MEDICAID FOR THE QUALIFIED MEDICARE BENEFICIARY

How Medicaid
can help pay
your Medicare
premiums,
deductibles
and
coinsurance

Iowa Department of Human Services

CONTENTS

Introduction

This pamphlet answers some questions on the "Qualified Medicare Beneficiary Program" (QMB). Some of the answers may be difficult to understand. If you have more questions, please contact your county Department of Human Services worker. (See page 4 for information about Specified Low Income Medicare Beneficiaries (SLMB), Expanded-Specified Low Income Medicare Beneficiaries (E-SLMB), and Home Health-Specified Low Income Medicare Beneficiaries (HH-SLMB).

What is Medicaid

Medicaid is an assistance program which pays certain medical and health care cost 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 the QMB program?

Under the QMB program, Medicaid pays Medicare premiums, deductibles and coinsurance for persons who are qualified Medicare beneficiaries. Medicaid will only pay for premiums, deductibles and coinsurance for medical services that are covered by Medicare.

WHO IS A QUALIFIED MEDICARE BENEFICIARY?

If you are entitled to Medicare Part A and your resources and income are within QMB limits, you could be eligible as a qualified Medicare beneficiary.

What does 'entitled to Medicare Part A' mean? To be 'entitled to Medicare Part A' means you are enrolled in Medicare (age 65 or older, blind, or disabled for two years) and eligible to receive Medicare Part A benefits.

If you do not know whether you are eligible for Medicare Part A, you can check with the Social Security office by calling **1-800-772-1213**.

What do you mean by resources? Resources are things you own, such as a house you are not living in, personal property, stocks and bonds, savings and checking accounts, or cash. The equity value of your car and the cash value of life insurance policies may also be considered in determining the amount of your resources. Not all resources are counted in the resource limit. A single person can qualify with countable resources of up to $4,000. A couple can qualify with countable resources of up to $6,000.

How does income affect eligibility? You must report all income for consideration by DHS, including interest, lump sums, earned and unearned income (such as Social Security, Veteran's Benefits or annuities), and the income of your spouse. You must also report the income of all family members who qualify for the QMB program. Your countable income must be equal to or less than the QMB income level in order to qualify for Medicaid under the QMB program.

The Social Security cost of living increase is not counted as income for the first three months of the calendar year for QMB eligibility.

The QMB monthly income level is 100% of the federal poverty income level. Please check with your worker for the QMB monthly income levels.

> **Example:** Mr. and Mrs. Smith apply for the QMB program on May 7. Both are enrolled in Medicare Part A. Their countable income is less than the QMB income level for a couple. They have countable resources which are less than the resource limits for a couple. Mr. and Mrs. Smith can qualify for Medicaid under the QMB program.

Note: To qualify for the QMB program you must also apply for, or be receiving, all other benefits for which you are eligible. Other benefits include Social Security, Iowa Public Employees Retirement System (IPERS), Railroad Retirement, Veteran's Benefits, pensions from private employment, etc.

WHAT IF MY INCOME OR RESOURCES ARE TOO HIGH FOR QMB?

If your total countable income or resources are higher than the QMB limits, you may still qualify for Medicaid under the Medically Needy program. You may qualify for Medically Needy if you have medical bills which bring your income down to the Medically Needy income level. Bringing your income down in this way is called a spenddown or deductible. You are responsible for paying your medical bills up to the spenddown amount. The amount of medical expenses that exceed the spenddown may be payable by Medicaid. See the pamphlet "Medicaid for the Medically Needy" for more information (available from your DHS worker).

If your total countable income is higher than the QMB limits, you may qualify for the Specified Low Income Beneficiary (SLMB) coverage group. The SLMB income limit is over 100% but less than 120% of the federal poverty level. SLMB pays only for your Medicare Part B premium. If you are over income for QMB, ask your DHS worker about SLMB.

If your income is higher than the SLMB limits, you may qualify for the Expanded-SLMB (E-SLMB) coverage group. The E-SLMB income limit is 120% but less than 135% of the federal poverty level. E-SLMB also pays only for your Medicare Part B premium. Ask your DHS worker about E-SLMB.

If your income is higher than the E-SLMB limits, you may qualify for the Home Health-SLMB (HH-SLMB) coverage group. The HH-SLMB income limit is 135% but less than 175% of the federal poverty level. HH-SLMB pays only for the home health portion of your Medicare Part B premium.

