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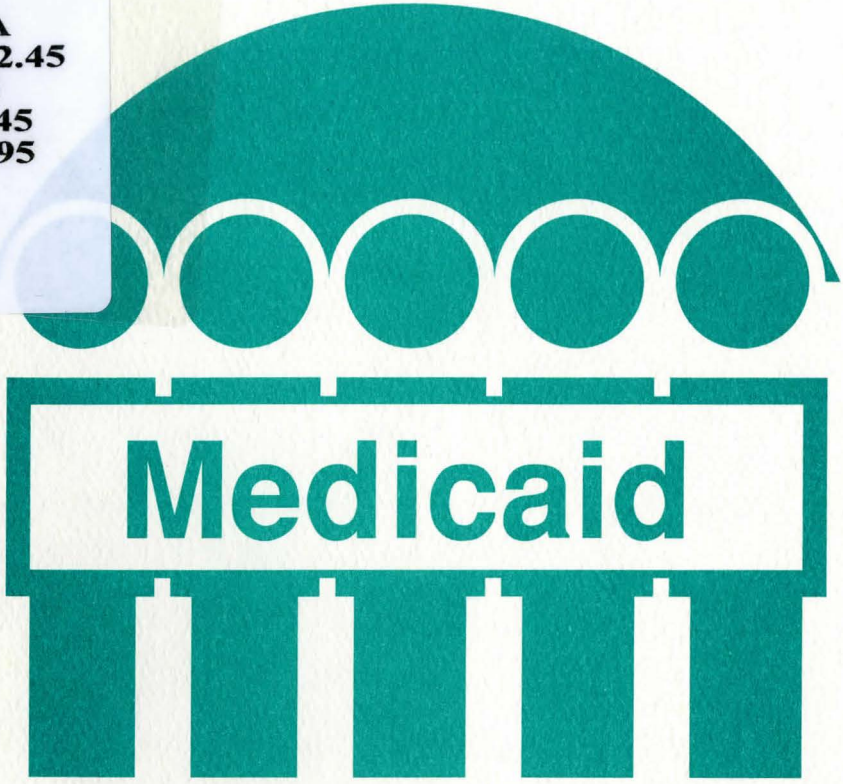

for the Medically Needy

Contents

Medicaid for the Medically Needy

WHAT IS MEDICAID?

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

WHAT IS MEDICALLY NEEDY?

"Medically Needy" is a program designed to provide medical coverage for you if you have either limited income or high medical expenses that use up most of your income. If you have too much income or resources to be eligible for cash assistance, but not enough to pay for medical expenses, you may qualify under the Medically Needy program.

The Medically Needy program may not pay all of your medical expenses. You may be responsible to pay some of your medical expenses.

WHO IS ELIGIBLE?

Pregnant women

You may qualify for the Medically Needy program if:

- You are pregnant **and**
- Your income exceeds the Mothers and Children (MAC) program income limits and your resources do not exceed $10,000.

People under 21

You may qualify for the Medically Needy program if:

- You are under 21 **and**
- You would be eligible for the Family Investment Program (FIP), the Child Medical Assistance Program (CMAP), or MAC except that your income or resources exceed limits.

People who are aged, blind, or disabled

You may qualify for the Medically Needy program if:

- You would be eligible for Supplemental Security Income (SSI) except that your income or resources exceed limits **and**
- You are age 65 or older **or**
- You are legally blind, with central visual acuity of 20/200 or less in the better eye with the use of corrective lens, **or**
- You are disabled with a physical or mental impairment which prevents you from working and has lasted or is expected to last a continuous period of at least 12 months.

Adults who care for dependent children under age 18 (19 if still in school)

You may qualify for the Medically Needy program if:

- You are a caretaker relative (parent, incapacitated stepparent, aunt, uncle, or grandparent, etc.) of a dependent child under age 18, or under age 19 if still in school, **and**
- You would qualify for FIP except that your income or resources exceed FIP limits.

WHAT ARE THE PROGRAM REQUIREMENTS?

To qualify for Medicaid under the Medically Needy program, the resources of household members must be within certain limits, and the income must be equal to or less than the Medically Needy Income Level (MNIL) or the income must be spent down to the MNIL.

