3410. MEDICAID ELIGIBILITY FOR QUALIFIED SEVERELY IMPAIRED INDIVIDUALS AND INDIVIDUALS IN '1619 STATUS

Under §201 of the Social Security Disability Amendments of 1980 (P.L. 96-265) enacted on June 9, 1980, certain disabled individuals who would have lost Supplemental Security Income (SSI) benefits or federally administered State supplementary payments, where applicable, because of their work activity could continue to receive special SSI benefits. If a disabled or blind individual's earnings were too high to receive the special SSI payment (or regular SSI payment, if blind) and/or federally administered State supplementary payments, they could continue to receive Medicaid benefits, under criteria prescribed under §1619 of the Social Security Act (the Act).

Under §1619(a) of the Act, disabled individuals who would otherwise have lost SSI because of work and the demonstration of the ability to perform substantial gainful activity, but continued to have a disabling impairment, could continue to receive special SSI benefits if they continued to be financially eligible for SSI benefits or State supplementary payments, based on their income. However, §1619(b) of the Act allowed disabled individuals whose income was too high to retain financial eligibility for the special SSI benefit under §1619(a) and blind individuals who lost regular SSI payments and/or federally administered State supplementary payments where applicable, to continue to receive Medicaid benefits under certain criteria specified in §1619(b) of the Act.

Section 1619 of the Act, as authorized by §201(a) of P.L. 96-265, was intended as a work incentive demonstration project to expire December 31, 1983. Subsequently, §14(a) of the Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460) extended the expiration date of §1619 of the Act without modification to June 30, 1987.

Section 9404 of the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) enacted on October 21, 1986, amended the Medicaid statute at §§1902(a)(10)(A)(i)(II) and 1905(q) of the Act to require States to cover certain "qualified severely impaired individuals" under Medicaid. For purposes of Medicaid eligibility, qualified severely impaired individuals are defined using language which is virtually identical to language which defines individuals as stated in the existing §1619(b) of the Act.

Prior to enactment of OBRA 1986, in States that cover individuals receiving SSI payments, an individual's §1619 status would automatically confer Medicaid eligibility. However, in States that cover individuals under more restrictive requirements than used in the SSI program (under the authority of §1902(f) of the Act), an individual's §1619 status did not confer automatic Medicaid eligibility. Section 7 of the Employment Opportunities for Disabled Americans Act (EODAA) (P.L. 99-643) enacted on November 10, 1986 revised Medicaid eligibility requirements for individuals in §1619 status in such States.

Finally, with the enactment of §2 of EODAA, §1619 of the Act was made permanent.

3411. PROVISIONS OF OBRA 1986 AND EODAA

Section 9404 of OBRA 1986 amends §§1902(a)(10)(A)(i)(II) and 1905(q) of the Act to make the Medicaid statute virtually identical to the §1619(b) provisions in SSI statute. With the enactment of §2 of EODAA, which makes §1619 permanent, individuals who are eligible or who become eligible under §1619 for SSI and Medicaid benefits will continue to be eligible for those benefits after June 30, 1987 (the original expiration date of §1619). Furthermore, §7 of EODAA contains provisions expanding coverage for certain individuals eligible under §1619 in States which cover individuals under the authority of §1902(f) of the Act.

3411.1 Relationship of §1619 Eligibility and Medicaid Eligibility in States Covering Individuals Receiving SSI.--Subsequent to OBRA 1986, the Medicaid statute at §§1902(a)(10)(A)(i)(II) and 1905(q) of the Act requires States that choose to cover individuals receiving SSI to provide Medicaid eligibility as mandatory categorically needy to individuals who are receiving SSI and/or federally administered State supplementary payments benefits or who are qualified severely impaired individuals. Individuals receiving SSI under §1619(a) are considered, for purposes of Medicaid to be receiving an SSI benefit. Individuals in §1619(b) status are also, for purposes of Medicaid, considered to be receiving an SSI benefit. Finally, qualified severely impaired individuals as defined in §1905(q) of the Act are virtually identical to individuals described in §1619(b). Thus, for purposes of Medicaid eligibility, qualified severly impaired individuals are equivalent to individuals who are currently in or who enter into and continue to be in §1619(b) status.

3411.2 Relationship of §1619 Eligibility and Medicaid Eligibility in States That Choose to Use More Restrictive Requirements for Medicaid Than SSI Requirements.--States which provide Medicaid eligibility to aged, blind or disabled individuals under the purview of §1902(f) of the Act, using more restrictive eligibility criteria than used under the SSI program (referred to as "209(b)" States), are not required to provide automatic Medicaid eligibility to individuals receiving SSI benefits or who are qualified severely impaired individuals (as is otherwise required by §1902(a)(10)(A)(i)(II) of the Act). Rather, 209(b) States apply Medicaid eligibility criteria authorized under §1902(f) of the Act. These eligibility criteria may be the same as applied in the SSI program or more restrictive, but not more restrictive than used under the State's January 1, 1972 Medicaid State plan.

However, §7 of EODAA revised Medicaid eligibility requirements for individuals in §1619 status in 209(b) States. Section 7 of EODAA amends '1619(b)(3) of the Act and makes conforming changes to §1902(f) of the Act to require that in States electing Medicaid coverage under the §1902(f) option, any individual who meets the following requirements must be Medicaid eligible as mandatory categorically needy:

- The individual qualifies for SSI benefits and/or federally administered State supplementary payments under §1619(a) of the Act, or meets the requirements under §1619(b)(1) of the Act as determined by the Social Security Administration; and

o The individual was eligible for Medicaid under the State plan in the month immediately preceding the first month in which the individual met the foregoing conditions.

Section 7 of EODAA requires 209(b) States to provide Medicaid to individuals whose work activity has caused them to come under §1619(a) or §1619(b) status as determined by the Social Security Administration (SSA), so long as in the month immediately preceding the month they entered §1619 status they were eligible for medical assistance under the State's approved Medicaid plan with the application of the appropriate Medicaid criteria (e.g., the 209(b) criteria) and they continue in §1619 status. In that context, "eligible for medical assistance" under the approved Medicaid State plan means that you must verify that the individual had actually been determined eligible for medical assistance by the Medicaid State agency under requirements applicable to the individual's eligibility category (categorically needy or medically needy) in the month immediately preceding the first month of §1619 status.

In order for an individual to remain eligible under §7 of EODAA, he or she must continue in '1619 status. Thus, if the individual loses §1619 status or if there is a break in '1619 status, Medicaid eligibility under §7 of EODAA is not met for the months when '1619 status is not met. (The individual may meet Medicaid eligibility under the other eligibility categories, e.g., medically needy). If the individual returns to §1619 status, determine continued Medicaid coverage by the eligibility test for the initial month of §1619 eligibility.

> Example: The individual is in a 209(b) State and first enters §1619 status in September 1987. The individual was eligible for medical assistance in August 1987. The individual remains in §1619 status until November 1987 when his resources are in excess of the SSI resource eligibility standard.
>
> Since the individual was eligible for Medicaid in August 1987 (the month immediately preceding the month in which the individual first went into §1619 status) and is in §1619 status beginning September 1987, the individual must be provided Medicaid for the months of September and October 1987 under the requirements of '7 of EODAA. Since the individual was not in §1619 status in November 1987 (due to excess resources) he is not eligible for Medicaid in November on the basis of §7 of EODAA.

You have an option in determining the first month of §1619 eligibility in cases where an individual has more than one period of eligibility under §1619 of the Act. This would be the case in situations when there are breaks in §1619 status (for example, when the individual returns to regular SSI status or becomes ineligible under §1611 of the Act or becomes ineligible under SSI altogether). In such situations, States must apply one of the following as the first month of §1619 status for purposes of §7 of the EODAA:

Option I--The first month of the first period the individual went into §§1619 status. That is, there are no periods of §1619 status occurring prior to this period.

