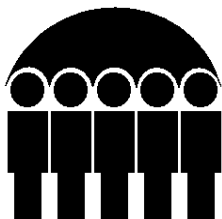


Revised September 19, 2000

Employees' Manual
Title 8
Chapter G

MEDICAID
CASE MAINTENANCE



Iowa
Department
of
Human Services

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OVERVIEW

This chapter covers policies relating to how to handle changes involving active Medicaid cases.

The first section deals with the client's responsibility to report changes in household circumstances and worker actions based on the information received about changes. Reported changes may result in reinstatement or automatic redetermination, which are topics that follow the discussion on changes.

The next two sections relate to specific FMAP-related and SSI-related case maintenance issues. Reporting fraud or misuse of Medicaid services by clients or providers comprises the final section of the chapter.

CLIENT REPORTING REQUIREMENTS

Client reporting requirements include:

- ◆ Supplying requested information or verification.
- ◆ Reporting changes.

NOTE: "Clients" include applicants, members, people who are conditionally eligible, and people whose income or assets are considered in determining eligibility for an applicant or member.

All clients are responsible for reporting changes timely as they occur. However, the specific changes required to be reported and the time frames within which they must be reported may differ depending on whether the member receives SSI-related or FMAP-related Medicaid.

The following sections explain requirements for:

- ◆ [Supplying information and verification.](#)
- ◆ [Reporting changes.](#)

Supplying Information and Verification

Legal reference: 42 CFR 435.916, 441 IAC 76.2(249A)

The client must supply complete and accurate information needed to establish ongoing eligibility. If you need additional information, give, mail, or fax a written request to the client. Inform the client in writing of the date the information is due and the consequences for failure to supply the information or verification.

The client must supply the information within ten calendar days of the day you give or mail a written request to the client. The ten-day period begins with the day after you issue the written request. When the tenth day falls on a nonworking day or a legal holiday, extend the due date to the next working day for which there is regular mail service.

“Supply” means the Department receives the requested information or verification by the specified date. You can allow additional time when the client is making every effort to obtain the information but is unable to do so in ten days and notifies you about the problem.

See [1-C-Appendix](#) for a list of release forms to use when obtaining information from a third party. Explain the following to the member, in writing:

- ◆ When the client must obtain information from a third party, it is the client’s responsibility to return the information timely. It is not the responsibility of the third party.
- ◆ It is the client’s responsibility to follow up with the third party before the due date to make sure the third party will have the information ready to pick up or has mailed the information in time to be received by the Department by the due date.
- ◆ The client may ask for more time to get the information to the Department if the third party does not have the information ready or it will not arrive by the due date.

Although it is the client’s responsibility to provide information, do not cancel assistance if the client is unable to get the information because of a disability, lack of education, or lack of knowledge. If requested, assist the client in getting information to establish continuing eligibility.

A client who provides a signed release to a specific individual or organization for specific information has met the requirement for supplying requested information or verification. The general release does not meet this requirement unless the client asks for help.

Cancel or deny Medicaid if the client fails to supply the information or refuses to authorize you to obtain it from other sources when the client is unable to obtain the information.

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

Ask the client to provide information that would help to verify what the client is telling you about the spouse who is no longer in the home. Determine eligibility from the information provided. If the member fails to provide the requested information, cancel the case.

Reporting Changes

Legal reference: 42 CFR 435.916(b) and (c);
441 IAC 75.4(3)“c,” 75.57(1), 75.57(2), and 76.10(249A)

The client or someone acting on the client’s behalf must report the following and any other changes that affect eligibility:

- ◆ Changes in household membership.
- ◆ Medical or health insurance starting, changing, or ending.
- ◆ A change in mailing or living address. Remember to offer *Voter Registration* forms when a client reports a change of address, either in person or by phone. Ask clients reporting an address change, “If you are not registered to vote where you live now, would you like to apply today to register to vote?” Send the *Voter Registration* form if the client wants to register.
- ◆ Filing of an insurance claim against a possible liable third party with the expectation of seeking restitution or payment of medical expenses that resulted from an injury and were paid by Medicaid.
- ◆ Retaining an attorney with the expectation of seeking restitution for an injury from a possible liable third party when Medicaid has paid the resulting medical expenses.
- ◆ The receipt of a partial or total settlement for payment from a liable third party of medical expenses due to an injury which were paid by Medicaid.

FMAP-related clients must also report beginning or ending income of a client. This includes:

- ◆ The receipt of non-recurring lump sum income.
- ◆ The continuing receipt of recurring lump sum income in irregular amounts.
- ◆ Beginning to receive recurring lump sum income from a source from which another type of income is currently being received.

See 8-E, [Recurring Lump Sum](#), for more information.

Clients who are **not FMAP-related** must also report:

- ◆ Receipt of resources by a client.
- ◆ Changes in income of a client
- ◆ Receipt of a social security number.
- ◆ Becoming incapacitated or disabled or recovering from incapacity or disability.

SSI-related clients and **members eligible for Medically Needy** must also report:

- ◆ Unmet medical bills.
- ◆ A change in health insurance premium expense, including completion of buy-in.

Members receiving **home- and community-based services** must also report residency in a medical institution for other than respite care for more than 15 days.

Clients may report changes in person, by telephone, or by mail. Give clients form 470-0499, *Ten-Day Report of Change*:

- ◆ At the time of review.
- ◆ When requested by the client.
- ◆ When the client submits the form to the local office and needs a new one.

Members and people being added to the existing eligible group must report changes within ten calendar days of the day the change occurred. If the last day to report a change is a nonworking day, the person must report the change by the next working day.

Act on changes and complete a redetermination within ten days of when you become aware of a change or when you verified the change, if verification is appropriate.

When the client reports changes in health insurance, send form 470-2826, *Insurance Questionnaire*, to the client to fill out and return. When the client reports filing an insurance claim, retaining an attorney, or receipt of a settlement, notify the Iowa Medicaid Enterprise Lien Recovery Unit at 1-888-543-6742.

When a probable change affects eligibility, act on the change if you have all information you need to establish eligibility, and the best information available indicates that the change will actually take place as reported. See 8-A, [Notification](#), for timely notice requirements. See [AUTOMATIC REDETERMINATION](#).

Establish a claim for any medical assistance that was incorrectly paid when a change affecting eligibility was not reported timely.

CHANGES IN HOUSEHOLD CIRCUMSTANCES

Legal reference: 441 IAC 76.10(5); 42 CFR 435.120, 42 CFR 435.919

After assistance has been approved, changes occurring during a month are effective the first day of the next calendar month, provided timely notice can be given. When timely notice is required and cannot be given, the effective date is the first day of the second month following the month the change was reported. For exceptions to this policy, see 8-F, [Transitional Medicaid](#).

The following sections explain procedures that apply to all Medicaid households for acting on:

- ◆ [Changes received through IEVS](#).
- ◆ [Changes received from other sources](#).
- ◆ [The death of a member](#).

When you become aware of unreported information, the date you receive a signed release for specific information from the member or the date the member otherwise acknowledges the previously unreported information is the date the member reports the change.

Do not cancel or deny anyone's Medicaid due to a failure to supply information about a change in circumstances that does not affect a person's eligibility.

Mrs. R and her three children receive Medicaid under FMAP. The youngest is receiving Medicaid as a newborn child of a Medicaid-eligible mother. Mr. R, the father of all three children, returns home and has earnings.

The worker requests income verification, but the information is not returned by the due date. The worker cancels the Medicaid for failure to return requested information. However, because the infant is in "newborn status," the newborn's Medicaid is not canceled.

See also [ADDITIONAL FMAP-RELATED CASE MAINTENANCE: Adding a New Member to an Existing FMAP-Related Case](#) and [Other Changes in the Household](#), for additional procedures specific to FMAP-related households.

Changes Reported From IEVS and Other Automated Sources

Legal reference: 42 CFR 435.945, 435.948, 435.955, 441 IAC 75.57(9) & 76.12

In addition to changes reported by the household, information that might affect eligibility is also available from reports generated through the Income and Eligibility Verification System (IEVS) and other sources. Check the description of each report that follows in this section and see [14-B\(4\)](#), [14-E](#), and [14-G](#) for more details.

When you receive IEVS information, act on the report as follows:

1. Determine if the client reported the information and if you have already acted on it. If so, note and date this on the IEVS report and file it in the case record.

Exception: Do not file the *SSA Earnings and Pension Report, S470X425-A*, or the *IRS Match Report, S470X615-A*, in the case record. If you have already acted on the information in these reports, note and date this in a narrative in the case record.

2. Act on information received from IEVS that was not previously reported by the household within 30 days from the date printed on the report. Check the description of each report to see whether the information must be verified or is already considered verified.

If the new information requires verification, contact the household in writing and obtain a specific release of information, if necessary. You may delay action beyond 30 days when a third party causes the delay by not providing requested verification. It may be necessary to reduce or cancel future benefits and to establish a claim.

3. If the income does not affect past, current, or future eligibility, note this on the IEVS report, date it, and file it in the case record.

Exception: Do not file the *SSA Earnings and Pension Report, S470X425-A*, or the *IRS Match Report, S470X615-A*, in the case record. If the income on these reports does not affect past, current, or future eligibility, note and date this in a narrative in the case record.

4. If the IEVS information affects eligibility, do an automatic redetermination and adjust future benefits. Do a claim if necessary.

IEVS Wage Report

Legal reference: 42 CFR 435.945(g), 435.948(a)(1), 441 IAC 75.57(2) & (2)“I”

Use information provided by Iowa Workforce Development on the *Wage Report*, S470X225-A, to determine if the household reported earnings. If the *Wage Report* indicates earnings that were not reported or were underreported, contact the client to verify information. Do not take any case action based solely on data taken from this report.

IEVS Unemployment Compensation Report

Legal reference: 42 CFR 435.945, 435.953(c), 441 IAC 75.57(1)“F”

The *Unemployment Compensation Report*, S470X160-A, is a monthly list of all Medicaid cases that contain a household member whose social security number matches with the social security number of a person to whom Iowa Workforce Development (IWD) issued unemployment benefits for the previous month.

Consider benefits received on the second day after IWD mailed the check. The column entitled “Date Received” shows this date. When the second day falls on a Sunday or legal federal holiday, the IEVS system extends the time to the next mail delivery date.

The report lists the amount withheld for child support. Consider this amount verified. This amount is considered income and must be added to the net amount received by the client. However, allow it as an income deduction or diversion if the child for whom the support is intended is not living in the home. See 8-E, [INCOME](#).

The amount listed as withheld for unemployment insurance recoupment is not considered income.

Consider the benefit amounts on this report to be verified income. Act on the unemployment benefit information before the next benefit month.

Allow the household to verify the amount of benefits actually received when the household indicates the amount of unemployment benefits provided through IEVS is wrong. Use the verified amount from the household instead of the amount shown on the printout.

The household must report the discrepancy before the first month affected by the discrepancy or ten days after the date of the *Notice of Decision* (whichever is later) to have medical eligibility redetermined for the first month affected by the discrepancy.

IEVS Bendex and State Data Exchange

Legal reference: 42 CFR 435.948(a)(3), 441 IAC 9.10(4)“c”

Use the information provided by the Social Security Administration on the Bendex and State Data Exchange to verify social security numbers and Social Security, Black Lung, and SSI benefits.

IEVS Earnings and Pension Report (IRS)

Legal reference: 42 CFR 435.948, 435.952, 435.953, 435.955, 441 IAC 9.10(4)“c”

Use the information on the *SSA Earnings and Pension Report*, S470X425-A, as an indicator of the wages and pensions. Consider the information unverified. **Do not file this report in the case record.**

IEVS Internal Revenue Service Report (IRS)

Legal reference: 42 CFR 435.948(a)(2) & (4), 441 IAC 9.10(4)“c”

Use the information on the *Internal Revenue Service Report*, S470X615-A, as an indication of earned and unearned income. Consider this information unverified. **Do not file this report in the case record.**

Iowa Central Employee Registry (ICER)

Legal reference: 42 CFR 435.948(a)(6) & (e), 441 IAC 9.10(4)“a” & “b”

The ABC system runs a daily match with the ICER system. If there is a match for a person connected with a Medicaid case, a tickler message will appear on the BINC screen. See [14-B\(4\)](#) for details regarding the BINC screen.

If the tickler message indicates employment that was not reported, contact the person to verify information. Do not take any case action based solely on data taken from the ICER match.

Child Care Assistance: CCA Warrant Report

Legal reference: CFR 435.948(a)(6) and 435.952; 441 IAC 9.10(4)a, b, and c and 75.57(249A)

When a review form is due in the current month, the ABC system matches with other Departmental systems to identify state Child Care Assistance payment warrants mailed in the previous two calendar months to persons who receive Medicaid or whose income must be considered when determining the household's eligibility.

If a Child Care Assistance warrant is mailed to a Medicaid member, the member's name will appear on the report. This report is issued to the local office the first working day of each month. Consider the benefit amounts on this report verified income. Act on the information before the next month.

Acting on IEVS Information on a Community Spouse

IEVS reports are sent for all people whose names and identifying information have been pended on the ABC system, including a community spouse. Do not delay processing eligibility if the IEVS report is not received within the 30-day-processing period.

If Medicaid is approved for the institutionalized spouse, leave the community spouse pended. You should receive an IEVS report on the community spouse as well as on the applicant.

If the Medicaid case is denied for the institutionalized spouse, or only an attribution is completed, leave both cases pending for Medicaid. Manually issue the *Notice of Attribution*. If the Medicaid case is denied, manually issue a notice denying the Medicaid.

An IEVS report should be issued for all pending cases. If there is no IEVS report within 60 days, close the pended case. There is no match for IEVS. If you believe that an IEVS report will not be forthcoming for either the applicant or the community spouse, document this in the case record.

When you receive the IEVS report, compare the resources that are made known with reported resources. If the attribution needs to be corrected, manually issue a *Notice of Decision* to correct the attributed amounts.

Acting on Changes Received From Other Sources

Legal reference: 42 CFR 435.952, 435.955, 441 IAC 76.7(249A)

When you receive a report from sources other than the client indicating that there may be unreported income or resources that may affect eligibility, contact the client to ascertain the facts and then determine the effect on eligibility.

If the subject of the report is an SSI-eligible person, forward the information to the Social Security Administration. Investigate only when the client is an institutionalized spouse with a community spouse, or the report alleges that:

- ◆ The client has a Medicaid qualifying trust.
- ◆ The information would affect eligibility for the Medicaid retroactive period.
- ◆ The client may have transferred resources to gain Medicaid eligibility.

The client must provide requested verification. See [Supplying Information and Verification](#).

You may also receive notification from the Iowa Medicaid Enterprise that a Medicaid member is eligible for Medicare Part A and B when this is not reflected on the current eligibility file. Verify the coverage with the Social Security Administration or with Bendex.

If an update is needed in the “Medicaid Resource Section” of the eligibility file, complete form 470-0397, *Request for Special Update*, according to the instructions in 6-Appendix.

AWARE Hotline Referrals

Policy:

The Income Maintenance Customer Service Center (IMCSC) tracks fraud complaints from the Anti-Welfare Abuse Recognition Effort (AWARE) hotline.

Procedure:

When the hotline receives a fraud complaint concerning a DHS client:

1. IMCSC records the information about the complaint on form 470-4768, *Fraud Complaint Referral*.
2. IMCSC sends an electronic copy of the form to the IM worker for the case and to the worker’s supervisor and income maintenance administrator or designee.

3. The IM worker takes appropriate action on the information.
4. The IM worker documents on the form what action was taken and returns the completed form to the IMCSC.
5. IMCSC records the return date and the disposition of the complaint.
6. IMCSC maintains a record of hotline tips and compiles a monthly summary report that reports the status of hotline complaints received.

