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Employees' Manual  
Title 8  
Chapter 0

# IOWACARE



Iowa Department  
of Human Services

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## **Overview**

This chapter provides information specific to the Medicaid waiver program called "IowaCare." The IowaCare program extends limited Medicaid eligibility to people who are not eligible for assistance under any Medicaid coverage group except the Iowa Family Planning Network. These include:

- ◆ Persons ages 19 through 64 whose countable household income is less than 200% of the federal poverty level.
- ◆ Pregnant women whose gross income is less than 300% of the federal poverty level and whose allowable family medical expenses bring their countable income to below 200% of the federal poverty level ("qualifying" pregnant women).

NOTE: Only a woman whose resources are over the limit for the Mothers and Children (MAC) coverage group will qualify for IowaCare instead of MAC. See 8-F, [MAC Resource Limit](#), for amounts.

- ◆ Newborn children born to qualifying pregnant women who are not eligible for MAC coverage. NOTE: A Medicaid application must be filed to establish that the infant does not qualify for Medicaid.

Eligibility for IowaCare is determined on a 12-month period, which is generally based on an applicant's declared circumstances. Retroactive eligibility is limited to one month.

| Members who have income over 150% of the federal poverty level for the household size must pay a premium for IowaCare coverage. The premiums are based on a sliding scale. A member must pay for at least four months of premiums. The premium may be waived on a month-by-month basis if a hardship is claimed.

IowaCare provides limited services (chiefly hospital and physician services) from a limited provider network the University of Iowa Hospitals and Clinics, Broadlawns Hospital in Des Moines, and designated federally qualified health centers.

Because IowaCare is not an entitlement program, IowaCare members are not entitled to receive services in the same way as under the Iowa Medicaid program. When available funds are committed before the end of the fiscal year, the program will be discontinued until funding is received for the next fiscal year. Approval of applications will be suspended, and applications may be approved for only partial benefits.

## **Legal Basis**

Legislation in 2005 Iowa Acts, Chapter 167, directed the Department to apply for waivers of federal Medicaid requirements to create a new "expansion population" for the Iowa Medicaid program. The Centers for Medicare and Medicaid Services approved the waivers with an effective date of July 1, 2005.

Iowa Code Chapter 249J, "IowaCare," has been revised by:

- ◆ 2006 Iowa Acts, Chapter 1184, changing provisions for reenrollment, health risk assessment, premium payment, and the IowaCare account.
- ◆ 2007 Iowa Acts, Chapter 218, clarifying premium payment standards.
- ◆ 2008 Iowa Acts, Chapter 1014, clarifying that acceptance of a premium payment doesn't confer eligibility.
- ◆ 2009 Iowa Acts, Chapter 110, relating to the agreement with the University of Iowa Hospitals and Clinics.
- ◆ 2009 Iowa Acts, Chapter 182, establishing a fund for reimbursement of nonparticipating providers.
- ◆ 2010 Iowa Acts, Chapter 1134, expanding the provider network to include federally qualified health centers.
- ◆ 2010 Iowa Acts, Chapter 1141, updating requirements for health risk assessment, tracking, and reporting and removing references to coverage at state mental health institutes.
- ◆ 2010 Iowa Acts, Chapter 1193, making editorial changes.

All state expenditures under the IowaCare program qualify for matching with federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to section 1115 of the Social Security Act (42 USC §1315). Therefore, IowaCare shall remain in effect only as long as these waivers are in effect.

## **Definitions**

**Legal reference:** 441 IAC 92.1(249A,249J)

**“Applicant”** means an individual who has applied for medical assistance under the IowaCare program described in this chapter.

**“Department”** means the Iowa Department of Human Services.

**“Dependent child”** means the:

- ◆ Child or stepchild of an applicant or member who is living in the applicant’s or member’s home and is under the age of 18 or is 18 years old and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching age 19. NOTE: Correspondence school is not an allowable program of study.
- ◆ Child or stepchild attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.
- ◆ If the child is a full time student, the parents may claim the child as a dependent up to the age of 24.

**“Enrollment period”** means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

**“Federal poverty level”** means the poverty income guidelines revised annually and published in the Federal Register by the U. S. Department of Health and Human Services.

**“Group health insurance”** means any plan of, or contributed to, by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer’s employees, former employees, or the families of the employees or former employees.

**“Initial application”** means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

**“IowaCare”** means the medical assistance program that provides limited Medicaid services by IowaCare network providers to persons who are not otherwise eligible for Medicaid. Exception: Women receiving Medicaid through the Iowa Family Planning Network may receive IowaCare coverage.

**“IowaCare network provider”** means a provider that participates in the IowaCare program. See [Network Providers](#).

**“Mandatory months”** means the four consecutive months immediately following the month in which the eligibility decision is made. Mandatory months are applied only at initial application and when there has been a break in coverage.

**“Medical expansion services”** means the following services:

- ◆ Inpatient and outpatient hospital care
- ◆ Physician and advanced registered nurse practitioner services
- ◆ Certain dental services
- ◆ Certain pharmacy services
- ◆ Pregnancy-related services and newborn care
- ◆ Services to help members quit smoking
- ◆ Transportation to and from the network provider
- ◆ Routine preventive medical examination

**“Medical home”** means a team approach to providing health care that:

- ◆ Originates in a primary care setting;
- ◆ Fosters a partnership among the patient, the personal provider, other health care professionals, and where appropriate, the patient's family;
- ◆ Utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential;
- ◆ Maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and
- ◆ Has all of the characteristics specified in Iowa Code section 135.158.

**“Member”** means a person who is receiving assistance under IowaCare or Medicaid.

**“Newborn”** means an infant born to a qualifying pregnant woman.

**“Qualifying pregnant woman”** means a pregnant woman whose resources are over MAC resource limits and whose gross income is under 300% of the federal poverty level but whose allowable family medical expenses bring her countable income to below 200% of the federal poverty level.

## **Processing IowaCare Applications**

**Legal reference:** 441 IAC 92.3(249A,249J), 92.4(249A,249J)

In processing IowaCare applications, base eligibility primarily on the information that the applicant self-declared on the application. A face-to-face interview is not required.

Require the applicant or member to provide verification of citizenship and identification. Do not require applicants or members to provide verification of income, household members, disability, social security number, age, *hawk-i* premium, group health insurance, or pregnancy. Request verification only when the information the applicant or member provided is questionable.

Notify the applicant or member in writing of any further verification requested. Give the applicant five working days to supply the requested information. The deadline may be extended for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

Deny applications for IowaCare or cancel IowaCare benefits when applicants or members fail to supply the requested information or refuse to authorize the Department to obtain the information from other sources.

This section explains different or additional requirements for IowaCare that do not apply to other Medicaid coverage groups.

- ◆ [Applications](#)
- ◆ [Information provided to applicant](#)
- ◆ [Self-declared eligibility factors](#)
- ◆ [Verified eligibility factors](#)
- ◆ [Time limit for eligibility decision](#)
- ◆ [Effective date of assistance](#)
- ◆ [IowaCare renewal application](#)

### **Applications**

**Legal reference:** 441 IAC 92.3(1), 92.11(249A,249J)

An application is required at the time of the initial application or to regain eligibility after cancellation. Persons applying for IowaCare may use Comm. 239 or Comm. 239(S), *IowaCare Application*, as the complete application.

A person who applies using one of the following forms must also sign form 470-4194 or 470-4194(S), *IowaCare Premium Agreement*:

- ◆ 470-2927 or 470-2927(S), *Health Services Application*,
- ◆ 470-0462 or 470-0462(S), *Health and Financial Support Application*,
- ◆ Comm. 156 or Comm. 156(S), "**hawk-i**: *Healthy and Well Kids in Iowa*,"
- ◆ 470-4016, *Healthy and Well Kids in Iowa (hawk-i) Electronic Application Summary and Signature Page*.

If a person applies for Medicaid on one of these forms but qualifies only for IowaCare, send the person the *IowaCare Premium Agreement* and form 470-4208 or 470-4208(S), *IowaCare Premium Agreement Cover Letter*, and request that the person sign the *IowaCare Premium Agreement*. Allow ten days for the signed form to be returned. Do not approve IowaCare eligibility until the applicant signs the *IowaCare Premium Agreement*.

Mr. F, age 64, applies for IowaCare on a *Health Services Application*. To be eligible for IowaCare he must sign and return the *IowaCare Premium Agreement*.

Assist the applicant with completing the application when requested. Applicants may authorize other people to represent them during the application process. Other people may also help the applicant during the application process.

An application may be filed on behalf of a deceased person. Eligibility is based on whether the person would have been eligible had an application been made on or before the date of death and whether there are unpaid medical bills from the network provider. However, eligibility cannot be established any earlier than one month before the month of application.

### **Who Must Sign the Application**

**Legal reference:** 441 IAC 76.1(249A), 92.3(249A,249J)

An application must have a legible name, address, and signature to be considered a valid application. Before eligibility can be approved, all application forms must be signed by one of the following:

- ◆ The applicant on the applicant's own behalf,
- ◆ The applicant's guardian or conservator, or
- ◆ Someone acting responsibly for an incompetent, physically incapacitated, or deceased applicant. (This includes a person or entity that has signed form 470-3356, *Inability to Find a Responsible Person*. See 8-B, [Responsible Person](#).)

NOTE: If the guardianship or conservatorship was established voluntarily, the applicant may sign the application. When a person voluntarily asks the court to appoint a guardian or conservator, the court may do so without making a determination that the person is incompetent to make personal or financial decisions.

If an authorized representative signs the application on behalf of the applicant, the signature of the applicant or responsible person must be on the application before eligibility can be approved. (See 8-B, [Representation](#).)

#### **Where the Application Must Be Filed**

**Legal reference:** 441 IAC 76.1(249A), 92.3(249A,249J)

Comm. 239, *IowaCare Application*, may be filed at:

- ◆ A local Department office (whether open full time or less than full time).
- ◆ A disproportionate-share hospital, federally qualified health center, mental health institute, resource center, or other facility where out-stationing activities are provided.

If you receive an application that should have been filed in another Department office, date-stamp the application and send it to the correct office for processing within two working days of receipt.

Service areas may decide to have the county receiving the *IowaCare Application* process the application before sending the case file to the county of residence. However, if the county where the member lives, the county of legal settlement, or the county where the facility is located has a less-than-full-time office, the application is processed at the full-time Department office associated with that county.

An income maintenance (IM) worker who is outstationed at a facility processes the application regardless of the applicant's county of residence.

### **Date of Application**

**Legal reference:** 441 IAC 76.1(249A), 92.3(249A,249J)

An application is considered filed on the date when Comm. 239, *IowaCare Application*, containing a legible name, address, and signature of the applicant or representative is received at a location listed under [Where the Application Must Be Filed](#).

The date the application is received is recorded in the Electronic Case File (ECF). If the application was filed in the incorrect Department office and sent to the appropriate office for processing, the date the application was filed in the first office is still the date of application.

When an application is left at a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that office was last open.

A faxed application shall be considered as an original application. A faxed application is considered filed on the date it is received during normal business hours. If the fax comes in after normal business hours (during the evening, weekend, or holiday), the faxed application is considered received on the first day that is not a weekend or state holiday following the day that office was last open.

### **Withdrawal of Application**

**Legal reference:** 441 IAC 76.1(249A), 92.3(249A,249J)

An applicant may withdraw the application entirely or for any month covered by the application if the request is made before the application is processed.

The request to withdraw the application may be done orally or in writing. Document the withdrawal in the case record. Issue an adequate notice of decision if the entire application is withdrawn. If only a month of the application is withdrawn, and a notice of decision will be issued when the remaining application is processed, a separate notice is not necessary.

### **Grace Period Following the Denial of an Application**

**Legal reference:** 441 IAC 92.4(1)"c"

See 8-B, [Grace Period Following the Denial of an Application](#).

### **Information Provided to Applicant**

Give applicants the following brochures:

- ◆ Comm. 51, *Information Practices*
- ◆ Comm. 209, *Information About Your Privacy Rights*
- ◆ Comm. 233 or Comm. 233(S), *Rights and Responsibilities*
- ◆ Comm. 123 or Comm. 123(S), *Important Information for You and Your Family Members About the Estate Recovery Program*

### **Self-Declared Eligibility Factors**

**Legal reference:** 441 IAC 92.4(1), 92.5(2)

The applicant self-declares the following:

- ◆ Unearned income
- ◆ Earned income, including net self-employment income. (Gross self-employment income minus self-employment expenses equals net self-employment income.)
- ◆ Household members
- ◆ Disability
- ◆ Social security number
- ◆ Age
- ◆ Group health insurance, whether it is affordable, and what services are covered
- ◆ Pregnancy and due date
- ◆ Newborn's date of birth
- ◆ **hawk-i** premium

1. Ms. G applies for IowaCare. She states her income is \$1,800 a month and that she pays a \$10 **hawk-i** premium for her son. The IM worker accepts Ms. G's statement for income and the amount of the **hawk-i** premium and does not request verification of the income or the amount of the premium.
2. Ms. E listed the gross amount of her self-employment income on her *IowaCare Application*. The IM worker contacts Ms. E for the net amount of her self-employment income. Ms. E calls and tells the worker the net amount of her self-employment income.

### **Verified Eligibility Factors**

**Legal reference:** 441 IAC 92.2(2), 92.4(1), 92.5(5)“b”

Verify the following:

- ◆ Citizenship
- ◆ Identity
- ◆ Alien status, if applicable
- ◆ Any information that is questionable
- ◆ Medical bills of a qualifying pregnant woman and her family to reduce the countable income to 200% of the federal poverty level

1. Mr. H states on his application that he is a qualified alien. The IM worker verifies that Mr. H does not have alien documentation. Therefore, Mr. H is not eligible for IowaCare.
2. In the “Income” section of the IowaCare application, Ms. Y states that the amount of her income from employment varies. Since the amount of her income is questionable, the IM worker requests that Ms. Y verify the amount of her monthly income from employment.

### **Time Limit for Eligibility Decision**

**Legal reference:** 441 IAC 75.1(249A), 76.3(1), 76.3(4), 76.3(6), 92.4(3)

Approve or deny an application as soon as possible, but no later than three working days after the filing date of the application, unless:

- ◆ The application is being processed for another Medicaid coverage group, including Medically Needy.
- ◆ The application is pending due to the non-receipt of information that is beyond the control of the applicant or the Department.
- ◆ Unusual circumstances exist which prevent a decision from being made within the specified time limit. “Unusual circumstances” include those situations where the local office and the applicant have made every reasonable effort to secure necessary information or emergencies such as fire, flood, or other conditions beyond the administrative control of the Department.