Option II--The first month the individual went into §1619 status in the most recent period of eligibility under §1619.

> Example 1: The individual is in a 209(b) State and first went into §1619 status in March 1984. In May 1986 the individual stopped working and returned to regular SSI status under §1611 of the Act. In November 1987 the individual began working again and returned to and continues in §1619 status. The individual was eligible for medical assistance in February 1984. The individual was not eligible for medical assistance in October 1987. The individual applies for medical assistance under §7 of EODAA for months beginning November 1987.
>
> The State chooses Option I above.
>
> Under Option I, since the individual was eligible for Medicaid in February 1984 (the month preceding the first month of §1619 status of the first period of eligibility under §1619) and goes into and continues in §1619 status in November 1987, the State must provide Medicaid to the individual for November 1987 and continuing months (so long as the individual remains in §1619 status). This is regardless of the fact that the individual was not eligible for medical assistance in October 1987 (the month preceding the most recent period of §1619 status).
>
> Example 2: Same facts as Example 1 except that the State chooses Option II above.
>
> Since the individual was not eligible for medical assistance in October 1987 (the month preceding the most recent period of §1619 status), the individual is not eligible for Medicaid under §7 of EODAA.
>
> Note, if in this case the individual had been eligible for medical assistance in October 1987, he would be eligible for Medicaid under §7 of EODAA under Option II.

3411.3 State Supplementary Payments and §1619 status.--You may at your option make State supplementary payments to individuals in addition to the basic SSI Federal payment. State supplementary payments are administered either by the SSA or the State making the payments. However, under the changes made by EODAA to §1619 of the Act, only Federally administered payments (e.g. basic SSI benefits and Federally administered State supplementary payments) are considered by the SSA in determining eligibility under §1619. SSA does not consider State administered State supplementary payments in the determination of §1619 eligibility.

However, individuals who received or currently receive State administered optional State supplementary payments before becoming a §1619 eligible are not necessarily excluded from becoming eligible under §1619. Rather, the SSA will consider only federally administered benefits in determining §1619 eligibility.

As discussed in §3412.1, from an operational perspective you need only ascertain §1619 status as determined by the SSA from the State Data Exchange.

3412. OPERATIONAL CONSIDERATIONS

3412.1 Determining Eligibility Status.--In the period prior to the effective date of §§9404 of OBRA 1986 and §7 of EODAA (i.e, prior to July 1, 1987 or later when State legislation is needed), continue to provide Medicaid eligibility to individuals in §1619 status in the same way provided prior to the enactment of OBRA 1986 and EODAA:

- If you have an agreement with the SSA under §1634 of the Act, individuals determined to be in §1619 status are considered to be SSI recipients and must be automatically determined eligible for Medicaid without the need to apply to the Medicaid State agency for Medicaid benefits.

- If you cover individuals receiving SSI, but do not have a §1634 agreement, individuals in §1619 status must apply separately to the States for Medicaid benefits.

- If you cover individuals under §1902(f) of the Act (209(b) States) individuals in §1619(a) or §1619(b) status must continue to be treated in the same way they were treated prior to the enactment of OBRA 1986 and EODAA. Thus, in 209(b) States, individuals in §1619 status must apply to the State Medicaid agency for Medicaid benefits and have their eligibility determined in the same way as do other SSI recipients in those States.

Effective July 1, 1987 (or later, if State legislation is needed) application requirements are the same as indicated for the period prior to July 1, 1987. Thus, individuals in §1619 status in States which have §1634 agreements with SSA must automatically be considered eligible for SSI and, therefore, Medicaid, without the need for a Medicaid application. Individuals in §1619 status in States which do not have a §1634 agreement and which provide Medicaid eligibility to SSI recipients, must apply separately to the Medicaid agency in order to obtain Medicaid benefits. Individuals in §1619 status in 209(b) States must apply separately to the Medicaid agency in order to obtain Medicaid benefits.

Effective July 1, 1987 (as reflected in SDX records received on or after July 14, 1987), in order to determine an individual's status under §1619 of the Act, refer to information provided by the SSA under the SSI State Data Exchange System (SDX) described below. The SDX file is comprised of eligibility, payment and demographic information obtained by SSA in the administration of the SSI program.

An individual's status under §1619(a) of the Act may be ascertained from reviewing the data element in the "Multicategory Indicator" field on the SDX. The usual codes found in the multicategory indicator field are:

Code	Description
1	Aged Eligibility
2	Blind Eligibility
3	Aged and Blind Eligibility
4	Disabled Eligibility
5	Aged and Disabled Eligibility
6	Blind and Disabled Eligibility
7	Aged, Blind and Disabled Eligibility

However, if a special SSI payment under §1619(a) of the Act is due, the numeric codes of 4, 5, 6, or 7 representing regular payments, will be converted to codes D, E, F, or G, respectively, (representing payments under §1619(a)).

In order to corroborate §1619(b) status, check the data element in the "Medicaid Test Indicator" field in the SDX:

- When an individual is in nonpay status due to excess income (N01), and codes A, B, or F appear in the Medicaid Test Indicator field, consider the individual to be a §1619(b) recipient for Medicaid purposes.

- When the individual is determined by SSA to not be eligible under §1619(b), codes C, D, E, G, H, J, K, L, or M will appear in the Medicaid Test Indicator field.

For further details regarding the coding on the SDX refer to section SI 02601.529 of the Program Operations Manual System (POMS) issued by the SSA to States.

If there are problems in ascertaining §1619 status from the SDX, contact the HFCA regional office to obtain further information from the SSA regional office which receives monthly listings of individuals in §1619 status.

3412.2 Notification and Application Requirements.--In certain cases, you will need to notify individuals in order to inform them of their potential eligibility for Medicaid and their need to file for such benefits.

3412.3 States Covering Individuals Receiving SSI.--If you cover individuals receiving SSI, a notification is unnecessary since individuals eligible under §1619 of the Act must be treated as any other SSI recipient in such States.

3412.4 209(b) States.--In 209(b) States, individuals in §1619 status, as well as other SSI recipients, must apply directly to the State in order to obtain Medicaid benefits. The 209(b) States must notify individuals in §1619 status who are not currently eligible for medical assistance as categorically needy of the following:

- The potential for Medicaid eligibility under the provisions of §7 of EODAA, and

- The need to apply with the Medicaid agency in order to obtain categorically needy medical assistance.

The SSA sends notices to individuals in §1619 status in 209(b) States. However, these notices are not sufficient in reaching the target population for Medicaid purposes. Specifically, for individuals already in §1619 status as of July 1, 1987 the SSA will not be providing any further notices. In general, the SSA provides a notice where there is a change in an individual's eligibility status or benefits. For example, when an individual first enters into §1619 status after June 30, 1987 the SSA would furnish a notice. The SSA would not provide a notice where, from its perspective, the individual's §1619 status has not changed.

In order to send the required notices, determine those individuals in §1619 status beginning July 1, 1987 (or a later date where State legislation is needed). The 209(b) States can verify an individual's §1619 status from the SDX as discussed in §3412.1.

3412.5 Determining the First Month of an Individual's §1619 Status in 209(b) States.--As indicated in §3411.2, 209(b) States must determine whether an individual was eligible for medical assistance in the month immediately preceding the first month the individual entered §1619 status. For individuals entering into §1619 status after June 30, 1987, as indicated in §3412.1, determine §1619 status from the SDX.

However, the SDX does not indicate the first month of 1619 status. The SDX merely indicates prospectively whether an individual is or is not (for the particular time period the SDX represents) in §1619 status. SDX records will not definitively show the first month an individual went into §1619 status. In that context, 209(b) States may use their own documentation (as obtained from, for example, State records, the individual, or other sources) in order to verify the first month of §1619 eligibility. (The first month of §1619 status could be as early as January 1, 1981).