If you are eligible for HH-SLMB, the home health portion of the Medicare Part B premium will be paid on an annual basis. Ask your DHS worker about HH-SLMB.

CAN I CHOOSE THE MEDICAL PROVIDER?

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

WHAT MEDICAL SERVICES ARE COVERED

When you qualify for Medicaid under the QMB program, you are entitled to limited Medicaid coverage. This means **Medicaid will pay only for the Medicare premiums, deductibles and co-insurance for medical services covered by Medicare**.

MUST I PAY ANYTHING FOR MEDICAL SERVICES?

All medical providers who participate in the Medicaid program are required to accept payments made through the program as payment in full for services covered by Medicaid. **No additional cost should be charged you**, unless you receive medical services that are not covered by Medicare. If you receive medical services that are not covered by Medicare, then Medicaid will not pay for them.

For a list of services covered by Medicare, you should get "The Medicare Handbook" from the Social Security Administration. For a copy of the handbook, you can call **1-800-772-1213**. If you have a specific question on Medicare's payment of medical services or the status of a medical claim, you can call the Medicare carrier for Iowa at 1-800-532-1285.

How are payments made?

After you qualify for the QMB program you will receive a "Medical Assistance Eligibility Card." The card is good only for the month indicated. Carry your card with you and show it to the medical provider every time you request service. Your card may not be used by people other than the individual listed on the card. If you lose your card, contact your county DHS office.

The medical provider will bill the Medicaid program. Payment for Medicare deductibles and co-insurance will be sent directly to the provider.

Where do I apply?

You may apply for the QMB program at the Department of Human Services office located in the county where you live.

When will coverage begin?

QMB coverage can begin the first day of the month following the date the county DHS office approves your application for the QMB program. The approval process may take up to 30 days. If you need assistance with medical bills prior to this time, discuss it with your DHS worker when you apply.

Example: Mr. Kent applied for the QMB program on March 15. The county DHS office approved his application on April 10. The first day of coverage is May 1.

CAN I STILL QUALIFY IF I HAVE HEALTH INSURANCE?

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

If you have health or accident insurance, you and the medical care provider (doctor, hospital, etc.) are expected to collect any settlement from the insurance company and apply it to your medical cost. Medicaid pays only for the part of your medical expenses that your own insurance or Medicare does not cover.

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

It is your responsibility to advise the 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 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 cost 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.

WHAT ARE MY RIGHTS AS AN APPLICANT OR CLIENT?

Appeals and Hearings: If you are dissatisfied with the actions or lack of action by DHS, you should discuss the matter with your DHS worker. If a satisfactory agreement cannot be reached, you have a 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 reviewed to see if the decision was correct or should be changed.

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

Appeals Section
Department of Human Services
Division of Policy Coordination
Hoover State Office Building, 5th Fl
Des Moines, IA 50319-0114

Filing an appeal within 30 days of the date on the "Notice of Decision" that you feel is incorrect can protect your right to a hearing. **Discussions with your worker or other DHS staff <u>do not</u> extend this time limit**.

Filing an appeal prior to the effective date on the "Notice of Decision" that you feel is incorrect can allow your benefits, including Medicaid, to continue until your appeal is heard or decided.

POLICY ON NONDISCRIMINATION: 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, 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:

Office of Equal Opportunity
Department of Human Services
Hoover State Office Building, 1st Fl
Des Moines, IA 50319-0114

WHAT ARE MY RESPONSIBILITIES?

Present your Medical Assistance Eligibility Card each time you request service from a medical provider.

Inform your county DHS office of any changes in your address, income, resources or household size (marriage, births, deaths) and any other change that may affect your eligibility or amount of benefits (such as the income and resources of other persons that are considered in determining your Medicaid eligibility). Please report any changes within 10 days for someone currently receiving benefits and within 5 days for any applicant.

Inform your medical providers of any medical resources that you have (Medicare, insurance, damage suits, etc.).

Notify your county DHS office within 10 days of any changes in your medical resources or health care coverage. You may be required to provide information and proof of any medical resources available to you.

File a claim or application for any income or medical resource that may be available to you. If required, you must also cooperate in the processing of any such claim or application.

Refund to DHS any money that you receive from a person or company to pay medical expenses that would otherwise be paid by Medicaid.

Failure to comply with your responsibilities can result in denial or cancellation of Medicaid. It may also result in the establishment of overpayments for which you will be responsible, or possible prosecution for fraud.

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