NOTE: The day after the application is received is day one.

1. Mrs. D applies for IowaCare on Thursday, July 21. She provides verification of citizenship and identification. The IM worker enters the information that Mrs. D self-declared into the Automated Benefit Calculation (ABC) system on the third working day after the application date, Tuesday, July 26.

2. Mr. K files an *IowaCare Application* at the local Department office. He has completed the entire section of "Tell Us About You," and has signed and dated the application. The spaces in the "Income" and "Resource" areas are blank.

The application states that if the information in the "Income" and "Resource" areas is left blank, the Department will take that to mean that the applicant does not have any money or resources. The applicant provides verification of citizenship and identification. The IM worker processes the application for IowaCare within the three-working-day period.

3. Ms. J files an *IowaCare Application* at the local Department office. She has completed the first page and only signed the second page. The "Health Insurance" section is left blank. She provides verification of citizenship and identification.

The IM worker calls Ms. J and asks the health insurance questions. The worker documents in the file Ms. J's answers and processes the *IowaCare Application* within three working days.

4. Same as Example 3, except the worker cannot reach Ms. J. The worker returns the *IowaCare Application* to Ms. J and requests that Ms. J answer the questions in the "Health Information" section and return the *IowaCare Application* in ten working days.

When the information is returned to the office, the worker enters the information into the ABC system no later than the day following the receipt of the requested information. If the information is not returned and no extension is requested, the worker denies the application.

5. Mrs. L applies for IowaCare on July 15. In screening her application, the IM worker finds that Mrs. L appears to be eligible for another Medicaid coverage group.

Because the *IowaCare Application* does not provide all of the information needed to determine Medicaid eligibility, the worker requests the additional information necessary. The 30-day period for processing Medicaid applications applies.

6. Mr. M files a completed *IowaCare Application*. The IM worker requests that he verify his citizenship and identity. Since all other information has been provided, the worker enters IowaCare approval in ABC. Mr. M provides citizenship and identity proof during the reasonable period of opportunity.

### **Effective Date of Coverage**

**Legal reference:** 441 IAC 92.6(249A,249J)

No payments will be made for medical care received before the effective date of IowaCare eligibility. Eligibility begins on the first day of the month the application was filed or the first day of the month in which all eligibility requirements are met, whichever is later.

EXCEPTION: Eligibility may be granted for one month before the month of application if certain requirements are met. See [Retroactive Eligibility](#).

The Department issues form 470-4164, *IowaCare Medical Card*, to persons determined to be eligible for IowaCare benefits. The *IowaCare Medical Card* is issued at the beginning of each certification period. If a member requests a new IowaCare card, make an entry of "C" in the TD03 ID GEN field.

### **Retroactive Eligibility**

**Legal reference:** 441 IAC 75.11(2)(c)(3), 92.6(2), 92.6(3)

IowaCare benefits are available for the month before the month in which the application is filed, to applicants who meet the following conditions:

- ◆ The applicant received Medicaid expansion services from an IowaCare provider within the IowaCare network during the month for which retroactive eligibility is sought.
- ◆ The applicant would have been eligible for IowaCare in the month for which retroactive eligibility is sought, if application had been made in that month.
- ◆ The applicant meets all other IowaCare eligibility requirements.
- ◆ The applicant's citizenship and identity have been verified. See 8-C, [Retroactive Eligibility](#), for requirements related to providing proof of citizenship and identity.

Do not enter the retroactive month until citizenship and identity are verified. If citizenship and identity were verified and coded for previous eligibility, the retroactive month can be entered at the same time the approval is entered in the ABC system. For ABC case actions, go to 14-B(10), [Retroactive IowaCare Eligibility](#).

IowaCare members may apply for the one month of retroactive eligibility at time of application or any time after the initial approval of their application. Retroactive eligibility may be determined only for the month before the month of the most recently approved IowaCare application. Retroactive eligibility cannot be determined at a later date on an application that was denied for ongoing benefits.

1. Mr. P is 25 and lives alone. He has no health insurance. Mr. P is in a farm accident on August 27 and is immediately taken to the University of Iowa Hospitals and Clinics. He is in a coma for about a week.

In September, an IM worker helps Mr. P complete an *IowaCare Application*. On the application, he checks "yes" to the question "Did you have unpaid medical bills in the last month?" And under "Where at?" he wrote his medical home.

Mr. P is approved for IowaCare on September 23 and is determined eligible retroactively to August 1.

2. Mr. O is approved for IowaCare effective September 1. In October, he receives a bill from Broadlawns Medical Center for health care that he received in August. He inquires about IowaCare paying for the August bill. The IM worker determines retroactive eligibility for August.
3. Mrs. S calls the last week of August to inquire if IowaCare will pay for medical services that she received at the University of Iowa Hospitals and Clinics in July. The IM worker explains that IowaCare has one month of retroactive eligibility and explains that if IowaCare is to cover services received in July, the Department's office must receive the *IowaCare Application* no later than the last working day of August.

### **Length of Certification Period**

The certification period for qualifying pregnant women continues only 60 days after the pregnancy ends. The certification period for a newborn child of an IowaCare-eligible pregnant woman ends 60 days after the child's birth.

The certification period for all other IowaCare members begins with the first month of eligibility and continues for 12 consecutive months. Certification periods may be shortened when two household members are combined on one case.

## **Renewal Application**

**Legal reference:** 441 IAC 75.11(2)“c,” 92.3(1), 92.3(2), 92.11(249A,249J)

A new application is required in order for IowaCare coverage to continue when a member's 12-month certification period has expired.

The Department mails form 470-4364 or 470-4364(S), *IowaCare Renewal Application*, to persons whose certification period will end. Also included in the mailing is an informational flyer about prescription discounts. (See [Comm. 260, Do You Need Help Paying for Your Prescription Drugs?](#))

The *IowaCare Renewal Application* is sent the day after timely notice of the eleventh month of the certification period. The *IowaCare Renewal Application* will also be sent to persons who are canceled for nonpayment of a previous premium. The IowaCare member may be reinstated before the certification period ends.

IowaCare can be renewed using any of the following application forms:

- ◆ *IowaCare Renewal Application* form that is mailed to the member, or
- ◆ *IowaCare Application*, or
- ◆ *Health Services Application*, or
- ◆ *Health and Financial Support Application*.

NOTE: A member who uses the *Health Services Application* or the *Health and Financial Support Application* must also sign form 470-4194 or 470-4194(S), *IowaCare Premium Agreement*.

The *IowaCare Renewal Application* has a due date of the **15th** of the month. This is a target date for IowaCare members to return the form. When the form is received after the due date:

- ◆ Process the form as a renewal if it is received in the month after the certification has ended.
- ◆ Process the form as an initial application if there is a break in eligibility of one month or more.

Treat the *IowaCare Renewal Application* as a new application.

### **Time Limit for Renewal Applications**

**Legal reference:** 441 IAC 92.11(249A,249J)

For renewal applications submitted before the last three working days of the current certification period, approve or deny by the last working day before the current certification period. See [Time Limit for Eligibility Decision](#) when the determination may take longer.

For an *IowaCare Renewal Application* submitted for a new certification period during the last three working days of the current certification period, eligibility determination shall be completed no later than three working days after the filing date of the application.

### **Grace Period for the Renewal Application**

**Legal reference:** 441 IAC 92.6(4)

If the IowaCare member returns the *IowaCare Renewal Application* during the grace period, follow the "Policy" and "Procedures" in 8-G, [Grace Period](#).

## **Determining IowaCare Eligibility**

### **Who Is Eligible for IowaCare**

**Legal reference:** 441 IAC 92.2(249A,249J)

IowaCare is available only to persons who:

- ◆ Are over income or over resources for Medicaid; or
- ◆ Are not categorically eligible for Medicaid coverage groups

NOTE: Persons who are eligible for a Medicare savings program, including qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, expanded specified low-income Medicare beneficiaries, and qualified disabled and working people, are considered to be "categorically eligible," but persons who are eligible for the Iowa Family Planning Network are not.

Persons 19 through 64 years of age are eligible for IowaCare if they have net countable income at or below 200% of the federal poverty level.

Pregnant women qualify for IowaCare if they:

- ◆ Are over resources for MAC; and
- ◆ Have gross countable income below 300% of the federal poverty level; and

- ◆ Have allowable family medical expenses that reduce countable income to 200% of the federal poverty level.

Newborn children are eligible for IowaCare if born to a mother who was a qualifying pregnant woman for IowaCare. Newborns under IowaCare are eligible while hospitalized and for a period not to exceed 60 days from the date of birth.

A Medicaid application must be filed on behalf of the infant to get ongoing Medicaid coverage. When the newborn qualifies for eligibility in a regular Medicaid coverage, open a new case for that eligibility type. Newborns of IowaCare-eligible mothers are not eligible as a newborn of a Medicaid-eligible mother.

1. Mr. A, age 30, and Mrs. A, age 29, have net countable income of 150% of the federal poverty level. They are not eligible for any other Medicaid coverage group. They meet the age and income guidelines for IowaCare.

2. Ms. M, who is pregnant, applies for IowaCare. Her countable income is below 300% of the federal poverty level but she has a bank account with a balance of \$13,000. She has unpaid medical expenses that reduce her income to 200% of the federal poverty level. Ms. M is approved for IowaCare as a qualifying pregnant woman.

When Ms. M's baby is born, Ms. M applies for Medicaid for the baby. The IM worker verifies that Ms. M's income is still below 300% of the federal poverty level and determines that the baby is eligible for MAC.

3. Mrs. J, who is pregnant, applies for IowaCare. Her net countable income is \$3,600 per month, which is below 300% of the federal poverty level. Mrs. J has \$450 in unpaid medical expenses. This reduces her income to \$3,150.

Mrs. J's income is not reduced to 200% of the federal poverty level. She is denied IowaCare. She may reapply when she has more unpaid medical expenses.

### **Who Is Not Eligible for IowaCare**

**Legal reference:** 441 IAC 92.2(249A,249J)

Persons are not eligible for IowaCare if they:

- ◆ Are under the age of 19.
- ◆ Are aged 65 or older.

- ◆ Have income above 200% of the federal poverty level and are not pregnant.

Mr. S. applies for IowaCare. His income is 210% of the federal poverty level. His application is denied as he is over income for IowaCare.

- ◆ Are pregnant and have income above 300% of the federal poverty level.
- ◆ Are eligible for Medicaid or would be eligible for Medicaid under any other coverage group (except for the Iowa Family Planning Network). The following persons are considered to be “eligible for Medicaid” for this purpose:
  - Persons who are eligible for a Medicare savings programs (qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, expanded specified low-income Medicare beneficiaries, and qualified disabled and working people).
  - Persons who have a premium to pay for Medicaid for employed people with disabilities (MEPD).
  - Persons who have a spenddown to meet and would be able to meet the spenddown (medically needy). See [Choice of IowaCare or Medically Needy With a Spenddown](#).

The month before an IowaCare member turns age 65, a system-generated tickler is sent to the IM worker stating that the member is turning age 65 and that the person needs to be canceled from IowaCare.

### **Screening for IowaCare**

Determine IowaCare eligibility for:

- ◆ Persons who do not have children, are not pregnant, are not disabled, and are between the ages of 19 and 64.
- ◆ Pregnant women whose gross income is below 300% of the federal poverty level but are over resources for Medicaid.

Determine eligibility for IowaCare if the woman does not have enough medical expenses to meet a spenddown for Medically Needy or is not expected to incur enough medical expenses to meet a spenddown.

- ◆ A parent of a child eligible for Mothers and Children (MAC) or Healthy and Well Kids in Iowa (*hawk-i*) coverage. Before determining eligibility for IowaCare, determine if the client could be eligible for Medically Needy by meeting a spenddown. To determine if a person could be Medically Needy eligible by meeting a spenddown, ask the following questions:
  - Does the person regularly meet the spenddown? If the answer is yes, then process the application for Medically Needy.
  - Does the person not meet spenddown or indicate that the medical expenses that the person has or would incur would not be enough to meet spenddown? If yes, then the person may choose between IowaCare and Medically Needy.
- ◆ A person claiming disability. Have the person file for Social Security Disability or Supplemental Security Income (SSI). Determine eligibility for IowaCare while waiting for the disability determination. If the person fails to provide information that the person has applied for Social Security disability, cancel IowaCare.

NOTE: If the person is determined eligible for IowaCare and then eligibility for Social Security Disability or SSI is approved later, determine if the person is eligible under another Medicaid coverage group. If the person is not eligible for another Medicaid coverage group, IowaCare continues. See the examples in the following chart:

<b>IowaCare and Disability Examples</b>			
<b>Case Action</b>	<b>Scenario 1</b>	<b>Scenario 2</b>	<b>Scenario 3</b>
Application for IowaCare July 1	Reports disability on the application.	Reports disability on the application.	Does not report disability on the application.
Action of IM worker	Approves IowaCare application and requests the member to apply for Social Security Disability (SSD).	Approves IowaCare application and requests the member to apply for SSD.	Approves IowaCare application.

<b>Case Action</b>	<b>Scenario 1</b>	<b>Scenario 2</b>	<b>Scenario 3</b>
Action of IowaCare member	Does apply for SSD and provides information to IM worker.	Does not provide information to IM worker.	Has a disabling event after the IowaCare approval, applies for SSD, and reports the disability to the IM worker.
Action of IM worker	Waits for the SSD decision. IowaCare coverage continues.	Cancels IowaCare case for failure to provide information.	Documents that the member reported applying for SSD. Waits for the SSD decision. IowaCare coverage continues.
Social Security approves disability	IM worker uses the 7/1 IowaCare application to determine Medicaid eligibility based on disability. Grants Medicaid eligibility, if otherwise eligible.	This person will need to file a new application for Medicaid for IM worker to determine eligibility.	IM worker uses the 7/1 IowaCare application to determine Medicaid eligibility based on disability. Grants Medicaid eligibility, if otherwise eligible. (Medicaid eligibility cannot go back further than date of application.
Difference	The IowaCare application is approved. The application is considered to be pending for a disability determination.	Member did not provide information requested about the disability and the case is canceled. The application is not considered to be pending for a disability determination.	Member reports disability after IowaCare application is approved. The application is considered to be pending for a disability determination.

<b>Case Action</b>	<b>Scenario 4</b>	<b>Scenario 5</b>	<b>Scenario 6</b>
Applies for IowaCare July 1	Does not report disability on the application.	Does not report disability on the application.	Does not report disability on the application.