It may be, in many if not most of the cases, that you will not be able to verify an individual's first month of §1619 status from State records. The Health Care Financing Administration and the SSA are developing a listing of these individuals and the dates of their first month of §1619 status in 209(b) States. This listing will be forwarded to the 209(b) States as soon as possible. In the meantime, States should hold in abeyance any applications for Medicaid received from these individuals pending receipt of the listing.

3420. INDIVIDUALS IN STATES USING MORE RESTRICTIVE ELIGIBILITY REQUIREMENTS

You may use eligibility requirements that are more restrictive than those used under the Supplemental Security Income (SSI) program. Regulations implementing this option are at 42 CFR 435.121. States using more restrictive eligibility requirements than those of the SSI program are often referred to as 209(b) States. More restrictive requirements can be limited to the nonfinancial eligibility conditions of blindness and disability, financial eligibility conditions, or a combination of both.

More restrictive requirements may apply to only the aged, blind, and disabled, or to any combination. For example, you may employ eligibility requirements more restrictive than SSI for the aged and disabled and provide Medicaid to all blind SSI recipients.

3420.1 Income Deductions.--Financial determinations under the more restrictive requirements option include special income deductions. Deduct from each individual's income the:

- SSI payment,
- State Supplementary payment,
- incurred medical expenses (regardless of whether these expenses are reimbursed under a public program other than the Medicaid program of a State or political subdivision), and
- Old Age Survivor's Disability Insurance (OASDI) increases required under 42 CFR 435.134.

In addition, you may deduct cost-of-living increases in OASDI benefits that would be disregarded under 42 CFR 435.135 and OASDI deductions under §1634(b) of the Act.

A State supplementary payment for purposes of this provision is one that meets the conditions described in the Social Security Administration's (SSA's) Program Operations Manual (POMS) at SI 01403.005A or §1902 (a)(10)(A)(ii)(XI) of the Act (whichever is appropriate). Section 1902(a)(10)(A)(ii)(XI) permits certain SSI criteria States and certain 209(b) States (i.e., those States without §§1616 or 1634 agreements with the Secretary) to use income eligibility requirements for optional State supplements (receipt of which could qualify an individual for Medicaid) that are more restrictive than described under SI 0111403.005A of the POMS.

SSI program policy also requires the deduction of State funded supplementary payments (as assistance based on need) that do not meet the requirements at SI 01403.005A. You may, but are not required to, deduct State payments for assistance based on need if they would have been deducted under your January 1, 1972 plan (1972 plan).

3420.2 More Restrictive Requirements.--If requirements more restrictive than SSI are used, they cannot be more restrictive than those used under your 1972 plan.

Do not apply 1972 plan policies which result in persons being treated more generously than they would be under SSI (or an approved optional State supplement program). When a particular 1972 plan policy can result in a more liberal treatment of a person than under equivalent SSI policy, the 1972 policy is more liberal than SSI (under this provision) even though it may not be in all circumstances. If your 1972 plan did not address a particular SSI policy or was more liberal than SSI, use SSI policy. For example, if you did not count burial funds in 1972, you cannot employ a policy that is more restrictive or more liberal than the SSI exclusion of burial funds.

However, where SSI excludes a type of income or asset that your 1972 plan counted, treat that income or asset in a manner which is not more restrictive than your treatment in 1972. In these instances, you can employ your 1972 policies to the specific income or asset. Since SSI excludes the income or asset, your different treatment of the item is more restrictive than SSI policy.

EXAMPLE: SSI policy excludes the home and all contiguous land. If your 1972 plan excluded the building used as a home and one acre of land and only excluded any remaining contiguous land if such land was producing income of at least $1.00 annually, your policy was more restrictive than the equivalent SSI policy. Therefore, you may use your 1972 policy under your current plan.

Election of this option requires that you compare each 1972 plan policy to the current comparable SSI policy to determine which 1972 plan policies may be used. Once you have identified the more restrictive requirements you may use, decide whether to use the 1972 plan policy, the comparable SSI policy, or a policy between these parameters. For example, you may elect to use an income standard that is higher than your 1972 plan standard, but not as high as the SSI Federal Benefit Rate (FBR).

3420.3 The Relationship of 42 CFR 435.230 and §1902(a)(10)(A)(ii)(XI) to 435.121.--Under 435.230, SSI States are permitted through payment of State supplements to extend Medicaid to individuals who would otherwise be eligible for SSI, but who have income higher than the amount necessary to qualify for SSI. Additionally, SSI criteria States and 209(b) States described in §3420.1 may provide Medicaid based on State supplements which are paid to individuals who meet income eligibility requirements that are more restrictive than SSI.

In order to extend the income parameters under 435.121 to include income standards described in §1902(a)(10)(A)(ii)(XI), you must make actual cash payments to all aged, or blind, or disabled, or to select categories of such individuals (e.g., aged individuals in domiciliary care). These payments are called optional State supplementary (OSS) payments.

OSS payments must be:

o based on need and paid in cash on a regular basis,

o equal to the difference between an individual's countable income and the standards used to determine eligibility, and

o available on a statewide basis.

"Countable income" under §1902(a)(10)(A)(ii)(XI) is income remaining after deductions required under the SSI program, more restrictive deductions or, at your option, more liberal deductions of the type recognized by SSI if you elect to use SSI criteria in SI0143.005A of the POMS.

If you elect to use more restrictive requirements of eligibility for Medicaid, you may also make supplementary payments to SSI recipients and individuals who do not receive SSI because their income is above the SSI FBR. If payments are made to individuals who would otherwise be eligible as categorically needy under your Medicaid plan and the supplementary payments meet the OSS payment requirements, you may use your SSP income standard and/or more liberal disregards in determinations of eligibility under 42 CFR 435.121.

For example, if you make OSS payments to all aged, blind, and disabled and elect to use that income standard rather than your 1972 plan or SSI standards, your OSS standard becomes the income standard for all aged, blind, and disabled individuals under 42 CFR 435.121. If OSS payments are made only to select categories of individuals (e.g., persons living in domiciliary care facilities) and you elect to use your OSS standard for determining Medicaid eligibility, the OSS income standard is used in determining Medicaid eligibility for all individuals in your select categories, regardless of whether an OSS payment is actually paid.

While you are not required to use the OSS standards and deductions for purposes of determining eligibility under 42 CFR 435.121, OSS payments that meet the requirements at SI010403.005A of the POMS or §1902(a)(10)(A)(ii)(XI) must be deducted in determining eligibility.

3420.4 Disabled Individuals Under Age 18.--Disabled individuals under age 18 who were not included under your 1972 plan as "disabled" must be included under your current Medicaid plan if such individuals meet the SSI definition of disability and meet your current AFDC requirements. Determinations of financial eligibility require the same deductions from income that are required for individuals age 18 and older (i.e., SSI payments, SSP payments, incurred medical expenses and OASDI cost-of-living increases).

If you limited Medicaid to disabled individuals by age under your 1972 plan and elect to remove the age limitation under your current plan, individuals under the prior age limit must meet your more restrictive financial requirements for the aged, blind, and disabled and your definition of disability.

3435. PERSONS WITH DRUG ADDICTION OR ALCOHOLISM

3435.1 General.--Under the drug addiction and alcoholism (DA&A) provisions in §1634(e) of the Act, effective March 1, 1995, you must continue to provide Medicaid eligibility for certain otherwise ineligible disabled individuals. The following instructions explain the specific circumstances and rules under which Medicaid eligibility must be maintained. Eligibility for these individuals must be continued if:

- They are disabled and drug addiction or alcoholism is material to the finding of their disability; and
- They would be receiving supplemental security income (SSI) benefits but for suspension due to noncompliance with treatment (see §1634(e) of the Act and subsection A below) or because of a mandatory suspension period while demonstrating compliance; or
- Their SSI benefits were terminated because of the 36 month limit for SSI benefits provided under the DA&A provisions.

