80	Net countable income

   If all other eligibility factors are met, the children are eligible for Medicaid.

3. The household consists of Mrs. P, her two children from a previous marriage, Mr. P, and their common 12-year-old child. Mr. P has projected earnings of $800 per month and pays $50 per month in child support outside the home. Mrs. P and her children have no income. The household wants Medicaid for the family.

   The worker determines FMAP eligibility as follows:

$	800.00	Mr. P's projected gross monthly earnings
-	160.00	20% earned income deduction
-	50.00	Child support paid to child outside the home
$	590.00	
-	342.20	58% work incentive deduction
$	247.80	Net countable projected income

   If all other eligibility factors are met, the family is eligible for FMAP.

The following sections explain:

- Deductions from unearned income
- Deductions from earned income
- Diversion for people not in the home
- Diversion for needs of an ineligible or voluntarily excluded person
- Treatment of a stepparent's income
- Deductions for ineligible parents

Unearned Income Deductions

Legal reference: 441 IAC 75 (Rules in Process)

Deduct reasonable income-producing costs from the gross unearned income to determine net unearned income from investments and nonrecurring lump-sum payments. "Costs" means the amount actually spent to produce the income, rather than the amount owed. Consider the income left after this deduction as gross income available to the eligible group.

Examples of investments are stocks, bonds, trusts, and rental property that is not owner-operated. (Be sure the nonexempt value of the investment plus other countable resources does not exceed the resource limit.)

Examples of income-producing costs are brokerage fees, a property manager's salary, and maintenance costs. The most common type of income-producing cost for a nonrecurring lump sum is an attorney fee.

Allow a deduction for attorney fees when automatically deducted from unearned income when the attorney was hired to obtain the payment.

Also allow a deduction for taxes as described under Taxes earlier in this chapter. When the owner manages rental property, determine the income according to instructions in FMAP-Related Self-Employment Income.

Also, deduct from unearned income diversions for people not in the home (for example, child support and alimony payments) and diversions for an ineligible or voluntarily excluded person's needs. See Diversion for People Not in the Home and Diversions for the Needs of an Ineligible or Voluntarily Excluded Person, for more information.

Earned Income Deductions

Legal reference: 441 IAC 75 (Rules in Process)

The following sections explain the allowable earned income deductions:

- 20% earned income deduction
- Adult or child care expenses
- 58% work incentive deduction (not allowed for MAC or Medically Needy coverage groups).

20% Earned Income Deduction

Legal reference: 441 IAC 75 (Rules in Process)

Apply a 20% deduction to the gross nonexempt monthly earned income of each person whose income must be considered when determining eligibility. This deduction is intended to include all work-related expenses other than child or adult care, such as:

- Taxes
- Transportation
- Meals
- Uniforms

Deduction for Child or Adult Care Expense

Legal reference: 441 IAC 75 (Rules in Process)

Each person whose income is considered is entitled to a deduction for care expenses as follows:

- **From earnings of people in the eligible group and ineligible parents**, allow child or adult care expenses for care of a person in the eligible group.

  Do not allow care expenses for a child living in the home who is not in the eligible group, such as a sanctioned child or a child who receives SSI.

  Do allow care expenses for a child not in the eligible group because the child receives Medicaid as the newborn child of a Medicaid-eligible mother.

- **From earnings of ineligible stepparents**, allow child-care expenses for care of the stepparent's ineligible dependents, including the common but ineligible child. Do not allow care expenses for an FMAP-related child.

- **From earnings of self-supporting parents**, allow child-care expenses for care of their ineligible dependents.

Allow the deduction without regard to whether the care is provided by a licensed facility. Do not allow the deduction when the expense is paid to a parent of the child, to another member of the eligible group or to any person whose needs are met by diversion of income from any person in the eligible group.

Allow a deduction for a grandparent paying the expenses for care of a grandchild who is in the same eligible group as the grandparent's own child, e.g., a three-generation FMAP-related case. Also allow the deduction for a child on a nonparental case when the nonparental relative also has a separate parental case, provided child care is needed for the nonparental child.

Guidelines for Applying the Child/Adult Care Deduction

Legal reference: 441 IAC 75 (Rules in Process)

Policy: When both parents are in the home, adult or child care expenses will not be allowed when one parent is unemployed and is physically and mentally capable to provide the care.

An applicant or member may receive a deduction for care expenses that have been billed or otherwise are anticipated to become due in the month. It is not required that the person actually pay the bill before it can be allowed as an expense. Accept the client's statement as to the amount of the expense. A receipt or signed statement from the care provider may be requested when the expense is questionable.

Procedure: Project and use the cost of care as a deduction only when it covers:

- The actual hours of the person's employment plus a reasonable period of time for commuting, or
- The period of time that the person who would normally care for the child or incapacitated adult is sleeping because the person's work schedule is such that the person must sleep during the waking hours of the child or incapacitated adult. Exclude any hours a child is in school.

Project and use the actual expense due in the month not to exceed the following:

- $175 per month per child for children age two or older.
- $200 per month per child for children under age two. (Allow $200 for the month the child turns two unless the birthday falls on the first of the month.)
- The going rate in the community if the going rate is less than the $175 or $200 limit.

Comment: Consider any special needs of a physically or mentally handicapped child or adult when determining the deduction. However, do not exceed the maximum allowable deduction amounts.

When the payment for care outside the home includes meals, consider the cost for the meals as part of the expense.

Do not deduct any part of the expense that is paid by a third party, such as the Child Care Assistance Program. Deduct only the part of the expense that was not paid by a third party, up to the allowable maximum amount.

1. Ms. A and her two children apply for FIP and Medicaid. Ms. A has $1,200 projected gross monthly earnings and pays $300 per month for child care. Ms. A has applied for Child Care Assistance (CCA) and wants to know how that will affect her eligibility. The worker uses the following calculations to help Ms. A decide whether to participate in the CCA program.

   Medicaid eligibility with a child care deduction:

$	1,200.00	Projected gross earnings
-	240.00	20% earned income deduction
-	300.00	Projected child care paid by Ms. A
$	660.00	
-	382.80	58% deduction
$	277.20	Projected net income (less than limit for three people)

   Ms. A and her two children would be eligible for Medicaid under FMAP.

   Medicaid eligibility without a child care deduction:

$	1,200.00	Projected gross earnings
-	240.00	20% earned income deduction
$	960.00	(Compared to Test 2; exceeds limit for three people)

   Ms. A and her two children would not be eligible for Medicaid under FMAP without a child care deduction. The two children could be eligible under MAC and Ms. A would be conditionally eligible under Medically Needy.

   Medically Needy spenddown calculation for Ms. A:

$	1,200.00	Projected gross earnings
-	240.00	20% earned income deduction
$	960.00	
-	566.00	MNIL for three people
$	394.00	x 2 months = $788 spenddown for Ms. A

   Ms. A states she has no other health insurance and needs her medical card. She chooses to continue to pay her own child-care expenses and not participate in the CCA program. Ms. A and her two children are eligible for Medicaid under FMAP.

2. Ms. B and her two children (over the age of two) receive FIP and FMAP. Her projected gross income is $1,400 per month and her projected monthly child care is $440. The worker uses the following calculations to help Ms. B decide whether or not to participate in the CCA program.

   Medicaid eligibility with a child care deduction:

$	1,400.00	Projected gross earnings
-	280.00	20% earned income deduction
-	350.00	Projected child care ($175 max per child)
$	770.00	
-	446.60	58% deduction
$	323.40	Projected net income (less than limit for three people)

   Ms. B and her children would continue to be eligible under FMAP.

Medicaid eligibility without a child care deduction:

$ 1,400.00	Projected gross earnings
- 280.00	20% earned income deduction
$ 1,120.00	(Compared to 133% of poverty for a MAC determination)
- 649.60	58% deduction
$ 470.40	Projected net income (exceeds limit for three people)

Ms. B and her children would not continue to be eligible for Medicaid under FMAP without a child-care deduction. The children could be eligible under MAC and Ms. B would be conditionally eligible under Medically Needy.

Medically Needy spenddown calculation for Ms. B:

$ 1,400.00	Projected gross earnings
- 280.00	20% earned income deduction
$ 1,120.00	
- 566.00	MNIL for three people
$ 554.00	x 2 months = $1,108 spenddown for Ms. B

If Ms. B chooses to participate in the CCA program, it will pay the entire $440 monthly child care costs, but she will only be conditionally eligible for Medically Needy with a spenddown. The children would be redetermined to the MAC coverage group.

If Ms. B chooses not to participate in CCA, they all remain eligible under FMAP, but she will be allowed only the maximum child care deduction of $350 when she actually projects paying $440 per month.

58% Work Incentive Deduction

Legal reference: 441 IAC 75 (Rules in Process)

After deducting the 20% earned income deduction, care expenses, and diversions, deduct 58% of the total remaining monthly nonexempt earned income of each person whose income must be considered in determining eligibility.

Follow FMAP-related policies when determining applicable deductions. If a person is eligible for these deductions also apply them when determining retroactive Medicaid eligibility under FMAP-related coverage groups.

Ms. A receives FMAP for herself and one child. Also in the home is another child who is not in the eligible group due to the lack of a social security number.

Ms. A's projected gross earnings are $700. She has $100 projected unearned income per month and projected child-care expenses of $175 per month for the child on FMAP. Ms. A has chosen not to participate in the Child Care Assistance (CCA) program.

$	700.00	Projected gross earnings
-	140.00	20% earned income deduction
$	560.00	
-	175.00	Projected child care expenses for the FMAP child
$	385.00	
-	65.00	Diversion for the ineligible child ($426 - $361 = $65)
$	320.00	
-	185.60	58% work incentive deduction
$	134.40	Projected countable earnings
+	100.00	Projected unearned income
$	234.40	Combined projected earned and unearned countable income
		Eligible for FMAP

Do not apply the 58% deduction in the 185% test (Test 1).

Do not apply the 58% deduction in the standard of living cost test (Test 2) when determining initial eligibility, regardless whether the person with the countable earnings is included in the eligible group.

1. Ms. B applies for Medicaid. She has two children. Her gross monthly earnings are projected at $1,200, and her child-care expenses are projected at $200 per month. She has chosen not to participate in Child Care Assistance (CCA).

   Test 1

   $1,200 projected gross income is less than the 185% standard of need for three. The household is eligible under Test 1.

   Test 2

$	1,200.00	Projected gross income
-	240.00	20% earned income deduction
-	200.00	Projected child care expenses
$	760.00	Less than $849 FMAP standard of living cost for three

   The household is eligible under Test 2.

   Test 3

$	1,200.00	Projected gross income
-	240.00	20% earned income deduction
$	960.00	
-	200.00	Projected child care expenses
$	760.00	
-	440.80	58% work incentive deduction
$	319.20	Less than the FMAP income limit for three

   The household is eligible under Test 3.

2. Household consists of: Mrs. Z, 32, no income
Child A, Mrs. Z's child
Mr. Z, 39, projected earnings of $1,230 per month
Child C, a common child

The family applies for Medicaid for Mrs. Z and Child A. Eligibility is explored for a four-member eligible group. The worker determines eligibility as follows:

$ 1,230.00	Mr. Z's projected earnings
- 246.00	20% earned income deduction
$ 984.00	
- 570.72	58% work incentive deduction
$ 413.28	Less than FMAP standard of need for four.

If they meet other eligibility factors, the Zs are eligible for Medicaid under FMAP.

3. Household consists of: Ms. T, 28, $500 projected monthly earned income
Child A, 5, Ms. T's child
Mr. R, 30, $1,000 projected monthly earned income
Child C, 3, a common child

Ms. T and Mr. R are not married. They apply for Medicaid for Ms. T, Child A, and Child C. The worker explains that because they want Medicaid for Child C, Mr. R must be included in the FMAP-related Medicaid eligible group. The household projects a $100 per month child care expense for each child. The worker determines FMAP-related Medicaid eligibility as follows:

Test 1

$ 1,000.00	Mr. R's projected earnings
+ 500.00	Ms. T's projected earnings
$ 1,500.00	Less than the FMAP 185% limit for four people

Test 2

$ 1,000.00	Mr. R's projected earnings
+ 500.00	Ms. T's projected earnings
$ 1,500.00	
- 300.00	20% earned income deduction
$ 1,200.00	
- 200.00	Projected child care for Child A and Child C
$ 1,000.00	Greater than the FMAP standard of need for four people

The eligible group is not eligible for Medicaid under FMAP. However, since $1,000 is less than 133% of poverty for four people, Child A and Child C are eligible for Medicaid under MAC. Ms. T and Mr. R are conditionally eligible for Medicaid under Medically Needy with a spenddown. The worker calculates the spenddown as follows:

$ 1,500.00	Combined projected earnings of Ms. T and Mr. R
- 300.00	20% earned income deduction
- 200.00	Projected child care for Child A and Child C
$ 1,000.00	Projected countable monthly income
$ 2,000.00	Projected countable monthly income for two months
- 1,332.00	$666 four person MNIL for two months
$ 668.00	Spenddown for Ms. T and Mr. R

4. Household consists of: Mrs. P, 38
Child A, 15, Mrs. P's child
Child B, 13, Mrs. P's child
Mr. P, 40, $800 projected monthly earned income
Child C, a common child

The family applies for Medicaid. Mr. P projects a $50 per month child support payment for a child outside the home. Mrs. P, Child A, and Child B have no income. The worker determines Medicaid eligibility as follows:

Test 1

$800.00	Mr. P's projected earnings are less than the FMAP 185% limit for five people.

Test 2

$ 800.00	Mr. P's projected earnings
- 160.00	20% earned income deduction
$ 640.00	
- 50.00	Projected child support paid by Mr. P
$ 590.00	Less than the FMAP standard of need for five people

Test 3

$ 800.00	Mr. P's projected earnings
- 160.00	20% earned income deduction
$ 640.00	
- 50.00	Projected child support paid by Mr. P
$ 590.00	
- 342.20	58% work incentive deduction
$ 247.80	Less than the FMAP income limit for five people

If all other eligibility factors are met, the five-member eligible group is eligible for Medicaid under FMAP.

5. Household consists of: Mrs. D, 28, no income
Child A, 5, Mrs. D's child, no income
Child B, 3, Mrs. D's child, no income
Mr. P, 40, $1,800 projected monthly earned income
Child C, a common child

The family applies for Medicaid for everyone. Mr. P projects a $50 per month child support payment for a child outside the home. The worker determines eligibility as follows:

Test 1

$ 1,800.00	Mr. P's projected monthly earnings are less than the FMAP 185% limit for five people.

Test 2

$ 1,800.00	Mr. P's projected monthly earnings
- 360.00	20% earned income deduction
- 50.00	Projected child support paid by Mr. P
$ 1,390.00	Greater than the FMAP standard of need for five people

Medicaid eligibility under FMAP does not exist because the projected countable income before the 58% earned income deduction exceeds the FMAP standard of need for five people. However, the three children are eligible for Medicaid under MAC, because the projected countable income of $1,390 is less than the MAC income limit at 133% of poverty for five people.

Mr. P and Mrs. D are conditionally eligible under Medically Needy with a spenddown. The worker determines the spenddown as follows:

$ 1,800.00	Mr. P's projected monthly earnings
- 360.00	20% earned income deduction
- 50.00	Projected child support paid by Mr. P
$ 1,390.00	Projected countable monthly income
$ 2,780.00	Projected countable monthly income for two months
- 1,466.00	$733 five person MNIL for two months
$ 1,314.00	Spenddown for Mr. P and Mrs. D

6. Household consists of: Mrs. F, 25, $400 projected monthly earned income
Child A, 6, Mrs. F's child
Mr. F, 27, $800 projected monthly earned income
Child B, a common child

The family applies for Medicaid. The worker determines eligibility as follows:

Test 1

$ 1,200.00	Mr. and Mrs. F's projected monthly earnings are less than the FMAP 185% limit for four people.

Test 2

$ 1,200.00	Mr. and Mrs. F's projected monthly earnings
- 240.00	20% earned income deduction
$ 960.00	Less than the FMAP standard of need for four people

Test 3

$ 1,200.00	Mr. and Mrs. F's projected monthly earnings
- 240.00	20% earned income deduction
$ 960.00	
- 556.80	58% work incentive deduction
$ 403.20	Less than the FMAP income limit for four people

If all other eligibility factors are met, the entire eligible group is eligible for Medicaid under FMAP.

Diversion for People Not in the Home

Legal reference: 441 IAC 75 (Rules in Process)

When the parent is actually making payments, divert nonexempt earned and unearned income of the FMAP-related parent to permit payment of court-ordered support to children (of the parent) who are not living with the parent.

Allow the diversion for back child support as well as current child support. Allow the diversion regardless whether the parent is in the eligible group (e.g., for an ineligible parent or the ineligible companion in the home).

Do not allow a diversion from the income of the FMAP-related parent for court-ordered alimony payments.

In some situations, child support can be deducted directly from social security disability income. The gross and net amounts on Data Sources may not reflect the child support payment. Verification other than Data Sources is necessary in these cases.

Diversion for the Needs of an Ineligible or Voluntarily Excluded Person

Legal reference: 441 IAC 75 (Rules in Process)

The following sections explain:

- How to divert income for the needs of an ineligible of voluntarily excluded child
- How to determine the needs of a common ineligible child
- How diversion applies to ineligible parents
- How diversion applies to voluntarily excluded parents

Ineligible or Voluntarily Excluded Child

Divert nonexempt earned and unearned income of the FMAP-related parent to meet the unmet needs of that parent's ineligible or voluntarily excluded dependent children who live in the family group. Ineligible children for whom a FMAP-related parent may divert income include:

- Ineligible common children.
- Children who are ineligible aliens.
- Children without social security numbers.
- Children voluntarily excluded for reasons other than excess income.

Do **not** divert income to meet the needs of a child who:

- Has been voluntarily excluded due to excess income.
- Is required to be in the eligible group but who has failed to cooperate, (e.g., a child who fails to apply for benefits from other sources such as unemployment benefits).

1. The Medicaid household consists of Mrs. C and her two children, Bob and Tom. Mrs. C is employed. Tom is ineligible because he does not have a social security number. Mrs. C's income from her earnings is diverted to meet Tom's needs.
2. The Medicaid household consists of Mrs. B, her son Jim, age 5, and her son Tony, age 17. Tony is not in school and he refuses to apply for unemployment (he was previously employed). Income is not diverted from Mrs. B to meet Tony's needs.
3. The Medicaid household consists of Ms. D and her three children. Ms. D voluntarily chooses to exclude Child A because Child A receives child support that would affect Ms. D's FMAP-related Medicaid eligibility. Income is not diverted from Ms. D to meet Child A's needs because the child support meets child A's needs.

Determine if a child has unmet needs before allowing a diversion from the FMAP parent's income. NOTE: A system-generated cancellation of a child due to the expiration of the 90-day reasonable opportunity period for verifying citizenship will convert the child to "considered" person status on the ABC system. The ineligible child is not allowed a diversion in this situation.

The maximum income that can be diverted to meet the unmet needs of the dependent ineligible children is the difference between:

- The needs of the eligible group with the ineligible children **included**, and
- The needs of the eligible group with the ineligible children **excluded**.

Use this formula for all FMAP-related programs, including MAC and Medically Needy.

Determining Needs of the Common Ineligible Child

This section applies to two-parent households with a common ineligible child and one or more children from a parent's previous relationship.

The household consists of Ms. A and Mr. B, their common child, and Ms. A's child from a previous relationship. The common child is not eligible for Medicaid because he does not have a social security number. Ms. A and her child are a two-member eligible group and Mr. B is a separate one-member eligible group. Mr. B is eligible for Medicaid because he has a child (the common child) in his care.

Either FMAP-related parent can divert income to the ineligible common child. The family should make the decision regarding which parent will divert income to the ineligible common child, based on the most advantageous situation for their circumstances.

Use the income of each ineligible child to meet only that child's needs.

The maximum income divertible to meet the needs of the common ineligible child is the standard of need for the child minus any countable income of the child.

Ineligible Parent

Ineligible parents remain part of the Medicaid-eligible group as "considered persons." No diversion is necessary to meet their needs.

Voluntarily Excluded Parents

Parents who are voluntarily excluded for the following reasons are not part of the Medicaid-eligible group. However, no diversion is allowed to meet the needs of these voluntarily excluded parents.

- The biological parent whose needs are voluntarily excluded because the income of a stepparent has been voluntarily excluded in order for a stepchild to establish Medicaid eligibility.
- The minor parent whose needs are voluntarily excluded because the income of the minor parent's self-supporting parents has been voluntarily excluded in order for the minor parent's child to establish Medicaid eligibility.

Treatment of Stepparent Income

Legal reference: 441 IAC 75 (Rules in Process)

When a stepparent is not included in the eligible group but is living with the parent **in the home of the eligible children**, treat the stepparent's income as you would the income of a natural parent, except as otherwise specified.

When the stepparent living in the home is not included in the eligible group, consider the eligible group and any dependent, but ineligible children of the parent, as one unit. Consider the stepparent as a separate unit. The common ineligible child is part of the stepparent's unit.

When the household consists of an SSI parent, the SSI parent's children, and a stepparent, the stepparent should be voluntarily excluded to avoid using the stepparent's income in determining eligibility of the children. The SSI parent's Medicaid is not affected by the stepparent being voluntarily excluded.

Count a nonrecurring lump sum received by a stepparent as income in the month received. Any income remaining after the stepparent's deductions are subtracted is considered unearned income available to meet the needs of the eligible group.

Consider any part retained by the stepparent in the month following the month of receipt to be a resource to the stepparent. Do not calculate a period of ineligibility due to receipt of the lump sum unless the *stepparent* is included in the eligible group.

The following sections explain:

- Income deductions allowed for stepparents
- Treatment of the parent's income in a stepparent case

Deductions

Legal reference: 441 IAC 75 (Rules in Process)

Allow the following deductions from the stepparent's monthly nonexempt gross earned income earned as an employee or the net profit from self-employment:

1. A 20% earned income deduction.
2. Adult or child-care expenses for the stepparent's ineligible dependents in the home, including the common child. Do not consider the stepparent's spouse (the FMAP-related parent) as a dependent of the stepparent.
3. The stepparent's alimony and child support payments, made to people not living in the home with the stepparent. The payments do not have to be court-ordered.

   If these payments have been made in the past and the stepparent is projecting child support and alimony payments will continue in the same manner, verify that the payments have been made and project accordingly.

   If these payments have not been made in the past or the stepparent is projecting payments in a manner different than they have been made in the past, obtain a signed and dated statement from the stepparent regarding the amount and frequency the stepparent anticipates making the payments.
4. Any verified amounts the stepparent pays to people who are not living in the home, but who are claimed (or could be claimed) by the stepparent as dependents for federal income tax purposes.

   If these payments have been made in the past and the stepparent is projecting the payments will continue in the same manner, verify that the payments have been made and projected accordingly.

   If these payments have not been made in the past or the stepparent is projecting payments in a manner different than they have been made in the past, obtain a signed and dated statement from the stepparent regarding the amount and frequency the stepparent anticipates making the payments.
5. From the income that remains after deductions 1-4, allow a diversion for the needs of the stepparent and the stepparent's ineligible dependents living in the home whom the stepparent claims or could claim for federal income tax purposes (including the ineligible common child).

   Determine the need of the stepparent and the stepparent's ineligible dependents in the home according to the Standard of Need for that size family.
6. Apply a 58% work incentive deduction to earnings that remain after deductions 1-5 have been subtracted from earnings.

   EXCEPTION: Do not allow the 58% work incentive deduction when determining:

   - Initial eligibility under the 185% test,
   - Initial eligibility under the standard of need test, or
   - Eligibility under MAC and Medically Needy.

Household consists of:
Mrs. M
Mr. M, stepparent
Child A, Mrs. M's child from a previous relationship
Child B, Mrs. M's child from a previous relationship

Mr. M has $800 gross earnings. He has no diversions except for his own needs. The family has no other income. They have applied for Medicaid. To determine eligibility under FMAP for Mrs. M and her two children, follow the following procedures:

1. 185% Test (test 1): Compare the gross figure for a three-person FMAP-eligible group to $800 gross earnings, minus 20%, the income deduction, minus $365, the diversion for Mr. M's needs. ($800 - $160 = $640 - $365 = $275 < $1,570.65)
2. Standard of Need Test (test 2): Compare the standard of need for a three-person FMAP-eligible group to $800 gross earnings, minus 20%, the income deduction, minus $365, the diversion for Mr. M's needs. ($800 - $160 = $640 - $365 = $275 < $849)
3. Benefit Standard Test (test 3): Compare the benefit standard for a three-person FMAP-eligible group to $800 gross earnings, minus 20%, the income deduction, minus $365, the diversion for Mr. M's needs, minus 58%, the work incentive. ($800 - $160 = $640 - $365 = $275 - $159.50 (58% of $275) = $115.50 < $426)

When the stepparent has both nonexempt earned and unearned income, and the earnings are less than the allowable deductions, subtract any remaining portion of deductions 3 through 5 from the unearned income. Apply any income that remains as unearned income to the eligible group.

If the stepparent has earned income that remains after allowable deductions, add any unearned income to the remaining earnings.

Apply the total remaining income of the stepparent after allowable deductions as unearned income to the eligible group. Except as noted in item 5, this is also the income that is applied to the eligible group when determining eligibility under the 185% standard, initial eligibility, and continuing eligibility.

Mrs. A receives FMAP for herself and her two children. Mr. A is the stepparent. Mrs. A has no income. Mr. A has projected gross earnings of $850 per month.

$ 850.00	Mr. A's projected gross income
- 170.00	20% deduction
$ 680.00	
- 365.00	Diversion for the stepparent
$ 315.00	
- 182.70	58% work incentive deduction
$ 132.30	Projected countable income

$132.30 is within the 185% FMAP income limit for the three-person eligible group.

Do not consider the income of the stepparent's dependents to be available to the eligible group. However, consider dependents' income when determining the amount of their unmet needs.

When determining unmet needs, treat the income of the dependents in the same way as the income of a person in the eligible group is treated.

> A mother and one child receive FMAP. They live with the stepparent and a voluntarily excluded common child. The stepparent has projected unearned income of $350 each month. The common child has projected unearned income of $356 each month.
>
> The common child's needs are $354 ($719 - 365). However, the child's $2 excess income cannot be used to meet the needs of the FMAP eligible group. Since there is no unmet need, none of the stepparent's income is used to meet the needs of this child.

In all calculations, determine the needs of the stepparent's unit, including the needs of the common child, based on the Standard of Need schedule.

To determine the needs of any person (or group of people) in either household unit, take the difference between the unit's needs with that person's needs included and the unit's needs with the person's needs excluded.

> The household consists of Mrs. P, her three children by a previous relationship, Mr. P, and their common child.
>
> If this household of six is not eligible as one unit, the group may become two units. Mrs. P and her three children comprise the parent's unit. Mr. P and the common child comprise the stepparent's unit. The children's needs are determined as follows:
>
> - The common child's needs are based on the standard of need (Test 2). Start with the standard of need for two people, Mr. P and the common child. Subtract the needs of Mr. P. ($719 minus $365 = $354).
> - If any of Mrs. P's other children are ineligible, start with the basic needs of all three children and Mrs. P (Test 3 for a four-member group). Subtract the needs of the ineligible children. For example, if two children were not eligible because they did not verify citizenship, their needs would be $134 ($495 minus $361 = $134).

Parent's Income in Stepparent Cases

Legal reference: 441 IAC 75 (Rules in Process)

When the income of a stepparent who is not in the eligible group is not enough to meet the needs of the stepparent and the dependent but ineligible children living in the home, divert the parent's income to meet the unmet needs of the children of the current marriage.

See Determining Needs of the Common Ineligible Child for exceptions when the FMAP parent cannot divert income to an ineligible common child.

The household consists of Mrs. J, her husband, a common child, and Mrs. J's child. The stepparent has projected countable income of $500. Mrs. J's income after allowable work expenses is $248. The worker diverts from Mrs. J's income to meet the needs of the common child.

$ 719.00	Needs of stepparent and common child
- 500.00	Stepparent's projected income
$ 219.00	Unmet needs of the common child
$ 248.00	Parent's projected net income
- 219.00	Diverted to meet the unmet needs of the common child
$ 29.00	Use for needs of eligible group

Do not divert the parent's income to meet the needs of the ineligible stepparent or the stepparent's dependent children living in the home.

The household consists of the parent, the stepparent, stepparent's child (not in the eligible group), and the parent's child. The stepparent has $250 projected countable income. The parent has $100 projected income after work expenses. None of the parent's income can be diverted to meet the unmet needs of the stepparent and the stepparent's child.

Ineligible Parent Deductions

Legal reference: 441 IAC 75 (Rules in Process)

If the ineligible parent's income, along with any other income of the eligible group, passes the 185% eligibility test (Test 1) for the size of the eligible group:

1. Deduct the 20% earned income deduction.
2. Deduct child and adult care expenses.
3. Divert for people not in the home (for example, court-ordered child support).
4. Divert for an ineligible or voluntarily excluded person's needs. See Diversion for the Needs of an Ineligible or Voluntarily Excluded Person.

   Remember: Use the Schedule of Living Costs (Test 2) for the standard of need test and the Schedule of Basic Needs (Test 3) for the eligibility test.
5. Apply a 58% work incentive deduction from earnings that remain after deductions 1 through 4 have been subtracted from the earnings. EXCEPTION: Do not allow the 58% work incentive deduction when determining initial eligibility under the standard of need test (Test 2) for the eligible group.

When the ineligible parent has both nonexempt earned and unearned income, and earnings remain after applying allowable deductions, add the unearned income to the remaining earned income. If the earnings are less than the allowable deductions, subtract any unused portion of the diversion for people not in the home or voluntarily excluded persons from the unearned income. Consider the balance to be countable income.

Apply all remaining income of the ineligible parent in determining eligibility for the eligible group.

1. Mr. A receives Medicaid for his two children. Mr. A is sanctioned for failure to cooperate with CSRU. He has projected gross earnings of $800, projected child-care expenses of $374 per month, and projects $100 monthly child support for a child not living with him.

$	800.00	Projected gross earnings
-	160.00	20% earned income deduction
$	640.00	
-	374.00	Projected child care deduction
-	100.00	Projected child support
$	166.00	Projected countable earnings
-	96.28	58% work incentive deduction
$	69.72	Projected countable income
$	426.00	Schedule of basic need for three (Mr. A is "considered")
-	69.72	
$	356.28	Medicaid eligible for the two children

2. Household composition: Mrs. E, who is employed, and her three children. Mrs. E's deceased husband was a veteran, but she refuses to apply for Veterans Benefits. Mrs. E is sanctioned and is no longer eligible for Medicaid. However, the eligible group remains a household of 4.

3. Mr. and Mrs. F apply for Medicaid on June 24, listing themselves and Mrs. F's four children from a previous relationship. Mrs. F is not eligible for Medicaid because she is an ineligible alien but she is included in the eligible group as a "considered" person. Mrs. F has projected gross monthly earnings of $1,000 and $100 projected child care costs per month. The family has no other income.

   Step 1: 185% Eligibility Test (Test 1)
   Mrs. F's $1,000 projected monthly gross earned income is less than the gross income limit of $2,020.20 for a five-person eligible group. Income passes Test 1.

   Step 2: Schedule of Living Costs (Test 2)

$	1,000.00	Mrs. F's projected monthly gross earnings
-	200.00	20% earned income deduction
$	800.00	
-	100.00	Monthly projected child care
$	700.00	Projected countable income

   Income passes Test 2. Projected countable income is $700 and the Schedule of Living Costs for five is $1,092.

   Step 3: Basic Needs Test (Test 3)

$	1,000.00	Mrs. F's projected monthly gross earnings
-	200.00	20% earned income deduction
$	800.00	
-	100.00	Monthly projected child care
$	700.00	
-	406.00	58% work incentive deduction
$	294.00	The four children are eligible for Medicaid since the projected countable income is less than the Basic Needs for five people.

Processing Medically Needy Applications

This section explains different or additional requirements for Medically Needy that do not apply to other coverage groups. Use the general guidelines provided in 8-B unless a unique requirement is listed in the following sections:

- Applications
- Recertifications
- Interviews
- Time limits
- Effective date of assistance
- Retroactive eligibility

Applications

Legal reference: 441 IAC 76.1(249A)

Use form 470-5170 or 470-5170(S), *Application for Health Coverage and Help Paying Costs*. See 8-B, *Which Application Form to Use*.

If it is necessary to determine Medically Needy eligibility for the period before a member's SSI eligibility was approved, accept the member's statement regarding the day of onset of blindness or disability unless there is evidence to the contrary. Examine retroactive eligibility for an SSI recipient the same as you would any other applicant.

Use form 470-5170 or 470-5170(S) to determine eligibility for SSI-related Medically Needy when an SSI member becomes ineligible for SSI due to income or resources after the effective date of the SSI eligibility approval.

An applicant may withdraw the application for the month filed if the applicant wants to have the certification period begin the following month. Issue a *Notice of Decision* for the month the applicant withdrew. Process the application for the two following months.

> Mr. T files an application on October 28. When the IM worker contacts Mr. T, he states that he does not have any medical expenses for the month of October and requests that his certification period begin with the month of November.
>
> The IM worker issues a *Notice of Decision* stating that the client withdrew the application for October. The IM worker processes the same application for the certification period of November and December.

See 8-B, *Grace Period Following the Denial of an Application*.

Recertifications

Legal reference: 441 IAC 75 (Rules in Process), 76 (Rules in Process)

Policy: Recertification is the process to establish a new certification period when the previous period has expired. The member must complete form 470-5482, 470-5482(S), 470-5482(M), or 470-5482(MS), *Medicaid/State Supp Review,* for a recertification.

Recertifications can be completed as long as there is no break in assistance (more than three months between the end of the last certification period and the beginning of the next certification period). If there is a break in assistance, the client must complete a new application to be recertified.

Comment: Recertification is not done for people with ongoing eligibility, but an annual review is required. No grace period is allowed for recertifications.

It is not a requirement that the Department send the *Medicaid/State Supp Review* to a person whose two-month certification period ends. If a person does not have enough medical expenses to meet the spenddown for a certification period, it is not recommended that the person complete the *Medicaid/State Supp Review*.

Medical expenses that occurred in a certification period when spenddown is not met cannot be moved forward to the next certification period. Depending on the situation, it may be better for the person to wait and apply when there are old bills that can be used to meet a spenddown.

Interviews

Legal reference: 441 IAC 75 (Rules in Process), 76 (Rules in Process)

An interview is not required when determining Medicaid eligibility for FMAP-related or SSI-related applicants or members unless you determine an interview is necessary to:

- Clarify information on the application,
- Clarify questionable information, or
- Ensure there is a better understanding of programs.

It is important to treat applicants and members equitably and to use the "prudent person concept." See 8-A, *Definitions* for "prudent person concept."

An interview shall not be required for children as defined by the Medicaid program. Grant an interview if the applicant, member, or authorized representative request one.

It may be necessary to contact the applicant to explain the differences in the Medically Needy program policies for Family Medical Assistance Program (FMAP)-related and Supplemental Security Income (SSI)-related coverage groups when a person would qualify under more than one coverage group.

If an applicant is ineligible for FMAP, provide the applicant an explanation of the Medically Needy program and process the application.

Ms. A, age 70, is approved for Medically Needy August 15. She continues to reapply every two months. The worker determines there is some information that needs to be clarified and schedules an interview. Ms. A informs her worker that her health does not allow her to go to the office.

As Ms. A does not have any family members or other persons that can represent her at the interview, the worker sets a time with Ms. A for either an interview by telephone or a home visit.

Procedure: To require a face-to-face interview or a phone interview, you must request a scheduled time with the applicant or member. When an interview is needed or is requested by an applicant, a member, or an authorized representative, schedule a date, time, place, and method of the interview (in the local office, home visit, or by phone, etc.).

Grant requests to reschedule when you determine that the applicant, member, or authorized representative is making every effort to cooperate with the interview process. Interviews rescheduled at the request of the applicant, member, or authorized representative may be agreed upon verbally and documented without written confirmation.

Failure to attend the interview you requested, including a scheduled phone interview, is cause to deny or cancel the adults on the application.

Contact the applicant or member whenever you need to clarify information in order to determine eligibility.

When you ask a client to come in to the local office for an interview, do not deny or cancel the children if the adult fails to attend the interview. However, if you request information at the same time as you set up an interview and the information is not provided within ten days, you may cancel or deny the entire household for failure to provide requested information.

Program Information

Legal reference: 42 CFR 435.905, Iowa Code Chapters 217 and 249A

In addition to the requirements listed under Interviews, you must also explain either orally or in writing the following to clients, prospective clients, and anyone asking about the Medically Needy program:

- The definition of "conditionally eligible" and "responsible relative."
- The use of the income and resources of all conditional eligibles and responsible relatives to determine eligibility.
- Resource guidelines.
- The Medically Needy income level.
- The spenddown process and the medical expense verification form.

Time Limit for Eligibility Decision

Legal reference: 42 CFR 435.912(c)(3)(i)-(ii), Iowa Code Section 249A.4

The applicant must receive a written notice of approval, conditional eligibility, or denial as soon as all information is available, but no later than 45 days from the date of application. Extend the notice deadline to 90 days from the date of application if an SSI-related applicant applies for benefits based on blindness or disability and a disability determination has not yet been made. See 8-B, *Processing Standards* for what to do if the determination exceeds 90 days.

Follow the guidelines in 8-B, *Processing Standards* regarding the extension of the time limit for sending a *Notice of Decision* when the applicant and county office make every reasonable attempt to obtain the necessary information and conditions exist that are beyond their control.

Effective Date of Assistance

Legal reference: 441 IAC 75 (Rules in Process), 76 (Rules in Process)

Eligibility begins on the first day of the first month of the certification period in which the client's income is reduced to the Medically Needy income level or the client was determined to have ongoing eligibility.

Enter all Medically Needy applications onto the Automated Benefit Calculation (ABC) system. Cases that are approved and have zero spenddown in the retroactive certification period or have ongoing eligibility are maintained by the ABC system and are not passed to the Medically Needy Subsystem. People with active fund codes are automatically eligible for Medicaid.

Cases that have a spenddown in either the retroactive or the prospective certification period have information passed to the Medically Needy Subsystem. When the spenddown obligation is met, the Medically Needy Subsystem issues a *Notice of Spenddown Status* (NOSS).

Retroactive Eligibility

Legal reference: 441 IAC 75 (Rules in Process), 76 (Rules in Process)

A client may be eligible for retroactive Medically Needy benefits for a period of one, two, or three months preceding the month when the application was filed. The applicant does not need to be eligible in the month of application to be eligible for the retroactive period. To be eligible for retroactive benefits, the applicant must meet the following:

- Have incurred medical expenses for Medicaid-covered services that were received during the retroactive period. These expenses may be paid or unpaid.
- Would have been eligible for Medicaid benefits in the month services were received if application had been made (even if the applicant is not alive when the application is filed).
- Meet a category of eligibility for the retroactive period as defined in 8-A, *Definitions*.

The retroactive certification period begins with the first of these three months in which the client received Medicaid-covered services. It continues to the end of the month immediately before the month of application.

Exclude from the Medically Needy certification period any month in which the client received Medicaid or if the applicant would have been eligible for Medicaid under another coverage group. (See Eligibility Under Another Coverage Group.)

Mrs. Z applies for Medically Needy for her family on September 19. They have previously received FMAP January through June. Mrs. Z has paid for medical services that she incurred in July. She has an unpaid medical bill for services her 11-month-old daughter received in August. The retroactive period for Medically Needy is established for only one month, August, and only for her daughter.

May	June	July	August	September	October
FMAP	FMAP	No eligibility	Retroactive period for Medically Needy for daughter	Current certification period	

If there are medical expenses for Medicaid covered services (either paid or unpaid) in any month of the retroactive period, complete a spenddown calculation. If there are no medical expenses in all months of the retroactive period, you do not need to do a spenddown calculation.

Mrs. J, a pregnant woman, applies for Medicaid May 4 and requests retroactive eligibility. She paid a medical bill on March 15. The medical expense was for Medicaid-covered services received in January. Mrs. J did not incur any medical expenses in the retroactive months of February, March, or April.

Retroactive eligibility is denied, because Mrs. J did not incur any medical expenses in the retroactive months of February, March, or April.

See Income and Spenddown in the Retroactive Period for more information on calculating spenddown.

Eligibility Under Another Coverage Group

Retroactive periods may involve eligibility determinations for several coverage groups. Therefore, before determining Medically Needy eligibility, establish that the applicant is ineligible for all other Medicaid coverage groups. Send form 470-0397, *Request for Special Update*, to Quality Assurance (QA) to update the Medicaid eligibility file in the following situations:

- Situation: The state ID does not show on SSNI. The client is eligible for Medically Needy in the current month or for ongoing eligibility and is eligible for the retroactive months under another coverage group. Enter the Medically Needy case on ABC. After ABC updates, send Quality Assurance a *Request for Special Update* for the retroactive months that are under another coverage group.
- Situation: The state ID does not show on SSNI. The client is not eligible for the month of application or ongoing eligibility, but is eligible for retroactive Medicaid. Process the denial for the current or ongoing eligibility on ABC. In this situation, QA builds an SSNI file for the retroactive months. QA needs the following to build an SSNI file:
  - Memo with all case and individual information.
  - *Request for Special Update* showing the aid type and months in which eligibility exists.

- Situation: Ongoing Medicaid eligibility does not exist. An individual eligibility record exists on SSNI. Enter retroactive periods that involve another coverage group and a Medically Needy zero spenddown period via the *Request for Special Update*.

Ms. T, age 32 and pregnant, applies for Medically Needy on October 6 for herself and child A, age 11 months. She reports unpaid bills for Medicaid-covered services received in July and August. She has never received Medicaid before. The worker determines Ms. T's eligibility in the retroactive period as follows:

July	**August**	**September**
Eligible for retroactive FMAP	Retroactive eligibility for Medically Needy	Retroactive eligibility for Medically Needy

Ms. T is eligible for retroactive Medicaid through the Family Medical Assistance Program (FMAP) coverage group for July if unpaid or paid medical expenses exist for Medicaid-covered services received in July.

The Medically Needy retroactive period is August and September, even though unpaid medical expenses exist only in August. July's income is not included in the Medically Needy retroactive period, since eligibility existed under another coverage group (FMAP).

Ms. T has a spenddown for the August-September Medically Needy retroactive period.

Her state ID does not show on the SSNI screen, since she has never received Medicaid. Therefore, Quality Assurance cannot enter her July Medicaid eligibility through a *Request for Special Update*.

The worker first processes Ms. T's case in ELIAS reflecting income of the family for the months of July, August, and September for the retroactive period, the month of application, and future months, as required.

Once ELIAS has processed this information, the worker enters Medically Needy eligibility information in the ABC system for the August-September Medically Needy retroactive period.

Determining the Coverage Group

Legal reference: 441 IAC 76.1(249A)

Screen the application to determine if there are other Medicaid coverage groups for which the client would be eligible, including State Supplementary Assistance dependent person. (The income limits of the dependent person coverage group are higher than the MNIL.) Document in the case record that the application was screened for other coverage groups.

Do not grant Medicaid eligibility under Medically Needy if the person could be determined eligible under another coverage group.

When determining if a person is eligible under another coverage group, consider whether the person is eligible for SSI. If a person who would be eligible for SSI wants to apply for cash assistance and Medicaid, refer the person to the Social Security Administration to apply for SSI benefits.

See the following sections for more information on:

- Groups who are eligible for Medically Needy
- Who is not eligible for Medically Needy
- People who are concurrently eligible under Medically Needy and also under QMB or SLMB

Who Is Eligible for Medically Needy

Legal reference: 441 IAC 76.1(249A); 75 (Rules in Process)

The Medically Needy coverage group is available only to people who are not eligible under other Medicaid coverage groups because of excess income or resources.

People eligible for the Medically Needy coverage group are:

- Children under the age of 19 who would be eligible for FMAP or SSI except that their income exceeds the limits.
- Relatives caring for a dependent child who have income or resources exceeding the FMAP limits and who meet the FMAP definition of specified relative.
- Pregnant women over income limits for MAC.
- Pregnant women not eligible for continuous eligibility for pregnant women.
- Women in the postpartum period.
- Newborn children of Medically Needy Medicaid-eligible mothers.
- Persons who are aged, blind, or disabled and who would be eligible for SSI except that their income or resources exceed the limits.
- Children in subsidized guardianship.

Residents of residential care facilities (RCFs) whose income is over the State Supplementary Assistance limits are eligible through the Medically Needy coverage group if they are categorically eligible, e.g., under 19, pregnant, aged, blind, or disabled. The Medically Needy coverage group does not pay for RCF care, but it does pay for other Medicaid-covered services the client receives if spenddown is met.

Applicants have the choice whether to have eligibility determined as SSI-related or FMAP-related, if the person would qualify under more than one group.

Household composition: Mr. and Mrs. S and their child, Sarah, age 13.

Mr. S is employed full time and earns $4,000 per month. Mrs. S is legally blind and works part time for the Blind Commission. She earns $500 per month and receives $2,100 social security disability benefits. The household is over income for FMAP. Mrs. S is not income-eligible for SSI and is over income for MEPD. The application is processed for Medically Needy.

The worker determines whether it is to Mrs. S's advantage to be SSI-related or FMAP-related in determining eligibility.

SSI-related: Follow the procedures for deeming income from a spouse (see 8-E).
FMAP-related: Include Mrs. S's income and treat according to FMAP policy.

If it is to Mrs. S's advantage to be treated as SSI-related, Mrs. S remains a considered person on the FMAP-related case, since she is a parent. If Mrs. S is on the SSI-related case, she cannot be excluded from the FMAP-related case. Mrs. S's medical bills would be used to meet spenddown on both cases. (See SSI-Related, FMAP-Related Composite Households later in this chapter.)

Who Is Not Eligible for Medically Needy

Legal reference: 441 IAC 76.1(249A); 75 (Rules in Process)

A person is not eligible for the Medically Needy coverage group if the person is eligible for another coverage group, with **two exceptions**:

- A client does not have to apply for any home-based or community-based services waiver to be eligible for the Medically Needy program. Allow a client who is eligible for either the Medically Needy coverage group or a waiver program to choose in which program to participate. Certain waivers allow Medically Needy coverage group when the person needs hospital level.
- A client may receive Medicaid under the qualifying Medicare beneficiary coverage group or the specified low-income Medicare beneficiary coverage group and be concurrently eligible for the Medically Needy coverage group. (See Concurrent Eligibles.)
- A person who qualifies both for Medicaid for employed people with disabilities (with or without a premium) and for Medically Needy (with or without a spenddown) may choose which coverage group eligibility is established under. (See 8-F, *Medicaid for Employed People with Disabilities: Relationship to Medically Needy*.)

A person with income less than FMAP-related limits or SSI limits (depending on the coverage group under which the person would be eligible) is not eligible for the Medically Needy coverage group unless resources exceed other Medicaid program limits.

If a person who would be eligible for SSI wants only Medicaid and not cash assistance, grant Medicaid eligibility under the coverage group for persons eligible for but not receiving SSI or SSA cash benefits -- not under the Medically Needy coverage group.

Concurrent Eligibles

Legal reference: Social Security Act, Sections 1902(a)(10)(E)(iii) and 1905(p)(1)

Clients who meet the eligibility requirements for qualified Medicare beneficiary (QMB) or specified low-income Medicare beneficiary (SLMB) may also be concurrently eligible for Medically Needy.

Expanded specified low-income Medicare beneficiaries (E-SLMB) may also be determined conditionally eligible for Medically Needy.

NOTE: Clients who are eligible for E-SLMB are not eligible for other Medicaid coverage groups. If a client who has been determined eligible for E-SLMB meets spenddown for Medically Needy, the Medicare Part B premium will be paid for as a Medically Needy recipient. However, do not cancel the client's E-SLMB case when the client meets spenddown.

QMB and SLMB clients who are concurrently eligible for Medically Needy and E-SLMB clients conditionally eligible for Medically Needy must have two cases:

- One case with a QMB, SLMB, or E-SLMB aid type (90-0, 90-1, or 92-0).
- A second case with a 37-E aid type.

Children in Subsidized Guardianship

Medicaid is available under the Medically Needy program to children in subsidized guardianship for whom Iowa has financial responsibility and who:

- Are not eligible for SSI or IV-E; and
- Are under age 21.

There is no financial test (income and resources) when determining eligibility for subsidized guardianship children.

Medically Needy will not pay for facility level-of-care. The child would have to qualify under some other coverage group that will pay the cost of facility care.

Nonfinancial Eligibility

Most nonfinancial eligibility requirements for Medically Needy eligibility are comparable to those of the underlying categorical eligibility groups. Exceptions and explanations of how these requirements apply in Medically Needy cases are included in the following sections:

- Determining the eligible group (for all coverage groups)
- Requirements for FMAP-related Medically Needy groups
- Requirements for pregnant and postpartum women and newborns
- Requirements for SSI-related Medically Needy groups

Determining the Eligible Group

Legal reference: 441 IAC 76 (Rules in Process)

Medically Needy households may include members who are FMAP-related and SSI-related. Each categorically related Medically Needy coverage group requires that certain household members be included in or excluded from the eligible group.

For **any** coverage group, exclude from the Medically Needy eligible group:

- People receiving FMAP or SSI. Do not count their income in the Medically Needy spenddown calculation. A "1619b" person is considered an ineligible spouse. The 1619b person has medical coverage under the SSI coverage group. See 8-F, *People Ineligible for SSI (or SSA): Due to Earnings Too High for an SSI Cash Payment (1619b Group)*.
- An unlawful alien who is not categorically eligible.
- For SSI-related households, establish an eligible group for a spouse who enters a medical institution expecting to stay 30 or more days and another eligible group for the community spouse. Refer to 8-I, *Income and Resources of Married Persons*.

When determining the eligible group for FMAP-related Medically Needy:

- Follow the guidelines listed under Eligible Group.
- Determine which members must be included or excluded.

- Include in the household size those people in the household who are:
  - Categorically eligible under FMAP-related Medically Needy.
  - Any additional people required to be considered.
- Remove any household members who are voluntarily excluded.
- Do not include in the Medically Needy eligible group:
  - A stepparent who is not the parent of any of the children living in the household unless the stepparent is incapacitated or needed to care for the children in the home. See Households With a Stepparent.
  - A legalized alien who is a considered person for the eligible group but is not categorically eligible.
  - An unlawful alien who is a considered person for the eligible group and is categorically related **unless an emergency medical service is needed**.

An adult alien who is ineligible for Medicaid, but is a "considered" person, is included in the household size.

When the household requests to add the voluntarily excluded person to the eligible group that has been certified, the voluntarily excluded person is not eligible until the month following the month of the request.

Voluntarily excluded people are **not** considered as responsible relatives. When a person is voluntarily excluded from the Medically Needy household, do not use that person's paid or unpaid medical expenses in meeting the household's spenddown.

1. The household consists of Mr. A, 60, and Mrs. A, 65. Mr. A receives Medicaid through in-home health-related care (IHHRC) program, but does not receive SSI. Mrs. A applies for SSI-related Medically Needy.

   Mr. and Mrs. A are both in the Medically Needy household. Mr. A is a responsible relative (he has income deemed to Mrs. A). Mrs. A is eligible or conditionally eligible individual. If a spenddown exists, Mr. A's IHHRC client's participation is an allowable medical expense in meeting Mrs. A's spenddown.

2. The household consists of Mr. T, age 41, and his children, Tom, age 20; Tim, age 15; and Ted, age 10. Mr. T is employed full time. After the 20% earned income deduction, his monthly net income is $2,500. Mr. T is over income for FMAP and other Medicaid coverage groups. His application is processed for Medically Needy.

   Tom is also employed. Mr. T can voluntarily elect to exclude Tom and request Medicaid eligibility only for the FMAP-related household members.

3. The household consists of Mr. and Mrs. Q and their children, K, age 20, X, age 10, and Y, age 5. The household is over income for FMAP. Child K has no income or resources. Since Mr. and Mrs. Q are not on FMAP, they are considered self-supporting parents and their income is used to determine eligibility for all of their children.

   A Qs' income is within the income limits for a household size of four for MAC. X and Y receive Medicaid coverage under MAC. X and Y are eligible for Medicaid coverage under MAC because the Q's income is within income limits for MAC.

People Who Have a Choice of Coverage Groups

Legal reference: 42 CFR 435.404, 441 IAC 76 (Rules in Process)

A person in the FMAP-related household who could also be SSI-related has a choice of being FMAP-related or SSI-related. Explain program guidelines of the options available, so the client can decide what is best for the household.

If a person in the household could be eligible as either FMAP-related or SSI-related, allow the client to choose under which program to be considered based on:

- The amount of spenddown for each case.
- Which family members usually incur medical bills.
- Which family members have unpaid bills incurred before the certification period.

If a client chooses to be FMAP-related, establish one case for all FMAP-related household members. If the household chooses for some of the members to be SSI-related, establish an SSI-related case and an FMAP-related case with separate FBUs. For more information on calculating spenddown in these cases, see SSI-Related, FMAP-Related Composite Households.

The household composition is Mr. and Mrs. J, Child A (SSI-related), and Child B (FMAP-related). The Js made the choice to have Child A considered as SSI-related rather than as FMAP-related. If the Js want Medicaid for both children, there will be an SSI-related case and an FMAP-related case.

The SSI-related case is a one-person household for Child A. The parents' income is used to determine eligibility following SSI policy. The parents are not responsible relatives on the SSI-related case. (NOTE**:** Following SSI policy, the parents receive a living allowance as a deduction.)

The FMAP-related case is a four-person household for Child B, Mr. and Mrs. J, and Child A, as a considered person on the case.

If the parents want Medicaid only for Child A, there will be an SSI-related case with a household size of one. NOTE**:** The Js may apply later for Child B as an FMAP-related child. If they do, Child A has to be included as a considered person on Child B's FMAP-related Medically Needy case.

If the parents want Medicaid only for Child B, there will be a FMAP-related case with the parents as responsible relatives with a household size of three. (Child A is excluded and there would not be an SSI-related case.)

FMAP-Related Medically Needy

Legal reference: 441 IAC 75 (Rules in Process), 75.14(249A)

Use the following FMAP policies to determine a client's eligibility for the FMAP-related Medically Needy coverage group when resources or income exceeds FMAP limits:

- Specified relative.
- Income, but not the FMAP income limits or the 58% work incentive deduction.
- Liquid resources, but not the nonliquid resource policies or resource limit.

Assignment of medical support is required. See 8-C, *Failure to Cooperate in Obtaining Support*.

FMAP-related specified relatives and their children may be eligible or conditionally eligible members of the Medically Needy household. Specified relatives must be over income or resources for FMAP to be eligible for Medically Needy.

The FMAP-related specified relative must have a child in the household. However, the child does not need to be included in the Medicaid-eligible group for the parent to be eligible or conditionally eligible for Medicaid. The family may choose to voluntarily exclude the child of a specified relative.