Case Action	Scenario 4	Scenario 5	Scenario 6
Action of IM worker	Approves IowaCare application.	Approves IowaCare application.	Approves IowaCare application.
Action of IowaCare member	Has a disabling event and applies for SSD. Reports disability to IM worker.	Has a disabling event and applies for SSD. Does not report disability to IM worker.	Has a disabling event and applies for SSD. Does not report disability to IM worker.
Action of IM worker	Documents that the member reported applying for disability. Waits for disability decision.  Premium not paid. Case is canceled.		Premium not paid. Case is canceled.
Social Security approves disability	IM worker uses the 7/1 IowaCare application to determine Medicaid eligibility based on disability. Grants Medicaid eligibility if otherwise eligible.	The member did not report application for disability and must file a new application for Medicaid. IM worker determines Medicaid eligibility based on disability.	The client reports receipt of SSD but must file an application for Medicaid. If eligible for SSI, the person's Medicaid eligibility is based on the SSI determination.
Difference	Reports disability after approval. The cancellation does not have anything to do with the disability. The application is considered to be pending for a disability determination.	Does not report disability, therefore the 7/1 application was not pending for a disability determination.	Does not report disability, therefore the 7/1 application was not pending for a disability determination. If the person receives SSI based on the disability determination, the SSI determination is treated as an application for Medicaid.

**Reminder:** If the person applies for social security disability and is approved for SSI for the first five months, the SSI determination is treated as an application for Medicaid. Follow the policies in 8-B, [Procedures for SSI Applicant or Potential SSI Eligibles](#), for determining eligibility for a person who is determined eligible for SSI.

### **Screening for Full Medicaid**

**Legal reference:** 441 IAC 92.2(1)"a"(1), 92.4(2)

Screen each *IowaCare Application* and *IowaCare Renewal Application* for other Medicaid eligibility. Persons eligible for other Medicaid coverage groups are not eligible for IowaCare. **There are two exceptions:**

- ◆ Iowa Family Planning Network. A woman eligible for Iowa Family Planning Network may also be concurrently eligible for IowaCare.
- ◆ Medically Needy. A person who is unable to meet the spenddown for the Medically Needy coverage group may choose to receive IowaCare instead of Medically Needy.

A person who is unable to meet the spenddown is not Medicaid-eligible and therefore should be given the option to choose IowaCare. See [Choice of IowaCare or Medically Needy With a Spenddown](#).

Determine that a person aged 19 or 20 is not eligible for other Medicaid coverage groups (e.g., Child Medical Assistance Program (CMAP)) before approving for IowaCare.

If the applicant is eligible under another Medicaid coverage group, the *IowaCare Application* shall be considered an application for that coverage group. If it appears the applicant may qualify for Medicaid but fails to cooperate in providing information necessary to establish eligibility under another Medicaid coverage group, deny the IowaCare application.

1. Mr. A receives SSI. He fails to return the requested information to the Department. He is not eligible for Medicaid until he returns the information. He applies for IowaCare.

The IM worker screens the application for other Medicaid coverage groups. A determination on Medicaid eligibility must be made first because the information on the application indicates that he may be eligible for Medicaid. The worker again requests the information to determine Medicaid eligibility. Mr. A does not return the information. His IowaCare application is denied.

2. Mr. and Mrs. C and their 17-year-old child apply for IowaCare. The IM worker screens the application for Medicaid and requests information to determine Medicaid eligibility. The information is not returned by the due date. The worker denies the IowaCare application because it could not be determined if the family was Medicaid eligible.

### **Concurrent Eligibles**

**Legal reference:** 441 IAC 92.2(1)"a"(1)

There are situations when a member may become eligible for another Medicaid coverage group while receiving IowaCare. These include:

- ◆ A woman age 19 through 44 receiving Iowa Family Planning Network (IFPN).
- ◆ An IowaCare-eligible woman who becomes eligible for MAC due to pregnancy.
- ◆ A woman who is determined presumptively eligible for Medicaid.
- ◆ An IowaCare member who can now meet the spenddown for Medically Needy.
- ◆ An IowaCare member who is now eligible for another Medicaid coverage group.

When a person has been determined eligible for IowaCare and then is later determined eligible for a Medicaid coverage group that has full Medicaid benefits, the IowaCare eligibility continues with the Medicaid coverage until the IowaCare can be canceled in a timely manner. EXCEPTION: A woman aged 19 through 44 may be eligible for both IowaCare and IFPN.

The SSNI=Medicaid Eligibility File screen will show a blended aid type for these situations. NOTE: The Medicaid Eligibility system cannot allow IowaCare to be an underlying eligibility with Medicaid coverage groups that have limited benefits, such as QMB and SLMB. Persons determined eligible for IowaCare and then later determined eligible for QMB or SLMB in the same month, require special handling. Contact central office.

### **Choice of IowaCare or Medically Needy With a Spenddown**

**Legal reference:** 441 IAC 92.2(1)"a"(1), 92.4(1)

#### **Policy:**

When processing an application, screen for Medicaid eligibility in the Medically Needy group.

1. Check to see if the applicant is eligible under Medically Needy:
  - ◆ Pregnant,
  - ◆ Has children in the household,
  - ◆ Is under 21, or,
  - ◆ Blind or disabled.
2. If the applicant meets one of these eligibility requirements, check with the applicant to find out about the applicant's current and expected medical bills.

3. If the applicant can meet the spenddown amount, the applicant must be approved for Medically Needy. The applicant does not have a choice between IowaCare and Medically Needy with the spenddown because the applicant will be eligible for Medicaid after meeting spenddown.
4. If the applicant **cannot** meet a spenddown with medical expenses that the applicant has or will incur, the applicant should be given a choice of Medically Needy or IowaCare. Document the person's choice in the case file. **Do not** give the applicant a choice if the applicant can meet the spenddown.

An applicant who is approved for Medically Needy with a spenddown cannot request IowaCare for the months of the Medically Needy certification period.

When a person is approved for IowaCare and later has high medical bills that would meet the spenddown, the person may file an application for Medically Needy for months that the person was already receiving IowaCare. Cancel the IowaCare case with timely notice.

1. Mr. and Mrs. A have two children in the MAC coverage group. The parents apply for Medicaid on May 5. The IM worker explains that the spenddown amount would be \$3,000.

Before Medically Needy is approved, the worker asks if Mr. and Mrs. A have medical expenses of \$3,000 or if they expect to have that much in medical bills for the two-month period. Mr. and Mrs. A state that they expect to have only \$500 in medical bills.

Since Mr. and Mrs. A cannot meet the spenddown of \$3,000 for Medically Needy, the worker explains that they could choose IowaCare. They request IowaCare. Before the worker approves IowaCare, the worker sends Mr. and Mrs. A form 470-4194, *IowaCare Premium Agreement*, to sign.

In August, Mrs. A calls the worker to report that Mr. A was hospitalized at the local hospital after an accident. The worker explains that IowaCare will not pay the bill because he is not at the University of Iowa Hospitals and Clinics and that Mr. and Mrs. A could apply for Medically Needy. They apply for Medically Needy on August 15. Medically Needy is approved September 10 and IowaCare is canceled with a timely notice effective October 1.

IowaCare shows as the primary coverage on SSNI for the months of August and September until the spenddown is met for Medically Needy. Once spenddown is met, Medically Needy shows as the primary coverage on SSNI.

2. Ms. R and Mr. B have two common children and one child of Ms. R's from a previous relationship living with them. They apply for full Medicaid in October with a *Health Services Application*.

Ms. R was released from the University of Iowa Hospitals and Clinics earlier in October. The three children receive *hawk-i*. Ms. R is conditionally approved for Medically Needy. She is eligible for Medicaid because she has enough medical expenses to meet the Medically Needy spenddown for the October and November certification period. The children stay on *hawk-i*.

Ms. R applies in December but states that she does not have enough medical expenses to meet the spenddown and won't incur medical bills to meet spenddown. The IM worker explains the IowaCare program.

An *IowaCare Application* is not needed since a *Health Services Application* was completed. Form 470-4194, *IowaCare Premium Agreement*, is sent to Ms. R to sign regarding payment of premiums.

## **Nonfinancial Eligibility**

Nonfinancial eligibility factors for IowaCare include:

- ◆ [Citizenship](#)
- ◆ [Residency](#)
- ◆ [Provision of a social security number](#)
- ◆ [Acceptance of benefits from other sources](#)
- ◆ [Residence in a public nonmedical institution](#)
- ◆ [Disqualification from Medicaid](#)

### **Citizenship**

**Legal reference:** 441 IAC 75.11(2) "a," 92.2(2)

To be eligible for IowaCare, a person must be one of the following:

- ◆ A U. S. citizen, defined as:
  - A person born in the United States (for qualifying as a U.S. citizen, "United States" is defined as the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and North Mariana Islands), or
  - A person born of parents who are citizens living outside of the United States, or
  - A person granted citizenship status.

- ◆ A national of the United States, defined as a person born in American Samoa or the Swain Islands.
- ◆ A qualified alien. See 8-L, [ALIENS](#), for more information on eligibility requirements.

The IowaCare applicant and the IowaCare member must verify citizenship. See 8-C, [Citizenship](#).

### **Residency**

**Legal reference:** 441 IAC 75.10(249A), 92.2(249A,249J)

A person must be a resident of Iowa to be eligible for IowaCare. In general, a resident of Iowa is one who is living in the state with the intent to remain permanently or for an indefinite period. IowaCare applicants and members self-declare their residency.

1. Ms. K, a college student, applies for IowaCare and lives in the dormitory. She is from Minnesota and pays out-of-state tuition. Deny the application for IowaCare, as Ms. K is not a resident of Iowa.
2. Mr. G, age 22, attends college in Mason City. His parents live in Polk County. He states on his application that he returns to Des Moines every weekend. The IM worker asks Mr. S, "Do your parents claim you as a dependent on their income tax returns?"

If the answer is "yes," Mr. G's residence is Polk County. If it is "no," the worker asks whether his residence is Cerro Gordo County or Polk County. His residence will make a difference as to which network provider he sees, as Broadlawns Medical Center provides services only to Polk county residents.

### **Providing a Social Security Number**

**Legal reference:** 441 IAC 75.7(249A), 92.2(249A,249J)

A social security number is required for each person applying for IowaCare. This requirement does not apply to a person who is a member of a recognized religious sect who conscientiously opposes applying for a social security number.

A person who will not apply for or use a social security number due to religious beliefs must provide verification from the church elder or other officiant that it is against the church doctrine.

### **Income Benefits From Other Sources**

**Legal reference:** 441 IAC 75.3(249A), 92.2(249A,249J)

As a condition of eligibility, IowaCare applicants and members must apply for and accept any income benefits for which they are eligible, unless they can prove an incapacity that prevents them from doing so. EXCEPTIONS: A person does not need to apply for or accept any income benefit that would be considered exempt income. See [Unearned Income](#).

The applicant or member may be entitled to cash benefits, such as:

- ◆ Social Security benefits
- ◆ Annuities
- ◆ Pensions
- ◆ IPERS
- ◆ Railroad benefits
- ◆ Job insurance benefits
- ◆ Workers' compensation
- ◆ Union benefits
- ◆ Veterans' benefits available to:
  - The veteran
  - The surviving spouse
  - The veteran's minor child
  - Some parents of service personnel or veterans who died on or after January 1, 1957

To "apply for and accept" means that the applicant or member:

- ◆ Files an application for benefits.
- ◆ Actively tries to obtain benefits by complying with all requests for information or evidence to establish eligibility.

If you decide the applicant or member may be entitled to other cash benefits, use form 470-0383, *Notice Regarding Acceptance of Other Benefits*, to notify the person of the requirement to apply for the benefits. See [6-Appendix](#), for instructions. The applicant or member indicates intent to "apply for and accept" by completing Part B of the form and returning it to your office.

Allow the applicant or member ten working days from the date when this notice was given or mailed to complete and return the form. If the applicant or member gives you a signed refusal to apply or does not return the form, deny or cancel IowaCare for the person who failed or refused.

Deny or cancel IowaCare when the applicant or member fails or refuses to:

- ◆ Comply with any income benefit, or
- ◆ Timely apply for any income benefit, or
- ◆ Accept any income benefit.

EXCEPTIONS: Do not deny or cancel IowaCare when good cause exists or when the person is mentally or physically incapable. If the applicant or member is incapable, either ask the applicant's or member's representative to pursue the other benefits or you may help the applicant or member apply, if the applicant's or member's representative has authorized you to do so.

### **Medical Benefits From Other Sources**

**Legal reference:** 441 IAC 75.2(249A), 92.2(249A,249J)

IowaCare applicants and members must apply for and accept any medical resources that are reasonably available to them **without charge**. A medical resource is considered "reasonably available" when it may be obtained by filing a claim or an application. Such medical resources include:

- ◆ Health and accident insurance.
- ◆ Eligibility for care through Veterans Affairs.
- ◆ Specialized health care services.
- ◆ Medicare.

Deny or cancel IowaCare benefits of the person when an IowaCare applicant or member fails to file a claim or application or to cooperate in the processing of that claim or application without proving good cause. See 8-C, [Cooperation in Obtaining Medical Resources](#).

### **Group Health Insurance**

**Legal reference:** 441 IAC 92.2(4)

A person who has access to group health insurance is not eligible for IowaCare. Group health insurance means any plan of an employer or contributed to by an employer to provide health care. Do not consider an applicant or member to have access to group health insurance if any of the following conditions exist:

- ◆ The applicant or member is not enrolled in the available group health plan and states that:
  - The coverage is unaffordable, or
  - Exclusions for pre-existing conditions apply, or
  - The needed services are not services covered by the plan.

1. Mrs. C, age 40, applies for IowaCare. Her employer offers a group health insurance plan at a cost of \$150 per month. Mrs. C states that she cannot afford the group health insurance plan. If Mrs. C meets all other eligibility requirements for IowaCare, her application is approved.
2. Mr. D, age 54, applies for IowaCare. His employer offers a group health insurance plan at no cost. He did not enroll in the group health insurance and the open enrollment is past. He states that he needs surgery that would not be covered by the group health insurance.

The IM worker approves IowaCare. At the time of the next open enrollment, Mr. D must enroll in his employer's group health insurance plan. Failure to do so will result in cancellation of IowaCare. If Mr. D still needs services that are not covered by the employer's plan, IowaCare can also continue.

The reason IowaCare is approved is that the needed services are not covered by the plan. Otherwise, IowaCare would have to be denied for failure to enroll in an affordable group health insurance.