Persons who meet these criteria are deemed under the law to be receiving SSI for Medicaid purposes and thus are categorically eligible.

A. Definitions.--The following definitions apply, as appropriate, to individuals who are disabled due to a substance addiction and meet the categorical eligibility requirements for Medicaid.

1. Disabled Based on DA&A.--An individual whose medically determined drug addiction or alcoholism is a contributing factor material to the finding of his/her disability is considered disabled based on DA&A.

2. Noncompliance.--An individual is noncompliant if he or she fails to meet the treatment requirements established in the DA&A provisions in §1634(e) of the Act. (A period of noncompliance must be followed by a demonstrated compliance period before SSI benefits can be reinstated.)

3. Material to Disability.--The individual would not be found disabled if drug or alcohol use were to stop.

4. Suspension.--Payment of SSI benefits ceases for noncompliance with treatment beginning the month after notification. The suspension continues throughout a demonstrated compliance period required by the DA&A statute.

5. Termination.--Termination is the removal of an individual from the SSI roles, rendering the individual ineligible for SSI benefits. Eligibility for SSI benefits terminates after 36 months of benefits for individuals disabled based on DA&A. (A 12 month period of suspension for any ineligibility reason including noncompliance with treatment provisions also results in termination of SSI benefits. Section 1634(e) does not apply to these terminations.)

3435.2 Effective Date.--The provisions in the Act to which these instructions apply are effective March 1, 1995.

3435.3 Medicaid Eligibility in Non-209(b) States.--Medicaid must be provided in non-209(b) States to any individual:

- o Whose SSI benefits are suspended (but not terminated) due to failure to comply with the treatment requirements of §1611(e)(3)(A) of the Act; or

- o Who are not receiving SSI benefits solely because of the application of the 36 month limit on receiving SSI by virtue of DA&A. (This 36 month limitation ends after September 2004.)

Medicaid does not continue for individuals who would be eligible for SSI benefits based on the DA&A provisions (but whose benefits are terminated due to a 12 month period of ineligibility for SSI because of noncompliance or some other reason for SSI ineligibility) unless they meet Medicaid eligibility requirements under your State plan for eligibility other than as an SSI recipient.

3435.4 Medicaid Eligibility in 209(b) States.--Individuals meeting the criteria established by the DA&A provisions must be eligible for Medicaid in your State as categorically needy if they:

- o Would be eligible for SSI benefits but for suspension of benefits for noncompliance or termination of benefits due to the 36 month limit on benefits; and

- o Continue to meet the Medicaid eligibility requirements under your State plan.

Medicaid does not continue for individuals who would be eligible for SSI benefits based on the DA&A provisions (but whose benefits are terminated due to a 12 month period of ineligibility for SSI because of noncompliance or some other reason for SSI ineligibility) unless they meet Medicaid eligibility requirements under your State plan for eligibility other than as an SSI recipient.

3435.5 Identification of DA&A Cases.--Beginning March 1, 1995, the State Data Exchange (SDX) is expanded to contain new codes to identify individuals who are affected by this legislation.

The payment status code (PSTAT) data element changes when SSI payment has been stopped. You can identify SSI cases that are in nonpayment status due to noncompliance when the PSTAT field indicates:

- N10 Nonpayment of SSI benefits due to recipient noncompliance with treatment requirements for substance addiction, or

- N11 Nonpayment of SSI benefits (recipient compliant with treatment requirements, but SSI payments are suspended while recipient serves sanction months).

In addition, the Medicaid eligibility code (Medic) field on the SDX has been expanded to contain a means of identifying when Medicaid continuation may be appropriate. In §1634 States, the Medic field contains a "P" when Medicaid continuation may be appropriate during suspensions for noncompliance/sanctions. The State must determine if the recipient would continue to be eligible for SSI and Medicaid but for the noncompliance/sanction suspension from payment.

In 209(b) States and SSI criteria States, the Medic code continues to contain an "S" code when either N10 or N11 appears in the PSTAT field. The coding of an "S" in the Medic field indicates that a decision by the State is necessary in order for Medicaid eligibility to continue.

New codes will be introduced by the Social Security Administration to identify DA&A individuals who are terminated due to the 36 month limit on the payment of benefits. States will be advised of the new codes when they are issued.

The following tables outline the coding process for DA&As in the SDX:

§1634 States	PSTAT	Medic
SSI suspended for noncompliance	N10/N11	P
SSI terminated after 12 months of SSI suspension	termination code (usually T31)	usually R
SSI terminated after 36 months of payment	unique termination code to be determined	code to be determined

Non-§1634 States	PSTAT	Medic
SSI suspended for noncompliance	N10/N11	S
SSI terminated after 12 months of SSI suspension	termination code	S
SSI terminated after 36 months of payment	unique termination code to be determined	S

3485 COVERAGE OF QUALIFIED DISABLED AND WORKING INDIVIDUALS

3485.1 General.--Section 6408(d) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) amended §1902(a)(10)(E) of the Act to make coverage of certain Medicare beneficiaries who are entitled to enroll for Medicare Part A premiums a mandatory Medicaid coverage group. Under this provision, you must cover under Medicaid those individuals who are Qualified Disabled and Working Individuals.

3485.2 Qualified Disabled and Working Individual.--A Qualified Disabled and Working Individual (QDWI) is an individual:

- Who is entitled to enroll in hospital insurance benefits (Medicare Part A) under §1818A of the Social Security Act;
- Whose income does not exceed 200 percent of the official poverty line as defined by the Executive Office of Management and Budget (EOMB) and revised annually under §673(2) of OBRA 81 (see §3485.7);
- Whose resources do not exceed twice the SSI resource limit; and
- Who is not otherwise eligible for Medicaid.

A QDWI must also meet the general non-financial requirements or conditions of eligibility for medical assistance, such as the filing of an application for Medicaid, obtaining a Social Security number, citizenship, residency, and assignment of rights.

Use an income standard of 200 percent of the official poverty line and the income methodologies of the SSI program when determining eligibility under this provision.

In determining resource eligibility, use the methodologies of the SSI program.

In determining eligibility, States may not use more liberal income and resource methodologies under §1902(r)(2) of the Act.]

3485.3 Eligibility in 209(b) States.--States which have chosen to exercise their option to use more restrictive eligibility criteria than are used by the SSI program may not use those criteria in determining eligibility for QDWIs under this provision. Instead, use the income and resource standards and methodologies described in §3485.2.

3485.4 Effective Date of Benefits.--The effective date of benefits under this provision is based on the date of application and the date on which all eligibility criteria, including enrollment for Medicare Part A under §1818A of the Act, are met. For example, if an individual applies for benefits on October 1, and is already enrolled in Medicare Part A, eligibility can be effective October 1 (or up to 3 months prior to October 1, if all eligibility criteria were met during the 3-month period). However, if in this example, the individual's enrollment for Part A is not effective until November 1, eligibility as a QDWI cannot be effective until that date. In no case can eligibility as a QDWI be effective prior to July 1, 1990, the effective date of the provision.

3485.5 Official Federal Poverty Line.--The official Federal poverty line as defined by EOMB is published annually in the Federal Register by HHS. As noted in §3485.2, you cannot establish an income standard which is greater than or less than 200 percent of the official poverty line.

3485.6 Payment of Monthly Premiums for Medicare Part A and Federal Financial Participation.--FFP is available for medical assistance to QDWIs for Medicare Part A monthly premiums. You are responsible for the payment of the monthly premium to the Medicare Part A Trust Fund. Although certain QDWIs may be responsible for payment of part or all of the monthly premium to the State, as described in §3485.7, you remain responsible for the payment of the monthly premium to the Medicare Part A Trust Fund. The amount of FFP available to you is reduced by the appropriate Federal Medical Assistance Percentage, for the portion of the premium paid to you by the QDWI. As described in §3485.2, you are required to cover all QDWIs who meet the requirements.