➧ **Resources: If you are *pregnant, or under age 21, or a caretaker relative,*** your resources must not exceed $10,000 for one or more persons. Countable resources for pregnant women, persons under age 21, and caretaker relatives include, but are not limited to, the following monetary resources:

- cash
- checking and savings accounts
- stocks and bonds
- certificates of deposit (CDs)

Medicaid qualifying trusts may be considered toward the resource limit for pregnant women, persons under age 21, or caretaker relatives. Your DHS worker can explain Medicaid qualifying trusts to you. Internal Revenue Service-defined retirement plans such as Individual Retirement Accounts (IRAs) and Keough plans are excluded.

If you are *aged, blind, or disabled,* your resources may not exceed $10,000 for one or more persons. Countable resources for aged, blind, or disabled people are things you own, such as:

- cash
- savings and checking accounts
- stocks, bonds and certificates of deposit (CDs)
- real estate you are not living on
- contracts for the sale of real property
- household goods and personal property in excess of $2,000
- the value of your car
- the cash value of some of your life insurance policies

Medicaid qualifying trusts may be considered towards the $10,000 resource limit for aged, blind, or disabled people. Your DHS worker can explain Medicaid qualifying trusts to you.

- **Income:** The earned and unearned income of all responsible relatives (parents and stepparents) and of all other potentially eligible family members is counted. FIP income policies, except for the income limit, are used if you are pregnant, under the age of 21, or a caretaker relative. SSI income policies, except for the income limit, are used if you are aged, blind, or disabled.

- **Medically Needy Income Level (MNIL):** The Medically Needy Income Level is 133% of the FIP payment based on family size according to federal regulations. The MNIL applies regardless of whether the family members are FIP- or SSI-related. The MNIL is subject to change.

Number of Persons	Medically Needy Income Level
1	$ 483
2	483
3	566
4	666
5	733
6	816
7	891
8	975
9	1,058
10	1,158

For each additional person, add $116.

If your total net countable income is equal to or less than the MNIL, all eligible members of your family will qualify for Medicaid without a spenddown.

If your total net countable income exceeds the MNIL, you will be required to meet a *spenddown* (which is like a deductible) to qualify for Medicaid through the Medically Needy program. If you pay health insurance premiums or have medical bills, these may be used towards meeting your spenddown. This process can bring your income down to the MNIL. The examples on the next page show how this works.

- **Certification period:** If you must meet a spenddown, you will be given a two-month certification period. If you do not have a spenddown to meet and you are FIP-related, you will be given a six-month certification period.

At the end of each certification period, you must file a new application and meet all eligibility requirements again.

- **Ongoing Eligibility:** If you are SSI-related and you are determined to have zero spenddown and continue to meet eligibility requirements, your eligibility continues. You will be asked to complete and return a review form once every 12 months.

- **Retroactive Eligibility:** If you have unpaid medical bills during the three months before your application, you may also be eligible for Medicaid during those three months. Tell your worker which months you received medical services that you paid and also those that you still owe.

Example 1

Household members:	4-member Smith family (CMAP-related)	
Certification period:	November and December	
Net countable income: (After deductions)	$600 + 500 =	$1,100
MNIL for 4-member household:	$666 + 666 =	- 1,332
Spenddown:		0

Because income is less than the MNIL in the first two months, then the six months' income is compared to the six months' MNIL for the household size. If the income is again less than the MNIL, a six-month certification period will be set.

This means the Smith children will receive medical cards for a six-month certification period (November through April).

Example 2

Household members:	3-member Jones family (FIP-related)	
Certification period:	January and February	
Net countable income: (After deductions)	$600 + 666 =	$1,266
MNIL for 3-member household:	$566 + 566 =	- 1,132
Spenddown:		134

Because income is more than the MNIL, the Jones family must have $134 in medical expenses before they can qualify for Medicaid. The $134 is the amount of their spenddown (or deductible) for the two-month certification period of January and February. The Joneses have a $300 doctor bill in January. $134 of the bill is applied towards spenddown. Medical cards for January and February are issued saying which members of the Jones family are eligible. The portion of the doctor bill that was not used for meeting the spenddown may be submitted for payment. The Joneses are responsible to pay the doctor $134.

HOW IS THE SPENDDOWN MET?

Medicare and other health insurance premiums are deducted from the spenddown at the time of certification.

If you must meet a spenddown, your worker will give you *Medical Expense Verification* forms (MEVs). Take the MEVs to medical providers who you are legally obligated to pay. Have the medical provider complete the MEVs for conditionally eligible persons or responsible relatives on your case. Your Notice of Decision tells you who is conditionally eligible and who the responsible relatives are.