- ◆ The applicant or member is enrolled in a group health plan but states that:
  - Exclusions for pre-existing conditions apply, or
  - The needed services are not covered by the plan, or
  - The limits of benefits under the plan have been reached, or
  - The plan covers only catastrophic health care.

Reminder: Send form 470-4542, *IowaCare Insurance Information Request*, and 470-2826 or 470-2826(S), *Insurance Questionnaire*, to the IowaCare member to complete.

1. Mr. E, age 55, applies for IowaCare. He does have health insurance. However, his health plan does not cover his pre-existing condition of heart problems. If Mr. E meets all other eligibility requirements for IowaCare, his application is approved. The IM worker sends Mr. D form 470-4542 to complete.

2. Ms. M, age 40, applies for IowaCare. She checks on the application that she has health insurance. The IM worker calls and asks Ms. M about her health insurance policy. Does it exclude pre-existing conditions? Are the needed services not covered by the plan? Has she reached the limit of the benefits under the plan?

Ms. M answers all of the questions "no." The reason she is applying for IowaCare is that she has a high deductible. The worker denies the *IowaCare Application*.

3. Ms. H, age 59, applies for IowaCare. She checks on her application that she has health insurance. Her health insurance has an annual coverage limit of \$10,000.

The IM worker calls and asks if Ms. H has met the annual limit for the year. Ms. H indicates that she has not met the limit yet. The worker explains that the limit must be met before she can approve IowaCare and suggests Ms. H reapply when the limit is met. The worker denies the application.

Persons receiving Medicare may be eligible for IowaCare. Medicare is not included in "group health insurance" provided through an employer.

Persons receiving Veterans Affairs benefits may be eligible for IowaCare.

### **Cooperation in Obtaining Medical Resources**

**Legal reference:** 441 IAC 75.2(249A), 92.2(249A,249J)

All applicants and members are required to cooperate with certain processes related to obtaining medical resources as a condition of eligibility for IowaCare, unless good cause exists for failure to cooperate. Form 470-2826 or 470-2826(S), *Insurance Questionnaire*, is required for IowaCare when health insurance is reported.

Deny or cancel IowaCare benefits to an applicant or member who fails to cooperate in determining the availability of medical resources.

This section covers procedures for:

- ◆ [Cooperation with the Third-Party Liability Unit](#)
- ◆ [Failure to cooperate with the Third-Party Liability Unit](#)
- ◆ [Good cause for failure to cooperate](#)

### **Cooperation With Third-Party Liability Unit**

**Legal reference:** 42 CFR 441.20, 441 75.2(249A), 75.4(3), 92.2(249A,249J)

The Third-Party Liability Unit is part of the Iowa Medicaid Enterprise (IME) Revenue Collection Unit. The Third-Party Liability Unit's primary purpose is to identify and collect monies from any available medical resource that can pay all or part of a member's medical expense. Third-party resources include:

- ◆ Medicare
- ◆ Insurance policies
  - Private health insurance
  - Group health insurance
  - Liability insurance
  - Family health insurance carried by an absent parent
- ◆ Railroad Retirement benefits
- ◆ Worker's compensation
- ◆ Veteran's Affairs
- ◆ Tri Care
- ◆ Liability lawsuits (tort action)
- ◆ Orders for restitution as a result of a criminal conviction

A member or a person acting on the member's behalf must cooperate with the Third-Party Liability Unit by providing information and verification about any medical or third-party resources.

EXCEPTION: A woman eligible under the IFPN can claim good cause for not cooperating with the Third-Party Liability Unit due to confidentiality if she is fearful of the consequences of a parent or spouse discovering that she is receiving family planning services.

If you become aware that a member has been involved in an accident and there may be a potential third-party payer, report this to the IME Lien Recovery Unit, P.O. Box 36446, Des Moines, IA 50315. Collect and report all necessary information, including:

- ◆ The name of the insurance company.
- ◆ The policy number.
- ◆ The type of insurance.
- ◆ The name and address of any attorneys involved.

Members must cooperate by:

- ◆ Filing a claim or an application when the resource is reasonably available.
- ◆ Assisting in the processing of the claim or application. A member is not required to initiate a legal suit or file criminal charges.
- ◆ Refunding to the Department any settlement or payment received that is intended to cover medical expenses that would otherwise be paid by Medicaid.
- ◆ Completing and returning form 470-0398, *Priority Leads Letter*, sent by the IME Revenue Collections Unit when requested, and giving complete and accurate information about any accident-related injuries.

### **Failure to Cooperate With Third-Party Liability Unit**

**Legal reference:** 441 IAC 75.4(249A), 92.2(249A,249J)

When a person fails to cooperate with the Third-Party Liability Unit, a sanction must be applied. EXCEPTIONS: See [Good Cause for Failure to Cooperate](#). A person under sanction counts in the household size as a considered person.

### **Good Cause for Failure to Cooperate**

**Legal reference:** 441 IAC 75.2(1), 92.2(249A,249J)

The Third-Party Liability Unit or the IM worker may be responsible for determining if good cause for failure to cooperate exists. Good cause for failure to cooperate with the Third-Party Liability Unit or the IM worker exists when the person or family has one or more of the following situations:

- ◆ There was a serious illness or death of a member of the person's family.
- ◆ There was a person or a family emergency or household disaster, such as a fire, flood, or tornado.
- ◆ The person verifies good cause reasons beyond their control.
- ◆ The person did not receive the request for information for a reason that was not the person's fault. Failure to provide a forwarding address does not qualify.

### **Medical Assistance Lien**

**Legal reference:** 441 IAC 75.4(249A), 92.2(249A,249J)

The Department has the legal right to file a lien to recover IowaCare payments made on behalf of any member if another (third) party is determined to have liability. "Third parties" include:

- ◆ Private health insurance
- ◆ Auto medical insurance
- ◆ Casualty insurance
- ◆ Worker's compensation insurance
- ◆ Tort liability cases

Tort liability exists when a member sues a third party and it is determined that injuries sustained were caused by the negligence of a third party.

When the Department makes IowaCare payments on behalf of a member, the IME Revenue Collections Unit files a lien for all monetary claims that the member may have against third parties, to the extent of IowaCare payments.

For a lien to be effective, the Revenue Collections Unit must file a notice with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility is established. These notices serve as formal notice to the third party of the Department's interest and right to be reimbursed for the member's medical expenses.

Possible liable third parties should be informed of the Department's interest at the earliest possible date, no later than ten days from the time that the Revenue Collections Unit becomes aware of the involvement of the third party.

### **Residents of Public Nonmedical Institutions**

**Legal reference:** 441 IAC 441 75.12(249A), 92.2(249A,249J)

A person is not eligible for IowaCare while the person is an inmate of a public institution.

A "public institution" is one that is the responsibility of a government unit or over which a governmental unit exercises administrative control. Public institutions include, but are not limited to, publicly operated jails, penal institutions, work release centers, and wholly tax-supported care facilities such as county residential care facilities.

EXCEPTION: A publicly operated community residence that serves fewer than 16 residents is not considered a public institution. For example, a county-owned and operated residential care facility that has fewer than 16 beds may be a publicly operated community residence. To be considered a "publicly operated community residence," the facility:

- ◆ Must provide some services beyond food and shelter, such as social services, help with personal living activities, or training in social and life skills.
- ◆ Must not be a jail, prison, or other holding facility for people who have been arrested or detained pending charges.
- ◆ Must not be located on the grounds of, or immediately adjacent to any large institution or multiple-purpose complex.

Ms. G, a member of an IowaCare eligible group, enters the county jail on September 5. She is expected to return home December 16. Her IowaCare is canceled effective October 1.

### **Halfway House**

**Legal reference:** 42 CFR 435.1009, 441 IAC 75.12(249A), 92.2(249A,249J)

Some people in halfway houses (also known as community residential facilities) are serving a prison sentence or have been placed on a work release program. Other people in halfway houses are on probation or parole and are ordered to live in a halfway house as a condition of the probation or parole.

To determine eligibility, you must verify whether the person living in a halfway house is serving a sentence, is on a work release program, or is on probation or parole.

People placed on probation or parole who are living in a halfway house are not considered inmates and can be eligible for IowaCare as long as they meet the other eligibility criteria.

People serving a prison sentence and those who have been placed on a work release program are considered inmates of a penal institution and are not IowaCare eligible unless they are an inpatient of a medical institution. The inmate is eligible only for the period that the person is an inpatient of a medical institution.

### **Inpatient Medical Institutions**

**Legal reference:** 42 CFR 435.1009, 441 IAC 75.12(249A), 92.2(249A,249J)

An inmate of a penal institution who is admitted as an inpatient of a medical institution (hospital, nursing facility, PMIC) that is not on the grounds of the penal institution and is not owned or operated by the penal institution may be eligible for IowaCare. The person must meet the other eligibility criteria before IowaCare can be approved. The inmate is eligible only for the period that the person is an inpatient of a medical institution.

### **Persons Disqualified for Medicaid**

**Legal reference:** 441 IAC 92.2(3)

A person who has been disqualified for Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

1. Ms. A applies for IowaCare. Five months ago, she applied for Medicaid and reported cash medical support. Her Medicaid application was denied for failure to provide child support information.

Ms. A is not eligible for IowaCare until she cooperates with Medicaid. If after cooperating with Medicaid it is determined that she is not eligible for Medicaid, then she may apply for IowaCare.

2. Ms. B applies for IowaCare. Two months ago, her Medicaid was sanctioned for failure to cooperate with Quality Control. She is given the opportunity to cooperate with Quality Control. If she does not cooperate with Quality Control, she is not eligible for IowaCare.

### **Quality Control**

**Legal reference:** 441 IAC 76.8(249A), 92.3(249A,249J)

Quality Control pulls a random sampling of cases to review eligibility. IowaCare members must cooperate with Quality Control. Failure to cooperate with Quality Control results in a sanction.

### **Availability of Funds**

**Legal reference:** 441 IAC 92.2(6)

The Department will notify the IM workers if funding for IowaCare is no longer available. Persons currently on IowaCare will not be canceled for this reason. However, if the case is canceled for another reason and the person reapplies, the application will be denied.

Do not approve IowaCare eligibility after the Department determines that there are insufficient funds available to pay for additional enrollment.

## **Income Policies**

**Legal reference:** 441 IAC 92.2(1)"a"(1), 92.2(1)"b"(1), 92.5(249A,249J)

Eligibility for IowaCare is based on the income of an applicant's or member's household as of the date of decision based on the applicant's or member's declaration of income. To be eligible, the household's income minus allowable deductions shall not exceed 200% of the federal poverty level for the household size, or 300% of the federal poverty level for a qualifying pregnant woman.

<b>Income Limit</b>	<b>IowaCare Household Size</b>						
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
200%	\$1,815	\$2,452	\$3,089	\$3,725	\$4,362	\$4,999	\$5,365
300%	\$2,723	\$3,678	\$4,633	\$5,588	\$6,543	\$7,498	\$8,453

1. Mr. S files an *IowaCare Application* and states that his monthly gross income from working is \$500. The IM worker determines his eligibility based on the information provided on the application.
2. Mr. J files an *IowaCare Application* on July 6 stating that his monthly gross income from working is \$600. On July 8, Mr. J calls to report that his income has changed and he will receive \$650 monthly income. The IM worker determines eligibility on July 9 using the \$650 income that he reported on July 8.

## **Household Size**

**Legal reference:** 441 IAC 92.1(249A, 249J), 92.5(1)

The household size includes the applicant or member and spouse and dependent or unborn children of the applicant or member who are living in the same home.

"Dependent child" means the child or stepchild who is under the age of 18 or is 18 years of age and will graduate from high school before reaching the age of 19. Include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return. EXCEPTION: Do not include the following:

- ◆ A spouse or dependent child who receives Supplemental Security Income,
- ◆ A foster child who is not included in the household size, or
- ◆ A child who is ineligible for Medicaid because of nonfinancial reasons or was voluntarily excluded.

A person who is absent from the home shall not be included in the household size, unless the absence is temporary. See [Temporary Absence](#). An applicant's or member's spouse shall not be considered absent from the home when:

- ◆ The spouse's absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.
- ◆ The spouse is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

1. Ms. M and Mr. D live in the home with their child, age 15. Ms. M and Mr. D are not married. Ms. M and Mr. D need medical care and are over resources for Medicaid. There will be two cases, both with a household size of two. Case A includes Ms. M and their child. Case B includes Mr. D and their child.
2. Mr. K, age 59, lives with his 79-year-old mother. Mr. K applies for IowaCare. The household size is one.
3. Ms. L, a 20-year-old college student, applies for IowaCare and lives in the college dormitory. Her parents claim her as a deduction for tax purposes. If Ms. L is not eligible for CMAP, the household size would include Ms. L, her parents, and any other siblings living at home under the age of 19.

4. Mr. and Mrs. A live in the home with their 18-year-old and 21-year-old sons. Mrs. A files an application for IowaCare and wants IowaCare for herself and the 21-year-old. Mr. and Mrs. A and the 21-year-old sign the application. The sons are no longer students and are not considered to be dependents.

The IM worker sets up a case for Mrs. A with Mr. A as a considered person and sets up a second case with only the 21-year-old on the case.

5. Mrs. H lives in the home with her 5-year-old daughter and her husband, the child's stepfather. Mrs. H and her daughter receive FMAP benefits. Mr. H's income, after deductions and diversion for his need, is used to determine FMAP eligibility. Mr. H applies for IowaCare. The household size is three. All countable income of the household is used to determine IowaCare eligibility.
6. Mrs. J applies for IowaCare. She lives with son, Jason, age 16; her daughter, Sarah, age 18; and Sarah's child. Sarah is not a student. The household size for IowaCare is two (Mrs. J and Jason).
7. Mrs. S applies for IowaCare. She lives with her son, Ray, age 16; her daughter, Sandy, age 18; and Sandy's child. Sandy meets the definition of a dependent child. Sandy and her child also receive MAC. The household size for IowaCare is three (Mrs. S, Ray, and Sandy).
8. Mrs. L applies for IowaCare. Her husband receives Social Security disability benefits and is on MEPD. The household size is two. Mr. L is a considered person on the case. His income is used to determine Mrs. L's eligibility. Mrs. L will be excluded from paying an IowaCare premium because Mr. L pays an MEPD premium.
9. Mr. and Mrs. A apply for IowaCare in October 2010. They are approved on the same case number with Mr. A as the case name. The certification period is October 2010 through September 2011. One monthly premium is assessed at the multi-person rate.