3485.7 Optional Sliding Scale for Premium Payments by Qualified Disabled and Working Individuals.--For QDWIs whose income is from 150 percent to 200 percent of the official poverty line, you may charge a premium, as specified in your approved State plan, expressed as a percentage of the Medicare Part A premium according to a sliding scale. This scale must be based on percentages increasing from 0 percent to 100 percent, in reasonable increments, as the individual's income increases from 150 percent to 200 percent of such poverty line. This equates to a 2 percent increase in the premium charged for every 1 percent increase in the poverty line above 150 percent. Although the "2 for 1" approach represents a reasonable approach for establishing a sliding scale, other approaches may include any evenly divided increments for increasing the premiums, e.g., a 20 percent increase in the premium charged for every 10 percent increase in the poverty line. Pending final regulations on adopting a specific approach, States may use any approach which is reasonable. Submit for HCFA approval as State plan amendments all sliding scale options.

Since income for QDWIs may vary monthly, you must account for any such changes. FFP is available for the State portion only of the Medicare Part A premium. Therefore, update QDWI eligibility and beneficiary liability for premium payments as the individual's income changes and, if a sliding scale option is chosen, submit data on the portion of the premium being paid by the State. Budget anticipated expenditures for Medicare Part A premiums on HCFA Form 25D. Account for actual expenditures on HCFA Form 64 and report on the summary sheet amounts collected from recipients. Maintain documentation to support the expenditures claimed. States are billed for the Part A premiums and expenditures for FFP are adjusted based on data received.

3485.8 Termination of Qualified Disabled and Working Individuals.--Eligibility as a QDWI may terminate as a result of no longer meeting any eligibility factor. These factors include but are not limited to an individual: (1) whose eligibility continues under Medicare Part A as described in §1818A requirements; (2) whose income does not exceed 200 percent of the official poverty line; (3) whose resources do not exceed twice the SSI resource limit; and (4) who is not otherwise eligible for Medicaid. You may also terminate the eligibility of a QDWI for non-payment of the premium when a sliding scale option is used. When a termination action is taken, it must be in compliance with the requirements in 42 CFR 431, Subpart E.

Pending issuance of final regulations States may establish a reasonable grace period (prior to termination) for QDWIs who are paying a portion of the Medicare Part A premiums and are in arrears. We believe it is reasonable to not terminate eligibility until the premium has been unpaid for a period of 60 calendar days from the date due. You may also waive payment of a premium imposed where you determine that requiring the payment creates an undue hardship. Undue hardship is determined in accordance with the guidelines in your approved State plan.

3490. COVERAGE OF QUALIFIED MEDICARE BENEFICIARIES FOR MEDICARE COST SHARING EXPENSES

3490.1 General.--Section 301 of MCCA amended §1902(a)(10)(E) of the Act to make coverage of certain Medicare beneficiaries for Medicare cost sharing expenses a mandatory Medicaid coverage group rather than an optional one. You must cover under Medicaid those individuals who are Qualified Medicare Beneficiaries for the purpose of paying Medicare cost sharing expenses on their behalf. (See §3490.12 for a discussion of Medicare cost sharing expenses.) This also applies to any State providing Medicaid to its residents under a waiver granted under §1115 of the Act. Coverage of this group remains optional in the territories, which for purposes of this provision include Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa. The territories also retain the option to use any income standard they choose as long as it is not greater than 100 percent of the Federal poverty level.

3490.2 Qualified Medicare Beneficiary (QMB).--A QMB is an individual who:

- Is entitled to Medicare hospital insurance benefits under Part A, with or without payment of premiums, but not entitled solely because he or she is eligible to enroll under §1818A of the Act. Section 1818A provides that certain working disabled individuals may enroll for Premium HI;

- Has income (as determined for SSI purposes) that does not exceed 100 percent of the Federal poverty level (FPL); and

- Has resources (as determined for SSI purposes) that do not exceed twice the maximum amount established for SSI eligibility.

A QMB must also meet the general nonfinancial requirements or conditions of eligibility for medical assistance, such as filing an application for Medicaid, furnishing a Social Security number, proving citizenship or satisfactory immigration status, proving residency, and assigning rights.

Use an income standard no lower than the minimum income standard applicable to your State specified in §1905(p)(2) of the Act and no higher than 100 percent of the poverty level. (See §§3490.6 and 3490.7 for specific instructions regarding these income standards for non-209(b) and 209(b) States.) For purposes of determining financial eligibility under this section, use the methodologies of the SSI program, unless more liberal methodologies are approved by HCFA under §1902(r)(2) of the Act.

Except as provided in §1612(b)(4)(B)(ii) of the Act (exclusion from income of impairment related work expenses of the disabled), costs incurred for medical or remedial care are not considered as reducing income in counting income for purposes of determining eligibility under this provision. Thus, applicants for eligibility under this provision may not spend down income to meet the eligibility criteria.

Cost of living increases in title II benefits (COLAs) are disregarded in determining income of QMBs through the month following the month in which the annual FPL update is published. In most years, this means that COLAs are disregarded through March since the new poverty levels are normally published

in February of each year. For QMBs who have title II income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded, or in most years, April. For QMBs without title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.

In determining resource eligibility, use the methodologies used in the SSI program unless more liberal methodologies are approved by HCFA under §1902(r)(2) of the Act.

3490.3 Individuals Eligible Both as QMBs and Under Other Eligibility Groups Under State Plan.--An individual who is otherwise eligible for Medicaid under the State plan (e.g., as categorically needy or medically needy) may also be eligible as a QMB. An individual who would be eligible as a QMB and under some other eligibility group may choose, per 42 CFR 435.404, to have eligibility determined only under one category. However, the individual is not required to make such a choice. He/she is entitled to have eligibility determined under all categories for which he/she may qualify. As an initial screening device only, you may establish a series of questions which can be used to determine whether an individual is likely to be eligible as a QMB as well as under another part of the State plan. However, provide full and complete information to the individual about the benefits available for each group for which the individual may be eligible prior to any choice of eligibility category being made. Also inform the individual of his/her right to have eligibility determined for all categories of Medicaid eligibility regardless of the apparent result of the initial screening. If an individual does not specifically and voluntarily choose to have his/her eligibility determined under one category only, and if he/she would be eligible both as a QMB and under another group in the State plan, make him/her eligible both as a QMB and the other group for which he/she is eligible.

Eligibility as a QMB constitutes an eligibility status which is in addition to eligibility under the other groups in the State plan for individuals who can be eligible under more than one group. Thus, eligibility as a QMB does not affect eligibility determinations for other eligibility groups. Eligibility for other groups, such as categorically needy or medically needy, is determined using the eligibility criteria for that group, including three month retroactivity. (See §3490.8 for a discussion of retroactivity for QMBs.) In turn, eligibility for QMB status is determined using the eligibility criteria in §3490.2.

In determining the eligibility of individuals who are both eligible as QMBs and as medically needy (or as categorically needy or medically needy in a 209(b) State), it is important to realize that while an individual can spend down to meet the eligibility criteria as medically needy or in a 209(b) State, as noted in §3490.2, he/she cannot spend down to be eligible as a QMB. Thus, ensure that eligibility for QMB status is determined on the basis of the individual's income before any spenddown is applied. Apply spenddown where appropriate in determining such an individual's eligibility as medically needy, or as categorically or medically needy in a 209(b) State.

3490.4 Benefits Available to Individuals Eligible as QMBs and Under Other Eligibility Groups in State Plan.--Where individuals are eligible both as QMBs and under another eligibility group, they are eligible for payment of Medicare cost sharing expenses (see §3490.12 for an explanation of cost sharing expenses) and for the full range of State plan services available to individuals eligible

under the other non-QMB group to which they belong. For example, if the individual is eligible as a QMB and is also eligible as medically needy, make payment for cost sharing expenses for Medicare services and for any services not covered by Medicare which are within the full range of State plan services available to the medically needy in that State.