Death of a Member

Legal reference: 42 CFR 431.213

Eligibility for Medicaid ends when the member dies. Verify the date of the member's death using a reliable source, such as a funeral director, hospital, courthouse record, newspaper obituary, or SDX. Send a *Notice of Decision* to the member's family, conservator, or guardian, as appropriate. See also 8-D, [ESTATE RECOVERY](#).

REINSTATEMENT

Legal reference: 441 IAC 7.7(249A), 7.7(6); 75.51(249A)

Reinstate a case without a new application when all information is provided at least three working days before the effective date of cancellation and eligibility can be reestablished. See [8-A](#) for notification requirements.

You can also reinstate a case without a new application when:

- ◆ All necessary information is provided after the third working day but before the effective date of cancellation, and
- ◆ Eligibility can be reestablished before the effective date of cancellation.

If you can process the information and make all necessary computer entries before the effective date of cancellation, the case can be reinstated even if the system does not process the information until after the effective date of cancellation.

Issue adequate and (if appropriate) timely notice whenever an attempt at reinstatement is made.

REINSTATEMENT

Iowa Department of Human Services

Title 8 Medicaid

Revised June 12, 2009

Chapter G Case Maintenance

When a notice to cancel is issued and the member resolves the issue but should be canceled for another reason, or reinstated with higher client participation, send timely and adequate notice of the new action, unless listed under [When Timely Notice Is Not Required](#) in 8-A.

If the additional timely notice required for a second reason cannot be issued in time to be effective the first day of the immediately following month, reinstate the case with the former client participation amount.

Then, issue the second timely notice to cancel the case or increase client participation effective the first day of the second following month. You cannot increase client participation on a canceled case during the reinstatement process unless you give timely notice.

The fact that you have already issued a *Notice of Cancellation* or a *Notice of Decision* to cancel a case does not stop you from manually issuing a second notice when a new reason for cancellation occurs. The client then must resolve both issues before assistance can be reinstated.

AUTOMATIC REDETERMINATION

Legal reference: 42 CFR 435.930(b), 441 IAC 76.11(249A)

Whenever a member no longer meets the eligibility requirements of the current coverage group, do an automatic redetermination of eligibility for other Medicaid coverage groups.

Exception: Do not do an automatic redetermination if the reason the client is ineligible under the current coverage group relates to a condition of eligibility that applies to all coverage groups. Examples include refusal to provide verification and failure to assign a third-party benefit.

When the member is eligible under a different coverage group, make system entries no later than the day before the effective date of cancellation from the previous coverage group. This will ensure the continuation of Medicaid assistance.

1. Mr. X, a 20-year old receiving Medicaid under the CMAP coverage group, does not return requested information. He is not eligible for any other FMAP-related coverage group because he did not provide information necessary to determine Medicaid eligibility. Therefore, an automatic redetermination is not applicable. The worker sends timely notice canceling Medicaid.

2. Household composition: Ms. Q, aged 20; Mr. R, aged 27; and Baby A, newborn common child born January 6.

Ms. Q has been receiving Medicaid under the CMAP coverage group. Mr. R’s income has not been considered in establishing Ms. Q’s eligibility. Baby A has been receiving Medicaid on Ms. Q’s case as the newborn child of a Medicaid-eligible mother.

On March 2, Ms. Q turns 21. The IM worker completes a redetermination to see if Ms. Q is eligible under another coverage group. Based on Ms. Q’s income and resources, she is not eligible for Medicaid under any other coverage group unless Baby A loses newborn status and is considered in the household.

Ms. Q chooses to leave Baby A in newborn status, and Ms. Q’s Medicaid benefits are canceled April 1. Baby A continues to be eligible as the newborn child of a Medicaid-eligible mother, even though Ms. Q is no longer eligible for Medicaid.

If an SSI-related person is no longer disabled, look for eligibility under FMAP-related Medicaid. If an FMAP-related person loses eligibility, check to see if the person is disabled for SSI-related Medicaid. “Disabled for SSI-related Medicaid” means that the person:

- ◆ Is currently receiving social security disability payments; or
- ◆ Has previously been determined disabled by the Department; or
- ◆ Is a child who lost SSI due to reevaluation of disability but who remains eligible for SSI-related Medicaid under the Balanced Budget Act of 1997.

The effective date of cancellation from the current coverage depends upon when you receive information that causes ineligibility.

Information Received:	Time Frames to Complete Automatic Redetermination	Effective Date of Cancellation
By the tenth of the month	Complete the redetermination by the end of month.	First day of the month following the month the information was received. Issue timely notice.
After the tenth of the month	Complete the redetermination no later than the end of the following month.	No later than the first day of the second month following the month the information was received. Issue timely notice.

During the redetermination period, provide Medicaid only to people who were receiving Medicaid in the eligible group when eligibility under the initial coverage group ceased. This applies only to situations where the information causing ineligibility was received after the tenth of the month.

If you need additional verification before you can complete a redetermination, cancel the case using form 470-3152 or 470-3152(S), *Notice of Cancellation/Redetermination*, and request the verification. Allow the client ten calendar days from the date of notification to return the requested verification.

- ◆ If the client returns verification by the due date on the *Notice of Cancellation/Redetermination*, complete the redetermination and issue a *Notice of Decision*.
- ◆ If the client does not return verification but has a legitimate reason not to supply verification by the due date, you can grant an extension but the cancellation remains in effect. If verification is received by the second due date, treat it as though it was received timely. Complete the redetermination and issue a *Notice of Decision*.
- ◆ If the client does not return verification and you have not granted an extension, do not do anything further. Do not send a *Notice of Decision*, because the client already received a *Notice of Cancellation/Redetermination*.

If you receive an SDX from the Social Security Administration and the payment status is N01, use the SDX as income verification when completing the automatic redetermination. **Note:** Some people in an N01 payment status may be eligible for the 1619b coverage group. See 8-F, [People Ineligible for SSI \(or SSA\): Due to Earnings Too High for an SSI Cash Payment \(1619b Group\)](#).

If the client is canceled from SSI for being over resources, status N04, call the Social Security Administration to determine the amount of resources. If resources are within Medicaid limits, document the contact and complete the redetermination process. Use the SDX for resource verification. If resources are **not** within Medicaid limits, contact the client and request verification of resources.

Mr. X is a 70-year-old SSI recipient. On June 5, the IM worker receives an SDX indicating Mr. X's SSI benefits would be canceled beginning July 1, because his countable resources exceed SSI eligibility limits. The worker contacts Social Security to find out the amount of Mr. X's resources. The resource information from Social Security indicates Mr. X is over resources for Medicaid.

The worker sends Mr. X the *Notice of Cancellation/Redetermination* on June 6, canceling Medicaid beginning July 1. On the notice, the worker requests that Mr. X provide verification of his resources. Mr. X has ten calendar days to return the requested verification. If Mr. X returns the requested information, the worker examines eligibility for other coverage groups.

Keep adequate documentation in the case record to show that a redetermination was completed. Document what steps were taken to complete the process and the results of that process.

If a client files a timely appeal and reinstatement of eligibility is required, reinstate to the coverage group under appeal until a final decision is reached.

Additional Information for SSI-Related Redeterminations

For SSI-related redeterminations, eligibility under a new coverage group is usually apparent. The only time it should be necessary to use the automatic redetermination aid type is when you need additional information to make a redetermination. This affects mainly:

- ◆ SSI recipients living in their own homes who lose SSI eligibility due to excess income.
- ◆ People in the 300% group who return to their own homes from a medical facility.
- ◆ People returning home from a residential care facility.

See the following chart for more specific information.

AUTOMATIC REDETERMINATION
Additional Information for SSI-Related Redeterminations
 Revised September 19, 2000

Canceled Group	New Location	New Aid Type	Information Needed
RCF	Home	SSI or automatic redetermination	Information for spenddown.
300% group or waiver	Home or home with dependent	Medically Needy	Information for spenddown. May be others in home who affect eligibility.
300% group	Home with in-home health-related care	In-home health-related care	Service report must be completed with service cost. Client must file an application for State Supplementary Assistance.
Would be eligible for SSI if not living in medical institution	Home	Eligible for but not receiving SSI cash assistance	Refer to SSI for application.
Would be eligible for SSI, if not living in medical institution	Home with dependent	Eligible for but not receiving SSI cash assistance	Take dependent person application. Refer to SSI for application.
SSI	Location not changed	Automatic redetermination	First check eligibility for 503, disabled children who get parental social security, or widow/widower group. Check pregnancy status for women. Then get information and application if none on file.
			If over income or resources for SSI, verify resources and income with the Social Security Administration and complete the redetermination.
			If other reasons exist to lose SSI, cancel case, unless there is continuous eligibility or eligibility for postpartum women.
300%, medical institution, waiver case, or any SSI eligibility	Psychiatric institution	Existing psychiatric institution aid types or QMB	Check age. If between 21 and 65, cancel case unless eligible for QMB or enrolled in the Iowa Plan (managed behavioral health care). Transfer case record to facility worker.

Canceled Group	New Location	New Aid Type	Information Needed
In-home health-related care	Medical institution	Medical institution	Deductions for CP, homestead determination, Case Activity Report, transfers of resources. If a spouse, reassess resources.
Medically Needy	Medical institution	Medical institution 300%	30-day stay, deductions for CP, Case Activity Report, transfers of resources. New application if certification period expired. Use medical institution aid type for the date of entry to medical institution. If a spouse, reassess resources.
RCF	Medical institution	Medical institution	Deductions for CP, homestead determination, Case Activity Report, transfers of resources. If a spouse, reassess resources.
Dependent person	Medical institution	Medical institution	Deductions for CP, homestead determination, Case Activity Report, transfers of resources. Only aged, blind, or disabled remain eligible. Dependent loses eligibility. If a spouse, reassess resources.
Eligible for SSI but living in medical institution (income over \$45)	RCF	Not receiving SSI cash assistance	Applications for State Supplementary Assistance and SSI.
SSI recipient living medical institution	RCF	SSI	Application for State Supplementary Assistance.
300% group	RCF	Automatic redetermination	Application for State Supplementary Assistance. If not eligible, determine eligibility for medically needy.
SSI eligible, 503, widow, widower, disabled adult child, people who could get cash	Medical institution	Medical institution	Review form for SSI cases: deductions for CP, homestead determination, Case Activity Report, transfers of resources. If a spouse, reassess resources.

Referrals to the *hawk-i* Program

Legal reference: 441 IAC 86.4(45141)

Refer a recipient child to the *hawk-i* program as part of the automatic redetermination when the child:

- ◆ Is only conditionally eligible for Medically Needy with a spenddown, or
- ◆ Has been voluntarily excluded from the Medicaid eligible group due the income or resources of the child.

1Note: Make referrals even if the child is insured. The *hawk-i* program staff will work with the family to coordinate the dropping of the child's health insurance and the *hawk-i* approval to provide seamless coverage.

Do not refer a child to the *hawk-i* program if the child:

- ◆ Is age 19 or older, or
- ◆ Does not meet Medicaid's alien requirements (they are the same for *hawk-i*), or
- ◆ Is ineligible for Medicaid due to noncooperation (failure to provide income verification, etc.).

Make a referral by completing form 470-3565, *Referral to the *hawk-i* Program*, within one working day of the determination that the child is ineligible for Medicaid, must meet a spenddown, or has been voluntarily excluded. A copy of the notice of decision showing the income calculation establishing Medicaid ineligibility must accompany the referral form. Fax the referral and notice of decision to 515-457-7701, or send them to:

Department of Human Services
Attn: MAXIMUS/*hawk-i* Program
Division of Financial, Health and Work Supports
Hoover State Office Bldg. – 5th Floor
1305 E Walnut ST
Des Moines, IA 50319-0114

ADDITIONAL FMAP-RELATED CASE MAINTENANCE

This section contains information on additional procedures for ongoing maintenance of FMAP-related cases, including:

- ◆ [Reporting forms](#)
- ◆ [Eligibility reviews](#)
- ◆ [Adding a new member to an existing FMAP-related case](#)
- ◆ [Other changes in the household](#)
- ◆ [Budgeting for ongoing eligibility](#)

Reporting on a RRED or Quarterly Report

Legal reference: 42 CFR 435.916, 441 IAC 75.52(249A)

Members must complete form 470-2881 or 470-2881(S), *Review/Recertification Eligibility Document*, for an annual review. Exception: See 8-J, [Recertifications](#), for requirements for members of FMAP-related Medically Needy assistance.

Members on transitional Medicaid must complete form 470-2663 or 470-2663(S), *Transitional Medicaid Notice of Decision/Quarterly Income Report*. (For more information, see 8-F, [Transitional Medicaid: Requirements After Eligibility Is Established](#).)

The review RRED is automatically mailed to the member in the month before the review month. The form is due to be returned in the review month and is used to conduct the annual review. Members should receive it by the end of the month before the review month. For example, a review RRED sent to the member on August 30 is for an annual review in September to be effective October 1.

Also give a copy of the RRED to any member who asks for one, along with a postage-paid return envelope. When you manually issue a form, you must complete the identifying information on the top of the form before giving it to the member. You can also issue the form by making entries on the computer system.

When the Department issues the review RRED in the regular end-of-month mailing, the member must return the form by the fifth calendar day of the review month. (If this day falls on a weekend or holiday, forms must be returned by the next working day following the fifth calendar day.)

When the form is issued outside the regular end-of-month mailing, the member must return the form by the seventh day after the date the form is mailed. Day one of the seven-day period is the day after the day the RRED is mailed. (If the seventh day is a weekend or holiday, the form must be returned by the first working day following it.)

When the form is issued and a due date established, issuing a replacement form at the member's request does not change the due date.

The following sections give more information on:

- ◆ [Requirements for a complete report.](#)
- ◆ [Procedures when a household fails to return a complete report.](#)

Requirements for a Complete Report

Legal reference: 441 IAC 75.1(31)“h” and 75.52(4)

For a report to be considered complete:

- ◆ All questions must be answered.
 - Questions with a “yes or no” response must have either “yes” or “no” marked.
 - If the answer is “yes,” all requested information must be completed.
 - The question is considered answered if the member does not answer on the form but sends verification of the information.
- ◆ The member must sign and date the form.
 - When both parents or a parent and stepparent are in the home, **either** may sign for the household, even if temporarily absent.
 - A member's authorized representative or someone acting responsibly for the member may sign when the member is incompetent or incapacitated and unable to do so. See 8-B, [Responsible Person](#).
 - Forms that are signed and then faxed or sent electronically, such as scanned and e-mailed, do not have to be resigned. A faxed report shall be considered an original report.
- ◆ All nonexempt income must be verified. **Exception:** Members do not need to verify prorated or annualized income that remains unchanged, as long as you and the member have established a set schedule for verifying the income.

Verification of earned income does not always mean that the household has submitted every pay stub. If a pay stub is missing but you can calculate the gross income from the missing pay stub by using the year-to-date figures on the pay stubs submitted, the earned income is verified.

Place a copy of all verification supplied by the recipient in the case record. Return all verification to the recipient. Do not keep originals unless specifically for the Department.

Changes reported on a report form in the sections “Other Changes” and “Expected Changes” do not have to include verification for the report form to be complete. Give the household ten calendar days to provide any needed verification.

Inform self-employed people that income and expense records must be supplied at the time of the annual review. This is a requirement for the RRED to be considered complete.

Allow the client ten calendar days to provide any additional records. If the records are still not provided, cancel Medicaid for failure to cooperate in providing information needed to establish eligibility.

A complete quarterly report is due by the 21st of the review month unless good cause exists.

If a Household Fails to Return a Complete Report

Legal reference: 441 IAC 75.1(31)“i”(1), 75.52(4)“b”

Under quarterly reporting, eligibility is dependent upon the recipient returning a complete quarterly report by the 21st of the month. If a system-generated quarterly report is received before the 21st of the month, code it on the system as received.