In March 2011, Mrs. A calls her worker to report that she divorced Mr. A and wants to have a separate IowaCare case with her own premium. Under standard procedures, the existing IowaCare case was canceled with the reason that the household size was changing.

Mr. A's case is then re-opened using his income only. The ending month is still September 2011, and a single person premium is assessed for him.

A separate case is created for Mrs. A using her income only. The last month of her certification is September 2011. She is assessed her own single premium. NOTE: The change is effective for the month after the change was reported.

### **Temporary Absence**

**Legal reference:** 441 IAC 75.53(4)"b," 92.5(1)"b"

Include in the eligible group the needs of a person who is temporarily out of the home, if otherwise eligible. A temporary absence exists when the person is:

- ◆ Out of the home to secure education or training.
- ◆ In a medical institution for less than a year.
- ◆ Out of the home for another reason and the payee intends that the person will return to the home within three months.

### **Absence for Education**

**Legal reference:** 441 IAC 75.53(4)"b," 92.1(249A,249J), 92.5(1)"b"

Include in the eligible group a person who is temporarily out of the home for the purpose of education or training. A temporary absence exists as long as the specified relative claims the child as a dependent on their state or federal income tax return.

### **Absence in a Medical Institution**

**Legal reference:** 441 IAC 75.53(4)"b," 92.5(1)"b"

A "medical institution" is a facility that provides medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include:

- ◆ Hospitals
- ◆ Nursing facilities
- ◆ Intermediate care facilities for mentally retarded
- ◆ Psychiatric medical institutions for children
- ◆ Psychiatric institutions
- ◆ Resource centers
- ◆ Mental health institutions

Include in the eligible group a person who is temporarily absent from the home and in a medical institution. EXCEPTION: Children in a psychiatric medical institution for children (PMIC) who are in court-ordered foster care status are not considered in the household size at home.

Assistance may be approved for a person who is confined to or living in a medical institution as long as the person:

- ◆ Is anticipated to be in a medical institution for less than a year, as verified by a physician's statement; and
- ◆ Will be returning directly to the home from the medical institution.

When determining the 12-month period, consider the first full calendar month after the person enters the medical institution as "month one."

A person who enters a medical institution from foster care, or from any place other than the home, is not considered in the household size at home. This is true even if the person anticipates being in the medical institution for less than a year and returning to the home upon leaving the medical institution.

EXCEPTION: Include in the household size a child who has remained in a medical institution since birth, but is expected to enter the home in less than one year.

1. Mrs. A applies for IowaCare for herself. She has a child, who has been in the hospital for five months. The child left the home to enter the hospital and is expected to return to the home in two months. The child is included in the household size, because the total time the child is expected to be out of the home and in a medical institution is less than one year.
2. Mrs. B applies for IowaCare for herself. Her child has been in a nursing facility for ten months. The child is expected to return to the home in four months. The child is not included in the household size, because the total length of time the child is expected to be out of the home is greater than one year.

### **Absence for Less than Three Months**

**Legal reference:** 441 IAC 75.12(249A), 75.53(4)"b," 92.5(1)"b"

Include in the eligible group a person who is temporarily absent from the home. A "temporary absence" exists when a person is out of the home for reasons other than in a medical institution or for education or training and it is expected that the person will return to the home within three months.

NOTE: A person who is in jail is not eligible for IowaCare services and is not a part of the eligible group or household size. See [Residents of Public Nonmedical Institutions](#). A child may be out of the home for purposes such as visiting the absent parent or vacation. The child remains part of the household group if the child's absence is anticipated to last less than three months.

Even though the specified relative's responsibility for care and control is lost, continue including the child as part of the household size as long as the loss is temporary. For example, a child visiting the other parent can be included in the household size, as long as the absence is expected to be less than three months.

Approve assistance when the total length of time the person is anticipated to be out of the home is less than three months. When determining the three-month period, consider the first full calendar month after the person has left the home as "month one."

For applicants, the total length of time is from the date the person left the home (not the date of application) until the date the person is expected to return.

1. Jim, who is included in the household size for the IowaCare case, leaves home on May 2 to visit his father. He is expected to return home August 29. He continues to be included in the household size for IowaCare.
2. Mrs. A applies for IowaCare for herself and Medicaid for her four children. Three of her children live with her. The fourth child has been living with the child's father for the past two months and will be returning to Mrs. A's home in two months.

Mrs. A may include the three children living in the home in her household size for IowaCare. The fourth child is not included in the household size until the child returns to the home, because the child's total length of absence from the home is anticipated to be greater than three months.

### **Unearned Income**

**Legal reference:** 441 IAC 92.5(2), 92.5(4)

Applicants or members self-declare the household's future unearned income based on their best estimate.

Count unearned income of all household members unless income is exempt. The following unearned income is exempt:

- ◆ The value of the Food Assistance benefits.
- ◆ The value of the United States Department of Agriculture donated foods (surplus commodities).
- ◆ The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.
- ◆ Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.
- ◆ Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.
- ◆ Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.
- ◆ Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe.
- ◆ Title 1 VISTA volunteer payments. These payments are exempted only when the Director of ACTION determines the value of all such payments is less than the federal or state minimum wage when dividing payments by the hours of service.
- ◆ Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.
- ◆ Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

- ◆ Experimental housing allowance program payments made under annual contribution contracts entered into before January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
- ◆ The income of a Supplemental Security Income recipient.
- ◆ Payments from the Family Support Subsidy program.
- ◆ Grants obtained and used under conditions that preclude their use for current living costs.
- ◆ All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative, conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents that are in the eligible group shall be counted as nonexempt income.
- ◆ Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.
- ◆ Bona fide loans. Evidence of a bona fide loan may include any of the following:
  - The loan is obtained from an institution or person engaged in the business of making loans.
  - There is a written agreement to repay the money within a specified time.
  - If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
- ◆ The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
- ◆ Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief, and Emergency Assistance Amendments of 1988.

- ◆ Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."
- ◆ Payments received from the Radiation Exposure Compensation Act.
- ◆ Reimbursements from a third party.
- ◆ Reimbursement from the employer for a job-related expense.
- ◆ All unearned nonrecurring lump-sum payments. Examples include:
  - Income-tax refund.
  - Retroactive Supplemental Security Income benefits.
  - Settlements for the payment of medical expenses.
  - Refunds of security deposits on rental property or utilities.
  - A lump sum received and expended for funeral and burial expenses.
  - A lump sum received and expended for the repair or replacement of resources.
- ◆ Payments received by the family for providing foster care when the family is operating a licensed foster home.
- ◆ A small monetary nonrecurring gift, such as a Christmas, birthday, or graduation gift, not to exceed \$30 per person per calendar quarter.
  - When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income.
  - When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.
- ◆ Earned income credit.
- ◆ General assistance from county funds, providing:
  - The assistance does not duplicate any of the basic needs as recognized under the Family Medical Assistance Program-related coverage group, or
  - The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
- ◆ Any payment received because of an urban renewal or low-cost housing project from any governmental agency.

- ◆ A retroactive corrective Family Investment Program payment.
- ◆ The training allowance issued by Iowa Vocational Rehabilitation Services, under the Department of Education.
- ◆ Payments from the PROMISE JOBS program.
- ◆ The training allowance issued by the Department for the Blind.
- ◆ Payments from passengers in a car pool.
- ◆ Income of a nonparental relative except when the relative is included in the eligible group.
- ◆ The first \$50 of a current monthly support payment or a voluntary support payment paid by a legally responsible person for a child in the household. The total amount exempted cannot exceed \$50 per month for the eligible group.

Lump-sum unearned income is not used to determine eligibility for IowaCare.

### **Unemployment Benefits**

**Legal reference:** 441 IAC 92.5(2)

Annualize unemployment benefits using the remaining balance at the time of application.

Ms. A applies for IowaCare October 15. She states on her application that she receives \$165 a week in unemployment benefits. The IM worker uses Iowa Workforce Development's DBRO screen to verify the remaining balance of unemployment benefits to be received. As of October 1, Ms. A has \$1,650 remaining in unemployment benefits.

The worker annualizes the remaining amount:  $\$1,650 \div 12 \text{ months} = \$137.50$ . The worker enters \$137.50 for the unearned income on the BCW2 screen in the ABC system. \$137.50 a month is below 100% of the federal poverty level. Ms. A will not have to pay a premium for IowaCare.

### **Earned Income**

**Legal reference:** 441 IAC 92.5(2), 92.5(3)

Applicants self-declare the household's future earned income based on their best estimate. Earned income includes income in the form of a salary, wages, tips, or profit from self-employment.

When a third or fifth check is given during the period being used to project income, do not ignore it. Instead, add all check amounts together, divide the total by the number of checks, and multiply that result by four, if the income occurs weekly, or by two, if the income occurs biweekly.

For income from salary, wages, or tips, "earned income" means the total gross amount of income irrespective of the expenses of employment. Applicants who receive earned income from salary, wages, or tips shall declare their household's monthly gross income and are not required to provide verification, unless the information is questionable.

Applicants who are self-employed, including self-employment on an irregular basis and from seasonal earnings, shall self-declare their household's net annual income.

For self-employment income, "earned income" means the net profit from self-employment. "Net profit" is defined as gross income less the costs of producing the income. Do not deduct depreciation and the cost of capital expenses. Do not offset any self-employment loss from a different source of income. Use the net annual income from self-employment to determine the net monthly income.

Applicants who are temporarily unemployed or who receive earnings on a seasonal basis or on an irregular basis shall self-declare their household's annual income.

Do not use income that ended in the month of application to project household income for the certification period for applicants who do not expect to return to work.

Count all earned income received by anyone included in determining the household size. EXCEPTION: Do not count the earnings of a child who is a full-time student in a secondary school setting.

Anticipated earned lump-sum income is prorated over the period for which it will be received.

1. Mr. K applies for IowaCare October 7. He states on the application that he earns \$1,800 per month and that he gets a \$2,000 bonus in December of each year. To project Mr. K's monthly income:  $\$1,800 \times 12 = \$21,600 + \$2,000 = \$23,600 \div 12 = \$1,966.67$ .
2. Mr. Z is employed at a farm, on a seasonal basis, from April through October. He reports that his earnings are \$1,000 a month. The IM worker annualizes his income.  $\$1,000 \times 7 \text{ months} = \$7,000 \div 12 = \$583.33$  per month.
3. Ms. R is not currently working and will be off work for 8 weeks. She usually grosses \$1,725 per month. To project her monthly income:  $\$1,725 \times 10 \text{ months} = \$17,250 \div 12 = \$1,437.50$  per month.
4. Mr. M asks for help in completing his application. He wants to know if he may count the expenses he has for self-employment and the depreciation on his machinery. The IM worker tells him that he may use business expenses except for depreciation.
5. Ms. Y applies for IowaCare on May 1. She reports earned income of \$1,000 a month from working in the school cafeteria. She states the job will end June 1. The IM worker calls Ms. Y and asks if she will be returning to work in August and how much income she made earlier in the year.  
  
Ms. Y states that she will return to work at the end of August and that she averages \$1,000 a month when working. She states that she will not receive a check in August. The worker annualizes Ms. Y's income.  $\$1,000 \times 9 \text{ months} = \$9,000 \div 12 = \$750$  per month.
6. Mr. Z applies for IowaCare on June 5. He states on his application that he will receive \$1,550 gross income in June. He will not be returning to work and is unable to look for a new job due to an injury. He will not receive any worker's compensation. The IM worker does not use his terminated income to determine his eligibility or premium amount.

### **Providing Child Care in Own Home**

**Legal reference:** 441 IAC 92.5(3)"c"

Gross income from providing child care in the member's own home includes the total payment received for the child care service, plus any payment received under Child Nutrition Amendments of 1978 for the cost of providing meals to the children.

Determine net profit by deducting 40% of the total gross income received to cover the cost of upkeep of the home and producing the income.

When the member claims to have expenses higher than the 40% considered, ask the member to provide the actual expenses. Determine net profit by deducting actual expenses from the total gross income.

### **Deductions**

**Legal reference:** 441 IAC 92.5(5)

Determine a household's countable income by deducting 20% percent from the household's self-declared gross earned income.

Unearned income is counted dollar for dollar; there are no deductions allowed.

Ms. L declares on the application that her monthly gross earned income is \$2,500 and that her household size is two. She is not pregnant. Ms. L meets all other eligibility requirements.

The IM worker enters \$2,500 into the ABC system. The ABC system deducts 20% from Ms. L's earned income and determines that her countable income is \$2,000. The ABC system compares the \$2,000 to 200% of the federal poverty level for a household size of two. The system sends Ms. L a *Notice of Decision* approving her for IowaCare.

### **Medical Expenses**

**Legal reference:** 441 IAC 92.5(5)"b"

Medical expenses for any person included in a qualifying pregnant woman's household that are not subject to payment by a third party may be used to lower the woman's income to 200% of federal poverty level. Medical expenses incurred during the month of application may be paid or unpaid. Medical expenses before the month of application must be unpaid.

Medical expenses are deducted only at the time of application. To receive the deduction, the woman must verify the expenses. The medical expenses that can be deducted are:

- ◆ Medical and dental expenses, and
- ◆ Health insurance premiums, deductibles, copayments, or coinsurance charges. NOTE: If the health insurance covers the qualifying pregnant woman, she must explain the reason she needs IowaCare.

1. Ms. N is pregnant and applies for IowaCare on July 15. She declares on her application that her monthly gross earned income is \$3,500.

Ms. N submits a copy of her pay stub showing a deduction of \$90 biweekly for her health insurance premium (a single plan). She also submits an unpaid bill for outpatient care for \$600 that occurred in June and a receipt indicating \$10 for prenatal vitamins that she bought on July 5. Her total medical expenses are \$790.

The household size is two as Ms. N's unborn is counted in the household size. When asked, Ms. N indicates that she would not be able to meet the high Medically Needy spenddown. Ms. N meets all other eligibility requirements for IowaCare as a qualifying pregnant woman.

The IM worker enters \$3,500 on the ABC BCW2 screen in an earned income field and the \$790 medical expenses in "DEDUCT 6" field.

**Step 1:** The ABC system deducts 20% from Ms. N's gross earned income and determines that her countable earned income is \$2,800. The ABC system determines that \$2,800 is below 300% of the federal poverty level for a household size of two.

**Step 2:** The ABC system then deducts the \$790 medical expenses from Ms. N's countable earned income of \$2,800. The countable income after the medical expenses deduction is \$2,010. The ABC system determines that Ms. N has reduced her income below 200% of the federal poverty level for a household size of two.

The system sends Ms. N a *Notice of Decision* to indicate that she is eligible for IowaCare and that she will have a premium to pay.