Medical expenses for which you are legally obligated to pay can be used to meet the spenddown. They are as follows:

1. Deductibles or coinsurance charges.
2. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid.
3. Medical expenses for necessary medical and remedial services that are covered by Medicaid.
4. Medical expenses paid in a certification period by state public programs other than Medicaid.

The above medical expenses may be used in the following circumstances:

These expenses can be used if they were incurred during the current certification period. An expense is "incurred" when the service is provided to you. Expenses incurred in the certification period may be paid or unpaid.

Expenses incurred prior to the time you were first certified for Medically Needy can be used for spenddown at any time as long as the expense remains unpaid, you are still obligated to pay it, and the expense was not previously used to meet spenddown.

Expenses incurred in the retroactive certification period but not needed to meet spenddown in the retroactive period can be used for spenddown in the certification period immediately following the retroactive period. These expenses from the retroactive period may be paid or unpaid.

Expenses incurred in a regular certification period when spenddown was met may be used to meet spenddown in a later certification period(s) if:

- the spenddown(s) in the previous certification periods were met;

- the expense was not previously used to meet spenddown;
- the expense was not payable by Medicaid (such as bills for a responsible relative); and
- you remain obligated to pay the expense.

An expense incurred in a regular certification period when spenddown was not met cannot be used in any later certification periods.

You will be asked to provide proof of your medical expenses. You will need to ask the provider to complete the MEV. Contact your worker if the provider will not complete the MEV.

After the MEVs are processed, you will receive a *Notice of Spenddown,* which explains to you which bills were applied to your spenddown and if your spenddown was met. Once the spenddown has been met, you will receive your Medical Assistance Eligibility Card(s) for the month(s) of your certification period. You should take the Medical Assistance Eligibility Cards to the providers where you have unpaid medical expenses that occurred during the month on the Medical Assistance Eligibility Card.

Medical expenses used in full for meeting the spenddown requirements are not payable by Medicaid. When part of the medical expense has been used to meet the spenddown, the remaining portion of the medical expense that was not used to meet spenddown may be payable by Medicaid. **It is your responsibility to pay the provider when an unpaid medical expense has been used to meet spenddown.**

WHAT MEDICAL SERVICES ARE AVAILABLE?

People eligible for Medicaid through the Medically Needy program are eligible for all services covered by Medicaid except:

- Care in nursing facilities or in intermediate care facilities for the mentally retarded or skilled nursing facilities.
- Care in a facility licensed for psychiatric care.
- Rehabilitative treatment services (for family preservation, family-centered services, family foster care and group care).

Medicaid covers most services which are medically necessary. A detailed list and explanation of the services covered and not covered by Medicaid is included in the pamphlet Your Guide to Medicaid. Please ask your DHS worker for a copy.

MUST I PAY ANYTHING FOR MEDICAL CARE?

If you are eligible for Medicaid, you may have to 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 the amount you must pay.

There is no copayment for people who are pregnant or under the age of 21, or for family planning services and supplies.

Except for copayment, all providers of service who participate in the Medicaid program are required to accept payments made by the Medicaid program as payment in full for covered services. No additional costs should be charged to you for services that Medicaid paid.

However, if you become eligible for Medicaid with a spenddown, you will be responsible for those medical expenses which reduce your income to the Medically Needy Income Level and for any other medical expenses you incurred that are not Medicaid-covered services. Services provided when the recipient is not covered by Medicaid are not payable.

It is possible for you to be conditionally approved for Medicaid with a spenddown and not receive a Medical Assistance Eligibility Card until after the certification period has ended. If this happens, and you need to see a doctor during the certification period, check with your provider to see if they will accept your card when you become eligible, so that the medical bill may be paid by Medicaid once your spenddown is met. You would be responsible for the amount of the spenddown.

WHAT HAPPENS IF I HAVE HEALTH INSURANCE, MEDICARE, OR RECEIVE A MEDICAL SETTLEMENT FROM ANOTHER SOURCE?

The fact that you have other insurance coverage does not affect your eligibility for Medicaid. **However, it is your responsibility to keep your worker at your county DHS office informed of any health insurance coverage that you may currently have**. You should also contact your county DHS office within 10 days if you change insurance companies, or if there is a change in who or what your insurance policy covers. This includes health insurance carried by you or by someone other than yourself which provides coverage for you.

Medicaid will pay your Medicare Part B premium if you are a Qualified Medicare Beneficiary, if you are a Specified Low Income Medicare Beneficiary, if you have a zero spenddown, or if you have met your spenddown.