For FMAP-related Medically Needy applications or automatic redetermination:

- First consider eligibility for all other FMAP-related Medicaid coverage groups.
- If the case is not eligible under any FMAP-related coverage group, examine the children's eligibility for Medicaid under the FMAP-related Medically Needy coverage groups and consider the child for Healthy and Well Kids in Iowa (***Hawki***).

Complete an automatic redetermination for the Mothers and Children (MAC) or Medically Needy coverage group when transitional medical ends for an FMAP case.

An FMAP-related Medically Needy household may consist of people under different coverage groups such as:

- One or more children on MAC.
- One or more children on Medically Needy.
- Pregnant woman on MAC.
- Parents on Medically Needy.

1. Household composition is Ms. J, age 25, and her children, Jimmy, age 6, and Jill, age 5. Ms. J is employed full time. She applies for FMAP. Ms. J's income exceeds the FMAP income limit.

   Ms. J is over income for FMAP, and other Medicaid coverage groups. Her application is processed for FMAP-related Medically Needy. . The children are both eligible for MAC. Ms. J is conditionally approved for Medically Needy.

2. The household consists of Mr. and Mrs. E and their two children, ages 2 and 4. The family applies for Medicaid on July 7. Mr. E works and the household is determined to be over income for FMAP. The children are determined to be eligible for MAC. Mr. and Mrs. E are conditionally eligible for Medically Needy for July and August.

FMAP-Related Nonparental Relative

Legal reference: 441 IAC 75 (Rules in Process), 75.14(249A)

Only one needy specified relative can be a member of the Medically Needy household. See Who May Be in the FMAP Eligible Group, for more explanation of needy specified relative.

A child living with a needy specified relative may qualify for FMAP based on the child's income. If the needy specified relative's income and resources exceed the limits for the needy specified relative to qualify for FMAP, determine eligibility for FMAP-related Medically Needy.

When the needy specified relative is over income or over resources for FMAP, consider income for a needy specified relative using FMAP policies, but do **not** allow the 58% work incentive deduction.

Divert the income of the needy specified relative to other members of the household using the FMAP Schedule of Basic Needs. The needy specified relative's spouse and children are responsible relatives and need to be on the ABC system.

The child can be on the Medically Needy case if the child's income exceeds FMAP limits or the MAC limit.

Household composition: Mr. and Mrs. H and their grandson.

Mr. H has income of $1,000 unemployment insurance benefits, and Mrs. H has income of $350 unemployment insurance benefits. Their grandson is eligible for FMAP and receives FIP. When this household applies, they request that Mrs. H be considered for FMAP "needy specified relative" and for Medicaid because she is experiencing health problems.

Mrs. H is not disabled or aged. Her eligibility for FMAP is calculated as follows:

$ 1,000.00	Mr. H's UIB
+ 350.00	Mrs. H's UIB
$ 1,350.00	Total gross income

There is no eligibility for FMAP for Mrs. H as a needy specified relative.

The next step is to determine eligibility under the Medically Needy coverage group as follows:

$ 1,350.00	Gross income for Mr. and Mrs. H
- 183.00	Diversion for Mr. H (Schedule of Basic Needs for 1)
$ 1,167.00	Monthly countable income considered as available to Mrs. H
$ 2,334.00	$1,167 income × 2 months
- 966.00	$483 MNIL (for Mrs. H only) × 2 months
$ 1,368.00	Spenddown

Mrs. H is entered on the ABC system as a Medically Needy FMAP-related specified relative. Mr. H is entered as a responsible relative. The grandson is not part of the Medically Needy household because he receives FIP.

Pregnant and Postpartum Women and Newborns

Legal reference: 441 IAC 75 (Rules in Process)

Pregnant women are eligible for Medically Needy when they would be categorically eligible for MAGI-related Medicaid (including MAC) or NonMAGI-related Medicaid except that income or resources exceed limits.

> Household composition: Mr. Z, age 27, and Mrs. Z, age 31, pregnant. Mrs. Z applies for Medicaid. Mrs. Z is employed full time. Mr. Z is not employed.
>
> Mrs. Z. is over income for MAC coverage. Her application is processed for FMAP-related Medically Needy. Mr. Z is not conditionally eligible for Medicaid.

NOTE: Do not put a pregnant woman who becomes over income for a Medicaid coverage group on Medically Needy. The woman remains continuously eligible for Medicaid through the pregnancy and postpartum period without regard to any changes in family income. See 8-F, *Continuous Eligibility for Pregnant and Postpartum Women*.

The 60-day postpartum period begins with the last day of pregnancy and continues through the last day of the month in which the sixtieth day falls. Medically Needy coverage group continues to be available for the postpartum period. Spenddown must be met for the woman to be eligible for the postpartum period. Spenddown can be met after the pregnancy ends.

Form 470-5482, 470-5482(S), 470-5482(M), or 470-5482(MS), *Medicaid/State Supp Review*, may be required for Medically Needy eligibility in the postpartum period if the woman's certification period expires before the postpartum period ends.

> Household composition: Mrs. F, age 25, pregnant, and Mr. F, age 29, works full-time
>
> 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.
>
> Mrs. F 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 spenddown for the new certification period, if applicable, before receiving Medicaid under the postpartum coverage group for December.

Medicaid is available to newborn children if the mother establishes Medically Needy eligibility, including emergency services, by meeting spenddown for the month of the child's birth. An application is not required for the newborn. Open the newborn on a Mothers and Children case.

Newborn coverage begins with the month of the birth and extends through the month of the child's first birthday if the child remains an Iowa resident. Determine eligibility when the child reaches one year of age.

SSI-Related Medically Needy

Legal reference: 441 IAC 75 (Rules in Process)

To be eligible for the Medically Needy coverage group as SSI-related, the client must meet the SSI criteria for age, blindness, or disability. The person must also be over income or over resources for SSI and other NonMAGI-related Medicaid coverage groups.

Applicants with income and resources less than the SSI standard or those who have applied for SSI and are waiting for an eligibility decision are **not** eligible for the SSI-related Medically Needy coverage group. Determine if eligibility exists under one of the other NonMAGI-related coverage groups.

> A married couple has income greater than the MNIL for a couple but less than the SSI benefit for a couple. This means the couple is not covered under Medically Needy. The worker examines eligibility under SSI-related coverage groups, such as State Supplementary Assistance dependent person.

Age Criteria

Legal reference: 441 IAC 75 (Rules in Process)

To be eligible for SSI-related Medically Needy as an aged person, the applicant must be age 65 or older. See 8-C, *Presence of Age, Blindness, or Disability* for more detailed information about the SSI or social security criteria for age.

Blindness Criteria

Legal reference: 441 IAC 75 (Rules in Process)

To be eligible for SSI-related Medically Needy as a blind person, the applicant must meet the SSI or social security criteria for blindness. See 8-C, *Presence of Age, Blindness, or Disability* for detailed information.

A state disability determination may need to be done by the Bureau of Disability Determination Services in the Department of Education if the applicant:

- Has been denied social security (Title II) benefits only (not SSI) by the Social Security Administration as not disabled due to blindness, or
- Is in the process of applying for benefits.

Disability Criteria

Legal reference: 441 IAC 75 (Rules in Process)

To be eligible for SSI-related Medically Needy as a disabled person, the applicant must meet SSI or social security criteria for disability. See 8-C, *Presence of Age, Blindness, or Disability* for detailed information.

To be eligible for SSI-related Medicaid based on disability, a person must be unable to engage in any "substantial gainful activity" because of a physical or mental impairment. (See 8-C, *When the Department Determines Disability* for more information.) The impairment must be medically documented and must be expected to last continuously for 12 months or result in death.

People are considered disabled when they receive Title II (social security disability) benefits or receive Railroad Retirement benefits that were based on the same criteria that the Social Security Administration uses to determine social security disability.

For Medically Needy, the Department is required to follow federal Social Security Administration decisions on disability for **SSI** with certain exceptions on denials by the Social Security Administration.

Always determine the status of any Social Security Administration activity before processing applications based on disability, regardless of the coverage group for which the person is applying. Possible statuses are:

- The person did not apply with Social Security for benefits.
- Benefits have been approved.
- An application for benefits is pending.
- An application for benefits has been denied. See 8-C, *SSA Disability Denial and Appeal Process*.

Based on Social Security Administration activity, either:

- Approve or deny Medicaid benefits.
- Request a separate disability determination. See 8-C, *When the Department Determines Disability*.

A state disability determination needs to be done by the Bureau of Disability Determination Services in the Department of Education if the applicant:

- Has not been determined disabled by the Social Security Administration.
- Has applied for social security disability benefits and a decision hasn't been made.
- Is in the process of appealing an earlier denial of social security disability benefits.
- Has been denied by the Social Security Administration for social security disability (Title II) as not disabled. NOTE: Medically Needy **cannot** rely on a Title II denial, but must do an independent determination.

To determine disability, obtain form 470-2465, *Disability Report for Adults*, or form 470-3912, *Disability Report for Children*, completed by the applicant or the applicant's representative. Also obtain one form 470-4459 or 470-4459(S), *Authorization to Disclose Information to the Department of Human Services.* For more information on these forms, see 6-Appendix.

Send all reports and authorizations to DDS along with form 470-2472, *Disability Transmittal*, which is a cover memo to help DDS in determining disability.

When a Client Has Been Denied SSI Disability Benefits

Legal reference: 42 CFR 435.541, 441 IAC 75 (Rules in Process)

Check Data Sources in WISE for an SSI denial or approval when you receive a Medicaid application based on disability. If there has been a disability denial, check the appeal coding to determine if an appeal has been denied. A denial based on disability is an indication that the applicant is not over income or over resources, and therefore does not qualify for Medically Needy.

If a person has been denied SSI benefits based on disability, check to see if the decision is final. (See 8-C, *SSA Disability Denial and Appeal Process* for an explanation of the SSA appeal process.) A Social Security decision is final when:

- The person has gone through the full Social Security appeal process, been denied at all levels, and cannot go further in the Social Security system; or
- A denial was made at any level of the Social Security appeal process and the person did not appeal to the next level within 65 days.

If the decision is not final, deny the application based on the SSI denial.

If the decision is final, determine if the person has a different condition than that considered by the Social Security Administration. Request a copy of the denial explanation from the applicant. Compare the information on the denial explanation to the information on the *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S).

If there is a different condition that is expected to last 12 months, do a disability determination. See 8-C, *When the Department Follows an SSA Disability Determination*. If there is no different disabling condition, check if 12 months have passed since the final decision.

If 12 months have passed and the person alleges a change or deterioration in the disability that is expected to last 12 months, do a disability determination. See 8-C, *When the Department Follows an SSA Disability Determination*. If the condition has not changed or deteriorated, and the person does not claim a new 12-month period of disability, deny the application based on the SSI decision.

If a decision has not been final 12 months, and the person claims the condition has worsened and claims a new 12-month disability period, ask the following questions:

- Has the Social Security Administration refused to reconsider the claim on the worsening of the condition?
- Does the person no longer qualify for SSI based on nondisability requirements, but qualifies for Medicaid based on nondisability requirements?

If the answer to either of these questions is "yes," complete a disability determination. If both answers are "no," deny the application based on the SSI decision and refer the person to the Social Security Administration.

Disability Determination on Reapplication

Legal reference: 441 IAC 75 (Rules in Process)

When a client reapplies for SSI-related Medically Needy based on disability, disability is redetermined as follows:

- If the client is currently receiving social security disability benefits, no further disability determination is required.
- If the Department determined the person's disability, no further disability determination is required unless reexamination is specified in the original disability determination.

  A new determination is not necessary if the person alleges that the condition has not changed (improved), and DDS has not established a review for the time that the person was canceled.
- When reexamination was specified in the original disability determination, send DDS:
  - A current form 470-2465, *Disability Report for Adults*, or form 470-3912, *Disability Report for Children*.
  - A current form 470-4459 or 470-4459(S), *Authorization to Disclose Information to the Iowa Department of Human Services*.
  - A current form 470-2472, *Disability Transmittal*.
  - All appeal documents (if eligibility is gained through a successful appeal of disability).
- If a person reapplies for Medicaid following rejection or cancellation based on a Department disability decision and alleges no change, deny the application on the basis of not meeting disability requirements.

Resource Policies

Legal reference: 441 IAC 75 (Rules in Process)

Count the resources of all responsible relatives and all eligible or conditionally eligible people living together. The resource limit for Medically Needy households is $10,000.

Disregard all liquid resources of all responsible relatives and all eligible or conditionally eligible people living together when determining eligibility for FMAP-related children.

FMAP-related people are resource-eligible if their resources are determined to be within the resource limits any time during the month before the eligibility is determined.

For FMAP-related households, count liquid resources such as:

- Cash.
- Checking and saving accounts.
- Stocks, bonds, and certificates of deposit.
- The available principal of Medicaid qualifying trusts.

Exempt for FMAP-related households:

- Retirement plans as defined by the Internal Revenue Service, such as:
  - IRAs.
  - Keoghs.
  - 401Ks.
  - 457 plans.
  - Deferred compensation accounts.
  - IPERS.
- Annuities.
- Bank accounts solely used for a self-employed person's business.

Do not count nonliquid resources for FMAP-related households.

Disregard the resources of all responsible relatives and eligible or conditionally eligible people living together when determining eligibility for SSI-related children.

Count resources of an SSI-related person as of the first day of the month. Treat the resources of SSI-related households according to SSI policy. (See Chapter 8-D, *Resources*.)

For all clients, count only the unobligated balance of a checking account. The unobligated balance is the balance listed in the checking account as of the date of decision for FMAP-related clients. Subtract any checks that have been written, as indicated on the registry by the client. Use the balance as of the first moment of the first day of the month for SSI-related clients.

Use the "prudent person" concept to determine whether to use the checking account register or to verify the balance with a financial institution. If the verified balance combined with other resources is close to the limit, you may verify any checks the client claims to have written. If necessary, request canceled checks or receipts showing payment made or obtain a specific release of information for the person to whom the check was written.

Follow Medicaid policies in 8-D, *Transfer of Assets* if assets were disposed of for less than the fair market value.

Examine Medically Needy eligibility when a household is ineligible for FMAP or as an SSI recipient because of available resources from a trust.

If the available resources from the trust exceed $10,000, deny. If the available resources from the trust are $10,000 or less, include them with other resources to determine resource eligibility. Also count the beneficiary's income, including income from the trust to determine the amount of the spenddown.

1. Mr. and Mrs. K and their two children apply for Medically Needy on July 10. Mr. K is disabled and asks to be considered an SSI-related person. Mrs. K is considered an FMAP-related person because the family asks for Medicaid for the children.

   Mr. and Mrs. K have a joint savings account. On July 29, the date of decision, the account balance is $1,000. As of July 1, the account had a balance of $22,000. Mr. K has a money fund account with a balance of $2,000 on July 1 and July 29.

   Mr. and Mrs. K's resources of $24,000 exceed the $10,000 resource limit for SSI-related Medically Needy. Mr. K is not eligible for Medicaid in July as an SSI-related person.

   Mr. K is considered as an FMAP-related person for July in determining Medicaid eligibility for the family, because they meet the resource limit on July 29 by applying the FMAP-related policies.

   Mr. K then has the choice of being SSI-related beginning the month of August. If he chooses to be SSI-related, he is a responsible relative on the FMAP-related case and his resources are used to determine eligibility for the FMAP-related case.

2. Mr. B receives SSD and he has a savings account of $5,000. His child has a savings account of $1,500. Mr. B wants to be considered as an SSI-related person. His resources of $5,000 are considered against the resource limit for Medically Needy for the SSI-related case.

   His child is considered as an FMAP-related person. Mr. B is a responsible relative on the FMAP-related case. The household's resources are not considered in determining eligibility for the child on the FMAP-related case.

If a resource is jointly owned by FMAP-related clients and SSI-related clients, use the policies of the program for which each client is eligible. That is, treat SSI-related clients on the SSI-related case according to SSI resource policies. Treat the FMAP-related clients and responsible relatives on the FMAP-related case according to FMAP policies.

The B family has two cases:

- The SSI-related household consists of Mr. B (the eligible spouse) and Mrs. B (the ineligible spouse).
- The FMAP-related household consists of Mr. B (the responsible relative), Mrs. B (the specified relative), and Bobbie and Barbie (FMAP-related children).

The B family's resources are as follows:

Mr. B:	Car equipped for his disability
	$1,400 life insurance with cash value of $200
Mrs. B:	Car with $4,600 equity value
Bobbie:	$10 savings account
Barbie:	$15 savings account

Countable resources are computed as follows:

SSI-related household:

The car equipped for Mr. B's handicap is excluded.
Mr. B's life insurance is exempt, as its face value is less than $1,500.
The equity value of Mrs. B's car is countable.
Countable resources are $4,600.

FMAP-related household (to determine eligibility for Mrs. B):

Mr. B's car is exempt.
Mrs. B's car is exempt.
Mr. B's life insurance policy is exempt.

$	10	Bobbie's savings
+	15	Barbie's savings
$	25	Total resources for FMAP-related HH members

The B family's SSI-related household and FMAP-related household are both resource-eligible for Medically Needy.

Income Policies

Legal reference: 441 IAC 75 (Rules in Process)

Treatment of income in a Medically Needy case varies depending on whether the person is:

- FMAP-related
- SSI-related
- In a medical institution

After calculating the eligible group's countable income, compare it to the Medically Needy income level (MNIL). The MNIL is calculated according to the federal formula, based on 133% of the FMAP schedule of basic needs as of July 16, 1996. The MNIL is based on family size, as follows:

Number of people	1	2	3	4	5	6	7	8	9	10	Each additional
MNIL	$483	$483	$566	$666	$733	$816	$891	$975	$1058	$1158	add $116

People whose net countable income is **equal to or below the MNIL** are eligible for Medically Needy without meeting a spenddown. People with a zero spenddown are approved for ongoing eligibility.

People whose net countable income is **above the MNIL** have a spenddown to meet and are conditionally eligible for Medically Needy. The spenddown amount is the difference between the net countable income and the MNIL.

"Spenddown" is the process by which a Medically Needy person's excess income is obligated for allowable medical expenses to reduce countable income to the applicable MNIL. When allowable medical expenses reduce income to the applicable MNIL, the conditionally eligible person is then eligible for Medicaid for the certification period. See Applying Medical Expenses to Spenddown.

When you have determined eligibility and spenddown status, send form 470-2330, *Notice of Decision for Medically Needy*, to the client.

- If the client has ongoing eligibility, the notice must contain:
  - The client's name and address.
  - The name of the eligible persons.
  - Manual and rule references.
  - The effective date.
- When the client has a spenddown, the notice must contain:
  - The client's name and address.
  - The names of the conditionally eligible persons.
  - The names of any responsible relatives.
  - The beginning and ending dates of the certification period.
  - The amount of the spenddown.
  - Manual and rule references.
  - The last date that claims can be submitted to meet spenddown for this certification period.
- Send a copy of the applicable *Medically Needy Spenddown Computation Worksheet* with the notice. (See the following sections for the forms applicable to each coverage group.)

The following sections describe:

- Income and spenddown calculation for FMAP-related cases
- Income and spenddown calculation for SSI-related cases
- Income and spenddown calculation for the retroactive period for all types of cases
- Treatment of income when a person is in a medical institution, for all types of cases

FMAP-Related Cases

Legal reference: 441 IAC 75 (Rules in Process)

Follow FMAP income policies for FMAP-related eligibles (but **do not** apply the income limit and the 58% work incentive deduction).

For FMAP-related cases, count all unearned and earned income of all responsible relatives, eligible persons, and conditionally eligible persons living together to determine eligibility, unless the income is specifically exempted, disregarded, deducted for work expenses or diverted.

To determine countable income of the Medically Needy eligible group, do not consider:

- The income of any person receiving FMAP or SSI.
- The income of any person who is voluntarily excluded unless the voluntarily excluded person is the parent.
- The income of a responsible relative that has been diverted to an FMAP household.

Complete the income computations on form 470-3088, *FMAP-Related Medically Needy Spenddown Computation Worksheet*.

Prospectively calculate the income of all responsible relatives and conditionally eligible persons. Use the projected income unless actual income is available. Use the following guides in determining what income to use:

- Base initial and ongoing FMAP-related Medically Needy eligibility on projected income. If the projected future income is not valid for the month of application, month of decision, or any months in between, use actual income received in the month to determine eligibility for that month.
- For applications, recertifications, or reviews, project income using all nonexempt income. See Projecting Income for more information on FMAP-related policies.
- Accept the statement of the client as to whether the 30-day period is representative of future income. If the client states that the 30-day period is not a good indicator of future income, use either a longer period of time that is a good indicator of future income or verification of future income from the income source.
- The decision on whether to use a longer period of time or to request verification of future income from the income source should primarily be the client's. However, when the client is unsure of which would be the best indicator of future income, request verification from the income source. Also, if the client does not have pay stubs from either the 30-day period or from a longer time period, request verification from the income source.
- When a third or fifth check occurs during the period being used to project income, do not ignore it. Instead, add all check amounts together, divide the total by the number of checks, and multiply that result by four, if the income occurs weekly, or by two, if the income occurs biweekly. See Projecting Income.
- For people who are self-employed, determine income from the previous year's income tax return. If the enterprise has been in business for less than a year, average income over the period of time the enterprise has been in existence.

  Project the monthly amount for the same period of time. See additional information on determining self-employment income in FMAP-Related Self-Employment Income.

The following sections describe:

- General instructions for calculating an FMAP-related spenddown.
- More specific instructions on income and spenddown for:
  - Households with a stepparent
  - Households with a newborn child
  - Households with an alien member
  - Households with lump-sum income
  - Household members who are sanctioned for failure to cooperate

FMAP-Related Spenddown Calculation

Legal reference: 441 IAC 75 (Rules in Process)

To calculate spenddown on an FMAP-related case:

1. Apply all allowable deductions to each month's income.
2. Add each month's net income together for the two-month certification period. (The certification period is usually the month of application and the following month. Establish a certification period of only one month when a client is eligible for benefits in another coverage group in the second month or the client is ineligible for Medicaid in one month.)
3. Determine the household size by including all responsible relatives and conditionally eligible persons for whom income is considered. Include all unborn children for FMAP-related households if pregnancy has been verified in writing.
4. Determine the MNIL for the certification period by adding each month's MNIL to arrive at a total.
5. Compare the total net countable income for the certification period to the total MNIL for the certification period for the family size.
6. Assign a two-month certification period if net countable income **exceeds** the MNIL in the two prospective months. The client is not eligible for Medicaid payment until the incurred medical expenses equal or exceed the difference between the net income and the MNIL.

   The spenddown amount is the difference between the net countable income and the MNIL. People with a spenddown are "conditionally eligible recipients." They are not eligible for Medicaid until they have incurred or paid medical expenses that equal the spenddown amount.

Household composition:	Mr. and Mrs. B and Baby B (FMAP-related group)	
Certification period:	January and February	
Net countable income:	$600 + $666 =	$ 1,266
MNIL	$566 + $566 =	– 1,132
Spenddown		$ 134

Because income exceeds the MNIL, the B family must incur $134 in medical expenses before they are eligible for Medicaid in January or February for the family. NOTE: Baby B is MAC-eligible and is a considered person for Medically Needy.

7. If the household's income **is equal to or less than** the MNIL in the two prospective months, the client has a zero spenddown. An FMAP-related client with a zero spenddown is approved for ongoing eligibility.

   Review the case at least once every 12 months. The client completes form 470-5482 or 470-5482(S), *Medicaid/State Supp Review*, as the review form. NOTE**:** If the *Medicaid/State Supp Review* is returned late, see 8-G, *Grace Period*.

   If the FMAP-related person's net countable income exceeds the MNIL in any month, redetermine spenddown. Assign a two-month certification period effective the month income exceeds the MNIL or the first month after timely notice has been given.

Ms. B applies for Medically Needy on October 15. She has two children eligible for MAC. Ms. B receives $300 child support for each child.

$	550.00	October ($600 - $50 exemption)
+	550.00	November ($600 - $50 exemption)
$	1,100.00	
–	1,132.00	MNIL ($566 × 2)
$	0.00	Spenddown

Her application is approved on November 1, effective October 1. Since Ms. B has zero spenddown, she has ongoing eligibility for FMAP-related Medically Needy.

On February 1, Ms. B reports that she began working on January 29 and will receive her first paycheck February 9. On February 12, Ms. B verifies that her income will be $280 per week and that she will receive three checks in February and five checks in March.

$	550.00	February ($600 - $50 exemption)
+	840.00	$280.00 × 3 checks
–	168.00	20% earned income deduction
$	1,222.00	Net countable income

$1,222 exceeds the MNIL of $566. On February 16 the worker sends a *Notice of Decision* assigning Ms. B a two-month certification period for March and April. (**Note:** To determine the March earned income and the April earned income, the worker projects four paychecks of $280 each, based on the verification from the employer.)

8. Determine eligibility for the retroactive period if the individual meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. See Income and Spenddown in the Retroactive Period.

Households With a Stepparent

Legal reference: 441 IAC 75 (Rules in Process) and 75.14(249A)

In a stepparent household in which there are no common children and the stepparent has no children, do not include the stepparent when determining the Medically Needy household size, unless the stepparent is incapacitated or needed to care for the children in the home.

Use the FMAP standard of need to calculate how much to divert to the stepparent's needs. If income remains after diverting the FMAP standard of need to the stepparent, use the remaining income to calculate spenddown.

Include the stepparent as a financially responsible relative to allow the stepparent's medical bills to meet spenddown if any of the stepparent's income has been used to determine the spenddown amount.

The household consists of Mr. and Mrs. S and her two children from a previous marriage. Spenddown is computed as follows:

$ 3,000.00	Mr. S's gross earned income
- 600.00	20% earned income deduction
$ 2,400.00	
- 365.00	Diversion to meet needs of Mr. S, based on the FMAP standard of need
$ 2,035.00	
	Deduction for child support for a dependent outside the household
- 100.00	Amount considered towards spenddown
$ 1,935.00	

The $1,935 is compared to the MNIL for a three-member household. Mr. S is not included in the household size in determining the MNIL. However, he is coded as a responsible relative on the system, because he has income that is countable for the Medically Needy household.

Consider the children for ***Hawki***.

When the family chooses to voluntarily exclude the stepparent's income, the natural or adoptive parent is excluded from the eligible group. The income of the stepparent is not counted, and bills of the stepparent cannot be used to meet spenddown. Income of the natural or adoptive parent must be counted for the eligibility determination, and bills of the parent can be used to meet spenddown.

When there is a common child, or the stepparent has a child, the stepparent can be included in the Medically Needy household.

The household consists of Mrs. T and Mr. T, their common child, and Mrs. T's child. Mr. T, the stepparent, has gross income of $1600. Mrs. T does not have income. The family is ineligible for FMAP.

The children are determined to be eligible for MAC.

Mr. and Mrs. T also want medical assistance.

$ 1,600.00	Mr. T's gross income
- 320.00	20% earned income deduction
$ 1,280.00	Net countable income
$ 2,560.00	Countable income ($1280 × 2 months)
- 1,332.00	MNIL for a four -person household ($666 × 2 months)
$ 1,228.00	Spenddown

Households With a Newborn

When there is a newborn common child in a stepparent household, divert from the stepparent's income to meet the newborn's needs. The amount to divert is the difference between the standard of need with the ineligible newborn child included and the ineligible newborn excluded.

The household consists of Mr. and Mrs. K, Mrs. K's child, A, and their child, C. C is a newborn child of a Medicaid-eligible mother and continues to have a newborn status. Mr. K's gross earned monthly income is $2000. Mrs. K's gross earned monthly income is $1550. Their income is considered as follows for determining the spenddown:

$ 2,000.00	Mr. K's gross earned income
- 400.00	20% earned income deduction
$ 1,600.00	
- 354.00	Diverted to meet the needs of the newborn (difference between a two-person and a one-person standard of need: $719 - 365 = $354)
$ 1,246.00	Diverted to meet the needs of the stepparent (standard of need for one person).
- 365.00	
$ 881.00	Income considered towards the FMAP-related Medically Needy group
$ 1,550.00	Mrs. K's gross earned income
- 310.00	20% earned income deduction
$ 1,240.00	
+ 881.00	Income from Mr. K
$ 2,121.00	Net countable income
$ 4,242.00	Countable income ($2121 × 2 months)
- 1,132.00	MNIL ($566 × 2 months)
$ 3,110.00	Spenddown

If the newborn common child is not in a stepparent household, do not divert to meet the newborn's needs.

The household consists of Mrs. P and her two children (A and B), Mr. T, common child C, and newborn common child D. D is a newborn child of a Medicaid-eligible mother and continues to have newborn status.

The Medically Needy FMAP-related household consists of all household members except the newborn, child D. Mrs. P and Mr. T cannot divert any income to child D, as they are both part of the eligible group.

Households With an Alien Member

Legal reference: 441 IAC 75 (Rules in Process) and 75.14(249A)

Include in the Medically Needy eligible group an alien who is eligible for Medicaid. See 8-L, *Aliens*.

If the ineligible alien is an adult and meets all other eligibility criteria:

- Include the ineligible alien in the household size as a "considered" person.
- Count the income and resources of the ineligible alien.
- Use bills of the ineligible alien "considered" person to meet the spenddown for the eligible group.

If the ineligible alien is a child:

- Do not include the child in the eligible group.
- Exclude the income of the child.
- Do not use bills of the child to meet spenddown for the eligible group.

An ineligible alien may be eligible for Medicaid if an emergency medical condition exists. When the three days of emergency medical services occur during one month, the Medically Needy certification period is one month. When the three days of emergency medical services spans two months, the Medically Needy certification period is two months. See 8-L, *Limited Eligibility for Certain Aliens*.

Households With Lump-Sum Income

Legal reference 441 IAC 75 (Rules in Process)

Receipt of a lump sum does not make a person ineligible for the Medically Needy coverage group. Treat the receipt of a lump-sum payment according to FMAP policies.

Add lump-sum income and any prospective countable income for FMAP-related Medically Needy together. Prorate the total by the FMAP schedule of living costs based on household size.

If the client received the lump sum in a retroactive month and wants retroactive benefits, prorate the lump sum plus any other countable income received in that month and use it beginning in the month of receipt.

Remember:

- Use the prorated lump sum to determine countable income for the certification period.
- A break in assistance does not affect the prorated amount or the period of time the lump sum is counted as income for FMAP. If the client later applies for FMAP, remember to consider the period of ineligibility because of the lump sum. For Medically Needy, continue to use the prorated amount for all months as originally determined.

Use FMAP policies, Conditions for Shortening the Period of Proration, to shorten the period of time the lump sum is counted as income.

Household composition: Mr. and Mrs. E and their three children (FMAP-related)

Certification period: January and February
Lump sum inheritance: $10,500 received January 5

Mr. E has net countable earned income of $650 for January and $800 for February. Mrs. E has unearned income of $500 for January and $700 for February.

Total lump sum and January income: $11,650

Proration of lump sum and January income:
$11,650 ÷ 1,092 = 10.66 months to consider the lump-sum income

			January and February		
Prorated lump sum	$1,092		$1,092		
Mr. E's income			+ 800		
Mrs. E's income			+ 700		
Total for certification period	$1,092	+	$2,592	=	$3,684

NOTE: The children are eligible for MAC in the month of January. The children are responsible relatives on the Medically Needy case for the month of January. The parents have been on Medically Needy before and there has not been a break in assistance.

Noncooperation

When the parent or specified relative who is conditionally eligible does not cooperate (e.g., with support recovery, Quality Control, or the Third-Party Liability Unit), that person is ineligible for Medicaid. However, the person remains a member of the household as a "considered" responsible relative for the purpose of establishing household size.

Use the ineligible person's income and allow the work expense deduction to determine the amount of spenddown.

Use the unpaid medical expenses of the parent or specified relative who has failed to cooperate to meet the spenddown.

SSI-Related Cases

Legal reference: 441 IAC 75 (Rules in Process)

When determining eligibility, consider the income of all responsible relatives and all conditionally eligible persons living together. Do not consider the income of:

- A responsible relative that has been diverted to a FIP household.
- A responsible relative that has been deemed to a person receiving SSI.
- Any person receiving FMAP or SSI. (NOTE: A 1619b person is not considered an SSI recipient for Medically Needy.)

Follow SSI policy to determine the amount of income to be deemed from the ineligible spouse, parent, spouse of a parent, or ineligible child.

Mr. and Mrs. Z are both disabled. Mr. Z receives Medicaid as a 1619b person. He works and receives social security disability. Mrs. Z has no income. Mrs. Z applies for Medicaid. The household size is two. The worker calculates the spenddown based on the couple's combined income, using SSI policies.

Complete the earned income computations on either:

- Form 470-2341, *SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet*, or
- Form 470-2626, *SSI-Related (Children in Household) Medically Needy Spenddown Computation Worksheet.*

Prospectively calculate the income of all responsible relatives and conditionally eligible persons. Use the best estimate, unless actual income is available. Follow SSI policy to determine the amount of income to consider. Use the following guides in determining what income to use:

- For applications or reviews, project income using all nonexempt income. See 8-E, *Projecting Future Income*, for more information on SSI-related policies.
- Convert weekly income to monthly income by multiplying by 4.3 and convert biweekly income to monthly income by multiplying by 2.15.
- If income fluctuates, use an average over a longer period of time if that would more accurately reflect the household's income. However, consider past circumstances only to the extent that they reasonably reflect what can be expected to occur in the future. Base projections of future circumstances on the best information available at the time of decision.
- When an income change has occurred or is anticipated, obtain a statement from the employer regarding future income.
- For persons who are self-employed, determine income from the previous year's income tax return. If the enterprise has been in business for less than a year, average income over the period of time the enterprise has been in existence. Project the monthly amount for the same period of time. See additional information on determining self-employment income in 8-E.

If an SSI-related person receives a lump sum payment, treat it as described in 8-E, *Lump-Sum Income*. If the lump-sum is received on a one-time basis and is over $10 and is earned income, or is over $20 and is unearned income, consider it as income in the month of receipt.

The following sections describe:

- General instructions for calculating an SSI-related spenddown
- More specific instructions on income and spenddown for households with an ineligible spouse and children

SSI-Related Spenddown Calculation

Legal reference: 441 IAC 75 (Rules in Process)

To calculate spenddown on an SSI-related case:

1. Apply all allowable deductions to each month's income.

   Mr. E, 65, SSI-related, receives each month $800 in social security benefits, $125 in Veterans aid and attendance, and $100 IPERS. (Veteran's aid and attendance is not countable income for Medicaid eligibility determination.)

$	800.00	Social security
+	100.00	IPERS
$	900.00	Gross income
-	20.00	Disregard (SSI-related)
$	880.00	Net income (used to determine the spenddown for a one-member household)

2. Add each month's net income together for the two-month certification period. (The certification period is usually the month of application and the following month. Establish a certification period of only one month when a client is eligible for benefits in another coverage group in the second month or the client is ineligible for Medicaid in one month.)
3. Determine the household size by including all responsible relatives and conditionally eligible persons for whom income is considered.
4. Determine the MNIL for the certification period by adding each month's MNIL to arrive at a total.
5. Compare the total net countable income for the certification period to the total MNIL for the certification period for the family size.
6. Assign a two-month certification period, if net countable income **exceeds** the MNIL in the two prospective months. The client is not eligible for Medicaid payment unless the incurred medical expenses equal or exceed the difference between the net income and the MNIL.

   The spenddown amount is the difference between the net countable income and the MNIL. Persons who have a spenddown are "conditionally eligible clients." They are not eligible for Medicaid until they have incurred or paid medical expenses that equal the spenddown amount.

Household composition:	Mrs. B (SSI-related)			
Certification period:	January and February			
Net countable income:	$800	+ $866	=	$ 1,666
MNIL:	$483	+ $483	=	- 966
Spenddown:				$ 700

   Because income exceeds the MNIL, Mrs. B must incur $700 in medical expenses before she is eligible for Medicaid in January or February.

7. If the household's net countable income is **equal to or less than** the MNIL in the two prospective months, the member has zero spenddown. An SSI-related member with a zero spenddown is approved for ongoing eligibility.

   Review the case at least once every 12 months. The member completes form 470-5482 or 470-5482(S), *Medicaid/State Supp Review*, as the review form. NOTE: If the *Medicaid/State Supp Review* is returned late, see 8-G, *Grace Period*.

   If the SSI-related member's net countable income exceeds the MNIL plus insurance deductions in any month, redetermine spenddown. Assign a two-month certification period effective the month income exceeds the MNIL or the first month after timely notice has been given.

8. Determine eligibility for the retroactive period if the individual meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. See Income and Spenddown in the Retroactive Period.

1. Ms. A, age 45, applies for Medically Needy on August 8. Her monthly gross social security disability check is $800. Ms. A does not have Medicare.

$	800.00	August social security
+	800.00	September social security
$	1,600.00	
-	40.00	General income exclusion ($20 × 2)
$	1,560.00	
-	966.00	MNIL ($483 × 2)
$	594.00	Spenddown
-	600.00	Health insurance premium ($300 × 2)
$	0.00	Spenddown after insurance

On August 15, her application is approved effective August 1. Since Ms. A has a zero spenddown, Ms. A has ongoing eligibility for SSI-related Medically Needy.

On January 5, Ms. A reports to her worker that her social security disability increased to $846 and that she no longer has health insurance. The worker determines that the January social security disability increase ($846 - $20 general disregard = $826) exceeds the MNIL of $483. Ms. A is assigned a two-month certification period for February and March.

Ms. A continues to complete the *Medicaid/State Supp Review* every two months to reapply.

2. Mr. B, age 75, applies for Medically Needy on August 2. His monthly gross social security income is $775. Mr. B is also QMB-eligible. Medicaid pays his Medicare Part B premium.

$	755.00	August social security ($775 - $20 general exclusion)
+	755.00	Sep. social security ($775 - $20 general exclusion)
$	1,510.00	
-	966.00	MNIL ($483 × 2 months)
$	544.00	Spenddown
-	80.00	Dental insurance (40 × 2 months)
-	500.00	Nursing home insurance ($250 × 2 months)
	0.00	Remaining spenddown

Mr. B has a zero spenddown and, therefore, has ongoing eligibility.

Data Sources in WISE at the end of November indicates that Mr. B's social security increases to $787 effective January 1. Mr. B also reports that he will start receiving an annuity payment of $100 per month beginning January 5. The worker determines that Mr. B's income will exceed the MNIL for a one-person household in January.

$	787.00	January social security
+	100.00	Annuity income
-	20.00	General income exclusion
$	867.00	
-	483.00	MNIL
$	384.00	Spenddown
-	40.00	Dental insurance
-	250.00	Nursing home insurance
	94.00	Spenddown after deducting insurance

Mr. B is redetermined to be eligible for Medically Needy with a spenddown. The worker calculates the spenddown for the two-month certification period of January and February. The worker issues a timely notice of decision in December to Mr. B explaining that he is now certified for a two-month certification period, that his spenddown is $188, and that he will need to reapply for the month of March. (Mr. B continues to be QMB-eligible.)

3. Mrs. C, age 70, applies for Medically Needy August 18. Mrs. C receives $800 gross social security and is also QMB-eligible. Medicaid pays her Medicare Part B premium. Mrs. C also pays $300 monthly for a Medicare supplemental insurance policy.

$	780.00	Aug. social security ($800 - 20 general income excl.)
+	780.00	Sep. social security ($800 - $20 general income excl.)
$	1,560.00	
-	966.00	MNIL ($483 × 2 months)
$	594.00	Spenddown
-	600.00	Health insurance premium ($300 × 2 months)
$	0.00	Spenddown after health insurance premium

Mrs. C has ongoing eligibility for Medically Needy.

On October 1, Mrs. C reports that she no longer has a Medicare supplement. The worker redetermines Mrs. C's Medicaid eligibility.

$	800.00	October social security
-	20.00	General income exclusion
$	780.00	
-	483.00	MNIL
$	297.00	Spenddown

Mrs. C no longer has ongoing eligibility. The worker calculates the spenddown for November and December. The worker notifies Mrs. C with a timely notice in October that she has been redetermined to be eligible for Medically Needy with a spenddown of $594 for the certification period of November and December. (Mrs. C continues to be eligible for QMB.)

4. Child A is under age 18 and disabled. His mother receives $999 social security disability per month. His father earns $1,071 per month. Child A's social security income is $500.

   Child A and Mrs. A will be on separate SSI-related Medically Needy cases.

   First, determine the amount of spenddown for Mrs. A. Follow instructions in 8-E for deeming from an ineligible spouse. Child A is treated as an ineligible child in this determination. Child A's income exceeds $472, so no income of the father can be allocated to child A. ($472 is the maximum amount to deem to an ineligible child.)

$ 999.00	Mrs. A's SSD income
- 20.00	General income exclusion
$ 979.00	Countable unearned income
$ 1,071.00	Mr. A's earned income
- 65.00	Work exclusion
$ 1,006.00	
- 503.00	½ the remainder
$ 503.00	Countable earned income
$ 979.00	Countable unearned income
+ 503.00	Countable earned income
$ 1,482.00	Total countable income
$ 2,964.00	$1,482.00 × 2 months
- 966.00	$483 × 2 months (MNIL for 2)
$ 1,998.00	Spenddown

   Second, determine eligibility for child A. Follow instructions in 8-E for deeming from an ineligible parent to an eligible child. In this situation, Mrs. A is treated as an ineligible parent, as she is not receiving SSI. Use both parents' income to determine the amount of spenddown for child A.

$ 999.00	Mrs. A's SSD income
- 20.00	General income exclusion
$ 979.00	Countable unearned income
$ 1,071.00	Mr. A's (father's) earned income
- 65.00	Work exclusion
$ 1,006.00	
- 503.00	½ the remainder
$ 503.00	Countable earned income
$ 979.00	Countable unearned income
+ 503.00	Countable earned income
$ 1,482.00	Total countable income
- 1,415.00	Parental exclusion
$ 67.00	Deemed to child A
$ 500.00	Child A's income
- 20.00	General income exclusion
$ 480.00	Child A's countable income
+ 67.00	Income deemed from parents
$ 547.00	Total countable income
$ 1,094.00	$547.00 × 2 months
- 966.00	$483 × 2 months (MNIL for 1)
$ 128.00	Spenddown

Households With Ineligible Spouse or Children

Legal reference: 441 IAC 75 (Rules in Process)

If the household includes the SSI-related person's spouse who is not aged, blind, or disabled, determine whether the ineligible spouse is a responsible relative.

If the case does not include children, deem income from the ineligible spouse to the SSI-related person. Do the deeming on form 470-2341, *SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet*. If the ineligible spouse does not have income to deem, the ineligible spouse is not a responsible relative for Medically Needy. Use the MNIL for a one-member household.

If the income of the ineligible spouse is deemed to the eligible spouse, use the MNIL for a two-member household. The ineligible spouse is a responsible relative on the Medically Needy case. Use the ineligible spouse's medical bills to meet spenddown.

If the household includes children, use form 470-2626, *SSI-Related (Children in Household) Medically Needy Spenddown Computation Worksheet*. First, deem income from the ineligible spouse's income to meet the needs of each child. Calculate the needs of each child at $457 minus any income of the child. Then determine if there is income from the ineligible spouse to deem to the eligible spouse.

If there is income to deem, use the MNIL for a two-member household. The ineligible spouse is a responsible relative on the Medically Needy case. The ineligible spouse's medical bills can be used to meet the spenddown.

If the ineligible spouse does not have income to deem to the eligible spouse, the ineligible spouse is not a responsible relative for Medically Needy. Use the MNIL for a one-member household.

Examine the case to determine if the ineligible spouse and children are eligible as an FMAP-related case. If the SSI-related person is a responsible relative on the FMAP-related case, apply FMAP policy to the person's income and resources to determine eligibility for the FMAP-related household members. See SSI-Related, FMAP-Related Composite Households.

1. Household composition:

   Mr. C, 70, has monthly unearned income of $1,006
   Mrs. C, 60, not blind or disabled; has monthly earned income of $816

   Mr. C's income exceeds SSI standards and he is requesting Medicaid eligibility through the Medically Needy program. The Medically Needy spenddown calculation is as follows:

   Step 1: Determine if Mrs. C will be a responsible relative (if she would have income deemed to Mr. C). Mrs. C's gross income of $816 exceeds $472. Proceed with the deeming process.

   Step 2: Determine how much of Mrs. C's income to deem to Mr. C.

$	816.00	Mrs. C's earned income (ineligible spouse)
-	65.00	Work exclusion
$	751.00	
-	375.50	1/2 remainder
$	375.50	Countable earned income available to Mr. C

   Step 3: Determine Mr. C's spenddown.

$	1,006.00	Mr. C's unearned income
-	20.00	General income exclusion
$	986.00	Mr. C's countable income
+	375.50	Mrs. C's income deemed to Mr. C
$	1,361.50	Total monthly countable income
$	2,723.00	$1,361.50 (monthly income) × 2 months
-	966.00	MNIL for 2 (483 × 2 months)
$	1,757.00	Spenddown

   Therefore, Mr. C is considered a conditionally eligible person and Mrs. C is considered as a responsible relative as she deemed income to Mr. C.

2. Mr. M has applied for Medicaid. He receives $990 social security disability benefits. Mrs. M receives unemployment insurance benefits (UIB) of $600. They have two children, Y and Z. Each child receives $185 social security benefits.

$	990.00	Unearned income of Mr. M
-	20.00	General income exclusion
$	970.00	Countable unearned income
$	943.00	SSI benefit for one person
-	970.00	Mr. M's countable income
$	0.00	

   Mr. M's income does create ineligibility for SSI. Proceed to the deeming process for SSI-related Medically Needy:

$	600.00	Mrs. M's unearned income
-	287.00	Allocation for ineligible child Y ($472 - 185 = $287)
-	287.00	Allocation for ineligible child Z ($472 - 185 = $287)
$	26.00	Mrs. M's countable unearned income

   $26 does not exceed $472. As the income is less than $472, there is no income available to deem to Mr. M.

   Mr. M's countable income of $970 is compared to the MNIL for a household size of one to determine the spenddown amount. Mrs. M is not a responsible relative on Mr. M's case.

SSI-Related, FMAP-Related Composite Households

Legal reference: 441 IAC 75 (Rules in Process)

An SSI-related client is a responsible relative or considered person on the FMAP case if the client is a:

- Parent of a child on the FMAP-related case.
- Sibling of a child on the FMAP-related case.
- Child of a parent on the FMAP-related case.

This is a composite case. Treat the person's income and resources according to SSI policy on the SSI-related case. Treat the person's income and resources according to FMAP policy on the FMAP-related case.

Use the same medical bills to meet spenddown on both cases when a person is conditionally eligible on one case and a responsible relative on the other case. Use only the portion of the medical bill that will not be paid by Medicaid to meet spenddown.

1. Household composition:

   Mr. B, 60, receives $950 per month in social security disability benefits
   Mrs. B, 55, receives $1,340 gross earned income each month
   Their children: Bobbie, 10, receives $240 social security.
   Barbie, 9, receives $240 social security.

   The B family requests Medicaid for all members. Mr. B chooses to be SSI-related, due to his verified disability. Mrs. B is an FMAP-related specified relative. Bobbie and Barbie are FMAP-related children. There are no child care costs.

   This household has two cases:

   - The SSI-related household consists of Mr. B (the eligible spouse) and Mrs. B (the ineligible spouse).
   - The FMAP-related household consists of Mr. B (the responsible relative), Mrs. B (the specified relative), and Bobbie and Barbie (FMAP-related children).

   The **SSI-related income calculation** for the B family is as follows:

   To determine if Mrs. B will be a responsible relative for Mr. B's SSI-related case, determine if she would have income deemed to Mr. B following SSI policy.

$	1,340.00	Mrs. B's gross earnings
-	232.00	Allocation for Bobbie's unmet needs ($472 - 240)
-	232.00	Allocation for Barbie's unmet needs ($472 - 240)
$	876.00	

   $876 exceeds the difference of the SSI benefit rate for an eligible couple and the SSI benefit rate for an individual ($472). Proceed to deeming calculation step. (If Mrs. B's income at this point were less than $472, deeming would not be applicable.)

$	876.00	Mrs. B's remaining earned income
-	65.00	Work exclusion
$	811.00	
-	405.50	1/2 the remainder
$	405.50	Amount of Mrs. B's income deemed to Mr. B

$	950.00	Mr. B's unearned income
-	20.00	General income exclusion
$	930.00	Mr. B's countable unearned income
+	405.50	Mrs. B's income deemed to Mr. B
$	1,335.50	

$	2,671.00	Income for the certification period ($1,335.50 × 2 months)
-	966.00	MNIL for the certification period ($483 × 2 months)
$	1,705.00	Spenddown

   The MNIL is for a two-person household. Mrs. B is a responsible relative on the SSI-related case, as she deemed income to Mr. B.

The **FMAP-related income calculation** for the household is:

Unearned income:

$ 950.00	Mr. B's social security disability
+ 240.00	Bobbie's social security
+ 240.00	Barbie's social security
$ 1,430.00	

Earned income:

$ 1,340.00	Mrs. B's gross earnings
- 268.00	20% earned income deduction
$ 1,072.00	Countable earned income

Total income:

$ 1,430.00	Total unearned income
+ 1,072.00	Countable earned income
$ 2,502.00	Total countable income

$ 5,004.00	Income for the certification period ($2,502 × 2 months)
- 1,332.00	MNIL for the certification period ($666 × 2 months)
$ 3,672.00	Spenddown

MNIL is for a four-person household. Mr. B is a responsible relative on the FMAP-related case. Spenddowns for the family in Example 1 are:

$1,705 for the SSI-related Medically Needy case.
$3,672 for the FMAP-related Medically Needy case.

NOTE: Bobbie and Barbie are eligible for MAC and are considered people on the FMAP-related case.

2. Mr. B from Example 1 has ongoing medical expenses of $2,500 per month.

   The worker advises the Bs to have two cases: SSI-related and FMAP-related. With an SSI-related case, Mr. B will have $795 of his medical expenses paid after he meets the spenddown. The FMAP-related case will not meet spenddown. Therefore, Mr. B would not want to be a conditionally eligible person on the FMAP-related case. (NOTE: Mr. B is a responsible relative on the FMAP-related Medically Needy case.)

3. Bobbie from Example 1 has a hospital bill of $16,800 that occurred before the certification period and remains unpaid. This bill has not been used before to meet spenddown. Mr. B has ongoing medical expenses of $1,250 per month.

   The worker advises Mr. B to be a conditionally eligible person on the FMAP-related case for five certification periods. They would not be able to use Bobbie's old medical bill to meet spenddown on the SSI-related case.

   As a conditionally eligible person on the FMAP-related Medically Needy case, Mr. B could have Medicaid pay all of the medical expenses that he incurs during the first five certification periods.

   During the sixth certification period, Mr. B would need to have an SSI-related case, as he would have more medical expenses paid.

4. Mrs. B from Example 1 requires minor surgery during the certification period. For this certification period, Mr. B has only $250 in medical expenses per month.

   Since Mr. B does not have enough medical expenses to meet spenddown on an SSI-related Medically Needy case, the worker advises Mr. B to be conditionally eligible on the FMAP-related case. More medical bills would be paid for the family.

   Because there are no unusual expenses expected for the B family in the next certification period, the worker advises the Bs to have both an SSI-related and an FMAP-related case.

5. Household composition:
   Mr. G, 65, receives $1,000 monthly social security
   Mrs. G, 56, receives $250 monthly social security
   George, 15, is in school and receives $250 social security

   The categorical relationship of each person is:
   Mr. G: SSI-related (aged)
   Mrs. G: FMAP-related specified relative
   George: FMAP-related child

   The certification period is for May and June.

   The household chooses to receive Medically Needy benefits for the SSI-related member and the FMAP-related group. This household has two cases.

   SSI-related Medically Needy household:

   To calculate spenddown for Mr. G, first determine if Mrs. G will be considered a responsible relative and if any of Mrs. G's income will be deemed to Mr. G.

   George's income: $ 250.00

Mrs. G's income:	$	250.00	Social security
	-	222.00	George: Allocation for ineligible child ($472 - 250)
	$	28.00	

   $28 is less than $472. Therefore, Mrs. G's income is not deemed to Mr. G, and she is not a responsible relative.

$ 1,000.00	Mr. G's social security income
- 20.00	General income exclusion
$ 980.00	
× 2	Months
$ 1,960.00	
- 966.00	MNIL for a one-person household ($483 × 2 months)
$ 994.00	Spenddown

   Mr. G is conditionally eligible for SSI-related Medically Needy. Medical expenses for Mrs. G and George are not usable in meeting the spenddown for Mr. G's Medicaid eligibility. Mrs. G and George are not coded on the ABC system as responsible relatives for the SSI-related case.

FMAP-related Medically Needy household:

The FMAP-related Medically Needy household is Mr. G, Mrs. G, and George. The household has the option of excluding George. The Gs do not exclude George.

The spenddown for the three-member FMAP-related household is calculated as follows:

Mr. G	$ 1,000.00	Responsible relative (parent)
Mrs. G	+ 250.00	FMAP specified relative
George	+ 250.00	FMAP-related child
	$ 1,500.00	Monthly net income to be considered for spenddown

$ 3,000	Income for two months ($1,500 × 2)
- 1,132	MNIL for a three-person household ($566 × 2 months)
$ 1,868	Spenddown

Mr. G has a choice of receiving Medicaid as SSI-related or FMAP-related. In this situation, it is to Mr. G's advantage to be SSI-related. Mr. G is conditionally Medicaid-eligible on the SSI-related case.

Because Mr. G is not receiving SSI, his income must be used to determine eligibility for his child and spouse on the FMAP-related case. Therefore, he is a responsible relative on the FMAP-related case. Mrs. G is conditionally Medicaid-eligible on the FMAP-related case. George is a considered person on the Medically Needy case, as he is MAC eligible.

Mr. G has a medical bill of $250 that occurred in January. (**Note:** The family was not certified for Medically Needy in January.) This bill remains unpaid as of May 1. This bill is applied to the spenddown for Mr. G and is also applied to the spenddown of the FMAP-related case.

Mr. G also has a $1,000 medical bill that occurred in May. $744 of this bill will be applied to meet his spenddown. The remaining amount of the medical bill is Medicaid-payable. Therefore, only $744 of the $1,000 medical bill may be applied to the spenddown of the FMAP-related case.

	SSI-related	**FMAP-related**
Spenddown	$ 994.00	$ 1,868.00
January bill	- 250.00	- 250.00
	$ 744.00	$ 1,618.00
$1,000 May bill	- 744.00	- 744.00
	0.00	$ 874.00
	Spenddown met	Spenddown not met

If Mrs. G has medical bills, she must meet the remaining spenddown amount on the FMAP-related case.

Composite Households With Lump-Sum Income

Legal reference: 441 IAC 75 (Rules in Process)

A lump sum payment received by a person in an SSI-related or FMAP-related composite household is treated according to the person's categorical relationship.