If a system-generated quarterly report is not coded as received, form 470-2716, *Quarterly Report Reminder*, is issued at MRTL cutoff notifying the recipient that a complete quarterly report must be received no later than the 21st of the month unless good cause exists.

If the report is received incomplete, send form 470-2721, *Quarterly Report Follow-Up*, to notify the recipient of what needs to be done to make the report complete and that a complete report must still be received by the 21st of the month. Mail the *Quarterly Report Follow-Up* as soon as you are able, allowing the recipient as much time as possible to return a complete quarterly report by the 21st.

Cancel transitional Medicaid effective the first of the seventh month, the eighth month, or the eleventh month when a recipient fails to return a completed quarterly report, as defined under [Requirements for a Complete Report](#). If a complete quarterly report is not received by the 21st of the month, an adequate notice is issued at cutoff closing the transitional Medicaid effective the first of the next month.

If the quarterly report is received between the 21st of the month and the effective date of cancellation, transitional Medicaid remains canceled unless the recipient has good cause. However, complete an automatic redetermination.

Cancel Medicaid for all household members if a recipient fails to return a completed RRED as defined under [Requirements for a Complete Report](#).

The system generates form 470-1968, *Notice of Cancellation* (NOC), whenever a RRED is not returned timely, or you do not make entries indicating a complete report was received. However, **you** must send the NOC when:

- ◆ The form is returned timely but is incomplete, or
- ◆ The recipient fails to return an out-of-cycle report form.

Return an incomplete report form along with the *Notice of Cancellation*, telling the recipient that the report form was received incomplete. Mark any incomplete sections in red. (Do not attach the form if verification is the only information needed.)

Mail the *Notice of Cancellation* within five working days after you receive the incomplete report form. Keep a copy of the report form if you return it to the client for correction.

Allow the client ten days after the date the *Notice of Cancellation* is mailed to complete and return the form. The date that the *Notice of Cancellation* was sent is day “one” of the ten days. Remember, when the tenth day falls on a weekend or legal holiday, you must allow the client until the next working day to return the form.

If the complete form is returned within ten days and eligibility is determined, reinstate the case. See [REINSTATEMENT](#) earlier in this chapter for more information.

If after receiving the *Notice of Cancellation*, the client submits an incomplete form within the time limits for reinstating assistance, return the form to the client. Attach a letter to the form indicating which sections are incomplete and explaining that Medicaid cannot be reinstated because of the incomplete form. List the manual references for the policy.

Do not send a second *Notice of Cancellation*, form 470-1968, or a *Notice of Decision*, form 470-0485 or 470-0486. Use a letter rather than a *Notice of Cancellation* or *Notice of Decision*, because the client’s appeal period begins when a notice is sent out, and a *Notice of Cancellation* was already sent when the client didn’t turn in the report form by the due date.

1. Ms. C receives a computer-issued *Notice of Cancellation* because her RRED was not received by May 5. On May 27, the worker receives the incomplete form. The worker returns the RRED to Ms. C no later than June 4, with a letter explaining that eligibility requirements are not met. Neither a second *Notice of Cancellation* nor a *Notice of Decision* is issued to Ms. C. She must reapply.
2. Mr. D receives a *Notice of Cancellation* attached to his incomplete RRED on June 8. The worker receives the RRED, still incomplete, on June 29. The worker returns the incomplete RRED to Mr. D with a letter explaining that eligibility requirements are not met. Neither a second *Notice of Cancellation* nor a *Notice of Decision* is issued to Mr. D.

Eligibility Reviews

Legal reference: 42 CFR 435.916, 441 IAC 76.7(249A)

Review each FMAP-related case at least every 12 months.

Although an interview is not required, you may require an interview upon written notice to the recipient. If the adults fail to attend the interview, cancel Medicaid of the adults only. Complete an automatic redetermination for the children.

For cases on which only children receive Medicaid, a review of eligibility factors is required, but an interview cannot be required.

Hold an interview if the recipient requests an interview.

Schedule the annual review to match the Food Assistance recertification date. Use form 470-2881, *Review/Recertification Eligibility Document (RRED)*, for annual reviews.

Exception: When the client has completed form 470-0462 or 470-0466 (Spanish), *Health and Financial Support Application*, for another purpose, it can be used as the review document.

When you send the appointment letter, also send a written request for information. If the information is not returned within ten days, you may cancel the children because the parents did not return the requested information.

Use the annual review to remedy any problems discovered in your review of the case. Issue the following pamphlets:

- ◆ Comm. 233 or Comm. 233(S), *Rights and Responsibilities*
- ◆ Comm. 4, *Care for Kids*
- ◆ Comm. 132 or 132(S), *Family Planning Counseling*
- ◆ 470-0499 or 470-0499(S), *Ten-Day Report of Change for FIP and Medicaid*

You may require an interview to discuss questionable information even if it is not time for an annual review. If the parents fail to show up for the interview, you may cancel them for not attending. However, do not cancel Medicaid for the children solely for the parents' failure to appear.

If the parents fail to supply requested information (whether in addition to failing to attend an interview or not), cancel Medicaid for the entire eligible group.

The household consists of Mr. and Mrs. D and their two children. They are receiving FMAP. Mr. D reports that Mrs. D has moved out of the home. Mrs. D is removed from the eligible group. However, the Ds have split up in the past and the children have always stayed with Mrs. D.

The worker finds the household composition questionable and makes an appointment for Mr. D to come into the office. Mr. D does not show up for the scheduled appointment, nor does he reschedule. The worker sends a *Notice of Cancellation* canceling Mr. D for failure to attend the interview. However, the children remain active under CMAP or MAC since an interview is not an eligibility factor for children.

The worker now sends a written request to determine household composition. If this information is not received by the due date, the children's Medicaid is canceled for Mr. D's failure to provide requested information.

Had the worker sent the request for information at the same time as the appointment letter, the worker could have canceled assistance for Mr. D and the two children, as long as ten days were allowed to return the information.

Voter Registration Procedures

Legal reference: 721 IAC Ch. 23

The *Voter Registration* form is mailed with the RRED.

When a recipient moves, ask them if they would like to register to vote at their new address. If yes, mail or give them the *Voter Registration* form. No follow-up is necessary to track the return of the *Voter Registration* form.

If the recipient returns a completed *Voter Registration* form, keep the declination section and return the voter registration information section to the recipient. Follow your local procedure for handling the form after completion.

If the recipient returns an incomplete *Voter Registration* form, contact the recipient to get a completed form. If the recipient chooses not to check "yes" or "no," leave the section blank and accept that they have chosen not to register to vote. If the recipient chooses not to sign the form, print the client's name and the date where indicated, and initial the form.

If the recipient requests help with registering to vote, be careful not to influence their voter registration option in any way.

See [6-Appendix](#) for office procedures regarding processing the forms.

Adding a New Member to an Existing FMAP-Related Case

Legal reference: 441 IAC 76.1(5)

A new application is not required to add a person to an **existing** FMAP or FMAP-related eligible group. This includes:

- ◆ New household members.
- ◆ Responsible relatives.
- ◆ People who were previously voluntarily excluded.
- ◆ Newborn children of Medicaid-eligible mothers.
- ◆ Ineligible household members

1. Ms. C's two children are receiving MAC. Ms. C is having some medical problems and has asked that she be added to the Medicaid case. Because there is no decrease in income, a paper application is required to determine eligibility under Medically Needy.

2. Ms. C's two children are receiving Medicaid under MAC. Ms. C has asked that she be added to the Medicaid case. Income has not decreased. However, Ms. C's 20-year-old son returns to the home and also needs medical assistance. First determine the family's eligibility under CMAP as a household of four with Ms. C as a considered person.

If the household is over income for CMAP, the two younger children remain eligible for MAC, with Mom as a considered person. The 20-year-old can receive Medicaid under CMAP, as a household of one, if otherwise eligible. Determine eligibility under Medically Needy as a household of four for Ms. C. The three children would be considered on the MN case. A paper application is needed for the Medically Needy determination.

3. Same as Example 1 above, except that Ms. C's income has decreased. She calls her worker to request Medicaid. Due to the decrease in income, Ms. C and her children are determined eligible for FMAP. No paper application is necessary, because Ms. C is being added to an existing FMAP-related eligible group. The application date is the date she requested Medicaid.

Because a paper application is not needed to add a person to an existing case, it is especially important to document contacts with the client. Detailed case record documentation is crucial to provide pertinent information that would substantiate your actions in the event of a Quality Control (QC) review or an appeal.

There is a difference between an **inquiry** and a **report** as far as what you do with the information:

- ◆ An **inquiry** occurs when the client contacts you to find out about the impact on the client's case if another person should join the household, but the client is not sure if or when the person may actually join.

In this situation, give the client the necessary information, and remind the client to contact you within ten days of when the change occurs or if possible, a week before the change is expected to occur. Document the client contact and your response in the case record. Do not issue a *Notice of Decision* (NOD).

- ◆ A **report** occurs when the client (or the client's authorized representative) contacts you with an approximate or specific date that the person is expected to join the household. (See 8-F, [Newborn Children of Medicaid-Eligible Mothers](#), for information on adding newborns.)

Note: A parent returning to the home may not be added to the eligible group if the parent was previously sanctioned and the sanction has not been cured. See [Other Changes in the Household](#) for more information.

The following sections give more information on:

- ◆ [Acting on a client's report of future changes.](#)
- ◆ [Establishing the date of application and eligibility.](#)
- ◆ [Determining the income of people added.](#)

Acting on a Client's Report of a Future Change

When a client has reported to you that a new person will be joining the household at some time in the future, the client still has a responsibility to timely report when the person actually joins the household.

Contact the client in writing within one or two days after the person was expected to enter the household. Ask for updated information about the anticipated change and any needed information about the person. The client has ten calendar days to provide the information.

If the client reports that the person will be joining the household **within 30 days** of the report, and you receive the information by the due date you gave the client, process the application to add the person.

If you do **not** receive the information by the due date, cancel the existing FMAP or FMAP-related case for failure to provide the information and deny the application to add a person to the household. Issue timely notice. Reinstate the case if the information is received before the effective date of cancellation. The date you receive the information is the new date of application to add the person.

If the client reports that the person will **not** be joining the household within 30 days of the report, issue an NOD denying the application to add the person. Follow up with the client at the time the person was expected to enter the household, as described above. Remember to document your contacts with the client.

Establishing the Date of Application and Eligibility

Legal reference: 441 IAC 76.1(2), 76.1(5), 76.5(2)

The date of application and the effective date of eligibility depend upon the client's situation.

The date of application to add a new person to an existing eligible group is usually the date the household reports the new person in the home. However, circumstances of the client's situation may affect the date of application.

When the household requests to add a new person to the eligible group and that person meets eligibility requirements, the effective date is the first day of the month in which the request is made.

Exception: When a household requests to add a previously voluntarily excluded person to the Medicaid-eligible group, add this person effective the first day of the month following the month that the household requests that this person be added.

Person Being Added	Date of Application	Effective Date of Eligibility
Household member who is in the home (unless voluntarily excluded)	Date of report.	Add the person effective as of the first day of the month in which eligibility is established.
	<p>1. On May 4, Mrs. A reports that Mr. A, the father of her children, returned home on May 3. The date of application to add Mr. A is May 4. The effective date of eligibility is May 1.</p> <p>2. On May 5, Ms. B reports that she got married to Mr. C on May 2. Mr. C is not the father of the FMAP child and is not a mandatory member of the eligible group.</p> <p>On June 5, Mrs. C (formerly Ms. B) reports that her husband was in an accident, and requests to add Mr. C to her case as an incapacitated stepparent. Since Mr. C is an optional household member, the date of application is June 5. The effective date is June 1.</p>	
Person who will join the household (anticipated)	Date of report.	No earlier than the first day of the month in which the person enters the household or the first day of the month in which entry is reported, whichever is later.
		Ms. D and her child receive FMAP. On May 20, she reports that another child will come to live with her within the next couple of weeks. On June 1, she reports that the child actually returned on May 25. The child is added to the eligible group May 1.
Person who lost their Medicaid eligibility because they failed to cooperate	Date the person indicates willingness to cooperate (e.g., cooperate with Third Party Liability or HIPP).	No earlier than the first day of the month in which the person indicates willingness to cooperate, which is the month of application. Do not take action to add the person until cooperation has actually occurred.

Person Being Added	Date of Application	Effective Date of Eligibility
Person previously sanctioned due to failure to cooperate with CSRU	Date the person indicates willingness to cooperate.	No earlier than the first day of the month in which the person indicates willingness to cooperate. Contact CSRU for this date if the client does not contact you directly. Do not take action to add the person until cooperation has actually occurred.
	Ms. G has not received Medicaid for several months because she failed to cooperate with CSRU. On May 10, she contacts her worker to indicate her willingness to cooperate with CSRU. On June 2, CSRU notifies IM that Ms. G has cooperated. She is approved for Medicaid effective May 1.	
Person ineligible for failure to provide a social security number or proof of application	Date the number or proof of application is provided.	No earlier than the first day of the month in which the number or proof of application is provided.
	Ms. T and her two children receive FMAP. A third child is ineligible due to lack of a social security number. On May 5, Ms. T provides proof of application for the child's number. The child is approved for Medicaid effective May 1.	

When the household fails to timely report a new person in the home, the date of application to add the person to the eligible group is still the date of report. In addition, determine the affect of the person's presence on eligibility as of the date the person entered the home.

Determining the Income of People Added

Legal reference: 441 IAC 75.1(28)“a”; 75.57(249A); 75.58(249A)

The income of people added to the eligible group is counted prospectively. See [Budgeting for Ongoing Eligibility for FMAP-Related Households](#) in this chapter and also 8-E, [Budgeting for FMAP-Related Households](#), for more information.

When the person being added was a recipient for the immediately preceding month, complete a new projection of future income. Do not use the amount projected for months before the person is added to the existing eligible group.

Mrs. A receives FMAP for herself and two children. They have no income. On May 2, Mr. A, who had been a Medicaid recipient in another eligible group in April, returns to the home. Mrs. A reports his return on May 5.

Although Mr. A’s income was projected at \$300 per month in the other eligible group, his income from part-time employment during the 30-day period before May 2 was \$250. This income is expected to continue at the same rate.

The worker projects \$250 monthly income for the new eligible group. The total May income is compared to the gross income level for four people. The income is under 185% of the Standard of Need test for four people. The Schedule of Basic Needs test is determined by allowing the 20% earned income deduction and the 58% work incentive deduction.

\$ 250.00	Mr. A’s income
- 50.00	20% earned income deduction
\$ 200.00	Income before work incentive deduction

\$ 84.00	Mr. A’s income after application of the 58% work incentive deduction is compared to the \$495, the schedule of basic needs for four people
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Eligibility for FMAP exists. Mr. A is added to the eligible group effective May 1.

The date of change depends on whether the new person is required to be a member of the eligible group or is an optional member of the eligible group.

Optional household members include:

- ◆ An incapacitated stepparent.
- ◆ A needy specified relative.
- ◆ A needy specified relative who acts as caretaker when the parent is in the home but unable to act as caretaker.
- ◆ A nonincapacitated stepparent required in the home to care for the dependent children while the FMAP parent works if it would be necessary to allow child care as a deduction if the stepparent were not available.

1. Mrs. A is an FMAP recipient with one child. On March 10, Mr. A, the father of the child, enters the home. Mrs. A reports the change the same day. Mr. A is disabled and receives social security benefits.

Since Mr. A's return was reported on March 10, March 1 is the effective date of assistance for Mr. A. However, because the family has difficulty in obtaining verification of Mr. A's income, the worker is not able to make a decision on the application until March 23.

Because of Mr. A's income, the family is now over income, even with Mr. A's needs included. The application to add Mr. A is denied. The worker issues timely notice to cancel the family's FMAP effective May 1 and informs the family that the child is eligible for MAC and Mr. and Mrs. A now have a spenddown under Medically Needy.

