

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services proposes to rescind Chapter 76, “Application and Investigation,” Iowa Administrative Code, and to adopt a new Chapter 76, “Enrollment and Reenrollment,” in lieu thereof.

This proposed amendment rescinds existing Chapter 76 and adopts a new Chapter 76 because Chapter 76 as written required a complete revision due to medical assistance changes required by the Affordable Care Act.

The Affordable Care Act implemented significantly changed policy about medical assistance application, enrollment and reenrollment requirements. These changes are effective October 1, 2013, for determining eligibility effective January 1, 2014.

The new Eligibility Integrated Application Solution (ELIAS), which will be implemented at the same time that the Affordable Care Act changes are implemented, also required modification of Chapter 76.

This amendment is required by the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) and 42 CFR Part 435, as amended.

This amendment is proposed simultaneously with an amendment published herein under Notice of Intended Action as **ARC 0909C** to adopt new rule 441—80.7(249A) whose content is identical to that in existing rule 441—76.13(249A), which is being rescinded as part of the rescission of Chapter 76.

Any interested person may make written comments on this proposed amendment on or before August 27, 2013. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by e-mail to policyanalysis@dhs.state.ia.us.

These rules do not provide for waivers in specified situations because there are no waivers applicable to these provisions of the Affordable Care Act. However, requests for the waiver of any rule may be submitted under the Department’s general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These rules are intended to implement Iowa Code section 249A.4.

The following amendment is proposed.

Rescind 441—Chapter 76 and adopt the following **new** chapter in lieu thereof:

**CHAPTER 76
ENROLLMENT AND REENROLLMENT**

PREAMBLE

This chapter specifies the process for enrolling and reenrolling in the Iowa Medical Assistance or “Medicaid” program and addresses related matters.

Eligible individuals must be enrolled for the date on which services are provided in order for payment to be made for the services received.

Initial enrollment must be based on an application submitted to the department, a referral from a health insurance marketplace, an express lane eligibility determination, a Social Security Income eligibility determination, a transmittal from the federal Social Security Administration for Medicare savings programs, or a presumptive eligibility determination, as described in rules 441—76.2(249A) through 441—76.7(249A).

Reenrollment is based on a review, as described in rule 441—76.14(249A), of all eligibility factors under 441—Chapter 75.

Applicants and members are required to report changes pursuant to rule 441—76.15(249A).

Department action on information received will occur as described in rules 441—76.15(249A) and 441—76.16(249A).

Automatic redeterminations of eligibility will occur as described in rule 441—76.17(249A).

This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—76.1(249A) Definitions.

“Authorized representative” means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.

“Electronic account” means a Web-based account established by the department for an applicant or member for communication between the department and the applicant or member.

“Electronic case record” means an electronic file that includes all information collected and generated by the department regarding each individual’s Medicaid eligibility and enrollment.

“Health insurance marketplace” means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

“Medicare savings program” refers to the limited Medicaid coverage groups that provide payment of Medicare premiums, coinsurance, and deductibles for low-income elderly or disabled individuals. Those groups are qualified disabled and working people (QDWP) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(ii), qualified Medicare beneficiaries (QMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(i), specified low-income Medicare beneficiaries (SLMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(iii), and expanded specified low-income Medicare beneficiaries (ESLMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(iv).

“Member” means an individual who has been determined eligible for medical assistance pursuant to 441—Chapter 75 and has been enrolled to receive assistance. For the medically needy program, “member” shall mean an individual who has been determined eligible for medical assistance under the medically needy program, has been enrolled, and has countable income at or below the medically needy income level (MNIL) or has reduced countable income to the MNIL during the certification period through spenddown.

“Modified adjusted gross income” means the methodology to determine income eligibility prescribed by 1902(e)(14) of the Social Security Act (42 U.S.C. § 1396a(e)(14)).

“Presumptive eligibility” means that a person is presumed to be eligible on a temporary basis based on information provided.

“Qualified entity” is an entity that is described in Paragraphs (1) through (10) of 42 CFR 435.1101 relating to coverage groups for children, 42 CFR 435.1110b relating to hospitals determining eligibility, U.S.C. § 1396r-1 relating to coverage groups for pregnant women, or 42 U.S.C. § 1396r-1b relating to the breast and cervical cancer coverage group, that has been determined by the department to be capable of making presumptive Medicaid eligibility determinations, and that has signed an agreement with the department as a qualified entity.