2. Ms. A is single and pregnant. She lives with the unborn child's father, Mr. B. Ms. A applies for IowaCare. She states that her monthly gross earned income is \$2,800 per month and Mr. B has \$1,800 monthly gross earned income. Based on this information, the IM worker determines that Ms. A would be over income for MAC.

Ms. A has no health insurance. She could enroll in her employer's health insurance plan at open enrollment but states it is too expensive. The household size is two, Ms. A and her unborn child. Mr. B's income is not used to determine IowaCare eligibility.

Ms. A sends her unpaid medical expenses in with her IowaCare application. Her unpaid bills are:

\$ 550	Personal dental bill from a year ago
135	Personal doctor bill from four months ago
+ 50	Dental premium for the month
\$ 735	

\$735 is used to reduce the countable monthly income. The IM worker enters the information from the application, the income information, and the \$735 medical expenses into the ABC system.

**Step 1:** The ABC system determines if the income is below the 300% federal poverty level.

\$ 2,800	Ms. A's monthly gross earned income
- 560	20% earned income deduction
\$ 2,240	Countable monthly income for household of two, which is under 300%

**Step 2:** The ABC system determines if medical expenses reduce Ms. A's income to 200% or below the federal poverty level.

\$ 2,240	Monthly income
- 735	Allowable medical deductions
\$ 1,505	Countable monthly income

Ms. A's medical expenses reduce her income below 200% of the federal poverty level. Ms. A is approved for IowaCare as a qualifying pregnant woman. The billing system determines her premium amount.

## **Premiums**

**Legal reference:** 441 IAC 92.7(249A,249J), 92.7(5)

With the exception of newborns, IowaCare members are assessed a monthly premium based on a sliding scale based on their income. Payment of the premium is a condition of eligibility unless a hardship exemption is requested.

**Premium Amount**

**Legal reference:** 441 IAC 92.7(249A,249J), 92.7(1)

The ABC system determines the monthly premium amount for a 12-month certification period beginning with the first month of eligibility. The premium is based on projected monthly income for the 12-month certification period.

On October 1, 2010, a change was implemented in the IowaCare premium scale for new applications and renewals:

- ◆ One premium scale is used for individuals who are the only IowaCare member in the household, and
- ◆ A second scale is used for a combined premium for multiple IowaCare members in the same household. (Members in the same household may not request to have separate premiums. The combined premium is less than twice the premium for one member.)

The monthly premium amount is based on the household's net countable monthly income as a percentage of the federal poverty level (FPL). If the household's income is at or below 150% of the poverty level, members are not assessed a premium. The system calculates the premium amount based on the lowest income level in each 10% increment of poverty level as follows:

<b>Premium Chart Effective June 1, 2011</b>			
One IowaCare member with income at or below the FPL of:	Member's premium amount is:	Two or more members with income at or below the FPL of:	Members' combined premium amount is:
150% = \$1,362	No cost	150% = \$1,839	No cost
160% = \$1,452	\$50	160% = \$1,962	\$68
170% = \$1,543	\$54	170% = \$2,084	\$72
180% = \$1,634	\$57	180% = \$2,207	\$77
190% = \$1,725	\$60	190% = \$2,330	\$81
200% = \$1,815	\$63	200% = \$2,452	\$85

The system rounds the poverty level up to the next whole number. For example, 159.30% rounds up to 160%. If a correction needs to be made to increase the premium, see 14-B(4), [MIPC=IowaCare Premium Change](#).

1. Mr. X 's income is 151% of the FPL. His premium is \$47.
2. Mr. and Mrs. M have household income of 176% of the FPL. They will pay a combined premium of \$72 per month.

### **Payment of Assessed Premiums**

**Legal reference:** 441 IAC 92.2(5), 92.7(249A,249J)

Premiums are assessed beginning the month after the system month in which the decision is made on the application. At a minimum, a member is responsible for paying the premium for four months. These are referred to as the "mandatory months." The mandatory months include the first month following the system month of decision and the following three months.

The member is responsible for paying the premium for:

- ◆ The four mandatory months, regardless of continued enrollment, and
- ◆ Each month of continued enrollment after the mandatory months.

The member will not be billed for the system month of decision or any months before the system month of decision, including the retroactive month.

If there is a break in enrollment of one or more months, a new four-month period of mandatory premiums is assessed, beginning with the month following the system month of decision on the new application.

Effective October 1, 2010, a person is **not** required to pay all past-due IowaCare premiums before the person can become eligible for IowaCare again. In other words, a person may reapply and become eligible for IowaCare even when the person has unpaid IowaCare premiums.

When there is more than one IowaCare member in a household, all of them must be on the same IowaCare case. When there are multiple members on one case, only one combined IowaCare premium is assessed for all the members on the case. If the combined premium is not paid, all members in the household will be canceled from IowaCare.

1. Mr. B is approved for IowaCare on March 15 (March system month). When Mr. B signed the *IowaCare Application*, he agreed to pay a premium for the mandatory four months (April, May, June and July). His countable income is above 190% but below 200% of the federal poverty level. He is responsible for a monthly premium for each month of the mandatory period.

2. Mr. B is approved for IowaCare on March 29 (April system month). When Mr. B signed the *IowaCare Application*, he agreed to pay a premium for the mandatory four months (May, June, July and August). His countable income is above 190% but below 200% of the federal poverty level. He is responsible for a monthly premium for each month of the mandatory period.

3. Mr. G's IowaCare enrollment period is approved November 15 for November 2010 through October 2011. Mr. G paid his IowaCare premium for the four mandatory months (December, January, February, and March). He requests cancellation at the end of the fourth mandatory month (March).

At the end of April 2011, Mr. G files an *IowaCare Application* and is approved effective April 1. Since there was no break in assistance, the new enrollment period does not have four mandatory months of premium payment.

4. Mr. M's IowaCare enrollment period is approved November 15 for November 2010 through October 2011. Mr. M paid his IowaCare premium for the four mandatory months. He requests cancellation at the end of the fourth mandatory month (March).

In June 2011, Mr. M files an *IowaCare Application* and is approved in June for IowaCare. Since there is a break in assistance, there will be four mandatory months of premiums. Mr. M's four mandatory months begin in July.

5. Mr. J's four mandatory months are January, February, March, and April. On March 1, he requests cancellation of his IowaCare.

The IM worker explains that he will still owe the premium for the month of April or, if he is unable to pay for the month of April, he may declare a hardship by signing the statement on the *IowaCare Billing Statement*. The hardship statement must be postmarked no later than the premium due date.

Waive the mandatory four months of premium when:

- ◆ A person turns age 65. Premiums are due through the month before the 65<sup>th</sup> birthday. Reduce any remaining mandatory months to zero premiums.
- ◆ A person becomes eligible under any Medicaid coverage group except IFPN. The MIPS will not send a bill for any month for which the member has other Medicaid coverage.
- ◆ A person has access to group health insurance (see [Definitions: Group health insurance](#)). The member must timely report having group health insurance. Reduce any remaining mandatory months to zero premiums.
- ◆ A person dies. Premiums are due through the month of death. Reduce the premium to zero for any month after the month of death if the case has not been canceled.

1. Mr. J is approved for IowaCare in December. His four mandatory months are January, February, March, and April. Mr. J dies in February. The family reports his death to the Department. The IM worker enters the date of death on ABC. MIPS will zero out the premiums for March and April.

2. Mr. K is approved for IowaCare in December. His four mandatory months are January, February, March, and April. Mr. K paid January and February premiums. Mr. K died in February. The family reported his death to the Department in June. The case was already canceled on May 31 due to nonpayment. The IM worker zeroed out the premiums for March, April, and May on the MIPC=IowaCare Premium Change screen.

3. Mr. A is approved for IowaCare in December. His four mandatory months are January, February, March, and April. On March 1, Mr. A reports that he will have affordable health insurance that covers everything beginning April 1. The IM worker cancels the case effective April 1 and zeroes out the premium for the month of April.

4. Mr. E applies for SSI in January 2007. He is approved for IowaCare in April 2007. His four mandatory months are May, June, July, and August.

Mr. E is approved for SSI in July 2007 with an effective date of January 2007. He is determined Medicaid-eligible beginning January 2007. The IM worker cancels IowaCare effective August 1 and requests refunds for months in which a premium was paid. If Mr. E had a premium, MIPS will not send a billing statement for August due to full Medicaid eligibility.

### **Deducting *hawk-i* Premiums**

**Legal reference:** 441 IAC 92.7(1)“c”

Deduct the cost of premiums paid for **hawk-i** from the premium assessed.

**hawk-i** premiums are: \$10, \$20, or \$15 (for dental only). The amount of the **hawk-i** premium is entered in the ABC system. The ABC system determines the amount of the premium to be assessed.

Ms. G applies for IowaCare. She states her monthly gross earned income is \$1,800 and that she pays a \$10 **hawk-i** premium for her son. The IM worker accepts Ms. G's statement for income and the amount of the **hawk-i** premium.

The worker enters the amount of **hawk-i** premium on the BCW2 screen in the DEDUCT 5 field. The system determines the premium amount by deducting the **hawk-i** premium.

### **Premium Exclusion**

When the IowaCare case has a considered person who has an assessed premium for Medicaid for Employed People with Disabilities (MEPD), the ABC system premium calculation will automatically exclude the IowaCare member from being assessed an IowaCare premium.

The exclusion from paying premiums to both programs will ensure that the family will not pay more than 5% of the total monthly household income for cost sharing.

### **Billing and Payment**

**Legal reference:** 441 IAC 92.7(2)

The Department mails form 470-4164, *IowaCare Premium Billing Statement*, on the first working day of the month to notify members of the premium. Effective October 1, 2010, *IowaCare Premium Notice Reminders* will not be sent.

The IowaCare member returns the portion of the billing statement with the payment or the signed hardship statement in the prepaid and preaddressed envelope provided by the Department. The address on the envelope is: Iowa Medicaid Enterprise IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

If an IowaCare member comes to a Department office to pay the premium, give the member a preaddressed envelope to mail the premium payment. If the member does not have the billing statement, tell the member to include the member's state identification number (SID) on the payment.

If an IowaCare member asks questions about the posting of premium payments, do not tell the member to contact the IME Member Services Unit. Member Services **does not process** the payments. Instead, contact the DHS, SPIRS Help Desk for assistance.

Local offices should maintain a supply of the IowaCare envelopes, 470-4196, to give to members who misplace the envelopes included with the billing statement. Order envelopes for IowaCare premium payments from the Supply Unit, Level A, in central office by e-mailing: [Supply@dhs.state.ia.us](mailto:Supply@dhs.state.ia.us).

Do not give an IowaCare billing envelope for MEPD bills or vice versa. The payments have separate processing procedures by different entities within the Department. When payments are mailed to the wrong address, eligibility for the member is delayed.

The premium is considered late if the payment is not postmarked by the due date. The IowaCare case is not canceled until the end of the month in which the 60-day grace period ends. See [Failure to Pay the Premium](#).

The premium is due the last calendar day of the month it is to cover. If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend. The envelope must be postmarked no later than the first working day following the holiday or weekend.

Ms. Y applies for IowaCare on February 15. Her application is approved on February 18. The effective date of the coverage is February 1. Premiums are due as follows:

- ◆ No premiums are due in February.
- ◆ The premium for March (the first month following the system month of decision) must be postmarked by the due date of April 30. If the premium is not paid before June timely notice, the case will be canceled.
- ◆ The April premium must be postmarked by the due date of April 30. If the premium is paid before June timely notice, the case will not be canceled.

- ◆ The May premium must be postmarked by the due date of May 31. If the premium is paid before July timely notice, the case will not be canceled.

NOTE: Ms. Y may claim hardship if the billing statement is postmarked no later than the due date on the billing statement.

EXCEPTION: When the case is approved after system cut-off, premiums for the first two months covered in the initial billing are due the last calendar day of the second initial billing month.

Ms. W applies for IowaCare on December 29. Her application is approved on January 15. The effective date of the coverage is December 1. Ms. W's premiums are due as follows:

- ◆ No premiums are due in December.
- ◆ No premiums are due in January.
- ◆ The premium for February (the first month following the system month of decision) must be postmarked by February 28. If the premium is paid in the month of March the case will not be canceled.
- ◆ The March premium must be postmarked by March 31. If the premium is paid in the month of April, the case will not be canceled.

NOTE: Ms. W may claim Hardship if the billing statement is postmarked no later than the due date on the billing statement.

The Department applies premium payments received to the oldest unpaid month in the current certification period and then forward. When premiums for all months in the current certification period have been paid, the Department holds any excess and applies it to any months for which eligibility is subsequently established.

### **Hardship**

**Legal reference:** 441 IAC 92.7(3)

A member who submits a written statement indicating that payment of the monthly premium will be a financial hardship is exempted from premium payment for that month.

To claim hardship, the member may use form 470-4165, *IowaCare Billing Statement*, or write and sign a personal statement. The member must submit a separate statement for each month in which hardship is claimed.

The hardship statement must be postmarked by the due date on the billing statement. If the statement is not postmarked by the premium due date, the member is obligated to pay the premium. There is no grace period for claiming hardship.

If hardship is claimed after the due date, MIPS SUMM (Summary) screen will indicate the postmark date of the hardship statement. If the postmark is illegible, the date that the statement is initially received by the Department or the Department's designee is considered the date of the hardship request.

A partial payment postmarked on or before the premium due date will be considered a request for a hardship exemption if the member also signs the hardship statement. If the hardship statement is signed, an exemption shall be granted for the balance of the premium owed for that month.

Partial payments received without a signed request for hardship are treated as a credit to the member's IowaCare account or used to pay the balance on a month owed.

1. Mr. T is single and applies for IowaCare on April 30. He is approved for IowaCare May 2. The four mandatory months are June, July, August, and September. When Mr. T finds out his premium amount, he says it will be tough to pay. The IM worker explains he can claim a hardship on his premium billing statement and that he must do this monthly.

Mr. T receives the billing statement for June with a due date of June 30. He signs a statement that he would have a hardship paying the premium for June. The envelope is postmarked June 30. Personnel at the IME enter hardship for the month of June.

In July, a billing statement is sent to Mr. T with a due date of July 31. He sends in \$25 as a partial payment and signs the hardship statement on the billing statement. This is postmarked by the due date on the billing statement. The Department applies the partial payment to the month of July and grants Mr. T a hardship for the remaining amount of the premium.

In August, another billing statement is sent to Mr. T. He doesn't sign and return the statement that he has a hardship by August 31. He is now required to pay the August premium.