Household composition:

SSI-related:	**FMAP-related:**
Mr. H, SSI-related (disabled)	Mrs. H, FMAP-related specified relative
Mrs. H, responsible relative	Holly, 10, FMAP-related child
	Henry, 18, FMAP-related child
	Mr. H, responsible relative

The application date is July 1 and the date of decision is July 30. On July 10, the household receives a retroactive social security disability lump sum:

Mr. H receives $4,000
Mrs. H receives $666
Holly receives $666
Henry receives $666

The lump sums received by Mr. and Mrs. H are counted in full ($4,666) as July's income for the SSI-related case.

For the FMAP-related case, the lump sums for Mr. H, Mrs. H, Holly, and Henry are totaled and added to any other income received in that month and then divided by the standard of living costs for four to determine the number of months to consider the lump sum.

Lump sum	$ 5,998.00
July net countable income	900.00
Total lump sum & July income	$ 6,898.00

Proration of lump sum & July income $6,898 ÷ 986 = 6.99 months to consider the lump sum income.

	July	and	August
Prorated lump sum and July income	$ 986.00		$ 986.00
August net countable income			900.00
Total for certification period	$ 986.00		$ 1,886.00 = 2,872

NOTE: Holly and Henry are eligible for MAC and are considered persons on the FMAP-related Medically Needy case for the month of July.

Income and Spenddown in the Retroactive Period

Legal reference: 441 IAC 75 (Rules in Process)

Assign a retroactive period of one, two, or three months depending on which month the retroactive period begins. (See Retroactive Eligibility for determining which months to include in the retroactive period.)

Consider all months of the retroactive period in which eligibility under another coverage group does not exist as a "unit." The "unit" for the Medically Needy retroactive period may be one, two, or three months depending on the first month in which Medicaid-covered services were received. Count all income for this unit, even if the household is ineligible in any month (for example, because of excess resources).

Determine the income for the retroactive period by adding the net countable income for each month of the Medically Needy retroactive period to arrive at a total. Do not count income from a month of the retroactive period when eligibility for that month is established under a coverage group other than Medically Needy.

Determine the MNIL for the retroactive certification period by adding the MNIL for each month of the Medically Needy retroactive period to arrive at a total.

Compare the net countable income to the MNIL for the retroactive period. (Use all months of the retroactive period, as previously determined, even if the client was ineligible for a part of it.)

1. The household, a pregnant woman, files an application November 10. The household paid a medical bill in August and has an unpaid medical bill in October. The retroactive period is August, September, and October. The household is over resource limits for September.

   Net countable income:

August	$ 700.00	
September	1,000.00	
October	+ 859.00	
	$ 2,559.00	Total net countable income for the retroactive period

   Income from all three months is totaled and considered in determining spenddown. As September is an ineligible month, retroactive eligibility is coded as first and third prior months only. When the Eligibility Status Turnaround Document is received, the individuals' fund code for the month of September is "9," not eligible.

2. Ms. S, a pregnant woman, files an application November 15 and requests retroactive benefits. She indicates that she has an unpaid bill for Medicaid-covered services received in October. She did not receive any Medicaid-covered services in August or September.

   The retroactive period consists of October. Income from October is used to determine the spenddown for the retroactive period.

3. Mr. and Mrs. T, a pregnant woman, applies for Medicaid April 2. Mrs. T was hospitalized in the month of February and the bills remain unpaid. They did not receive any Medicaid-covered services in January or March.

   The retroactive period includes the months of February and March. The worker uses income from February and March to determine the spenddown for the retroactive period.

4. Ms. G, a pregnant woman, applies for Medicaid April 15. She paid medical bills in January and has unpaid bills in March. These bills were for Medicaid-covered services. She did not receive any Medicaid-covered services (paid or unpaid) in February.

   The retroactive period includes the months of January, February, and March. The worker uses income from all three months to determine the spenddown amount.

Income of an Institutionalized Person

Legal reference: 441 IAC 75 (Rules in Process)

Persons in medical institutions who have income exceeding the 300% Medicaid cap or resources exceeding the SSI resource limit may be conditionally eligible for Medically Needy **if all other eligibility factors are met**. **No payment** is made for nursing facility care by Medicaid under the Medically Needy coverage group. NOTE: The cost of the nursing facility care may be used to meet spenddown.

To determine Medically Needy eligibility for the community spouse of an institutionalized eligible spouse, use the community spouse's income plus any income diverted by the institutionalized spouse to the community spouse.

See 8-I, *Income and Resources of Married Persons*, for the policies on counting income and resources for spouses when one spouse enters a medical institution.

- When the institutionalized spouse is expected to stay in a medical institution less than 30 consecutive days, consider the resources and income of both spouses together in determining Medicaid eligibility.
- When the institutionalized spouse (who entered the institution on or after September 30, 1989) is expected to stay more than 30 consecutive days or has stayed 30 days, use only the institutionalized spouse's income to determine eligibility, both in the initial month and in the succeeding months.

  Complete an attribution of resources for the month that one spouse enters an institution expecting to stay 30 consecutive days when there is a community spouse.

1. Mrs. W, age 66, enters a nursing facility on June 16. Her monthly gross income is $2,000 social security and $870 IPERS. Her countable income of $2,870 exceeds the Medicaid cap for the 300% group. To determine Medically Needy countable income, deduct the $20 general income exclusion.

   Certification period: June - July income

$ 2,870.00	Gross unearned income
- 20.00	General income exclusion
$ 2,850.00	
$ 2,850.00	
+ 2,850.00	
$ 5,700.00	Net countable income for the certification period
- 966.00	MNIL for the certification period ($483 × 2 months)
$ 4,734.00	Spenddown

   Even if spenddown is met, no Medicaid payment will be made to the facility. Mrs. W is responsible for payments to the facility.

2. Mr. Z resides in a nursing facility and is Medicaid eligible. His monthly income is $737.00 social security and $564 IPERS. He is eligible for the 300% group ($737.00 + 564.00 = $1,301.00). Mrs. Z, the community spouse, has $600.00 social security, $200 IPERS, and the Medicare Part B premium of $174.70 is deducted from her social security check.

   Mrs. Z: Determination of unmet maintenance needs.

$ 3,853.50	Monthly maintenance needs allowance
- 800.00	Mrs. Z's monthly gross income
$ 3,053.50	Unmet maintenance needs

   Mr. Z:

$ 1,301.00	Total gross income
- 50.00	Personal needs
$ 1,251.00	Amount that may be diverted to Mrs. Z.

   Mrs. Z's Medically Needy determination:

$ 600.00	Social security income
+ 200.00	IPERS income
+ 1,251.00	Mr. Z's diversion for Mrs. Z's maintenance needs
$ 2,051.00	Total countable income
- 20.00	General income exclusion
$ 2,031.00	Net countable income
× 2	Months
$ 4,062.00	Two months of net countable income
- 966.00	MNIL for one for two months ($483 × 2)
$ 3,096.00	Spenddown
- 349.40	Medicare premium ($174.70 × 2)
$ 2,746.60	Final spenddown

Applying Medical Expenses to Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

"Spenddown" is the process in which a Medically Needy person's excess income is obligated for allowable medical expenses in order to reduce countable income to the household's MNIL. When incurred medical expenses have reduced income to the applicable MNIL, the conditionally eligible person becomes eligible for Medicaid for the certification period.

Health insurance premiums and Medicare premiums are allowable medical expenses to meet spenddown. Deduct these premiums from the client's spenddown on the *Medically Needy Spenddown Computation Worksheet* to determine the **final** spenddown amount before entry of the spenddown amount on the ABC system.

Cases that have a spenddown in either the retroactive or the prospective certification period have information passed to the Medically Needy subsystem. The Medically Needy subsystem builds files for recipients with spenddown amounts and tracks the verified expenses applied to meet the spenddown obligation.

Providers submit claims to the Iowa Medicaid Enterprise (IME) for Medicaid-covered services incurred during the certification period.

The client or the provider submits information on non-Medicaid-payable expenses to you on a claim form. Attach the claim to *Medically Needy Transmittal*, form 470-3630, and submit both forms to the IME Medically Needy Unit by one of the following methods:

- Electronically to: imemedicallyneedy@dhs.state.ia.us
- Fax it to (515) 725-1350, or
- Send it to the IME Medically Needy Unit, Hoover Building, Des Moines.

Data from these claims is entered into the Medically Needy subsystem for processing. The Medically Needy subsystem prioritizes and accepts or rejects medical expenses, and automatically calculates whether spenddown has been met. The subsystem generates a computer-issued *Notice of Spenddown Status*, form 470-1967:

- Biweekly, when the IME Medically Needy Unit has input a claim.
- Biweekly, when changes in circumstances affect the spenddown calculation.
- On the day when a conditionally eligible recipient has met spenddown.

When the spenddown obligation is met, the Medically Needy subsystem notifies IME that the client is eligible for Medicaid and that certain bills are not payable because they were used to meet the spenddown obligation. The subsystem issues an *Eligibility Status Turnaround Document* (ESTD), form 470-1941, to document the case's status for each month of the certification period.

See 14-I(1) for information on ABC system entries for Medically Needy and 14-I for more information on the Medically Needy subsystem. See the following sections for more information on:

- Deducting health insurance premiums
- Deducting Medicare premiums
- Submitting Medical expenses for spenddown
- When medical expenses may be used to meet spenddown
- Allowable expenses for spenddown
- Determining the client's obligation
- Order of deducting expenses

Deducting Health Insurance Premiums

Legal reference: 441 IAC 75 (Rules in Process)

Verify health insurance premiums by bills from the insurance company, pay stubs, or other documentary evidence. MEPD premiums for the responsible relative are an allowable deduction from the spenddown amount. Prorate the premiums over the period they are intended to cover. Use the applicable *Medically Needy Spenddown Computation Worksheet* to deduct these amounts from the spenddown before entering it on the system.

NOTE: Premiums for insurance policies that pay a flat rate to the policyholder may be deducted from spenddown if:

- The policy was purchased to pay for medical care and with regard to anticipated charges, and
- The benefit is payable only if the policy holder actually receives the type of medical care for which the policy was purchased, and
- The benefit is intended to be used to pay for medical care for which the policy was purchased, and
- The benefit is not being counted as income for determining eligibility.

NOTE: Most discount drug plans are not health insurance contracts and thus should not be considered a health insurance premium. Obtain a copy of the plan if you are in doubt.

Do not allow the deduction for a premium that is paid by the Health Insurance Premium Payment (HIPP) program. Allow premiums paid by the AIDS/HIV Health Insurance Premium Payment program. See Medical Expenses Paid by a State Public Program.

When a client's countable income is below the MNIL and the health insurance premium is not used to meet the spenddown, the person may be eligible for the HIPP program. See 8-M, *Who Is Eligible for HIPP*. If the client is covered or could be covered by an employer's group health insurance plan, send a copy of the *Employer's Statement of Earnings*, form 470-2844 or 470-2844(S), to HIPP unit.

Deducting Medicare Premiums

Legal reference: 441 IAC 75 (Rules in Process), 75.52(5)

Medicare premiums are an allowable medical expense. However, do not allow deduction for the Medicare premium if it is paid by Medicaid.

People in the qualified Medicare beneficiary (QMB) coverage group cannot use Medicare premiums, deductibles or coinsurance to meet spenddown, because Medicaid pays these costs. Similarly, people in the specified low-income Medicare beneficiary (SLMB) and expanded specified low-income Medicare beneficiary (E-SLMB) coverage groups cannot use the Medicare Part B premium to meet spenddown.

Iowa "buys in" Medicare premiums for all Medicaid members. The buy-in automatically occurs for people whose social security claim number is correctly coded and who receive Medicare Part B. The buy-in tape is sent two days before the ABC month end. If buy-in is in effect for a Medically Needy member, buy-in will continue if the client has met spenddown before the buy-in tape is sent.

For clients who are not QMB, SLMB, or E-SLMB eligible, determine if Medicare Part B buy-in is in effect. Do **not** allow the Medicare premium as a medical deduction for the current certification period if the buy-in is in effect or if there is time to enter the Medically Needy case on the ABC system before the buy-in tape is sent.

If the buy-in tape will not be updated until **after** the two-month certification period is entered onto the system **or** the client meets spenddown, allow the premium deduction for the entire two-month certification period.

If the buy-in tape will not be updated until after ongoing eligibility is entered onto the system, allow the premium deduction until buy-in occurs. On the applicable *Medically Needy Spenddown Computation Worksheet*, deduct the Medicare premium from the client's spenddown before entering it on the system.

Tell the client to notify you when the buy-in occurs. (You can also determine when buy-in occurs from the SSBI screen, from the Bendex report in WISE, by the change of the Medicare premium coding on the TD03 screen in ABC, or by an alert in WISE.) When the buy-in occurs, recalculate the client's spenddown.

When the client meets spenddown at the end of the certification period or after the certification period, request a manual buy-in. To request a manual buy-in, notify the staff in the IME Policy Unit in writing by e-mail to: medicarebuyin@dhs.state.ia.us. Provide the following information on the people whose Medicaid buy-in needs to be processed:

- Member's name.
- SID number.
- Social security claim number.
- Months of eligibility for buy-in.

1. Ms. Z applies for Medically Needy on December 11 for the first time. She does not want Medicaid in December. Her social security disability income is projected as follows:

January	**February**	
$800.00	$800.00	Her Medicare premium is $174.70 for each month. Her Medicare supplement is $200.00. She is over resources for QMB.

In processing the application on January 3, the IM worker determines that since Ms. Z is not already "bought in," the Medicare premium is allowable as a deduction. The calculation is as follows:

January	+	**February**	=	**Total Period**	
$ 800.00		$ 800.00		$ 1,600.00	Gross income
- 20.00		- 20.00		- 40.00	Disregard
$ 780.00		$ 780.00		$ 1,560.00	Net income
- 483.00		- 483.00		- 966.00	MNIL
$ 297.00		$ 297.00		$ 594.00	Spenddown
- 174.70		- 174.70		- 349.40	Medicare premium
- 200.00		- 200.00		- 400.00	Medicare supplement
$ 00.00		$ 00.00		$ 00.00	

Since there is no spenddown in the initial two months, Ms. Z has ongoing eligibility.

When buy-in is reported, the IM worker recalculates the spenddown for the certification period. This causes the ongoing eligibility to be redetermined to a two-month certification period, since the Medicare premium is not allowed as a deduction after buy-in has occurred.

2. Mr. Y is QMB-eligible. He applies for Medically Needy on December 11. He has social security disability income of $850 and the Medicare premium of $174.70 is paid by Medicaid.

The IM worker is processing this application on January 3 and **does not** allow the Medicare premium as a deduction, since Mr. Y is in the buy-in process (He is QMB-eligible). The calculation for spenddown is as follows:

January	+	**February**	=	**Total Period**	
$ 850.00		$ 850.00		$ 1,700.00	Gross income
- 20.00		- 20.00		- 40.00	Disregard
$ 830.00		$ 830.00		$ 1,660.00	Net income
$ 483.00		$ 483.00		- 966.00	MNIL
				$ 694.00	Spenddown

3. Mr. Z has $950 gross social security and is over resources for SLMB. Mr. Z met his spenddown for the April-May certification and buy-in for his Medicare premium occurred in May.

   At the end of May, Mr. Z reapplies for Medically Needy for June-July certification. Since buy-in is already in effect and the application is being processed on June 3, no deduction is allowed for the Medicare premium.

June	+	July	=	Total Period	
$ 950.00		$ 950.00		$ 1900.00	Gross income
- 20.00		- 20.00		- 40.00	Disregard
$ 930.00		$ 930.00		$ 1860.00	Net income
$ 483.00		$ 483.00		- 966.00	MNIL
				$ 894.00	Spenddown

   Mr. Z is assigned a two-month certification period. If spenddown is never met or is met after the buy-in tape is produced in January, buy-out will occur.

   On the next recertification, if buy-in is not in effect, allow the monthly amount of Mr. Z's Medicare premium (except for Part D) as a deduction. Mr. Z's Part D premium is paid by Extra Help for Medicare Part D.

4. Ms. A is now age 65 and has just enrolled for Medicare. As a new Medicare enrollee her Medicare Part B premium is $174.70. Ms. A applies for Medically Needy and QMB on April 15. Her social security income is $980 and she has the Medicare Part B premium deducted from her social security check.

   The IM worker processes the application on May 5. Ms. A is QMB eligible effective June 1. The IM worker allows the Medicare Part B premium as a deduction for the April - May certification period. The calculation for spenddown is as follows:

April	+	May	=	Total Period	
$ 980.00		$ 980.00		$ 1,960.00	Gross income
- 20.00		- 20.00		- 40.00	Disregard
$ 960.00		$ 960.00		$ 1,920.00	Net income
- 483.00		- 483.00		- 966.00	MNIL
$ 477.00		$ 477.00		$ 954.00	Spenddown
- 174.70		- 174.70		- 349.40	Medicare premium
$ 302.30		$ 302.30		$ 604.60	Final spenddown

   Ms. A sends an application to the IM worker on June 2. The IM worker processes the application for the June - July certification period. Mrs. A is now QMB eligible. The Medicare Part B premium is not allowed as a deduction, as Medicaid is paying for it. Ms. A's spenddown for the June - July certification period is $954.

5. Mr. M applies for Medically Needy and QMB November 2. On November 20, Mr. M is approved for QMB effective December and for a November-December certification for Medically Needy.

   Mr. M is a Medicare enrollee and $174.70 is deducted from his social security check. The Medicare premium of $174.70 is allowed for a deduction for November but is not allowed for December, because the client is eligible for QMB for December.

Submitting Medical Expenses

Legal reference: 441 IAC 75 (Rules in Process)

Send the client a *Notice of Decision for Medically Needy*, form 470-2330, as soon as the certification period is on the ABC system. Tell clients to inform their providers that they are on Medically Needy and that the provider should:

- Send claims for Medicaid-covered services occurring in the certification period to Iowa Medicaid Enterprise (IME).
- Send all other claims to the IM worker.

Conditionally eligible clients inform their providers that they have a spenddown to meet by showing the provider their *Notice of Decision for Medically Needy* when they receive services. If services are received in the certification period before the client gets the notice of decision, the client should inform the provider of the spenddown obligation.

The provider needs either the state ID number or the social security number for the person receiving the services in order to check the Eligibility Verification System (ELVS) for billing information. ELVS notifies the provider if the client is conditionally eligible and the remaining amount of spenddown.

When the conditionally eligible person or the responsible relative receives Medicaid-covered services during the certification period, the provider completes a paper claim, electronic claim, or point-of-sale claim, and sends it to the IME.

When the state ID number is on the SSNI system for the 37-E aid type with a "P" or "S" fund code for the month of service, the IME enters the claim information into the Medically Needy subsystem. The IME notifies the provider that the claim has been denied for payment and that the claim has been submitted for spenddown consideration.

If the client asks a provider to submit a claim to be used to meet spenddown before the certification period is on both the ABC system and the Medically Needy subsystem, the claim will be denied and will not be submitted for spenddown consideration.

Mr. and Mrs. A file an application for Medically Needy. The worker determines that they have a spenddown of $230 for a May-June certification period. Mrs. A calls and states that Mr. A has an unpaid medical bill of $50 at the Wall Clinic that was incurred four months ago. She also states that she has a medical bill of $80 at Pharmacy C for May 2.

The worker advises Mrs. A to show Wall Clinic and Pharmacy C the *Notice of Decision for Medically Needy*. Wall Clinic sends the $50 claim to the worker. Pharmacy C sends an $80 claim to the IME for spenddown consideration.

The worker also advises them to show the *Notice of Decision for Medically Needy* to providers during the certification period until they meet spenddown and get Medicaid cards.

Expenses Submitted Through IM Worker

Legal reference: 441 IAC 75 (Rules in Process)

When the conditionally eligible person or responsible relative has received services before the certification period or receives non-Medicaid-covered services during the certification period, the provider submits a paper claim form to the IM worker.

NOTE: If a provider questions submitting a paper claim instead of filing electronically, refer the provider to the ***Medicaid All Providers Manual***, CHAPTER II. MEMBER ELIGIBILITY: Medically Needy Conditional Eligibility.

Allow applicants 12 months after the end of the certification period to submit medical expenses to be used to meet spenddown. Allow 12 months from the date of the notice of decision when the certification period or the retroactive certification period has ended before the issuance of the notice of decision.

Claims that are received after the 12-month period can be used for later certification periods **only** if spenddown was met for the original certification period and the bill is not Medicaid-payable. EXCEPTION: Bills incurred in the retroactive period can be applied to the certification period immediately following the retroactive period.

When you receive claims, determine:

- Whether the claim is for a period of time that can be allowed for spenddown. (See When Incurred Medical Expenses May Be Used.)
- Whether the expenses are of a type that is allowable for spenddown. (See Allowable Medical Expenses for Spenddown.)
- Whether the client still remains obligated for the expenses. (See Determining the Client's Obligation.)

When the expenses meet these tests, submit the completed claim forms to the IME Medically Needy Unit **within five days of receipt**. Attach the *Medically Needy Transmittal* to the claim form. (If the provider does not send a claim for an old bill, attach the provider's statement to the *Medically Needy Transmittal*.)

Medical transportation costs incurred when the client was not certified for Medically Needy are an allowable deduction for spenddown if the transportation expense remains unpaid. Clients must submit evidence of transportation medical expenses.

When the client submits transportation expenses, determine whether the expenses remain unpaid on the first day of the certification period and whether a third-party payment is anticipated. If the expenses are allowable, transfer the information onto the *Medically Needy Transmittal*, form 470-3630.

When the client verifies residential care personal care services, enter the amount on the *Medically Needy Transmittal* and send it to the IME Medically Needy Unit.

If an alien who is only eligible for emergency services does not have a bill, a statement, or a claim, verify the diagnosis code. Mail form 470-4299, *Verification of Emergency Health Care Services*, to the provider for completion.

The Medically Needy subsystem generates the *Bill Status Turnaround Document* (BSTD), 470-1942, to track the application of the expenses to the spenddown. When the bill is large enough to be applied to more than one certification period, use the BSTD to resubmit it for subsequent periods.

Once spenddown is met, the Medically Needy subsystem will accept changes to:

- Decrease the amount of spenddown. (Use the ESTD.)
- Apply an old bill or noncovered Medicaid payable claim that occurred before the spenddown date. (Submit the claim with the *Transmittal*.) When this type of claim is received after spenddown has been met, the Medicaid covered claim will be backed out of the Medically Needy subsystem and the provider will be paid.

When Incurred Medical Expenses May Be Used

Legal reference: 441 IAC 75 (Rules in Process)

Use paid or unpaid medical services that occurred in the certification period to meet the spenddown obligation for that period.

> The S family has a spenddown of $300 for the certification period of June and July. During June, they pay or incur $200 in medical expenses. In July, they pay or incur $125 in medical expenses. They are eligible for Medicaid as Medically Needy for June and July. Medicaid will not pay the bills used to meet the $300 spenddown.

Paid and unpaid expenses incurred in the retroactive period may be used to meet spenddown in the certification period that immediately follows the retroactive period if they were not used for spenddown in the retroactive period.

Use incurred medical expenses to meet spenddown only if they were not already used in full to meet spenddown in a previous certification period and were not Medicaid-payable. (NOTE: For these expenses to be allowed in the subsequent certification period, the spenddown in the previous certification period must have been met.)

Medical expenses incurred in a certification period where spenddown is not met cannot be used to meet spenddown in any subsequent certification period. If the spenddown was not met in a preceding certification period (other than the retroactive period), do not carry unpaid medical expenses that were incurred in that period forward to the current certification period.

See the following sections for more details on applying these expenses:

- Expenses from months not certified as Medically Needy
- Expenses from the retroactive period
- Expenses from a prior certification period

Expenses From Months Not Certified for Medically Needy

Legal reference: 441 IAC 75 (Rules in Process)

Apply old unpaid bills for services received when the client was not certified for Medically Needy (conditionally eligible or eligible) to any certification period, regardless of whether or not spenddown was met in a certification period.

The unpaid bill must remain unpaid on the first day of the month of the certification period. Only the portion of the bill that was not used to meet a spenddown may be applied to a subsequent certification period. See Old Bills With Remaining Balances.

> Ms. Z is conditionally eligible for the October-November certification period with a $200 spenddown. Ms. Z has a dental bill for $335 that she incurred on May 15. She was not certified for Medically Needy in the month of May.
>
> The dentist submits a claim or bill indicating that Ms. Z still owes the $335. The dental expense is applied to the $200 spenddown for the October-November certification period. The dental bill has a remaining value of $135 that may be applied to the next certification period, if the expense remains unpaid.

Expenses From the Retroactive Period

Legal reference: 441 IAC 75 (Rules in Process)

Use the following guidelines to apply paid or unpaid medical expenses incurred in the retroactive period to meet spenddown for the certification period that immediately follows the retroactive period:

- It does not matter if spenddown was met in the retroactive period.
- Use non-Medicaid-covered expenses that were incurred in the retroactive period to meet spenddown for the certification period that immediately follows it, if they were not used to meet spenddown in retroactive period. This applies whether the expenses are paid or unpaid.
- Use paid bills incurred in the retroactive period to meet spenddown in the certification period that immediately follows the retroactive period, if the expense has not been used to meet spenddown in the retroactive period. Do not use these paid expenses from the retroactive period to meet the spenddown for any subsequent certification period.
- If the bill incurred in the retroactive period is unpaid and is for a service that will be paid by Medicaid, do not use the bill to meet spenddown in the following certification period.

The certification period that "immediately follows" the retroactive period means that there has been no lapse in time between the retroactive certification period and the next certification period.

NOTE: If the retroactive period is not entered on the Medically Needy subsystem, the subsystem will not allow the paid medical bill from the retroactive period to be applied to the following certification period.

Ms. M, a pregnant woman, files an application April 2 and does not request retroactive benefits. The worker contacts Ms. M and asks if she has any unpaid medical bills in the retroactive months. Ms. M states that she did not.

The worker then asks if she had paid any medical bills that she incurred during the retroactive period. Ms. M remembers that in February she went to the dentist for a check-up and paid the dental bill of $65. There were no other medical expenses in the retroactive period.

The worker determines Ms. M has a spenddown of $500 for the retroactive period (February and March). The worker enters a two-month retroactive certification period on the Automated Benefit Calculation (ABC) system.

Ms. M does not have any unpaid medical bills for services received before the retroactive period. The worker determines that Ms. M would not meet the spenddown of $500 for the retroactive period with the $65 dental bill.

Therefore, the February dental bill of $65 is applied to the spenddown for the April-May certification period. Ms. M has a spenddown of $500 for the April-May certification period.

Expenses From a Prior Certification Period

Legal reference: 441 IAC 75 (Rules in Process)

When the spenddown has been met in the previous certification period, move the remaining value of unpaid non-Medicaid covered expenses from that certification period to the following certification period. (This does not apply to unpaid bills in the retroactive certification period being moved to the certification period that immediately follows the retroactive period.)

Medical expenses that occurred in a prior certification period that did not meet spenddown may **not** be used in a following certification period.

1. The M family has a $500 spenddown for the June-July certification period.

   Junior M incurs a medical expense of $800 on June 5 with a non-Medicaid provider. ($500 is applied to the spenddown and the remaining value of $300 may be applied to the next certification period if still obligated.) The M family meets the spenddown for the June-July certification period.

   The M family applies for the August-September certification period. They are approved with a spenddown of $500. Mrs. M still owes the non-Medicaid provider for her son's April bill. The $300 remaining value of the $800 medical expense that was not used before is applied to the spenddown amount.

   The M family does not incur any medical bills in the August-September certification period. Spenddown is not met for the August-September certification period. (NOTE: Spenddown was not met for this certification period, therefore, the $300 cannot be moved to the next certification period.)

2. Same situation as Example 1, except the M family does not apply for the August-September certification period. They wait and apply after Mrs. M is hospitalized in October. They are approved with a spenddown of $400 for the October-November certification period.

   The worker asks Mrs. M if they still owe the non-Medicaid provider the $300 from the $800 bill that was incurred in June. (Because the M family met spenddown for the June-July and this amount is still obligated it may be applied to the spenddown for the next certification period after the June-July certification period.)

   Mrs. M states that they still owe $200. This is verified with a call to the provider and the BSTD is submitted to indicate the payments of $400 on July 20 and $200 on September 10. The $200 is applied to spenddown and Mrs. M's hospital bill is used to meet the remaining spenddown amount.

Allowable Medical Expenses for Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

Apply actual expenses for necessary medical and remedial services and approved transportation expenses incurred by a recipient or conditionally eligible person or responsible relative to the spenddown amount for the certification period. This includes some over-the-counter drugs. See the Medicaid provider's manual for the covered services. Incurred medical expenses are:

- Medical bills paid during the certification period or retroactive certification period by:
  - A recipient or a conditionally eligible person.
  - A responsible relative.
  - A public program of a state or political subdivision (other than Medicaid).
- Unpaid medical expenses for which the recipient or conditionally eligible person or responsible relative remains obligated to pay. See When Incurred Medical Expenses May Be Used and Determining the Client's Obligation.

Bills for a person who is not a responsible relative or a conditionally eligible person cannot be used to meet spenddown. Bills of any person voluntarily excluded from the household cannot be used to meet spenddown.

The family consists of Ms. H, who receives child support, and her two children, ages 15 and 14. The 14-year-old is hospitalized. The 15-year-old, who receives $500 unearned income, is healthy.

When the 15-year-old is included in the Medically Needy household, there is a high spenddown caused by the 15-year-old's income. When the 15-year-old is excluded from the FMAP-related household, there is a much lower spenddown for the Medically Needy household. The family chooses to exclude the 15-year-old.

Only the incurred expenses of the Medically Needy household are used to reduce spenddown. Incurred expenses of the 15-year-old excluded child are not allowable in meeting spenddown.

If a person is conditionally eligible on one case and also a responsible relative or considered person on another case, use the same bills to meet both spenddowns. Do not include any portion of a bill paid by Medicaid. See SSI-Related, FMAP-Related Composite Households for examples.

If the noncustodial parent is legally responsible for medical expenses and does not pay, use these expenses for spenddown when the medical expenses revert to the conditionally eligible or responsible relative to pay.

When medical expenses are used to reduce the period of time a lump sum is considered, also use these same medical expenses to meet the client's spenddown.

The following sections give more detail in these areas:

- Noncovered Medicaid services
- Prepaid medical coverage
- Medical expenses of stepparents
- Medical expenses paid by a state public program
- Personal care services in a residential care facility
- Acupuncture services

Noncovered Medicaid Services

Legal reference: 441 IAC 75 (Rules in Process)

Bills for a service that is not "necessary," as defined by Medicare and Medicaid, cannot be used for spenddown.

Medical expenses that are ordinarily covered by Medicaid but are not payable for the Medically Needy client may be used for spenddown. This includes services that are not payable because:

- The provider is not enrolled in Medicaid.
- The expense is for a responsible relative who is not in the Medically Needy eligible group.
- Services were received before the start of the certification period.
- The service is a nonemergency service provided to aliens who are eligible only for payment of emergency medical expenses.
- The Medically Needy program does not pay for the service, although it is available under other Medicaid coverage groups. These services include:
  - Payment for care in a nursing facility or NF/MI.
  - Payment for care in a Medicare-certified skilled nursing facility.
  - Payment for care in an intermediate care facility for persons with an intellectual disability.
  - Payment for care in an institution for mental disease.
  - Payment for rehabilitative treatment services. These are specified services in the family preservation, family-centered services, family foster care treatment, and group care programs.

Prepaid Medical Coverage

Legal reference: 441 IAC 75 (Rules in Process)

With a prepaid medical package, such as orthodontia or prenatal care, allow the cost of medical services that:

- Were received during the certification period, or
- Remain unpaid as of the first day of the certification period.

EXCEPTION: For orthodontia for children that would be billed under Care for Kids (EPSDT) after spenddown is met, use the prepaid amount to meet spenddown. This is allowable because EPSDT allows Medicaid prepayment at the time of banding to cover active treatment and the retainer for a 30-month period. The client must obtain prior approval for Medicaid to pay any remaining amount. The client should pursue the prior approval immediately (before the spenddown is met).

1. The orthodontist requires a prepayment for braces of $2,000. The orthodontist received prior approval for the braces from the IME. The prepayment is due May 1. Mrs. X, age 28, pays the $2,000 on May 1. Mrs. X receives $200 in dental services for the month of May and $150 for the month of June.

   The worker allows only $350 to meet the spenddown for the May-June certification period. The remaining $1,650 that was paid is not allowed as a deduction in any certification period, as it does not represent an obligation for medical services received. The remaining medical services have been prepaid.

2. Mrs. Z asks the orthodontist if Medicaid would pay for the treatment. He states that for Medicaid to pay, prior approval needs to be requested and granted. Mrs. Z explains that they have a $500 spenddown to meet before they would be eligible.

   The orthodontist submits the request for prior approval January 5. After the dentist receives prior approval, treatment begins on February 20. The claim submitted to IME January 10 indicates the total private-pay charge. Spenddown is met.

   After spenddown is met, the IME pays $2,000. Mrs. Z is responsible for paying $500 of the $2,500 for treatment. (**Note:** If the prior approval is denied, Mrs. Z will be responsible for paying the private pay charges.)

Medical Expenses of Stepparents

Legal reference: 441 IAC 75 (Rules in Process)

Use the medical expenses of stepparents who are included in the FMAP-related Medically Needy household to meet spenddown.

Use the expenses of stepparents who are not included in the FMAP-related Medically Needy household if income from the stepparent was diverted to that household. (The stepparent is considered a responsible relative.)

1. The family consists of Mrs. D, her child, and Mr. D, the stepparent. There are no common children. Mr. D, who is not disabled, is not considered in the Medically Needy group.

   The resources of Mrs. D and her child exceed FMAP limits but are within Medically Needy limits. Mrs. D has net countable income of $600.

   Mr. D has $1,700 earnings. There is stepparent income attributable to the household after applicable deductions and diversions. The income calculation is as follows:

$ 1,700.00	Stepparent's earnings
- 340.00	20% earned income deduction
$ 1,360.00	
- 365.00	Stepparent's needs
$ 995.00	Attributable to Mrs. D and her child
+ 600.00	Mrs. D's net countable income
$ 1,595.00	Is compared to MNIL for a household of two

   Mr. D is not included in the MN household size to determine the MNIL. However, he is entered on ABC as a financially responsible relative, so that his unpaid medical expenses are usable in meeting the Medically Needy household's spenddown.

2. Same situation as above, except that Mr. D has only $450 earnings. He has no income to attribute to the FMAP-related household of Mrs. D and her daughter. Mrs. D has net countable income of $750. His income is calculated as follows:

$ 450.00	Stepparent's earnings
- 90.00	20% earned income deduction
$ 360.00	
- 365.00	Stepparent's needs
$ 0.00	

   There is no income to attribute to Mrs. D and her child. Mr. D is not included in the Medically Needy household size to determine the MNIL. His unpaid medical expenses are not allowed as a deduction in meeting spenddown for Medically Needy group, as his income was not used to determine spenddown.

   NOTE: Ms. D's daughter is eligible for MAC and is a considered person for Medically Needy.

Medical Expenses Paid by a State Public Program

Legal reference: 441 IAC 75 (Rules in Process)

Use incurred medical expenses paid **in a certification period** by a state public program (other than Medicaid) to meet spenddown. If a medical expense was paid **before** the certification period by a public program, do not allow it as a spenddown deduction.

A state public program is a program administered by the state or financed by state appropriations (including a political subdivision). A state public program does not receive any federal funding. Examples of state public programs are:

- Veteran's Assistance (soldier's relief).
- General Relief.
- Renal programs.
- AIDS/HIV health insurance premium payment program.
- State Public Health Nursing Grant.

- County nurses.
- State payment program for MH/ID/DD state cases.

Treat payments made by these programs the same as patient payments. The payment reduces the obligated medical expense when it is made before the certification period. Disregard payments when they are made within the certification period.

> Mr. A's certification period is October 1 through November 30. The spenddown is $50. Mr. A verifies that he incurred a $50 physician bill on September 15. General Relief paid the $50 medical expense for Mr. A on October 1.
>
> The General Relief payment is disregarded because it occurred during the certification period. The entire physician expense is applied towards spenddown. When the spenddown is met on the Medically Needy subsystem, Mr. A is issued a Notice of Spenddown Status (NOSS).

Medical expenses written off by a medical facility as part of its Hill-Burton commitment apply to spenddown when this was done in the certification period. Determine through discussion with the client or provider if Hill-Burton assistance was granted.

Medicare Part D

Medicare Part D is a prescription drug benefit available to Medicare beneficiaries. Enrollees in Part D may be required to:

- Pay a monthly premium.
- Pay a co-payment on each prescription.
- Meet a deductible.

Medically Needy clients who enroll in a prescription drug plan may use prescription drug expenses not covered by the plan to meet their spenddown. NOTE: Prescription drug plans vary, so costs to enrollees will be different.

Do **not** deduct prescriptions paid by Medicare Part D or another party from the spenddown for people who are eligible for Part D.

Deductions to Allow for Spenddown

Deduct the following expenses for spenddown for people who are eligible for Part D:

- Medicare Part D premiums the client paid.
- Prescriptions paid by the client that apply to the Medicare Part D deductible.
- Coinsurance or copayments the client paid for Medicare Part D prescriptions.
- Prescriptions paid by the client that are not paid by Medicare Part D because they are not covered in the Part D plan's formulary when the client has applied for and been denied an exception for the plan to cover the drug.
- Prescriptions paid by the client that are in a class of drugs not covered by Medicare Part D. After spenddown is met, these drugs may be Medicaid payable.

- Prescriptions paid by the client for Part D-covered drugs when the client is eligible for Part D, but has not signed up.

Applying Part D Expenses to the Spenddown

Apply Part D expenses to spenddown in the following order:

1. **Medicare Part D Premiums:** Subtract Part D premiums from the calculated spenddown on the applicable *Medically Needy Spenddown Computation Worksheet* before the spenddown is entered on ABC, along with any other health insurance or Medicare premiums.
2. **All other Medicare Part D related medical expenses:**
   - The client submits the monthly statement from the drug plan and any drug plan exception notices to you, the worker. (Prescription drug plans must issue a statement to the client at least monthly to explain all benefits paid and denied.)
   - You review the drug plan statement and circle in red the prescription expenses that should be applied to the spenddown.
   - Attach form 470-3630, *Medically Needy Transmittal*, to the completed claim form, and submit it to the IME Medically Needy Unit within five working days of receipt. The claim and transmittal can either be:
     - Electronically sent to: imemedicallyneedy@dhs.state.ia.us
     - Faxed to the Medically Needy Unit at: 515-725-1350, or
   - Mailed to: IME Medically Needy Unit, 1305 E. Walnut St., Des Moines, Iowa 50319-0114.

NOTE: Advise applicants and recipients to keep their drug plan monthly statements and exception notices and to submit them to determine whether the denied drugs can be applied to the spenddown.

Personal Care Services in a Residential Care Facility

Legal reference: 441 IAC 75 (Rules in Process)

In addition to food and shelter, residents of residential care facilities may also receive personal care services from the facility. Any resident of a licensed residential care facility qualifies for this medical expense deduction. Verify the client's residence with the facility.

"Personal care services" include assistance with activities of daily living, such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication. For purposes of the Medically Needy coverage group, these personal care services do meet the definition of a necessary medical and remedial service.

The medical expenses deduction for personal care services is based on the average per day health care costs for a member in a residential care facility, which currently is $32.36, or $983.74 per month.

Allow $983.74 per month for the cost of medically necessary personal care services provided in a licensed residential care facility as a medical expense deduction from spenddown. If a client is in the residential care facility for only part of the month, prorate expenses for the medical expense deduction, allowing $32.36 per day.

Do not allow any facility charges for maintenance to meet spenddown, because a residential care facility is not classified as a medical institution.

Acupuncture Services

Legal reference: 441 IAC 75 (Rules in Process)

Allow acupuncture services that are necessary medical and remedial service for spenddown. Medicaid does not cover acupuncture services.

Determining the Client's Obligation

Legal reference: 441 IAC 75 (Rules in Process)

Medical expenses for which the recipient or responsible relative remains obligated to pay are allowable for spenddown. Applying an expense toward a client's spenddown is considered to meet that obligation.

Therefore, the following are **not** allowable for spenddown:

- Bills paid by Medicaid or other insurance.
- Bills used in full for spenddown previously on this case or another case.
- A paid bill incurred and used in full to meet spenddown in the retroactive period.
- A paid bill incurred in the retroactive period that was not used to meet spenddown in the retroactive period or the certification period immediately following the retroactive period.
- Bills incurred in a certification period that did not meet spenddown. These bills cannot be applied to spenddown for a subsequent certification period.

If the recipient paid with a bank loan or credit card, the recipient could be obligated to the credit card company. See Loans to Pay Medical Expenses.

When a person files bankruptcy and later signs a written agreement to pay medical bills, the person is once again obligated and the bill can be applied to spenddown. If a court assigns the person a payment plan, the bill is the person's obligation and is usable for spenddown.

Several situations that require more effort to determine the client's current obligation for medical expenses are addressed in the following sections:

- Old bills with remaining balances
- Loans to pay medical expenses
- Estimating expenses paid by insurance or another third party

Old Bills With Remaining Balances

Legal reference: 441 IAC 75 (Rules in Process)

If a client has bills that have not been paid in full but were incurred before the client was certified for Medically Needy (as conditionally eligible or eligible), apply these charges to spenddown if they were not previously used to meet a spenddown. The client must verify with a statement or bill from the provider any payments made during the certification period and the balance due.

Determine if bills that the provider turns over to a collection agency for collection are still legally obligated to the provider. If the expenses are still legally obligated to the provider, the expenses may be applied towards spenddown. Verify the status of the bill with the provider. Do not use the following for spenddown:

- Late fees or finance charges.
- Any charge no longer owed to the provider. This includes bills that the provider has written off and unpaid bills that a provider sells to a collection agency.

To apply payments made on old medical bills:

1. Total all payments before the certification period.
2. Apply payments against each charge (beginning with the oldest).
3. Determine if the charges exceed payments. If so, enter remaining balance on the *Medically Needy Transmittal* and attach a copy of the claim or the provider's statement. Be sure to enter the total charges on the *Medically Needy Transmittal* for that date of service and, if applicable, any payments that apply to the charge.

Attach the *Medically Needy Transmittal* to the claim for old medical bills (or to the bill, if the provider submits a bill rather than the claim). Enter the total remaining charges on the *Medically Needy Transmittal*. Highlight the remaining charges on the bill. If only a portion of the service is payable, highlight the service and indicate the remaining portion.

If the total payments exceed total charges, bills are considered paid in full and cannot be used to meet spenddown. When a medical expense was determined to be paid in full, send a manual *Notice of Decision*. Include the date of service, provider name, patient name, charge, and the reason an expense was not allowed for spenddown.

Deduct the amount applied against spenddown in the certification period from the balance due at the beginning of that certification period. When medical expenses are allowed for meeting spenddown, only the balance remaining can be applied in subsequent periods.

If a payment is made on an obligation that has been counted toward spenddown in a previous certification period that met spenddown, deduct the amount paid from the amount previously allowed. Only the remaining value can be counted toward spenddown in the next certification period, so that deductions are not allowed once as an obligation and later as payment.

1. The G family has a March-April certification period. They have a doctor bill of $200 incurred in November that they still owe. They were not on Medically Needy when they incurred the bill. The Gs have a spenddown amount of $200 for the certification period. The family meets the March-April spenddown.

   The Gs reapply for the months of May-June. In May they pay the doctor $75 on the November bill. This payment does not count toward the May-June spenddown, because the payment is for an expense that was previously counted for spenddown.

2. The D family has a November and December certification period. They have a hospital bill of $500 from two years ago for which they are legally obligated. They were not on Medically Needy when they incurred the bill.

   The Ds have a spenddown amount of $200 for the certification period. The spenddown of $200 for November and December is deducted from the $500 bill, leaving $300 that can be applied to future certification periods.

   The Ds make a $200 payment on December 26 after spenddown was met. They are recertified for January-February. The worker indicates on the payment section of the BSTD that a payment of $200 was made on December 26.

   The Medically Needy subsystem applies this payment to the amount that was previously used to meet spenddown. The worker resubmits the BSTD to have the remaining value of $300 applied to the January-February certification period.

3. The E family received a bill for a non-Medicaid-covered service of $1,000 in January. The family was certified for January-February with a $400 spenddown. The potential remaining value of the bill is $600.

   The family is recertified for March-April with a $500 spenddown. The family still owes $600 on the non-Medicaid-covered service, which is applied to the spenddown for the March-April certification period. The potential remaining value of the bill to be applied to the next certification period is $100.

   The family is recertified for the May-June certification period with a spenddown of $400. The remaining value of $100 is applied to the spenddown, as it still remains obligated. The family incurs $200 more in medical expenses for May-June, which are also applied to spenddown.

   The family does not meet spenddown for the May and June certification period. Even if the total $300 in bills remains unpaid, these bills **cannot be carried forward** to the next certification period.

Loans to Pay Medical Expenses

Legal reference: 441 IAC 75 (Rules in Process)

The balance of a loan used to pay medical expenses for a member of the Medically Needy group or a responsible relative may be used to meet spenddown. Loans include repayment arrangements with financial institutions, credit card companies, private individuals, etc. Do not allow accrued interest or any portion of the loan obtained and used for purposes other than for medical expenses.

If an incurred medical expense that has been paid by a loan has been previously submitted for meeting spenddown for the retroactive period, apply only the remaining value of the medical expense to the two-month certification period immediately following the retroactive certification period.

If an incurred medical expense paid by a loan has been previously submitted and spenddown was met, apply only the remaining value of the medical expense to the subsequent certification period.

As of the first day of the certification period, consider for meeting spenddown the portion of the loan balance that:

- Remains obligated and
- Was used to pay allowable incurred medical expenses for a member of the medically needy group or a responsible relative.

To consider the loan as a medical expense:

1. Verify that the loan was for medical expenses. Examine the repayment or loan document or obtain a statement from the financial institution.

   If the loan was not made by an institution, obtain a statement signed by both parties describing the obligation to repay. This statement does not necessarily have to have been drawn up when the loan was received. A current statement from both parties is enough to verify that an obligation exists to repay the loan.

2. Verify what payments have been made on the loan before the beginning of the certification period.

   The client may have paid medical expenses by using a credit card. If the client pays a portion of a credit card bill, count the first expense incurred as the first paid off. If expenses were incurred on the same day, apply the payment to the advantage of the client.

   For example, if the client incurred a bill for a medical expense and another non-medical expense on the same day, apply the payment to the non-medical expense. This allows the medical expense to be used for spenddown.

3. Deduct any interest from the payments made on the loan.

4. Gather information regarding the medical expense paid in order to record the incurred medical expense in the comment section of the *Medically Needy Transmittal*.

5. Calculate the balance of the medical expense portion of the loan as of the first day of the certification period.

6. Enter in the comment section of the *Medically Needy Transmittal* any payments made on the loan before the certification period and during the certification period. Enter on the *Medically Needy Transmittal* all payments made directly on the bill (payments other than from the loan).

7. For resubmittal of the medical expenses, record any principal payments made since the last determination on the *Bill Status Turnaround Document* (BSTD).

Record all payments toward the incurred medical expense other than payments made from the loan. Determine what the balance of the loan was as of the first day of the certification period. This may involve requesting verification from the financial institution of what the unpaid balance was on that date.

Deduct the balance as of the first of the certification period from the original loan balance. This reflects the reduction of the principal from the loan date to the beginning of the certification period. Record this difference on the *Medically Needy Transmittal* as a payment made before the certification period.

If the bill is resubmitted for use in meeting a future spenddown, again determine the loan balance for the medical expense as of the first day of the new certification period. Again record the difference between these two balances as a payment before this latest certification period.

1. On November 10, Mrs. M gets a loan to pay off the $3,000 remaining balance of a medical expense. The total charge was $5,000 and was incurred for her hospitalization of October 10 through October 20. Insurance paid $2,000 on November 1.

   On March 1, Mrs. M learns of the Medically Needy program and applies for current Medicaid coverage. The IM worker establishes a March-April certification period with a spenddown of $200.

   Mrs. M brings in verification of the October hospitalization, a copy of the loan agreement, and verification that the hospital bill was paid in full. She reports that she made three $50 payments ($150) on the loan before March 1. The IM worker records the total hospitalization expenses ($5,000) in the comment section of the *Medically Needy Transmittal.*

   The payment that is indicated on *Medically Needy Transmittal* reflects the $2,000 paid on November 1 by insurance. To determine the amount of payment that was incurred to pay medical expenses, the worker views the client's loan payment book. On March 1, the current balance was $2,900. ($3,000 original loan balance minus $2,900 equals $100.)

   The worker records a $100 payment on the *Medically Needy Transmittal* with a date before the start of the certification period (March 1). Even though Mrs. M made $150 in payments on the loan, only $100 was paid on the original medical expense. The remaining $50 was for interest, which is not an allowable deduction.

   The claim is attached to the *Medically Needy Transmittal* and sent to the IME. The comment section includes the following information:

10/10 - 10/20	Total charge	$5,000
11/1	Insurance payment	$2,000
Before 3/1	Client payment	$100
	Loan balance as of March 1	$2,900

2. Mr. D, age 20, is hospitalized from December 1 through December 4 and incurs a medical expense of $2,000. He has no health insurance coverage. He has savings of $500, which he decides to use towards his hospital bill. To pay the balance of the bill, Mr. D goes to his credit union and takes out a loan for $1,500 on December 10. He pays the hospital in full on December 11.

On December 20, Mr. D learns that he may be eligible under the Medically Needy program. On December 24, he applies for Medicaid and explains that he paid for his hospitalization by taking out a loan. He further explains that the hospital has told him that if he becomes Medicaid-eligible, the hospital will reimburse him the payment he has made minus any spenddown obligation that may be established.

The IM worker approves Mr. D as potentially eligible for Medically Needy for a December-January certification period. He has a spenddown of $350.

The hospital submits a claim to the IME for use in meeting Mr. D's spenddown. The payment made to the hospital by the proceeds of the loan is not recorded. (Since this medical expense was incurred within the certification period, the computer disregards client payments.)

Mr. D meets the spenddown and cards are issued. The hospital refunds Mr. D all but $350 of his payments made in December, and then the hospital bills Medicaid.

3. Ms. J, age 20, incurs a medical expense with Dr. N on January 2 for $50. She pays this bill in full with her newly obtained MasterCard. (This is the first bill she paid with her MasterCard.) On June 10, Ms. J applies for Medicaid and is conditionally approved with a $50 spenddown for the June through July certification period.

   Between January 10 and June 10, Ms. J used her MasterCard to pay for $500 in nonmedical expenses. She inquires whether the medical expense she paid by MasterCard is usable toward meeting her spenddown.

   The IM worker verifies that Ms. J made four $20 payments on her MasterCard before June 1. This total payment of $80 exceeds the $50 charge plus interest that was first incurred on MasterCard. The IM worker informs Ms. J that there is no unpaid balance of the $50 charge remaining. Therefore, there is no medical expense to be submitted toward meeting her current spenddown.

Expenses Paid by Insurance or Third Party

Legal reference: 441 IAC 75 (Rules in Process)

When the client has other health insurance coverage and either the provider or the IM worker submits a claim to the IME, the claim must reflect the third-party insurance information and payment, when applicable. The IME will deny payment on claims that do not reflect this information.

It is not your responsibility to make sure the claims carry insurance information. Forward the claim to the IME as submitted. The IME will make a determination regarding third-party insurance involvement.

See the following sections for more information on:

- Clients who have Medicare and QMB
- Estimating Medicare Part A payments
- Estimating Medicare Part B payments
- Changes or corrections to insurance payments

Clients Who Have Medicare and QMB

Legal reference: 441 IAC 75 (Rules in Process)

If the client has Medicare and is also eligible for QMB, do not use Medicare claims to meet the spenddown. QMB pays Medicare premiums, deductibles, and coinsurances. The provider will submit the claim to Medicare for payment. Medicare crosses the claim over to Medicaid for payment.

Medicare Part A Payments

Legal reference: 441 IAC 75 (Rules in Process)

If the client has Medicare coverage and is not eligible for QMB, the client may need to meet the Medicare Part A deductible of $1,632. If the deductible has not been met, the Medicare Part A deductible is used to meet the spenddown.

The provider submits the claim to Medicare for payment. Medicare sends the claim to Medicaid for payment of the deductible amount. This is called "crossover" from Medicare to Medicaid.

Medicare Part A includes the following services:

- Inpatient hospital charges (room and board, general nursing, and miscellaneous hospital services and supplies).
- Care in a skilled nursing facility following a hospital stay.
- Home health care for a homebound person. If the client does not have Medicare Part A, then home health care can be paid under Medicare Part B.
- Hospice care for terminally ill persons.

Medicare Part B Payments

Legal reference: 441 IAC 75 (Rules in Process)

If the client has Medicare Part B and is not eligible for QMB, the client may need to meet the Medicare Part B deductible of $240. If the Medicare Part B deductible has not been met, the deductible is used to meet spenddown.

Use the following services to meet the Medicare Part B deductible:

- Physician services.
- Physician charges for inpatient and outpatient medical and surgical services and supplies.
- Physical and speech therapy.
- Ambulance services.
- Diagnostic tests, such as X-rays.
- Outpatient hospital treatment.

- Blood.
- Durable medical equipment.
- Home health care for the homebound if the client does not have Medicare Part A.
- Clinical laboratory services, such as blood tests, urinalyses, biopsies, etc., provided by a Medicare certified laboratory.

The provider submits the claim to Medicare for payment. Medicare submits the claim to Medicaid for payment of the deductible amount or copayment amount. This is called a "crossover" from Medicare to Medicaid. The IME submits the claim to the Medically Needy subsystem for spenddown consideration if the client has a copayment or deductible to pay.

Changes or Corrections on Payments

Legal reference: 441 IAC 75 (Rules in Process)

Make changes or corrections when there is a change in insurance coverage.

If the client verifies that the client no longer has Medicare, complete form 470-0397, *Request for Special Update*, and send it to Quality Assurance.

If the client no longer has insurance, complete an *Insurance Questionnaire*, form 470-2826 and indicate the date insurance was terminated. Send the *Insurance Questionnaire* to the IME Third Party Liability (TPL) Unit. A special update is not required if the date the insurance terminated is on the *Insurance Questionnaire*.

Do not send the claim and *Medically Needy Transmittal* unless the Insurance Questionnaire has been sent to the IME TPL Unit. Indicate on the *Medically Needy Transmittal* that the client no longer has insurance and that the Insurance Questionnaire has been sent. The address of the IME TPL Unit is P.O. Box 36475, Des Moines, IA 50315. The TPL Unit fax number is (515) 725-1352.

Order of Deducting Expenses for Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

To meet spenddown, deduct medical expenses in the following order:

1. Health insurance premiums. (These are deducted when calculating the spenddown.)
2. Deductibles, coinsurance, or Medicaid copayments, if they remain unpaid.
3. Expenses for necessary medical and remedial services **not covered** under the Medicaid program chronologically by date of submission. (See Noncovered Medicaid Services.)
4. Expenses for necessary medical and remedial services covered by Medicaid. A responsible relative's expenses are deducted before those of a conditionally eligible person chronologically by date of submission.

