# Medicaid for FIP-Related Persons

Iowa Department of Human Services

# Contents

This booklet is planned to answer some of the most commonly asked questions about Medicaid for Iowa FIP and FIP-related persons. Some of the information may be hard to understand, so if you have any questions, please talk to your county Department of Human Services worker.

## WHAT IS MEDICAID?

Medicaid is an assistance program that pays for certain medical and health care costs of persons who qualify. Medicaid is funded by the federal and state governments, and is managed by the Iowa Department of Human Services (DHS).

The Medicaid program is sometimes called the Title 19 program. This should not be confused with Medicare. Medicare is an insurance program managed by the federal Social Security Administration.

## DO I QUALIFY?

Most persons receiving benefits under the Family Investment Program (FIP) are eligible for Medicaid. The following persons and families may also qualify for Medicaid:

- Parents or relatives caring for children under the age of 18 who are income and resource eligible for FIP benefits but who do not receive FIP benefits.
- Persons "deemed" to be receiving FIP (persons not receiving cash assistance because their FIP check would be less than $10 or persons whose FIP benefits are suspended for one month).

- Children under the age of 21 who are income and resource eligible for FIP benefits but who do not receive FIP benefits.
- Families who become ineligible for FIP because of an increase in income from employment may continue to be eligible for Medicaid for up to 12 months after FIP benefits stop.
- Families who become ineligible for FIP due to child or spousal support may continue to receive Medicaid for four months after FIP benefits stop.
- A newborn child of a Medicaid-eligible mother may be continuously eligible for Medicaid until the child is one year old, as long as the child lives with the mother and the mother continues to be eligible for Medicaid or the mother would be eligible if she were pregnant.
- Pregnant women whose family income does not exceed FIP limits when the unborn child is counted in the household size.
- Certain persons who are not eligible for FIP due to FIP's standard filing unit policy.
- Women who were eligible for Medicaid because they were pregnant may be eligible for an additional 60 days of postpartum coverage after the end of the pregnancy.
- Pregnant women and infants (under one year of age) whose family income or resources are more than the FIP limits but whose family income does not exceed 185% of the federal poverty level and whose family resources do not exceed $10,000.
- Children over the age of one but under the age of six whose family income or resources are more than the FIP limits but whose family income does not exceed 133% of the federal poverty level and whose family resources do not exceed $10,000.

- Children over the age of six but under the age of 19 who were born after September 30, 1983, whose family income or resources are more than FIP limits but whose family income does not exceed 100% of the federal poverty level and whose family resources are not more than $10,000.
- Children in licensed foster care facilities for whom DHS has assumed financial responsibility in whole or in part.
- Persons for whom DHS is paying a subsidy under a subsidized adoption agreement.
- Persons who have too much income or resources to be eligible for cash assistance, but not enough to pay for medical expenses may be eligible for the Medically Needy Program. These persons may be required to pay a part of their medical expenses. For more information, please see the pamphlet "Medicaid for the Medically Needy", which is available from your DHS worker.

## *WHAT SERVICES ARE COVERED?*

The different types of services available through Medicaid are covered only if they are medically necessary. A detailed list and explanation of the services covered and not covered by Medicaid are included in the pamphlet "Your Guide to Medicaid" (available from your DHS worker).

## *CAN I CHOOSE MY DOCTOR?*

If you are in one of the groups described on pages 1 through 3 and, therefore, eligible for Medicaid, you may receive your medical services through traditional Medicaid or through one of Medicaid's managed health care options. In some counties, you will be required to choose a managed health care provider.

You generally have free choice of the doctor, dentist, hospital, etc. However, some service providers do not take part in the program. To avoid any misunderstanding concerning who will pay the medical bills, make sure you show your Medicaid card to the provider before receiving any medical care.

If you are enrolled with a MediPASS (Medicaid Patient Access to Service System) doctor you must get most services from that doctor or be referred by that doctor, unless it is an emergency.

Managed health care options such as MediPASS and HMO are only available in certain counties.