Mr. A is also conditionally eligible for Medically Needy for March and April with Mrs. A and their child as considered people, since they are already receiving Medicaid.

March is considered the month of change, since Mr. A, a mandatory member of the eligible group, returned to the home in that month. No overpayment exists for April, because the family reported the change timely and provided the information timely.

2. On March 1, Ms. B reports that Bobby, a half-brother of Ms. B's other children, entered her home on February 28. Ms. B will receive social security benefits on Bobby's behalf beginning in March.

Bobby's social security benefits do not make the household ineligible. Bobby is issued a medical assistance eligibility card for March. Retroactive eligibility is determined for the month of February.

3. On February 27, Mrs. C marries Mr. D, who enters the home the same date. There are no common children. Mr. D receives social security benefits. On March 2, the family requests to add Mr. D to the eligible group.

The social security benefits that Mr. D receives do not make the family ineligible for Medicaid. The effective date of assistance for Mr. D is March 1. Retroactive eligibility is determined for the month of February.

Since Mr. D is an optional member of the eligible group, the date the family requested to add him to the eligible group (March 2), rather than the date of entry into the household (February 27), is the date of change. March and April are Mr. D's initial two months of eligibility.

4. Ms. E receives FMAP for herself and one child. On April 5, Ms. E's son, Joe, returns to the home. She reports the change that day. Since Joe's social security benefits do not create ineligibility for the household, he is added to the eligible group effective April 1, with April and May as the initial months.

On April 18, Ms. E's daughter, Jill, enters the home and Ms. E reports the change. Jill has no income. Jill is added to the eligible group effective April 1, with April and May as the initial months.

The system will perform the first calculation for Joe. However, the system will show Joe as already on the case and, therefore, cannot perform a second calculation for both Jill and Joe for April. This calculation must be performed manually.

Other Changes in the Household

The following sections contain more information on what to do when:

- ◆ [A parent returns but is not added to the eligible group.](#)
- ◆ [A natural father enters the household but paternity has not been established.](#)
- ◆ [A minor parent turns 18 or marries.](#)
- ◆ [A person on an active case becomes ineligible.](#)
- ◆ [A child goes into foster care.](#)

Returning Parent Not Eligible for Medicaid

Legal reference: 441 IAC 75.57(249A)

Count the income of a returning parent who is not eligible for Medicaid (e.g., a sanctioned parent or an ineligible adult alien) when determining eligibility unless it is specifically exempted, disregarded, or deducted for work expense. Also count the returning parent in the household size. Project income of the returning parent using either:

- ◆ The 30-day period before the return, or
- ◆ A longer period of time, if the income received during that period is not a good indicator of future income, or
- ◆ Verification of future income from the income source.

See [8-E](#) for how to treat income of ineligible parents. See [Determining the Income of People Added](#) when the returning parent is added to the FMAP-eligible group.

Natural Father Enters the Household

Legal reference: 441 IAC 75.14(2);76.5(249A); 76.10(5)

When a natural father enters an existing Medicaid household and paternity has not been established, request, in writing, that the client provide a signed statement from the father acknowledging paternity for a child in the eligible group.

Do not add the father to the eligible group before obtaining the statement (unless the case record already contains evidence of paternity, such as the father's signature on a previous application or a birth certificate listing the person as the child's father). The effective date of assistance is the first day of the month in which the report that the natural father entered the home was made, provided eligibility otherwise exists.

Attach a copy of the father's statement to a notarized form 470-2220, *Notarized Statement for Child Support Recovery Office*, and send both statements to CSRU. File the father's original statement and a copy of form 470-2220 in the permanent section of the case record. (See 6-Appendix for further details on form 470-2220.)

Cancel the existing case (subject to timely notice) if the requested paternity statement is not provided by the due date because the eligible group cannot be established without the statement. (Extend the due date, if applicable.) Also deny the application to add the parent, if the parent was requesting assistance.

If the statement is received in time for reinstatement, reinstate the existing case. Since the application to add the parent was denied, the date the statement is received is the new date of application to add the parent to the eligible group.

Minor Parent Turns 18 or Marries

Legal reference: 441 IAC 75.57(249A); 76.5(249A); 76.10(5)

Exempt the income of the self-supporting parents of a minor (unmarried, underage) parent who marries or turns 18 (regardless if the minor parent is in high school and expected to complete the curriculum before age 19).

The exemption is effective the first day of the month following the month that the parent turns age 18 or marries. When the parent turns age 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

1. Ms. A, an FMAP recipient and a minor parent, lives with her self-supporting parents. She turns age 18 on July 5. The income of her parents that is attributable to her becomes exempt beginning with the month of August.
2. The same situation as Example 1, except that Ms. A turns age 18 on July 1. Her parents' income becomes exempt beginning with the month of July.
3. Ms. B, aged 17, lives with her self-supporting parents. On July 3, she marries. Her parents' income becomes exempt beginning with the month of August.
4. Ms. K and her child live with her self-supporting parents. Ms. K will turn 18 on June 23. On June 4, she applies for Medicaid. Her parents' income is used to determine Ms. K's eligibility for June. Her parents' income will no longer be used beginning with the month of July.

Person Becomes Ineligible for Medicaid

Legal reference: 441 IAC 75.57(9)

If a Medicaid eligible person is determined to be ineligible for Medicaid, cancel the person's Medicaid effective the first of the following month allowing a 10-day notice.

If the person is a parent of a child in the eligible group and the parent continues to reside with the household, the parent continues to be counted in the household size. If the person is not a parent of a child in the eligible group, the person is no longer counted in the household size, even if the person continues to reside with the household.

When there is a period of proration, a nonrecurring lump sum received by a person who has left the home continues to be counted, unless the income is no longer available to the eligible group. See [8-E](#) for policies relating to lump-sum income.

1. Child A leaves the household and is removed from the eligible group effective January 1. Child A's unearned income of \$40 per month is not counted when determining eligibility for the remaining members of the eligible group beginning with the month of January.
2. The Medicaid household consists of Mr. and Mrs. B and Mrs. B's two children from a previous relationship. Mr. B is an incapacitated stepparent and a part of the FMAP eligible group of four.

At the yearly review, the worker checks on Mr. B's incapacity. The doctor has determined that Mr. B is no longer incapacitated. Mr. B's Medicaid is canceled effective the first of the next month allowing a 10-day notice. The FMAP eligible group reduces from a household size of four to a household size of three.

3. Mr. and Mrs. C and their child receive Medicaid under FMAP. In April, Mr. C receives a retroactive nonrecurring lump-sum benefit of \$8,490, which is timely reported and verified. The period of proration is ten months beginning with May ($\$8,490 \div \849 Standard of Need = ten months). Mr. and Mrs. C are conditionally eligible under Medically Needy and their child is eligible under MAC.

Mr. C moves out of the home in July. He leaves the lump sum in a bank account available to Mrs. C. The same period of proration continues. Since Mr. C did not take any portion of the lump sum with him, it is still available to the eligible group.

4. Mr. and Mrs. D receive Medicaid under FMAP for themselves and their two children. Mr. D has failed to cooperate with Third Party liability. The worker is notified and Mr. D's Medicaid is canceled effective the first of the next month, allowing a ten-day notice.

Although Mr. D is sanctioned, the household remains a four-member group. Therefore, Mr. D's income and needs are used in determining eligibility for Mrs. D and the children.

5. Mr. and Mrs. Q receive Medicaid under FMAP for themselves and their two children, Bob, age 12 and Gary, age 17. Gary is not in school and has been employed for quite some time. Mrs. Q reports that Gary lost his job. The worker instructs Gary to apply for Unemployment benefits. Gary refuses to apply.

Gary's Medicaid is canceled effective the first of the next month, allowing a ten-day notice. Because Gary is not a parent, he cannot be a member of the eligible group. The household size is reduced to a three-member group. Gary's income and resources are not used in determining eligibility for Mr. and Mrs. Q and Bob.

Child Goes into Foster Care

Legal reference: 441 IAC 76.1(5), 76.5(2)

When a child leaves the home to enter foster care, remove the child's needs from the eligible group effective the first day of the following month. System requirements may delay the effective date until the first day of the second month after the month in which the child left the home.

However, if the child returns to the home before the effective date of cancellation, reinstate the child or case without a new application.

When a child leaves the home to enter foster care, but returns to the household in the same month and has not yet been canceled from the case, do not remove the child from the eligible group.

1. Mrs. A receives Medicaid under FMAP for herself and one child. The child is placed in foster care July 2. Notice is issued to cancel the case effective August 1, as Mrs. A is not eligible under any other coverage group.

The worker establishes a foster care Medicaid case with an FBU of 19 for the child with an effective date of August 1. On July 19, the child returns to the home. The foster care case is canceled and the original case is reinstated.

2. Mrs. B receives Medicaid under FMAP for herself and one child. The child is placed in foster care July 25. Since it is too late to cancel for August, the case is canceled effective September 1.

The worker establishes a foster care Medicaid case with an FBU of 19 for the child with an effective date of September 1. The child returns to the home August 4. The foster care case is canceled and the original case is reinstated.

3. Mrs. C receives Medicaid under FMAP for herself and one child. The child is placed in foster care July 17. The case is canceled effective August 1. The child returns to the home August 8.

An automatic redetermination of eligibility is completed for the child when leaving foster care. Mrs. C calls the county office on August 15 and asks to be added for Medicaid. Eligibility begins August 1.

Budgeting for Ongoing Eligibility for FMAP-Related Households

Legal reference: 441 IAC 75.13(1), 7557(2249A), 75.58(249A)

When a change in income is reported, act on it regardless of whether the change was required to be reported or not. First, determine if the change being reported is indicative of future income.

If the change is not indicative of future income, document in the case that the change was reported but a new projection of income was not completed because the change is not indicative of future income.

If the change is indicative of future income, request, in writing, verification of the change. Accept the client's statement as to whether the change is indicative of future income, unless questionable.

1. Mr. H receives Medicaid for himself and his son under FMAP. On November 20, Mr. H reports that he will be working ten additional hours per week in December. He states that the additional hours will only occur in December, due to the holidays, and that he cannot anticipate working any overtime in the future.

The worker documents the reported change in Mr. H's case file. The worker further documents that the reported change is a one-time change and is not representative of future income. Verification of the change is not requested, and a new projection of income is not completed.

2. Ms. I receives Medicaid for her children under MAC. She does not receive Medicaid for herself. On August 27, Ms. I reports that she began working the evening shift on August 25. The evening shift pays an additional \$.50 per hour. Ms. I states that her employer was unclear as to whether this change was temporary or permanent.

The worker requests verification from the employer, which is received September 3. It indicates that Ms. I will be working the evening shift only until September 15, at which time she will return to her usual shift and her usual hourly rate. The worker documents this in the case file and does not complete a new projection of income, since the change is not representative of future income.

3. Same as Example 2, except that the verification from the employer indicates that Ms. I will be working the evening shift until at least November 1 and perhaps longer. The worker completes a new projection of income based on the increase in Ms. I's hourly rate. The new income projection is used beginning with the month of October.

Income Changes Reported on Review Forms from Other Programs

Some FMAP-related Medicaid members may also receive benefits from other programs. The other programs' reporting requirements may affect Medicaid eligibility.

When income reported on a review form differs in the amount that was projected for FMAP-related Medicaid, act on the new amounts as a reported change if it is indicative of future income.

When the change is **only** due to a third or fifth check, do not enter the income for FMAP-related Medicaid. Allow the income used for eligibility the previous month to roll forward.

1. Mr. and Mrs. J apply for Medicaid and Food Assistance on May 3. They request Food Assistance for the entire family and Medicaid for just their two children. The application is approved for both programs. Mr. J's earnings are the only income for the family. At application, the projection was \$1,500 gross per month.

At recertification for Food Assistance, the J family reports that Mr. J now has monthly gross earned income of \$1,700. The worker enters the same income into the computer system for both programs.

2. Mrs. K and her two children receive Medicaid under FMAP in addition to FIP and Food Assistance. Mrs. K has earned income of \$515 bi-weekly. \$1,030 per month is entered into the computer system for all three programs.

At the next FIP review, Mrs. K reports income of \$1,545 due to a third paycheck. Since this income is not a good indicator of future income, the income of \$1,030 is allowed to roll forward for FMAP-related Medicaid.

At the next FIP review, Mrs. K reports an increase in income to \$530 bi-weekly. Since this income did not include a third check and is indicative of future income, \$1,060 is entered into the computer system for FMAP-related Medicaid.

Acting on Changes

Legal reference: 42 CFR 435.911(b) & (c), 435.916(1)(c) and (2), 435.919, 435.930, 435.948, 435.952, 435.953, 441 IAC 76.10(5); 76.11 (249A), 75.52(5)

Act on the change as soon as possible, but no later than ten working days from the date you become aware of the change, unless using the automatic redetermination policy for information received and verified after the 10th of the month.

Complete an automatic redetermination when changes are reported or become known. See [AUTOMATIC REDETERMINATION](#). Verification requirements apply before acting on changes. See 8-A [NOTIFICATION](#), for timely notice requirements.

When a probable change affects eligibility, act on the change if you have all information you need to establish eligibility, and the best information available indicates that the change will actually take place as reported.

Change Reported	Effect on Eligibility	Effective Date	Do a Recoupment or Adjustment?
Timely reporting for members is within ten days after the change occurred.			
Timely	Positive	The month following the month the change is reported . Timely notice is not required.	No, if the Department acted timely.
	Negative	The month following the month change is reported . Timely notice is required.	No, if the Department acted timely.

Change Reported	Effect on Eligibility	Effective Date	Do a Recoupment or Adjustment?
Timely reporting for members is within ten days after the change occurred.			
Not Timely (or not at all)	Positive	The month following the month the change is reported or became known. (Do not adjust benefits back to when the change occurred.)	No, if the Department acted timely.
	Negative	The month following the month the change occurred , regardless of when the change occurred or became known.	Yes, if benefits were received incorrectly. Redetermine eligibility beginning with the month following the month of the change. Lump sum prorations begin the month of receipt; therefore, so do recoupments.
Not Required to be Reported Until Annual Review	Positive	The month following the month the change is reported.	No, if the Department acted timely.
	Negative	The month following a timely notice.	No, if the Department acted timely.

Notes:

- ◆ If the change is adding someone to the eligible group or results in an application, follow application policies regarding effective dates. See 8-B, [APPLICATION PROCESSING](#).
- ◆ If the change results in cancellation from the current coverage group, follow the automatic redetermination policy on whether the information was received by or after the 10th of the month. See [AUTOMATIC REDETERMINATION](#).

- ◆ When a lump sum is not timely reported, the recoupment begins the month when the lump sum was received, because the proration begins with the month of receipt. See 8-E, [Period of Proration](#).
- ◆ If the household would have been eligible under the Medically Needy program, determine the spenddown amount for each certification period. See 8-J, [INCOME POLICIES](#).
- ◆ See 8-A, [When Timely Notice Is Not Required](#), for more information on when timely notice is not required.

1. Positive Change Timely Reported:

Mr. and Mrs. X receive Medicaid under FMAP for themselves and their children. Mr. X is the only one with income. Mrs. X reports on August 3 that Mr. X has left the home July 25.

Although the loss of a household member is negative, this change is positive because Mr. X is the only one with income. Since this change was reported timely in August, Mr. X is canceled effective September 1 and his income is no longer used for eligibility purposes. No claim is established for August.

Had this same change been reported untimely, a claim for Mr. X would have been completed for the month of August and any months thereafter, since the change occurred in July and was not reported timely.

2. Negative Change Timely Reported:

Mr. B receives Medicaid for himself and his children under FMAP. On July 23, he timely reports beginning unearned income that will make him and his children only conditionally eligible under Medically Needy (MN) with a spenddown. He provides verification timely on August 5.