The chart on this page shows the order of deducting bills in the Medically Needy subsystem, as well as the priority within that order. Try to process bills or claims for old bills immediately at the beginning of the certification period, so that they can be applied before current bills.

Type (in priority order)	**Priority of Consideration**
1. Bills paid in the retroactive period	Apply the balance of the bill that was not used to meet spenddown in the retroactive period to the spenddown of the certification period immediately following the retroactive period.
2. Credits	A credit occurs when a nonpayable bill was used to meet spenddown in previous certification period, but then was deleted from spenddown for that period. Use only if the nonpayable bill remains obligated.
3. Nonpayable bills: Old bills Responsible relative bills Non-Medicaid providers Not payable by Medicaid	A. Apply a bill paid in full by the client or a state public program in or after the certification period. B. Apply the paid portion of a bill partially paid by the client or a state public program other than Medicaid in or after the certification period. C. Apply the unpaid portion of the partially paid bills. D. Apply bills with no payments.
4. Medicaid-payable bills incurred within the certification period	A. Apply a bill paid in full by the client or state public program in the certification period. B. Apply the paid portion of a bill partially paid by the client or state public program in the certification period. C. Apply the unpaid portion of the partially paid bills. D. Apply bills with no payments.

Removing Expenses Previously Deducted

Legal reference: 441 IAC 75 (Rules in Process)

When a provider submits a claim to the IME that would be payable by Medicaid but spenddown has not been met, the claim is used to meet spenddown.

However, if a bill or claim for a service that is not Medicaid-payable is received after spenddown has been met **and** the service on the bill or claim has a higher priority than the Medicaid-payable claim occurring in the certification period (see chart: Priority of Consideration), the Medicaid-payable claim needs to be removed or "backed out" of the Medically Needy subsystem.

To back out a claim, the noncovered service must have occurred **before** the spenddown was met. Do not request to back out a claim for the eligible person when a bill or claim is received for a service that occurred after spenddown is met.

After the Medicaid-covered service is backed out of the Medically Needy subsystem, it is Medicaid-payable. See 14-I, *Special Procedures*, for instructions on backing claims out of the Medically Needy subsystem.

Mrs. B has a spenddown of $75 for the July-August certification period. She indicates to the worker that she has a $500 medical bill that she owes.

The notice of decision is sent July 15. Mrs. B goes to the pharmacy on July 16. Her prescriptions cost $85. The pharmacist submits a point-of-sale claim for $85 on July 16 and is informed that the client has a spenddown to meet. The claim is denied and submitted for spenddown consideration.

Mrs. B meets spenddown on July 17.

On July 20, the worker receives a claim for a service not payable by Medicaid that occurred before Mrs. B was certified for Medically Needy. The worker sends a copy of the claim and *Transmittal* to the IME Medically Needy Unit, requesting that the pharmacy bill be backed out and the older bill be used to meet spenddown.

A *Notice of Spenddown Status* (NOSS) is sent to the worker. The worker sends the NOSS to the client. This notifies the client that the pharmacy bill is now Medicaid-payable. The IME reimburses the pharmacy. The pharmacy reimburses the client.

Acting On Changes

Legal reference: 441 IAC 75 (Rules in Process)

A change reported by the client during the certification period is effective the first day of the next calendar month if timely notice is not required and the certification period has not expired.

If timely notice is required, make the change effective the first day of the month following timely notice if the certification period has not expired.

If a client becomes eligible under another coverage group during the certification period, redetermine eligibility.

1. Certification period November and December

Net income	$600	+	$600	=	$ 1,200
MNIL	$483	+	$483	=	- 966
					$ 234 Spenddown

Change: On November 24, the F family files an application for FIP and FMAP because Mr. F lost his job. A *Notice of Decision* issued December 15 states that eligibility exists for FIP and FMAP effective December 1. (The family is still over income for FMAP in November.)

Certification period	November
Net income	$ 600
MNIL	- 483
	$ 117 Spenddown

If incurred medical expenses equal or exceed $117 in November, the family is eligible as Medically Needy. Since the family is eligible for FIP and FMAP in December because of decreased income, the family is no longer eligible under the Medically Needy program.

2. Same situation as Example 1, except the family had already met spenddown for the November-December certification period. Follow procedures in 14-I, *Special Procedures: Deleting Claims: Decrease In Spenddown For a Frozen Period*.

For Medically Needy households that are also on other programs, act on changes that are reported on that program's report form.

See 8-G, *Reporting Changes* for changes that need to be reported.

Effect On Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

When a change is reported, recalculate spenddown unless the change is reported timely in the last month of a certification period. If the change was not reported timely, do a recoupment if the spenddown increases.

Mr. S	(No income)
Mrs. S	($2,000 earned income)
Child W	
Child X	

Mr. S leaves the home February 18 during the February-March certification period. The change is reported to the local office February 22. By removing Mr. S, the spenddown **increases**, as there is one less person to consider for the MNIL. Timely notice is required to remove Mr. S from the case. There is **no** recoupment for March.

Adding An Excluded Person to the Household

Do not add the excluded person to household for the excluded month. If the household requests, the person may be added the following month, regardless of the date of the request in the excluded month.

If the excluded person is added after timely notice and the spenddown increases, do a recoupment for the additional spenddown amount.

If the excluded person is added before timely notice and the spenddown increases follow the instructions in 14-I, Special Procedures: Increasing Spenddown.

Increase in Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

Changes that are reported or discovered may increase a spenddown amount that has previously been entered in the Medically Needy subsystem. Do not establish eligibility for the succeeding months of the certification period until difference between the original spenddown amount and the new spenddown amount has been met.

If spenddown for the certification period has not been met, changes in the spenddown may be made on the ESTD, provided timely notice can be issued to the household.

If there is a zero spenddown or if spenddown has been met, spenddown cannot be changed on the Medically Needy subsystem. If spenddown has been met:

1. Cancel the original case on the ABC system, using the zero notice reason.
2. Change the fund codes to "9" for people coded with an S or P on the ESTD for the subsequent month.
3. Establish a new FBU to reflect the corrected spenddown amount for the subsequent month. The difference between the new and the original spenddown amount is the amount of spenddown entered on the new FBU.
4. Payable bills from a prior period cannot be used to meet spenddown for the second month of the certification period that has been established on the new FBU.

1. Certification period: November & December

Net income	$540	+	$540	=	$ 1,080
MNIL (1 person)	$483	+	$483	=	- 966
					$ 114 Spenddown

Change: On November 10, the SSI-related conditionally eligible person reports a $50 increase in income. Spenddown for the November-December certification period has not been met. The IM worker recalculates as follows and sends timely notice:

Certification period: November & December

Net income	$540	+	$590	=	$1,130
MNIL (1 person)	$483	+	$483	=	- 966
					$ 164 Spenddown

New spenddown	$164	
Original spenddown	- 114	
	$ 50	Additional spenddown for December

The IM worker changes the spenddown amount to $164 on the ESTD and sends the ESTD to the IME Medically Needy Unit.

2. The SSI-related case has an April-May certification period with a spenddown of $155. On April 10, an increase in income is reported. The new spenddown is $250. The difference is $95. The IM worker checks the Medically Needy subsystem and discovers that spenddown was met on April 9. Therefore, the certification period is frozen.

   The IM worker issues a timely notice of decision effective May 1 informing the client of the new spenddown. As it is before April timely notice, the IM worker cancels the Medically Needy case effective May 1. The IM worker changes the ESTD for May, using a fund code of 9 for persons coded with an S or P.

   Once the case is canceled and the ESTD has been corrected, the IM worker establishes a new FBU for the month of May only with the new spenddown amount of $95 (the difference between the new spenddown amount and the previous spenddown that was met). The IM worker ensures that the bills used previously to meet spenddown are not allowed on the new FBU.

   The IM Worker establishes the June-July certification period using the original FBU.

3. In a May-June certification period, spenddown is met May 5. Due to a reported change, the IM worker establishes a separate FBU for the month of June. The spenddown for June is $55.

   A provider submits a claim showing charges for May 30. Once spenddown was met, the client became eligible for Medicaid in May. These charges are Medicaid-payable and do not represent a legal obligation. Therefore, the May bill cannot be used to meet spenddown for the June-only certification period. Allowable medical bills incurred in June are used to meet spenddown for that month.

If a change results in a **spenddown for a case that did not have a spenddown**, assign a two-month certification period. Provide timely notice of the conditionally eligible status, the amount of spenddown, and the months of the certification period.

If the timely notice deadline has passed and the change cannot be made for the certification period, follow recoupment procedures for those errors made by the worker or due to untimely reporting by the household.

Use old medical bills that are not payable in a prior period and remain legally obligated to meet spenddown. See 14-I, *Resubmittals*, for instructions on when to resubmit bills on the *Bill Status Turnaround Document*.

If the change results in a **decrease in spenddown**, recalculate the spenddown. Enter the change on the ESTD regardless of whether spenddown has been met. Send the ESTD:

- Electronically to: imemedicallyneedy@dhs.state.ia.us,
- Faxed to: Medically Needy Unit at 515-725-1350, or
- Mailed to: IME Medically Needy Unit, 1305 E. Walnut St., Des Moines, IA 50319-0114

If bills payable by the Medicaid program were used to meet spenddown the claims will be deleted from the Medically Needy subsystem and paid.

If a nonpayable bill used to meet spenddown is still unpaid, a credit will be indicated on the *Bill Status Turnaround Document*.

Provide notice to the client of the new spenddown amount.

1. February-March Certification Period

   Mr. M ($2000 earned income)
   Mrs. M ($ 500 UIB)
   Child W
   Child X

   Mr. M leaves the home on February 4. This is reported February 15. The county office is not required to issue timely notice, as the overall program effect is positive. Mrs. M continues to be eligible for March with a reduced spenddown. The children are determined eligible for MAC and are considered persons for Medically Needy.

   The IM worker sends a *Notice of Decision* indicating a decrease in spenddown and changes the spenddown amount on the ESTD. The IM worker also sends a *Notice of Decision* on MAC eligibility for the children.

2. Household composition: Mr. T, age 20, and Mrs. T, age 19.

   Mr. T receives $462 unemployment benefits per month. Mrs. T receives $50 worker's compensation per month. The date of decision is November 1.

Certification period	November	and	December			
Net income	$512	+	$512	=	$ 1,024	
MNIL for two	$483	+	$483	=	$ 966	
				=	$ 58	Spenddown

   Mr. T timely reports on November 21 (the first month of the certification period) that Mrs. T has left the home and has filed for divorce. On November 28, the IM worker acts upon the reported change and recalculates the spenddown as follows:

	November		December			
Net income	$512	+	$462	=	$ 974	
MNIL for two	$483					
MNIL for one		+	$483	=	$ 966	
				=	$ 8	Spenddown

   The reported change has a positive effect on the spenddown (it reduces it). The IM worker sends a notice informing Mr. T that his spenddown has been reduced to $8 and changes the amount on the ESTD.

3. Mr. Q's (SSI-related) spenddown for the November-December certification period was calculated as follows:

Certification period	November	and	December			
Net income	$450	+	$534	=	$ 984	
MNIL	$483	+	$483	=	$ 966	
					$ 18	Spenddown

   On November 20, Mr. Q reports his December income will be only $450. Spenddown is recalculated as follows:

Certification period	November	and	December			
Net income	$450	+	$450	=	$ 900	
MNIL	$483	+	$483	=	$ 966	
					$ 0	Spenddown

   The IM worker sends a *Notice of Decision* informing Mr. Q that there is no longer a spenddown obligation for the November-December certification period and changes the amount on the ESTD.

Department of HUMAN SERVICES

Employees' Manual
Title 8, Chapter K

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Psychiatric Institutions

Page

Overview

Psychiatric institutions are medical facilities that offer psychiatric services to the resident. To be considered a psychiatric institution, the facility must provide only psychiatric services to the majority of its residents. The types of psychiatric facilities in Iowa are:

- State mental health institutes (MHIs), which provide hospital level of care.
- Nursing facilities for mental illness (NF/MIs), which provide intermediate care facility (ICF) level of care.
- Psychiatric medical institutions for children (PMICs), which provide mental health **or** substance abuse care.

Medicaid eligibility for people residing in psychiatric facilities is handled somewhat differently because of state and federal rules that apply only to these types of facilities. This chapter provides specific information about eligibility and program requirements for these facilities.

Persons who establish and maintain eligibility under most coverage groups are eligible for Medicaid payments to a psychiatric institution if the age and medical necessity requirements are met. EXCEPTION: The Medically Needy coverage group does not pay for psychiatric medical institution care.

Chapter 8-I, *Medical Institutions*, describes income, resource, and nonfinancial eligibility policies for all members in medical institutions, including members in psychiatric medical institutions, and an explanation of client participation. Use this chapter in combination with 8-I to determine initial and continuing eligibility for individuals in these types of facilities.

This chapter also includes information on the workflow process for authorization of facility payment by using the Institutional and Waiver Authorization and Narrative System (IoWANS). See 8-I, *Use of IoWANS*, and 14-M, *IoWANS User Guide*.

Facility Participation in Medicaid

Legal reference: 441 IAC 85.1(249A), 85.21(249A), 85.41(249A); Iowa Code Section 135H.1

Psychiatric institutions participate in Iowa Medicaid as follows:

- **Mental health institutes (MHIs).** There are two state mental health institutes, at Cherokee and Independence. Medicaid can pay MHI services for Medicaid-eligible people who are:
  - Under the age of 21, or
  - Aged 65 or older
- **Nursing facility for mental illness (NF/MIs).** An NF/MI is either:
  - A nursing facility that has a special license to care for persons with mental illness, or
  - A distinct part of a hospital that is certified as a nursing facility and meets the requirements for a psychiatric hospital.

  Medicaid can pay NF/MI services for Medicaid members who are aged 65 or older. Placement in an out-of-state NF/MI is not payable.
- **Psychiatric medical institution for children (PMIC).** A PMIC is a nonsecure institution that provides 24 hours of continuous care and diagnostic or long-term psychiatric services to children (under age 21).

  A PMIC may provide mental health or substance abuse services. The facility must be licensed as a PMIC and must also have a license as either a foster care facility or a substance abuse treatment facility.

The Bureau of Long Term Support Services notifies local offices of PMICs that may participate in Medicaid. Currently, those facilities are:

Facility	National Provider Identifier (NPI)	Type of Service
Beloit Lutheran Home	1023187507	Mental health
Boys and Girls Home Residential Treatment	1063511038	Mental health
Bremwood Lutheran Home	1023187507	Mental health
Children's Square USA	1134265291	Mental health
Four Oaks Inc	1710046255	Mental health
Hillcrest Family Services	1780880310	Mental health
Jackson Recovery Centers, Inc	1811994973	Substance abuse and mental health
Orchard Place	1245220938	Mental health
Tanager Place	1114083474	Mental health

Most of these facilities are licensed as both foster care and medical facilities. However, both foster children and non-foster children may be placed in any PMIC.

- **Out-of-state facilities.** When no in-state facilities are available to meet the needs of a person, placement in an out-of-state psychiatric hospital for acute care or other specialized psychiatric or neurobehavioral treatment facility requires prior approval through the "exception to policy" process for individuals not currently enrolled with an MCO.

  Such "exception" requests are reviewed by the IME Policy Unit, which then forwards a coverage recommendation to the Director's Office for the Director's approval and signature. Placements are approved only if:

  - The special services being sought are not available in Iowa facilities, or
  - The person for whom placement is being sought presents treatment, care, or behavioral challenges not able to be addressed by any Iowa facilities.

  Approval through an exception to policy requires documentation that attempts were made to place the person in at least six in-state facilities, but each facility denied the placement.

  Reasons for denials typically include, but are not limited to, aggressive behavior or other problematic or unique behavioral issues or challenges exhibited by the person needing placement, which in-state facilities are not staffed to care or provide treatment for the person safely or effectively.

Who Is Eligible

Legal reference: 42 CFR 441.151; 441 IAC 85.1 (249A), 85.21 (249A), and 85.41 (249A)

In order for services to be paid by Medicaid, residents of psychiatric medical institutions, including children in PMICs, must meet the income, resource, and program guidelines of a Medicaid coverage group.

EXCEPTION: The Medically Needy coverage group does not pay for psychiatric medical institution care. However, other Medicaid-covered services may be paid for a Medically Needy eligible person while in the psychiatric institution.

If a Medically Needy eligible person wants payment of the psychiatric institution services, you will need to complete a redetermination to determine if the person has eligibility for another coverage group, such as the 300% group for those under 21 or over 65.

The person must also meet the eligibility requirements for payment for care in a medical institution. A person must:

- Need the level of care provided by the medical institution.
- Be certified for care by an independent team.
- Have lived in an institution for 30 days if the person's eligibility will be determined under the 300% eligibility group.
- If married, meet specific income and resource guidelines for married couples.

See 8-I, *Eligibility*, for more information about these requirements.

The PMIC or MHI must obtain authorization for admission and continued stay for Medicaid applicants or members. The Iowa Medicaid Enterprise (IME) Medical Services Unit, Medicare, or the MCO authorizes the level of-care, depending on the payment source.

- For adults in MHIs, Medicare makes the determination when Medicare is covering the stay. The provider will report this on the case activity report.
- For children in PMICs and MHIs, the IME Medical Services Unit or the MCO makes the determination for children.

Application Processing

Legal reference: 441 IAC 76 (Rules in Process)

The income maintenance (IM) worker for an MHI accepts and processes applications for MHI payment for people who live or who have lived in that facility. The MHI worker handles the ongoing case for the person entering and residing in the MHI.

The Centralized Facility Eligibility Unit (CFEU) accepts and processes applications for PMIC payment for people who live or have lived in the PMIC. The worker assigned to the facility processes eligibility for the child in the PMIC and enters system information.

When a person enters a PMIC, an NF/MI, or an MHI, the IM worker handling the facility case should check to see if the person is already a Medicaid member.

See Children in Foster Care or Subsidized Adoption in PMICs when processing an application for foster children in a PMIC. See Voluntary Placement in PMICs for all other children.

Application After Discharge

If a member is admitted and discharged before a Medicaid determination is made, determine eligibility according to the policies earlier in this chapter. Send form 470-3924, *Request for IoWANS Changes*, to DHS, IoWANS-Facilities. Include on the form:

- Member's name, State ID,
- Aid type
- Date of entry
- Date of discharge
- Facility national provider identifier (NPI) number
- Client participation amounts and dates. If there are different amounts for different dates, specify all.

Submit form 470-0397, *Request for Special Update*, to Quality Assurance to authorize Medicaid eligibility for specific months.

Person Already Receiving Medicaid

Legal reference: 441 IAC 76 (Rules in Process)

Do not require a new application when a Medicaid member enters a medical facility for psychiatric care. EXCEPTION: If the certification period for a Medically Needy member is ending within 30 days of the person's entry to the institution, a new application must be filed.

If other people are active on the case with the person in the facility, that case record does not go to the facility worker. The facility worker opens a new case or reopens a case for the person in the institution and obtains a copy of the latest application *or* review from the family's case record. The case retains the same aid type and fund code until new information is obtained (if needed to process the case for facility payments).

When the person in the facility was eligible with a family at home, the worker assigned to the facility and the worker assigned to the family must work together to determine continued eligibility. The family's worker processes the family's Medicaid eligibility based on the admission of a household member to the facility and the expected length of stay.

Foster children who are IV-E-eligible on entering an MHI or a PMIC must have Medicaid eligibility established under a coverage group other than IV-E, since these are not IV-E-eligible placements.

Establish a separate family budget unit (FBU) of 19 for a foster child or a child in subsidized adoption in a PMIC so that the Family And Children Services (FACS) system continues to communicate with the Automated Benefit Calculation (ABC) system.

Medicaid members enrolled with an MCO who are 21 to 65 years of age and are in an MHI for 15 or fewer days per month are eligible for payment to the MHI through the MCO. Do not close the member when they enter the MHI. Review the member's eligibility and if they continue to be eligible under the same coverage group, leave the case active. The MHI facility worker will need to add the MHI stay to IoWANS.

Persons Not Receiving Medicaid

Legal reference: 441 IAC 76.1(249A)

People who are not receiving Medicaid must file an application and be determined eligible before Medicaid will pay for services. See 8-B, *Application Processing*, for general application processing procedures. Follow interview procedures defined in 8-B, *Interviews*.

Members whose Medically Needy certification is ending in the month of entry must file a new application to determine if they are eligible for a coverage group for which facility services will be paid.

The retroactive period, if any, is covered by Medicaid if the individual meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*.

In many cases, the coverage group for which the applicant is eligible in the retroactive period may be different from the coverage group for the month of application. Retroactive benefits are available only for up to three months preceding the month the application is filed, even if the applicant entered the facility earlier.

Nonfinancial Eligibility

There are additional nonfinancial eligibility requirements for Medicaid payment for psychiatric institutional care:

- Children must have a certification of their need for psychiatric institutional care.
- Each applicant and recipient must meet level of care requirements (medical necessity).

Age

Legal reference: 42 CFR 441.151(a); 441 IAC 85.1(249A), 85.3(1), 85.4(249A), 85.22(1), 85.43(249A)

Persons in an NF/MI must be 65 years of age or older.

To be eligible for payment of services in a PMIC, the person must be under age 21. When age has already been verified, it does not need to be verified again.

If an eligible child begins treatment in a PMIC or MHI immediately before turning 21, continue coverage until the 22nd birthday or until the last day of the last month when the person is unconditionally discharged, whichever comes earlier.

Certification of the Need for Care

Legal reference: 42 CFR 441.152; 441 IAC 85.3(3)

Children under age 21 must have a preadmission evaluation. As a condition of eligibility for Medicaid payment of services in a PMIC or MHI, a team that is independent of the facility must certify all of the following:

- Inpatient services are expected to improve the child's condition or prevent further regression, so that ongoing inpatient services will eventually not be required.
- The child needs inpatient care under the direction of a physician.
- Outpatient services currently available in the community do not meet the treatment needs of the child.

For a child who is not Medicaid-eligible before admission, lack of a certification does not prevent the child from entering a PMIC or MHI. However, the certification must be completed before any Medicaid payment will be made. For this reason, a facility may refuse to admit a child until the certification of need is performed.

The IME Medical Services Unit or the MCO will ensure that the certification has been completed for non-emergency entries to a PMIC before providing a level-of-care determination for children entering any of the PMICs.

Medical Necessity

Legal reference: 441 IAC 78.3(249A), 81.3(249A), 81.7(249A), 85.6(1)"f", 85.24(1)"f," 85.45(1)

Payment will be made to a psychiatric medical institution only if the care provided is determined to be reasonable, necessary and appropriate. This determination must be done before ABC entries are made to allow facility payments.

A determination of the medical necessity for the level of care provided is required when a person:

- Enters a psychiatric medical facility.
- Moves to a bed that is certified for a different level of care.
- Returns to the psychiatric medical facility after leave beyond reserve bed days.
- Moves to a different medical facility, even if at the same level of care.

The IME Medical Services Unit makes the determination for people who are **not** currently enrolled in Medicaid. For people who are currently enrolled in Medicaid with an MCO, the MCO determines medical necessity.

When a child in foster care is a candidate for PMIC placement, the social worker contacts the facility so the facility can request a level of care determination from the IME Medical Services Unit or the MCO. The IME Medical Services Unit or the MCO usually calls the facility with a determination within one working day.

The day the determination is made, the facility sends the IM worker form 470-0042, *Case Activity Report*. Review this form to verify approval for the level of care that the person is seeking. If the person meets all other eligibility requirements and the level of care is medically necessary, complete ABC system entries for an eligibility determination. See 14-B(9) for system instructions.

Contact the facility if the effective date on the *Case Activity Report*, form 470-0042, does not match the date the person wants Medicaid payment to begin or if you do not receive a *Case Activity Report*.

If an applicant who meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*, has requested retroactive eligibility to cover the cost of medical institution care, check to see if the IME Medical Services Unit or the MCO has made a retroactive determination. A person may have needed institutional care in the retroactive period even if such care is not medically necessary now.

If Level of Care Is Denied

Legal reference: 441 IAC 85.7(2), 81.3(1)

If the IME Medical Services Unit or the MCO determine that the person does not need the level of care or the type of facility that the person is in, it will issue a letter to:

- The applicant,
- The facility physician,
- The facility,
- The income maintenance worker, and
- The service worker, if involved.

The person may appeal to the Department if the person disagrees with the decision.

If PMIC level of care is denied for a child in foster care, payment for the child's care is made at the foster care rate through the foster care program, instead of the Medicaid program. Cancel the Medicaid facility payment for the child effective the day of denial and refer the case to the responsible service worker to arrange for foster care payments to the PMIC.

To continue Medicaid for foster children or children in subsidized adoption without facility payment, change the coverage group from a facility coverage group to a non-facility coverage group to reflect the proper coverage group of the child as if they were not in a facility, such as a MAGI or Non-MAGI coverage group, or a foster care and subsidized adoption Medicaid state-only aid type of 40-9.

Continued Stay Reviews

Legal reference: 441 IAC 81.7(249A), 85.24(1)"f," 85.45(1)

The IME Medical Services Unit or the MCO complete the recertification reviews. The facility is responsible for obtaining the recertification of the need for care. Assume that the level of care continues to be approved unless you receive other notice.

If the level of care is denied at the time of review for persons in a MHI, the policy is the same as in 8-I, *Medical Necessity*. Lower level of care payments may apply. The payment to the facility is made at a reduced level.

If level of care is denied at the time of review for children in a PMIC, Medicaid will not continue payment for PMIC services.

If it is determined that a child no longer needs the level of care in the PMIC, staff at the IME Medical Services Unit or the MCO will phone the facility with the finding. On the same day, the IME Medical Services Unit or the MCO will notify the resident, the physician, and the facility, by letter. The IoWANS system will notify the workers when it is determined that a person no longer meets level of care.

> Charles, age 20, enters an MHI. At the continued stay review, the IME Medical Services Unit finds that Charles no longer needs MHI care, so Medicaid will not pay the MHI. Charles' MHI services are not covered while arrangements are made for a different placement. The MHI case is closed. Charles continues to be eligible for Medicaid payments of any other services. His Medicaid is reopened under another coverage group.

Reconsideration reviews and appeals follow the same process as outlined in the previous section for the initial determination.

If the person moves to another facility, the admitting facility should send a *Case Activity Report* indicating that a level of care determination has been obtained.

Coverage Groups

Legal reference: 441 IAC 75 (Rules in Process), 76 (Rules in Process), 85.3(4), 85.4(249A), 85.22(4), and 85.43(249A)

Persons who establish and maintain eligibility under most coverage groups are eligible for Medicaid payments to a psychiatric institution if the age and medical necessity requirements are met. EXCEPTION: The Medically Needy coverage group does not pay for psychiatric medical institution care. However, a person may be eligible for other Medicaid-covered services under Medically Needy.

Children who are not in foster care have Medicaid eligibility established under MAGI or Non-MAGI policies. Their MAGI-related eligibility, other than the 300% group, must be determined considering the parents when they go from home to the psychiatric medical institution and are expected to return home in less than 12 months. See 8-F, *MAGI-Related Coverage Groups*.

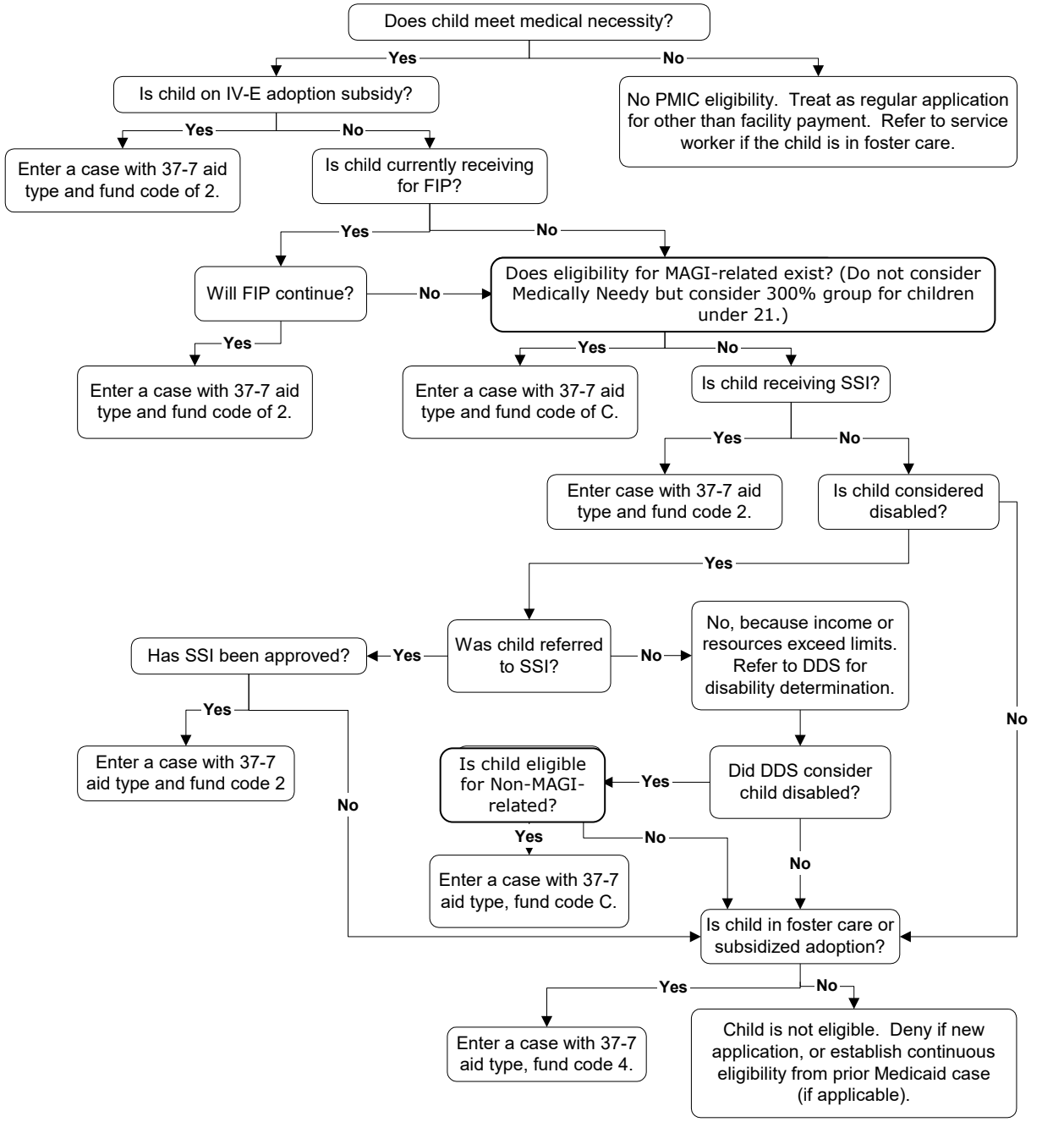
If a MAGI-eligible child is expected to stay in the institution more than 12 months or does not enter the institution from the home, base eligibility on the child's circumstances only.

When determining eligibility under the 300% group, the parent's income is not deemed to the child when the child is in a medical facility for a full calendar month. If the child enters a medical facility after the first of the month, deeming of income stops the month after the month of entry.

> Marge, age 14, is placed in the PMIC by her parents on October 28. They file an application October 30. Marge is expected to return home by December 31. Since Marge is not a foster child, her Medicaid eligibility is determined with her family according to absence from the home policy. The parent's income is in excess of all MAGI-related Medicaid coverage groups, except Medically Needy.
>
> Once Marge has resided in the facility for 30 consecutive days, her eligibility can be determined under the 300% group. For the 300% group, Marge is considered separate from her parents starting the first month after entry to a facility. The parent's income is not considered in determining Marge's eligibility or client participation starting November 1. No Medicaid payments can be made to the PMIC facility for the days in October.
>
> If Marge had entered the PMIC on October 1, her parent's income would not be considered in determining her eligibility or client participation starting October 1.

A MAGI-eligible child placed in foster care and in a psychiatric facility loses MAGI eligibility after the month of entry because the child is no longer considered a member of the household.

Summary of PMIC Eligibility



Code persons eligible for Medicaid in the coverage group for which they qualify. See 14-B-Appendix, *TD01: Section 1. Identification: TD01 AID*, *TD01 MED AID*, and *TD03 Section VII. Personal Information: TD03 FUND*, for proper coding.

MAGI-Related Eligibility

Legal reference: 441 IAC 75 (Rules in Process)

A person who is eligible for a MAGI-related coverage group can qualify for psychiatric institution payments if that person meets additional eligibility requirements that apply to institutional care as listed under Certification of the Need for Care and Medical Necessity.

The policies of the coverage group for which the person is eligible apply. If the person loses that eligibility, determine if continuous eligibility for children applies, or do an automatic redetermination to determine if other Medicaid eligibility exists. See 8-F, *Continuous Eligibility for Children*, or 8-G, *Automatic Redetermination*, for additional information.

When it is determined that the income of the family at home creates ineligibility for a person, explore eligibility under the 300% group. There may be eligibility under the 300% group for children under age 21. For more information, see 8-F, *Coverage Groups*.

1. Sharon, age 17, is placed in the MHI by her parents on March 13. Sharon's doctor states she will be discharged to come home in less than 12 months. Sharon remains a member of the household at home. All of the family members are considered in determining household size and countable income. The family meets eligibility and MAGI-related income limits.

   Sharon is included in the MAGI-related household for Medicaid. A second case is opened for Sharon so that payment can be made to the facility. Deemed income from Sharon's parents is counted for client participation for the partial month of admission but is not considered available for ongoing months' client participation.

2. Sam, age 19 and not disabled, lived with his parents before entering the MHI. Sam's doctor states he is expected to remain in the MHI for at least 60 days. The plan is to return Sam to his parents' home after completion of treatment. Sam's eligibility is determined with the family at home. The family's income is in excess of the MAGI-related limits.

   300% group eligibility can be established after Sam has been in a medical institution for 30 consecutive days. The worker counts the income of Sam and his parents for the month of entry, but counts only Sam's income for any months following the month of entry.

   Sam may not be eligible for facility coverage for the month of entry due to the deeming of parental income. If he needs help with other medical costs for that month, he may be eligible for Medically Needy.

Non-MAGI-Related Eligibility

Legal reference: 441 IAC 75 (Rules in Process)

A person who is eligible for a Non-MAGI-related coverage group (except Medically Needy) can qualify for psychiatric institution payments if that person meets additional eligibility requirements that apply to institutional care as listed under Certification of the Need for Care and Medical Necessity.

The policies of the coverage group for which the person is eligible apply. If the person loses that eligibility, determine if continuous eligibility for children applies, or do an automatic redetermination to determine if other Medicaid eligibility exists. See 8-F, *Continuous Eligibility for Children*, or 8-G, *Automatic Redetermination*, for additional information.

NOTE: There may be eligibility under the 300% group for persons who are disabled. When it is determined that income creates ineligibility for a Non-MAGI-related person, explore eligibility under the 300% group. For more information, see 8-F, *Coverage Groups*.

When an SSI recipient enters a psychiatric institution, use form 470-0641, *Report of Change in Circumstances—SSI-Related Programs*, to notify the Social Security Administration. Admission to a psychiatric institution may affect the SSI recipient's benefits or eligibility. Verify any changes to the SSI benefits through the State Data Exchange (SDX) process.

The Social Security Administration will cancel SSI benefits for a person living in a public medical institution if Medicaid does not or is not expected to pay for at least 50% of the cost of care. EXCEPTIONS:

- If the person was eligible for SSI and Medicaid under 1619(a) or (b), then SSI will continue for two months after entry.
- If the SSI-eligible person will return home within three months, then SSI will continue for those three months.
- Non-MAGI-related Medicaid is not canceled if the person entering a public medical facility is under the age of 21 or over the age of 65.

If the person enters a non-public medical psychiatric institution and Medicaid is expected to pay at least 50% of the cost of care, the Social Security Administration does not cancel the case but reduces the SSI benefits and income level to $30.

If a Non-MAGI-related person who is eligible under the 300% group is denied level of care, the person may be eligible under the Medically Needy program for services other than facility payments. If the person is a child in foster care, Medicaid will continue with state-only funding. See 8-F, *Coverage Groups*.

People in a Psychiatric Medical Institution Within the 300% Income Limit

Legal reference: 42 CFR 435.201; 441 IAC 75 (Rules in Process), 85.3, 85.4, 85.22, and 85.43

Medicaid is available to a person who meets all of the following requirements:

- The person receives care in a hospital, nursing facility, NF/MI, or psychiatric medical institution and has been institutionalized for 30 consecutive days.
- The person meets medical necessity requirements for the institution as established by the IME Medical Services Unit, Medicare, or by the MCO. See 8-I, *Medical Necessity*.
- The person is under the age of 21 or is age 65 or older.
- The person meets all Supplemental Security Income (SSI) eligibility requirements except income.

  EXCEPTION: Do not consider resources for children under 21.
- The person has gross monthly income that is more than the SSI standard but does not exceed 300% of the federal SSI benefit for one person living at home.

See 8-F, *People in Medical Institutions: 300% Income Level* and 8-I, *Eligibility for the 300% Group*, for more information.

1. Ms. Q, age 35 and not currently on Medicaid, enters a MHI in January. Before that, she was living with her family at home. She receives social security disability income of $980 per month and meets all other Non-MAGI-related Medicaid eligibility criteria. Regardless of meeting all other eligibility criteria, Ms. Q does not meet the age requirements.
2. John, age 14, enters a PMIC on July 5 and is expected to stay more than 12 months. He does not meet absence from the home policy, so his Medicaid eligibility is determined separately from the family at home. He is considered as a household of one the month following the month of entry.

   He must meet the eligibility requirements of the 300% group, including the 30 day stay requirement for ongoing eligibility.

Client Participation

Legal reference: 42 CFR 435.725; 441 IAC 75 (Rules in Process), 85.5(249A), 85.23(249A), 85.44(249A)

Medicaid members are required to participate in the cost of payment toward psychiatric institution care. Client participation and medical payments from a third party must be paid toward the total cost of care for the month before any Medicaid payment is made. Medicaid pays the balance of the cost of care for the remainder of the month.

With a few exceptions, client participation for persons in PMICs and nursing facilities for the mentally ill (NF-MI) is calculated and assessed in the same manner as client participation for persons in other medical institutions. The same income and deductions are allowed as for persons in nursing facilities. See 8-I, *Client Participation*.

EXCEPTION: People in MHIs are not assessed client participation.

Do not calculate client participation or notify these members that they owe client participation to the MHI.

People in facilities are allowed a deduction for unmet medical needs. Health insurance premiums can be allowed when children are covered under a family insurance policy. When the insurance is in the name of a parent or spouse of an institutionalized person, the premium can be allowed as an unmet medical deduction even if the policy covers other members of the family as well as the member.

Service fees charged by a bank or financial institution for handling the health insurance payments are not allowable unmet medical needs.

> Mrs. A pays $300 monthly for health insurance coverage for her family. One of Mrs. A's children, Betty, is approved for Medicaid and PMIC facility payments effective May 1. Betty is covered under the family's health insurance. Betty receives $530 social security. She is allowed a deduction of $300 unmet medical needs in computing her client participation.

Collecting Client Participation in PMICs

Legal reference: 441 IAC 85.23(249A)

The consideration of unearned income in the PMIC client participation calculation is not different from other medical facilities. However, how that client participation is collected may be different, depending on whether or not the income has been assigned to the Department.

The IM worker is responsible for the calculation of the client participation, sending the notice, and making the system entries. The PMIC is responsible for collecting the client participation.

Facilities are notified of the amount of client participation through Iowa Medicaid Provider Access (IMPA). The facility makes arrangements directly with the member for collection of client participation.

> Ted's father admitted him to a PMIC. Ted's mother receives child support of $300 monthly for Ted and his sister. The IM worker sends Ted's father a notice explaining that Ted owes client participation. Ted's mother refuses to pay the client participation. The IM worker is not responsible for resolving this issue. Ted's father may want to seek legal counsel about the situation.

The "governmental income" of foster children who enter PMICs is assigned to the Department. The assignment continues while the child is in foster care. This assigned income cannot be considered for client participation to be paid to the facility. It is used to credit the Medicaid payment to the facility.

When a foster child in a PMIC has income such as Social Security, SSI, Veterans, Railroad Retirement, etc., the income is assigned to or collected by the Department. If the child has been in a foster care setting before entering the PMIC, this assignment will likely already be done. If not, the child's service worker should initiate this assignment and inform you when completed.

When the unearned income is assigned to the Department, the worker still informs the member that income is being considered toward client participation. However, the worker should also explain that because this income is being sent to the Department, the Department will collect this portion of the client participation.

Indicate on the *Notice of Decision* that the assigned income is paid for client participation to the Department, but don't put the income on the ABC system to be paid to the facility while it is assigned. All unearned income that is not assigned will continue to be sent to the child's representative and should be used for client participation according to policies in 8-I, *Client Participation*.

The Bureau of Accounting Services will credit the Medicaid program with the amount of the client participation accessed from income assigned to the Department and will also send the personal needs allowance to the facility for the member.

Although a member with only assigned income will technically have client participation and should be sent a notice indicating this, there will not be any

client participation reflected on the ABC system or the facility's payment. Effectively, in this situation, the Department is collecting client participation instead of the PMIC.

> Tim, an SSI recipient who is a foster child, enters a PMIC on July 1. Tim receives Social Security income of $200 per month. Because Tim is a foster child, his Social Security benefit is assigned to the Department. The IM worker enters zero client participation on the ABC system. The Department will handle collecting the client participation and adjusting the Medicaid facility payment based on the amount collected.
>
> If Tim had not been a foster child, the Social Security income would not be assigned to the Department. The IM worker would send a notice explaining that Tim must pay client participation.

If the member transfers from a foster care setting in which the member contributed income towards the cost of foster care assistance, the amount paid for foster care in the month of entry to the PMIC is not available for client participation.

> Sam, a foster child, enters a PMIC on November 18. Sam's Social Security benefit of $500 has already been assigned to the Department. For November 1 through November 17, Sam was responsible for paying $200 towards his foster care costs. For the month of November, the amount paid for foster care is not counted for client participation.
>
> The IM worker sends a notice explaining that Sam owes client participation and that the Department will collect this from the Social Security income the Department was already receiving. The worker enters $0 client participation on the system. When the PMIC bills the Department, the client participation is not subtracted from the PMIC's payment. The Department sends Sam his personal needs allowance and credits the remaining income to the Medicaid program.

Child support income is assigned to the Department for a child receiving foster care cash assistance. The assigned child support paid by the noncustodial parent to CSRU is not sent to the child or the custodial parent but is instead paid to the foster care program.

When a foster care child enters a PMIC, the service worker completes entries into the FACS system. FACS communicates to CSRU that the child has entered a PMIC. The communication results in CSRU terminating the assignment of the child support to the state.

The IM worker is not responsible for billing and collection of the client participation. The PMIC is responsible for collecting any client participation.

Facilities are notified of the amount of client participation through Iowa Medicaid Provider Access (IMPA). If the facility asks for assistance in collecting child support from the noncustodial parent, tell the facility to use any collection method they would normally use to collect any other debt.

Any child support that is paid to CSRU by the noncustodial parent (other than medical support) will be sent to the child or the child's representative.

While the child support is assigned, list it on the notice as income for determining client participation, because the child support that should be paid will go to the parent upon the termination of assignment.

When determining client participation for current and future months, project the amount of child support that will be received. Project future child support payments using the child support payment history screen on Iowa Collection and Reporting System (ICAR) as a tool.

Often the payment history will reflect sporadic payments or amounts that vary from month to month. Using the payment history, project future payments as accurately as is possible. However, if the payments that the child actually receives differ from what was projected and used for client participation, adjust the client participation accordingly. Make this adjustment at least once every six months. See 8-I, *Changes in Client Participation*.

Tim enters a PMIC. He is eligible for MAGI-related Medicaid. Tim regularly receives child support income of $75 per month that has not been assigned to the Department. The IM worker sends Tim a notice explaining that he owes client participation.

When child support is not assigned and is being paid to the child, the full amount of the payment must be applied towards client participation. (Neither the 1/3 disregard used for non-MAGI-related eligibility purposes nor the $50 exemption for MAGI-related child support income is applicable for client participation.)

1. Bill enters a PMIC from foster care on December 1. Bill regularly receives child support income of $700 per month that has been assigned to the Department. CSRU is notified on December 15 that Bill has entered a PMIC and that foster care cash assistance has been canceled beginning December 1.

   Unless information is received indicating otherwise, the IM worker sends Bill a notice explaining that he owes client participation. If the assignment is not actually terminated in December and child support payments of $700 are not received, the client participation for December should be adjusted.

2. Jan enters a PMIC from foster care on January 1. Jan receives Social Security income of $300 and regular child support income of $200. Jan's Social Security and child support are both assigned to the Department. However, CSRU was promptly notified of the PMIC placement and foster care assistance was canceled. The child support assignment has now been terminated.

   The IM worker sends Jan a notice explaining the amount of total client participation owed. The client participation will be collected from her Social Security income, which is assigned to the Department after allowing a personal needs deduction. The notice also informs Jan that she should pay the remaining income to the PMIC from her child support.

<table>
<tr><th colspan="4">Client Participation Calculation for Facility Residents</th></tr>
<tr><th colspan="2">Medical institution stay will be less than 12 months (MAGI-related eligibility):</th><th colspan="2">Medical institution stay will be more than 12 months (MAGI-related eligibility):</th></tr>
<tr><th>Month of Entry</th><th>Subsequent Months</th><th>Month of Entry</th><th>Subsequent Months</th></tr>
<tr>
<td>• If the family receives FIP benefits, there is no CP.

Otherwise:
• Count the income of the institutionalized person and the family.</td>
<td>• If the family receives FIP benefits, there is no CP.

Otherwise:
• Count only the institutionalized person's income.</td>
<td>• If the family receives FIP benefits, there is no CP.

Otherwise:
• For children, count the child' income and the parents' deemed income.
• For adults, count only the income of the person in the facility.</td>
<td>• Count the institutionalized person's income.</td>
</tr>
<tr><th colspan="2">Medical institution stay will be less than 30 days (300% group):</th><th colspan="2">Medical institution stay will be more than 30 days (300% group):</th></tr>
<tr><th colspan="2">Month of Entry Not Applicable</th><th>Month of Entry</th><th>Subsequent Months</th></tr>
<tr>
<td colspan="2">• For children, count the income of the institutionalized person and the family.
• For adults, count the income of the institutionalized person and the spouse.</td>
<td>• For children, count the income of the institutionalized person and the family.
• For adults, count the income of the institutionalized person and the spouse.</td>
<td>• Count only the institutionalized person's income.</td>
</tr>
</table>

Case Maintenance

The following sections explain how to treat persons in psychiatric institutions with respect to:

- Review and redetermination of Medicaid eligibility
- Discharge from the facility
- Payment for reserved beds during absence from the facility
- Voluntary placements

Reviews and Redeterminations

Legal reference: 441 IAC 76.14(2)

Review eligibility according to the policies for the coverage group under which the member is eligible. The following chart shows by coverage group when reviews are required. For any coverage group, when there is a change in the person's circumstances that might affect eligibility, complete a desk review to determine the effect of the change.

Medicaid Coverage Group	Review Due	Review Form
Non-MAGI-related	Annually	*Medicaid/State Supp Review*, form 470-5482, 470-5482(S), 470-5842(M), and 470-5482(MS)
MAGI-related	Annually	*Medicaid/Hawki Review*, form 470-5168, 470-5168(S), 470-5168 (M), and 470-5168(MS)
Foster care children Subsidized adoption children State-only medical assistance Unaccompanied refugee minors	Annually	No form used.

Send the applicable review form to the person who signed the application. When the review form is returned, complete the review and request needed verification.

For children in foster care, complete a desk review using information from the service worker.

Redetermine Medicaid eligibility as state-only with a FUND code of "4" if the service worker cannot provide information to establish ongoing eligibility under the current coverage group.

See 8-G, *Additional MAGI-Related Case Maintenance: Eligibility Reviews* and *Additional Non-MAGI-Related Case Maintenance: Eligibility Review*.

Payment for Reserving a Bed in a Psychiatric Medical Institution

Legal reference: 441 IAC 85.7(3), 85.25(3), 85.46(249A)

People in NF/MIs do not have reserve bed days.

People in MHIs do not have hospitalization leave but do have 30 visit days per calendar year.

For children in a mental health PMIC, payment will be approved for a maximum of ten days per calendar month during which the child is confined in an acute-care general hospital. Payment will not be authorized for over ten days per month for any continuous hospital stay.

Payment for a child in a mental health PMIC may also be approved for 30 days per year during which the child is out of the PMIC at the time of a nightly census for the purpose of a visit. The 30 days can be extended with a service plan approved by the service area administrator or designee.

The facility should contact the service worker before any absence of the foster child or child in subsidized adoption, unless an emergency exists. The absence for the visit may also be for detention, shelter care, or because the child ran away.

Send a copy of the *Case Activity Report* to the service worker to inform the worker about visit days for foster children and children in subsidized adoption. If an absence for detention, shelter care, or runaway is reported on the *Case Activity Report* contact the service worker to find out whether payment for reserve bed days should be made to the facility.

If the plan is for the child to return to the facility, visit days are approved and payment made. If not, visit days are denied, and no payment is made for the time that the child was out of the institution.

The mental health PMIC receives full payment when the resident has an approved absence. Other psychiatric institutions receive reserve bed day payments depending on the level of care. See 8-I, *Payment for Reserve Bed Days*.

Discharge From a Psychiatric Facility

Legal reference: 441 IAC 85.6(2), 85.24(2), and 85.45(2)

When you receive a *Case Activity Report* from the facility indicating that the member has been discharged, send a copy of the *Case Activity Report* to the service worker for a child in foster care. The service worker will then send back the form indicating the child's new living arrangement.

Determine if continuous eligibility applies or complete an automatic redetermination for another coverage group when form 470-0042, *Case Activity Report*, from the facility shows that a person has been discharged.

Voluntary Placement in PMICs

When a child is voluntarily placed in a PMIC, the IM worker processes the application. The following chart summarizes the responsibility for processing the case.

Summary of Responsibility for Processing PMIC Voluntary Placement	
Duties of Service Staff	**Duties of IM and Others**
Service workers are not normally involved with voluntary placements.	1. Professional (doctor, counselor, etc.) recommends PMIC care. Parents contact facility. PMIC collects general information and, if admitted, refers the family to apply for Medicaid. 2. The Centralized Facility Eligibility Unit (CFEU) is responsible for processing the PMIC entries. The PMIC IM worker pends the application in the ABC system. If the person meets absence from the home policy, the person may also be on a family case. The family IM worker will need to work with the PMIC IM worker in sharing information and copies of forms needed to determine eligibility. 3. The PMIC IM worker responds to IoWANS workflow. The worker responds that the IME Medical Services Unit will complete the determination.

Duties of Service Staff	Duties of IM and Others
	4. Once the level of care decision and Medicaid eligibility determination are complete, the PMIC IM worker enters denial or approval in the ABC system and responds to any final IoWANS workflow. 5. Requests for payment of additional reserve bed days must be approved in writing by the service area manager or designee. 6. Upon discharge from the PMIC, the IM worker determines if a child is continuously eligible or completes an automatic redetermination of Medicaid eligibility. See 8-F, *Continuous Eligibility for Children*, or 8-G, *Automatic Redetermination*.

Children in Foster Care or Subsidized Adoption in PMICs

When a foster child enters a PMIC, both the service worker and income maintenance (IM) worker must share responsibilities for communicating information needed to determine the child's eligibility.

When children in subsidized adoptions go into PMICs, it may not involve a service worker. However, some children who are in subsidized adoption can become foster children when placed in a PMIC.

Some policies only apply to a foster child entering a PMIC. These policies are outlined in the following sections:

- IV-E eligibility
- State-only funding

IV-E Eligibility

Legal reference: P.L. 96-272, 45 CFR 1355 and 1356

If a child in subsidized adoption is currently eligible under the IV-E coverage group, IV-E eligibility continues while the child is in a PMIC, as long as the child retains the specified status. Eligibility for IV-E-related Medicaid in subsidized adoption does not depend on living in a IV-E placement. See 8-H, *Title IV-E*, for a full description of IV-E eligibility.

If a foster child is already IV-E Medicaid-eligible when entering a PMIC, IV-E-related Medicaid eligibility is suspended after the month of entry, since no foster care maintenance payment is made. This eligibility must be determined under a coverage group other than IV-E. See Coverage Groups earlier in this chapter.

If a IV-E-eligible foster child from out of state is placed in a PMIC, the child loses IV-E Medicaid eligibility. Since the child has no Iowa residency, payment for the child's care is a responsibility of the placing state.

When a child's first foster care placement is in a PMIC, IV-E is not the correct coverage group for Medicaid eligibility, since PMICs are not IV-E-eligible placements.

Even though a foster child cannot be eligible for Medicaid under the IV-E coverage group while in a PMIC, determine if the child meets the income and resource requirements for IV-E eligibility at the time of application. It is much easier to establish the child's initial financial circumstances at that time than to attempt to make this determination later when the child enters a IV-E-eligible placement.

See 8-H, *Title IV-E*, for additional information about IV-E-related Medicaid eligibility criteria.

State-Only Funding

Legal reference: 441 IAC 75.1(10)

If a foster child meets the PMIC level of care but is not eligible for Medicaid under a MAGI-Related or Non-MAGI-related group, the child is eligible for Medicaid under state-only payment.

The child under state-only funding is treated as a Medicaid-eligible child for payment, client participation, IME Medical Services Unit determination, and reserve bed days. Code the child with the state-only fund code of "4."

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8, Chapter L

Revised May 12, 2023

Medicaid
Aliens

Page

Overview

Legal reference: P.L. 99-603, Immigration Reform and Control Act of 1986 (IRCA); P.L. 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), 110 Stat. 2105; P.L. 104-208, Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA); Division C of the Defense Department Appropriations Act 1997, 110 Stat. 3008; P.L. 105-33, *Balanced Budget Act of 1997 (BBA)*, 111 Stat. 251; P.L. 111-3, Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); P.L. 116-260, Section 208 of the Consolidated Appropriations Act of 2021; 42 CFR 435.956(c)(2); P.L. 117-43 Section 2502

This chapter contains Medicaid eligibility requirements for people who are not citizens or nationals of the United States. Federal law divides these people into two categories:

- Those legally qualified to live permanently or indefinitely in the United States are regarded as "qualified aliens."
- Those who are in the United States without having met legal conditions for permanent or indefinite residence are regarded as "nonqualified aliens."

Medicaid eligibility for aliens is based on whether the alien is a "qualified" or "nonqualified" alien and otherwise meets the Medicaid eligibility requirements. The requirements in this chapter are in addition to the Medicaid eligibility requirements explained in the rest of Title 8.