If you have a zero spenddown and your health insurance premium was not used to reduce your spenddown to zero, you may be eligible to have Medicaid pay your premium. Ask your worker about the Health Insurance Premium Payment Program.

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. Medicaid pays only for that part of your medical expenses which your own insurance or Medicare does not cover.

It is also your responsibility to advise your county DHS office of any accident or injury that you may suffer, if there is a possibility that you may receive a settlement or cash payment because of the accident or injury.

By law, DHS does not need your consent to recover medical payments made on your behalf. DHS 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, DHS 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 DHS'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 DHS. 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.

WHERE DO I APPLY?

You may apply for the Medically Needy program at the DHS office in the county in which you live.

HOW LONG DO I HAVE TO WAIT BEFORE I HEAR ABOUT ELIGIBILITY?

If you have a zero spenddown, medical cards are issued after a decision on eligibility is made. DHS usually has 45 days to make a decision on eligibility for Medically Needy. For cases based on disability, DHS has 90 days to make a decision. If you do not hear about conditional eligibility or eligibility within 45 days (or 90 days in the case of disability), **you have a right to file an appeal**. See the section on page 14 and 15 for information on filing an appeal.

WHAT DO I TELL MEDICAL PROVIDERS BEFORE I MEET MY SPENDDOWN?

In some cases, you may need to get medical care before you have met your spenddown. When this happens, tell your provider that you have applied for Medically Needy. Also tell your provider that if you are found eligible and meet your spenddown, Medicaid **may** pay for the service to be provided. Tell the provider that you will have to pay for services used to meet the spenddown.

A form stating that you have applied for Medically Needy benefits and may be eligible after you meet your spenddown is available from your caseworker. You will not automatically be given this form; **you must ask for it**. If you apply for Medically Needy benefits and believe you will have a spenddown, you can ask your caseworker for a copy of this form to show providers so the providers know you **may** be eligible for Medicaid.

CAN I CHOOSE MY OWN MEDICAL PROVIDER?

You generally have a choice of the doctor, dentist, hospital, etc. that provides you medical services. However, if the provider does not participate in the Medicaid program, the services you are given will not be paid for by Medicaid. To avoid any misunderstanding about payment, make sure the provider you select participates in the Medicaid program.

If you or anyone in your household needs mental health services, you are under the Mental Health Access Plan unless you are age 65 or older; you are enrolled in an HMO; you reside in a PMIC or ICF/MR; or you have a spenddown. You will need to call the number on your Medicaid medical card before receiving mental health services. Look at your Medicaid medical card each month you receive it. If you need to call before receiving mental health services there will be a message on the card including the phone number. If there is not a message on your Medicaid medical card you are not under the Mental Health Access Plan and you may choose your own provider for mental health services.

WHAT HAPPENS WHEN I AM ELIGIBLE FOR BOTH MEDICARE AND MEDICAID?

Medicaid pays your Medicare Part B premiums when you are a Qualified Medicare Beneficiary, or a Specified Low Income Medicare Beneficiary, or you have a zero spenddown, or after you have met your spenddown. This is called "buy-in" for Medicare. Ask your worker when the buy-in will occur. **Be sure to tell your provider that you have Medicare and Medicaid coverage. This will help the provider in the billing process.**

HOW DO I GET MEDICAL CARE?

You will receive a Medical Assistance Eligibility Card when you have a zero spenddown or when you have met your spenddown. The card is good only for the month indicated. You must present it every time you request service. If you received the card after the month stated on it, and if you still have unpaid medical expenses for that month that were not used to meet spenddown, you may present the card to the provider and they can bill Medicaid. Your card may not be used by people other than those listed on the card. If you lose your card, please contact your county DHS office.

HOW ARE PAYMENTS MADE?

DHS sends a check to the medical provider for services you receive that are covered by Medicaid. When necessary medical care is not available in your community, to be reimbursed for your transportation cost to the nearest provider you should check with your DHS worker before you leave.

You must file a claim with your worker promptly and on a special form in order to receive payment. Ask your worker which form you need to use before you go to the provider.

WHAT HAPPENS IF I PAY THE PROVIDER?

Under Medicaid rules, **DHS will not pay you back if you pay the provider for services.** This means that if you pay the provider, you will not be reimbursed by Medicaid. Exception: Reimbursement may be made after a successful appeal of denial of eligibility. This reimbursement is made only for Medicaid covered services when the bill was paid between the date of denial and a subsequent notice of approval due to the appeal decision.

WHAT ARE MY RESPONSIBILITIES?