The effect of the change on eligibility is adverse and requires a timely notice. The effective date of the change is September 1. The MN certification period is September/October. No claim is established for August, since the change was reported timely.

The children remain continuously eligible under FMAP until the annual review. If the children are no longer eligible at the annual review due to income, they are referred to *hawk-i*.

3. Negative Change Timely Reported:

Ms. G and her children receive Medicaid under FMAP. Ms. G starts a new job and receives her first paycheck on May 23. Ms. G reports the change timely by June 2. The worker requests verification and it is returned timely by June 15.

The effective date of the change is July 1 if the worker acts on the change by timely notice in June. The effective date of the change is August 1 if the worker acts on the change after timely notice in June but before timely notice in July.

No claim is established in either situation because the verification was received after August 10.

If Ms. G and her children go over income for FMAP and are otherwise eligible for transitional Medicaid (TM), TM begins the first of the month after FMAP ends.

The children remain continuously eligible until the annual review. If the children are no longer eligible at the annual review due to income, and TM does not apply, they are referred to *hawk-i*.

4. Positive Change Not Timely Reported but Required to Be Reported:

Mr. F's children receive Medicaid under MAC. In June, Mr. F reports that he got a new job the previous December with a new company and had a decrease in income.

Due to this change, Mr. F is eligible for Medicaid under FMAP. The effective date of the income change is July 1, since he reported the job in June.

The worker explains to Mr. F that it appears he would now be eligible for Medicaid. Mr. F states he has health insurance and doesn't want Medicaid. The children's case is changed to CMAP with Mr. F as a considered person.

In August, Mr. F calls his worker and requests Medicaid. He says he has medical bills that his health insurance didn't cover for the past six months.

Mr. F's request for Medicaid is treated as an application. The worker explores whether Mr. F is eligible for August and ongoing and for the retroactive period of May, June, and July. Mr. F is not eligible for Medicaid for February, March, and April because he requested Medicaid in August.

5. Negative Change Not Timely Reported but Required to Be Reported:

Ms. C and her children receive Medicaid under FMAP. On September 3, it is discovered that Ms. C failed to timely report beginning earned income. Ms. C received her first paycheck on July 23. Since the change was not reported timely, the effective date of the change is August 1. The worker redetermines Medicaid eligibility for August, September, and ongoing.

If a change in eligibility occurs, a timely notice must be issued. If appropriate, a claim is established for Ms. C.

If eligibility is only under Medically Needy with a spenddown, the certification period is August and September.

The children remain continuously eligible under FMAP until the annual review. If they are over income for MAC at the annual review, they are referred to *hawk-i*.

6. Required to Be Reported Only at Annual Review But Reported Earlier:

Mr. G and his children are approved for Medicaid under FMAP in November. In December, Mr. G goes from part-time employment to full-time employment at the same company. Mr. G reports this to his worker the following February. The increase in income makes the family over income for FMAP.

Although the change was not required to be reported until the annual review, since it was reported, the worker acts on the report and the family is eligible for transitional Medicaid (TM) beginning March 1.

It is not a negative action to change coverage from FMAP to TM since they are both full Medicaid programs. Therefore, a ten-day negative action is not sent for FMAP, although a TM notice is issued.

No claim is established, since Mr. G was not required to report the increase in income until the annual review.

7. Reported at the Annual Review as Required:

Mr. J and his children are approved for Medicaid under FMAP in November. In December, Mr. J goes from part-time employment to full-time employment at the same company. Mr. J reports this at his annual review in October.

The increase in income makes the family over income for FMAP. They are eligible for transitional Medicaid (TM) beginning November 1.

No claim is established, since this was not a new job but an increase in income and it was not required to be reported between annual reviews.

Had Mr. J changed employers, he would have been required to report the new job since it is stopping and starting income.

8. Addition of Household Member Reported Timely; Cancellation and Automatic Redetermination; Information Received by 10th of Month:

Ms. K and her children receive Medicaid under FMAP. On April 20, Mr. K joins the household and the change is timely reported to the Department. Mr. K requests Medicaid and has unearned income. The worker requests necessary information and it is timely provided May 10.

The unearned income makes the family over income for FMAP. The children are continuously eligible until the annual review when eligibility is examined.

The worker completes an automatic redetermination to MN for the parents in May, effective June 1. An April/May MN certification period is set up for Mr. K and a June/July MN certification period is set up for Mr. And Mrs. K

If Mr. K wants retroactive coverage, his eligibility would have to be determined under another coverage group because he did not live with Ms. K and the children.

9. Addition of Household Member Reported Timely; Cancellation and Automatic Redetermination; Information Received after 10th of Month:

Mr. Q and his children receive Medicaid under FMAP. On April 20, Mrs. Q joins the household and the change is timely reported to the Department. Mrs. Q requests Medicaid and has unearned income. The worker requests necessary information and it is timely provided May 11.

The unearned income makes the family over income for FMAP. If time permits, the worker completes an automatic redetermination to MN for the parents in May, effective June 1. However, a redetermination **must** be completed no later than timely notice in June effective July 1. No claim is established in either situation.

The children remain continuously eligible under FMAP until the annual review. If they are over income for MAC at the annual review, they are referred to *hawk-i*.

Alternative Scenario: If the information is not provided by the due date, a Notice of Cancellation is sent canceling Medicaid effective June 1.

If the information is received after timely notice in May, June benefits are reopened and a redetermination would be completed effective July 1. No claim is established.

10. **Addition of Household Member Not Reported Timely; Cancellation and Automatic Redetermination; Information Received after 10th of Month:**

Mr. S and his children receive Medicaid under FMAP. On April 20, Mrs. S joins the household and the change is reported to the Department untimely on June 30. Mrs. S requests Medicaid and has unearned income. The worker requests necessary information and it is timely provided July 19.

The unearned income makes the family over income for FMAP. An automatic redetermination must be completed no later than August effective September 1 for Mr. and Mrs. S. If appropriate, a claim is established beginning in May for Mr. S.

If eligibility is only under Medically Needy with a spenddown, the certification periods are May/June and July/August.

The children remain continuously eligible under FMAP until the annual review. If they are over income for MAC at the annual review, they are referred to *hawk-i*.

Note: If the annual review is due in April, May or June, continuous eligibility may not apply and an overpayment may have occurred on the children.

The effective date of a change that is either reported untimely or not reported at all, is the month following the month in which the change occurred, regardless of when in the month the change occurred and regardless of the effect the change has on eligibility.

Ms. C and her children receive Medicaid under FMAP. On September 3, it is determined that Ms. C failed to timely report beginning earned income. Ms. C received her first paycheck on July 23. The effective date of the change is August 1. The worker redetermines Medicaid eligibility for August and September and establishes recoupment, if appropriate.

The effective date of a change that was timely reported but was not acted upon depends on when the change occurred, regardless of whether the change was required to be reported or not.

Exception: When a lump sum is not timely reported, the recoupment will begin the month the lump sum was received. See 8-E, [Period of Proration](#).

1. Mr. and Mrs. D receive Medicaid under MAC for their children. Mr. and Mrs. D do not receive Medicaid. On October 18, Mrs. D timely reports beginning income. In December, it is determined that the worker failed to act on the reported change.

The worker requests verification, which Mrs. D provides on December 10. Because the change was timely reported after October 10, the effective date of the change is December 1.

2. Same as Example 1, except that the change was timely reported October 3. Because the change was timely reported on or before October 10, the effective date of the change is November 1.

3. Ms. E receives Medicaid for herself and her son under FMAP. On May 5, she reports a permanent increase in her hourly rate, which is effective with the paycheck she will receive May 12.

In September, it is determined that the worker failed to act on the reported change. The worker requests verification, which Ms. E provides on September 22. Even though Ms. E was not required to report the change, because it was reported, it is acted upon like any other reported change. Since the change was reported on or before May 10, the effective date of the change is June 1.

ADDITIONAL SSI-RELATED CASE MAINTENANCE

This section contains information for SSI-related cases on:

- ◆ [Eligibility review](#)
- ◆ [MEPD case maintenance](#)
- ◆ [New members in SSI-related households](#)

Eligibility Review

Legal reference: 441 IAC 76.7(249A)

Review eligibility at least once every 12 months for all SSI-related cases where:

- ◆ No member receives SSI or only a blind or mandatory State Supplementary Assistance payment, or
- ◆ The member who receives SSI or a blind or mandatory State Supplementary Assistance payment has a trust in which income and resources are treated differently for Medicaid eligibility than for SSI eligibility.

The member shall complete form 470-3118 or 470-3118(S), *Medicaid Review*, for the annual review.

An interview is not required as part of the annual eligibility review process. Do not require an interview for cases on which only children receive Medicaid.

Complete a redetermination when changes are reported or made known. See [AUTOMATIC REDETERMINATION](#).

MEPD Case Maintenance

Legal reference: 441 IAC 75.1(39)“b”(1)

Premiums for Medicaid for employed people with disabilities (MEPD) are established at a fixed monthly rate for 12 months at a time. Use form 470-3118 or 470-3118(S), *Medicaid Review*, to gather income information to determine the new monthly premium amount for each 12-month period. The Automated Benefit Calculation (ABC) system issues the form to the member at the end of the eleventh month of the premium period.

In order to have the correct premium amount in the system for billing for the new 12-month premium period, the review must be processed and the review entries made in ABC before timely notice of the twelfth month of the current premium period.

Effect of Nonpayment of Premiums

Legal reference: 441 IAC 75.1(39)“b”(2) and (3)

Eligibility is contingent upon payment of any premium assessed. The member will not have eligibility for a month until the premium for that month is received. To become eligible for the month the premium payment covers, the member must pay the premium within three months of the latter of the month of eligibility or the month of initial billing.

When a premium is not received by the due date, an e-mail will notify you to cancel the case. You will be notified via e-mail when payments are made after the due date. The case can be reinstated if payment is received before the effective date of cancellation. The case can be reopened if payment is received in the month following the month it is due.

1. Mr. B applies for MEPD on January 30. Approval entries are made on March 10 (before system cutoff). Mr. B receives a *MEPD Billing Statement* stating:

- ◆ The premium for January is due by June 14.
- ◆ The premium for February is due by June 14.
- ◆ The premium for March is due by April 14.

Mr. B does not pay the March premium by April 14, so a “warnings, information fatal and summary” (WIFS) message is issued to his worker. The worker cancels the case with timely notice in April.

Mr. B pays all three premiums on June 10. After June 10, he receives Medicaid eligibility for January, February, and March because the payments were paid within three months of the billing month.

After the payments are posted in June, the worker receives another WIFS message explaining that the payments were received. It is too late to reopen the case. If Mr. B wants to get MEPD again, he must re-apply.

2. Mr. Z applies for MEPD on January 5 and is approved on January 28 (after cutoff). His first *MEPD Billing Statement* shows:

- ◆ The premium for January was due by February 14.
- ◆ The premium for February was due by February 14.

Mr. Z doesn't pay the premiums by February 14, so a WIFS message is issued to the worker that he did not make the payments. The worker cancels the case with timely notice in February.

Mr. Z pays both of the premiums on March 1. A WIFS message is issued stating that the premiums had been paid. Mr. Z has Medicaid eligibility in January and February due to the premium payments. The worker should check to see if Mr. Z still meets all other eligibility criteria. If so, the MEPD case may be reopened.

An automatic redetermination of eligibility is required when a member with a premium obligation does not pay the premium and is canceled. Redetermine eligibility under Medically Needy. Wait to complete the automatic redetermination until the end of the month following the month the payment was to cover, due to the reopening provisions under MEPD.

Reopening a Case Canceled for Failure to Pay Premium

Legal reference: 441 IAC 75.1(39)“b”(5)

Reopening is allowed when a member does not remit payment by the end of the month of coverage. To qualify for a reopening, payment must be received by the last day of the month following the month it is to cover and the person must be otherwise eligible.

By exercising this provision, the member may regain eligibility without filing a new application.

Note: Explain to the member that the current month's premium must also be paid before the case can be reopened.

Premium Change for Current or Past System Months

Monthly MEPD premiums can be reduced for the remainder of a premium period due to a change in income that decreases the premium amount. Reduce premiums effective the month following the month the lower income is reported.

Premiums should not be increased within the 12-month premium period due to an increase in income. You may increase a premium only when an error has been made. The error may be due to the member underreporting the income, an error in the income amount entered on the ABC TD05 screen, or an error in how income was calculated.

Decrease a Premium

Use the MEPC screen to decrease the premium for a current month or months before the current month due to an agency error or the timing of case processing. See 14-B(9), [Change to MEPD Premium](#). Send a *Notice of Decision* with the new premium amount and the month the decrease is effective.

When you use the MEPC screen to lower a premium that has been paid, the MEPD system will calculate the difference between the premiums already paid and the lower amount. The balance of overpaid premiums will be held as a credit or applied to other months' premiums that are unpaid or become due.

When the MEPD premium amount is decreased for the **next calendar month**:

- ◆ Income entries made on the TD05 screen **before** cutoff will update the MEPD system and an *MEPD Billing Statement* will be issued with the revised amount.
- ◆ Income entries made on the TD05 screen **after** cutoff will not update the MEPD system and a revised *MEPD Billing Statement* will not be issued. Changes entered in the ABC system after cutoff require MEPC screen entries.

1. An *MEPD Billing Statement* for a \$110 premium is issued to Mrs. B on March 16. On March 23, Mrs. B reports on the *Medical Review* form that her earned income has decreased. The lower income causes the amount of her premium to decrease to \$80.

On March 30, the worker enters the review on the ABC TD05 screen with the lower earned income and the unearned income. Since the entries are made **after** March cutoff, MEPD does **not** automatically update and issue a revised *MEPD Billing Statement* for April.

On March 31, the worker makes MEPC entries to change the premium amount for April to \$80. After the premium amount updates to \$80 in MEPD, a revised *MEPD Billing Statement* for \$80 is issued for April. The worker follows the instructions in 14-B(9), [Change to MEPD Premium – Decrease](#), to issue notice message 487.

2. An *MEPD Billing Statement* for a \$53 premium is issued on March 16 to Mr. K. On March 18, Mr. K reports via a letter that he lost his job on March 17 and he is searching for a new job.

On March 19, the worker enters zero earned income and unearned income on the ABC TD05 screen, which decreases Mr. K's premium to \$29 for April. Since the change is entered before March cutoff, MEPD is updated with the lower premium amount of \$29 for April. A revised *MEPD Billing Statement* for April is issued with a \$29 premium.

Increase a Premium

During the 12-month premium period, you may increase a premium only due to a correction to the amount of income used for the premium determination.

When this happens, you need to contact the member to report that the premium was incorrect and give the member the choice of either:

- ◆ Having the premium corrected to a higher amount for past months, or
- ◆ Referring the underpayment for collections.

The MEPD premium may be increased for past months only when the member has agreed to accept the higher premium without timely notice. You must ask the member for a signed and dated statement giving permission to increase the premium for past months without timely notice.

If the member agrees to the higher premium without timely notice, send a manually issued *Notice of Decision* stating the corrected premium amount and the months involved.

Use the MEPC screen to increase a premium for current or past months. See 14-B(9), [Change to MEPD Premium](#). A revised *MEPD Billing Statement* will be issued for the months corrected. Using the MEPC screen to increase the premium for current or past months will allow the member to pay the higher premium without having a claim established for the difference.

You **cannot** make entries on the ABC TD05 screen to calculate a higher premium for the member during a premium period. Therefore, you **must contact** the SPIRS Help Desk to request the change to the higher ongoing premium.

When Ms. Z applies for MEPD, she reports gross income below 150% of the federal poverty level (FPL). She is approved for MEPD with a zero premium.

Two months later, it is discovered that disability pension income was reported on the application, but not entered on the ABC TD05 screen by the worker.