Alien Categories

Any person who is not a citizen or national of the United States is termed an "alien." Alien status is governed by the U.S. Citizenship and Immigration Services (USCIS). The following are definitions for some of the different types of aliens:

- **"Nonimmigrant"** means an alien who seeks temporary entry to the United States for a specific purpose. Nonimmigrant alien classes include:
  - Temporary workers
  - Students and exchange visitors
  - Visitors for business or pleasure
  - Foreign government officials

NOTE: **A person must meet Iowa residency requirements in order to qualify for Medicaid.** When a person applies for a nonimmigrant visa, the USCIS generally requires the person to show intent to maintain and return to the person's residence abroad. Therefore, a nonimmigrant alien status is an indicator that a person might not meet Iowa residency requirements.

However, alien status may **not** be used to determine a person is not an Iowa resident. All policies found at 8-C, *Residency* and *Intent to Live in Iowa* must be applied when determining whether or not a nonimmigrant meets Iowa residency requirements.

NOTE: Some children under age 21 who have a "nonimmigrant" alien classification are "qualified aliens" and may be eligible for Medicaid if all other eligibility requirements (including state residency) are met. See the list of these alien statuses following the definition of "lawfully residing."

1. Mr. Z, age 20, applies for Medicaid. He is in the United States on a currently valid nonimmigrant student visa. Because he is under age 21, he is a qualified alien in the "lawfully residing" alien category.

   The worker determines that Mr. Z entered Iowa seeking employment.
   Mr. Z is considered a resident of Iowa and may be eligible for Medicaid if all other eligibility requirements are met.

2. Same as Example 1, except Mr. Z did not enter Iowa for employment purposes. The worker evaluates all facts and circumstances surrounding Mr. Z's living arrangement in order to establish whether Mr. Z is living in Iowa with the intent to remain here either permanently or indefinitely.

   Mr. Z may be eligible for Medicaid if all eligibility requirements, including residency, are met.

3. Ms. K, age 25, applies for Medicaid. She is in the United States on a currently valid nonimmigrant student visa. She entered Iowa with a job as a graduate teaching assistant. Ms. K is potentially eligible for MAGI-related Medicaid.

   Ms. K is considered a resident of Iowa because she entered Iowa with a job commitment. Because she is over age 21, she is a nonqualified alien. She is ineligible for full Medicaid but may be eligible for limited Medicaid for emergency services if all other eligibility requirements are met.

4. Mr. and Mrs. G, both age 25, apply for Medicaid. They are in the United States. on currently valid nonimmigrant student visas. Their daughter, age 2, is a U.S. citizen.

   The worker evaluates all facts and circumstances about their living arrangements and determines that Mr. and Mrs. G do not meet Iowa residency requirements. The entire family, including the U.S. citizen child, is ineligible for Medicaid due to not being residents of Iowa.

5. Mr. W, age 25, and Mrs. W, age 20, are in the United States on currently valid nonimmigrant student visas. Mrs. W applies for Medicaid because she is pregnant.

   Since she is under age 21, Mrs. W is a qualified alien in the "lawfully residing" alien category. Although Mr. W entered Iowa with a graduate teaching assistantship, Mrs. W is not working and has never intended to work.

   Because Mrs. W did not enter Iowa for employment purposes, the worker evaluates all the circumstances of Mrs. W's living arrangement and determines that Mrs. W is not living in Iowa with the intent to remain here permanently or indefinitely. Mrs. W is ineligible for Medicaid due to not being a resident of Iowa.

- **"Asylee"** means an alien living in the United States who is unable or unwilling to return to the country of the person's nationality (or the place where the person last lived) or to seek the protection of that country because of persecution or a well-founded fear of persecution. Fear of persecution may be based on the alien's race, religion, nationality, social status, or political opinion.

  See 6-D(1), *Refugee Medical Assistance* for information on how to determine Medicaid eligibility for asylees.

- **"Refugee"** means an alien living outside the person's country of nationality who is admitted into the United States because the person is unable or unwilling to return to that country (or to the place where the person last lived) because of fear of persecution. Fear of persecution may be based on the alien's race, religion, nationality, social status, or political opinion.

  See 6-D(1), *Refugee Medical Assistance* for information on how to determine Medicaid eligibility for refugees.

- **"Qualified alien"** means an alien who is lawfully admitted to the country and is allowed to reside permanently or indefinitely in the United States. Qualified aliens may be in one of the following categories:

  - Lawful permanent residents (LPRs)
  - Refugees (includes certain Amerasians)
  - Asylees
  - Persons granted withholding of deportation or removal
  - Conditional entrants
  - Persons granted parole by the USCIS for a period of at least one year
  - Cuban or Haitian entrants
  - Certain abused immigrants, their children, and their parents
  - Certain American Indians born outside the United States
  - Victims of trafficking
  - Iraqi and Afghan Special Immigrants
  - Afghan Parolees
  - Ukrainian Humanitarian Parolees and non-Ukrainian individuals who last habitually resided in Ukraine
  - Citizens of the Compact of Free Association States (COFA), which includes the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau, who are lawfully residing in the U.S.
  - Children under age 21 who are "lawfully residing" in the United States in either an immigrant or nonimmigrant status that permits the child to remain in the United States either permanently or indefinitely. See the list of these alien statuses following the definition of "lawfully residing."

  Being "qualified" does not necessarily mean that the person is eligible for Medicaid. A qualified alien is only eligible for Medicaid once the person has maintained the qualified status for at least five years, except when the person is exempt from the five-year bar.

  Qualified aliens who entered the United States before August 22, 1996 (the effective date of PRWORA) generally are eligible for Medicaid providing other Medicaid eligibility criteria are met.

Qualified aliens who entered the United States on or after August 22, 1996, may either be subject to a five-year bar or be exempt from the five-year bar. See Aliens Subject to Five-Year Bar and Aliens Exempt from Five-Year Bar for more information.

Qualified aliens subject to the five-year bar are not eligible for Medicaid, except for emergency services, for five years from the date of entry. When these aliens have been in the United States in a qualified status for five years, they may become eligible if all other Medicaid eligibility requirements are met.

NOTE: Lawful permanent residents may have a "sponsor." See Sponsor Affidavits of Support and Deeming for information on deeming a sponsor's income and resources to the lawful permanent resident.

- **"Lawfully residing"** means an immigrant or nonimmigrant alien that the Department of Homeland Security considers as a long-term resident who has moved to the United States, is not required to maintain permanent residence in another country, and is allowed to remain in the United States either permanently or indefinitely.

  Only children **under age 21** in a "lawfully residing" status are qualified aliens and may be eligible for Medicaid if all other eligibility requirements (including state residency) are met. Adults age 21 and over in a lawfully residing status are **not** considered qualified aliens for Medicaid eligibility purposes.

  NOTE: A person **must meet Iowa residency requirements** in order to qualify for Medicaid**.** The USCIS may require persons in some alien statuses (e.g., nonimmigrants) to show they intend to maintain and return to their residences abroad. Therefore, such an alien status is an indicator that a person might not meet Iowa residency requirements.

  However, alien status may **not** be used to determine a person is not an Iowa resident. All policies found at 8-C, *Residency and Intent to Live in Iowa* must be applied when determining whether or not a nonimmigrant meets Iowa residency requirements.

  > Mr. and Mrs. X have three children. Mrs. X (age 34), Mr. X (age 35), and Child 1 (age 14) each have an I-94, *Arrival/Departure Record*, showing their status as a "lawfully residing" nonimmigrant. Child 2 and Child 3 (ages 10 and 8) are United States citizens.
  >
  > If all other Medicaid eligibility requirements are met, including state residency, all three children are **eligible** for Medicaid. Mr. and Mrs. X are **ineligible** for full Medicaid because they are "lawfully residing" aliens age 21 and over. Limited Medicaid is available to cover treatment for an emergency medical condition if all other Medicaid eligibility requirements are met.

A **partial** list of "lawfully residing" class of admission and employment authorization codes is provided below. Additional alien categories and status codes may qualify. Contact SPIRS with questions.

- Aliens in a nonimmigrant status who have not violated the terms of the status under which they were admitted or to which they changed after admission. Such persons may include, **but are not limited to**:
  - A parent or child of a person with special immigrant status under Section 101(a)(27) of the INA, as permitted under Section 101(a)(15)(N) of the INA (N8 or N9 visa, or A7 on EAD);
  - A fiancé of a citizen, as permitted under Section 101(a)(15)(K) of the INA (K1 visa or A6 on EAD);
  - A religious worker under Section 101(a)(15)(R) (R1 visa or B16 on EAD);
  - A person assisting the Department of Justice in a criminal investigation, as permitted under Section 101(a)(15)(S) of the INA (S visa or C21 on EAD);
  - A battered alien under Section 101(a)(15)(U) (U1-U5 visa or A19 or A20 on EAD); and
  - A person with a petition pending for three years or more, as permitted under Section 101(a)(15)(V) of the INA (V1-V3 visa).
- Aliens who have been paroled into the United States under section 212(d)(5) of the INA **for less than 1 year**, except for aliens paroled for prosecution, deferred inspection, or pending removal proceedings;
- Aliens belonging to one of the following classes:
  - Aliens whose visa petition has been approved and who have a pending application for adjustment of status (e.g., form I-485, *Application for Adjustment of Status*);
  - Aliens currently in temporary resident status as an amnesty beneficiary (Section 210 or 245A of the Immigration and Nationality Act (INA));
  - Aliens currently under temporary protected status under Section 244 of the INA, and pending applicants for temporary protected status who have been granted employment authorization (A12 on EAD);
  - Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24) (C9, C10, C16, C18, C20, C22, or C24 on EAD);
  - Family unity beneficiaries under Section 301 of the Immigration Act of 1990 or Section 1504 of the Legal Immigrant Family Equity (LIFE) Act amendments (A13 or A14 on EAD);
  - Aliens currently under deferred enforced departure (DED) under a decision made by the President. (DED is not an immigration status. Persons under DED are allowed to remain in the United States during the period ordered by the President.);
  - Aliens currently in deferred action status. (This does not include aliens approved under the Deferred Action for Childhood Arrivals (DACA) process.);

- Pending applicants for asylum under Section 208(a) of the INA or for withholding of removal under section 241(b)(3) of the INA or under the Convention Against Torture who has been granted employment authorization, and such an applicant under age 14 who has had an application pending for at least 180 days;
- Aliens who have been granted withholding of removal under the Convention Against Torture; and
- Aliens who have a pending application for Special Immigrant Juvenile status under section 101(a)(27)(J) of the INA.

- **"Nonqualified alien"** means a noncitizen residing in the United States. This includes all other aliens whose classification is not specifically listed under either Aliens Subject to Five-Year Bar or Aliens Exempt from Five-Year Bar.

  A qualified alien or a nonqualified alien may be eligible for limited Medicaid for emergency services. See Limited Eligibility for Certain Aliens.

Public Charge

Legal reference: 8 CFR 212.21; 42 CFR 431.300

Most forms of Medicaid do not result in a finding that an alien is "likely at any time to become a public charge". The term "likely at any time to become a public charge" refers to an alien who is likely at any time to become primarily dependent on the government for subsistence by either:

- The receipt of public cash assistance for income maintenance, or
- Long-term institutionalization at government expense.

"Public cash assistance for income maintenance" includes receipt of:

- Supplemental Security Income (SSI),
- Temporary Assistance for Needy Families (TANF) (the Family Investment Program (FIP) in Iowa),
- State cash assistance programs, such as State Supplementary Assistance, or
- Local cash assistance programs, such as General Assistance.

"Long-term institutionalization at government expense" means long-term government assistance for institutionalization including in a nursing home or mental health institution. "Long-term institutionalization" does not include imprisonment for conviction of a crime or institutionalization for short periods for rehabilitation purposes.

The U.S. Citizenship and Immigration Services (USCIS) makes the "likely at any time to become a public charge" finding on a case-by-case basis.

Individuals with questions about their specific situation should consult an immigration attorney.

Note: State Medicaid agencies restricts the use or disclosure of Medicaid information concerning applicants or members to purposes directly connected with the administration of the Medicaid program. The determination of whether an individual is "likely at any time to become a public charge" **is not** directly related to administration of the Medicaid program. This means that the state Medicaid agency **cannot** share Medicaid enrollment information for an applicant or member with the Department of Homeland Security/USCIS for this purpose.

Alien Status Attestation and Verification Requirements

Legal reference: 42 CFR 435.406, 435.949, 435.952, and 435.956; 441 IAC 75.11(1), (2), and (4); 76.13(3); P.L. 104-193 and 105-33; 42 U.S.C. 1396b(v) as amended by P.L. 111-3

Individuals who are not citizens or nationals of the United States must attest to and have their eligible alien status verified in order to qualify for full Medicaid coverage. See 8-C, *Declaring Citizenship or Alien Status* for attestation requirements. **NOTE:** An answer of blank or 'No' the question "…do you have eligible immigration status?" is treated as an attestation of eligible immigration status in some scenarios as detailed in NJA0063, Alien Chart.

To have an eligible alien status, an individual must be a "qualified alien" and either have maintained the qualified status for at least five years or be exempt from the five-year waiting period.

Individuals whose eligible alien status cannot be verified through an electronic data match shall be allowed a 90-day Reasonable Opportunity Period (ROP) to provide proof. See Reasonable Opportunity Period (ROP) for Eligible Aliens for details.

Individuals who do not qualify for full Medicaid coverage due to their alien status may qualify for limited Medicaid for emergency services. Attestation and verification of eligible alien status are **not** required in order to qualify for limited Medicaid for emergency services coverage. See Limited Eligibility for Certain Aliens for information on Medicaid for emergency services.

Electronic data matching is the primary method of verifying attested eligible alien status. An individual shall **only** be required to verify alien status when verification could not be obtained electronically. **Only** verify alien status for applicants or members who claim to have eligible alien status, either by:

- Answering Yes to the question, "Do you have eligible immigration status?", or
- Otherwise indicating they have eligible alien status. For example, despite answering No to the question, "Do you have eligible immigration status?" the person provides immigration document information indicating a possible eligible alien status. NOTE: Expired documents provided by or on behalf of an applicant or member may be used for attestation or verification of alien status unless questionable.

Do not attempt to verify alien status on individuals who have clearly indicated they are undocumented or not here legally, or whose immigration document information indicates they would never be eligible for anything except limited Medicaid for emergency services (e.g., those whose immigration document would always produce an outcome of "restricted" in the Alien Chart – Medicaid Only document).

Similarly, **never** attempt to verify alien status for individuals who are only listed as members of the household but are not actually applying. Comm. 233, *Rights and Responsibilities* informs individuals that we will not contact the Department of Homeland Security about those who are not applying.

However, do attempt to verify alien status for applicants or members who have indicated they are here legally/have eligible alien status, even if it is apparent the person does not yet meet the 5-year bar.

Refer to NJA0063, *Alien Chart* and NJA0062, *Electronic Data Source Verification* for complete verification procedures.

Individuals for whom eligible alien status is not verified are eligible only for limited Medicaid for emergency services if they would otherwise be eligible for Medicaid.

Reasonable Opportunity Period (ROP) for Eligible Aliens

Legal reference: 42 CFR 435.956(b), 435.911(c); 441 IAC 75.11(2)(c)

Individuals whose attested eligible alien status cannot be verified through an electronic data match shall be allowed a 90-day ROP to provide proof. The ROP begins with the date the *Notice of Action* is received and continues for 90 days. The date of receipt is considered to be 5 days from the date of the *Notice of Action*.

Full Medicaid shall be provided during the ROP if the person is otherwise eligible. If proof is not received by the end of the 90-day ROP, benefits end subject to timely notice requirements.

Even though they are eligible for full Medicaid during a 90-day reasonable opportunity period (ROP), individuals are not eligible for full Medicaid for any retroactive months until the attested eligible alien status has been verified. Only approve full Medicaid coverage for any retroactive months once the necessary verification of attested eligible alien status is received, and provided that retroactive coverage is needed and all retroactive eligibility requirements have been met as detailed at 8-B, *Determining Eligibility for the Retroactive Period* and 8-A, *Definitions: Retroactive Period*.

If the attested eligible alien status is not verified via data matching, determine if the person is eligible for a 90-day reasonable opportunity period (ROP) by running EDBC in ELIAS. If the 90-day ROP is approved, send the client a *Notice of Action* approving Medicaid along with Comm. 258, *Verifying Citizenship/Identity and/or Immigration Status*. ELIAS will automatically deny at the end of the 90-day ROP if no verification is returned.

If the 90-day ROP is denied, leave the case in pending status in ELIAS and send a Request for Information (RFI) for verification of alien status. If the verification is not received by the due date, deny or cancel full Medicaid for that individual.

NOTE: Since attestation and verification of an eligible alien status are **not** required in order to qualify for limited Medicaid for emergency services coverage, determine eligibility for limited Medicaid for emergency services, including eligibility for any retroactive months as detailed at 8-B, *Determining Eligibility for the Retroactive Period* and 8-A, *Definitions, Retroactive Period* as described under Limited Eligibility for Certain Aliens.

A new ROP must be allowed each time the person is required to verify eligible alien status.

To determine continued eligibility for full Medicaid, alien status must be reverified when the individual reports a change in alien status or the department receives information indicating there has been an alien status change, and at annual review for alien statuses that are subject to change. For example, lawful permanent resident (LPR) alien children under the age of 21 who have resided in the United States less than five years, lawfully residing alien children under the age of 21, and children with battered alien or parolee status must have their continued alien status verified at each annual review or if their alien status changes. Refer to NJA0063, *Alien Chart* for additional details.

Alien Verification

Documentation of alien status is issued by the U.S. Citizenship and Immigration Services (USCIS), part of the Department of Homeland Security. Older documents were issued by the Immigration and Naturalization Service (INS).

Eligibility Indicators returned by the Verify Lawful Presence (VLP) electronic data matching service are the primary source used to verify and determine alien status for Medicaid eligibility purposes.

When Eligibility Indicators obtained via VLP are insufficient to determine Medicaid eligibility, the determination of alien status is based upon the Alien Documentation Chart – Medicaid Only.

This chart lists some documents commonly used to show alien status. Note that there may be **other** documents acceptable to show alien status that are **not listed** in this chart. See Aliens Subject to Five-Year Bar and Aliens Exempt from Five-Year Bar for complete explanation of Medicaid status.

Prior to the creation of VLP, the Systematic Alien Verification for Entitlement (SAVE) system was used to verify alien status. Since SAVE returns the same information as VLP, there is no longer a need to attempt SAVE in most situations. SAVE should only be used in limited circumstances where VLP cannot be accessed, such as when the Medicaid case is being processed in ABC rather than ELIAS or when SAVE needs to be used as a workaround because VLP is not working correctly. Note that a VLP Eligibility Indicator Status of "Invalid Indicators – Insufficient to Run EDBC" simply means that the determination of alien status must be made using the Alien Documentation Chart-Medicaid Only and is **not** a reason to attempt SAVE.

Subject to the requirement to use electronic data matching to attempt to validate reported alien status, expired documents provided by or on behalf of an applicant or member may be used for attestation or verification of alien status unless questionable.

1. When Mr. N applies he provides a passport that expired several years earlier. This passport shows he was born in one of the COFA Islands. Where a person was born is not something that changes, so the passport showing he is a citizen of one of the COFA Islands is a sufficient document to use even though it is expired
2. Same as example 1, but the worker has reason to question either the validity of the passport itself (e.g. it appears to be forged, altered, or is otherwise inauthentic or unreadable) or the alien status shown (e.g. the passport shows a name, DOB, or place of birth that is inconsistent with other available information). The worker requests additional information/verification to resolve any discrepancies.

Nonfinancial Eligibility

Legal reference: 441 IAC 75.11(1), (2), (3), and (4); 42 U.S.C. 1396b(v) as amended by P.L. 111-3; P.L. 117-43 Section 2502

In addition to requirements in this chapter that are specific to aliens, eligible aliens must meet the categorical, financial, and nonfinancial eligibility criteria of an existing MAGI-related or Non-MAGI-related coverage group. See 8-C, *Nonfinancial Eligibility* and 8-F, *Coverage Groups*.

The following sections address:

- Aliens subject to five-year bar
- Aliens exempt from five-year bar
- Migrants
- Social security numbers
- Victims of trafficking
- Iraqi and Afghan Special Immigrants
- Afghan Parolees

Aliens Subject to Five-Year Bar

Legal reference: 441 IAC 75.11(249A), P.L. 104-193; 42 U.S.C. 1396b(v) as amended by P.L. 111-3 and Iowa Code 249A.3A

Aliens listed in this section who enter the United States **on or after** August 22, 1996, are barred from receiving Medicaid except limited Medicaid for emergency services for five years. The five-year period begins on the date the person enters the United States with one of the following statuses and retains a legal status:

- Aliens aged 21 or over who are lawfully admitted for permanent residency. NOTE: **Lawful permanent residents (LPRs)** may be required to have a sponsor and may be subject to deeming of income or resources from the sponsor. See Sponsor Affidavits of Support and Deeming for more information.
- Aliens ages 21 or over who are **paroled** into the United States under section 212(d)(5) of the Immigration and Nationality Act (INA) for a period of at least one year. **NOTE:** See one exception, for children paroled less than one year, under the definition of "lawfully residing".
- **Battered aliens** ages 21 or over who are designated under 8 USC 1641(c) and who do not live with the abuser. Refer to Battered Aliens for more information.

NOTE: The five-year bar does not apply to aliens in these categories who entered the U.S. before August 22, 1996. The five-year bar also does not apply to aliens in these categories who are children under the age of 21.

Aliens Exempt From Five-Year Bar

Legal reference: 441 IAC 75.11(249A), P.L. 104-193, P.L. 105-33; 42 U.S.C. 1396b(v) as amended by P.L. 111-3, and Iowa Code 249A.3A

If all other Medicaid eligibility factors are met, aliens with one of the following statuses are eligible for Medicaid from the date the person obtains the status:

- **Qualified aliens who entered the United States before August 22, 1996**, including conditional entrants under section 203(a)(7) of the Immigration and Nationality Act (INA) as in effect before April 1, 1980.

  NOTE: Contact SPIRS for help when an alien entered before August 22, 1996, but obtained a qualified status on or after that date.

- **Refugees** admitted under section 207 of the INA.
- **Amerasian** aliens treated as refugees.
- Aliens granted **asylum** under section 208 of the INA.
- Aliens whose **deportation or removal is withheld** under section 243(h) or section 241(b)(3) of the INA.
- **Cuban or Haitian entrants** under section 501(e) of the Refugee Education Assistance Act of 1980.
- Members of **federally recognized American Indian tribes and Canadian-born American Indians who have treaty rights** to cross the United States borders with Canada and Mexico. There is an extensive list of these tribes. Contact SPIRS if you question whether a tribe is included.
- Aliens lawfully admitted for permanent residence who are **veterans honorably discharged** for reasons other than alienage and their spouses, surviving unremarried spouses, and unmarried dependent children. This includes the alien spouses, surviving unremarried spouses, and unmarried dependent children of veterans who are U.S. citizens or deceased veterans.
- Aliens lawfully admitted for permanent residence who are **active-duty personnel** of the United States Armed Forces and their spouses, surviving unremarried spouses, and unmarried dependent children.

  This includes the alien spouses, surviving unremarried spouses, and unmarried dependent children of active duty personnel who are U.S. citizens or of deceased active-duty personnel. "Active duty" excludes temporary full-time duty for training purposes performed by members of the National Guard or Reserves.

- **Victims of trafficking** with a certification letter (for adults) or an eligibility letter (for minor children) issued by the U.S. Department of Health and Human Services (HHS) that has been verified by calling the trafficking verification line. Trafficking victims are eligible only for a limited period of time from the date in the original certification or eligibility letter, unless HHS issues a recertification letter. See Victims of Trafficking for additional information.

  Without this letter or when the time limit expires, trafficking victims are not eligible for Medicaid unless another qualifying status is obtained.

- **Iraqi and Afghan Special Immigrants**. See Iraqi and Afghan Special Immigrants for specific instructions. These Special Immigrants are either lawful permanent residents (LPRs) or Conditional Permanent Residents (CPRs) but are eligible for Medicaid to the same extent as refugees.
- **Afghan Parolees.** These individuals are eligible for Medicaid to the same extent as refugees. See Afghan Parolees for specific instructions, including time limits specific to Afghan Humanitarian Parolees.
- **Ukrainian Humanitarian Parolees (UHP) and non-Ukrainian individuals who last habitually resided in Ukraine and received humanitarian parole.** These individuals are eligible for Medicaid to the same extent as refugees. See Ukrainian Humanitarian Parolees for specific instructions, including time limits specific to Ukrainian Humanitarian Parolees.
- **Citizens of the Compact of Free Association States (COFA)**, which includes the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau, who are lawfully residing in the U.S.

  NOTE: COFA migrants age 21 and over who adjust to LPR status are no longer exempt from the five-year bar (unless they meet another exemption from the five-year bar); children under age 21 who adjust from COFA to LPR status remain exempt from the five-year bar. The five-year bar for individuals age 21 and over who adjust from COFA to LPR status is calculated as follows:

  - If the individual adjusted to LPR status before 12/27/2020, the five-year bar begins on the date they adjusted to LPR.
  - If the individual adjusted to LPR status after 12/27/2020, the five-year bar started on the date they entered the US as a COFA migrant. Such individuals could be qualified non-citizens (with a VLP Eligibility Indicator QNC=Y) as early as 12/27/2020.
- Alien children under the age of 21 who are:
  - Paroled into the United States under section 212(d)(5) of the INA for a period of at least one year;
  - Battered as defined in 8 USC 1641(c). Refer to Battered Aliens for more information; or
  - In one of the statuses listed after the definition of "lawfully residing." NOTE: Verification that these children continue in one of these statuses is required at each annual review.
  - Attempt to use the documentation presented at application to verify the child's continued lawfully residing status.
  - If additional documentation is needed, the household must provide proof of continued lawfully residing status for the child.
  - When continuation in one of these statuses cannot be verified, see also Limited Eligibility for Certain Aliens for benefits available to the child.

  When these lawfully residing children reach age 21, they become ineligible for Medicaid other than limited Medicaid for emergency services unless they obtain another qualified alien status.

- Children under age 21 who have been lawfully admitted for permanent residence (LPR).

  NOTE: Verification that these children continue in LPR status is required at each annual review. When reverifying alien status for these children, follow policies and procedures detailed at Alien Status Attestation and Verification Requirements, Reasonable Opportunity Period (ROP) for Eligible Aliens, and Limited Eligibility for Certain Aliens.

  When LPR children reach age 21, they become subject to the five-year bar. They are ineligible for Medicaid other than limited Medicaid for emergency services until they meet the five-year requirement or meet another exemption.

  A system-generated notice will be issued canceling the child at age 21 and recalculating eligibility for other household members based on the reduced household size.

1. Child A (age 20) receives FMAP with her 2-year-old son. She has been in the United States as an LPR for seven years. When she turns age 21, she can continue on FMAP with her child, if all other eligibility requirements are met.
2. Same as example 1, except Child A has been in the United States as an LPR for only two years. When she turns age 21, she is no longer eligible for Medicaid (except for emergency services) unless another exemption from the five-year bar applies.

Migrants

Legal reference: 441 IAC 75.11(1), (2), and (3)

Migrants are people who travel between states or counties to find work on a seasonal basis. They are usually employed in agricultural situations. If the migrant is also an alien, verify the migrant's alien status to determine Medicaid eligibility.

When a migrant enters Iowa for employment purposes, the person is considered a resident. This policy makes it possible for migrants to meet the residency requirement and to receive Medicaid, if otherwise eligible. The migrant must meet all other program eligibility requirements.

Social Security Number

Legal reference: 42 CFR 435.910, IAC 75 (Rules in Process)

Except for aliens in the United States unlawfully who may qualify only for limited Medicaid for emergency services, each person applying for Medicaid must meet the requirements described at 8-C, *Social Security Number*.

Individuals who are not in the U.S. lawfully do not have the documentation required to apply for a SSN. However, do not assume that an individual currently without a lawful alien status does not have a SSN.

Some unlawful aliens may have SSNs because they originally gained entrance to the United States with a lawful status, but their status has since changed to unlawful. Ask for the SSN from an unlawful alien, but do not deny assistance if the person fails to provide the number.

When necessary, assist Victims of Trafficking in obtaining non-work SSNs by sending a letter to the Social Security Administration that:

- Is on letterhead.
- Includes the applicant's name.
- Mentions that this person is a trafficking victim.
- References that the number is required to receive Medicaid, not for work.
- States that the applicant meets the requirements to receive Medicaid except for the SSN.

Victims of Trafficking

Legal reference: Trafficking Victims Protection Act of 2000 (TVPA), P.L. 106-386 {8 U.S.C. 7105(b)(1)} and Trafficking Victims Protection Reauthorization Act of 2003 (TVPRA), P.L. 108-193; 45 CFR 400.211; 441 IAC 60.7(217), 75 (Rules in Process)

Aliens who are certified as Victims of Trafficking by the U.S. Department of Health and Human Services' (HHS) Administration for Children and Families' Office on Trafficking in Persons (OTIP) are "qualified aliens" for Medicaid. A victim of trafficking is eligible for Medicaid to the same extent as a person with refugee status for the period for which HHS certifies them.

The HHS certifies a victim of trafficking for the period described at 6-D(1), *Time Limit*. The person's "date of entry" is the date stated in the body of the HHS certification letter (for adults) or eligibility letter (for children under 18 years old).

Notify the Bureau of Refugee Services of individuals with victim of trafficking status using form 470-0481, *Notification to the Bureau of Refugee Services*.

Applicants without HHS victim of trafficking letters are subject to all the regular eligibility requirements of the Medicaid program. However, if you encounter a person you believe may meet the definition of a trafficking victim, go through the usual channels to obtain instructions on providing the person with assistance in contacting HHS for possible certification. See Comments at the end of this section for additional instructions for some specific immigration document types.

Some victims of trafficking may have standard immigration documents in addition to the HHS letter, while other victims of trafficking will only have the HHS letter. Processes for determining a Medicaid applicant is a victim of trafficking depend upon what documentation the individual has available.

When a possible victim of trafficking applies for Medicaid:

- If sufficient information is available to attempt an electronic data match and when prompted to do so by the electronic data match response (e.g. when the VLP response sets the Five-Year Bar Apply indicator to P for an individual with a T1 or ST6 COA, or Form I-766 Category Code A16), request additional documentation from the individual to verify status as a victim of trafficking.

  A victim of trafficking should always have a letter issued by the HHS, and this letter must be obtained from the applicant and verified to establish the individual is a trafficking victim for Medicaid eligibility purposes.

The HHS letter is not a document that can be verified by electronic data match, and it must not be submitted in VLP/SAVE. Instead, contact the trafficking verification line at (866) 401-5510 to confirm the validity of the HHS letter and to notify the HHS of the assistance for which the person has applied.

- **If sufficient information is not available to attempt an electronic data match,** request the HHS victim of trafficking letter from the individual. Contact the trafficking verification line at (866) 401-5510 to confirm the validity of the HHS letter and to notify the HHS of the assistance for which the person has applied.

An HHS letter for an individual with a trafficking victim status means that individual is not subject to the five-year bar during the period described at 6-D(1), *Time Limit*.

Track the end of the period of trafficking victim status. Redetermine eligibility at that time. If a victim of trafficking becomes a qualified alien based on regular alien policies, use the new eligible alien status when redetermining eligibility for that person.

The time limit for trafficking victim status is set by the procedure found in 45 CFR 400.211. On March 28, 2022, the time limit increased from eight months to twelve months for individuals that entered the country on or after October 1, 2021. This change was communicated to states in Dear Colleague Letter 22-12 and published in the Federal Register at https://www.govinfo.gov/content/pkg/FR-2022-03-28/pdf/2022-06356.pdf. Refer also to NJA0063, *Alien Chart*, for ELIAS system instructions.

Comments: A victim of trafficking may have a "Derivative T visa." People who have a Derivative T visa are eligible for Medicaid provided they meet other program criteria.

Alternatively, a victim of trafficking may have a U visa (or code A19 or A20 on the *Employment Authorization Document* (EAD)); this is an indication that a person might be a victim of trafficking. However, U visas are also issued to victims of other crimes, so a U visa does not automatically mean the adult is a victim of trafficking. If an adult provides a U visa (or EAD with code A19 or A20), follow up to find out if they are either a victim of trafficking or a battered alien. NOTE: A child under age 21 with a U visa (or code A19 or A20 on the EAD) is a qualified alien under the definition of "lawfully residing."

Refer to the Alien Documentation Chart – Medicaid Only for additional document types and section codes that may indicate status as a victim of trafficking.

Iraqi and Afghan Special Immigrants

Legal reference: P.L. 110-161 (December 26, 2007); P.L. 110-181 Section 1244(g) (January 28, 2008); P.L. 110-329 Section 101 of Division A (September 30, 2008); P.L. 111-08 (March 10, 2009) Section 602; P.L. 111-118 (December 19, 2009) Section 8120; P.L. 117-43 Section 2502

This section only applies to Iraqi and Afghan Special Immigrants (aka Iraqi and Afghan Special Immigrant Visa (SIV) Holders). It does **not** apply to Afghan Parolees (i.e. Special Immigrant Parolees or Humanitarian Parolees) discussed later in this chapter.

Certain Iraqis and Afghans who acted as interpreters for the U.S. military or were employed by or on behalf of the U.S. government were given a special immigrant status. Beginning December 19, 2009, all Iraqi and Afghan aliens granted special immigrant status were lawful permanent residents (LPRs).

In 2021 due to the urgent need to relocate Afghan individuals affiliated with the U.S. mission in Afghanistan (and their spouses/unmarried children under age 21), some Afghan Special Immigrants also began to be admitted with Conditional Permanent Resident (CPR) rather than LPR status. The date of entry is calculated differently for Afghan SI CPRs; see 6-D, *Documentation Required* for more information on determining the date of entry for Afghan SI CPRs.

All Iraqi and Afghan Special Immigrants (whether with LPR or CPR status) are exempt from the five-year bar on assistance and eligible for full Medicaid assistance to the same extent as refugees.

Apply all alien status attestation and verification requirements already discussed in this chapter. See also special handling instructions including workaround instructions in the Afghan Evacuees section of NJA0063, *Alien Chart* to ensure correct eligibility results in ELIAS.

Comment: The effective date of eligibility for Iraqi and Afghan Special Immigrants initially began no earlier than December 26, 2007. Before December 19, 2009, Iraqi and Afghan Special Immigrants over the age of 21 were subject to the five-year bar after an eight-month initial Medicaid eligibility period; (before March 11, 2009, the initial period for Afghans was limited to six months).

Afghan Parolees

Legal reference: P.L. 117-43 Section 2502

In 2021, due to the urgent need to relocate Afghan individuals affiliated with the U.S. mission in Afghanistan and their spouses/unmarried children under age 21, Afghan individuals began to be admitted with the following Parolee statuses:

- Afghan Special Immigrant (SI/SQ) Parolees - Individuals who would be eligible for a Special Immigrant Visa (SIV) from USCIS but were evacuated to the U.S. before completing the SIV application process.
- Afghan Humanitarian Parolees (Non-SI/SQ) Parolees - Individuals who are not eligible for SIV status from USCIS who were evacuated for humanitarian reasons and paroled into the U.S.

Afghan Parolees (both SI/SQ and Humanitarian) will generally receive a parole period of 2 years. While in such status, they are exempt from the five-year bar on assistance and are eligible for full Medicaid assistance to the same extent as refugees, **with the following limitations** specific to Afghan Humanitarian (Non-SI/SQ) Parolees:

- Only Afghan Humanitarian Parolees paroled into the U.S. between July 31, 2021 and September 30, 2022 are eligible under this provision. In addition, the following family members of Afghan Humanitarian Parolees are eligible under this provision even if they are granted parole after September 30, 2022: spouses or children; and parents or legal guardians if the Afghan individual is an unaccompanied minor.

- Afghan Humanitarian Parolees are **only** eligible for a limited time period, either through March 31, 2023 or until the end of their parole term, whichever is later. At the end of this time limit, eligibility for adults 21 and over will depend upon their updated alien status; children under 21 may remain qualified aliens not subject to a five-year bar while they hold "lawfully residing" status.

  NOTE: Adults age 21 and over who arrived in the U.S. as Afghan Humanitarian Parolees before July 31, 2021 are subject to the five-year bar. Children under age 21 who arrived in the U.S. as Humanitarian Parolees before July 31, 2021 are qualified aliens not subject to the five-year bar while they hold "lawfully residing" status.

The date of entry is calculated differently for Afghan Parolees. See 6-D, *Documentation Required* for more information on determining the date of entry for these refugee statuses. Apply all alien status attestation and verification requirements already discussed in this chapter. See also special handling instructions including workaround instructions in the Afghan Evacuees section of NJA0063, *Alien Chart* to ensure correct eligibility results in ELIAS.

Ukrainian Humanitarian Parolees

Legal reference: P.L. 117-128 Section 401

Ukrainian Humanitarian Parolees (UHP) and non-Ukrainian individuals who last habitually resided in Ukraine and received humanitarian parole arriving in the U.S. between February 24, 2022, and September 30, 2023, are eligible to receive full Medicaid/CHIP, without a five-year bar, if they meet all other eligibility requirements. These individuals are exempt from sponsor deeming requirements.

These policies also apply to the following family members of these individuals, even if they are granted parole after September 30, 2023: spouses, children, parents, legal guardians, and primary caregivers of such individuals who were unaccompanied minors.

NOTE: If UHP or non-Ukrainian individuals mentioned above are ineligible for Medicaid they may be eligible for Refugee Medical Assistance (RMA). The 12-month eligibility period for RMA starts on May 21, 2022, or the individuals date of humanitarian parole, whichever is later. If an individual from either of these populations was paroled and entered the United States between February 24, 2022, and May 21, 2022, their date of eligibility is May 21, 2022. If they entered the United States after May 21, 2022, their date of eligibility is their date of humanitarian parole.

Apply all alien status attestation and verification requirements already discussed in this chapter. See also special handling instructions including workaround instructions in the Ukrainian section of NJA0063, *Alien Chart* to ensure correct eligibility results in ELIAS.

Acceptable Documents for Ukrainian Humanitarian Parolees (UHP) and Non-Ukrainian individuals Who Last Habitually Resided In Ukraine and Received Humanitarian Parole Who Arrived in the U.S. Between February 24, 2022 and September 30, 2023 or is a specific family member granted parole after September 30, 2023, as noted above.

Immigration Status or Category of Applicant	Documentation
Ukrainian citizen or national who received humanitarian parole, known as Ukrainian Humanitarian Parole (UHP)	Form I-94 noting humanitarian parole (per INA section 212(d)(5) or 8 U.S.C. Section 1182(d)(5) **Or** Foreign passport with DHS/CBP admission stamp noting "DT" **Or** Foreign passport with DHS/CBP admission stamp noting United for Ukraine or "U4U" **Or** Foreign passport with DHS/CBP admission stamp noting Ukrainian Humanitarian Parolee or "UHP" **Or** Form I-765 Employment Authorization Document (EAD) receipt notice with code C11 **Or** Form I-766 Employment Authorization Document (EAD) with the code C11 **Or** Form I-797 (EAD) Notice of Action with code C11
A non-Ukrainian individual who received humanitarian parole and the U4U or UHP class of admission in response to their displacement from Ukraine	Foreign passport with DHS/CBP admission stamp noting Uniting for Ukraine or "U4U" **Or** Foreign passport with DHS/CBP admission stamp noting Ukrainian Humanitarian Parolee or "UHP"
A non-Ukrainian individual who last habitually resided in Ukraine and received humanitarian parole, but without the U4U or UHP class of admission	Any of the forms or stamps listed above for UHP's **And** Documentation of last habitual residence in Ukrain, including Crimea. per U.S. Department of State, Crimea is part of Ukraine, see https://www.state.gov/crimea-is-ukraine-2/ Acceptable documentation indicating last habitual residency in Ukraine includes an original Ukrainian government-issued document, such as a driver's license or identification card. For documentation outside of these examples, contact the SPIRS helpdesk for assistance.

Sponsor Affidavits of Support and Deeming

Legal reference: P.L. 104-193, P.L. 104-208, 8 U.S.C. §§ 1182(a)(4), 1183a(1996); 42 U.S.C. 1396b(v) as amended by P.L. 111-3; 20 CFR 416.1160(a), 416.1166a; 441 IAC 75.11(3)

Aliens who seek admission to the United States as lawful permanent residents must establish that they will not become a "Public Charge." Many aliens establish that they will not become public charges by having "sponsors" who pledge to support them. An alien may have more than one sponsor. A sponsor is a person who signs an "affidavit of support" agreeing to support an alien to help the alien obtain lawful permanent resident status. There are three versions of the *Affidavit of Support:*

- Form I-864 or Form I-864A. This form is enforceable since December 19, 1997.
- Form I-134. This form is not enforceable.
- Form I-361. This form is enforceable and must be submitted with a petition for treatment as an Amerasian. However, deeming will not apply to persons with this type of support affidavit.

Sponsor deeming is the process of considering the income and resources of the sponsor to be available to the sponsored person, whether or not the income or resources are actually made available. The sponsor deeming rules apply **only** to persons who:

- Are lawful permanent residents (LPRs),
- Applied for lawful permanent resident status on or after December 19, 1997, and
- Are sponsored by a person who signed Form I-864, *Affidavit of Support,* or Form I-864A. (Sponsors can also include spouses or other eligible adult members of the household of the individual providing the Form I-864, *Affidavit of Support*, if they execute a Contract Between Sponsor and Household Member (Form I-864A).)

NOTE: Income (and for Non-MAGI-related, resources) deemed from or actually provided by a sponsor is not countable for the eligibility of other members of a sponsored alien's household unless they themselves are also sponsored by an individual who signed a Form I-864, *Affidavit of Support,* or a Form I-864A Contract.

For deeming purposes, deeming will not apply when the sponsor is:

- An organization such as a church or service club.
- An employer who does not sign an affidavit of support.
- The alien's eligible or ineligible spouse or a parent whose income is otherwise considered in determining the alien's Medicaid eligibility.
- If the eligible couple separates and begins living in separate households, then the sponsor-to-alien deeming rules apply.

The following sections explain:

Affidavits of Support

Legal reference: P.L. 104-193, P.L. 104-208; 8 U.S.C. §§ 1183a(1996); 441 IAC 75.11(3)

All affidavits of support signed before December 19, 1997, are "old version" affidavits of support. Do not assume that because the person entered the United States after December 19, 1997, the person will have a new *Affidavit of Support*. The person may have entered the country **after** December 19, 1997, but applied for an immigrant visa **before** that date.

The following are affidavits of support:

- **Form I-134:** The USCIS will certify whether an applicant has a sponsor and, if so, what kind of affidavit the sponsor signed. Do **not** deem income or resources from a sponsor that has signed the *Affidavit of Support*, Form I-134, as these are not enforceable contracts.
- **Form I-361:** This is an enforceable contract for Amerasians for certain nationals of Korea, Vietnam, Laos, Kampuchea, or Thailand born after 1950 and before October 22, 1982. However, do **not** deem income or resources from a sponsor that has signed the Form I-361.
- **Form I-864 or Form I-864A:** For people who are applying for either a Non-MAGI-related or MAGI-related coverage group and have an *Affidavit of Support*, Form I-864, or Form I-864A, deem income, and for Non-MAGI-related, resources, to the sponsored lawful permanent resident alien unless one of the exemptions under Exceptions to Deeming applies. NOTE**:** Because sponsor deeming only applies to people sponsored under the *Affidavit of Support*, Form I-864, or Form I-864A, electronic data matching returns information only about sponsorships provided under these versions of the affidavit of support.

Verifying Sponsorship and Sponsor's Information

Legal reference: Section 421 of P.L. 104-193; 42 U.S.C. 1396b(v) as amended by P.L. 111-3

Verify sponsorship of any Medicaid applicant or member who became a lawful permanent resident (LPR) on or after December 19, 1997, unless the person is exempt from sponsor deeming. See Exceptions to Deeming later in this chapter for additional information on who is exempt from sponsor deeming.

Electronic data matching is the primary method of verifying sponsorship. An individual shall only be required to verify sponsorship when verification could not be obtained electronically. NOTE: If the person voluntarily provides *Affidavit of Support*, Form I-864, or Form I-864A, accept this as proof of sponsorship.

To verify sponsorship via data matching:

- In VLP, enter a value of Y in the VLP INITIREQUESTSPONSORDATAIND field and leave empty the NOSPONSRSNCODE field. These entries will ensure VLP data matching identifies when an individual is sponsored under *Affidavit of Support*, Form I-864, or Form I-864A.
- In SAVE, verify sponsorship through SAVE by selecting REQUEST ADDITIONAL VERIFICATION on the CASE DETAILS page. Complete the *Additional Verification Data Request* form and enter "sponsorship information request" in the SPECIAL COMMENTS field. If the response from SAVE indicates the person was not sponsored on Form I-864, or Form I-864A, sponsor deeming does not apply.

If the electronic data match response verifies that the person has a sponsor who signed *Affidavit of Support*, Form I-864, or Form I-864A, the name, address, and SSN of the sponsor will be provided in the response. NOTE: If the individual has a joint sponsor, substitute sponsor, and/or multiple sponsors, the electronic data match response will return identifying information on each sponsor.

If sponsorship under Form I-864 or Form I-864A is verified, ask the alien applicant or member if their sponsor is actually providing support. See Indigent Aliens to determine if they are exempt from sponsor deeming based on the actual amount of income the sponsor is providing.

When sponsor deeming applies, request verification of the income (and for Non-MAGI-related, resources) of the sponsor from the sponsored alien. NOTE: Sponsor deeming requirements apply to each sponsor (including joint/substitute/multiple sponsors) who executed Form I-864, as well as to any of their household members who executed a Form I-864A Contract.

Do not approve Medicaid eligibility for sponsored alien(s) until you receive the sponsor's verification. However, when the sponsored person needs more time or help obtaining information from a sponsor, follow the procedures in 8-B, *Verification* for obtaining information from a third party.

An applicant or member who provides a signed release to a specific individual for specific information has met the requirement for supplying requested information or verification. If a third party does not provide the requested information, contact the applicant to obtain the best information available about the sponsor's income (and for Non-MAGI-related, resources) and determine eligibility based on the information provided.

NOTE: While waiting for the sponsor's verification, do not delay the eligibility determination for other members of a sponsored alien's household unless they themselves are also sponsored by an individual who signed a Form I-864, *Affidavit of Support*, or Form I-864A.

Exceptions to Deeming

Legal reference: P.L. 104-193 as amended by Section 552 of P.L. 104-208; 42 U.S.C. 1396b(v) as amended by P.L. 111-3; 20 CFR 416.1166a and 416.1204

Lawful permanent resident aliens whose sponsor signed a new version *Affidavit of Support*, Form I-864, or Form I-864A, are exempt from sponsor to alien deeming when the alien:

- Has attained citizenship.
- Can be credited with 40 qualifying quarters. See Establishing Qualifying Quarters and Verifying Qualifying Quarters.
- Entered the United States or applied for a visa or adjustment of status before December 19, 1997.
- Adjusted to lawful permanent resident (LPR) from an alien status that is not required to have an affidavit of support on file (i.e. refugees, asylees). Persons who adjusted from these statuses are exempt from sponsor deeming, even if they have sponsors.
- Does not have a sponsor. (This includes when a sponsor dies.)
- Has a sponsor who signed an *Affidavit of Support* other than Form I-864 or Form I-864A. Sponsor deeming does not apply if the sponsor signed Form I-134 or Form I-361, which are also affidavits of support.
- Is a victim of battering or extreme cruelty in the United States. The victim's children or parents are also exempt from sponsor deeming. This exception applies for 12 months from the date it is determined that the person qualifies as a battered alien. See Battered Aliens for more information.
- Is indigent. This exception applies for 12 months from the date it is determined that the person is indigent. See Indigent Aliens.
- Is a "lawfully residing" child under age 21 as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

In addition, end sponsor deeming:

- When the sponsored alien dies or permanently leaves the United States (Deeming stops effective with the month the change occurs.)
- For SSI-related Medicaid, if the sponsored alien becomes blind or disabled (at any age) after admission to the United States as an LPR. (Deeming stops effective with the month the person's disability or blindness begins.)
- For SSI-related Medicaid, three years after the date the sponsored alien was admitted to the United States as an LPR. (Deeming stops effective the month in which the third anniversary from admission to the United States occurs.)

Establishing Qualifying Quarters

When a lawful permanent resident is not otherwise exempt from sponsor deeming, you must determine the number of qualifying quarters with which the person can be credited. The following chart lists the amount a person had to earn to get one credit for the years 1978 and later. (For years before 1978, contact SPIRS for assistance.)

To calculate the number of quarters for a year, divide the person's total earnings for the year by the amount needed to get one credit. Use only full quarters. For example, 2.95 quarters are rounded **down** to 2 quarters. For earnings from employment, use the gross amount of earnings. For earnings from self-employment, use the amount of earnings after allowable self-employment expenses have been deducted.

Amount Needed to Earn a Qualifying Quarter			
Year	Earnings Needed to Get One Credit	Year	Earnings Needed to Get One Credit
1978	$250	2002	$870
1979	$260	2003	$890
1980	$290	2004	$900
1981	$310	2005	$920
1982	$340	2006	$970
1983	$370	2007	$1,000
1984	$390	2008	$1,050
1985	$410	2009	$1,090
1986	$440	2010	$1,120
1987	$460	2011	$1,120
1988	$470	2012	$1,130
1989	$500	2013	$1,160
1990	$520	2014	$1,200
1991	$540	2015	$1,220
1992	$570	2016	$1,260
1993	$590	2017	$1,300
1994	$620	2018	$1,320
1995	$630	2019	$1,360
1996	$640	2020	$1,410
1997	$670	2021	$1,470
1998	$700	2022	$1,510
1999	$740	2023	$1,640
2000	$780	2024	$1,730
2001	$830		

Each person can get up to a total of four qualifying quarters of credit each calendar year based on the person's own earnings. (The person may be credited with additional quarters in a calendar year based on earnings of a parent or spouse, as described later in this section.)

> Mr. G earned $5,000 gross income in 1995. ($5,000 divided by $630 = 7.936) Although the result equals over seven quarters, he is credited with four qualifying quarters in 1995.

NOTE: Starting with January 1, 1997, do not count the income from any quarters in which an alien received any type of federal means-tested public assistance during the quarter. "Means-tested public assistance" includes FIP, SSI, Medicaid, and Food Assistance.

Medicaid received by an individual, household, or family eligibility unit (except for limited Medicaid for emergency services) counts as receipt of "means-tested public assistance."

> Child A receives MAC. Although the parents are not receiving Medicaid for themselves, they are part of the family eligibility unit that is receiving "means–tested public assistance." Do not count the parents' income from the quarter that the child received MAC for the 40-quarter determination.

The quarters in a calendar year are: January through March, April through June, July through September, and October through December.

This means if an alien received FIP, Food Assistance, Medicaid, or SSI in June 1997, you would subtract the person's April, May, and June earnings from the total 1997 earnings and divide the remainder to figure how many qualifying quarters the person has.

Lawful permanent residents can count their spouse's quarters earned during the marriage in addition to their own quarters in order to meet the 40-quarter requirement. For example, if each spouse had 20 quarters, you would add the quarters together. Both spouses would be counted as having 40 quarters and both would meet this requirement.

Use the same formula to calculate qualifying quarters earned by a parent or spouse. Count the spouse's quarters earned during the marriage, regardless of whether the spouse is a citizen or not, when:

- The couple is currently married, or
- A spouse is deceased and the surviving spouse is not remarried, or
- The couple is separated but not divorced.

> Mr. and Mrs. L are working in 2004. Mr. L earned $25,000 gross income and Mrs. L earned $3,000 gross income. $25,000 divided by $900 = 27.77, which is converted to the maximum allowable four quarters. $3,000 divided by $900 = 3.33, which is converted to three quarters. Both Mr. and Mrs. L are credited with seven qualifying quarters for 2004.

When calculating creditable quarters for the year in which the couple became married, count all earnings received beginning with the date of marriage.

> Mr. and Mrs. B married on May 25, 2006. Mr. B had no earnings in 2006. Mrs. B earned $15,000 between May 25 and December 31, 2006. $15,000 divided by $970 = 15.46, which is converted to four quarters. Both Mr. and Mrs. B are credited with four qualifying quarters for 2006.

If the couple divorces, any quarters earned by the spouse during marriage are lost. However, if the divorce occurs after the person has already been credited with the 40 quarters and determined eligible for Medicaid, do not subtract qualifying quarters earned by the former spouse.

> 1. Mr. and Mrs. J entered the United States in July 2006 as lawful permanent residents (LPRs). In July 2011, they apply for Medicaid. Although Mr. J has a sponsor, it is determined that sponsor deeming does not apply because Mr. J can be credited with 20 qualifying quarters of his own and 20 quarters of Mrs. J's.
>
>   Mr. J is exempted from sponsor deeming. All other eligibility factors are met, so Medicaid is approved. In October 2011, the couple divorces. The qualifying quarters previously credited to each spouse are not recalculated.
>
> 2. Same as Example 1 except the couple has already divorced by the time Mr. J applies for Medicaid in July 2011. Mr. J can be credited with his own qualifying quarters but not those of his former spouse.
>
>   Mr. J is not exempt from sponsor deeming until he has 40 creditable qualifying quarters. Eligibility for Mr. J's eligible group will be determined using the income deemed from the sponsor and any other countable income of the eligible group.

In some circumstances, lawful permanent residents can also count the quarters earned by a parent in addition to their own quarters to meet the 40-quarter requirement. For this policy, "parent" means the natural or adoptive parent or the stepparent.

A lawful permanent resident may be credited with any qualifying quarter earned by the person's parents while the person was under 18 years of age. This includes quarters worked by the parents before the person's birth. Count a parent's quarters regardless of whether the parent is a citizen or not.

When calculating creditable quarters for the year in which a child turned 18, count all earnings received by the person's parents while the child was less than 18 years of age.

> Child D turned 18 on June 15, 2006. His mother earned $12,000 between January 1, 2006, and June 14, 2006. Divide $12,000 by $970 = 12.37, converted to the maximum allowable four quarters. Child D is credited with four qualifying quarters from his mother in 2006.

Count the quarters earned by a stepparent during the stepparent relationship if the stepparent relationship still exists. Do not count quarters earned before the stepparent relationship began. Death of the stepparent does not end the relationship.

If the parent and stepparent divorce, any quarters earned by the stepparent are lost. However, if the divorce occurs after the person has already been credited with the 40 quarters and determined eligible for Medicaid, do not subtract qualifying quarters earned by the stepparent.

Do not count quarters earned by a child toward the eligibility of a parent.

Verifying Qualifying Quarters

When an exception to sponsor deeming will affect the eligibility determination, verification of qualifying quarters must be obtained. Electronic data matching is the primary method of verifying qualifying quarters.

An individual shall only be required to verify qualifying quarters when verification could not be obtained electronically. This includes getting verification of the qualifying quarters earned by a spouse, parent, or stepparent.

In addition to verification from the Social Security Administration (SSA), you can use documentation such as:

- Wage stubs or W-2's
- Employer's statement
- Income tax forms

Do not request proof of qualifying quarters if an exception to sponsor deeming will have no impact on the Medicaid eligibility determination.