- Assist in providing verification of medical expense to be used in meeting your spenddown.
- Apply for and accept any cash benefits to which you are entitled.
- Present your Medical Assistance Eligibility Card each time you request service from a medical provider, unless you are conditionally eligible and have not met your spenddown.
- After spenddown has been met, Medical Assistance Eligibility cards are mailed to you. Notify providers to whom you owe bills, that you are now Medicaid eligible. Give the provider your ID number that is on the card.
- Inform your medical providers of any medical resources that you have (Medicare, insurance, damage suits, etc.).
- Inform your county DHS office of changes in your medical resources.
- Inform your county DHS office of changes in your address, income or resources, household size (marriage, pregnancy, births, deaths, people moving in), or any other change that may affect your eligibility or amount of benefits.
- Cooperate with the Child Support Recovery Unit to establish paternity or obtain support for children under 18.

- File a claim or application for any medical resources that may be available to you. You must also cooperate in the processing of a claim or application.
- Refund to DHS any money that you receive from a person or company to pay medical expenses which would otherwise be paid by Medicaid.
- Pay copayment and medical expenses used in meeting your spenddown.

Failure to meet your responsibilities as a Medicaid client can result in denial of claims or cancellation of your Medicaid benefits. If Medicaid pays for services for which you were not eligible, you will be required to repay Medicaid.

WHAT ARE MY RIGHTS?

- To have the Medically Needy coverage group explained.
- To have the county office of the Department of Human Services serving your area accept your application in person or by mail. You may have anyone you choose help you in applying for assistance.
- To be treated with dignity and respect.
- To have questions answered promptly and courteously.
- To receive a written decision within 45 days, if you have timely given all necessary information.
- To request an appeal hearing in writing if you disagree with any action of the county office.
- To have information about your family kept private.
- To receive help, if eligible, regardless of your race, color, national origin, sex, age, religion, creed, mental or physical disability, or political belief.

WHO DO I CONTACT WHEN THERE ARE PROBLEMS WITH MY MEDICALLY NEEDY ELIGIBILITY?

1. You should contact your worker at your county DHS office if you have any problems or questions about Medicaid eligibility.

2. If your worker is unable to give an answer to your question, you should contact the worker's supervisor.

3. In some cases, such as when a doctor is billing you for a Medicaid service, or payment for a bill is denied by Medicaid, you should call the toll free number on the back of your medical card.

USE OF THE MEDICAID TOLL-FREE HOT LINE

On the back of your Medical Assistance Eligibility Card, there is a toll-free telephone number (**1-800-532-1215**) to help you resolve unpaid bills that you thought Medicaid should have covered. The person who answers this line will take down the information about your bill and submit it to the Division of Medical Services for review and reconsideration.

Before you call the Medicaid hot line, you should have the following information in front of you: the medical bill, a brief description of what services were provided, and your or your family member's State Identification Number listed on your Medical Assistance Eligibility Card.

Do not use this hot line to ask questions concerning Medicaid policy or if medical procedures or equipment are covered by Medicaid. Direct these questions to your county DHS worker or to your medical provider.

APPEALS AND HEARINGS

When DHS makes a decision on your case, you will be sent a Notice of Decision. The Notice of Decision tells you whether you are eligible, conditionally eligible or not eligible for Medically Needy. If you have a spenddown, it will tell you the amount.

If you feel the Notice of Decision is incorrect, you may file an appeal within 30 days of the date on the notice which will protect your right to a hearing. Discussions with your worker or other DHS staff do not extend this time limit.

You may file an appeal to ask for a hearing by **writing** to your county DHS office or by **writing** to:

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

Filing an appeal before the effective date on the Notice of Decision can allow your benefits, including Medicaid, to continue until your appeal is heard or decided.

If a hearing is allowed, it 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 reviewed to see if the decision was correct or should be changed.

You may be eligible for free legal assistance with your appeal. Contact Legal Services Corporation of Iowa (LSCI) at 1-800-532-1257 if you need assistance. Contact the Legal Aid Society of Polk County (LASPC) at 243-1193 if you live in Polk County and need assistance.

DHS Policy on Nondiscrimination

No person shall be discriminated against because of race, color, national origin, sex, age, physical or mental 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, service providers, or contractors.

If you have any 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.

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

IOWA CIVIL RIGHTS COMMISSION
211 E Maple St 2nd Fl
Des Moines IA 50309-1858

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Civil Rights Region VII
601 E 12th Street Rm 248
Kansas City MO 64106

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