In September, the fourth mandatory billing statement is sent to Mr. T with a due date of September 30. He signs a statement that it would be a hardship paying the premium for September. Personnel at the IME enter hardship for the month of September.

Mr. T has not paid the premium due August 31. He receives a notice of cancellation effective November 1. If he pays the premium and it is postmarked before October 31, his IowaCare case will be reopened.

2. Mr. A receives a *Notice of Decision* stating the amount of his premium. Mr. A calls his IM worker on May 18 and explains that he does not have enough money to pay his May premium, but that he could pay \$20.

The worker tells him to send the check for \$20 and to sign the hardship statement at the bottom of the *IowaCare Billing Statement*. The worker also tells him that the hardship claim must be postmarked no later than May 31. The worker explains that the \$20 will be applied to the month of May and Mr. A will be exempted from paying the remainder of the May premium.

The worker explains that for the future months, Mr. A has three options:

- ◆ To pay the premium in full, or
- ◆ To make a partial payment (the amount that he can afford to pay) and sign the hardship statement stating he is unable to pay, or
- ◆ To sign the hardship statement indicating that he is unable to pay the entire premium due to hardship.

3. The premium is \$54 and the balance owed is \$54. The member pays \$25 and signs the *IowaCare Billing Statement* claiming hardship. The statement is postmarked by the due date. \$25 is applied to the month and MIPS zeroes out the remainder of the amount. The balance is zero.
4. The premium is \$54 and the balance owed is \$54. The member pays \$25 and does not sign the IowaCare Billing Statement claiming hardship. MIPS applies the \$25 as a credit. The balance owed is \$29.

The member may still claim hardship for the remainder of the month by sending in a signed written statement that is postmarked by the due date.

5. The premium is \$54 and the balance owed is \$108 (current month and previous month). The member pays \$54 and signs the *IowaCare Billing Statement* claiming hardship. The statement is postmarked by the due date. MIPS applies the \$54 credit to the previous month and hardship is granted for the current month. The balance owed is zero.
6. The premium is \$54 and the balance owed is \$108 (current month and previous month). The member pays \$25 and signs the *IowaCare Billing Statement* claiming hardship. The statement is postmarked by the due date. MIPS applies the \$25 partial payment as a credit to the previous month and hardship is granted for the current month. MIPS will show \$54 owed. The actual balance owed is \$29 (\$54 owed - \$25 credit).
7. The premium is \$54 and the balance owed is \$54. The member pays \$54 and signs the *IowaCare Billing Statement* claiming hardship. The statement is postmarked by the due date. MIPS applies the \$54 to the month. MIPS does not allow hardship for the month as the member made full payment for the month. The balance owed is zero.
8. The premium is \$54 and the balance owed is \$54. The member pays \$74 and signs the *IowaCare Billing Statement* claiming hardship. The statement is postmarked by the due date. MIPS applies \$54 to the month and applies a \$20 credit. MIPS does not allow hardship for the month as the member made full payment for the month. The balance shows a \$20 credit.

### **Failure to Pay the Premium**

**Legal reference:** 441 IAC 92.7(4)

Effective October 1, 2010, a 60-day grace period beyond the due date is allowed for payment of the IowaCare premium before IowaCare will be canceled. If the member fails to pay the premium by timely notice in the month in which the 60th day falls, the IowaCare case will be automatically canceled by the ABC system.

If the premium payment is postmarked by the last day of the month of cancellation, a WIFS message will be issued to the worker as notification of the premium payment. If all other eligibility factors are still met, the IowaCare case will be reopened. Otherwise, do not reopen IowaCare without a new application.

1. Mr. B does not pay his premium payment by the due date of April 30. If his payment is received and entered in MIPS before June timely notice day, a cancellation notice will not be sent. Otherwise, the system will send a *Notice of Cancellation* at timely notice in June effective July 1.

If Mr. B's April premium payment is received after June timely notice day but is postmarked by June 30, the IM worker will reopen his case.

2. Mr. and Mrs. J are canceled from IowaCare January 1, 2011, for nonpayment of their combined premium. They owe the combined premium for the months of October, November, and December. They file an application for IowaCare on May 15, 2011. They do not have to pay old premiums before they can get IowaCare again.

### **Premium Refunds**

**Legal reference:** 441 IAC 92.7(5)

Send requests for IowaCare premium refunds to the SPIRS Help Desk. Request a refund of payments credited for any month after the effective date of cancellation when coverage is canceled due to one of the following circumstances:

- ◆ The member paid premiums in advance and later requests cancellation for future months.
- ◆ An error is made in calculating the premium and the member now has a credit.
- ◆ The member has access to group health insurance (see [Definitions: Group health insurance](#)).
- ◆ The member is determined to be eligible for full Medicaid for months that the member was on IowaCare.
- ◆ The member reaches age 65.
- ◆ The member dies.
- ◆ The member no longer meets program requirements and the four mandatory months have been met.

The amount of the refund shall be offset by any outstanding premiums owed in the current certification period. Refunds are automatically issued when the member has a credit and:

- ◆ There have been two consecutive months of inactivity on the IowaCare case; or
- ◆ The premium has been reduced to zero for two consecutive months.

## **Case Maintenance**

The following sections address:

- ◆ [The member's responsibility for reporting changes](#)
- ◆ [Terminating eligibility](#)
- ◆ [Recovery of overpaid benefits](#)
- ◆ [The member's right to appeal an adverse action](#)
- ◆ [Automatic redetermination](#)

### **Reporting Changes**

**Legal reference:** 441 IAC 7.7(1), 92.10(249A,249J), 92.13(249A,249J)

A member shall report the following changes no later than ten calendar days after the change takes place:

- ◆ The member moves.
- ◆ The member obtains other health insurance coverage.
- ◆ The member enters a nonmedical institution, including but not limited to a jail or other penal institution.

When a change is not timely reported, any incorrect program expenditures shall be subject to recovery. See [Recovery](#).

### **Acting on Changes**

**Legal reference:** 441 IAC 92.5(6), 92.7(1)"d," 92.7(1)"e," 92.10(2), 92.10(3), 92.13(249A,249J)

After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

- ◆ Timely notice of adverse action is required (ten day notice).
- ◆ The certification period has expired.

A person found to be income-eligible upon application or renewal of eligibility remains income-eligible for the certification period regardless of any change in income or household size.

Do not increase the premium established for a certification period due to an increase in income or a change in household size. Decrease a premium when a member reports a decrease in income or an increase in household size. This change is effective the first of the month following the change report.

1. Ms. J is approved March 1 for IowaCare. On May 5, she reports that she now has health insurance and requests that her IowaCare be canceled.

The IM worker cancels the case effective June 1. Because Ms. J has health insurance and reported the change, the worker zeroes out the premium for June. (Even though June is a mandatory month, Ms. J does not owe for June since she now has health insurance.)

2. Ms. K is approved March 1 for IowaCare. She starts working in April and does not report that she started receiving health insurance in May. Her case is canceled August 1 because she did not pay the May premium. She owes the premiums for May, June, and July.

Ms. K loses her job and applies for IowaCare in September. She does not think she should pay the premium for May and June, since she had other health insurance. It's too late to decrease the premium amount for May and June. Since Ms. K did not timely report the change, the worker does not zero out the premium for July.

3. Ms. L reports to her IM worker that her income increased on November 15. Ms. L did not need to report this change in income. The worker does not act on the change.

4. Ms. M's household size is three when IowaCare eligibility is determined in July. She reports that her husband has moved out of her home. He did not have income at the time of the application. Ms. M did not need to report this change. The worker does not act on the change that would otherwise increase the premium. The premium stays the same.

5. Mr. J returns his *IowaCare Renewal Application* on July 30. He states on his application that his gross earned income is \$1,200 a month. On August 10, the IM worker approves the application. Mr. J's new IowaCare certification period will begin September 1.

On August 15, Mr. J reports that his pay increased. The worker does not act on the change because the *IowaCare Renewal Application* is already approved.

6. Mr. N reports on May 15 that his income has decreased. The IM worker enters the new monthly income into the ABC system. The change is effective June 1. The premium amount is decreased for June.
7. Mr. S reports on May 29 that his income has decreased. The IM worker enters the new monthly income into the ABC system. The change is effective June 1. The IM worker has to access the MIPC screen to reduce the premium for June because the change was entered after May system month end.
8. Ms. G reports that her husband has returned home. The IM worker changes the household size on the ABC system from two to three, effective the following month. The premium amount is decreased. Since the premium cannot be increased due to income increasing for the household, the worker does not ask about Mr. G's income.
9. Mr. Z, age 61, is approved for IowaCare effective February 1. He has earned income that is used to determine his premium. Mrs. Z, age 61, is a considered person on the IowaCare case.

In July, the Zs want Mrs. Z to receive IowaCare. They also report that Mr. Z's earned income has decreased and that both Mr. Z and his wife will start receiving Social Security income in August.

The IM worker changes Mrs. Z to an active person on the case and decreases the earned income amount. They will have a new combined premium amount. The worker does not use the Social Security income until the Z's submit the *IowaCare Renewal Application* in January.

Recalculate the member's eligibility when it is discovered that:

- ◆ A member's premium was miscalculated, or
- ◆ A member misrepresented household circumstances.

If the member remains eligible, reassess the premium for future months. Give the member the opportunity to claim hardship for an increased premium only when the Department miscalculated the premium.

Mr. X declares that his unearned income is \$1,050 per month. His premium is calculated to be \$49 per month beginning July 1. Quality Control reviews his case in December and finds that his unearned income is \$1,500 per month and that he should have been paying a premium of \$72 per month.

The IM worker enters the \$1,500 on to the BCW2 for January. The worker does not give Mr. X the opportunity to claim hardship. The IM worker completes a recoupment for the months of July through December for \$138 (\$23 x 6 months). The worker asks the SPIRS help desk staff to correct the premium to the higher amount on the ABC TD05 screen.

### **Recovery**

**Legal reference:** 441 IAC 76.12(249A), 92.10(2), 92.13(249A,249J)

The Department recovers all IowaCare funds incorrectly expended on behalf of the member. See 8-A, [Recovery](#).

Establish an overpayment for months that IowaCare was received incorrectly. When establishing an overpayment for past months, determine if the overpayment was an agency error or a member error. If it is established that the member should have paid a premium:

- ◆ Allow the member the opportunity to claim hardship for the past months if the overpayment was an agency error.
- ◆ Do not allow the member to claim hardship for the past months if the overpayment is due to the member misrepresenting household circumstances.

The Department shall recover IowaCare funds expended on behalf of a member from the member's estate. See 8-D, [Estate Recovery](#).

Any funds that a provider (other than a state mental health institute) recovers from third parties, including Medicare, shall be submitted to the Iowa Medicaid Enterprise, and an adjustment shall be made to a previously submitted claim.

1. Mr. Y declares that his gross income was under 200% of the federal poverty level. He is approved for IowaCare July 1. Quality Control reviews his case in November and finds that his gross income was 250% of the federal poverty level for the month of July. Mr. Y was not eligible for IowaCare.

The IM worker cancels the case and does a recoupment for the months that Mr. Y was on IowaCare.

2. Same Example 1, except Quality Control finds that in October Mr. Y's income dropped below 200% of the federal poverty level. The IM worker does not cancel the case, but does do a recoupment for the months of July, August, and September.

## **Terminating Eligibility**

**Legal reference:** 441 IAC 92.12(249A,249J)

IowaCare eligibility ends when one or more of the following occur:

- ◆ The certification period ends.
- ◆ The member begins receiving Medicaid with full or partial benefits, except IFPN. (A person eligible for the IFPN may also be eligible for IowaCare.)
- ◆ The member does not pay premiums or request hardship timely.
- ◆ The member no longer meets the nonfinancial eligibility requirements for IowaCare. See [Nonfinancial Eligibility](#).
- ◆ The member has been determined ineligible due to member misrepresentation or agency error.
- ◆ The member requests cancellation.
- ◆ The member moves out of state.
- ◆ The member dies.

Mrs. G is approved for IowaCare in May. In July, her two minor children return to her home. Mrs. G files an application for Medicaid for the children. Although the children are approved for Medicaid, Mrs. G does not provide HIPP information and is sanctioned. Her IowaCare is canceled until she cooperates.

## **Automatic Redetermination**

When a person is no longer eligible for another Medicaid coverage group, determine if the person would be eligible for IowaCare. If the person would be eligible for IowaCare, do not approve eligibility unless the person has signed form 470-4194 or 470-4194(S), *IowaCare Premium Agreement*.

Do not do an automatic redetermination when an IowaCare member is canceled. If it appears the person may be eligible for another Medicaid coverage group, send the member a Medicaid application.

NOTE: A newborn may be eligible for Medicaid. Send the member a Medicaid application for the newborn when the birth of the baby is reported.

The household consists of Ms. M and her son, Ben, who are receiving Medicaid under FMAP. Ben graduates from high school on June 5 and turns age 19 on June 30. FMAP is canceled effective July 1. Ben is automatically determined to be eligible for CMAP effective July 1.

Ms. M is no longer categorically eligible for any other Medicaid coverage group. She has no dependent child in the home and is not aged, disabled, or pregnant.

Therefore, the IM worker determines that Ms. M would be eligible for IowaCare. The worker sends Ms. M form 470-4208, *IowaCare Premium Agreement Cover Letter*, with form 470-4194, *IowaCare Premium Agreement*. Ms. M must return the signed *IowaCare Premium Agreement* before the automatic redetermination is completed. A new Medicaid application is not required.

Ben starts a job and is over income for CMAP. He is automatically redetermined to Medically Needy with a spenddown. The worker does not do an automatic redetermination to IowaCare when Ben's Medically Needy certification period ends. If Ben reapplies, the worker determines if he would be able to meet his spenddown for Medically Needy before processing the application for IowaCare.

### **Right to Appeal**

**Legal reference:** 441 IAC 7.5(217), 92.15(249A,249J); 42 CFR 431.200, 431.220

The applicant or member has the right to request an appeal hearing on any decision. No one may limit or interfere with this right. Examples of adverse actions in which a hearing may be granted include:

- ◆ The denial or cancellation of IowaCare.
- ◆ The delay in acting on the member's application with reasonable promptness.
- ◆ The premium amount.

Applicants or members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program.

See 1-E, [APPEALS AND HEARINGS](#), for a complete explanation of the Department's appeal process, including IM worker and applicant or member responsibilities, time limits, and appeal decisions.