> Ms. J is a sponsored LPR living with her two minor children. The IM worker determines Ms. J is eligible for FMAP even if income is deemed from her sponsor. Because an exception to sponsor deeming has no impact on Medicaid coverage, proof of qualifying quarters is not requested from Ms. J.

A person who does not have acceptable proof is responsible for obtaining necessary verification from the SSA. SSA can verify quarters starting with the year 1930. If the applicant provides verification from SSA of less than the required 40 qualifying quarters but disputes the SSA records, allow the applicant an opportunity to resolve the discrepancy.

In either situation:

1. Instruct the applicant in writing to obtain:
    - The necessary verification, or
    - Proof that the verification has been requested or that SSA is investigating the discrepancy.

Include in the note that income (and for Non-MAGI-related, resources) will be deemed from the sponsor if the requested verification is not received within ten calendar days. Also ask that the applicant let you know if more time is needed to obtain the requested verification or proof of request for the verification.

2. Deem income (and for Non-MAGI-related, resources) from the sponsor if you do not receive the requested verification or proof for requesting the SSA verification or investigation by the due date (or the extended due date, if applicable).

3. If the applicant provides the requested proof, pend the application until the SSA verification of qualifying quarters is received or until the SSA investigation is completed. Periodically contact the applicant to check on the status of the SSA verification or investigation of the disputed qualifying quarters.

   However, do not delay the eligibility determination for household members who can be determined eligible without proof of 40 qualifying quarters and the resulting exception to sponsor deeming.

   > Mr. M is a sponsored LPR living with his two minor children. He applies for MAGI-related Medicaid for the entire family. Proof of qualifying quarters is needed to determine eligibility for Mr. M because he will be over income for MAGI-related coverage groups if an exception to sponsor deeming is not allowed.
   >
   > However, the children are not themselves sponsored. MAGI-related Medicaid eligibility is determined for the children without waiting for proof of 40 qualifying quarters.

4. Process the application upon receipt of the SSA verification or the results of the completed investigation. Do not deem income from the sponsor if SSA verifies at least 40 qualifying quarters.

   If the completed SSA investigation still verifies less than 40 qualifying quarters, continue to deem income from the sponsor.

Battered Aliens

Legal reference: P.L. 104-193 as amended by Section 552 of P.L. 104-208

The determination of battered alien status may impact both the determination of whether:

- An individual has a qualified alien status, as described earlier in this chapter, and
- An individual is exempt from sponsor deeming. A lawful permanent resident (LPR) alien sponsored under *Affidavit of Support*, Form I-864 or Form I-864A, is exempt from sponsor deeming if it is determined that the sponsored person is a battered alien.

Electronic data matching is the primary method of verifying battered alien status. An individual shall only be required to verify battered alien status when verification could not be obtained electronically.

When prompted to do so by the electronic data match response, request documentation from the individual to verify battered alien status.

When an alien is the spouse or child of a United States citizen or a lawful permanent resident, the citizen or lawful permanent resident generally must file USCIS Form I-130, *Petition for Alien Relative*, to allow these family members to remain in the United States. If the petition is not filed (or is withdrawn), the alien has no lawful immigrant status and may face being deported.

In abusive situations, control over the alien's immigration status strengthens the batterer's hold on the victims. For example, the batterer may threaten to stop the visa process if the abused spouse or child attempted to leave their common home or to report the abuse to authorities.

A U visa (or code A19 or A20 on the *Employment Authorization Document* (EAD)) is an indication that a person might be a battered alien. However, U visas are also issued to other categories of aliens, so a U visa does not automatically mean the adult is a battered alien. If an adult provides a U visa (or EAD with code A19 or A20), follow up to find out if they are either a victim of trafficking or a battered alien. A child under age 21 with a U visa (or code A19 or A20 on the EAD) is a qualified alien under the definition of "lawfully residing." Refer to the Alien Documentation Chart – Medicaid Only for additional document types and section codes that may indicate status as a battered alien.

The battered person may be the alien, or the child or parent of the alien. The abuser may be a United States citizen or lawful permanent resident family member (spouse, parent, or other relative) who lived in the same household in the United States. To qualify as a battered alien, the person must:

- Present documentation of an approved or a pending petition for a family-based immigrant visa, a self-petition for an immigrant visa, or cancellation of removal, or suspension of deportation, **and**
- No longer live with the abuser.

NOTE: Because of the abusive relationship, battered aliens may not have copies of documents they filed themselves or that were filed on their behalf. Refer applicants who do not have any documentation or who are not certain that a petition for lawful permanent residency has been filed on their behalf to the USCIS.

These individuals may already be working with a domestic violence service provider. If not, also refer them to the National Domestic Violence Hotline (1-800-799-7233) or to the local domestic violence service provider. The local service provider may be able to assist the applicant in obtaining necessary documentation of alien status without jeopardizing the alien's safety or immigration efforts.

Since the 1994 enactment of the Violence Against Women Act, a battered alien may self-petition for lawful permanent residency by using the USCIS Form I-360, *Petition for Amerasian, Widow(er), or Special Immigrant*, without the cooperation or knowledge of the abuser.

Indigent Aliens

Legal reference: P.L. 104-193 as amended by Section 552 of P.L. 104-208

A lawful permanent resident (LPR) alien whose sponsor signs *Affidavit of Support*, Form I-864, or Form I-864A, is exempt from sponsor deeming if it is determined that the sponsored person meets indigent criteria of being unable to obtain food and shelter.

Explain to the applicant or member that income (and for Non-MAGI-related, resources) will be deemed from the sponsor and will be considered the sponsored person's income and resources in determining eligibility, unless it is determined that the sponsored person meets indigent criteria of being unable to obtain food and shelter.

If the sponsored person is living with the sponsor, assume that the sponsor is providing food and shelter, so the need for food and shelter is being met. The indigence exception will not be granted and deeming will apply.

If the sponsored person is living apart from the sponsor, ask the sponsored person how much income the sponsor and others outside the household are making available.

Find the sponsored person unable to obtain food and shelter if the gross income of the sponsored person's household (including any income provided by others, including the sponsor) is less than 100% of the federal poverty level for the sponsored person's household size. (See 6-Appendix, RC-0130, *Medical Assistance Desk Aid*.)

In determining whether the indigence exemption applies, count only the **actual** amount of income that the sponsor and others make available to the sponsored person.

1. Mr. B is an LPR sponsored by an individual under Form I-864, *Affidavit of Support*. Mr. B does not live with his sponsor and does not have the 40 qualifying quarters needed to exempt him from sponsor deeming. Mr. B and his wife are qualified aliens who have met the five-year bar. Their children are U.S. citizens.

   Mr. B applies for Medicaid for himself, his wife (not pregnant), and their two children, ages 2 and 3. The household's only income is Mr. B's gross monthly earnings of $400, plus $200 provided by his sponsor.

   The $600 total income of Mr. B's household is less than 100% of the federal poverty level for his household size of four persons. Mr. B is determined to be indigent, and sponsor deeming will not apply.

2. Same as Example 1 except that Mr. B is disabled. He receives $900 Social Security Disability (SSD) income each month, and each of his two children receives $100 social security because of his disability. Mr. B's sponsor also provides $200 to him each month.

   The total household income of $1,300 is less than 100% of the federal poverty level for Mr. B's household size of four persons. Mr. B is determined to be indigent, therefore sponsor deeming will not apply.

3. Same as Example 2 except Mr. B has no earnings history, so neither he nor his children receive any social security income. Mr. B's only income is $763 SSI and $200 actually provided by his sponsor. A determination of indigence is not needed for Mr. B since he receives SSI.

   The IM worker uses income as reported on Mr. B's State Data Exchange (SDX) to determine Mr. B's Medicaid eligibility.

   If the worker is aware of income Mr. B is receiving from his sponsor that is not reported on the SDX, the worker reports this income to the Social Security Administration using form 470-0641, *Report of Change in Circumstances – SSI-Related Programs*.

   Since Mr. B is on SSI, eligibility for Mrs. B and the two children is determined as a MAGI-related household of three without considering Mr. B's income.

Calculating Deemed Sponsor Income and Resources

Legal reference: 441 IAC 75.11(3); 20 CFR 416.1166a, 20 CFR 416.1204; 42 U.S.C. 1396b(v) as amended by P.L. 111-3

When a lawful permanent resident (LPR) alien is sponsored by a person who signed form I-864, *Affidavit of Support*, or Form I-864A, and sponsor deeming applies, income (and for Non-MAGI-related, resources) are deemed to the sponsored alien after applying allowable deductions and diversions.

Do not include the sponsor(s) in the household size unless they are required according to policy. Determine the household composition according to policies for either Non-MAGI-related or MAGI-related coverage groups.

Calculate the amount of **income** to deem as follows:

1. Determine the amount of each sponsor's monthly nonexempt gross earned and unearned income in accordance with either MAGI-related or Non-MAGI-related policies.
2. For both MAGI-related and Non-MAGI-related coverage groups, allow deductions as follows:
   - Allow a deduction equal to the full SSI amount for one person for the sponsor, or for each sponsor even if married.
   - Allow a deduction equal to one half the SSI amount for one person for the sponsor's spouse (unless both spouses received the full SSI amount deduction because both are sponsors) and for each of the sponsor's dependents. Do not subtract the dependent's income from the amount allowed as a deduction for the dependent.
   - Deduct alimony or child support payments made to persons not living with the sponsor.
   - Deduct payments made to persons not living with the sponsor but who are claimed (or could be claimed) by the sponsor for federal income tax purposes.
   - Divide the amount remaining by the number of aliens sponsored by this sponsor, if known; if not known, the entire amount counts.

3. The result is the amount of income deemed to the sponsored person. Count this amount as unearned income **only** when determining eligibility for the sponsored person(s). Income deemed from or actually provided by a sponsor is **not** countable for the eligibility of other members of a sponsored alien's household unless they themselves are also sponsored by the individual who signed a Form I-864, *Affidavit of Support*, or a Form I-864A Contract.

1. Mr. H applies for Medicaid for himself, his wife (not pregnant), and their two children, ages 2 and 3, who are U.S. citizens. Mr. H is an LPR who is subject to sponsor deeming. No one else in the household is sponsored.

   Mr. H and his wife are qualified aliens who have met the five-year bar but do not have 40 qualifying quarters. Mr. H has gross monthly earnings of $400.

   The sponsor has gross monthly earnings of $3,000. The sponsor's household includes her husband and one child. The sponsor does not pay any alimony or child support, nor does the sponsor make payments to anyone not living with her who is claimed or could be claimed as a tax dependent.

   First, the amount of income to deem from the sponsor is calculated as follows:

$	3,000.00	Sponsor's gross earnings
-	943.00	Divert for sponsor
-	471.50	Divert for sponsor's spouse
-	471.50	Divert for sponsor's child
$	1,114.00	Countable as unearned income to the sponsored person

   Next, MAGI-related income for Mr. H is calculated as follows:

$	1,114.00	Deemed from sponsor
+	400.00	Mr. H earnings
$	1,514.00	Mr. H total countable earned and unearned

   The only income countable to the rest of the household is the $400 earned by Mr. H.

2. Mr. N applies for Medicaid for himself and his wife. Mr. and Mrs. N are both elderly and have no children living with them. Mr. N is an LPR who is subject to sponsor deeming. No one else in the household is sponsored.

   Mr. N is a qualified alien who has met the five-year bar. His wife is a U.S. citizen. Mr. N receives $400 social security per month. Mrs. N receives $1,100 social security.

   The sponsor is married with no children. The sponsor's income is $1,000 social security and a $500 monthly pension. The sponsor does not pay any alimony or child support, nor does the sponsor make payments to anyone not living with him who is claimed or could be claimed as a tax dependent.

   The amount of income to deem from the sponsor is calculated as follows:

$	1,500.00	Sponsor's gross income
-	943.00	Diversion for sponsor
-	471.50	Diversion for sponsor's wife
$	85.50	Countable as unearned income to the sponsored person

Next, Non-MAGI-related Medicaid income for Mr. N is calculated as follows:

$ 1,100.00	Mrs. N's social security
+ 400.00	Mr. N's social security
+ 85.50	Deemed from Mr. N's sponsor
$ 1,585.50	Countable income for Mr. N
- 20.00	Deduction
$ 1,565.50	> $1,371 SSI limit for 2

The only income countable for Mrs. N's eligibility determination is her $1,100 social security and Mr. N's $400 social security.

Calculate the amount of **resources** to deem as follows:

1. Determine the amount of nonexempt resources of the sponsor in accordance with Non-MAGI-related policies. There are no resource tests for MAGI-related Medicaid.
2. Allow deductions as follows:
   - $2,000 if the sponsor does not live with a spouse,
   - $3,000 if the sponsor lives with a spouse who is not a sponsor, or
   - $4,000 if the sponsor lives with a spouse who is also the alien's sponsor.
3. The result is the amount of resources deemed to the sponsored member. Resources deemed from or actually provided by a sponsor are **not** countable for the eligibility of other members of a sponsored alien's household unless they themselves are also sponsored by the individual who signed a Form I-864, *Affidavit of Support*, or a Form I-864A Contract.
4. Disregard the resources of all household members, including resources deemed to the sponsored adult, when determining eligibility for children in accordance with policies for the applicable Medicaid coverage groups.

Limited Eligibility for Certain Aliens

Legal reference: 42 CFR 435.406(b), 42 CFR 440.255(b)-(c), 441 IAC 75.11(1) and 75.11(4)

Medicaid benefits are available to pay for the cost of emergency services for an alien who does not meet Medicaid citizenship or alien requirements or social security number requirements. However, the person must meet the financial and categorical eligibility requirements and state residency requirements of an MAGI-related or Non-MAGI-related coverage group.

Emergency medical coverage is also available to otherwise eligible people whose alien status cannot immediately be determined through data matching and who do not qualify for a 90 day ROP, or who do not claim to have a qualified alien status.

Categories of aliens who are potentially eligible for emergency medical coverage include:

- Qualified aliens not eligible for full Medicaid coverage due to the five-year bar.
- Nonqualified alien adults age 21 or over "lawfully residing" in the United States. This may include adults in a "nonimmigrant" alien status.
- Undocumented aliens or aliens in the U.S. unlawfully.

NOTE: A person eligible only for limited Medicaid for emergency services must cure any prior noncooperation issues if cooperation is a requirement of the applicable coverage group. Inform the applicant in writing of any cooperation issue and allow the applicant ten calendar days to cooperate.

Sponsor deeming does not apply when determining eligibility for this coverage.

As a condition of eligibility, the applicant must have had or currently have an emergency medical condition (including labor and delivery). See Existence of an Emergency Medical Condition. Limits of coverage are described under Payment for Emergency Services.

A person must meet **Iowa residency requirements** to qualify for limited Medicaid for emergency services. The USCIS may require persons in some alien statuses (e.g., nonimmigrants) to show they intend to maintain and return to their residence abroad. Therefore, such an alien status is an indicator that a person might not meet Iowa residency requirements.

However, alien status may **not** be used to determine a person is not an Iowa resident. All policies found at 8-C, *Residency* and *Intent to Live in Iowa* must be applied when determining whether or not an alien meets Iowa residency requirements.

The following categories of people may be ineligible, depending on their Iowa residency status:

- Crewmembers on shore leave.
- Aliens traveling through the United States.
- Treaty traders or investors and their families.
- Temporary workers, including agricultural contract workers.
- Visitors for business or pleasure, including exchange visitors.
- Members of foreign press, radio, film or other information media and their families.

- Foreign government representatives on official business, their families and servants.
- International organization personnel and their families and servants.
- Foreign students and their families who are here as dependents and are not otherwise eligible.

1. Mr. P, 40 years old, is unlawfully living in the United States. He received emergency medical care for treatment of a broken nose sustained in an auto accident. Mr. P has no income and is not the parent or other caretaker of a child. Mr. P could be categorically eligible under IHAWP.
2. Ms. D, age 36 and an LPR still within the five-year bar, is living in the United States with her 13-year-old daughter. Ms. D has received emergency medical care. Ms. D has no income, but she is a parent of a child. Ms. D can be eligible for payment of emergency services.
3. Same as Example 2, but Ms. D. has a previous noncooperation with Child Support Recovery Unit (CSRU). The sanction was not imposed because she was not a Medicaid member at the time. Cooperation with CSRU is a requirement of FMAP, the applicable coverage group for Ms. D. She must cooperate with CSRU in order to be eligible for payment of emergency services.
4. Ms. G, 30 years old, is a nonqualified alien residing in Iowa with her 4-year old son. She has a previous noncooperation with CSRU that was not imposed due to her inactive Medicaid status. She receives emergency medical care related to a current pregnancy.

   Because Ms. G meets the categorical eligibility requirement for MAC, and CSRU cooperation is not a requirement for the MAC group, the CSRU sanction does not affect her eligibility for Medicaid coverage of emergency services.

Existence of an Emergency Medical Condition

Legal reference: 42 CFR 440.255(b)-(c), 441 IAC 75.11(1)

"Emergency medical condition" means a medical condition of sudden onset (including labor and delivery) manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy, or
- Serious impairment of bodily function, or
- Serious dysfunction of any bodily part or organ.

The following medical conditions are not considered emergency medical conditions:

- Organ transplant procedure
- Routine prenatal care
- Routine postpartum care

Before granting eligibility, verify the existence of the emergency medical condition and that medical expenses were incurred. Send the *Verification of Emergency Health Care Services*, form 470-4299, to the medical provider who treated the applicant for the emergency medical condition. Either the provider or the provider's designee may sign the form.

You may also use a signed statement from the medical provider containing the same information as requested by form 470-4299.

> Mr. A, 17 years old, is unlawfully living in the United States. He has no income or resources and has filed an application for Medicaid. Mr. A has not been treated for an emergency medical condition. His application is denied, because aliens unlawfully living in the U.S. are eligible only for payment of medical expenses for treatment of any past or current emergency medical condition.

Keep form 470-4299 or the statement verifying the medical care was an emergency in the electronic case file and available for Iowa Medicaid Enterprise (IME) to identify payable claims to avoid overpayments.

Payment for Emergency Services

Legal reference: 42 CFR 440.255(a), 441 IAC 75.11(1) and 76.13(3)

Payment for emergency services is limited to services necessary to treat an emergency medical condition for the dates of service of the emergency.

"Emergency services" means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of an emergency medical condition. Labor and delivery services are covered, including normal deliveries.

Payment may be made for covered services for an alien who requires emergency medical care more than once in a calendar month or in different months. NOTE: A new application is not required for any subsequent emergencies within the same month or month(s) for which limited emergency Medicaid is approved.

Send form 470-4299, *Verification of Emergency Health Care Services*, to the medical provider for each separate medical emergency, including multiple emergencies within the same month.

The IME Provider Services Unit will identify payable claims based on dates of service and services billed by the providers as indicated by the "E" fund code (the third digit of the aid code) in ELIAS, or by the entry of the "C" code in either the TD03 SRV field in the Automated Benefit Calculation (ABC) system or on the *Request for Special Update*, form 470-0397. NOTE: Do not use the *Request for Special Update* form for ELIAS cases; instead, follow processes in EJA0327, *Medical Condition Manage*.

Do not approve emergency services for anyone who has received care related to an organ transplant procedure furnished on or after August 10, 1993.

When an application is approved for an alien who is eligible for emergency services only, it is approved for the months the emergency occurred. This may mean that a person is eligible for one month; if eligible under the Medically Needy coverage group, use a one-month certification period for ongoing eligibility. (Refer to 8-J, *Retroactive Eligibility* for policy on retroactive eligibility certification periods).

If an application was not filed in the month of the emergency services, retroactive eligibility for limited emergency Medicaid may be granted only if the applicant meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*.

If the dates of service of the emergency span more than one month, the person must be determined categorically and financially eligible for each month. This may mean that a person is eligible for one month and not the others, or the person may be eligible for all months. If eligible under the Medically Needy coverage group, this may mean a larger spenddown due to using income for more than a one-month certification period.

1. Ms. Q, an LPR still in her five-year bar, delivers a baby on April 30. She applies for Medicaid on May 10. Form 470-4299, *Verification of Emergency Health Care Services*, shows the dates of service for treating her emergency medical condition are April 30 through May 5. She is categorically and financially eligible for both months.

   The application is approved for emergency services for April and May. The baby, who is a U.S. citizen, is eligible under deemed newborn status through the month of the child's first birthday.

2. Mr. C, a 65-year-old nonqualified alien, has an emergency March 25. He files an application on March 27. Form 470-4299, *Verification of Emergency Health Care Services*, shows March 25 is the only date of service for treating his emergency medical condition. The application is approved for the month of March only.

3. Ms. W, an undocumented pregnant alien, applies for Medicaid on August 3. Form 470-4299, *Verification of Emergency Health Care Services*, shows she was treated for an emergency medical condition for the dates of service of July 25 through August 2. Ms. W is categorically eligible for Medicaid but exceeds the income limits except for Medically Needy.

   Because the emergency spanned two months, the Medically Needy certification period will be August with a one-month retroactive certification for July.

Cases processed in ELIAS will receive correct coverage and notices when processed according to EJA0327, *Medical Condition Manage*. The instructions that follow below are **not** applicable to cases in ELIAS. For applications processed in ABC, manually issue a notice of decision. For applications received and approved in the same month before timely notice day, make entries in ABC for Medicaid coverage of the emergency services. See 14-B(7), *Emergency Medical Services for Aliens*.

Close the individual or the case effective the first of the month following the last date of service for the emergency. Suggested wording for the manual notice of decision:

> Your application for Medicaid is approved for limited benefits only, because you do not meet Medicaid citizen/alien requirements. Payment for emergency services is limited to services necessary to treat an emergency medical condition for the dates of services of the emergency.
>
> Su solicitud para recibir los servicios de Medicaid está aprobada solo para determinados beneficios debido a que usted no cumple con los requisitos respecto de la condición de ciudadano/extranjero de Medicaid. El pago de servicios de emergencia se limita a aquellos servicios que sean necesarios para el tratamiento de una emergencia médica en las fechas de prestación de dichos servicios.
>
> EM 8-L, Existence of an Emergency Medical Condition; 441 Iowa Administrative Code 75.11(249A) and 76.13(3); EM 8-J, Who is Eligible for Medically Needy; 441 Iowa Administrative Code 75.1(35), 75.11(249A), and 76.13(3); EM 8-C, Citizenship; EM 6-B, Eligibility for Aliens; Iowa Administrative Code 50.2(1); 42 CFR 435.406; 42 CFR 440.255.

For applications approved after timely notice day, complete and submit form 470-0397, *Request for Special Update* to update eligibility rather than make entries on the ABC system. EXCEPTION: For Medically Needy cases with spenddown, open all cases in the ABC system so that the Medically Needy subsystem can track spenddown.

For denials, make ABC system entries and send a system notice of decision.

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8, Chapter M

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Medicaid
Services

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Overview

This chapter contains an explanation of the services and programs available to Medicaid members (people who have been determined eligible for Medicaid benefits). Detailed information about coverage of specific services, conditions of provider participation, and billing and payment can be found in the Medicaid Provider Manuals.

Providers of Medical Services

Legal reference: 441 IAC 77, 79.6(249A), 80, 81, 82, 85

Participation in the Medicaid program is open to all qualified providers of medical and remedial services in the following categories:

- Noninstitutional providers:
  - Advanced registered nurse practitioners
  - Ambulance services
  - Ambulatory surgical centers
  - Area education agencies
  - Assertive community treatment providers
  - Audiologists
  - Behavioral health service providers
  - Behavioral health intervention providers
  - Birth centers
  - Case management organizations
  - Child care medical services
  - Chiropractors
  - Community-based neurobehavioral rehabilitation services
  - Community mental health centers
  - Crisis response services
  - Dentists
  - Family planning clinics
  - Federally qualified health centers
  - Health home service providers
  - Health insurance premium payment (HIPP) providers
  - Hearing aid dealers
  - Home health agencies
  - Home- and community-based habilitation service providers
  - Home- and community-based waiver service providers
  - Hospices
  - Independent laboratories
  - Indian Health Service facilities
  - Infant and toddler programs
  - Lead investigation agencies
  - Local education agencies
  - Maternal health centers
  - Medical equipment dealers
  - Occupational therapists
  - Opticians
  - Optometrists
  - Ordering and referring providers
  - Orthopedic shoe dealers
  - PACE organizations
  - Pharmacies
  - Physical therapists
  - Physician assistants
  - Physicians
  - Podiatrists
  - Psychologists
  - Public health agencies
  - Qualified Medicare Beneficiary (QMB) providers
  - Rehabilitation agencies
  - Rural health clinics
  - Screening centers
  - Speech-language pathologists
  - Subacute mental health services

- Institutional providers:
  - Acute-care hospitals
  - Critical-access hospitals (CAHs)
  - Intermediate care facilities for persons with intellectual disabilities (ICFs/ID), including the state resource centers
  - Nursing facilities for people with mental illness aged 65 and older (NFs/MI)
  - Nursing facilities, including facilities certified to provide skilled care (NFs/SNFs)
  - Psychiatric medical institutions for children (PMICs)
  - State mental health institutes (MHIs) licensed as hospitals

All providers that wish to participate in the Iowa Medicaid program must apply to the Iowa Medicaid for certification as a Medicaid provider. The IME Provider Services Unit assigns a Medicaid provider number to each approved provider and issues instructions on accessing the Medicaid provider manual on the Internet and a supply of claim forms (when the claim forms are not available commercially).

Medical institutions in Iowa are licensed by the Department of Inspections and Appeals. After being licensed, the institution can ask to be certified to participate in the Medicaid program.

Nursing facilities that are certified in the Medicare program for skilled nursing care can provide and be paid either for skilled nursing care or nursing care, depending upon the needs of the member. A nursing facility that is not certified in the Medicare program may be paid only for nursing care, even if the care the member receives would be considered skilled nursing care in a Medicare-certified facility.

Direct questions about facilities participating in the Medicaid program to the IME Provider Services Unit.

Requirements for Providers

Legal reference: 441 IAC 79.2(249A), 79.3(249A), 79.5(249A), 79.6(2), 79.8(249A)

Providers cannot charge members for Medicaid services in addition to the Medicaid reimbursement the provider receives. However, they can charge members or agencies for services that are **not** covered by Medicaid.

Abortions, sterilizations, and hysterectomies have specific documentation requirements that must be included with each claim. These requirements are defined in the ***Physician Provider Manual***, among others.

Certain services require prior approval from the IME to ensure that the services are necessary. Providers must submit form 470-0829, *Request for Prior Authorization*, to the IME to obtain prior approval. Providers who are unsure if an individual or service meets the Medicaid criteria for payment can also submit a prior approval request.

Medically Needy clients who are conditionally eligible must also comply with prior approval requirements to receive Medicaid payment after spenddown is met for services or items for which prior approval is required. Prior authorization is explained further in the provider manuals.

Providers must:

- Keep records for five years from the date of service documenting the services, supplies, and care furnished to Medicaid members.

- Provide records or related information when requested by the Department or by the U.S. Department of Health and Human Services.
- Comply with Title VI of Civil Rights Act of 1964, which prohibits discrimination based on race, creed, or national origin.
- Comply with Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination based on handicap.

Providers may be subject to sanctions for program violation such as filing a false claim or failure to comply with provider certification on Medicaid check endorsement. Sanctions include suspension, probation from program participation, or termination from Medicaid participation.

Nonemergency Medical Transportation

Legal reference: 441 IAC 78.13(249A)

Nonemergency medical transportation services are available to members with full Medicaid benefits and Iowa Health and Wellness Plan members who have a medically exempt status. These services provide travel reimbursement or a ride to medical or dental appointments. Hawki members are not eligible for nonemergency medical transportation services.

For any questions regarding nonemergency medical transportation, refer the member to Member Services at the Iowa Medicaid or the member's Managed Care Organization (MCO).

Managed Health Care

IA Health Link

The IA Health Link managed care program began April 1, 2016. Most Medicaid members are enrolled in the IA Health Link managed care program. This program gives members health coverage through a Managed Care Organization (MCO). Members choose which MCO they will enroll with and will see a provider who works with the MCO they choose.

The benefits a member receives from the member's selected MCO will depend on the type of Medicaid coverage they qualify for.

There are some members who are excluded from MCO enrollment. They are listed below:

- Members who qualify for the Health Insurance Premium Payment program (HIPP). See Health Insurance Premium Payment Program (HIPP) for more information.
- Members who qualify for the Medicare Savings Program (MSP) only.
  - Qualified Medicare Beneficiary plan (QMB)
  - Specified Low-Income Medicare Beneficiary (SLMB)
- Members who are eligible for emergency services only.
- Members who are on the Medically Needy program also known as the spenddown program.

- Presumptively eligible members (subject to change once ongoing eligibility is determined).

Some members may choose to participate in MCO enrollment:

- Members who are enrolled with the PACE program.
- American Indian or Alaskan Native members may also choose to enroll in the Managed Care program. If a member identifies as American Indian or Alaskan Native, they may contact Iowa Medicaid Member Services at 1-800-338-8366 to learn about enrolling in the IA Health Link Managed Care program.

Each MCO has a network of providers who the member may see for care. The MCOs will coordinate the care for their enrolled members.

Program for All-Inclusive Care for the Elderly (PACE)

Legal reference: 42 CFR 460; 441 IAC 88

The program for all-inclusive care for the elderly (PACE) is designed to allow enrolled Medicaid members to stay healthy and live in the community as long as possible. PACE is a seamless way of providing "managed" long-term care to Medicaid members. PACE becomes the sole source of services for Medicare and Medicaid eligible enrollees.

PACE is similar to the Medicaid home- and community-based service (HCBS) waiver programs in that members must live in the community and meet nursing facility level of care in order to qualify. PACE eligibility differs from HCBS waiver programs because Medicaid members who are enrolled in PACE continue to be eligible for PACE services if they become a resident of a medical institution.

PACE is a specialized managed care organization that receives a monthly Medicaid capitation payment for each eligible PACE enrollee. It is an optional State Plan program for members who meet its eligibility requirements. Also, applicants or members who meet PACE eligibility requirements may choose PACE as a managed care option instead of an IA Health Link MCO.

The PACE benefit package, regardless of the source of payment, must include all Medicare and Medicaid covered items and services. All other services determined necessary by the PACE IDT to improve and maintain the member's overall health status and well-being. Common PACE services can include, but are not limited to, the following:

- Durable medical equipment
- Emergency care
- Hospital
- Nursing facility care
- Personal care
- Physical and occupational therapy and other restorative therapies
- Prescriptions
- Primary physician services
- Respite care
- Skilled nursing services
- Social work services

- Specialty care
- Therapeutic recreational services
- Transportation

Who Can Be Enrolled

Legal reference: 42 CFR 460.150; 441 IAC 88.24(249A)

In counties served by a PACE provider, Medicaid members or individuals who are eligible for Medicaid have the option to enroll in PACE to meet their long-term health care needs if they:

- Are 55 years of age or older.
- Reside in a county served by a PACE provider.
- Live in a community setting at the time of enrollment (are not institutionalized) and choose to receive PACE services.
- Are determined eligible for SSI-related Medicaid, including the 300% group but excluding the Medically Needy coverage group.
- Are determined to meet nursing facility level of care.

NOTE: PACE eligibility cannot be concurrent with any other Medicaid eligibility. Other Medicaid programs must be canceled before PACE eligibility begins.

How Medicaid Members Are Enrolled

Legal reference: 42 CFR 460.152-156; 441 IAC 88.24(249A)

The income maintenance (IM) worker, the PACE enrollment coordinator, and the Iowa Medicaid Medical Services Unit share the responsibility for determining that all PACE eligibility criteria have been met. The PACE enrollment coordinator will begin the process by notifying the IM worker of an individual who chooses to apply for the PACE program.

Application Processing

Legal reference: 441 IAC 76.2(249A), 441 IAC 88.24(1)

The IM worker determines income and resource eligibility for PACE based on a Medicaid application. A prospective PACE enrollee wanting to apply for PACE services must complete:

- An application online at https://dhsservices.iowa.gov/apspssp/ssp.portal, or
- Form 470-5170 or 470-5170(S), *Application for Health Coverage and Help Paying Costs*.

Determine if the applicant resides in a county served by a PACE provider. All other application policies and general eligibility requirements, other than those described under Who Can Be Enrolled, are the same for people applying for PACE services.

Follow the processing procedures described in 8-B, *Application Processing*, and the eligibility requirements found in the following:

- 8-C, *Nonfinancial Eligibility*,
- 8-D, *Resources*,
- 8-E, *Income*,
- 8-F, *Coverage Groups*, and
- 8-I, *When Applying for or Receiving Waiver or PACE Services*.

Provide the applicant a copy of Comm. 316, *PACE - Program of All-Inclusive Care for the Elderly*.

Level of Care

Legal reference: 441 IAC 88.24(1)

PACE enrollees must meet the nursing facility level of care. The PACE physician completes form 470-4490, *Level of Care Certification for PACE Program*. The PACE enrollment coordinator submits the level of care form along with supporting documentation to IME Medical Services.

The Medical Services nurse reviewer will review the form and the supporting documentation. The Medical Services Unit then sends a level-of-care notification through IoWANS to the IM worker and the PACE organization.

Effective Date of Enrollment

Legal reference: 441 IAC 88.24(2)

If level of care is approved:

1. Process financial and nonfinancial Medicaid eligibility. A PACE enrollee is considered as an institutionalized person. Treat the applicant as an institutionalized person for attribution of resources and deeming of income and resources.

   There is no retroactive eligibility for PACE.
2. The PACE organization will obtain applicant's signature on the PACE organization's *Enrollment Agreement* (a non-DHS form but required by CMS).
3. Once Medicaid eligibility has been determined and the PACE enrollment form has been signed, approve PACE eligibility on the first day of the month following the date the PACE provider receives the signed enrollment form.

   NOTE: PACE enrollment cannot be concurrent with any other Medicaid eligibility. All other Medicaid programs must be canceled before PACE eligibility can begin. Timely notice is not required because the member has signed the PACE enrollment form accepting PACE services.
4. The PACE organization can view the effective date of approval and any client participation amount through Iowa Medicaid Provider Access (IMPA) in addition to IoWANS.

Client Participation for Enrollee Living at Home

Legal reference: 42 CFR 460.152-156; 42 CFR 435.725; 441 IAC 88.28(2)

Client participation is the amount a PACE enrollee is required to contribute to the cost of PACE services. The PACE provider arranges directly with the enrollee to collect client participation.

To calculate client participation for PACE enrollees who are receiving services in their homes:

1. Determine the total gross monthly income of the enrollee only, according to 8-I, *Income Available for Client Participation*.
2. Subtract 300% of the SSI benefit for one person. See 8-E, *SSI-Related Income Limits*.
3. Add in the following:
   - Veteran's aid and attendance,
   - Veteran's housebound allowance, and
   - Third-party medical payments.

The result is the client participation amount.

> Mr. J, age 60, lives alone and applies for PACE services on October 2. His gross monthly income includes $843 Social Security benefit, $250 private pension, and $100 VA aid and attendance. The worker determines client participation as follows:
>
> $843 Social Security + 250 pension = $1,093 total gross monthly income
>
> $1,093 – $2,829(300% of SSI benefit) = $0
>
> $0 + $100 VA aid and attendance = $100 client participation

See 14-B(9), *SSI–Related Medicaid And Facility Case Actions* for the necessary case actions for the ABC system. IoWANS will notify the PACE provider of the amount of client participation to be paid, if any.

Members With a Medical Assistance Income Trust

To calculate client participation for PACE enrollees with a medical assistance income trust, see 8-I, *Trust Payments*.

Case Maintenance

Legal reference: 42 CFR 460.160; 441 IAC 88.24(249A)

In general, follow the procedures in 8-G, *Case Maintenance*.

Once a member is enrolled to PACE, the PACE provider will provide all of the member's medical needs and services. A PACE enrollee can continue to be enrolled in PACE even if the enrollee enters a medical institution.

If a PACE enrollee enters a medical institution, consider eligibility as if it is a change in facilities, not a change from noninstitutional care to institutional care. Do not make entries to the member's PACE case in the ABC system. All transfers to and from a medical institution are done in IoWANS. See PACE Enrollee Enters a Medical Institution.

A PACE enrollee who moves out of the PACE service area will no longer be eligible for PACE services. For involuntary disenrollment, see Disenrollment.

See the following sections for detailed procedures for the following:

- PACE enrollee enters a medical institution
- PACE enrollee leaves a medical institution
- Annual recertification

PACE Enrollee Enters a Medical Institution

No changes are needed when a PACE enrollee enters a **hospital**.

When a PACE enrollee enters a **nursing facility**, **ICF/ID**, or **NF/MI** for other than respite care, make changes through IoWANS as follows:

- Click on the "entering facility" button on the PACE program request.
- A pop-up box will appear for you to enter the date the PACE enrollee went into the facility. Enter the date of entry according to the *Case Activity Report* and click "move consumer."
- IoWANS will create a new program request with the new begin date. The program field in IoWANS will show as "PACE-NF."
- A workflow is generated to notify the PACE provider that the member has entered a facility.

Client Participation for Enrollee Living in a Medical Institution

When a PACE enrollee enters a **nursing facility**, **ICF/ID**, or **NF/MI** for other than respite care, recalculate client participation effective the first of the month following the month of entry to a medical institution.

The following deductions from gross monthly income are allowed for people who are in a medical institution:

- Personal needs allowances, which are:
- An ongoing personal needs allowance.
- Personal needs in the month of entry to the institution.
- Maintenance needs of a spouse and dependents.
- Unmet medical needs.

See 8-I, *Client Participation*.

Enter the new client participation amount on the ABC TD05 screen effective the first day of the month following the month of entry to a medical institution.

The new client participation amount will roll to IoWANS.

1. Mr. J, a PACE enrollee, enters a nursing facility from his home on May 15. His gross income is $989 monthly and his PACE client participation while he is living at home is $0.

   The IM worker enters the transfer to the program request in IoWANS to move Mr. J from PACE at home to PACE-NF effective May 15.

   The IM worker recalculates Mr. J's client participation effective June 1 allowing for a $50 personal needs allowance, making his client participation $939. The IM worker then enters the new client participation amount on TD05 using a positive date of June 1.

2. Ms. J, a PACE enrollee, is admitted to the hospital on April 28. On May 8 she is transferred to a nursing facility for a long-term stay. Her gross monthly income is $1,015 and her PACE client participation while she is living at home is $0.

   The IM worker enters the transfer to the program request in IoWANS to move Ms. J from PACE at home to PACE-NF effective May 8.

   The IM worker redetermines Ms. J's client participation as follows:

   April: Since Ms. J was living at home in April, her client participation for April does not change.

   May: The PACE provider receives the full capitation payment for May, so Ms. J's client participation continues to be $0.

   June: The $50 personal needs allowance is subtracted from Ms. J's gross monthly income, making her client participation for June $965. The IM worker enters the new client participation amount on the ABC TD05 screen using a positive date of June 1.

PACE Enrollee Leaves a Medical Institution

When a PACE enrollee is discharged from a medical institution:

- Click on the "leaving facility" button on the PACE program request in IoWANS.
- A pop-up box will appear for you to enter the date the PACE enrollee was discharged from the facility. Enter the date of discharge as recorded on the *Case Activity Report* and click "move consumer."
- IoWANS will create a new program request with the new begin date. The program field in IoWANS will show as "PACE."
- A workflow is generated to notify the PACE provider that the consumer has left a facility.

- When a PACE enrollee leaves a nursing facility, ICF/ID, or NF/MI, recalculate client participation for the month the PACE enrollee leaves the facility and goes to a private living arrangement. See 8-I, *Deductions From Client Participation*.
- Recalculate the client participation amount for ongoing months according to Client Participation for Enrollee Living at Home.

  Enter the new client participation amount on the ABC TD05 screen effective the first day of the month following the month of discharge from a medical institution.

  The new client participation amount will roll to IoWANS.

Mr. S, a PACE enrollee, enters a nursing facility from his home on April 16. His gross income is $1075 monthly and his PACE client participation while living at home is $0.

The IM worker recalculates his client participation effective May 1 as follows:

$	1075	Income
-	50	Personal needs allowance
$	1025	Client participation

Mr. S is discharged from the nursing facility and returns to his home on June 5. The worker recalculates his client participation for June and July as follows:

June

$	1075	Income
-	943	HMA month of discharge
-	50	Personal needs allowance
$	82	Client participation to NF

July

$	1075	Income
-	2,829	Waiver PNA
$	0	Client participation

Client Participation for Medicare Skilled Stays

When a PACE enrollee enters a medical institution as skilled and Medicare will be participating in the cost of care, do not assess client participation until after the first 20 days.

Determine if client participation for a Medicare skilled stay should be split by following these steps:

1. Determine the number of days remaining for the month after the first 20 days of a Medicare skilled stay.
2. Multiply the days remaining by the nursing facility's per diem rate.
3. Determine the monthly client participation based on gross monthly income and allowing the deductions.
4. Compare the calculation in #2 with the calculation in #3. The client participation will be the lesser of the two amounts.
5. For the month following the month the enrollee entered a nursing facility as Medicare skilled, determine client participation based on the enrollee's gross monthly income.

1. Mr. M, a PACE enrollee, enters a nursing facility as Medicare skilled from his home on May 5. His gross monthly income is $2,060. His PACE client participation while he is living at home is $0.

   The IM worker determines that the first 20 days of Medicare skilled is May 5 through May 24. The IM worker recalculates Mr. M's client participation effective June 1 allowing for a $50 personal needs allowance, making his client participation $2,010.

2. Mr. J, a PACE enrollee, is admitted to a nursing facility as Medicare skilled on May 28. His gross monthly income is $1,093 plus $100 VA aid and attendance. His PACE client participation while he was living at home was $100. The per diem rate of the nursing facility is $150.

   The IM worker determines that the first 20 days of Medicare skilled is May 28 through June 16. Mr. J's client participation for May and June is as follows:

   May: Mr. J entered the nursing facility on May 28. His client participation would not change until the first of the month following the month of entry. Mr. J's client participation for May would continue to be $100.

   June: Days 1 through 16 are covered by Medicare.

   Determine the cost of the remaining 14 days (June 17-30):

$	150	Nursing facility per diem rate
x	14	Days
$	2,100	Cost of the remaining 14 days

   Calculate client participation based on Mr. J's gross monthly income:

$	1,093	Gross monthly income
-	50	Personal needs allowance
+	100	VA aid and attendance
$	1,143	

   The 14 days per diem rate ($2,100) is more than Mr. J's monthly client participation amount ($1,143) so Mr. J's client participation will be $1,143.

3. Mr. P, a PACE enrollee, enters a nursing facility as Medicare skilled on March 30. His gross monthly income is $2,090. His PACE client participation while he is living at home is $0. The per diem rate of the nursing facility is $150.

   The IM worker determines that the first 20 days of Medicare skilled is March 30 through April 18. Mr. P's client participation for April is as follows. Days 1 through 18 are covered by Medicare.

   Determine the cost of the remaining 12 days (April 19-30):

$	150	Nursing facility per diem rate
x	12	Days
$	1,800	Cost of the remaining 12 days

   Calculate client participation based on Mr. P's gross monthly income:

$	2,090	Gross monthly income
-	50	Personal needs allowance
$	2,040	Client participation

   The 12 days per diem rate ($1,800) is less than Mr. P's monthly client participation amount ($2,040) so Mr. P's client participation for April will be $1,800.

Annual Recertification

Legal Reference: 42 CFR 435.916; 441 IAC 76 (Rules in Process); 441 IAC 88.24(4)

The PACE provider completes a level of care determination at least annually for all PACE enrollees. The IME Medical Services Unit will determine whether nursing facility level of care continues to be met.

Review financial eligibility according to the requirements for the enrollee's particular coverage group.

Document a change in eligibility in the case record. Respond to IoWANS milestones to record cancelation of PACE services or a change in level of care or client participation. Send the appropriate notice of decision to the enrollee.

Disenrollment

Legal reference: 441 IAC 88.24(249A)

The effective date of PACE Medicaid cancellation shall be the Medicaid timely notice date. See 8-A, *Notification*. Complete an automatic redetermination to see if the member is eligible for Medicaid under another coverage group. See 8-G, *Automatic Redetermination*.

Circumstance	Policy
Enrollee death	The effective date of PACE Medicaid cancellation shall be the date of death.
Enrollee voluntary disenrollment	PACE enrollees may voluntarily disenroll at any time.
Enrollee involuntary disenrollment	A PACE enrollee may be involuntarily disenrolled for the following reasons: ▪ Failure to pay client participation, if applicable. ▪ Disruptive or threatening behavior. ▪ Behavior that jeopardizes the enrollee's health or safety or the safety of others. ▪ Consistent refusal by the enrollee to comply with the individual plan of care or the terms of the *PACE Enrollment Agreement* (when the enrollee has decision-making capacity). ▪ The enrollee moves out of the PACE service delivery area. ▪ The enrollee no longer meets the nursing facility level of care requirement and is not eligible for deemed continued eligibility. ▪ The PACE organization cannot provide the required services due to loss of licensure or contracts with outside providers.
Provider disenrollment	A PACE provider cannot disenroll a member without prior approval from the Department.

List of Providers and Counties Served

The following PACE organizations have contracts with Iowa Medicaid and are located in the following counties:

Siouxland PACE

Counties served:
- Cherokee
- Monona
- Plymouth
- Woodbury

1200 Tri View Ave
Sioux City, IA 51103

(712) 224-7223
1-888-722-3713 (24 hours)

http://www.unitypoint.org/siouxcity/services-pace.aspx

Pathways PACE – SW Iowa
Immanuel Communities

Counties served:
- Harrison
- Mills
- Pottawattamie

1702 N 16th Street
Council Bluffs, IA 51501

(712) 256-7284
TTY: 1-800-537-7697

Online at:
https://www.immanuel.com/immanuel-pathways

Pathways PACE – Central Iowa
Immanuel Communities

Counties served:
- Boone
- Dallas
- Jasper
- Madison
- Marshall
- Marion
- Polk
- Story
- Warren

7700 Hickman Road
Windsor Heights, IA 50324

(515) 270-5000

Online at:
https://www.immanuel.com/immanuel-pathways

Medicare, VA, and Private-Pay PACE Enrollees

The Department is federally required to do level-of-care assessments for all PACE enrollees whether they apply for Medicaid or not. The following steps are taken for the enrollees who do not apply for Medicaid.

1. The PACE provider contacts the IME Medical Services Unit to do a level-of-care assessment.
2. The Medical Services Unit sends a message to either the IoWANS-Facilities inbox or the PACE policy specialist and requests to have the PACE enrollee manually entered into IoWANS.
3. A PACE program request is created with a unique case number and the enrollee information is logged on a spreadsheet. The case number represents the type of funding and the sequence number on the log.
   - For a veteran enrollee, the case number is coded as PACEVA1, PACEVA2, etc.
   - For a private-pay enrollee the case number is coded as PRIPAY1, PRIPAY2, etc.

4. The PACE workflow is started and the level of care information is recorded in IoWANS.
5. Once the person is enrolled in PACE, the workflow is completed and a begin date is added to the PACE program request. The program request remains open so that IoWANS can generate the annual LOC Review workflow.

NOTE: There will not be an active ABC case for these PACE enrollees and the PACE provider will not receive the monthly Medicaid capitation payment.

Care for Kids (EPSDT)

Legal reference: 42 CFR 441, Subpart B; 441 IAC 84

Federal law requires states to provide early and periodic screening, diagnosis, and treatment (EPSDT) to Medicaid members who are under age 21. In Iowa this program of preventive health screening and follow-up treatment is called "Care for Kids."

Care for Kids provides children with regular health check-ups, continual health maintenance, and a means of early detection and treatment of disease. The program includes outreach, follow-up, and supportive services to encourage participation. All Medicaid members who are under 21 years of age are eligible for Care for Kids.

Screening Services

Legal reference: 441 IAC 84.3(249A); Section 1905(a)(4)(b) of Social Security Act

Periodic screenings or examinations allow a child's overall health to be continually monitored. Screening services include:

- A comprehensive health and developmental history.
- Assessment of both physical and mental health development.
- An assessment of nutritional status.
- A comprehensive unclothed physical examination with physical inspection of:
  - Eyes, ears, nose, and throat.
  - Mouth and teeth.
  - All organ systems, such as pulmonary, cardiac, and gastrointestinal.
- Immunizations appropriate for the child's age and health history.
- Health education, including anticipatory guidance.
- Vision and hearing screening.
- Direct dental referral for children over age 12 months.
- Appropriate laboratory tests, including:
  - Hematocrit or hemoglobin.
  - Rapid urine screening.
  - Blood lead testing for all children aged 12 months to 72 months.
  - Hemoglobinopathy screening.
  - Serology.
  - Tuberculin test.

Recommended Ages for Screenings

Legal reference: 441 IAC 78.18(3), 84.4(1) and 84.4(2)

Iowa recommends that children receive health, vision, and hearing screenings at the following ages:

- Two or five days if released from the hospital 24 hours or less after delivery
- 1 month, 2 months, 4 months, and 6 months
- 9 months, 12 months, 15 months, 18 months, and 24 months
- Yearly from 3 years to 20 years

An oral health exam of the oral cavity and dentation, and teaching about oral and dental health care should occur at every well child visit.

These schedules are the minimum requirements for screenings and are called "periodicity schedules." Click here to view the Iowa's EPSDT Periodicity Schedule.

Children may need more frequent examinations. Examinations performed more frequently are "interperiodic" screenings. Interperiodic screening, diagnosis, and treatment strengthen the preventive nature of the program. Interperiodic screenings are usually requested by the parent or guardian and may be required by foster care or for educational purposes. The screenings may also be necessary for camp or sport activities.

Screening Providers

Members may choose their screening provider. Families are encouraged to choose a permanent provider. Members enrolled in a managed care program are encouraged to obtain the services from their managed care provider.

Each county has a designated child health center under contract to the Iowa Department of Public Health (IDPH) to provide well-child services. A list of these providers can be found on the IDPH website.

Other providers who can do screenings include:

- Physicians
- Child health centers
- Advanced registered nurse practitioners
- Rural health centers
- Federally qualified health centers
- Clinics
- Dentists

If a member wants to choose a private provider, the member will need to find out if the provider participates in Medicaid screenings and tell the provider at the time of the appointment that the visit is for an EPSDT "Care for Kids" screening examination.

Treatment Services

Legal reference: Section 1905(a)(4)(b) of the Social Security Act

Medicaid covers services necessary to diagnose or to treat a condition identified during a health, visual, hearing, or dental screening examination when all of the following conditions exist:

- The service is required to treat the condition.
- The provider of services is a Medicaid provider.
- The service is consistent with federal and state laws that govern health care.
- The service is medically necessary, safe, and effective, and is not considered experimental.

Services not ordinarily covered under the Medicaid program can be covered under Care for Kids (EPSDT) when they meet these conditions.

If a child needs services not covered under Medicaid or beyond Medicaid limits, the child can be referred to similar child health programs, such as:

- Head Start
- 1st Five
- Special Supplemental Food Program for Women, Infants and Children (WIC)

If no other source of payment is available, request authorization for Medicaid payment from the Division of Medical Services under an exception to policy. Send the following information in with the exception to policy:

- Physician's name and address.
- Physician's statement of the need for service.
- Member care plan.
- Estimated cost.
- Expected outcome.

See procedures in 1-B, *Exceptions To Policy*.

Procedures for Notification and Tracking

This section explains IM procedures for the initial offer of screening and when to make system entries to send the member's name to the designated child health center.

Medicaid members are informed about the Care for Kids program by child health centers designated by the Department of Public Health. In these cases, the IM worker is responsible only for notifying members that they will be contacted by the designated agency.

ELIAS sends the K code for any person under 21 years of age in both the daily and monthly transactions. The K code indicates informing and care coordination services are provided by designated child health centers.

Medically Needy applicants with a spenddown and children in foster care remain in ABC. IM workers do have specific procedural responsibilities for these children. The report *Medicaid EPSDT Enrollees* listing these members is generated monthly for each local office.

IM responsibilities for these children involve making system entries in the SCR field on the ABC system's TD03 screen. All Medicaid members under the age of 21 must have a K code entered in this field. (See 14-B-Appendix for more information.) Informing and care coordination services provided by designated child health centers will be provided for these children.

Offer of Screening

Legal reference: 441 IAC 78.18(3), 84.4(1), 84.4(2), 84.5(249A)

All families receive a computer-generated reminder, form 470-5271, *Care for Kids Wellness Exam Reminder*, which makes them aware that, as a new eligible, screening is due immediately.

Billing and Payment

Legal reference: 441 IAC 80.2(249A), 80.3(249A)

Providers participating in the Medicaid program submit claims to the Iowa Medicaid for services rendered that are not paid on a capitation basis. (See the provider manuals in 8-Appendix for billing instructions for providers.)

To establish the amount of payment to be made, the IME deducts from the established cost for the service the amount of any payment made directly to the provider of care by the member, relatives, or any other source. (See 8-A, *When Members Are Responsible for Payment of Medical Bills*, for a list of member copayment requirements for various services.)

The following sections give more information on:

- Submitting claims for payment
- "Pay and chase" provisions
- Review of trauma claims
- Medical Assistance liens

Submitting Claims

Legal reference: 42 CFR 447.45(d)(4), 441 IAC 80.4(249A)

Providers may submit claims any time during the month for most services. Exceptions: Nursing facilities and home health agencies may not submit bills before the end of a calendar month. Most hospitals cannot bill until a member is discharged.

The IME will not pay claims received more than 365 days after the date of service unless the initial submission was delayed due to:

- Delays in receiving third-party payments, or
- Retroactive certification of eligibility on newly established cases.

To be payable, these claims must be submitted less than 24 months from the date of service, and the reason the claim is not timely submitted must be stated on the claim form.

Providers have 12 months from the time that the local office is notified of retroactive SSI eligibility to submit claims. Example: SSI notifies the worker by SDX on August 2, 2004, that the person is eligible for SSI back to June 1, 2002. Providers have until August 2, 2005, to submit the claim.

The IME processes claims older than 12 months when:

- Eligibility is established retroactively.
- There is a third-party liability problem.
- There is a DHS appeal decision or court decision. This may include claims for people who were originally denied for SSI eligibility but appealed and were then approved.

If you receive claims that need to be processed by the IME, return the claims to the provider with instructions to follow directions for the submission of such claims. The provider may contact the IME Provider Services Unit for assistance.

Pay and Chase

Legal reference: 441 IAC 75 (Rules in Process)

Under the normal "cost-avoidance" method of paying claims, the service provider must bill the other medical resource before submitting a claim to Medicaid. The IME approves payment only for those services or that part of the cost of a given service for which no medical resources exist, unless pay and chase provisions apply.

"Pay and chase" means that the IME pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. Pay and chase applies only to claims for:

- Prenatal care for pregnant women.
- Preventative pediatric services.
- Services provided to a person for whom there is court-ordered medical support.

If providers call for more information about the program, refer them to their provider manual or the IME Provider Services Unit. Providers should call the ELVS number (515) 323-9639 or (800) 338-7752 to obtain member insurance information.