3490.5 Determining QMB Status for Individuals Already Eligible for Medicaid.-Because a large number of aged or disabled individuals eligible under the State plan can also be eligible as QMBs, ensure that such individuals, who wish to receive eligibility as QMBs, receive such eligibility as well as under other provisions in the State plan. Therefore, conduct a review of all recipients currently eligible under the State plan who are also entitled under Medicare Part A to determine whether they meet the eligibility requirements for QMB status. Where an individual does meet those requirements, and has not elected to decline QMB eligibility, make him/her eligible as a QMB (in addition to his/her eligibility in another group) and notify him/her of his/her new status.

3490.6 Income Standard in Non-209(b) States.--The income standard beginning calendar year 1991 is 100 percent of the FPL.

3490.7 Income Standard in 209(b) States.--For those 209(b) States which, as of January 1, 1987, used more restrictive income standards than SSI, for individuals age 65 or older, the phase-in schedule is as follows:

- For calendar year 1991, the standard must be at least 95 percent of the FPL; and
- For calendar year 1992 and thereafter, the standard must be 100 percent of the FPL.

Specify in your State plan the income standard used. Except for the additional year afforded certain 209(b) States to raise their income standards to 100 percent of the FPL, 209(b) States may not apply any more restrictive rules in determining QMB eligibility than are applied by SSI States. Income and resource methodologies which are more liberal than SSI may be used if approved by HCFA under §1902(r)(2) of the Act.

3490.8 Effective Date.--Eligibility for payment of Medicare cost sharing is effective the first day of the month after the month in which QMB status is first determined. For example, if you determine an individual meets all eligibility requirements for QMB status on August 15, the effective date of eligibility for payment of premiums, deductibles, and coinsurance is September 1. However, in no case are benefits effective prior to January 1, 1989, which is the effective date of this provision. Retroactive eligibility is precluded under this provision.

3490.9 Determinations and Redeterminations of QMB Eligibility.--A determination that an individual is a QMB is normally effective for a period of 12 months. However, you may make redeterminations more frequently than every 12 months, as long as they are not made more frequently than every 6 months. This limitation on the frequency of redeterminations does not apply in situations where you become aware of an actual change in the individual's situation that could affect

his or her eligibility. In such a situation, make a redetermination in accordance with your regular procedures per 42 CFR 435.916. Determinations of eligibility must be made on a timely basis in accordance with the requirements of 42 CFR 435.911.

3490.10 Federal Poverty Level.--The FPL is published annually (usually mid-February) in the Federal Register by HHS. You may not exceed the poverty level as set forth in the Federal Register for a family of the appropriate size in determining eligibility. However, if you are a 209(b) State which used an income standard lower than SSI on January 1, 1987, you may establish an income limit which is lower than the maximum allowed, provided that it is no lower than permitted under the phase-in schedule listed in §3490.7. Generally, the new poverty levels are effective no later than the date of publication in the Federal Register.

3490.11 Identification of QMBs.--Individuals who meet the eligibility requirements in §3490.2 as not exceeding 100 percent of the FPL, must be identified through the Medicaid identification card system as QMBs. This alerts providers that special coverage and reimbursement rules apply. QMBs are Medicaid eligible and are entitled to the same rights and subject to responsibilities applicable to Medicaid eligibles (e.g., fair hearings and reporting requirements). For individuals eligible only as QMBs, benefits are limited to medical assistance for Medicare cost sharing expenses for services covered by Medicare. (See §3490.4 for a discussion of benefits available to individuals who are Medicaid eligible both as QMBs and under any one of the other eligibility groups in your State plan.)

3490.12 Medicare Cost Sharing Expenses and Federal Financial Participation.--FFP is available for medical assistance for Medicare cost sharing expenses. These expenses are defined as:

- Monthly premiums for Medicare Part B and, where applicable, for Premium Hospital Insurance under Medicare Part A;

- Medicare Part A and Part B deductibles and coinsurance, including deductibles and coinsurance that HMOs and CMPs charge their Medicare enrollees in lieu of the Medicare deductibles and coinsurance that the beneficiaries would pay if they were not enrolled in an HMO or CMP; and

- At your option, premiums for enrollment with a Health Maintenance Organization (HMO) or a Competitive Medical Plan (CMP) under §1876 of the Act.

Note that FFP is available for Medicare cost sharing expenses at the beginning of the month after the month in which you determine an individual is eligible for Medicaid as a QMB.

3490.13 Payment of Monthly Premiums for Medicare Part B and for Premium Hospital Insurance Under Medicare Part A.--You are required to pay the full amount of monthly premiums for Medicare Part B and, where applicable, for Premium Hospital Insurance under Medicare Part A. You may enroll QMBs and pay the Medicare Part B premiums under the State buy-in process under §1843 of the Act. Effective January 1, 1990, a State may request and obtain a buy-in agreement modification to include payment of Part A premiums on behalf of QMBs. Payment of premiums through buy-in is advantageous because premiums paid through this method are not

subject to the increases otherwise applicable in the case of late enrollment or re-enrollment. States without a buy-in agreement for Part B and/or Part A, are billed for the premiums (which may include any penalty applicable to the QMB for late enrollment) when the State seeks to enroll the QMB in Part A or Part B.

3490.14 Payment of Medicare Part A and Part B Deductibles and Coinsurance.--

A. State Agency Responsibility.--You are required to pay for Medicare Part A and Part B deductibles and coinsurance for Medicare services, whether the services are covered in your Medicaid State plan. The actual amount of your payment depends on the payment rates for particular Medicare services, or the payment rates for the Medicare deductibles and coinsurance that you establish in your State plan for QMBs. If the State has set Medicaid payment rates for particular Medicare services, and if the amount actually paid by Medicare exceeds this rate, the State does not make a payment. When the Medicaid rate exceeds the amount paid by Medicare, pay the difference between the amount paid by Medicare and the Medicaid payment rate. Medicare's payment is equal to a percentage (usually 80%) of the Medicare approved charge for the service, less the annual deductible amount (if the deductible was not previously met). If the State has set Medicaid payment rates for Medicare deductibles and coinsurance with respect to particular services covered by Medicare, pay these amounts (minus any Medicaid copayments which are the recipient's liability) when a QMB incurs liability for services which are subject to the Medicare deductible, or which are considered Medicare coinsurance.

In either case, Medicaid's actual payment, plus the QMB's liability for Medicaid copayment under the State plan, if any, is payment in full for Medicare deductibles and coinsurance.

1. Medicare Services Covered by Medicaid.--For Medicare services which are also covered under your State's Medicaid plan (whether they are within the amount, duration, and scope limitations of that plan), you have several options. Your payment rates for particular services may be the same as the payment rates applicable for Medicaid recipients who are not Medicare eligible, or you may choose to set separate, higher payment rates up to the Medicare allowable rate for service or the Medicare deductible and coinsurance.

2. Medicare Services Not Covered by Medicaid.--For Medicare services which are not covered under your State's Medicaid plan, you have the following options. Your State plan may provide reasonable payment rates for particular services, up to the Medicare rates for services, or reasonable payment rates under which a portion or the total amount of Medicare deductibles and coinsurance is payable. Any payment rates must be justified as reasonable, and approved by HCFA, where you choose rates that are less than the Medicare rate for a service or less than the Medicare deductibles and coinsurance.