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## **Covered Services**

**Legal reference:** 441 IAC 92.8(249A,249J)

IowaCare payment will be made only for covered services provided by IowaCare network providers except as noted below. IowaCare services are limited to the following services as covered by Iowa Medicaid:

- ◆ Inpatient and outpatient hospital care, including any needed drugs that are part of inpatient or outpatient hospital treatment or care.
- ◆ Physician and advanced registered nurse practitioner services.
- ◆ Services to help members quit smoking.
- ◆ Transportation to and from the network provider.
- ◆ Certain dental services. IowaCare providers **may** choose to provide limited dental services at their own cost.
- ◆ Certain pharmacy services. IowaCare providers **may** choose to provide prescription drug services, with member copayments determined by the IowaCare provider.

Conditions for services include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

No payment will be made for any service provided elsewhere or by another provider. Medical services not covered by IowaCare are the responsibility of the IowaCare member to pay. Exceptions:

- ◆ Payments will be made for routine preventive medical examinations by an IowaCare network provider or any physician, advanced registered nurse practitioner, or physician assistant who participates in Medicaid if the member is not assigned to a medical home.
- ◆ For IowaCare members qualifying as pregnant women, the covered services consist only of pregnancy-related services and newborn care. Certain pregnant women may obtain covered services from any provider or general hospital that participates in Iowa Medicaid.

## **Network Providers**

**Legal reference:** 441 IAC 92.8(249A,249J)

It is the Legislature's intent that IowaCare members will have a medical home for primary care and ongoing medical services. In 2010, legislation directed the Department to expand the IowaCare provider network services using federally qualified health centers (FQHCs). The purpose of this expansion is to provide IowaCare members with better access to primary care services.

The "medical home" designation is being phased in. Currently:

- ◆ Broadlawn Medical Center (BMC) in Des Moines is the medical home for IowaCare members who live in Polk County.
- ◆ People's Community Health Clinic in Waterloo is the medical home for IowaCare members who live in Black Hawk, Bremer, Buchanan, Butler, Cerro Gordo, Chickasaw, Fayette, Floyd, Franklin, Howard, Mitchell, Winneshiek, or Worth County.
- ◆ Siouxland Community Health Center in Sioux City is the medical home for IowaCare members who live in Cherokee, Crawford, Harrison, Ida, Lyon, Monona, O'Brien, Osceola, Plymouth, Shelby, Sioux, or Woodbury County.
- ◆ The University of Iowa Primary Care Clinics are the medical home for IowaCare members who live in Benton, Cedar, Iowa, Johnson, Jones, Keokuk, Linn, Louisa, Muscatine, or Washington County.

IowaCare members who have been assigned to a medical home must use that provider for their primary care and ongoing medical services. They may use the University of Iowa Hospitals and Clinics when referred there by their medical home for advanced and specialty care that is not available at the medical home.

All IowaCare members who have not been assigned to a medical home must obtain care at the University of Iowa Hospitals and Clinics (UIHC) with the following exceptions:

- ◆ Qualifying pregnant women in the 300% group (aid type 60-P) who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain pregnancy-related services from any provider or general hospital that participates in Iowa Medicaid.
- ◆ Members without a medical home may receive an annual routine preventive medical examination from any physician, advanced registered nurse practitioner, or physician assistant who participates in Medicaid.

Pregnant women who are not in the “qualifying” 300% group but are eligible for IowaCare (e.g. over resources for MAC) must receive covered services at their medical home or at UIHC.

1. Ms. A, an IowaCare qualifying pregnant woman (aid type 60-P), lives in Boone County. Since she is a qualifying pregnant woman, she may receive obstetric services at any licensed hospital or health care facility that accepts Medicaid. However, if she moves to Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, Ms. A must receive her obstetric services at the UIHC.

2. Ms. C, an IowaCare qualifying pregnant woman (aid type 60-P), lives in Woodbury County. She may receive obstetric services at any licensed hospital or health care facility that accepts Medicaid.

However, since there is a medical home in her geographic area, once her pregnancy ends she must go to the medical home that serves her county of residence to receive services.

3. Ms. B lives in Cedar County and is over resources for MAC. Her income is below 200% of the federal poverty level. She is eligible for IowaCare (aid type 60-E) in her own right and not because she is pregnant. Since her basis of eligibility is not because she is a qualifying pregnant woman, she must receive all her care, including obstetric services at the UIHC.

### **Obstetric Coverage for Qualifying Pregnant Women**

**Legal reference:** 441 IAC 92.8(3)

Covered IowaCare services for qualifying pregnant women are limited to:

- ◆ Inpatient hospital services when:
  - The primary or secondary diagnosis code is V22 through V24.9, and
  - The diagnosis-related group submitted for payment is 370 to 384.
- ◆ Outpatient hospital services when:
  - The primary or secondary diagnosis code is V22 through V24.9, and
  - The ambulatory patient group submitted for payment is 175, 304, 492, 493, or 494.
- ◆ Services from another Medicaid provider if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

Qualifying pregnant women who live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County must receive these services from the University of Iowa Hospitals and Clinics.

Qualifying pregnant women who live in other counties may receive these services from any provider participating in the Iowa Medicaid program.

### **Newborn Coverage**

**Legal reference:** 441 IAC 92.8(3)

Covered services under IowaCare for newborn children of mothers who were qualifying pregnant are limited to the following services provided while the newborn is hospitalized for a period not to exceed 60 days from the date of birth:

- ◆ Inpatient hospital services when the diagnosis-related group submitted for payment is between 385 and 391.7.
- ◆ Services from a health care provider other than a hospital, subject to normal Medicaid coverage limitations.

Once the newborn leaves the hospital of birth, the newborn is not eligible for any other medical coverage under IowaCare except for one check-up, if done within 60 days after birth.

Ms. A is eligible for IowaCare as a qualifying pregnant woman. She delivers her baby at a Sioux City hospital in January and reports it to her IM worker. The worker mails an application to Ms. A and requests proof of Ms. A's income in order to determine whether the baby qualifies for a Medicaid coverage group.

The worker determines that the newborn is not eligible for Medicaid because Ms. A's income is now over the MAC income limits. The worker makes the system entries to add the newborn to the IowaCare case and issues a *Notice of Decision*.

The newborn has health complications and remains in the Sioux City hospital for two weeks after birth. At the end of the two weeks, the newborn is transferred to the University of Iowa Hospitals and Clinics.

The newborn was eligible for IowaCare while in the hospital of birth. However, the newborn is not eligible for IowaCare upon transfer to another hospital, including the University of Iowa Hospitals and Clinics.

### **Prescriptions**

**Legal reference:** 441 IAC 92.8(2)

If the IowaCare member received inpatient care, the member may receive a 30-day supply of "take-home" drugs. The IowaCare member may also receive any drug that is administered in the outpatient clinic.

Take-home prescriptions when a member is released from the hospital may vary depending on the member's needs and the hospital policy. The Department does not make that determination. UIHC may provide a ten-day supply of carryover take-home drugs for IowaCare members.

If the member was on state papers in state fiscal year 2005 (July 2004 – June 2005) and received drugs for an ongoing chronic condition, the member will continue to receive the prescription only for the chronic condition.

### **Routine Preventive Medical Examinations**

**Legal reference:** 441 IAC 92.8(4)

A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury. A routine preventive medical examination is the annual physical or checkup. Basic laboratory work associated with the medical examination may also be paid.

If during the routine examination, the provider identifies a specific health issue or concern for the IowaCare member, then the member needs to be referred to the IowaCare provider for follow-up. A member who has a health concern needs to make an appointment with the IowaCare network provider. The routine preventive examination is not used for treatment or diagnosis for specific illness, symptom, complaint, or injury.

### **Services to Quit Smoking**

The IowaCare program covers medication to help members quit smoking. IowaCare members who smoke may go to their IowaCare doctor to get a prescription to help them quit smoking at no cost to the members. After initially seeing the IowaCare provider, the member may have the prescription filled at any pharmacy that accepts Medicaid payment.

After getting the prescription from the IowaCare network provider, the member must use QUITLINE IOWA services in order to keep getting the prescription to help the member quit smoking. QUITLINE IOWA is free to IowaCare members who have contacted their IowaCare doctor.

IowaCare provides up to 12 weeks of prescriptions and counseling covered during any one-year period.

## **Transportation**

**Legal reference:** 441 IAC 92.8(2)

The University of Iowa Hospitals and Clinics (UIHC) is currently providing transportation to and from its Iowa City location only for confirmed IowaCare patients or pre-existing chronic condition patients with scheduled appointments. UIHC-provided transportation is not available to or from another health care provider's location.

Pickups can be scheduled by calling (319) 356-2346 between 7:00 a.m. and 4:00 p.m. Monday through Friday. Next-day service may be possible but is not guaranteed, so advance registration is strongly encouraged.

Same-day return service is also not guaranteed, and all riders will be required to acknowledge in writing before being transported that they understand that they will be personally responsible for any lodging and meal expenses that must be incurred.

Patients using this service will be expected to be ready for a timely departure from their home at any time during the pickup window provided. The UIHC reserves the right to discontinue transportation services during inclement weather or if other circumstances so dictate.

Broadlawns Medical Center and the mental health institutes do not provide transportation. The Department does not reimburse the IowaCare member for transportation.

## **Pre-Existing Chronic Condition Group**

To be eligible for the pre-existing chronic condition group, a person must:

- ◆ Have applied for IowaCare or Medicaid and indicate the existence of a chronic health condition in state fiscal year 2006 (July 1, 2005 through June 30, 2006), and
- ◆ Have received state papers in state fiscal year 2005 (July 1, 2004 through June 30, 2005), and
- ◆ Have been treated for an eligible chronic medical condition at the University of Iowa Hospitals and Clinics (UIHC), and
- ◆ Have received verification from the UIHC that the person was treated for an eligible chronic medical condition, and
- ◆ Be denied for IowaCare. (People eligible for IowaCare may receive treatment for their chronic medical condition at the UIHC).

No new cases for the pre-existing chronic condition will be approved after July 1, 2006.

A person can be eligible for the pre-existing chronic condition group and also:

- ◆ Be eligible for qualified Medicare beneficiary (QMB) coverage;
- ◆ Be eligible for specified low-income Medicare beneficiary (SLMB) coverage;
- ◆ Be eligible for Iowa family planning network (IFPN); or
- ◆ Have group health insurance (see [Definitions: Group health insurance](#)).

A person who is eligible for the pre-existing chronic care condition group **cannot** be eligible for:

- ◆ Medicaid for employed people with disabilities (MEPD), with or without a premium
- ◆ Expanded specified low-income Medicare beneficiary (E-SLMB)
- ◆ Qualified disabled and working people (QDWP)
- ◆ Medically Needy without a spenddown
- ◆ Any other Medicaid coverage group with full benefits

If the person is eligible for Medically Needy with a spenddown and the person regularly meets the spenddown, the person is not eligible for the pre-existing chronic condition program. If the person indicates that the medical expenses the person has or would incur would not be enough to meet spenddown, the person may choose between the pre-existing chronic condition program and Medically Needy.

For the pre-existing chronic condition group there is no:

- ◆ Age limit
- ◆ Income limit (must be over 200% of federal poverty level)
- ◆ Premium to pay
- ◆ Interview

The pre-existing chronic medical condition coverage group covers only medical services related to the chronic medical condition the person was treated for under the state papers program in state fiscal year 2005. New medical conditions will not be covered.

The difference between someone who has a pre-existing chronic medical condition who is eligible for IowaCare and a person who is eligible only for the pre-existing chronic condition coverage group is that members will receive different services.

- ◆ The person eligible for IowaCare will receive all services allowed under IowaCare including the pre-existing condition. People eligible for IowaCare who have a pre-existing chronic condition will be required to pay a premium unless they claim a hardship on the billing statement.
- ◆ The person eligible for the pre-existing group will receive services only for the pre-existing condition.

Medical cards are not issued to persons eligible for the pre-existing chronic condition group. Members will receive a letter stating they are eligible and for how long they are eligible. There is no retroactive coverage.

The person's state identification number will be on the Eligibility Verification System (ELVS). SSNI will show the aid type as 77-7. The aid type 77-7 is not entered on ABC.

### **Notice of Decision**

Do not send a *Notice of Decision* for the pre-existing chronic condition coverage. Those who are eligible will receive a letter issued by the presumptive system to verify that they are eligible for this coverage and for how long. They will take the letter with them to the UIHC. The Department will already have sent a denial for the IowaCare program and the person may appeal that *Notice of Decision*.

If a person is not eligible, the IM worker may, as a courtesy, send a memo explaining that although the person may have received state papers in SFY '05 (July 1, 2004 through June 30, 2005), the person is not eligible for the pre-existing chronic condition coverage because the person does not meet the criteria for receiving chronic (ongoing) care.

### **Reporting Requirements**

Persons in the pre-existing chronic condition group are not required to report the following changes and workers **do not** act on these reports:

- ◆ Household size, or
- ◆ Income.

The person must report within ten days if:

- ◆ The person is no longer an Iowa resident.
- ◆ The person obtains health insurance coverage that will cover treatment for their pre-existing condition.
- ◆ The person enters a nonmedical institution, including a penal institution.

### **Acting on Changes**

The presumptive system will close the case at the end of the 12 months. No *Notice of Decision* is required since the persons were told in the eligibility letter that they were eligible for 12 months.

Send the appropriate application to persons whose income decreases or who become age 65. When the person becomes age 65, determine if the person would now be eligible for a full Medicaid coverage group or a Medicare savings program.

Report changes to the Quality Assurance Unit by phone at 1-800-373-6306 or in Des Moines, 281-8253, or by e-mail of the following:

- ◆ Address changes
- ◆ Worker number changes
- ◆ County changes
- ◆ Closing the case
- ◆ Death of the person

Quality Assurance will forward the information to IME staff, who will update the system. Information on closing will be passed to IME staff, who will enter the information into the Presumptive System. Information will show on the Medical Eligibility SSNI screen.

To view the Presumptive System:

- ◆ Clear your screen and type in PRSM and press the ENTER key.
- ◆ Put an "X" in "Display Episodes" field and press the ENTER key.
- ◆ Type in the person's state identification number and press the ENTER key.
- ◆ The "type" column will have a "C" entered for this group.

### **Case File**

Keep a copy of the following:

- ◆ Application.
- ◆ Tear-off sheet (when provided) or documentation that the person had state papers in state fiscal year 2005.
- ◆ Notification from UIHC about the chronic condition.
- ◆ Letter stating that the person is eligible to receive medical services for a chronic condition.
- ◆ All information and documentation showing how eligibility was determined.