System codes that indicate pay and chase for coverage by absent parents are located on the SSNI or MMIS screen.

The absent parent indicator is located in the second position of the medical resource code on the SSNI screen. The codes are H, K, and 8. Field 10 on the MMIS screen has an indicator of absent parent insurance for the insurance coverage that is described on the page open for viewing. Each page has information on a different health insurance policy.

Review of Trauma Claims

Legal reference: 441 IAC 75 (Rules in Process)

The IME Revenue Collection Unit screens Medicaid claims indicating an accidental injury or "trauma" in order to pursue potential third-party liability for the costs of treatment. The Unit reviews all Medicaid claims over $250 submitted with an ICD diagnosis code indicating an accident or injury.

When additional information is needed regarding the accident or injury, the Revenue Collection Unit worker sends computer-generated form 470-0398, *Accident Injury Request*, to the injured person. The form asks the person to supply details of the accident or injury.

Upon receipt of the completed letter, the Revenue Collection Unit worker:

- Reviews the member's response to determine if a third party is available to pay for part or all of the medical expenses.
- Follows up with the third-party resources identified to substitute the Department's claim for that of the injured person. (This process is called "subrogation.")

Medical Assistance Lien

Legal reference: Iowa Code Section 249A.6, 441 IAC 75 (Rules in Process)

The Department has the legal right to file a lien to recover Medicaid payments made on behalf of any member if another (third) party is determined to have liability. "Third parties" include:

- Private health insurance
- Auto insurance
- Casualty insurance
- Worker's compensation insurance
- Tort liability cases

Tort liability exists when a member sues a third party and it is determined that injuries sustained were caused by the negligence of a third party.

When the Department makes Medicaid payment on behalf of a member, the IME Revenue Collection Unit files a lien for all monetary claims that the member may have against third parties, to the extent of Medicaid payments. For a lien to be effective, the Revenue Collection Unit must file a notice:

- With the clerk of the district court in the county where the member resides and
- With the member's attorney when the member's eligibility is established.

These notices serve as formal notice to the third party of the Department's interest and right to be reimbursed for the member's medical expenses. Possible liable third parties should be informed of the Department's interest at the earliest possible date, no later than 45 days from the time that the Revenue Collection Unit becomes aware of the involvement of the third party.

Medicare

Legal reference: 441 IAC 75 (Rules in Process)

This section describes general policies for Medicare (Title XVIII of the Social Security Act) including eligibility groups, available services, and the buy-in process.

Medicare coverage is shown as a third-party resource in the eligibility systems to ensure that there is Medicare involvement in payment of any covered service. The health coverage code does not have a direct bearing on the buy-in process, but the health insurance resource should reflect Medicare coverage as soon as a member becomes eligible for Medicare, even if the buy-in has not been completed.

Medicare pays on claims for services covered by both programs before Medicaid pays. Medicaid is responsible for paying the deductible and coinsurance required by Medicare. Exceptions:

- For members eligible for the qualified Medicare beneficiary (QMB) coverage group, Medicaid pays only the Medicare premiums, deductibles, and coinsurance. See 8-F, *Qualified Medicare Beneficiaries*.
- For members eligible for the specified low-income Medicare beneficiary (SLMB) coverage group or the expanded specified low-income Medicare beneficiary (E-SLMB) coverage group, Medicaid pays only the Medicare Part B premiums. See 8-F, *Specified Low-Income Medicare Beneficiaries* and *Expanded Specified Low-Income Medicare Beneficiaries*.

Remember that some people are not entitled to social security benefits but are entitled to Medicare. Most people are entitled to both Part A and B. However, some people are not eligible for free Part A. In most cases, the state will pay the Part A premium for these people.

The beneficiary's *Health Insurance Card* indicates if the person is entitled to both parts. If a person was eligible for Part B but did not choose to enroll in Part B, the health insurance resource code reflects both part A and B, because the state will automatically buy-in to Part B coverage.

Refer clients who ask for more information on Medicare to the local Social Security office.

Medicare Part A

Legal reference: 42 CFR 406.10, 406.11, 406.12, 406.13, 406.20, and 409.5; OBRA 1989

Medicare Part A helps pay for the following services:

- Hospital
- Skilled nursing care
- Home health services
- Hospice programs

Part A may require a deductible or coinsurance and may limit the number of days covered during a spell of illness (benefit period).

To be eligible for Medicare Part A, an applicant must be in one of four categories:

- **Age 65 or older** and one of the following conditions is met:
  - Is entitled to social security retirement or survivor benefits.
  - Is entitled to railroad retirement benefits.
  - Would qualify for social security benefits if federal employment was treated the same for social security purposes.
- Is not a social security retirement or railroad retirement beneficiary, but had at least a minimum number of quarters of coverage under social security or railroad retirement. This was a special transition provision that expired in 1974.
- Does not have a work history that qualifies for social security or railroad retirement benefits but voluntarily enrolls in Medicare and pays a premium.
- **Under age 65** and one of the following conditions is met:
  - Has been entitled to disability benefits from Social Security or the Railroad Board for 24 consecutive months. This does not include a person receiving SSI.
  - Is insured under Social Security or Railroad Board and receives renal dialysis or has had a kidney transplant or is a spouse or dependent child of an insured or entitled person. There may be a three-month waiting period.

    Persons who receive Medicare because of a permanent kidney failure are eligible for Medicare benefits for 12 months after the month in which maintenance dialysis treatment stops, or 36 months after the month in which the person receives the kidney transplant.
- Is a **widow** age 50 or over who has been severely disabled for at least 24 consecutive months but who has not filed a claim on disability because the widow receives social security checks as a mother caring for a young or disabled child.
- Has received social security disability for more than 24 months, and whose social security was terminated when the person went to work but who continues to have a disability. Medicare continues up to 36 months after the disability benefit ends.

A disabled person may be able to purchase Medicare Part A benefits if the person has exhausted the 36 months of extended Medicare benefits provided after a social security disability benefit stops. This person must meet the following conditions:

- Be under age 65.
- Be blind or continue to have the disabling physical or mental condition that was the basis of the person's social security disability insurance or to be a disabled qualified railroad retirement beneficiary.
- Have earnings that exceed the substantial gainful activity limits, resulting in termination of entitlement for social security disability insurance.
- Have worked continuously for 48 months while receiving the extended social security disability cash benefits for the first 12 months and then 36 months of extended Medicare benefits after termination of the cash benefits.

- Be entitled to Medicare benefits for disabled persons after the 36 months of extended Medicare has ended.
- Not be entitled to any other benefits under Medicare (Title XVIII).

Part A Premiums

Legal reference: 42 CFR 406.21, 406.22, and 406.32; 441 IAC 75 (Rules in Process)

In most cases, social security or railroad retirement beneficiaries do not have to pay a premium for Medicare Part A coverage. For persons not entitled to these benefits, premiums can be paid by the federal government (in the case of transitional entitlement) or the state (for qualified Medicare beneficiaries or for qualified disabled and working persons).

Part A beneficiaries who do not have a work history or who are disabled and working persons may pay their own premium for Part A because they are not automatically eligible to receive the benefit at no cost. If these persons are eligible as a qualified Medicare beneficiary or as a qualified disabled and working person, Medicaid pays the Part A premium.

The Social Security Administration assesses a penalty to a person who must pay a premium for Medicare Part A if the person enrolls 12 full months after the initial enrollment period or re-enrolls 12 full months after the last period of Medicare eligibility. The penalty is 10% of the monthly premium and is twice the number of months that the person delayed enrolling in Part A.

If the state pays the premium for QMB-eligible persons through the buy-in process, the state is not assessed a penalty. Medicaid pays the Part A premium, including penalty, if a person is eligible for the qualified disabled and working persons coverage group.

1. Mr. K, age 66, an SSI recipient, does not have a work history and is ineligible to receive social security benefits. He receives Medicare Part B. His initial enrollment period for Medicare Part A ended in January 1994. He was eligible to enroll for Part A Medicare at that time, but had to pay a premium.

   Since Mr. K is eligible for QMB and currently receives Medicare Part B, the state processes the Part A enrollment and pays the Part A premium. The state is not assessed a penalty for Mr. K's late enrollment.

2. The social security disability benefits for Mrs. O (age 50) were terminated January 1996, because her income exceeded the substantial gainful activity limit. She received 12 months of extended social security disability benefits and then received 36 months of extended Medicare benefits because she was continuously employed for 48 months but still had the disabling condition.

   The Social Security Administration gave her the opportunity to purchase Medicare Part A from March 2000 to August 2000. Mrs. O chose not to purchase Medicare Part A during her initial enrollment period. She waited until March 2001 (during the open enrollment period) to enroll for Medicare Part A. This is a delay of eight months. Mrs. O is assessed a 10% penalty for 16 months on the Part A premium.

   Mrs. O applies for Medicaid to pay for the Part A premium and meets eligibility requirements for QDWP. Since she is considered eligible for Medicaid under the QDWP coverage group, Medicaid pays the Part A premium and 10% penalty.

Part A Enrollment Period

Legal reference: 42 CFR 406.22, P.L. 100-239

People who receive social security or railroad retirement benefits because of a qualified work history may enroll in Medicare Part A at any time.

- People who are not entitled to social security or railroad retirement benefits due to insufficient work history and disabled people who have exhausted their Medicare benefits may enroll for Part A either:
- During the initial enrollment period, which is the three months before and the three months after the person becomes eligible for Medicare.
- During the open enrollment period from January 1 through March 31 of each year. If enrolled during the open enrollment period, Part A coverage is effective the following July 1.

  EXCEPTION: People who are QMB-eligible and who are already entitled to Medicare Part B are not required to wait for the open enrollment period to enroll for Medicare Part A. The state buy-in process automatically establishes Medicare Part A entitlement for people already receiving Part B.

Medicare Part B

Legal reference: 42 CFR 407.2, 407.10

Medicare Supplemental Medical Insurance, referred to as Part B, helps pay for the following types of care:

- Physician, surgeon
- Outpatient physical therapy and speech pathology
- Outpatient hospital
- Prosthetic devices, durable medical equipment, medical supplies
- X-rays, laboratories

- Ambulance
- Home health care
- Rural health clinic

Part B may require a deductible or coinsurance. Medicaid pays deductibles and coinsurance for Medicaid members.

To be eligible for Part B, the person must either:

- Have Medicare Part A, or
- Be age 65 or older and either a U.S. citizen or an alien lawfully admitted for permanent residence who has lived in the United States for five years before the month of application for Medicare Part B.

Part B Premiums

Legal reference: 42 CFR 408.6, 408.82

People enrolled in Part B pay a premium. The state pays the part B premium for Medicaid members. See Medicare Buy-In.

A penalty is assessed for a person who does not enroll in Part B as soon as the person becomes eligible. Medicaid pays the increased monthly premium when the person is eligible for the qualified Medicare beneficiary coverage group.

Part B Enrollment Period

Legal reference: 42 CFR 407.12, 407.14, 407.17

A person may enroll in Medicare Part B either at the same time social security benefits are approved or during the open enrollment period, which is January 1 through March 31 of each year.

Medicaid members do not have to wait until Medicare's next open enrollment to be eligible for buy-in of Part B. If there is a Medicare eligibility record, Medicaid automatically buys in for those members who are eligible for Part B.

Services Not Covered by Medicare

Legal reference: 42 CFR 410.10, 409.5

Neither Medicare Part A nor Part B pays for:

- Routine checkups.
- Glasses or examinations for glasses.
- Hearing aids or examination for hearing aids.
- Routine foot care (treatment of warts is covered).
- Orthopedic shoes.

- Cosmetic surgery.
- Most dental work.
- Most immunizations (flu, pneumococcal, and hepatitis B vaccinations are covered).
- Private duty nurse.
- Drugs given in an inpatient hospital stay that the government determines to be "less than effective."
- Items and services determined not to be medically necessary.
- Custodial care unless part of hospice.
- Personal comfort items for a patient's hospital room, such as telephone, radio, television.
- The first three pints of blood or packed red blood cells (applied separately under both Part A and Part B).
- Charges by immediate relatives or household members.
- Homemaker services except when part of hospice care.
- Meals delivered to the home.
- Surgical services for which a second opinion is required but not obtained.
- Items or services for which Medicare is the secondary payer. This includes situations where the beneficiary has worker's compensation or an employer group health plan, or is entitled to compensation from an automobile or liability insurance plan.

Medicare Buy-In

Legal reference: 42 CFR 431.625, 441 IAC 75 (Rules in Process)

The Department pays the Medicare Part B premium for Medicaid members. This "buy-in" transfers some medical costs from the Medicaid program, which is partially state-funded, to the Medicare program, which is funded by the federal government and premiums.

To be eligible for the buy-in, a person must be a full Medicaid member and be eligible to enroll in Medicare. People in the following "limited benefit" coverage groups are **not** eligible for buy-in:

Eligibility
Chronic care group
Concurrent eligibility under two or more limited benefit aid types (blended aid types shown on SSNI)
Family planning
Medically Needy with spenddown
Presumptive eligibility for breast and cervical cancer treatment (BCCT)
Presumptive eligibility for children
Presumptive eligibility for pregnant women
Qualified working disabled person

If requested, you can help the person apply for Medicare by calling the local Social Security office and asking that a sign-up card be sent to the person. If the person refuses to sign up for Medicare, see 8-C, *Benefits From Other Sources*.

Iowa has an agreement with the Social Security Administration to initiate buy-in for all recipients of SSI or federally administered State Supplementary Assistance who are eligible to enroll in Medicare.

People who are already enrolled in Medicare or who discontinue their Part B coverage do not have to take any action on their own to complete the buy-in process. If a person is eligible for Medicare coverage but is not participating, tell the person to contact the local Social Security office and sign up for Medicare so the buy-in process can occur.

The Buy-In Process

Legal reference: 42 CFR 407.40

To add Medicaid members to the buy-in, the Department sends the person's claim number to the Centers for Medicare and Medicaid Services (CMS) in Baltimore. Three types of claim numbers are used for Medicare:

- A railroad claim number, which has six to nine digits with an alphabetical prefix. You can get the railroad claim number from a health insurance card, award letter, premium notice, or from the Railroad Retirement Board. Bendex reports are not issued for persons whose claim number is a railroad number.
- The social security number of the person on whose earnings social security benefits are being paid with a suffix known as the beneficiary identification code (BIC).

  The BIC is a one- or two-character code that identifies the type of social security benefits the person receives, such as wage earner's benefits, spouse's benefits, or child's benefits. The BIC has a letter in the first position and may have either a number or a letter in the second position.

  You can get the social security claim number from the beneficiary's award letter or premium notice, or from the Social Security office. When the Social Security Administration changes a claim number because the benefit type changed or an incorrect number is sent, the number is automatically changed on the systems.
- The Medicare Beneficiary Identifier (MBI) is eleven characters using numbers and upper case letters. The MBI is randomly generated and does not have any hidden or special meaning. You can get the MBI from the beneficiary's health insurance card.

The Department's buy-in file is sent to CMS once a month at the system month-end cutoff, which is usually around the 21st to 23rd of the month but may be earlier or later depending on holidays and the length of the month.

CMS processes the file by comparing the claim numbers or the MBI to the CMS master file. If there is a match, the buy-in is completed. If there is no match, the name is rejected. DHS is notified in either case when CMS returns the file at the beginning of the next month.

Bendex is not immediately updated when the state buy-in is completed. But buy-in information is updated on the SSBI screen. For a buy-in history, use the PF8 key. The buy-in information is updated later on the Bendex screen.

Buy-In Effective Date

Legal reference: 42 CFR 407.47

The buy-in is effective the first month the person is eligible for Medicaid, unless the person:

- Is not eligible for Medicare in that month (for example, is not 65); or
- Is already on buy-in through another state that hasn't completed buy-out.

When the buy-in is complete, the Medicare premium is no longer deducted from the social security or railroad retirement check. If the person was being billed, the billing ends after buy-in is complete.

If the health coverage code on the ABC system is not consistent with the buy-in records, the code is automatically updated on ABC to show Medicare Part B coverage only. Verify whether this is correct and update the code to indicate both Part A and B coverage, if applicable.

Premium Refund Checks

Members who paid the Medicare premium or had it deducted from their monthly social security or railroad retirement payment will receive refunds for the months covered by the buy-in. Refunds of premiums are sent to the member in the same month that the buy-in is completed.

> The buy-in file is sent to CMS at March month-end. CMS returns the file at the beginning of April. By the end of April, the Social Security Administration issues refunds to members whose buy-in was completed.

A member living in a nursing facility may owe the refund check to the facility.

A waiver member who has a medical assistance income trust (MAIT) may owe the refund check to a waiver provider.

Members living in a residential care facility are entitled to keep the retroactive refund check. No deduction is allowed for the Medicare Part B premium when computing client participation before the buy-in is complete.

Tell members at the time of approval whether they should turn over the refund check to facility when they receive it. Recalculate the client participation in the month the refund is received.

Adjust ongoing client participation to reflect the fact that buy-in is complete. The Medicare Part B premium is no longer allowed as a deduction.

Buy-Out

Legal reference: 42 CFR 407.48, 407.50

The buy-in continues until Medicaid is canceled. Entering a negative action for Medicaid on the system automatically triggers the cancellation from buy-in. Buy-out is effective the month Medicaid eligibility ends.

NOTE: If CMS accepts a buy-in for a person with more than one claim number, duplicate billing has occurred. There is no retroactive time limit when adjusting duplicate billing.

When the buy-out occurs, a member can choose to withdraw from Part B coverage. The date a person notifies the Social Security Administration of the choice to withdraw from Part B determines when Part B coverage ends.

- If the member requests a withdrawal from Part B more than six months after buy-out occurred, Part B coverage ends at the end of the month after the month Social Security is notified.
- If the member requests a withdrawal from Part B during the last month of the buy-in coverage or during the six succeeding months, Part B ends in the month the notice was filed.
- If the member is not receiving social security or railroad benefits and is not paying the Part B premium, coverage ends at the end of the third month.

Health Insurance Premium Payment Program (HIPP)

The Health Insurance Premium Payment (HIPP) Program uses Medicaid funds to pay for health insurance coverage through an employer-related plan or an individual plan. Medicaid then becomes the secondary payer of claims.

The HIPP Unit, at the Iowa Medicaid, determines if it is cost-effective to pay for a member to get and keep group or individual health insurance coverage or for Medicaid to pay for the services. If the insurance is determined cost-effective, the HIPP program pays the premium directly to the employee, the employer, or the health insurance company on behalf of the member.

IM duties concerning HIPP include:

- Distributing Comm. 91, "The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid Recipients" upon request. This brochure contains form 470-2875, *Health Insurance Premium Payment Program Application*.
- Making referrals to the HIPP Unit when insurance is available to:
  - Applicants or members at application or when new employment is reported.
  - Parents in Medicaid households with children who are Medicaid-eligible.

  See Situations Not Covered by HIPP later in this chapter for a list of when not to make a referral to the HIPP Unit.

To make a referral to the HIPP Unit, have the member, applicant, or parent contact the HIPP Unit as follows:

Phone: toll-free 1-888-346-9562; local (515) 974-3282
Fax: (515) 725-0725
Interoffice mail: IME/HIPP
E-mail: HIPP@dhs.state.ia.us (DHS, HIPP Program)
U.S. mail: HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

Examples of changes that need to be reported include, but are not limited to:

Event	Why the HIPP Unit Needs to Know
Birth of a baby	Generally, a baby must be added to the health insurance within 30 days after the date of birth. Otherwise, the baby's hospital bills from birth will not be covered by the insurance plan.
The policyholder leaves the household	If the policyholder is not in the Medicaid household, the HIPP Unit will need to reevaluate whether reimbursement can continue.
Loss of employment	Usually when the employment ends the insurance ends. The HIPP Unit will need to determine if there is COBRA coverage available or if there is a new employer with health insurance available.

For more information on IM procedures and member cooperation requirements, see 8-C, *Cooperation With the Health Insurance Premium Payment (HIPP) Unit*.

Who Is Eligible for HIPP

Legal reference: 441 IAC 75.21(1), (2) and (4) and (249A)

Three groups of people may be eligible for HIPP:

- **Mandatory participants** are Medicaid members who have or are eligible to enroll in group health insurance through an employer. Mandatory participants are automatically evaluated for HIPP participation.

  If the HIPP Unit determines that the employer group health insurance is cost-effective, a mandatory participant must keep or enroll in this health insurance as a condition of Medicaid eligibility, unless insurance is being maintained on the Medicaid member through another source (e.g., an absent parent is maintaining insurance on the member's children).

- **Voluntary participants** are Medicaid members who have health insurance from a source other than an employer, such as an individual policy. They can be eligible for HIPP if they apply and it is determined that the health insurance is cost-effective. They are not required to keep or enroll in the health insurance as a condition of Medicaid eligibility.

- **Non-Medicaid-eligible participants** are family members who are not eligible for Medicaid but who must be enrolled in the health insurance plan in order to obtain coverage for the Medicaid-eligible family members. Only the needs of the Medicaid-eligible members are considered in determining the cost-effectiveness of the plan.

1. Mr. and Mrs. M have three children who are all eligible for Medicaid under MAC. Mr. and Mrs. M are eligible only for Medically Needy with a spenddown. Mr. M's employer offers group health insurance to his employees. Mr. M states he cannot afford to pay the employee's share of the premium.

   Two of the children have serious medical conditions that require frequent treatment and hospitalization. These services would be covered by the group insurance available through Mr. M's employer.

   The HIPP Unit determines that it would cost less to pay Mr. M's share of the premium than to pay for these services only with Medicaid. By purchasing a family plan to cover the children, Mr. and Mrs. M will also have insurance coverage, even though they are not eligible for Medicaid.

2. Mr. and Mrs. K have two children who are eligible for Medicaid under MAC. Mr. and Mrs. K are eligible only for Medically Needy with a spenddown. Mr. K's employer offers the following options under the group health insurance plan:

Employee	$10 per pay period
Employee + spouse	$60 per pay period
Employee + children	$40 per pay period
Family	$100 per pay period

   Since Mrs. K is not a Medicaid member, and the employer offers an option to cover only the employee and the children, this option is examined for cost-effectiveness. Payment is not made for the family coverage, since it is not necessary to purchase the family option to provide coverage to the Medicaid-eligible children.

When some household members are eligible for full Medicaid benefits and some only for the Medically Needy program, the premium is paid if determined cost-effective based only on the people receiving full Medicaid benefits. If the HIPP program pays the premium, the people in the Medically Needy program cannot use the premium as a deduction.

1. Household composition:

   Ms. M, age 36, potentially eligible for Medically Needy
   Billy, age 4, receiving Medicaid under the MAC program
   Julie, age 2, receiving Medicaid under the MAC program

   Ms. M's employer group health insurance is determined cost-effective when comparing its cost to the average Medicaid expenditures for the children only. Therefore, Ms. M is required to enroll in the policy as a condition of her Medicaid eligibility.

   The premium is not used as a deduction when determining the remaining amount of Mrs. M's spenddown.

2. Same as Example 1, except that Ms. M is already enrolled in the health plan and the premium is being used as a deduction to spenddown when determining the remaining amount of Ms. M's spenddown for a May-June certification period.

   On June 10, the HIPP worker determines the policy is cost-effective. Eligibility for the HIPP program is approved as of July 1. The premium is not used as a deduction to Ms. M's income for her July-August certification period.

3. Ms. J and her two children are eligible for Medicaid under the Transitional Medicaid coverage group. Mrs. J's employer provides insurance free to her. The cost for insuring the children is $50 per month.

   The HIPP Unit determines it would be cost-effective to pay the $50 monthly premium to insure the children and requests that Ms. K apply for coverage. Ms. K responds that her ex-husband has insurance coverage on the children and provides verification. Ms. K is not required to add the children to her health insurance plan.

Situations Not Covered by HIPP

Legal reference: 441 IAC 75.21(5) and 75.21(14)(b)

If one of the following circumstances applies, premiums will not be paid by the HIPP program:

- On the date HIPP eligibility is determined, no one covered by the insurance is a Medicaid member.
- On the date HIPP eligibility is determined, the coverage is no longer cost-effective.
- The only Medicaid-eligible member has Medicare.
- Is eligible for Medicaid only under one or more of the following coverage groups:
  - Medicaid for Kids with Special Needs (MKSN)
  - Medically Needy

If one of the following circumstances applies, you do not need to make a referral to the HIPP program:

- Insurance is provided by the Health Insurance Plan Iowa (HIPIOWA).
- Another entity is maintaining health insurance on the Medicaid member (e.g., an absent parent is maintaining insurance on the Medicaid member's children, or when the policyholder is not in the Medicaid household).
- The insurance plan is designed to provide coverage for a temporary period.
- The insurance plan is an indemnity policy that supplements the policyholder's income or pays a predetermined amount for medical services, e.g., $50 per day for hospital services instead of 80% of the charge.
- The insurance plan is offered on the basis of attendance or enrollment at a school.
- The policyholder is an absent parent. CSRU is responsible for obtaining cash and medical support for children in households where a parent is absent.
- The health insurance premium is used as a deduction in computing the client participation.
- The policyholder or potential policyholder is an undocumented alien.

HIPP eligibility ends when:

- The policyholder leaves the household and becomes an absent parent.
- The policyholder fails to provide requested information.
- All members covered by the policy lose Iowa Medicaid eligibility.
- The insurance is no longer cost-effective.
- The insurance coverage is no longer available.

For more information on the Health Insurance Premium Payment Program, contact the HIPP Unit.

AIDS/HIV Health Insurance Premium Payment Program

Legal reference: 441 IAC 75.22(249A)

The AIDS/HIV Health Insurance Premium Payment (HIPP) Program pays for continuing health insurance coverage for people living with AIDS or HIV-related illnesses who can no longer pay the insurance premiums. This program is funded by 100% state funds with an annual capped appropriation of $60,000.

The HIPP Unit in the Iowa Medicaid administers the program. The HIPP Unit is responsible for:

- Maintaining the application log.
- Tracking expenditures and reserving funds for future premium payments.
- Determining initial and ongoing eligibility.
- Tracking the remaining unobligated funds.
- Maintaining the waiting list.

Local office responsibility is to receive applications. Give people who ask about the program Comm. 99, "The Iowa AIDS/HIV Health Insurance Premium Payment Program," which includes the application and a business reply envelope to send the application directly to the HIPP Unit.

The Department must protect the confidentiality of people applying for or participating in the program. When contacts are made, acknowledge only that information is needed to determine eligibility for public assistance. Never acknowledge that the person is living with AIDS or an HIV-related illness without the person's express written consent.

AIDS/HIV Application Processing

Legal reference: 441 IAC 75.22(2)"a" and "b"

People applying for the program must complete form 470-2953, *AIDS/HIV Health Insurance Premium Payment Application*, included in Comm. 99. The application must contain the applicant's name, address, and signature.

Applicants who do not use the business reply envelope in Comm. 99 may file the application at the local office. If the local office receives an application:

- Date-stamp the application.
- Take all precautions to ensure its confidentiality.
- Send the application to the IME/HIPP Unit addressed to the HIPP supervisor by:

  Fax: (515) 725-0725
  Interoffice mail: IME/HIPP
  U.S. mail: HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

For more information on the Iowa AIDS/HIV Health Insurance Premium Payment Program, contact the HIPP Unit.

Money Follows the Person (MFP) Grant Services

Legal reference: P.L. 109-171, Deficit Reduction Act (DRA), Section 6071; Affordable Care Act, ACA, Section 2403

Money Follows the Person (MFP) grant services provide an opportunity for members to move out of a nursing facility (NF) or intermediate care facilities for persons with intellectual disabilities (ICF/ID) and into their own homes in the community of their choice. In some circumstances, a person placed in a hospital setting may also qualify.

Grant funds provide funding for the transition services and enhanced supports needed for the first year after they transition into the community. MFP assistance is available to members who:

- Have a diagnosis of mental retardation or brain injury,
- Have lived in a NF or ICF/ID for at least three months,
- Have expressed an interest moving from the NF or ICF/ID into the community, and
- Need home- and community-based services (HCBS) in order to reside successfully in a community-based setting.

The MFP grant provides enhanced funding for services intended to support a successful transition and to help support members in community living. Participants may be covered by the MFP program for 365 consecutive days, after which time an HBCS waiver will provide ongoing services. Members who have to return to a facility during the MFP 365 days will not have those days spent at the facility count towards the MFP 365 days. Once the member returns to the community the 365 day count will continue.

The MFP program helps members locate a place to live and arrange for medical, rehabilitative, home health, and other services in the community, as needed. The assistance of a transition specialist in coordinating transition planning, implementation, and follow-up in securing essential services are included.

The following sections give further instructions on:

Referral to MFP Services

The facility will make a referral to a transition specialist when a resident requests MFP grant services. (The facility should not contact the IM worker to make a referral for targeted case management. If you are contacted by the facility provider, refer the provider to the transition specialist to make the MFP referral.)

The transition specialist will create an MFP program request in IoWANS and start a workflow. You will receive an informational milestone in IoWANS notifying you:

- When a member has applied for MFP, and
- When a member has been approved for MFP.

Members referred for MFP grant services continue to be active on a NF or ICF/ID facility case.

> Mr. J has been in an ICF/ID for two years and is a Medicaid member. He requests MFP services. The ICF/ID makes a referral to the transition specialist.
>
> The transition specialist creates an MFP program request in IoWANS and starts a workflow. The IM worker receives a milestone in IoWANS that MFP services have been requested. The IM worker responds to the milestone. No further action is required until Mr. J is discharged from the ICF/ID.

Approval of MFP Services and Transition Period

MFP services begin before a member is discharged from the facility. MFP funds can be used to transition the member into a community-based setting. The member continues to be active on a facility case.

You will receive an informational milestone in IoWANS when a member has been approved for MFP. Do not make ABC system entries to pend or approve a waiver case until the member is discharged from the facility.

When the member is close to being discharged from the facility, the transition specialist will provide a signed statement from the member or the member's representative requesting waiver services (in lieu of an application). The transition specialist will send the statement to the IM worker by FAX or email.

Discharge From NF or ICF/ID

The transition specialist will email you with the member's date of discharge from the facility. Once you have received the *Case Activity Report* from the facility indicating a discharge from the facility, you can approve the member for MFP.

Set up the MFP case as a waiver case in the ABC system. Use the member's facility case to approve MFP by either:

- Closing the facility case first and reopening the case as a waiver. NOTE: When making these entries, the end date of the facility case and the positive date of the waiver case **must** be the same date. Or,
- Making transfer entries to move the member from facility to a waiver. See 14-B(9), *Facility Case Actions Move, Same Day*.

Use the aid type and waiver code applicable for the person's age and the type of disability. Most MFP cases are set up as intellectual disabilities (ID) waiver cases. However, a member may also qualify for another home- and community-based services waiver. Contact the transition specialist to determine what waiver type would be most appropriate, if questionable.

Code the INFO field on the ABC TD01 screen to indicate that the member is active for MFP.

Once the ABC entries pass to IoWANS, IoWANS will:

1. Add the end date on the facility program request.
2. Add a future end date on the MFP program request 365 days from the facility end date.
3. Create a new waiver program request with a future beginning date 366 days from facility end date.

The member may remain on MFP for 365 days after discharging from the facility.

Transfer to Waiver at Day 365 of MFP

Once the member has used 365 days of MFP, the member will be transitioned to an HCBS waiver.

A full waiver workflow will be started in IoWANS 60 days before the end date of MFP. You may need to request case manager information from the member to assign the CM/SW role in IoWANS, if unknown for fee-for-service members.

You will receive the milestone. *"The consumer has been given a choice between HCBS waiver services and institutional services. Do you want to continue with waiver eligibility?"* Respond, *"Continue, consumer has chosen HCBS."* The signed statement choosing HCBS waiver should have already been received the previous year when the member applied for MFP.

Once the full waiver workflow is completed, the program request will be authorized for payment. The waiver case manager will issue a *Notice of Decision* to the member and the providers regarding the authorized services under the waiver program.

You will **not** need to make entries in the ABC system, since the member is already active on a waiver case. Since there is no change in Medicaid benefits, there is no need to issue a new *Notice of Decision* when the member switches from MFP to the waiver.

Case Maintenance

In general, follow the procedures in 8-G, *Case Maintenance*. If a member goes into a medical institution, consider eligibility as if it is a change in facilities, not a change from noninstitutional care to institutional care.

Occasionally, a member may need to return to the facility. If you receive a *Case Activity Report* from a facility indicating that a member has been admitted back to the facility, either:

- Close the waiver case and re-open it as a facility case, or
- Make transfer entries to move the member from waiver back to the facility. See 14-B(9), *Facility Case Actions Move, Same Day*.

Follow the steps under Discharge From NF or ICF/ID when the member is discharged from the facility and moves back to MFP.

The MFP program manager and transition specialist will determine the number of days the member was on MFP and will manually adjust the dates in IoWANS.

NOTE: The MFP days do not start over at 365 days.

Skilled Nursing Services Available for IHAWP Members Who Do Not Have a Medically Exempt Status

The Iowa Wellness Plan offers up to 120 days of facility based skilled nursing services per year for members that meet the level of care determination. Skilled nursing services include:

- necessary therapy,
- medications,
- wound care,
- stoma care,
- ventilator,
- tracheostomy care, or
- tube feedings.

Skilled services are payable when provided in nursing facilities, skilled nursing facilities and hospital swing beds.

For any questions regarding skilled care coverage for IHAWP, refer the member to Member Services at the Iowa Medicaid or the member's Managed Care Organization (MCO).

Nursing Facility Services Available for MAGI Members and IHAWP Members Who Have a Medically Exempt Status

Nursing facility services are a state plan benefit and are a covered service for all Medicaid members who have full coverage. This includes IHAWP members who have a Medically Exempt (ME) status.

Nursing facility services are also covered under the Hawki benefit plan (not including Hawki Dental Only coverage).

For any questions regarding nursing facility coverage for MAGI members and IHAWP who have a medically exempt status, refer the member to Member Services at the Iowa Medicaid or the member's Managed Care Organization (MCO).

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8

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Home- and Community-Based Waivers

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Overview

This chapter provides information specific to the Medicaid home- and community-based service (HCBS) waivers, with emphasis on the role of the income maintenance worker.

HCBS waivers provide a variety of services in members' homes that are not available through regular Medicaid. Waiver services are provided only to certain targeted groups for whom a federal waiver has been approved. There are currently seven HCBS waivers, targeting the following groups:

- People who have AIDS or have been infected with HIV (AIDS/HIV)
- People who have a brain injury (BI)
- Children who have a serious mental, behavioral, or emotional disorder (CMH)
- People who are elderly (EW)
- People who are ill or handicapped (HD)
- People who have an intellectual disability (ID)
- People who have a physical disability (PD)

Services are available only to people who meet eligibility criteria, which includes meeting the level of care in a designated medical institution. Eligibility under the waivers is based on the following:

- Income and resource criteria
- Age, disability, or medical need
- Level of institutional care needed
- Need for waiver services
- A determination that the cost of the waiver program does not exceed the established cost limit for the person's level of care

Waiver services are beyond the scope of the Medicaid state plan. Services provided under the waivers are not available to other Medicaid members. Provision of these services must be cost-neutral. The total costs of these services and regular Medicaid cannot exceed the total cost of care and services provided in a medical institution.

General Medicaid eligibility policies in Chapters 8-A through 8-E apply to HCBS applicants and members except where specified in this chapter. For Automated Benefit Calculation system (ABC) data entry instructions, see 14-B(9), *Home- and Community-Based Waiver Case Actions*.

The first section of this chapter covers policies and procedures that are common to all HCBS waivers, such as general application procedures, client participation, reviews, and payment information. The rest of the chapter is divided into sections on the individual HCBS waivers, and the policies and procedures that are unique to each waiver.

HCBS waivers are also discussed in 16-K, *Medicaid Waiver Services*, with an emphasis on the role of case managers. Chapter 16-K provides a detailed description of the enrollment process for each waiver with emphasis on the use of IoWANS.

Legal Basis and History

The legal basis for the Medicaid home and community-based services waivers is found in Section 1915(c) of the Social Security Act. The purpose and intent of a Medicaid HCBS waiver is stated in Section 1902(c) of the Social Security Act. States may request waivers to provide cost-effective home- and community-based services to eligible people so they can avoid or leave institutionalization.

Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981 (OBRA), contains provisions allowing states to request waivers to provide cost-effective home- and community-based services to eligible people so they can avoid or leave residence in a medical institution.

Section 2176 of OBRA amended the Social Security Act to create the HCBS waiver program. The purpose and intent of a Medicaid HCBS waiver is stated in Section 1902(c) of the Social Security Act.

The Omnibus Budget Reconciliation Act of 1987 established that people residing in nursing homes who meet assessment criteria for specialized services to access HCBS waiver programs.

The portions of the Code of Federal Regulations specifically dealing with home- and community-based services are in Title 42, Parts 431.50, 435.3, 435.217, 435.726, 435.735, 440.1, 440.180, 440.250, 441.300 through 441.306, and 441.310. These regulations:

- Specify requirements that the state must meet to be eligible for federal financial participation, and
- Along with the Social Security Act, serve as the basis for state law and administrative rules.

States may seek waivers of the statutory requirements for making the same services available for all Medicaid members on a statewide basis. Waivers are initially approved for a three-year period and after that are renewable every five years.

The Centers for Medicare and Medicaid Services (CMS) allows states to choose to provide waiver services through either a "model" or a "regular" waiver program. A model waiver is limited to 200 members at any one time. Under a regular waiver, participant numbers are established according to a predetermined plan.

The waiver request must be limited to a specified target group, such as the following:

- Aged, disabled, or both
- Intellectually disabled, developmentally disabled, or both
- Mentally ill
- Physically disabled

Members of the target groups must meet the level of care criteria identified in the waiver request.

The total number of people receiving services under any specific Medicaid waiver is limited to the number approved by the secretary of the U.S. Department of Health and Human Services.

To meet the requirement for cost-neutrality, states must demonstrate that the total cost to Medicaid for waiver recipients will not exceed the total cost that Medicaid would incur for these people if they were institutionalized. The financial constraints related to cost neutrality are based on the average cost for the target group, and do not compare costs between HCBS and alternative institutional services on an individual, case-by-case basis.

Legislation authorizing the Iowa Medicaid program is found in Iowa Code Chapter 249A. The portions of the Iowa Administrative Code specifically dealing with Medicaid waiver services are 441 Chapters 24, 77, 78, 79, and 83. The legislative history of Iowa's waivers is as follows:

- 1982 Iowa Acts, Chapter 1260, requested the Department pursue pilot projects to provide HCBS waivers. During 1982, the Department received approval for a Medicaid waiver to fund assessment and case management services through the Iowa Gerontology Model Project in Scott County.
- Health and disability waiver: 1983 Iowa Acts, Chapter 201, requested the Department establish a task force with providers and consumer groups to develop a proposal for a program of home- and community-based services under Medicaid.

  The Department applied for four waivers at the recommendation of the task force. A model waiver for people who are ill or handicapped was the only waiver that was approved. It was effective August 1, 1984, with implementation October 1, 1984, as a model waiver for 50 eligible blind and disabled people. On February 1, 1996, this waiver was converted from a model waiver to a regular waiver. The waiver was renamed as the health and disability waiver effective December 1, 2012.
- Elderly and AIDS/HIV waivers: 1989 Iowa Acts, Chapter 318, directed the Department to seek federal approval of HCBS waivers to provide cost-effective alternative services for elderly people and for people with acquired immunodeficiency syndrome (AIDS). The target population was those who met criteria for placement in a medical institution.

  The model waiver for the elderly was approved for implementation on August 1, 1990, and the AIDS waiver was approved for implementation on February 1, 1991. The model waiver for the elderly was converted to a regular waiver on August 1, 1993.
- Intellectual disability waiver: 1991 Iowa Acts, Chapter 267, Section 130, directed the Department to seek approval of HCBS waivers for people with an intellectual disability.

  The waivers for people with an intellectual disability (ID) and people with an intellectual disability residing in nursing homes (ID/OBRA) were merged and then approved in November 1991 for implementation on March 1, 1992. The waiver was renamed as the intellectual disability waiver effective July 1, 2009.
- Brain injury waiver: 1994 Iowa Acts, Chapter 1160, directed the Department to seek approval of HCBS waivers for people with a brain injury. The waiver for people with a brain injury was approved on May 29, 1996, and implemented on October 1, 1996. Effective July 1, 2014, the age cap of 65 years old was removed.
- Physical disability waiver: 1999 Iowa Acts, Chapter 203, Section 7, directed the Department to seek approval of an HCBS waiver for people with a physical disability. The waiver for people with a physical disability was approved on July 30, 1999, for implementation on August 1, 1999.

- Children's mental health waiver: 2005 Iowa Acts, House File 841, Section 66, directed the Department to seek approval of an HCBS waiver for children with serious emotional disturbance. The waiver for children with serious disturbance was approved on July 1, 2005, for implementation on October 1, 2005.

  NOTE: The children's mental health waiver was originally approved at the federal level as a demonstration waiver under Section 1115a of the Social Security Act, but became a Section 1915(c) waiver effective July 1, 2010. (This is the same authorization as the other six waivers.)

- 2012 Iowa Acts, Senate File 2336 removed the statutory requirements for county governments to pay the nonfederal share of medical assistance costs for services provided under the home- and community-based services intellectual disability waiver or brain injury waiver effective July 1, 2012.

Summary of Waiver Characteristics

Legal reference: 441 IAC 83

The following chart compares the similarities and differences in eligibility factors among the waivers. At the end of this chapter are the specific eligibility requirements for each waiver. Click on the link below under "waiver" to be taken to the specific section.

Waiver	Basic Character	Medicaid Coverage Group	Disability Required?	Level of Care	Other Criteria
AIDS/HIV	Diagnosis of AIDS/HIV	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group Medically Needy meets hospital level of care	Yes, for Non-MAGI No, for children under 21 in the 300% group	ICF SNF Hospital	Need services Choose waiver Assigned payment slot
Brain Injury (BI)	Diagnosis of brain injury	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group	Yes, for Non-MAGI No, for children under 21 in the 300% group	ICF/ID ICF SNF	At least 1 month of age Need services Choose waiver Assigned payment slot
Children's Mental Health (CMH)	Diagnosis of serious emotional disturbance	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group	Yes, for non-MAGI No, for children under 21 in the 300% group	Hospital	Children under age 18 and not in foster care Need services Choose waiver Assigned payment slot
Elderly (EW)	Age 65 or over	Non-MAGI (including 300% group)	No	ICF SNF	Need services Choose waiver Assigned payment slot

Waiver	Basic Character	Medicaid Coverage Group	Disability Required?	Level of Care	Other Criteria
Health and Disability (HD)	Blind or disabled	Non-MAGI (including 300% group and MEPD)	Disabled according to SSI guidelines	ICF SNF ICF/ID	Under age 65 Need services Choose waiver Assigned payment slot
Intellectual Disability (ID)	Diagnosis of intellectual disability	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group Foster care	Yes, for non-MAGI No, for children under 21 in the 300% group No, for foster care	ICF/ID	Need services Choose waiver Assigned payment slot
Physical Disability (PD)	Have a physical disability	Non-MAGI (including 300% group and MEPD) Children under 21 in the 300% group	Disabled according to SSI guidelines	ICF SNF	Aged 18 to 64 Ineligible for ID waiver Need services Choose waiver Assigned payment slot

Summary of Waiver Services

The following chart identifies the services available under each HCBS waiver:

Waiver Services	AIDS	BI	CMH	EW	HD	ID	PD
Adult day care	✔	✔		✔	✔	✔	
Assisted living services				✔			
Assistive devices				✔			
Behavioral programming		✔					
Case management		✔		✔			
Chore service				✔			
Consumer choice option	✔	✔		✔	✔	✔	✔
Consumer-directed attendant care	✔	✔		✔	✔	✔	✔
Counseling	✔				✔		
Day habilitation						✔	
Environmental modifications and adaptive devices			✔				
Family and community support services			✔				
Family counseling and training		✔					
Home and vehicle modification		✔		✔	✔	✔	✔
Home-delivered meals	✔			✔	✔		
Home health aide	✔			✔	✔	✔	
Homemaker	✔			✔	✔		
Interim medical monitoring and treatment		✔			✔	✔	

Waiver Services	AIDS	BI	CMH	EW	HD	ID	PD
In-home family therapy			✔				
Mental health outreach				✔			
Nursing	✔			✔	✔	✔	
Nutritional counseling				✔	✔		
Personal emergency response		✔		✔	✔	✔	✔
Prevocational services		✔				✔	
Respite care	✔	✔	✔	✔	✔	✔	
Senior companion				✔			
Specialized medical equipment		✔					✔
Supported community living		✔				✔	
Supported residential-based community living						✔	
Supported employment		✔				✔	
Transportation		✔		✔		✔	✔

Waiver Forms

The following chart lists forms income maintenance workers use in the waiver programs. Directions for completion of these forms are found in 6-Appendix and 16-K-Appendix.

Form	AIDS	BI	CMH	EW	HD	ID	PD
470-5170, *Application for Health Coverage and Help Paying Costs*	✔	✔	✔	✔	✔	✔	✔
470-4833, *Waiver Slot Notice*	✔	✔	✔		✔	✔	✔
470-3924, *Request for IoWANS Changes*	✔	✔	✔	✔	✔	✔	✔

Definitions

Legal reference: 441 IAC 24.1(225C), 83.1(249A), 83.21(249A), 83.41(249A), 83.60(249A), 83.81(249A), 83.101(249A), 83.121(249A)

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional activities of daily living, leisure, or work.

"Adult" means a person aged 18 or over.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control, "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of *Morbidity and Mortality Weekly Report*.

"Appropriate" means that the services, supports, or activities provided or undertaken by the organization are relevant to the member's needs, situation, problems, or desires.

"Assessment" means the review of the member's current functioning in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Attorney in fact under a durable power of attorney for health care" means a person that:

- Is designated by a durable power of attorney for health care, pursuant to Iowa Code Chapter 144B, as an agent to make health care decisions on behalf of another person, and
- Has consented to act in that capacity.

"Behavior" means skills related to regulating one's own behavior, including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate socio-sexual behavior.

"Blind person" means a person who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Brain injury" means clinically evident damage resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasm of brain, cerebrum
- Malignant neoplasm of brain, frontal lobe
- Malignant neoplasm of brain, temporal lobe
- Malignant neoplasm of brain, parietal lobe
- Malignant neoplasm of brain, occipital lobe
- Malignant neoplasm of brain, ventricles
- Malignant neoplasm of brain, cerebellum
- Malignant neoplasm of brain, brain stem
- Malignant neoplasm of brain, midbrain, peduncle, or medulla oblongata
- Malignant neoplasm of brain, cerebral meninges
- Malignant neoplasm of brain, cranial nerves
- Secondary malignant neoplasm of brain
- Secondary malignant neoplasm of other parts of the nervous system, cerebral meninges
- Benign neoplasm of brain and other parts of the nervous system, brain
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges
- Encephalitis, myelitis, or encephalomyelitis
- Intracranial or intraspinal abscess
- Anoxic brain damage
- Subarachnoid hemorrhage
- Intracerebral hemorrhage
- Other and unspecified intracranial hemorrhage
- Occlusion and stenosis of precerebral arteries
- Occlusion of cerebral arteries
- Transient cerebral ischemia
- Acute, but ill-defined, cerebrovascular disease

- Other and ill-defined cerebrovascular diseases
- Fracture of vault of skull
- Fracture of base of skull
- Other and unqualified skull fractures
- Multiple fractures involving skull or face with other bones
- Concussion
- Cerebral laceration or contusion
- Cerebral edema
- Cerebral palsy
- Subarachnoid, subdural, or extradural hemorrhage following injury
- Other and unspecified intracranial hemorrhage following injury
- Intracranial injury of other and unspecified nature
- Poisoning by drugs, medicinal or biological substances
- Toxic effects of substances
- Effects of external causes
- Drowning or nonfatal submersion
- Asphyxiation or strangulation
- Child maltreatment syndrome
- Adult maltreatment syndrome
- Status epilepticus

"Case management" means services that assist a member in gaining access to medical, social, and other appropriate services needed for the member to remain in the member's home. Case management is provided at the direction of the member and the interdisciplinary team.

"Child" means a person aged 17 or under.

"Client participation" means the amount of the member's income that the member must contribute to the cost of waiver services, exclusive of medical vendor payments, before Medicaid will participate.

"CMS" means the federal Centers for Medicare and Medicaid Services, which sets federal Medicaid policy and approves waivers to federal Medicaid requirements.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current Supplemental Security Income (SSI) guidelines.

"Department" means the Iowa Department of Human Services.

"Direct service" means consumer services provided face to face.

"**Disabled person"** means a person who is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

NOTE: See 8-C, *Presence of Age, Blindness, or Disability*, for further description of disability and blindness standards.

"Financial participation" means client participation and medical payments from a third party, including veterans' aid and attendance.

"Guardian" means a parent of a minor member or guardian appointed in juvenile or probate court.

"HCBS" means home- and community-based services, which are services intended to enable people to live in their own homes or communities instead of in a medical institution.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"IME" means the Iowa Medicaid Enterprise.

"IME Medical Services Unit" means the contracted entity in the Iowa Medicaid Enterprise that determines level of care for members initially applying or continuing to receive Medicaid waiver services.

"Intellectual disability" means a diagnosis of intellectual disability that shall be:

- Based on an assessment of the person's intellectual functioning and level of adaptive skills.
- Made by a psychologist or a psychiatrist who is professionally trained to complete the following:
  - Administer the tests required to assess intellectual functioning.
  - Evaluate a person's adaptive skills.
- Made in accordance with the criteria provided in the *Diagnostic and Statistical Manual of Mental Disorders*, Current Edition, published by the American Psychiatric Association.
- Made only when the onset of the person's condition was before the age of 18 years.

"Interdisciplinary team" means a collection of people with varied professional backgrounds who develop one plan of care to meet a member's needs for services.

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means a medical institution that includes the following:

- Has the primary purpose of the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions, and
- Provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or related services to help each resident function at the person's greatest ability in a protected residential setting, and
- Is an approved Medicaid vendor.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"IoWANS" means Institutional and Waiver Authorization and Narrative System. This computer program supports the waiver programs by tracking cases and authorizing the IME to make payments to providers.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food, and household supplies.

"Managed Care Organization (MCO)" means a health plan that coordinates care for a member.

"Medicaid case management" means services established pursuant to Iowa Code Chapter 225C to assist members in gaining access to appropriate living environments, needed medical services, and interrelated social, vocational, and educational services. Case management services have the following responsibilities:

- Linking members to service agencies and support systems responsible for providing the necessary direct service, and
- Coordinating and monitoring those services.

"Medical institution" means an institution that:

- Is organized to provide medical care, including nursing and convalescent care;
- Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;
- Is authorized under state law to provide medical care; and
- Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include:
    - Adequate and continual medical care and supervision by a physician;
    - Registered nurse or licensed practical nurse supervision and services and nurses' aid services sufficient to meet nursing care needs; and
    - A physician's guidance on the professional aspect of operating the institution.

"Mental health professional" means a person who meets all of the following conditions:

- Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing or social work, or is a doctor of medicine or doctor of osteopathic medicine and surgery;
- Holds a current Iowa license when required by the Iowa licensure law; and
- Has at least two years of post-degree experience supervised by a mental health professional in assessing mental health problems, mental illness and needs of people and in providing appropriate mental health services.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps taken to implement a policy.

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury:

- A psychologist;
- A psychiatrist;
- A physician;
- A physician assistant;
- A registered nurse;
- A certified teacher;
- A social worker or mental health counselor;
- A physical, occupational, recreational, or speech therapist; or
- A person with a Bachelor of Arts or science degree in psychology, sociology, or public health or rehabilitation services.

"Qualified intellectual disability professional" or **"QIDP"** means a person who has at least one year of experience working directly with people with an intellectual disability or other developmental disabilities and who is one of the following:

- A doctor of medicine or osteopathy.
- A registered nurse.
- A psychologist with a master's degree in psychology from an accredited school.
- A social worker with:
    - A graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body, or
    - A bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or a comparable body.
- An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or a comparable body.
- A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or a comparable body.
- A speech-language pathologist or audiologist who:
    - Is eligible for certification of clinical competence in speech-language pathology or audiology by the American Speech-Language Hearing Association or a comparable body, or
    - Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.
- A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music, or physical education.
- A professional dietitian who is eligible for registration by the American Dietetics Association.
- A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling or psychology.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that:

- Is of sufficient duration to meet diagnostic criteria for the disorder specified by the *Diagnostic and Statistical Manual of Mental Disorders*, Current Edition (DSM), published by the American Psychiatric Association; and
- Has resulted in a functional impairment that substantially interferes with or limits a child's role or functioning in family, school, or community activities.

"Serious emotional disturbance" shall not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM as "other conditions that may be a focus of clinical attention," unless they co-occur with another diagnosable serious emotional disturbance.

- The following are developmental disorders as specified in the DSM and are not classified as a serious emotional disorder:
  - Asperger's disorder
  - Autistic disorder
  - Childhood disintegrative disorder
  - Pervasive developmental disorder NOS
  - Rett's disorder
- Substance-related disorders categories include the following as specified in the DSM and are not classified as a serious emotional disorder:
  - Alcohol-related disorders
  - Amphetamine-induced disorders
  - Caffeine-related disorders
  - Cannabis-related disorders
  - Cocaine-related disorders
  - Hallucinogen-related disorders
  - Inhalant-induced disorders
  - Nicotine-related disorders
  - Opioid-related disorders
  - Phencyclidine-related disorders
  - Polysubstance-related disorder
  - Sedative-induced, hynotic-induced, or anxiolytic-induced disorders
  - Other (or unknown) substance-related disorders
- Other conditions that may be a focus of clinical attention are identified in the DSM as having one of following criteria:
  - The problem is the focus of diagnosis or treatment and the person has no mental disorder.
  - The person has a mental disorder but it is unrelated to the problem.
  - The person has a mental disorder that is related to the problem, but the problem is sufficiently severe to warrant independent clinical attention.

"Service plan" means a written member-centered outcome-based plan of services developed using an interdisciplinary process that addresses all relevant services and supports being provided. The service plan can involve more than one agency.

Sufficient details about the written service plan are entered into IoWANS to enable tracking of the case and authorization for IME to make payments. This information in IoWANS is also referenced as a "service plan."