If you enroll in a Health Maintenance Organization (HMO) you must use the doctors and other providers who participate with the HMO, unless it is an emergency. Ask your worker about your choices and how to receive additional information about managed health care.

You may be required to receive mental health services and substance abuse services through a Medicaid managed health care option. Your medical card will have a message telling you this and phone numbers to call for these services. Make sure you show your Medicaid card to providers before receiving mental health or substance abuse services.

## WHAT IF I AM A MEDICARE BENEFICIARY?

If you are a Medicare beneficiary, Medicaid will pay for the Medicare deductible and coinsurance. DHS will also pay the Social Security Administration for Medicare Part B premiums. If you are a Qualified Medicare Beneficiary (QMB), DHS will also pay for your Mediare Part A premium.

## DO I PAY ANYTHING FOR MEDICAL CARE?

For some medical services you must pay the provider a small part of the total charges. This is called copayment. If copayment applies to the service you are receiving, the provider will tell you how much you must pay. You do not have to pay any copayment for covered services if you are enrolled in an HMO, and no copayment is charged to children under the age of 21 or pregnant women.

Except for copayment, all providers of service who participate in the Medicaid program are required to accept payments made through the program as payment in full for covered services. Please see the pamphlet "Your Guide to Medicaid" for information about what services are covered by Medicaid. No additional costs should be charged to you.

If you are on the Medically Needy program and have a spenddown (deductible), you will be responsible for paying those bills used to meet your spenddown.

If you belong to an HMO (described on p. 4) and use providers not affiliated with the HMO, you will be responsible for paying the bill, except for emergencies.

## *CAN I STILL QUALIFY IF I HAVE OTHER HEALTH INSURANCE*

You may still qualify for Medicaid even if you have other insurance. However, it is your responsibility to tell the county Department of Human Services office if you have other health insurance coverage. You should also tell your county office within 10 days if you change insurance companies, or if there is a change in what your insurance covers. This includes any insurance coverage carried by someone other than yourself which provides coverage for you.

If you have health or accident insurance, you and the medical provider (doctor, hospital, etc.) are expected to collect any settlement from the insurance and apply it to your medical costs. Bills must be sent to your insurance company first. If the insurance company doesn't pay the bill, or pays only part of the bill, Medicaid will consider paying the balance. Medicaid pays only for that part of your medical expenses which your own insurance or Medicare does not cover.

## *WHAT HAPPENS IF I RECEIVE A MEDICAL SETTLEMENT FROM ANOTHER SOURCE?*

It is also your responsibility to tell the Department of Human Services (and the HMO if you are enrolled in one) of any accident or injury that you suffer, if there is a possibility that you may receive a settlement or insurance payment because of the accident or injury.

By law, DHS does not need your permission to recover medical payments made on your behalf. The Department may make a claim against any person or company that may be responsible for paying the costs of your medical expenses. If you or your attorney request it, the Department of Human Services will provide documents or claim forms describing the medical services which have been paid for you. These documents may also be provided to a third party when necessary to establish the extent of the Department's claim.

If you receive a direct payment from another source for medical expenses that were already billed to Medicaid, you must refund this payment to the Department. Failure to do so, or failure to cooperate in establishing another person's or company's liability for your expenses can result in the termination of your Medicaid coverage.

## HOW AND WHERE DO I APPLY?

You may apply for FIP and FIP-related Medicaid at your county DHS office. *No separate application for Medicaid is necessary.*

If you are eligible for Medicaid, you will receive a monthly Medical Assistance Eligibility Card. The card is good only for the month indicated and must be shown every time you request service.

The card may be used only by the people listed on the card. If you lose your card, contact your DHS worker.

People who are enrolled in a managed health care option receive a special health plan identification card each month that lists the managed health care option they are enrolled in to show to providers when medical care is requested.

## HOW ARE PAYMENTS MADE?

DHS will send a check to the service provider for covered medical care you receive. When necessary medical care is not available in your community, reimbursement may be made for your transportation cost to the nearest provider. You should check with your DHS worker before traveling. You must file a claim with the county DHS office to receive reimbursement. To file a claim, you must get a form for travel reimbursement from your county worker. The form must be signed by the doctor who refers you to another community for medical services. The doctor that provides the service in the other community must also sign the form. You then return the form to your caseworker.