B. Payment to Providers.--Subject to State law, a provider has the right to accept a patient either as private pay only, as a QMB only, or (if the patient is both a QMB and Medicaid eligible) as a full Medicaid patient, but the provider must advise the patient, for payment purposes, how he/she is accepted. Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Medicaid participating providers, even though a Medicare service may not be covered by Medicaid in the State plan. A provider agreement necessary for

participation for this purpose (e.g., for furnishing the services to the individual as a QMB) may be executed through the submission of a claim to the Medicaid agency requesting Medicaid payment for Medicare deductibles and coinsurance for QMBs. The claim may not be disallowed on the basis that the Medicare service is not covered by Medicaid in the State plan or that the provider accepts the patient as a QMB only. The actual payment made by Medicaid, plus the QMB's Medicaid copayment liability, if any, under the State plan, is payment in full for Medicare deductibles and coinsurance. In this case, the provider is restricted under §1902(a)(25)(C) of the Act, from seeking to collect any amount from a QMB for Medicare deductibles or coinsurance, which is in excess of his/her liability under Medicaid, even if Medicaid's payment is less than the Medicare deductibles and coinsurance.

Effective for physicians' services under Medicare Part B (as defined in §1848(j)(3) of the Act) furnished on or after April 1, 1990, to a QMB (or any Medicaid recipient), Medicare payment for the service is made on an assignment related basis. Medicare payment in these cases is made directly to the provider. However, if a provider is not required to, and does not accept Medicare assignment under Part B, he/she may bill an individual who is a QMB only, for the difference between his/her charge for the service and Medicare's rate for the service. An individual may have a potential liability for services other than physicians' services, if accepted by the provider as a QMB only and the provider's charges are greater than the amount recognized by Medicare. If the individual is a QMB and is also dually eligible for Medicaid services in the plan which are also covered by Medicare, then any Medicaid payment for the Medicaid covered service is considered payment in full with respect to providers who accept the individual as a full Medicaid patient. The provider, in this case, accepts the individual as a Medicaid patient even though he/she does not accept Medicare assignment, and may not seek to collect the difference between his/her charge and Medicare's rate for the service. (See examples.)

C. QMB's Liability.--You may elect to impose nominal Medicaid copayments for covered or non-covered Medicare services on QMBs, as provided in 42 CFR 447.50 et seq. The same copayment restrictions applicable to categorically needy individuals apply to QMBs. A QMB's liability, if any, for Medicare deductibles and coinsurance, therefore, is limited to the nominal copayment amounts established in the State plan.

D. Examples.--Following are examples of situations to illustrate the payment responsibilities in subsection B. In each of the examples, the provider accepts Medicare assignment. In each of the examples, if the provider is not required to, and does not accept Medicare assignment and the individual is a QMB only, the provider may only bill the individual for the $25 difference between the charge and the Medicare rate for service.

Column A shows Medicare deductible is met and State imposes no Medicaid copayment.

Column B shows Medicare deductible is met and State does impose Medicaid copayment.

Column C shows Medicare deductible is not met and State imposes no Medicaid copayment.

MEDICAID RATE FOR MEDICARE DEDUCTIBLES AND COINSURANCE

Example 1

	A	B	C
Provider charges	$125	$125	$125
Medicare rate for service	100	100	100
Medicare deductible not met	0	0	50
Medicare pays 80% of rate for service less deductible not met	80	80	40
Medicare coinsurance	20	20	10
Medicaid rate for Medicare			
--deductible	50	50	50
--coinsurance	20	20	10
Medicaid copayment option	0	5	0
Medicaid pays for Medicare deductible and coinsurance	20	15	60
Patient copayment liability under Medicaid	0	5	0

MEDICAID RATE FOR MEDICARE SERVICE

Example 2

	A	B	C
Provider charges	$125	$125	$125
Medicare rate for service	100	100	100
Medicare deductible not met	0	0	50
Medicare pays 80% of rate for service less deductible not met	80	80	40
Medicare coinsurance	20	20	10
Medicaid rate for Medicare service	100	100	100
Medicaid copayment option	0	5	0
Medicaid pays for Medicare deductible and coinsurance	20	15	60
Patient copayment liability under Medicaid	0	5	0

MEDICAID RATE FOR MEDICARE SERVICE

Example 3

	A	B	C
Provider charges	$125	$125	$125
Medicare rate for service	100	100	100
Medicare deductible not met	0	0	50
Medicare pays 80% of rate for service less deductible not met	80	80	40
Medicare coinsurance	20	20	10
Medicaid rate for Medicare service	90	90	90
Medicaid copayment option	0	5	0
Medicaid pays for Medicare deductible and coinsurance	10	5	50
Patient copayment liability under Medicaid	0	5	0

Example 4

	A	B	C
Provider charges	$125	$125	$125
Medicare rate for service	100	100	100
Medicare deductible not met	0	0	50
Medicare pays 80% of rate for service less deductible not met	80	80	40
Medicare coinsurance	20	20	10
Medicaid rate for Medicare service	80	80	80
Medicaid copayment option	0	5	0
Medicaid pays for Medicare deductible and coinsurance	0	0	40
Patient copayment liability under Medicaid	0	0	0

3491. COVERAGE OF SPECIFIED LOW INCOME MEDICARE BENEFICIARIES FOR MEDICARE PART B PREMIUMS

3491.1 General.--Section 4501(b) of OBRA 1990, amended §1902(a)(10)(E) of the Act to mandate coverage of specified low-income Medicare beneficiaries, beginning January 1, 1993. It requires medical assistance payment of Medicare Part B premiums in the 50 States and the District of Columbia. This also applies to any State providing Medicaid to its residents under a waiver granted under §1115 of the Act. Coverage of this group remains optional in the territories, which for purposes of this provision include Guam, Puerto Rico, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

3491.2 Specified Low-Income Medicare Beneficiaries (SLMB).--A SLMB is an individual who meets all of the eligibility requirements for QMB status (see §3490.2), except for income in excess of the QMB income limit, but not exceeding the limits in §3491.3.

3491.3 Income Levels and Effective Dates.--Effective for calendar years 1993 and 1994, the income limit is 110 percent of the FPL. Effective for calendar years beginning 1995, the income limit is 120 percent of the FPL. Unlike QMBs, retroactive eligibility (of up to three calendar months) applies to this group.

Cost of living increases in title II benefits (COLAs) are disregarded in determining income eligibility through the month following the month in which the annual FPL update is published. In most years, this means that COLAs are disregarded through March since the new poverty levels are normally published in February of each year. For SLMBs who have title II income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded, or in most years, April. For SLMBs without title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.

3491.4 Federal Poverty Level.--The FPL is published annually (usually mid-February) in the Federal Register by HHS. You may not exceed the percentage of the poverty level as set forth in the Federal Register for a family of the size involved. Generally, the new poverty levels are effective no later than the date of publication in the Federal Register.

3491.5 Payment of Medicare Part B Premiums.--You are required to pay the full amount of monthly premiums for Medicare Part B. You may enroll SLMBs and pay the Medicare Part B premiums under the State buy-in process under §1843 of the Act. Individuals eligible as SLMBs are considered QMBs for purposes of accretion under the Part B State buy-in process. However, unlike for QMBs, FFP is available for the premiums based on an eligibility which may be retroactive for up to three months.

3492. COVERAGE OF QUALIFYING INDIVIDUALS FOR MEDICARE PART B PREMIUMS

3492.1 General.--Section 4732 of the Balanced Budget Act of 1997 amended §§1902(a)(10)(E) and 1905(b) and added new §1933 of the Social Security Act establishing a capped allocation for each of 5 years beginning January 1998, to States and the District of Columbia for payment of all or part of Medicare Part B premiums for two new mandatory eligibility groups of low-income Medicare beneficiaries, called Qualifying Individuals.

3492.2 Qualifying Individuals (QIs).--QIs are Medicare beneficiaries who would be eligible for Medicaid benefits as Qualified Medicare Beneficiaries (QMBs) but for the fact that their income exceeds the income levels established for QMBs and Specified Low-income Medicare Beneficiaries (SLMBs). This means that QIs must be entitled to Medicare hospital insurance benefits under Part A, with or without payment of premiums, and have resources that do not exceed twice the maximum amount established for Supplemental Security Income (SSI) eligibility. Unlike QMBs and SLMBs, who may be determined eligible for Medicaid benefits in addition to their QMB or SLMB benefits, **QIs cannot be otherwise eligible for medical assistance under the State plan.** (See §1902(a)(10)(E)(iv)(I) of the Social Security Act.) Retroactive eligibility (of up to 3 calendar months prior to application) applies if: (1) the individual met all QI eligibility criteria in the retroactive period, and (2) the retroactive period is no earlier than January 1 of that calendar year.