When the extra income is included, Ms. Z remains under the 250% FPL for eligibility. (Higher gross income caused the premium calculation to be over 150% of FPL.) Ms. Z should have been paying a premium of \$29 per month.

Ms. Z is given the choice either to have the premiums for the prior months recouped or to sign a statement that she agrees to accept the assessed premiums for the prior months. Ms. Z agrees to the higher premiums, signs a statement, and returns it to her worker. The worker will:

- ◆ Contact the SPIRS Help Desk to request the higher premium amount for ongoing months.
- ◆ Follow the MEPC instructions to increase the premium amount for the current and past months.
- ◆ Manually-issue a new *Notice of Decision* stating the higher premium amount and the months involved.

After the MEPC entries update, a revised *MEPD Billing Statement* will be issued.

Refunds

Legal reference: 441 IAC 75.1(39)“b”(4)

When the member has paid in more than is owed, refunds are automatically issued if:

- ◆ The premium has been reduced to zero for two consecutive months, or
- ◆ There are funds in the MEPD premium account and there have been two consecutive months of inactivity on the MEPD case.

When there are excess funds in the MEPD account, the Department will also issue a refund upon the member’s request. To request a refund for an MEPD member, send an e-mail to the DHS, SPIRS Help Desk. Include the member’s name, state identification number, the amount to be refunded, and the reason for the refund.

New Members in SSI-Related Households

Legal reference: 441 IAC 76.1

For SSI-related Medicaid purposes, the “eligible group” concept and “adding a new member to an eligible group” do not apply in the same way as for FMAP-related cases. Rather, except for eligible married couples, SSI-related cases are based on an individual’s eligibility.

SSI-related Medicaid eligibility for unmarried persons is determined individually rather than as an “eligible group.” Therefore, a new member may not be added to an unmarried person’s SSI-related Medicaid case. **Note:** A newborn child of an SSI-related Medicaid-eligible mother may be eligible on the newborn’s own case under the coverage group in which the mother received Medicaid at the time of birth.

SSI-related eligibility for married couples in which both spouses are aged, blind, or disabled is determined together (as a couple) when both spouses are receiving or have applied for SSI-related Medicaid. When two SSI-related members marry, determine their ongoing eligibility as a couple in the month following the month of marriage.

When an SSI-related Medicaid member marries a person who is aged, blind, or disabled but is not receiving Medicaid, the spouse must file an application to begin receiving SSI-related Medicaid.

When an SSI-related member is living with a spouse who turns 65 or becomes blind or disabled, the spouse must file an application to begin receiving SSI-related Medicaid.

Treat an aged, blind, or disabled spouse who has not applied for Medicaid as an ineligible spouse when determining the member's ongoing Medicaid eligibility (i.e., apply income deeming policies).

When an SSI-related member marries and the spouse is not Medicaid-eligible, determine the effect on the Medicaid member for the next month. If the new spouse applies for Medicaid when the other spouse is already eligible, determine their eligibility as a couple and, when they are eligible, grant Medicaid for the month of application to the spouse who has applied. Then, put the couple together the next month.

When parents or stepparents are also in the home, treat them as considered persons.

FRAUD AND OVERUSE OF MEDICAID SERVICES

Legal reference: 441 IAC 76.9(7) and (8)

The Iowa Medicaid Enterprise (IME) Medical Services Unit reviews health care provided to Medicaid members and determines overuse or misuse of medical services. "Overuse of medical services" is defined as receipt of treatments, drugs, medical supplies, or other Medicaid benefits from one or multiple providers in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the member.

If you become aware of a situation where it appears that Medicaid services are being overused or excessive or inappropriate Medicaid services are being provided, report the situation to the IME Medical Services Unit at 1-800-383-1173 or in Des Moines at 725-1008. Ask for the person who handles lock-in issues. You will need the member's name and state identification number.

If you become aware of any situation that indicates potential fraud by a medical provider, report the circumstances to the IME Surveillance and Utilization Review System (SURS) Unit at 1-877-446-3787 or in Des Moines at 725-1346. Examples of such situations include:

- ◆ Billing for services, supplies, or equipment that were not rendered to or used for members.
- ◆ Billing for supplies or equipment that is clearly unsuitable for the member's needs or so lacking in quality or sufficiency for the purpose as to be virtually worthless.

- ◆ Flagrant and persistent overutilization of medical or paramedical services with little or no regard for results, the member's ailment, conditions, medical needs, or the doctor's orders.
- ◆ Claiming of costs for noncovered or nonchargeable services, supplies, or equipment disguised as covered items.
- ◆ Material misrepresentations of dates and descriptions of services rendered or of the identity of the member or the person who rendered the services.
- ◆ Duplicate billing that appears to be deliberate, e.g., billing twice for the same services.
- ◆ Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the Medicaid program using various devices to siphon off or conceal illegal payments.
- ◆ Charging to the Medicaid program by subterfuge costs that were not incurred or that were attributable to nonprogram activities, other enterprises, or personal expenses.

Lock-In

Legal reference: 441 IAC 76.9(2), (4)

The IME Medical Services Unit reviews referrals from DHS workers and data gathered through the Surveillance and Utilization Review System (SURS) to search for records indicating overuse of Medicaid services.

If the IME Medical Services Unit determines that a member is overusing services, the member may be restricted or "locked in" to receive services from designated providers for at least 24 months. The purpose of the lock-in program is to:

- ◆ Promote high quality health care.
- ◆ Prevent harmful practices such as duplication of services, drug abuse, and possible drug interaction.

Once a member has been identified as overusing medical services, a nurse reviewer from the IME Medical Services Unit sends an educational letter to the member outlining appropriate ways to use medical services. The letter also includes the contact numbers (1-800-383-1173 or in Des Moines at 725-1008) the member may call to discuss concerns or questions about health care services with a nurse review coordinator.

If it is determined that the member had duplicated medications or services, that member's claims are reviewed again in six months. A physician reviewer makes the final determination that the member is overusing or misusing Medicaid medical services and that the member would benefit from the restrictions of the lock-in program.

After the lock-in determination, an IME Medical Services Unit nurse reviewer notifies the member of the lock-in restrictions. The member then has the opportunity to choose a primary provider, pharmacy, hospital, and special physicians to meet the member's needs. If the member does not select providers, the IME Medical Services Unit will select the restricted providers.

The lock-in program is not intended to limit the member's free choice of a provider, nor to apply to situations where the primary physician refers the member to a specialist requiring office visits, such as a surgeon, internist, or obstetrician. When the member has reason to receive regular care from more than one physician, more than one physician can be designated as primary.

Providers must check the Eligibility Verification System to determine lock-in status. If you have any questions about lock-in or member health education (MHEP), contact the IME Medical Services Unit at 1-800-383-1173 or in Des Moines at 725-1008.

Changing Primary Providers

Legal reference: 441 IAC 76.9(239A)

Members in the lock-in program can change their primary provider only if:

- ◆ The provider or member moves.
- ◆ The provider no longer participates.
- ◆ The provider refuses to see the member.

See 6-Appendix for instructions on how to change a member's provider using form 470-1945, *Change of Primary Provider*. A change in provider can be effective only at the beginning of a month. When care is needed and the former primary provider is not available, the change is effective the date the member makes the request and is approved.



TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

June 25, 1996

GENERAL LETTER NO. 8-G-12

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *Case Maintenance*, Title page, revised; Contents page 1, revised; and pages 1 through 19, new.

Summary

This general letter transmits the revised 8-G, *Case Maintenance*. Policy information in the existing chapter VIII-G, *Utilization Review*, has been rewritten to incorporate the department's new manual style and format, and is contained in the rewritten 8-G along with selected policy information from VIII-A, B, C, and D.

There is no new policy information in this chapter.

Effective Date

August 1, 1996

Material Superseded

Remove all existing pages from the Employees' Manual, Title VIII, Chapter G, and destroy them.

Also obsolete:

- ◆ Manual letter VIII-G-1, "Recipient Health Education and Lock-In Interviews," dated August 6, 1991.
- ◆ Interpretative memo MS-VIII-92-2, "Monthly Reporting for Newborn Children of Medicaid-eligible Mothers."

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

CHARLES M. PALMER, DIRECTOR

February 11, 1997

GENERAL LETTER NO. 8-G-13

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *Case Maintenance*, Contents (page 1), revised; and page 1, revised.

Summary

This general letter changes the word "provide" information to "supply," as a result of revisions of the rules in the Iowa Administrative Code.

There is no new policy information.

Effective Date

March 1, 1997

Material Superseded

Remove Contents (page 1), and page 1, both dated June 25, 1996, from the Employees' Manual, Title 8, Chapter G, and destroy.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.

Effective Date

Policies relating to the delinking of Medicaid from FIP cash assistance are effective retroactively to December 1, 1997.

Elimination of the 30-day wait applies to all applications filed on or after January 1, 1998.

New policies regarding obtaining information from the spouse who has left the household are effective upon receipt of this general letter.

Policies regarding the disregard of assigned child support are effective February 1, 1998.

Material Superseded

Remove the entire Employees' Manual, Title 8, Chapter G, and destroy it. This includes:

<u>Page</u>	<u>Date</u>
Title page	June 25, 1996
Manual Letter No. 8-G-2	March 25, 1997
Contents, (page 1)	February 11, 1997
1	February 11, 1997
2 - 19	June 25, 1996

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



January 13, 1998

GENERAL LETTER NO. 8-G-14

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *Case Maintenance*, Contents, page 1, revised, Contents page 2, new; pages 1 through 19; revised, and and pages 20 through 47, new.

Summary

This general letter transmits several changes:

- ◆ There is new policy on gathering information about estranged spouses.

The Polk County Court District Court issued a decision in a recent case which reversed the Department's final appeal decision. The appellant had applied for Medicaid. At the time of his application the appellant was no longer living with his wife and their child.

The Department's position was that since the appellant was applying for retroactive coverage during a month when he was a member of the household, the cooperation of the appellant's wife was necessary in determining eligibility and benefits. The court disagreed and determined that the appellant had cooperated and that it was unreasonable to require the cooperation of a spouse who was no longer in the household.

Do not cancel a case when the client is unable to provide verification from the spouse who is no longer in the household. Interview the client to obtain the best information available. Ask the client to provide information that would help to verify what he is telling you about the spouse who is no longer in the home. From the information provided, determine eligibility. If the client fails to provide the requested information cancel the case.

- ◆ Medicaid is being "delinked" from FIP cash assistance.

Since Title XIX was added to the Social Security Act in 1965, families who were eligible for cash assistance under the Family Investment Program (FIP), were with a few exceptions, automatically eligible to receive Medicaid.

Policies governing the FIP cash program were the basis of eligibility for Medicaid expansions in later years as more coverage groups were created to provide Medicaid to families, pregnant women, and children. These programs came to be known as "FIP-related" coverage groups.

When Congress passed the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193), states were given new flexibility to administer their FIP cash programs and a five-year lifetime limit was set on receiving cash assistance. There was concern that if the link between Medicaid and FIP remained, people would lose Medicaid eligibility and become uninsured.

As a result, Congress “delinked” Medicaid from FIP, and the term “FIP-related Medicaid” no longer applies. The intent of “delinking” Medicaid from FIP is to preserve Medicaid eligibility, regardless of changes made in FIP, by “freezing” the Medicaid eligibility policies that were in place as of July 16, 1996.

Although the PRWOA mandates states to maintain the policies that were in place as of July 16, 1996, states do have some latitude as to which July 16, 1996, policies they use. For example, if a state had waivers in place, the state can choose to keep some or all of the waiver policies for Medicaid. Additionally, the state can choose to adopt income and resource policies that are more liberal than the policies that were in place on July 16, 1996.

The Family Medical Assistance Program (FMAP) has been designated as the coverage group under which families (both adults and children) that meet the FIP eligibility criteria in place on July 16, 1996, will receive Medicaid. Since Medicaid eligibility must be determined independently of FIP, the administrative rules and Employees’ Manual have been amended so that Medicaid policy can “stand alone.”

This chapter has been revised to delete references to “FIP-related” Medicaid coverage groups and to incorporate new policies around FMAP-related coverage groups. This results in the following changes:

- Persons who receive FIP do not automatically qualify for Medicaid.
- Cross references to Chapters 8-D, **Resources**, and 8-E, **Income**, have been added to the chapter. Although these references use the term “FMAP-related,” revisions to these chapters are not yet completed. Continue to follow FIP-related policy in Title 4 (in addition to current Medicaid policy, as appropriate) until the FIP income and resource policies are incorporated into Title 8.
- ◆ A 30-day waiting period will no longer apply to parents who are employed 100 hours or less. The effective date of eligibility for persons applying for FMAP who are unemployed is the first day of the month in which the application was filed.
- ◆ Assigned child support will no longer be considered when determining ongoing eligibility.
- ◆ References to the work transition period (WTP) have been removed from the manual.

Effective Date

Policies relating to the delinking of Medicaid from FIP cash assistance are effective retroactively to December 1, 1997.

Elimination of the 30-day wait applies to all applications filed on or after January 1, 1998.

New policies regarding obtaining information from the spouse who has left the household are effective upon receipt of this general letter.

Policies regarding the disregard of assigned child support are effective February 1, 1998.

Material Superseded

Remove the entire Employees' Manual, Title 8, Chapter G, and destroy it. This includes:

<u>Page</u>	<u>Date</u>
Title page	June 25, 1996
Manual Letter No. 8-G-2	March 25, 1997
Contents, (page 1)	February 11, 1997
1	February 11, 1997
2 - 19	June 25, 1996

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



December 22, 1998

GENERAL LETTER NO. 8-G-15

ISSUED BY: Insurance Purchasing Unit, Bureau of Health Care Purchasing and Quality Management, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *Case Maintenance*, Contents (page 1), revised, and pages 3, 12, and 13, revised; and page 12a, new.

Summary

This general letter transmits the policy to be followed when making a referral to the HAWK-I program.

When a family becomes ineligible for Medicaid due to excess resources or due to an increase in income which results in having to meet a spenddown under the Medically Needy program, a referral shall be made to the HAWK-I program for the children under the age of 19 if it appears the family is otherwise eligible. The *Referral to the Healthy And Well Kids in Iowa (HAWK-I) Program*, form 470-3565, has been created for this purpose.

A referral is not required if HAWK-I eligibility clearly does not exist (e.g. a parent is employed by the state of Iowa or all of the children have other health insurance). Additionally, a referral is not required if the family would be eligible for Medicaid but is not eligible because they have failed to cooperate with an eligibility requirement of the program (e.g. fails to cooperate with CSRU).

Referrals shall be made to Eligibility Services Incorporated (ESI), the third party administrator for the HAWK-I program. The *Referral to the Healthy And Well Kids in Iowa (HAWK-I) Program*, form 470-3565, is considered an application for the HAWK-I program. Upon receipt, ESI will notify the family that they have received the referral form and will proceed with determining eligibility for the HAWK-I program.

Making the referral to the HAWK-I program does not change other policies regarding the automatic redetermination process for Medicaid. Existing automatic redetermination policies must be followed for determining Medicaid eligibility.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

February 9, 1999

GENERAL LETTER NO. 8-G-16

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *Case Maintenance*, pages 1, 2, 3, 7, 10, 11, 18, and 27, revised.

Summary

Policy has been changed in the length of time a client has to supply information or verification. Current policy requires a client to supply information or verification within five working days. With this change, clients will be required to supply information or verification within ten calendar days. This change provides for consistency with food stamp policies.

All references that state that information or verification be provided within five working days have been changed to ten calendar days.

The cross reference on page seven is corrected.