## *WHAT ARE MY RIGHTS AS AN APPLICANT OR CLIENT?*

### Appeals and Hearings

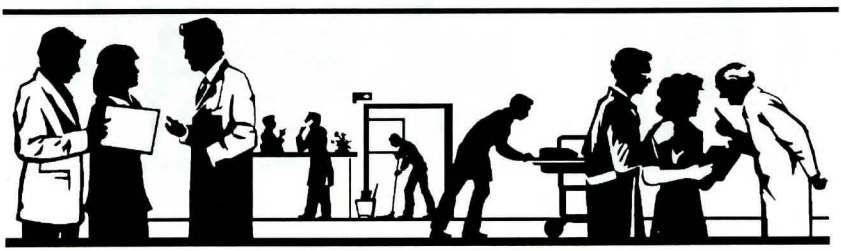
If you are dissatisfied with the actions or lack of action by the Department of Human Services, you should talk with your worker. If a satisfactory agreement cannot be reached, you have the right to file an appeal and ask for a hearing. If one is allowed, the hearing will be an informal meeting before an Administrative Law Judge from the Department of Inspections and Appeals in which you can present your complaint. All the facts will be received to see if the decision was correct or should be changed.

You may ask for a hearing by writing your county Human Services office or by writing to:

**Appeals Section, Bureau of Policy Analysis**
**Department of Human Services**
**Hoover State Office Building**
**Des Moines, IA 50319-0114**

Filing an appeal within 30 days of the date on the "Notice of Decision" you disagree with will protect your right to a hearing. Discussions with your worker or other Department staff do not extend this time limit.

Filing an appeal prior to the effective date on the "Notice of Decision" you disagree with may allow your Medicaid to continue until your appeal is heard.



## *WHAT ARE MY RESPONSIBILITIES?*

- Show your Medical Assistance Eligibility Card each time you request service from a health care provider.
- Inform health care providers of any other medical resources (Medicare, insurance, damage suits, etc.) that you may have.
- Inform your county DHS office of any changes in your medical resources (Medicare, insurance, damage suits, etc.)
- Inform your county DHS office of any changes in your address, income or resources, household size (marriages, births, pregnancies, deaths), or any other change that may affect your eligibility or amount of benefits.
- Provide information and proof, when DHS requests.
- File a claim or application for any medical resource which may be available to you. You must also cooperate in the processing of the claim or application.
- Refund to the Department any money that you receive from a person or company to pay medical expenses which would otherwise be paid by Medicaid.
- Prompt reporting (within 10 days) of changes that might affect your eligibility will help protect you from possible charges of fraud for receiving benefits to which you are not entitled.
- Enroll in cost-effective employer group health plans when DHS asks you to do so.

## Nondiscrimination Policy

No person shall be discriminated against because of race, color, national origin, sex, age, mental or physical disability, creed, religion, or political belief when applying for or receiving benefits or services from the Iowa Department of Human Services or any of its vendors, purchase-of-service providers, or contractors.

If you have reason to believe that you have been discriminated against for any of the above reasons, you may write to the Iowa Department of Human Services, the Iowa Civil Rights Commission (if you feel you were treated differently **BECAUSE OF** your race, creed, color, national origin, sex, religion, or disability), and/or the United States Department of Health and Human Services.

**Office of Equal Opportunity**
**IOWA DEPARTMENT OF HUMAN SERVICES**
**Hoover State Office Building, 5th Floor**
**Des Moines, IA 50319-0114**

**IOWA CIVIL RIGHTS COMMISSION**
**211 E. Maple Street, 2nd Floor**
**Des Moines, IA 50309-1858**

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Office for Civil Rights, Region VII**
**601 E. 12th Street, Room 248**
**Kansas City, MO 64106**

*Printed on Recycled Paper*

*Comm. 27 (Rev. 11/95)*