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Substantial gainful activity (SGA)" means productive activities that add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency that is liable to pay part or all of the medical costs incurred as a result of injury, disease, or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

Policies Common to All HCBS Waivers

Legal reference: 441 IAC Chapter 83

Each of the HCBS waivers has individual requirements. However, the following processes are common to all programs:

- Enrollment process:
  - Joint administration
  - Use of Institutional and Waiver Authorization and Narrative System
- Application processing:
  - Time limits
  - Choose waiver services
  - Waiver slots
  - Effective date of eligibility
  - Notice of decision completion
- Medicaid eligibility determination:
  - Level of care
  - Income and resources
  - Coverage groups
- Payment for services:
  - Service plan
  - Provider enrollment
  - Third-party payments and client participation
  - Co-payment

- Managing ongoing cases:
  - Monitoring services
  - Temporary absences
  - Redetermination of eligibility
- Adverse actions:
  - Denial of service eligibility
  - Reduction
  - Cancellation (termination)
  - Appeals

Enrollment Process

Legal reference: 441 IAC 83.3(249A), 83.43(249A), 83.62(249A), 83.83(249A), 83.103(249A), 83.123(249A)

The waiver enrollment process involves a sequence of steps needed to be completed before payment for waiver services can be authorized. The Iowa Department of Human Services (DHS) has developed a computer program, named the "Institutional and Waiver Authorization and Narrative System" or "IoWANS," to support the Medicaid waiver and long-term care facility programs. The purpose of IoWANS is to assist workers in these programs in processing and tracking requests. See 14-M for IoWANS user instructions.

Upon approval, participants will use IoWANS to provide the Iowa Medicaid Enterprise with information and authority to make payments to or on behalf of a member. The member is tracked in IoWANS until that member is no longer accessing a waiver program.

A case normally starts with the income maintenance (IM) worker entering information into the Department's Automated Benefit Calculation (ABC) system. The ABC system passes pertinent information about the case to IoWANS. Then IoWANS identifies a key task (called a "milestone") for the IM worker who entered the original data into ABC.

This key task is the first in a series of milestones for actions by case managers, child health specialty clinic workers, and many others.

These milestones form a workflow taking a request for a waiver program to denial or final approval. The normal IoWANS workflow for each waiver can be accessed in IoWANS or in 16-K, *Medicaid Waiver Services*.

A request for waiver program services is processed through an IoWANS workflow that concludes with a milestone for the IM worker to give final approval. When the IM worker gives a positive response to this milestone, the Iowa Medicaid Enterprise (IME) is authorized to make payments to providers. It is important for the IM worker to ensure that all actions, including those outside of IoWANS, are complete and accurate before responding.

The following sections contain more information on:

- Joint administration
- IoWANS roles
- IoWANS milestones
- IoWANS entries
- IoWANS change flows

Joint Administration

Legal reference: 441 IAC 83.2(249A), 83.22(249A), 83.42(249A), 83.61(249A), 83.82(249A), 83.103(249A). 83.123(249A)

The HCBS waiver program requires joint administration between the Department and non-Department agencies. At certain points in the IoWANS process, contact with designated Department and non-Department agencies must be made in order for the IoWANS to proceed.

The income maintenance (IM) worker:

- Determines financial eligibility for Medicaid.
- Approves Medicaid benefits.

The Iowa Medicaid Enterprise (IME):

- Enrolls providers.
- Maintains the application and waiting list for waiver slots.
- Certifies waiver providers.
- Conducts quality assurance reviews required for certification.
- Approves the services ordered in the service plan.

The IME Medical Services Unit is responsible for:

- Determining the member's level of care.
- Assessing service necessity.
- Confirming the diagnosis.

The case manager or integrated health home's responsibilities include:

- Completing appropriate level of care assessment form.
- Assisting, if necessary, with obtaining documentation for the IME Medical Services Unit to complete the level of care assessment.
- Coordinating the development and completion of the member's service plan.
- Locating providers.
- Initiation of waiver services.

Use of Institutional and Waiver Authorization and Narrative System

IoWANS Roles

In IoWANS, specific people will be assigned to the roles, including the following:

- Service worker or case manager (SW/CM)
- Service worker or case manager supervisor (SW/CM Sup)
- Income maintenance worker (IM)
- Iowa Medicaid Enterprise Medical Services Unit (IME)
- Child Health Specialty Clinic staff (CHSC)

Supervisors may assign roles to people they supervise, to other supervisors, and even to themselves. Workers can reassign a role they were given back to their supervisor, but they cannot assign a role to anyone else.

Check your own demographic data when you first appear on a MEMBER STATUS screen. If something needs correction, inform your supervisor.

IoWANS Milestones

IoWANS milestone screens present a question, instruction, or a statement followed by choices for a response on two to five response buttons. See 14-M, *Key Tasks (Milestone) Screens* for illustrations of these screens. See 16-K for the step action chart pertaining to each specific waiver workflow.

All milestones in the process of approving a waiver case must be completed before the IME is authorized to start making payments. Thus, there are no "unimportant" milestones in IoWANS.

When you receive an IoWANS milestone and do not immediately know how to respond, click on the CANCEL button to postpone the needed response. The CANCEL button will close the milestone screen and bring you back to the previous screen. You will be able to access the milestone screen again when you are ready to respond.

NOTE: You do not necessarily need to wait to be notified through IoWANS that another person's task (IoWANS milestone) is completed before starting your work. Do your work as you normally do.

Bear in mind that many things outside IoWANS must happen to support the accomplishment of a milestone (key task). Responding to a milestone, while easy to do on line in IoWANS, may be delayed due to necessary procedures outside of IoWANS.

All users must recognize that often many activities will have to take place outside of IoWANS before a person is ready to respond to a milestone. Remember that while IoWANS tends to speed the process, it does not replace all the work that must still be done.

Some milestones are generated to inform you that some action has taken place. These notification milestones require no action by you other than to acknowledge that you have read the milestone. You should respond to a notification milestone promptly.

If you respond prematurely with insufficient or erroneous information, it may be possible to "undo" the milestone. To see if it is possible, navigate to the STATUS screen for the member by clicking on the STATUS subtab when the member is selected.

If it is possible to undo the milestone, a trashcan icon will display in the last column of the milestone's record. If the undo is not permitted (e.g., if "downstream" milestones have been accomplished), you must contact people who have performed the downstream milestones to arrange for a series of "undo" actions or contact the DHS Service Help Desk for assistance.

IoWANS Entries

Workers make entries into IoWANS, depending on the waiver type. IoWANS entries are "real time," which means changes are visible to all workers once the entry is completed.

Based on information entered into the ABC system, IoWANS may receive an "estimated" level of care. The CLIENT LEVEL OF CARE field may be populated with that estimated level of care. The IME Medical Services Unit can either accept this "initial" level of care or choose something different from the pull-down menu (whichever is correct).

The county of legal settlement may be included in the initial entry of a case in ABC or when a member reapplies after a break in services. After the initial entry, the correct county of legal settlement is maintained in IoWANS. The IM worker should change county of legal settlement in the ABC system to match what is in IoWANS.

IoWANS provides a screen that displays the current and past program request. Use form 470-3924, *Request for IoWANS Changes*, to transmit requests for adding, changing, or terminating program request information in IoWANS when the information can't be submitted directly through IoWANS entries.

IoWANS does not provide the means for changing the demographic information for a member. Enter changes to a member's demographic information in ABC. ABC passes the information to IoWANS. IoWANS will not generate notifications when demographic information changes.

If you believe that a waiver type for a particular member is wrong, it cannot be changed in IoWANS. To change the waiver type on a pending or active case, deny or close the case in ABC and open a new case using the new waiver type.

IoWANS Change Flows

In addition to the normal flows, IoWANS generates a series of milestones known as "change flows" in response to "change" events.

For example, after waiver services are started, a member's health may improve or worsen over time to a point that justifies a new determination of the level of care. In this situation, an IoWANS change flow can be started to accomplish milestone tasks to establish a new level of care and perform associated actions.

IoWANS will start a change flow:

- When an annual Medicaid eligibility review is coming due. The Medicaid eligibility review is tracked outside of IoWANS by the ABC system.
- When IoWANS receives a new client participation amount from ABC that differs from what IoWANS already has. The milestones will differ by waiver type and depending on whether the start date is in the current or a future month, or is in a month before the current month.
- When a case manager clicks on the INIT LOC button found on the PROGRAM REQUESTS screen when a new level of care determination is justified after a waiver case has been approved. This change flow will be to accomplish milestones needed to change the level of care and perform associated actions.
- If IoWANS receives a denial for a case from ABC, the change flow will include canceling all outstanding milestones in the normal flow.
- When IoWANS receives a cancellation from the ABC system due to the death of a member. The milestones will differ depending on whether services had started for that member, and will be different for each specific waiver program.
- If IoWANS receives a denial for a case from the ABC system. The change flow will include canceling all outstanding milestones in the normal flow. With a denial no services will be paid. Therefore, the original workflow does not need to be finished.
- IoWANS starts a notification change flow at 60 days before a health and disability or physical disability waiver member's 65th birthday.
- For children's mental health waiver, the income maintenance worker and the case manager receives an IoWANS milestone 30 days before the child's 18th birthday.

  These notifications are reminders that transition planning must be implemented to ensure that the child has appropriate services when the child turns 18 years of age and the children's mental health waiver services end.

Application Processing

Legal reference: 441 IAC 76 (Rules in Process), 83.3(249A), 83.23(249A), 83.43(249A), 83.62(249A), 83.83(249A), 83.103(249A), 83.123(249A)

Policy: The IM worker determines income and resource eligibility for the waiver programs based on a Medicaid application.

A person who is not currently eligible for Medicaid and chooses to apply for home and community based waiver program services must complete form 470-5170, *Application for Health Coverage and Help Paying Costs*.

A person who is currently Medicaid-eligible is not required to file a new application, unless the person is at the end of a Medically Needy certification period. The date of the waiver request will be one of the following:

- The date that the person or the person's authorized representative signs the section "Verification of HCBS Waiver Consumer Choice," on the designated waiver assessment.

- The date the IM worker receives a signed and dated written statement from the person or the person's authorized representative requesting HCBS.

Procedure: Obtain updated information for current Medicaid members as necessary. Request any additional information needed to determine whether the member meets the eligibility requirements for the waivers.

For persons under age 21 applying for the health and disability waiver notify the Child Health Specialty Clinic. The locations, addresses, and phone numbers of the regional centers are listed on Internet at: https://chsciowa.org/.

Follow the application process as stated in 8-B, *Filing a Medicaid Application*. See 8-B, *Procedures for SSI Applicants or Potential SSI Eligibles* regarding when to make referrals to the Social Security Administration based on the applicant's income and SSI status.

See 8-C, *When the Department Determines Disability*, for an explanation of the disability determination process to be used when the applicant's income is more than SSI standards and the applicant is not receiving social security disability. A disability determination is not required for children under 21 in the 300% group.

The AIDS, brain injury, children's mental health, health and disability, intellectual disability, and physical disability waivers have limits on the number of people who can be served. The state designates the number of people to be served under each waiver. See Waiver Slots.

Applicants may voluntarily withdraw or be determined ineligible at any point during the application process. See Withdrawal of an Application.

Time Limits

Legal reference: 441 IAC 76 (Rules in Process), 83.3(3)"a," 83.23(3)"a," 83.43(3)"a," 83.62(3)"a," 83.83(2)"a," 83.103(2)"a," 83.123(2), 130.2(4)

Policy: Applications for waiver programs must be processed within 45 days unless one or more of the following conditions exist:

- An application has been filed and is pending for federal Supplemental Security Income benefits.
- You have not received information for reasons that are beyond the control of the applicant or the Department.
- The application is pending due to the disability determination process performed through the Department.
- The application is pending because a level of care determination has not been made. (A completed assessment has not been submitted to the IME Medical Services Unit.)

Procedure: When waiting for information to continue processing an application, check the appropriate source weekly. Document the contact in the case record by noting who was contacted, the date of contact, the type of contact, and the results of the contact.

Choose Waiver Services

Legal reference: 441 IAC 83.3(3)"c," 83.23(3)"c," 83.43(3)"c," 83.62(3)"c," 83.83(2)"c," 83.103(2)"d," 83.122(5)

Policy: An applicant must be given the choice between HCBS waiver services and institutional care.

Procedure: Explain to the applicant or the applicant's representative the differences between HCBS waiver and institutional care. The applicant or the applicant's representative can indicate the choice for HCBS waiver by either:

- Marking the waiver box on form 470-5433, *Appendix A Application for Health Coverage,*
- Sending a written request asking for waiver services, or
- Verbally confirming their choice with the IM and IM documents the conservation.

Document the applicant's choice in IoWANS using the "comments" box and also in online narrative.

Waiver Slots

Legal reference: 441 IAC 83.3(2), 83.61(3) and (4), 83.82(4), 83.102(5) and (7), 83.123(1)

Policy: There are limits to the number of members who can receive HCBS. In other words, there are a limited number of HCBS waiver slots. When all waiver slots are assigned, the applicant's name is placed on a waiting list maintained by the Iowa Medicaid Enterprise (IME).

Once a waiver slot is assigned, the slot is available for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program.

If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

Procedure: Request a waiver slot by making ABC entries to initiate an IoWANS workflow. NOTE: If eligibility is dependent upon disability, a disability determination must be done **before** a slot can be assigned.

- For people not currently receiving Medicaid, make the entries by the end of the fifth working day after receipt of a completed application, or within five days after receipt of disability determinations, whichever is later.
- For Medicaid members, make the entries by the end of the fifth working day after receipt of one of the following:
    - A written request for HCBS services signed and dated by the applicant or the applicant's authorized representative, or
    - The appropriate assessment form signed by the member or member's representative indicating the choice of HBCS waiver.

IME will inform you through IoWANS whether a waiver slot is available.

- If a waiver slot is available, continue with the application process.
- If a slot is not available, the applicant is not eligible for a waiver and their name is placed on the waiver waiting list. See Slot Waiting List.

Waiver Slot Reissue and Attrition Guidelines

Waiver slot closure reasons that allow a slot to be immediately reassigned to the next applicant upon notice to the Department (if the waiver has available slots):

- The applicant or member aged out of the waiver for Children's Mental Health (CMH), Physical Disability (PD), and Health and Disability (HD) waivers.
- The applicant or member moved out of state.
- The applicant or member is deceased.

Waiver slot closure reasons that allow a slot to be reassigned to the next applicant after 30 days of closure notice to the IME (if the waiver has available slots):

- The application is withdrawn and notification is made to the DHS Contact Center.
- The applicant or member chose another waiver.
- The applicant or member is in foster care (CMH only).
- The applicant or member is admitted to an Intermediate Care Facility for the Intellectually Disabled (ICF/ID) or Psychiatric Medical Institution for Children (PMIC).

Waiver slot closure reasons that allow a slot to be reassigned to the next applicant after 120 days of closure notice to the IME (if the waiver has available slots):

- The applicant did not respond to the notice from the IM worker (response deadline within 30 days).
- The member or applicant has been admitted to a nursing facility.
- The member or applicant has been denied level of care (LOC).
- The member or applicant has not completed annual Medicaid financial review timely.
- The member or applicant requested waiver to be closed.
- The member or applicant exceeds the allowable financial resources.
- The member or applicant reported other income variables.
- The member or applicant needs cannot be met by the waiver.
- The member did not access one unit of service during the most recent calendar quarter.
- The member or applicant is under juvenile court order.

For members who meet all of the following criteria, the IME will place that member on the waiting list in accordance with the member's original application date for the specific waiver:

- The member had been actively on a waiver but was closed off the waiver, and
- The member requested a slot, and
- The request is received by the IME between days 121-180 after notice of closure.

For members who had been on a waiver but the waiver has been closed for more than 180 days, or applicants who never accessed a waiver, once the waiver slot is closed:

- The member must reapply, and
- The member will have a new application date based upon that date of application.

Slot Waiting List

Policy: If no payment slot is available, the applicant's name is placed on a waiting list maintained by the Iowa Medicaid Enterprise (IME).

Procedure: If a slot is not available, the applicant is not eligible for a waiver. Send a *Notice of Decision* denying services based on the limit and stating that the person's name will be put on a waiting list.

As slots become available, people are selected from the waiting list to keep the number of approved members on the program based on their order on the waiting list.

When a payment slot is assigned to a person who was on a waiting list, use the *Waiver Slot Notice*, form 470-4833, to give written notice to the applicant.

In some cases, an applicant for the Brain Injury Waiver, Children's Mental Health Waiver, Health and Disability Waiver, Intellectual Disability Waiver, and Physical Disability Waiver whose name has been placed on the waiting list may have emergent or urgent need for waiver services. The applicant can complete form 470-5795, *Waiver Priority Need Assessment (WPNA)* and submit it to the Department for consideration of wait list prioritization. If a local office receives this form, forward the form to Iowa Medicaid, Attention: HCBS Wait List, PO Box 36330, Des Moines Iowa 50315 or by email to Waiverslot@dhs.state.ia.us

Service Plans

Legal reference: 441 IAC 83.2(2)"a," 83.7(249A), 83.27(249A), 83.47(249A), 83.67(249A), 83.87(249A), 83.107(249A), 83.127(249A), 130.7(234)

Policy: Each person's need for waiver services shall be assessed and documented in a detailed written format that addresses all plan requirements, and

The service plan is developed by the case manager. Only services included in the approved service plan may be reimbursed.

Effective Date

Legal reference: 441 IAC 83.3(3)"b" and "d," 83.3(4), 83.23(3)"b" and "d," 83.23(4), 83.43(3)"b" and "d," 83.43(4), 83.62(3)"b" and "d," 83.62(4), 83.83(2)"b" and "e," 83.83(3), 83.103(2)"c" and "f," 83.103(3), 83.123(3)

Do not approve a case until the following criteria are met:

- Medicaid eligibility is established.
- Level of care is established.

Waiver eligibility begins on the date when both eligibility requirements have been completed.

The waiver start date can't be before the application date or before the date when level of care was determined.

Waiver services will begin once the case has been approved and a case manager has developed a waiver service plan based on the individual member's needs.

You may establish Medicaid eligibility retroactively for individuals who meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*, but waiver services cannot be paid retroactively.

Retroactive Medicaid Eligibility

Legal reference: 42 CFR 435.914, 435.915(a); 441 IAC 76.13(3)

Medicaid benefits are available for all or any of the three months preceding the month in which the application is filed for an individual who meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions* if:

- The member has paid or unpaid medical bills for covered services that were received during the three-month retroactive period, including a Medicare premium payment; **and**
- The member would have been eligible for a Medicaid coverage group in the month services were received if a Medicaid application had been made.
- Retroactive Medicaid benefits are for regular Medicaid services, such as physician services and drugs. Retroactive Medicaid benefits do not include HCBS waiver services.
- Establish retroactive eligibility in accordance with 8-B, *Determining Eligibility for the Retroactive Period*. Do not apply waiver eligibility criteria for the retroactive period. NOTE: The member does not need to be eligible in the month of application to be eligible in any of the three months before the month of application.

When to Deny an Application

Legal reference: 441 IAC 83.8(1), 83.28(1), 83.48(1), 83.68(1), 83.88(1), 83.108(1), 83.128(1)

Deny an application for HCBS waiver services when you have determined that the applicant is not eligible for waiver services because:

- A slot is not available; or
- Disability, resources, income, level of care, or other Medicaid eligibility factors have not been met.

Deny an application for HCBS waiver services when the case manager notifies you in writing that:

- The applicant is not eligible for the service; or
- The applicant does not need waiver services on at least a quarterly basis; or
- HCBS service needs exceed the total monthly cost allowed or cannot meet the applicant's needs; or
- Needed services are not available or are not received from qualified providers; or
- The service requested is not identified in the applicant's service plan; or
- There is another community resource available to provide the service or similar service free of charge that will meet the applicant's needs; or
- The applicant failed to provide information needed to determine eligibility.

NOTE: An applicant may still be eligible for Medicaid under another coverage group even though the applicant does not qualify for waiver services.

Issue adequate notice when you deny an application. See 8-A, *Notification* for more information about notice requirements. Send a *Notice of Decision* to the applicant.

Grace Period Following the Denial of an Application

Legal reference: 441 IAC 76 (Rules in Process)

Policy: A "grace period" is a specified period of time during which an applicant has the opportunity to "cure" the reason for the denial of an application. The grace period is defined as the 14 calendar days immediately following the date of denial.

"Day one" of the 14-day grace period is the day following the date printed on the notice of decision. If the 14th day falls on a weekend or a state holiday, the 14th day is extended to the next working day for which there is regular mail service.

A previously denied application shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the date of denial. Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

If the applicant is eligible, the original filing date of the application establishes the effective date of eligibility. Waiver eligibility begins on the date when **all** eligibility requirements have been completed. See Effective Date.

Comment: The grace period does not apply to late payment of premiums or noncooperation. Denial reasons for which a grace period may apply include, but are not limited to, failure to provide information necessary to determine eligibility, denial of level of care, and inability to locate the applicant.

If the application was denied because mail was returned or the Department was otherwise unable to locate the applicant, a new application is not required if the household contacts the Department within the 14 days, provides a current Iowa address, and eligibility can otherwise be established.

Procedure: Based on the case circumstances, take the appropriate action as follows:

- **No information provided:** When no information is provided by the 14th day after the date of denial, no further action is required.
- **Partial information provided:** When some of the information is returned, but there is still information needed to determine eligibility:
  - Attempt to contact the household to let them know what is needed and that if the information is not received so that a decision can be made by the end of the grace period, the household will have to reapply. A written request for the previously requested information is not required.
  - If the information is not provided by the end of the grace period, no further action is necessary.
- **Requested information provided and a change has occurred:** If the original requested information is provided, but the household also reports a change for which verification is necessary:
  - Make every effort to verify the information and inform the applicant that you cannot reconsider the application unless the change is verified by the end of the grace period. If a generic release is on file, use it to obtain the information if possible. A written request for the new information is not required.
  - If the new information is not verified so that an eligibility determination can be made by the end of the 14-day grace period, send a "remain denied" notice. This is because the original reason for denial has been cured, but you cannot process the application due to a change in circumstances that is required to be verified.
  - **Unable to verify change within grace period:** When an additional change is reported and it is unlikely the information can be verified and eligibility established by the end of the 14-day grace period, attempt to notify the applicant that they will need to file a new application.

Comment:

1. Mr. A, a waiver applicant, fails to provide two pieces of information requested by the Department. The IM worker issues a denial notice on April 1, which is dated April 2. Mr. A provides all of the requested information on April 16. There have been no other changes in the household circumstances. The IM worker processes Mr. A's application.
2. Ms. B, a waiver applicant, fails to provide three pieces of information requested by the Department. The IM worker issues a denial notice on May 10, which is dated May 11. Ms. B provides two of the items on May 13. The worker attempts to contact Ms. B about the third item.

   The third item is received on May 25. There have been no other changes in the household circumstances. The IM worker processes the application.
3. Mr. C's application for the elderly waiver is denied on April 20 based on level of care. The IM worker issues a denial notice on April 21, which is dated April 22.

   Mr. C's case manager provides additional information to the IME Medical Services Unit on May 3. IME approves Mr. C's level of care effective May 3. The IM worker reopens Mr. C's application and processes it.

Withdrawal of an Application

When an applicant voluntarily withdraws the application for waiver services during the application process, send a *Notice of Decision* to the applicant. Also notify the following, as applicable:

- The IME Medical Services Unit.
- The case manager.
- The Child Health Specialty Clinics central office (319-356-1035 or toll free at 866-219-9119) for people under age 21 applying for the health and disability waiver.

Medicaid Eligibility Determination

Legal reference: 441 IAC 83.2(249A), 83.21(249A), 83.42(249A), 83.61(249A), 83.82(249A), 83.102(249A), 83.122(249A)

Unless otherwise specified in this chapter, application policies and general eligibility requirements are the same for people applying for HBCS waiver services as for any other applicant. Follow processing procedures described in 8-B, *Application Processing* and eligibility requirements in 8-C, *Nonfinancial Eligibility*, 8-D, *Resources*, 8-E, *Income*, and 8-F, *Coverage Groups*.

In addition to these eligibility requirements, all waiver applicants must meet the institutional level of care requirements specific to that waiver, corresponding to the requirements at 8-I, *Medical Necessity* for applicants in medical institutions.

If the applicant's income is under SSI limits and eligibility is determined under non-MAGI, refer the applicant to the Social Security Administration for application and disability determination, unless the application was previously denied in the past year and circumstances have not changed. See 8-C, *When the Department Follows an SSA Disability Determination*.

Level of care Determination

Legal reference: 441 IAC 83.2(1)"d," 83.22(1)"d," 83.42(1)"b," 83.61(1)"c," 83.82(1)"f," 83.87(3), 83.102(1)"h," 83.122(3)

Policy: Each person applying for waiver services must have a level of care determination done before eligibility can be determined. To be determined eligible for waiver services, the applicant must meet a level of care allowable for the waiver for which the applicant is applying.

Waiver	Level of Care
AIDS/HIV	ICF, SNF, hospital
Brain injury	ICF, SNF, ICF/ID
Children's mental health	Hospital
Elderly	ICF, SNF
Health and disability	ICF, SNF, ICF/ID
Intellectual disability	ICF/ID
Physical disability	ICF, SNF

Procedure: The IME Medical Services Unit certifies if the person meets level of care at time of application. Continued stay reviews are done by IME Medical Services Unit for members who are not with an MCO. For members who are with an MCO, the MCO will complete the continued-stay review.

If a member is denied level of care at the continued stay review, cancel the waiver case for not meeting level of care and send a *Notice of Decision* to the member. The member then has the right to appeal the cancellation.

Income and Resources

Legal reference: 441 IAC 83.2(1)"f," 83.22(1)"c," 83.42(1)"c," 83.61(1)"b," 83.82(1)"b," 83.102(1)"e," 83.122(4)

A waiver member is considered to be an institutionalized person. Treat the member as an institutionalized person for attribution of resources and deeming of income and resources. If a member goes into a medical institution, consider eligibility as if it is a change in facilities, not a change from noninstitutional care to institutional care.

For members eligible under the MEPD coverage group, treat income and resources according to MEPD limits. See 8-F, *Medicaid for Employed People With Disabilities*.

Attribution of Resources

Legal reference: 441 IAC 83.3(5), 83.23(5), 83.43(5), 83.62(5), 83.83(4), 83.103(4)

Policy: When a waiver member is married and has a community spouse, the resource eligibility is determined by the attribution of resources between the spouses.

Procedure: See 8-D, *Attribution of Resources*. Use the first day of the month in which the IME Medical Services Unit determines the waiver member meets level of care as the date to determine the attribution. This date is reported through IoWANS.

Comment: If an attribution was completed for the member in a nursing facility and the member enrolls in waiver, use the previous attribution. Do not complete a new attribution.

Determining Coverage Group

Legal reference: 441 IAC 83.2(1)"a," "b," and "c," 83.22(1)"c," 83.42(1)"c," 83.61(1)"b," 83.82(1)"b," 83.102(1)"e," 83.122(4)

When a person who is not a Medicaid member requests waiver services, establish Medicaid eligibility through a non-MAGI coverage group or through the children under 21 in the 300% group, depending on the waiver type. The non-MAGI coverage group may be a facility coverage group or MEPD. See 8-F, *Coverage Groups*.

For elderly and health and disability waivers, only non-MAGI coverage groups qualify. If the applicant does not qualify under these groups, waiver services cannot be provided. For other waivers, determine eligibility under either the children under 21 in the 300% group or non-MAGI criteria.

For members qualifying in the 300% group, including children under 21 who do not have a disability, services must be expected to last for 30 consecutive days in order to meet the 30 day stay requirement.

Eligibility under most coverage groups includes eligibility for Medicaid HCBS waiver services if the medical necessity requirements are met. Exceptions are as follows:

- The Medically Needy coverage group does not cover nursing facility (NF), skilled nursing facility (SNF), intermediate care facility for persons with an intellectual disability (ICF/ID), psychiatric medical institution for children (PMIC), or waiver services.

  EXCEPTION: If Medically Needy is the only coverage group under which the applicant qualifies, approve waiver services for the AIDS/HIV waiver if the applicant is at hospital level of care. Deny the applicant for all other waivers.

- The qualified Medicare beneficiary (QMB) coverage group provides limited coverage for hospital and skilled nursing care and no coverage for nursing care or ICF/ID care. Only Medicare premiums, coinsurance, and deductibles are covered.

- The qualified disabled and working persons (QDWP) coverage groups provides Medicaid payment only for Medicare Part A premiums.
- The specified low-income Medicare beneficiary (SLMB) and the expanded specified low-income Medicare beneficiary (E-SLMB) coverage groups provide Medicaid payment only for Medicare Part B premiums.

Examine such cases to determine if the members would be eligible for HCBS waiver payment if in another coverage group. Obtain a new application only if a Medically Needy certification is about to end.

For **children** who qualify for facility coverage groups:

- Do not count resources for coverage groups where resources are not considered for children. See 8-D, *Resource Eligibility of Children*.
- Count a parent's income and resources for the first partial month of waiver services. If waiver services begin on a day other than the first day of the month, count the parent's income or resources for that month. See 8-D, *Deeming From a Parent to a Child*, and 8-E, *Deeming From an Ineligible Parent to an Eligible Child*.
- Do not count a parent's income or resources for the first full calendar month of waiver services when waiver is expected to last 30 days. When waiver services begin on the first of the month, do not count the parent's income or resources for that month.

1. Johnny's waiver services are set to begin May 12. Both parents' income is countable to him for May. Johnny is over the income limit for May. Beginning June 1, none of Johnny's parents' income is countable and his income is within the limit. Johnny is eligible for waiver services beginning June 1.
2. Mary's waiver services are scheduled to begin May 1. None of her parents' income is countable to her.

Aid Types

Procedure: The Automated Benefit Calculation (ABC) system uses the aid type for the coverage group in combination with the waiver code to identify the type of waiver case. See 14-B-Appendix, TD01 AID, TD01 MED AID, and TD03 WVR, for instructions.

Treatment of Spouses

For married persons applying for waiver services, treat income and resources separately when one spouse expects to be on the waiver and the other is a community spouse.

The income of the spouse not on the waiver is not considered when determining the waiver spouse's countable income for eligibility, but is considered when determining allowable deductions for client participation.

If the community spouse enters a medical facility, treat the spouses as a married couple living in separate facilities for eligibility. However, a diversion to the community spouse can continue when determining client participation.

When one spouse is currently on the waiver and the other spouse goes onto a waiver, apply the policies in 8-I, *When a Spouse Moves Into the Same Room*. If one spouse has been on the waiver for six months before the other spouse enters the waiver, that spouse can choose to be treated separately.

If eligibility is determined together, add the countable income of both the spouses together and compare the total to two times the 300% limit. Add the countable resources of both spouses and compare the total to the couple resource limit. Each spouse will need their own separate waiver case in the ABC system.

Eligibility for Waiver and MEPD

Policy: Members eligible for MEPD can be eligible for a waiver as long as they also meet the requirements specific to the waiver program they want to access.

Procedure: Members who are eligible for Medicaid only through MEPD but also receive waiver services need two cases opened in the ABC system: one case for the MEPD coverage and one for the waiver.

Open the MEPD case first to allow the information to pass to the MEPD billing system.

Members accessing the waiver through the MEPD program will not have client participation assessed for their waiver case.

Comment: Do not make ABC entries on both cases on the same day.

Eligibility for Waiver and State Supplementary Assistance

Legal reference: 441 IAC 177.4(2)

Policy: A member who is eligible to receive State Supplementary Assistance for in-home health-related care (IHHRC) or residential care facility care (RCF) may also receive waiver services if the following conditions are met:

- The member meets the eligibility requirements of each program.
- Each program provides different services. For example, the elderly waiver provides adult day care and respite and the in-home health-related care program provides the personal care and home maintenance for the same person.

Procedure: Establish two separate cases in ABC: one for waiver eligibility and one for State Supplementary Assistance.

Determine eligibility and client participation according to the rules of each program. There is no client participation in the waiver programs unless the member receives veteran's aid and attendance, long-term care insurance payments, or has a medical assistance income trust.

The in-home health-related care program requires client participation when the member's income is over a specific amount. Apply the aid and attendance and other client participation to either the IHHRC or the waiver first, as the member chooses.

Comment: Do not make ABC entries on both cases on the same day.

Payment for Waiver Services

Legal reference: 441 IAC 75 (Rules in Process), 83.4(2), 83.24(2), 83.44(2), 83.63(2), 83.84(2), 83.104(2)

Policy: Medicaid payment cannot be claimed for waiver services that:

- Are not included in the written service plan; or
- Are furnished **before** the service plan is developed.

If a member's client participation covers all or part of the cost of a service, the provider must collect from the member before billing Medicaid or the MCO.

If a member has Medicare or private insurance that covers all or part of a service, providers of that service must bill Medicare or the insurance company before billing Medicaid or the MCO. If the Medicare or private insurance and client participation do not pay the full amount allowed by Medicaid or the MCO, Medicaid or the MCO will pay the difference.

If the sum of the third-party payment equals or exceeds the estimated cost of waiver services, Medicaid or the MCO will make no payments to waiver service providers but will make payments to other medical vendors, as applicable.

Procedure: Determine the third-party payments and client participation while eligibility is being established. If the member is eligible, the case manager issues a *Notice of Decision* to notify the member and the service provider of the client participation or third-party payments due the provider.

Client Participation

Legal reference: 441 IAC 83.4(249A), 83.24(249A), 83.44(249A), 83.63(249A), 83.84(249A), 83.104(249A)

Policy: Client participation is the amount that a member is required to contribute toward the cost of waiver services. To calculate client participation:

1. Determine only the member's total gross monthly income. See 8-I, *Income Available for Client Participation*.
2. Subtract a maintenance needs allowance of 300% of the current SSI benefit for one person.
3. Add in veteran's aid and attendance and veteran's housebound allowance.

The result is the client participation amount.

Procedure: Make client participation entries on the Automated Benefit Calculation (ABC) system. Notify the case manager of the type and amount of client participation to be paid, if any.

Do not inform the provider or the IME of the client participation. It is a case manager's responsibility to apply the client participation toward a specific service.

Members With a Medical Assistance Income Trust

To calculate client participation for waiver members with a medical assistance income trust, see 8-I, *Members With a Medical Assistance Income Trust*.

Case Maintenance

In general, follow the procedures in 8-G, *Case Maintenance*.

The following chart indicates how IoWANS initiates a milestone for the IME Medical Services Unit to process level of care determinations for various situations. The case manager may request a new assessment when a change in the level of care may be needed.

Situation	Assessment
Initial approval	Yes
Annual level of care review	Yes
Cancellation of waiver services following entry into any medical institution, including a hospital, for less than 30 days	No
Change to different waiver, e.g., moving to elderly waiver at age 65	Yes
Transfer between counties	No
Cancellation	No
Redetermination of waiver eligibility after cancellation following institutionalization for more than 30 days	Yes
Nonroutine changes in level of care (not related to any of the above)	Yes

See the following sections for detailed procedures for the following:

- Members who enter a hospital
- Members who enter a nursing facility or other medical institution
- Reviews
- Members who reach age 65

Member Enters a Hospital

Legal reference: 441 IAC 83.3(4)"d," 83.23(4)"c," 83.43(4)"c," 83.62(4)"d," 83.83(3)"c," 83.103(3)"c," 83.125(2)

When a waiver member's stay in a hospital, is less than 30 days, no system entries are needed. This includes stays in a psychiatric hospital or a psychiatric hospital serving persons under the age of 21.

When a waiver member enters a hospital (for other than respite care funded through a waiver) and stays or is expected to stay more than 30 days:

1. Close the Medicaid waiver case on the ABC system. Use the date of entry into the hospital as the waiver negative date on the ABC TD05 screen. Allow timely notice for Medicaid cancellation.

   Closure of the ABC case triggers an IoWANS change flow that generates milestones to notify the social worker or case manager of the cancellation.

2. Issue a system-generated notice or form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, canceling the waiver and Medicaid eligibility.

3. Complete a redetermination of eligibility if necessary to keep the member eligible throughout the hospital stay.

4. If the member returns home within 120 days, reopen the waiver case in the ABC system effective on the date that the member returned home and waiver services will begin. ABC entries trigger an IoWANS workflow to restart waiver services.

   NOTE: When a new assessment requested by the case manager results in a change in the level of care determination, follow the procedures under Application Processing and Medicaid Eligibility Determination.

A member who returns home after more than 120 days must reapply for the waiver.

Member Enters a Medical Institution

Legal reference: 441 IAC 83.3(4)"d," 83.23(4)"c," 83.43(4)"c," 83.62(4)"d," 83.83(3)"c," 83.103(3)"c," 83.125(2)"b"

Policy: For this section, "entering a medical institution" includes entering a nursing facility, an intermediate care facility for persons with an intellectual disability, a state mental health institute (for members under age 21 or age 65 or over), or a psychiatric medical institution for children.

Procedure:

1. When a member enters a medical institution other than for respite care funded through a waiver, you can either close the waiver case or transfer the waiver case to a facility medical case.

   - To **close** the waiver case, complete the following process:

     - Make entries to close the waiver case on the ABC system to allow payment to the medical institution. See 14-B(9), *HOME- AND COMMUNITY-BASED WAIVER CASE ACTIONS: Closing Waiver*. Use the date of entry into the medical institution as the waiver negative date. Allow timely notice for the Medicaid cancellation.

       Closure of the waiver case triggers a change flow in the IoWANS system that generates milestones on the waiver program request that notify the case manager of the waiver cancellation.

     - Issue a system-generated notice or form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, canceling the waiver and Medicaid eligibility.

- Reopen the case with any entries needed to approve medical institution payment. Remove the waiver code from the TD03 screen while medical institution entries are made to ensure that the case is identified as a medical institution case rather than a waiver case.

▪ To **transfer** the waiver case, complete the following process:

- Make entries on the waiver case on the ABC system to transfer the case into a facility medical case. See 14-B(9), *FACILITY CASE ACTIONS: Move: Same Day*. Use the date of entry into the medical institution as the facility positive date.

  Closure of the waiver case triggers a change flow in the IoWANS system that generates milestones on the waiver program request that notify the case manager of the cancellation.

- Issue a system-generated notice or form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistanc*e, approving facility medical assistance.

2. When the member leaves the medical institution and returns home, make any entries needed to close the medical institution payment.
3. If the member returns home within 120 days, make ABC system entries to reopen the waiver effective the date waiver services will be restarted. Entry of the waiver code on the TD03 screen identifies the case as a waiver case rather than a facility case.

   Pending the case before approval is not required. Either pending or approving the waiver will start a new workflow in IoWANS. The IME Medical Services Unit must re-enter the level of care.
4. If the member returns home after more than 120 days, the member must reapply for the waiver.

Reviews

Legal reference: 441 IAC 83.5(249A), 83.25(249A), 83.45(249A), 83.64(249A), 83.85(249A), 83.105(249A), 83.125(249A)

Policy: Eligibility shall be reviewed at least once every 12 months according to the requirements for the member's particular coverage group and waiver. The member shall complete form 470-5482, 470-5482(S), 470-5482(M), or 470-5482(MS), *Medicaid/State Supp Review*, for the annual Medicaid eligibility review.

Procedure: The IM worker evaluates the information on the *Medicaid/State Supp Review* to determine if the member remains eligible for Medicaid under the current coverage group. A redetermination is completed when a change is reported that would result in the member no longer being eligible under the current coverage group.

Respond to IoWANS milestones to record:

- Cancellation of HCBS services,
- A change in level of care, or
- A change in client participation.

Document a change in eligibility in the member's case record and send the appropriate notice of decision to the member.

Members Reaching Age 65

Legal reference: 441 IAC 83.2(1), 83.102(1)"f"

Policy: When health and disability, and physical disability waiver members reach age 65, they are no longer eligible to receive services under those waivers. These members may continue eligibility under the elderly waiver only.

The member may apply for the elderly waiver up to 60 days before the member's 65th birthday by sending a written request to the IM worker.

A new level of care determination is not needed as long as it is current. EXCEPTION: A member at the ICF/ID level of care must qualify under another level of care since there is no ICF/ID level of care under the elderly waiver.

Procedure: For members who are not enrolled with an MCO, IoWANS notifies the case manager when a member is reaching age 65 by issuing a milestone reminder 90 days before the member turns 65.

During this period, the service worker or case manager should contact the member to discuss options for other services to ensure a timely transition and avoid any lapse in services. They should also notify the IM worker if the member wants to continue waiver services through the elderly waiver.

Cancellation

If Medicaid is canceled due to a financial change, entry to a medical institution, or noncompliance by the member, an IoWANS change flow will start. The case manager also needs to cancel the waiver services because of this cancellation.

If the case manager cancels services due to reasons connected with the service plan, the IM worker needs to reexamine eligibility under the current coverage group and complete an automatic redetermination to another Medicaid coverage group as needed.

Issue adequate and timely notice when denying or canceling a case. Complete an automatic redetermination to see if the member is eligible for Medicaid under another coverage group. See 8-G, *Automatic Redetermination*. Also see 8-F, *Continuous Eligibility for Children* to determine when continuous eligibility applies to children leaving a waiver.

When to Cancel

Legal reference: 441 IAC 83.8(2), 83.28(2), 83.48(2), 83.68(3), 83.88(3), 83.108(3), 83.128(2)

Members can be canceled from waiver services for the same reasons that apply to all Medicaid members, such as timely reporting, or failure to cooperate with the Quality Control Unit.

Also cancel waiver services when any of the following occur:

- The member's income or resources exceed the financial guidelines.
- The member refuses to cooperate in establishing level of care, income, or resources.
- The member does not meet level of care criteria.
- The member does not meet other waiver-specified criteria.
- The member is in a hospital or medical institution for at least 30 consecutive days excluding respite care. See Case Maintenance.
- The member, legal guardian, or authorized representative asks for the termination of services.

The case manager may cancel the waiver if:

- Service needs exceed the aggregate monthly costs, service units, or reimbursement maximums.
- Needed services are not available or are not received from qualified providers.
- Another community resource is available to provide the service or a similar service free of charge that will meet the member's needs.
- Minimum service requirements are not met.
- The member no longer needs the service authorized. Waiver eligibility must be canceled if a member is receiving only one waiver service and no longer needs that service.
- The physical or mental condition of the member requires more care than can be provided in the member's own home, as determined by the case manager in consultation with the interdisciplinary team.
- The member's service needs are not met by the services provided.
- The member, legal guardian, or authorized representative requests termination of services.

Reinstatement of a Canceled Case

Legal reference: 441 IAC 7.7(249A), 7.7(6), 76 (Rules in Process)

Policy: Eligibility shall be reinstated without a new application when eligibility can be reestablished:

- Before the effective date of cancellation, or
- After the effective date of cancellation as allowed under Grace Period.

Comment: If you can process the information and make all necessary computer entries before the effective date of cancellation, the case can be reinstated even if the system does not process the information until after the effective date of cancellation.

On April 29, the worker discovers that the member has resources that are over the resource limit. Timely notice must be given (ten days in advance of the effective cancellation date). The worker cannot cancel this case effective May 1. The case remains active for the month of May and is canceled with an effective date of May 31.

If the member verifies that the resources are below the limit before June 1 (the effective date of cancellation) and meets all other eligibility requirements, the waiver case can be reopened without going through the application process.

Procedure: If the waiver case can be reinstated before the effective date of cancellation, no new level of care determination or service plan needs to be completed.
If the waiver case is not reinstated before the effective date of cancellation, treat it as a new application. In either situation, complete all IoWANS milestones on a timely basis.

Issue adequate and (if appropriate) timely notice whenever an attempt at reinstatement is made. See 8-A, *Notification* for notification requirements.

Grace Period

Legal reference: 441 IAC 76 (Rules in Process)

Policy: A "grace period" is a specific period of time during which a member has the opportunity to "cure" the reason for cancellation. The grace period is defined as the 14 calendar days immediately following the effective date of cancellation. If the fourteenth day falls on a weekend or state holiday, the fourteenth day is extended to the next working day for which there is regular mail service.

Eligibility on a canceled case shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the effective date of cancellation. Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

If the member is eligible, the effective date of assistance shall be the first day of the month following the month of cancellation. See 8-G, *Effect of Nonpayment of Premiums*. See 8-A, *Notification* for notification requirements.

Comment: The grace period does not apply to late payment of premiums or to noncooperation actions.

Cancellation reasons for which a grace period may apply include, but are not limited to, failure to provide information necessary to determine eligibility and inability to find the member.

If the case was closed because mail was returned or the Department was unable to find the member, a new application is not required if the household contacts the Department within the 14 days to provide a current Iowa address and eligibility can otherwise be established.

Procedure: Based on the circumstances of your case, take the appropriate action as follows:

- **No information provided**: When no information is provided by the 14th day after the effective date of cancellation, no further action is required.
- **Partial information provided**: When some of the information is returned, but there is still information needed to determine eligibility:
  - Attempt to contact the household to let the household know what is needed and that if the information is not received by the end of the grace period, the household will have to reapply. Document the contact. A written request for the previously requested information is not required.
  - If the information is not provided by the end of the grace period, no further action is necessary.
- **Requested information provided and a change has occurred**: If the original requested information is provided, but the household also reports a change for which verification is necessary:
  - Make every effort to verify the information and inform the member that you cannot make an eligibility determination unless the change is verified by the end of the grace period. Document the contact. A written request for the new information is not required.
  - If the new information is not verified by the end of the 14-day grace period, send a "Remain Canceled" notice. This is because the original reason for cancellation has been cured, but you cannot determine eligibility due to a change in circumstances that is required to be verified. Document your decision.
  - **Unable to verify change within grace period**: When an additional change is reported and it is unlikely the information can be verified by the end of the 14-day grace period, attempt to notify the member to file a new application. Document the contact.

NOTE: If a generic release is on file, it should be utilized, if possible.

Comment:

1. Mr. M, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice is issued to cancel the case effective May 1 for failure to provide requested information.

   Mr. M provides two of the items on April 17 and the third item on May 5. There have been no other changes in the household circumstances. Medicaid is reinstated for Mr. M effective May 1.

2. Ms. C, a Medicaid member, fails to provide two pieces of information requested by the Department. A notice to cancel the case is issued effective June 1 for failure to provide requested information. Ms. C provides the two items on July 17. Ms. C is not eligible to be reinstated. No additional notice is issued. Ms. C must reapply.

3. On April 1, Ms. G's level of care for the physical disability waiver is reviewed. It is determined that she no longer meets the level of care required. The IM worker receives a milestone indicating level of care is denied, closes the waiver, and issues a *Notice of Decision* dated April 2.

   Ms. G's case manager provides additional information to the IME Medical Services Unit on April 12. IME determines that Ms. G does meet level of care for the PD waiver and approves level of care effective April 12.

   The IM worker reopens the physical disability waiver case on April 14 because additional information was received to approve level of care within the 14-day grace period.

Appeal Rights

Legal reference: 441 IAC 83.9(249A), 83.29(249A), 83.49(249A), 83.69(249A), 83.89(249A), 83.109(249A), 83.129(249A)

Members in the HCBS programs have the same appeal rights as other members. See 1-E, *Appeals and Hearings*, for a description of appeal rights and the appeal process.

Eligibility for the AIDS/HIV HCBS Waiver

Legal reference: 441 IAC Chapter 83, Division III

The AIDS/HIV HCBS waiver pays for services for people with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection who would otherwise require care in a medical institution.

"AIDS" is the medical diagnosis "acquired immunodeficiency syndrome" described in the Center for Disease Control's "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of *Morbidity and Mortality Weekly Report*. *"HIV"* is the medical diagnosis "human immunodeficiency virus infection" based on a positive HIV-related test.

To be eligible for the AIDS/HIV waiver, a person must meet all of the following requirements:

- Be diagnosed by a physician as having AIDS or be infected with HIV. The IME Medical Services Unit is responsible for verifying the applicant's diagnosis.
- Be certified by the IME Medical Services Unit as in need of the level of care that would, but for the HCBS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility
  - Hospital
- Be eligible for Medicaid under one of the coverage groups listed below:
  - Non-MAGI
  - Children under 21 in the 300% group
  - Medically Needy if the level of care is hospital
  - 300% group or eligible for SSI but living in a medical institution. See 8-F, *People in a Medical Institution Within the 300% Income Limit*.
- Choose home- and community-based services instead of institutional care.
- Require and use at least one HCBS service quarterly, as determined by the member and the interdisciplinary team.
- Have service needs that can be met within the scope of the waiver and do not exceed the cap established for the HCBS AIDS/HIV program.

Eligibility for the Brain Injury Waiver

Legal reference: 441 IAC, Chapter 83, Division V

The brain injury (BI) waiver pays for services for people with a specific brain injury diagnosis to allow them to live in the community. To be eligible for the brain injury waiver, a person must meet all of the following requirements:

- Have a diagnosis of brain injury as verified by the case manager. See Definitions: Brain Injury, for a list of qualifying diagnosis. The IME Medical Services Unit will verify the brain injury diagnosis.
- Be at least one month of age.
- Be certified by the IME Medical Services Unit as in need of level of care that would, but for the HCBS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility
  - Intermediate care facility for persons with an intellectual disability
- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - Children under 21 in the 300% group
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution

- Choose home- and community-based services instead of institutional care.
- Require and use at least one HCBS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of this waiver and that do not exceed the cap established for the HCBS BI program.

Eligibility for the Children's Mental Health Waiver

Legal reference: 441 IAC, Chapter 83, Division VII

The children's mental health (CMH) waiver pays for services for children with a serious mental, behavioral, or emotional disorder. To be eligible for the CMH waiver, the child must meet all of the following requirements:

- Be diagnosed with a serious emotional disturbance. (See Definitions.)
- Be certified by the IME Medical Services Unit as in need of hospital level of care.
- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - Children under 21 in the 300% group
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution
- Be under 18 years of age.
- Choose home- and community-based services over institutional care.
- Require and use at least one HCBS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of this waiver and that do not exceed the cap established for the HCBS CMH program.

Integrated Health Homes

An Integrated Health Home (IHH) is a team of professionals working together to provide whole-person, patient-centered, coordinated care for adults with serious mental illness (SMI) and children with a serious emotional disturbance (SED). This includes those members enrolled in the Habilitation and Children's Mental Health waivers.

Currently, the waiver slot manager will assign the IHH as the CM in IoWANS.

Eligibility for the Elderly Waiver

Legal reference: 441 IAC Chapter 83, Division II

The elderly waiver pays for services to elderly Iowa residents so they can stay in the home instead of entering a nursing facility.

To be eligible for elderly waiver services, a person must meet all of the following requirements:

- Be 65 years of age or older.
- Be certified by the IME Medical Services Unit as in need of a level of care that would, but for the HCBS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility
- Be eligible for Medicaid as if the person were in a medical institution. See 8-I, *Medical Institutions*.
- Choose home- and community-based services over institutional care.
- Require and use at least one HCBS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of this waiver and that do not exceed the cap established for the HBCS elderly waiver program.

Eligibility for the Health and Disability Waiver

Legal reference: 441 IAC Chapter 83, Division I

The health and disability (HD) waiver pays for services for people who are blind or disabled to allow them to live in the community. To be eligible for the health and disability waiver, all of the following requirements must be met:

- Be either blind or disabled, as determined by the receipt of social security disability benefits or through the Department's disability determination process. See 8-C, *Presence of Age, Blindness, or Disability*.

  NOTE: People aged 65 or over are not eligible for the health and disability waiver. The elderly waiver is available statewide.
- Be certified by the IME Medical Services Unit as in need of level of care that would, but for the HBCS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility
  - Intermediate care facility for persons with an intellectual disability
- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution
- Choose home- and community-based services instead of institutional care.
- Require and use at least one HBCS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of the waiver and that do not exceed the cap established for the HCBS HD program.

Child Health Specialty Clinics

The Child Health Specialty Clinics (CHSC) is Iowa's statewide program for children and youth with special health care needs. The program's mission is to improve the health status of young people with known or suspected chronic illness or disability from birth to the twenty-first birthday. The program generally does not provide services for acute illness or primary well-child care.

The Department and the CHSC have entered into a written agreement that defines responsibilities of each party in the assessment, planning, and care coordination activities related to non MCO-enrolled applicants and members who are 21 or under. Specialized child health services offered by CHSC include:

- Expert diagnosis and evaluation
- Consultation and training for primary care providers
- Care coordination and related family support services

Clinics and services bring together experts from several agencies and many disciplines, including:

- Audiology
- Cardiology
- Hematology
- Nursing
- Nutrition
- Occupational therapy
- Orthopedics
- Otolaryngology
- Pediatrics
- Physical therapy
- Psychology
- Pulmonology
- Respiratory therapy
- Speech/language
- Other subspecialties

The services of CHSC are made available through 13 regional child health centers and through the CHSC central office, located in Iowa City. The locations, addresses, and phone numbers of the regional centers are listed on Internet at: https://chsciowa.org/.

For questions about these services, you may contact the CHSC central office by phone at 866-219-9119. For questions when enrolling a person age 21 or under in the HD waiver, contact the CHSC central office or a CHSC regional center.

Address correspondence to Health Service Coordinator, Child Health Specialty Clinics at the regional address.

Eligibility for the Intellectual Disability Waiver

Legal reference: 441 IAC Chapter 83, Division IV

The intellectual disability (ID) waiver pays for services to people with a primary diagnosis of an intellectual disability who would otherwise require care in a medical institution. To be eligible for the ID waiver, a person must meet all of the following requirements:

- Have a primary diagnosis of an intellectual disability, as verified by the case manager. The IME Medical Services Unit uses the required assessment tool and support documentation to determine level of care.
- Be certified by the IME Medical Services Unit as in need of the level of care that would, but for the HCBS program, would otherwise be provided in an intermediate care facility for persons with an intellectual disability (ICF/ID).

- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - Children under 21 in the 300% group
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution
  - Foster care
- Choose home- and community-based services instead of institutional care.
- Be receiving Medicaid case management services or be identified to receive case management services immediately following waiver enrollment.
- Require and use at least one HCBS service quarterly, as determined by the case manager, the member, and the interdisciplinary team.
- Have service needs that can be met within the scope of the waiver and that do not exceed the cap established by the HCBS ID waiver.

Residential-Based Supported Community Living Waiver Slot

Residential-based supported community living (RBSCL) is a separate service under the ID waiver which requires a specific slot separate from the ID waiver slot. The RBSCL slot does not transfer.

The case manager requests a residential-based support community living slot from the waiver slot manager.

Eligibility for the Physical Disability Waiver

Legal reference: 441 IAC, Chapter 83, Division VI

The physical disability (PD) waiver pays for services for people with a physical disability who would otherwise require care in a medical institution. To be eligible for the PD waiver, a person must meet all of the following requirements:

- Have a physical disability.
- Be blind or disabled as determined by the receipt of Social Security disability benefits or through the Department's disability determination process. See 8-C, *Presence of Age, Blindness, or Disability*.
- Be aged 18 through 64 years.
- Be certified by the IME Medical Services Unit as in need of level of care that would, but for the HCBS program, otherwise be provided in either a:
  - Nursing facility
  - Skilled nursing facility.
- Be eligible for Medicaid in one of the following coverage groups:
  - Non-MAGI
  - Children under 21 in the 300% group
  - MEPD
  - The 300% coverage group consistent with a level of care in a medical institution

- Be ineligible for the HCBS intellectual disability (ID) waiver.
- Choose home- and community-based services instead of institutional care.
- Have service needs that can be met within the scope of the waiver, and with the state supplementary assistance in-home health-related care program, if necessary, and that do not exceed the cap established for the HCBS PD program.
- Have the ability to hire, supervise, and fire the provider as determined by the service worker, and is willing to do so; or have a guardian named by probate court that will take this responsibility on behalf of the member.