Effective Date

Upon receipt of this manual material.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
1, 2	January 13, 1998
3	December 22, 1998
7, 10, 11, 18, 27	January 13, 1998

Additional Information

Refer questions about this general letter to your regional benefit administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 22, 1999

GENERAL LETTER NO. 8-G-17

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *Case Maintenance*, Contents (pages 1 and 2), revised; and pages 4, 5, 6, 23, 24 and 43, revised; and pages 6a through 6c, new.

Summary

The Seventy-Eighth Session of the Iowa General Assembly directed the Department to eliminate the face-to-face interview as a condition of ongoing Medicaid eligibility for children under age 21. This letter transmits changes to the sections discussing eligibility reviews for both FMAP-related and SSI-related cases. The change eliminates the face-to-face interview as a part of the Medicaid eligibility review for both FMAP-related and SSI-related children under age 21.

This chapter is also revised to:

- ◆ Add information regarding the state warrant monthly match which will generate a tickler message to workers notifying them of persons who have received certain state warrants. This change addresses the first phase of implementing the new WRNT screen. In phase one of the implementation, day care warrants will be identified. At a later date, child support and adoption subsidy warrants will be added.
- ◆ A new category: Changes Reported From IEVS and Other Automated Sources. (ICER information has been moved from Chapter E to Chapter G.)

Effective Date

July 1, 1999

For ongoing FMAP-related or SSI-related Medicaid cases with reviews due in July and later months, do not require a face-to-face interview as part of the annual review for children under age 21.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	December 22, 1998
Contents (page 2)	June 13, 1998
4, 5, 6, 23, 24, and 43	January 13, 1998

Additional Information

When adults need to be canceled for failing to attend the face-to-face interview but the children are remaining active, a manual notice of decision must be issued for the adults. Suggested wording of the notice is:

- ◆ For State Supplemental Assistance and all Medicaid, except Medically Needy, and QMB and SLMB groups:

Medical Assistance for (names) is canceled beginning (date) because you did not attend your required interview.

EM 6-B Application Processing; EM 8-B Interviews; EM 8-G Eligibility Reviews; 441 Iowa Admin. Code 50.2(249), 50.4(4), 76.1(3), 76.2(1), 76.7(249A), and 76.13(249A)

- ◆ For Medically Needy:

Medical Assistance for (names) is canceled beginning (date) because you did not attend your required interview.

EM 8-J Interviews; EM 8-B Interviews; 441 Iowa Admin. Code 75.1(35)"k," 76.1(249A), 76.13(249A)

- ◆ For QMB and SLMB groups:

Medical Assistance for (names) is canceled beginning (date) because you did not attend your required interview.

EM 8-B Interviews; EM 8-G Eligibility Reviews; 441 Iowa Admin. Code 76.2(1), 76.7(249A), and 76.13(249A)

Refer questions about this general letter to your regional benefit administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

August 10, 1999

GENERAL LETTER NO. 8-G-18

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *Case Maintenance*, Contents (pages 1 and 2), revised; and pages 1, 3, 7, 14, 15, 16, 23, 29, 30, 34, 35, 38, and 42, revised.

Summary

Revisions to this chapter:

- ◆ Eliminate the sanction for people who fail to timely report changes in earnings or fail to timely report earnings on the monthly report form.
- ◆ Remove monthly reporting requirement for people with income or recent work history from earnings in kind. See General Letter 8-E-45 for specific information.
- ◆ Correct the date a person is added to the case after providing the social security number or proof of the number.
- ◆ Remove the section on returning or recovering parents who are in the eligible group. See **Budgeting for Ongoing Eligibility** on how to count the income of a returning parent not in the eligible group.

Effective Date

The elimination of the earned income sanction is effective with the September 1999 benefit month.

The exemption of earnings in kind is effective with the September 1999 benefit month. Therefore, monthly reporting is no longer required based solely on either income or a recent work history from earnings in kind. See General Letter 8-E- 45 for more information.

The remaining changes are effective upon receipt.

Implementation Instructions

Beginning with the benefit month of September 1999:

- ◆ Apply the 20% earned income deduction and deductions for child care and adult care (as appropriate) to earnings even if the person fails to timely report changes in income or fails to report earnings on the monthly report form by the sixteenth day of the report month.
- ◆ Do not cancel FMAP and FMAP-related recipients for September when a recipient whose sole reason for monthly reporting is based on income or a work history from earnings in kind fails to return a complete monthly report for the July budget month. These recipients are no longer required to report monthly beginning with the July 1999 budget month.
- ◆ When processing PAERs or RREDs for these cases for the July budget month, remove the monthly reporting code by system cutoff in August to prevent the system from issuing a monthly report for the August budget month.

Note: Monthly reports for recipients with either income or a work history from earnings in kind are still required for the June budget month. Cancel FMAP and FMAP-related recipients effective August when the recipient fails to return a complete report as required.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (pages 1 and 2)	June 22, 1999
1, 3, 7	February 9, 1999
14-16, 21-23, 29, 30, 34, 35, 38, 42	January 13, 1998

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

November 2, 1999

GENERAL LETTER NO. 8-G-19

ISSUED BY: Insurance Purchasing Unit, Bureau of Health Care Purchasing and
Quality Management, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *Case Maintenance*, page 13, revised.

Summary

This General Letter transmits a change in how income is considered when determining eligibility for the HAWK-I program. When considering family income to compare to the income limit, apply a 20% deduction to earned income.

Effective Date

Apply the new income guidelines to all HAWK-I applications filed on or after November 1, 1999, for coverage December 1, 1999, or later.

Material Superseded

Remove from the Employees' Manual, Title 8, Chapter G, page 13, dated December 22, 1998, and destroy it.

Additional Information

Refer questions about this general letter to your regional benefit administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

March 28, 2000

GENERAL LETTER NO. 8-G-20

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *Case Maintenance*, Title page, revised; Contents (pages 1 and 2), revised; pages 1 through 47, revised; and pages 48 through 52, new.

Summary

Page 2 is revised to clarify the worker's and the recipient's responsibility when third party information is needed for eligibility purposes and to change the word "deny" to "cancel."

Page 6b is revised to add child support payments to types of warrants that are reported on the WRNT screen.

Pages 7 and 8 are revised to include policies and examples regarding suspension of FMAP-related Medicaid cases.

Page 13 is revised to clarify when to make referrals to the HAWK-I program and to remove references to children being ineligible for Medicaid due to excess resources. The 1st bullet is changed from gross family income to family countable income. The 4th bullet is revised to change the word "inmate" to "residents."

Page 17 and 18 are revised to add a legal reference, clarify who must sign the report, and add reference to the transitional Medicaid quarterly report.

Page 19 is revised to clarify the procedures to follow when a PAER, RRED, or quarterly report is returned incomplete. Clarification is also added to Example #1.

Page 21 is revised to add a legal reference and to clarify that monthly reporting and reviews of eligibility pertain to FMAP-related Medicaid recipients, not just FMAP recipients.

Page 23 is revised to add emphasis to the policy and to add examples.

Page 24 is revised to clarify procedures when clients inquire about the impact on their Medicaid benefits of a potential change in circumstances.

Page 25 is revised to clarify

- ◆ When Medicaid can be reinstated after a cancellation due to failure to supply requested information regarding a reported change.
- ◆ The exception to the policy regarding adding a new household member to an existing FMAP-related Medicaid eligible group.

Page 27 is revised in the first example to change “FMAP” to “CMAP” and to further clarify that the family is eligible for FMAP once the parent is added to the eligible group.

Page 28 is revised to correct the legal reference and clarify the chart for determining the income of people being added to an existing eligible group.

Page 29 is revised to direct the reader to another manual chapter for policies when a person being added to an existing eligible group was a Medicaid recipient on another case during the two months prior to the month the person is being added.

Page 31 is revised to correct items 3, 4, and 5 in the chart. Clarification is also added regarding the use of the prospective income of a person being added to a retrospectively budgeted eligible group. Example 1 is also clarified.

Page 32 is revised in Example 1 to change “FMAP” to “CMAP.”

Page 35 is revised in Example 3 to clarify that a nonrecurring lump sum is prorated.

Page 37 is revised to add clarification regarding what income to use in determining eligibility in the retrospectively budgeted months immediately following the two initial prospectively budgeted months. Clarification is also added to Example 1.

Other pages are revised to:

- ◆ Clarify the charts and examples.
- ◆ Remove redundant wording.
- ◆ Make minor wording changes.

Effective Date

Upon receipt.

Material Superseded

Remove entire Employees' Manual, Title 8, Chapter G, and destroy it. This includes the following pages:

<u>Page</u>	<u>Date</u>
Title page	January 13, 1998
Contents (pages 1 and 2)	August 10, 1999
1	August 10, 1998
2	February 9, 1999
3	August 10, 1999
4-6, 6a-6c	June 22, 1999
7	August 10, 1999
8, 9	January 13, 1998
10, 11	February 9, 1999
12, 12a	December 22, 1998
13	November 2, 1999
14-16	August 10, 1999
17	January 13, 1998
18	February 9, 1999
19, 20	January 13, 1998
23	August 10, 1999
24	June 22, 1999
25, 26	January 13, 1998
27	February 9, 1999
28	January 13, 1998
29, 30	August 10, 1999
31-34	January 13, 1998
35	August 10, 1999
36, 37	January 13, 1998
38	August 10, 1999
39-41	January 13, 1998
42	August 10, 1999
43	June 22, 1999
44-47	January 13, 1998

Additional Information

Refer questions about this general letter to your regional benefit administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 13, 2000

GENERAL LETTER NO. 8-G-21

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Contents (page 1), revised; and pages 4, 19, 20, 27, and 46 through 49, revised.

Summary

Page 19 is revised to change the third-party administration of the HAWK-I program to MAXIMUS effective June 1, 2000.

Pages 19 and 46 are revised to reflect the increase in the MAC income limit to 200% of the federal poverty level for pregnant women and infants.

This general letter also transmits information to include the Spanish PAER, form 470-3719(S), *Reporte de Elegibilidad de Asistencia Publica*, to the revised pages. Other form numbers are also updated.

Effective Date

June 1, 2000, MAXIMUS replaces ESI as the third-party administrator for HAWK-I.

July 1, 2000, the income limit changes to 200% of the federal poverty level for pregnant women and infants under the MAC coverage group and the HAWK-I program.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	March 28, 2000
4, 19, 20, 27, 46-49	March 28, 2000

Additional Information

This Spanish PAER will not be system-issued and is not available as a template. Hand-issue and manually track this form. Make copies as needed until supplies are available from Anamosa.

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

June 27, 2000

GENERAL LETTER NO. 8-G-22

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Contents (page 2), revised; pages 48 and 49, revised; and page 48a, new.

Summary

The Medicaid for employed people with disabilities (MEPD) coverage group provides that premiums be assessed when gross income of the disabled person is above 150% of the federal poverty level. The monthly MEPD premium amount is set for a six-month period. This letter releases instructions for reviews of the current premium amount.

Workers must gather income information before the end of the current premium period to determine the monthly premium amount to charge for the next six months. Form 470-3693, *Earned Income Statement for Premium*, has been developed to gather the income information. The form is on line on the public state-approved forms folder on Outlook. Workers must enter the address and other information as identified on the form and mail it to the client for completion.

The new premium amount for the next six-month premium period must be entered on ABC by timely notice day of the the fifth month of the current premium period for correct bills to be issued to the clients for the first month of the next premium period. For MEPD clients whose coverage began in March 2000, income information must be gathered in June and put on the system by July timely notice day to ensure correct premiums are collected for September.

Effective Date

Immediately.

Material Superseded

Remove Table of Contents (page 2), dated March 28, 2000, and pages 48 and 49, dated June 13, 2000, from Employees' Manual, Title 8, Chapter G, and destroy them.

Additional Information

The Division of Data management will produce a report from the ABC system listing MEPD clients who are in the fourth month of their premium period. The first report is expected to be issued June 26. Refer questions about this general letter to your regional benefit administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

September 19, 2000

GENERAL LETTER NO. 8-G-23

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Title page, revised; Contents (pages 1 and 2), revised; and pages 1 through 48, revised.

Summary

This chapter is revised due to changes for FMAP-related coverage groups, including:

- ◆ The elimination of monthly reporting, retrospective budgeting, and the six-month review.
- ◆ The limiting of changes a client is required to report after eligibility has been established.

Clarification has also been added in determining the effective date of a change. Some other minor changes were also made.

Monthly Reporting

October 2000 is the first month for which clients are not required to monthly report as a condition of FMAP-related Medicaid eligibility. The report normally issued at the end of October will not be issued.

However, FMAP-related recipients who are subject to monthly reporting for FIP or Food Stamps and those programs will be issued monthly report forms for October. Failure to submit a complete report will continue to be cause for cancellation for the FIP and food stamp programs, but will no longer be cause for cancellation for FMAP-related Medicaid.

Retrospective Budgeting

Since October 2000 will be the first month for which a monthly report form will not be issued for FMAP-related Medicaid, December 2000 will be the first month subject to prospective budgeting.

Determine eligibility for October 2000 retrospectively, using the August 2000 income reported on the monthly report form received in September. Determine eligibility for November 2000 retrospectively using the September income reported on the monthly report form received in October.

Allow the income from September, used to determine November eligibility, to roll forward to be used for eligibility for December and future months, unless you have information that indicates September income is not the best indicator of future income. In that situation, in November, request the recipient to provide one of the following:

- ◆ Proof of income from the 30-day period before the date of the request, if indicative of future income, or
- ◆ Proof of income from a longer period of time (e.g., 60 or 90 days before the date of the request), if indicative of future income, or
- ◆ Verification of anticipated future income from the source of the income.

Semi-Annual Review

The six-month review is eliminated for FMAP-related coverage groups. Beginning with reviews conducted in October, form 470-2881, *Review/Recertification Eligibility Document*, will be sent for all FMAP-related Medicaid reviews unless the FIP semi-annual review is due in the same month. (In that case, a PAER will be sent and used to conduct both reviews.)

Beginning with the system month of October (the day after September cutoff through October cutoff), when entries are made in field TD05, 118, MED LAST REV, the ABC system will calculate the date that goes in field TD05, 119, MED NEXT REV as an annual date, unless alignment shortens the date.

Conduct a face-to-face interview for annual reviews of cases on which adults receive Medicaid. Do not require face-to-face interviews for annual reviews of cases on which only children receive Medicaid. Do not cancel Medicaid of children when their parents who receive Medicaid fail to attend the face-to-face interview.

Changes Required to be Reported

Beginning with October, FMAP-related Medicaid recipients are required to report only certain changes between approval and the first annual review, and between annual reviews. These changes are:

- ◆ Beginning and ending income, including beginning to receive recurring lump-sum income from the same source as other income is currently received.
- ◆ Changes in household composition.
- ◆ Changes in mailing or living address.
- ◆ Changes in health insurance coverage, including starting or dropping coverage.

At annual reviews, recipients continue to be required to report all changes. If a recipient reports a change between annual reviews that is not required to be reported, treat it as a reported change and take the appropriate action.

Effective Date

October 1, 2000

Material Superseded

Remove the entire Chapter G from Employees' Manual, Title 8, and destroy it. This includes the following pages.

<u>Page</u>	<u>Date</u>
Title page	March 28, 2000
Contents (page 1)	June 13, 2000
Contents (page 2)	June 27, 2000
1-3	March 28, 2000
4	June 13, 2000
5-18	March 28, 2000
19, 20	June 13, 2000
21-26	March 28, 2000
27	June 13, 2000
28-45	March 28, 2000
46, 47	June 13, 2000
48, 48a, 49	June 27, 2000
50-52	March 28, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

October 10, 2000

GENERAL LETTER NO. 8-G-24

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Contents (page 1), revised; pages 5, 8, and 10, revised; and pages 10a and 10b, new.

Summary

DHS and DIA have jointly developed a template form 427-0578, *AWARE Hotline Complaint*, which will be used by DIA and DHS for sharing hotline referral information received by DIA. Information is being added to this chapter describing the process and the form generated by DIA as a part of DIA's Anti-Welfare Abuse Recognition Effort (AWARE).