3492.3 QI-1s.--Individuals in the first group of QIs (QI-1s) are eligible if their incomes are at least 120 percent of the official poverty line, but less than 135 percent. The Medicaid benefit for QI-1s consists of payment of the full Medicare Part B premium. QI-1s are to be accreted into the State Buy-in system under code "U". (QMBs are code "P", and SLMBs are code "L").

3492.4 QI-2s.--Individuals in the second group of QIs (QI-2s) are eligible if their incomes are at least 135 percent of the official poverty line, but less than 175 percent. The Medicaid benefit for this group consists of payment of only the portion of the Medicare Part B premium that is attributable to the shift of some home health benefits from Medicare Part A to Part B. The amount of this benefit in 1998 is $1.07 per month. This is equivalent to 1/7 of the cost of the home health shift. The amount will increase by an additional 1/7 in each of the following years through 2002. The benefit may be paid directly to the eligible QI-2s, since it represents a refund of overpayment of Part B premiums they have already paid. The benefit may be paid prospectively or retroactively, on a monthly, quarterly, or annual basis.

3492.5 Eligibility.--All QIs must be permitted to apply for assistance during a calendar year beginning 1998. However, because of the capped allotment, the number of QIs selected in a calendar year must be limited so that the aggregate amount of benefits provided to such individuals in the calendar year is estimated not to exceed your allocation for the fiscal year ending in that calendar year. QIs will be selected on a first-come, first-serve basis (in the order in which they apply).

QIs have the same appeal rights as QMBs, SLMBs, or any other individual potentially eligible for Medicaid. If an individual under appeal is determined eligible, eligibility will be granted based on the date of application. Estimated allowance should be made for individuals on appeal so that an eventual determination of eligibility will not cause the allocation to be exceeded.

Once a QI is selected to receive assistance in a calendar month, the QI is entitled to receive assistance for the remainder of the calendar year, if the individual continues to be a QI. However, the fact that a QI receives assistance at any time during the year does not necessarily entitle the individual to continued assistance for any succeeding year. For calendar years after 1998, preference shall be given to individuals who were QIs, QMBs, SLMBs, or Qualified Disabled and Working Individuals (QDWIs) in the last month of the previous year and who continue to be, or become QIs. These individuals in the carryover period may be determined eligible on the basis of a redetermination in lieu of an application.

3492.6 Federal Financial Participation (FFP).--If an approvable QI plan amendment has been submitted, you may claim FFP at the Federal Medical Assistance Percentage (FMAP) rate of 100 percent for the amount of premiums paid for each group of QIs during calendar quarters in a calendar year. The HCFA 37 and HCFA 64.9 have been modified for you to estimate and to claim these expenditures. The FMAP will remain at 100 percent to the extent that the expenses for the Medicare Part B premiums do not exceed the State's allocation. Any expenses for the Medicare Part B premiums that are in excess of your allocation will not be reimbursed under FFP. Administrative expenses for this program remain at the 50 percent Medicaid level and are not part of the capped allotment.

For each fiscal year 1998 through 2002, the amount specified in §1933(c)(1) of the Act is to be allocated among States that have executed a State plan amendment, according to the formula indicated in §1933(c)(2). The allocation is based on the Secretary's estimate of the ratio of the sum of twice the number of QI-1s and the total number of QI-2s in the State to the sum of those amounts for all States. The fiscal year allocation available to each State will be published in the Federal Register.

3493 MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI PAYMENT.

The Balanced Budget Act (BBA), enacted August 5, 1997, provides that children who were being paid SSI on August 22, 1996 who but for the enactment of §211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 would continue to be paid SSI are mandatorily eligible for Medicaid. This provision is effective for those children who lose SSI payment on or after July 1, 1997.

A. Children Covered by §1902(a)(10)(A)(i)(II) (§4913 of the BBA).--Covered children are those former SSI recipients who have the following characteristics.

- The child was being paid SSI on August 22, 1996.
- The child's SSI payment stopped on or after July 1, 1997.
- The decision to stop SSI payments was due to a determination that the child does not meet the definition of disability enacted on August 22, 1996 as § 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
- The child would, except for the determination described in the preceding bullet, continue to be paid SSI.

B. Action by §1634 and Criteria States upon receiving information from SSI, or from the recipient or recipient's representative, that a Medicaid eligible child is no longer receiving SSI payments.--

- If the SSI action meets the criteria listed above, the child should not be terminated from Medicaid.
- If the State has already terminated a child meeting the listed criteria, reinstate Medicaid eligibility and then perform a redetermination to determine whether the child continues to meet SSI eligibility criteria. For this purpose continue to use the pre August 22, 1996 definition of disability.

o Medicaid eligibility for children covered by this provision will continue until the earlier; attainment of age 18, or the child no longer meets the criteria of the SSI program for payment of benefits (other than the post August 22, 1996 definition of disability for children), or the child is not eligible under another Medicaid eligibility basis.

C. Eligibility of Former SSI Children for Poverty Level Medicaid Eligibility.--Children who are eligible for Medicaid under any of the mandatory eligibility groups described in §1902(a)(10)(A)(i)(I) through (III) are excluded from the definition of poverty level child under §1902(l). So long as such a child meets the eligibility criteria in paragraph A above that child may not be a poverty level child, since the eligibility group described in paragraph A above is covered under §1902(a)(10)(A)(i)(II). Therefore, since passage of the BBA, a child being paid SSI on August 22, 1996 who loses such payment but meets the criteria of this section, may not be classified as a poverty level child in a State which has not elected the option under §1902(f). See paragraph F. for discussion of the impact of §4913 in §1902(f) States.

D. Redetermination of Medicaid Eligibility for Former SSI Children.--Redetermine whether a child eligible under this section meets the non-disability eligibility criteria at least every 12 months. The 12 month period begins on the date a child covered by this section becomes a Medicaid only case.

E. Redetermination of Disability for Medicaid Eligible Children Who Lost SSI Because of the Enactment of §211(a) of Public Law 104-193.-- Redetermine disability following the rules in 20 CFR 416.920-930 as in effect on April 1, 1996 in the Code of Federal Regulations. Establish a date to conduct a redetermination of disability and conduct such redetermination following the policies in the succeeding two bullets.

o Follow the rules used by SSA in 20 CFR 416.990 as published on April 1, 1996 in the Code of Federal Regulations with the following modifications to the frequency of review. Review disability after at most 18 months if medical improvement is expected. Review disability after at most 3 years if disability is not permanent but medical improvement cannot be predicted. Review disability after at most 7 years if disability is permanent.

o The beginning date for the periods described in the preceding bullet is the date a disabled child becomes a Medicaid only case upon an administratively final SSI termination. For example, a child who lost SSI on July 1, 1997 because the child did not meet the new disability definition enacted August 22, 1996, but who had appealed the notice received from SSA, will not have a diary date established until a final administrative decision upon completion of the appeal and any subsequent SSA appeal is made by SSA and transmitted to the State.

F. Applicability in §1902(f) States of Continued Medicaid for Children Terminated From SSI Because of the New Disability Definition.--A State which operates its Medicaid program under the option in §1902(f) of the Act, does so "notwithstanding any other provision of Title XIX." Therefore, §4913 of the BBA permits but does not require that the State provide Medicaid to disabled children who lose their SSI by virtue of the 1996 change to the SSI definition of disability for children if the State used the SSI childhood disability rules in effect on August 21, 1996 for determining the Medicaid eligibility of those children, and the child meets the State's other Medicaid eligibility criteria under its State plan.