Other minor corrections in references are included.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	September 19, 2000
5, 8, 10	September 19, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 12, 2000

GENERAL LETTER NO. 8-G-25

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Contents (pages 1 and 2), revised; and pages 1, 2, 4 through 10, 10a, 10b, 18 through 22, 25, 26, 28, 31 through 34, 38, 47, and 48, revised.

Summary

Page 2 is revised to clarify when the ten-day period begins and to clarify what "supply" means.

Page 4 is revised to clarify reporting of recurring lump sum income.

Page 5 is revised to clarify that you do not cancel or deny anyone's Medicaid due to information or changes in circumstances that do not affect their eligibility and to add an example.

Page 9 is revised to add information about an exception to procedure for the income amount and delivery date of account type 15 child support payments appearing on WRNT.

Page 18 is revised to update a telephone number for MAXIMUS.

Page 19 is revised to remove "PAER" and add "Quarterly Report."

Page 20 is revised to clarify that:

- ◆ An original signature is required on a faxed report.
- ◆ You may have verification of earned income without having all pay stubs.

Page 21 is revised to clarify that reported changes do not always require verification for a report to be considered complete and to update a form number.

Page 25 is revised to change Example 2.

Pages 26, 28, 31, 33, and 34 are revised to remove references to deprivation.

Pages 32 and 33 are revised to remove the chart on adding a considered person, as this is addressed under "Establishing the Date of Application and Eligibility." Adding a considered person is handled in the same way as adding a new person.

Page 38 is revised for a minor word usage correction.

Pages 22, 47, and 48 are revised to update form numbers.

Effective Date

January 1, 2001

Material Superseded

Remove the following from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (p. 1)	October 10, 2000
Contents (p. 2)	September 19, 2000
2, 4	September 19, 2000
5	October 10, 2000
6, 7	September 19, 2000
8	October 10, 2000
9	September 19, 2000
10, 10a, 10b	October 10, 2000
18-22, 25, 26, 28, 31-34, 38, 47, 48	September 19, 2000

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

March 13, 2001

GENERAL LETTER NO. 8-G-26

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, pages 21 and 22, revised; and page 20a, new.

Summary

Page 21 is revised to clarify the procedures regarding a system-generated quarterly report. It is not a change in policy.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
20, 21	December 12, 2000

Additional Information

Refer questions about this general letter to your regional benefit administrator.



August 14, 2001

GENERAL LETTER NO. 8-G-27

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, CASE MAINTENANCE, Contents (pages 1 and 2), revised; pages 25 through 29, and 33 through 36, revised.

Summary

The manual is being updated to reflect a change in the way we sanction adults who do not cooperate with the department, ineligible adult aliens, and adults who do not have a social security number.

The change will allow sanctioned adults, undocumented adult aliens, and adults who are ineligible due to no social security number to remain a part of the household size.

Ineligible children will not be included in the household size, nor will their income or resources be used in determining eligibility of the eligible group.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

Table with 2 columns: Page, Date. Lists pages 1-2, 25, 26, 27, 28, 29, 33, 34, 35, 36 and their respective destruction dates from 2000.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

December 18, 2001

GENERAL LETTER NO. 8-G-28

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, page 43, revised.

Summary

This chapter is revised to:

- ◆ Remove the references to forms 470-3118, *Medically Needy Recertification/State Supplementary and Medicaid Review*, and 470-0442, *Application for Medical Assistance or State Supplementary Assistance*, from the chapter.
- ◆ Add the use of the *Health Services Application*, form 470-2927 or 470-2927(S), for all SSI-related reviews and Medically Needy recertifications.

Effective Date

January 1, 2002

Material Superseded

Remove page 43, dated September 19, 2000, from Employees' Manual, Title 8, Chapter G, and destroy it.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

April 30, 2002

GENERAL LETTER NO. 8-G-29

ISSUED BY: Unit of Health Support, Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, pages 43 and 44, revised.

Summary

This chapter is revised to reflect changes in the date to conduct a premium review for Medicaid for employed people with disabilities (MEPD) due to billing system changes effective June 1, 2002, and to clarify premium review procedures.

Currently premiums are due the month before the month the premium is to cover, and premium reviews are due in the fifth month of the premium period. Under rule changes effective June 1, premiums will be due in the month the premium is to cover. Therefore, premium reviews will be due in the sixth month of the premium period.

Effective Date

June 1, 2002

Discontinue MEPD premium reviews or annual reviews in the fifth month of the premium period effective with the month of May 2002.

Under current rules, premium reviews for the six-month premium period of July through December would be due in May. With conversion to the new billing system, no premium review for the premium period July through December can be entered until June. Therefore, do not complete the July through December premium reviews or enter them on the system in May.

Material Superseded

Remove page 43, dated December 18, 2001, and page 44, dated September 19, 2000, from Employees' Manual, Title 8, Chapter G, and destroy them.

Additional Information

The 617 report, MEPD Premium Reviews, will be changed beginning with the printout issued at May month end to identify premium reviews due in the sixth month of the premium period rather than the fifth month of the premium period.

Refer questions about this general letter to your service area IM supervisor II.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

November 19, 2002

GENERAL LETTER NO. 8-G-30

ISSUED BY: Unit of Health Support, Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Contents (page 2), revised; pages 43 and 44, revised; and page 44a, new.

Summary

This chapter has been revised to:

- ◆ Clarify policy and procedure for increasing or decreasing a premium for Medicaid for Employed People with Disabilities (MEPD) using the redesigned billing system and
- ◆ Correct an error of the name for MEPD on page 43.

Before June 1, 2002, decreases or increases to a MEPD premium were completed through the ABC, TD05 screen. With the implementation of the redesigned billing system, changes to premiums are made using the MEPC screen on ABC. This revision incorporates policy for use of the new MEPC screen.

Effective Date

June 1, 2002

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 2)	August 14, 2001
43, 44	April 30, 2002

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
JESSIE K. RASMUSSEN, DIRECTOR

January 21, 2003

GENERAL LETTER NO. 8-G-31

ISSUED BY: Unit of Health Support, Division of Financial, Health, and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, page 18, revised.

Summary

The section dealing with referrals to the *hawk-i* program has been revised to more clearly indicate when a referral is to be made and how to make the referral.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy it:

<u>Page</u>	<u>Date</u>
18	December 12, 2000

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

April 27, 2004

GENERAL LETTER NO. 8-G-32

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, page 18,
revised.

Summary

The following clarifications have been made regarding the *hawk-i* referral process.

- ◆ The reference to the hardship criteria for dropping a child's health insurance has been removed. Families paying less than 5% of their gross income toward their health insurance are no longer assessed a six-month waiting period before *hawk-i* coverage can begin.
- ◆ The instructions to not refer a child to *hawk-i* if family income (gross earnings –20% + unearned income) exceeds 200% or if the child is a dependent of a state of Iowa employee have been removed. All children who are only conditionally eligible for Medically Needy should be referred to the *hawk-i* program for an official determination of *hawk-i* eligibility, regardless of the amount of income or parental employment, to ensure that family's appeal rights are protected.
- ◆ The name of the form used to make referrals to the *hawk-i* program has been changed to *Referral to the hawk-i Program*. The form number, 470-3565 remains unchanged.
- ◆ Instructions regarding the documents that must accompany the *Referral to the hawk-i Program*, form 470-3565 have been revised. The referral form needs to be accompanied only by the notice of decision that contains the income calculation establishing Medicaid ineligibility under coverage groups other than Medically Needy.

Effective Date

Upon receipt.

Material Superseded

Remove page 18, dated January 21, 2003, from Employees' Manual, Title 8, Chapter G, and destroy it.

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

January 28, 2005

GENERAL LETTER NO. 8-G-33

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, page 20,
revised.

Summary

A faxed *Review/Recertification Eligibility Documents* (RRED), form 470-2881, shall be treated as an original. An original signature will no longer be required.

Effective Date

February 1, 2005

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy it:

<u>Page</u>	<u>Date</u>
20	December 12, 2000

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.



November 25, 2005

GENERAL LETTER NO. 8-G-34

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, pages 19,
43, and 44, revised.

Summary

This chapter is revised to reflect new form 470-3118 or 470-3118(S), *Medicaid Review*. This form will be used to gather information for:

- ◆ SSI-related Medicaid reviews, instead of the *Health Service Application*.
- ◆ FMAP-related Medically Needy recertifications, instead of the *Review/Recertification Eligibility Document*.
- ◆ The six-month premium review for Medicaid for employed people with disabilities (MEPD), instead of form 470-3693, *Earned Income Statement for Premium*.

Effective Date

December 1, 2005

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
19	December 12, 2000
43, 44	November 19, 2002

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

February 3, 2006

GENERAL LETTER NO. 8-G-35

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Contents
(page 2), revised, and pages 45 through 48, revised.

Summary

This chapter is revised to:

- ◆ Add the new organizational units and phone numbers within the Iowa Medicaid Enterprise that handle member overuse of medical services and lock-in.
- ◆ Change references from "recipient" to "member" on the pages revised.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (p. 2)	November 19, 2002
44a	November 19, 2002
45, 46	September 19, 2000
47, 48	December 12, 2000

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

January 26, 2007

GENERAL LETTER NO. 8-G-36

ISSUED BY: Bureau of Medical Supports, Division of Financial Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*,
page 43, revised.

Summary

The "Additional SSI-Related Case Maintenance" section of this chapter is revised to:

- ◆ Clarify under "Eligibility Review" when the IM worker is responsible for an annual review of eligibility.
- ◆ Indicate under "Premium Redetermination for MEPD" that the *Medicaid Review* form is now generated from the Automated Benefit Calculation system for MEPD cases.

Effective Date

Upon receipt.

Material Superseded

Remove from Employees' Manual, Title 8, Chapter G, page 43, November 25, 2005, and destroy it.

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



August 3, 2007

GENERAL LETTER NO. 8-G-37

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MANAGEMENT*, Contents (pages 1 and 2), revised; and pages 2, 3, 4, 7, 8, 9, 20, 20a, 23 through 26, 30, and 39 through 47, revised.

Summary

This chapter is revised to:

- ◆ Eliminate the requirement for an interview.
- ◆ Clarify wording that a third party is not responsible for returning client information timely.
- ◆ Correct legal references.
- ◆ Clarify what changes must be reported by the client regarding third-party liability.
- ◆ Clarify that verification requirements apply when acting on changes.
- ◆ Change the state warrant information to add the *Child Care Assistance - CCA Warrant Report*.
- ◆ Clarify the requirements for a complete report.
- ◆ Remove the word "budget" month that references retrospective budgeting.
- ◆ Add language that a quarterly report is due by the 21st of the month.
- ◆ Add that Comm. 233, *Rights and Responsibilities*, must be sent or given at the annual review.
- ◆ Clarify the voter registration procedures.
- ◆ Update changes received on other program's forms and update examples.
- ◆ Clarify that recoupment begins the month a lump sum was received when a lump sum is not timely reported.
- ◆ Change the earned income deduction from 50% to 58%.

Effective Date

Effective August 1, 2007, eliminate the requirement for an interview and change the earned income deduction from 50% to 58%.

All other changes are effective upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents, page 1	August 14, 2001
Contents, page 2	February 3, 2006
2	December 12, 2000
3	September 19, 2000
4, 7, 8, 9	December 12, 2000
20	January 28, 2005
20a	March 13, 2001
23, 24	September 19, 2000
25, 26	August 14, 2001
30, 39-42	September 19, 2000
43	January 26, 2007
44	November 25, 2005
45-47	February 3, 2006

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

December 7, 2007

GENERAL LETTER NO. 8-G-38

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Contents
(page 2), revised; pages 42 through 47, revised; and pages 48 and 49, new.

Summary

Updates were made due to the following changes:

- ◆ The premium period for Medicaid for employed people with disabilities (MEPD) has changed from six months to 12 months.
- ◆ The limit on the number of times an MEPD case may be reopened after the receipt of a late payment in the month following the month that the payment was due has been removed.
- ◆ The current process for assessing MEPD premiums allows for several premium adjustments throughout the year due to annual changes in the premium amounts and the federal poverty levels. The new process assigns one premium amount per 12-month premium period, which will not change unless the member reports a decrease in income.
- ◆ Clarification on situations that allow for an increase in the MEPD premium during the 12-month premium period has been added.
- ◆ The following sections have been added to the chapter:
 - "Effect of Nonpayment of Premiums"
 - "Reopening of a Case Canceled for Failure to Pay Premium"
 - "Refunds"
- ◆ References to 470-3348, *Medical Assistance Eligibility Card (Lock-In)*, have been removed due to the change to an annual Medicaid card.

Effective Date

November 1, 2007

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 2)	August 3, 2007
42-47	August 3, 2007

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



July 25, 2008

GENERAL LETTER NO. 8-G-39

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Contents (pages 1 and 2), revised; pages 9, 10, 10a, 10b, 11, 12, and 45 through 49, revised; and pages 50 and 51, new.

Summary

This chapter is revised to:

- ◆ Remove reference to the *ICER Cover Letter*, form 470-3625. This form has been revised and renamed *Employer's Statement of Earnings Cover Letter*. The form is available for completion in eForms with the *Employer's Statement of Earnings*, form 4700-2844, attached.
- ◆ Change a section name from "Premium Change" to "Premium Change for Current or Past System Months"; add more detail and some examples on how to decrease or increase an MEPD premium; and change language under the "Refund" section. The SPIRS Help Desk now handles MEPD premium refunds.
- ◆ Update terms and references.

Effective Date

Immediately

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 1)	August 3, 2007
Contents (page 2)	December 7, 2007
9	August 3, 2007
10, 10a, 10b	December 12, 2000
11, 12	September 19, 2000
45-49	December 7, 2007

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I GESSOW, DIRECTOR

October 17, 2008

GENERAL LETTER NO. 8-G-40

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MANAGEMENT*, pages 19 and 20, revised.

Summary

This chapter is revised to specify that when both parents or a parent and stepparent are in the home, either may sign the report form.

Effective Date

November 1, 2008

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
19	November 25, 2005
20	August 3, 2007

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

March 6, 2009

GENERAL LETTER NO. 8-G-41

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MANAGEMENT*; pages 39 and 40, revised; and pages 40a through 40f, new.

Summary

This chapter is revised to clarify policy on acting on changes.

Effective Date

Upon receipt.

Material Superseded

Remove from Employees' Manual, Title 8, Chapter G, pages 39 and 40, dated August 3, 2007, and destroy them.

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

April 3, 2009

GENERAL LETTER NO. 8-G-42

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MANAGEMENT*; pages 1
through 6, revised.

Summary

This chapter is revised to clarify that a client who provides a signed release to a specific individual or organization for specific information has met the requirements for supplying requested information or verification.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
1	December 12, 2000
2-4	August 3, 2007
5, 6	December 12, 2000

Additional Information

Refer questions about this general letter to your area income maintenance administrator.



June 12, 2009

GENERAL LETTER NO. 8-G-43

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, *CASE MAINTENANCE*, Contents
(page 1), revised; and pages 5, 6, and 9 through 14, revised.

Summary

Changes to Chapter 8-G include:

- ◆ Revision of newborn policy to implement a federal law change that eliminates the requirement that the mother must be eligible for Medicaid if she were still pregnant.
- ◆ Update of the procedure on AWARE hotline referrals.
- ◆ Revision of report names to match current versions.

Effective Date

July 1, 2009.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

<u>Page</u>	<u>Date</u>
Contents (p. 1)	July 25, 2008
5, 6	April 3, 2009
9, 10, 10a, 10b, 11, 12	July 25, 2008
13, 14	September 19, 2000

Additional Information

Refer questions about this general letter to your area income maintenance administrator.