“Responsible person” means an individual recognized by the department pursuant to subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant’s or member’s own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

“Supplemental security income” or *“SSI”* is a federally administered program established by Title XVI of the Social Security Act to provide supplemental income to individuals who have attained the age of 65 or are blind or disabled.

“WIC” is the Special Supplemental Nutrition Program for Women, Infants, and Children established by 42 U.S.C. § 1786.

441—76.2(249A) Application with the department. This rule describes the process of applying for medical assistance directly with the department of human services.

76.2(1) Application for eligibility effective prior to January 1, 2014. Application for the Medicaid or HAWK-I program to be initially effective prior to January 1, 2014, must be made as provided in this subrule.

a. Forms.

(1) An application for family medical assistance-related Medicaid programs shall be submitted on Health and Financial Support Application, Form 470-0462 or Form 470-0462(S); Health Services Application, Form 470-2927 or Form 470-2927(S); HAWK-I Application, Comm. 156; or HAWK-I Electronic Application Summary and Signature Page, Form 470-4016.

(2) An application for SSI-related Medicaid shall be submitted on Health Services Application, Form 470-2927 or Form 470-2927(S), or Health and Financial Support Application, Form 470-0462 or Form 470-0462(S).

(3) An application for Medicaid for persons in foster care shall be submitted on Health Services Application, Form 470-2927 or Form 470-2927(S).

b. Who can file. An application may be filed by the applicant, an adult in the applicant’s household or family, an authorized representative recognized pursuant to subrule 76.9(2), or a responsible person recognized pursuant to subrule 76.9(1).

c. How and where to file.

(1) An application may be filed over the Internet at www.dhs.iowa.gov, by submission to any local office of the department, or by submission to a department outstation at a disproportionate share hospital, federally qualified health center or other facility where outstationing activities are provided. Applications may be submitted in person, by mail, by fax or by e-mail.

(2) Health Services Application, Form 470-2927 or Form 470-2927(S), may also be filed at the office of a qualified entity for presumptive Medicaid eligibility determinations, a WIC office, a maternal health clinic, or a well child clinic.

(3) Individuals applying for medical assistance for family planning services under 441—subrule 75.1(41) or 441—Chapter 87 may also apply at any family planning agency as defined in rule 441—87.1(82GA,ch1187).

(4) An application for HAWK-I may be filed with the third-party administrator as provided at 441—subrule 86.3(3).

d. Minimum application requirements. A valid application is an application containing a legible name, a legible address, and a signature. An authorized representative or responsible person recognized pursuant to rule 441—76.9(249A) may sign on an applicant’s behalf. Electronic and handwritten signatures transmitted via electronic transmissions are acceptable. An application that does not include a legible name, a legible address, and a signature will be rejected without a determination of eligibility.

e. Interviews.

(1) The department may require a face-to-face or telephone interview with adult applicants, authorized representatives, or responsible persons.

(2) The department shall notify the applicant, authorized representative, or responsible person of the date, time and method of an interview. This notice shall be provided to the applicant, authorized representative, or responsible person personally, by telephone, by e-mail, by mail or by fax.

(3) Failure of the applicant, authorized representative, or responsible person to attend a scheduled interview shall be a basis for denial of an application or cancellation of assistance for adults. Failure to attend an interview shall not serve as a basis for denial of an application or cancellation of assistance for children.

f. Additional information or verification needed to determine eligibility. The department shall notify the applicant, authorized representative, or responsible person in writing that additional

information or verification is required to establish eligibility. This notice shall be provided to the applicant, authorized representative, or responsible person personally or by mail or fax.

(1) The department shall allow the applicant, authorized representative, or responsible person ten calendar days to supply the information or verification requested.

(2) The department may extend the deadline for a reasonable period of time when the applicant, authorized representative, or responsible person is making every effort but is unable to secure the required information or verification.

(3) The application shall be denied if the department does not receive one of the following by the due date:

1. The information or verification,
2. An authorization for the department to obtain the information or verification, or
3. A request for an extension of the due date.

(4) If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department shall complete the eligibility determination as though the information or verification were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant, authorized representative, or responsible person shall have until the next business day to provide the information.

76.2(2) Application for eligibility effective on or after January 1, 2014. Application for the Medicaid or HAWK-I program to be initially effective on or after January 1, 2014, must be made as provided in this subrule.

a. Form. Application for the Medicaid or HAWK-I program shall be submitted on Application for Health Coverage and Help Paying Costs, Form 470-5170 or 470-5170(S).

b. Who can file. An application may be filed by the applicant, an adult in the applicant's household or family, an authorized representative recognized pursuant to subrule 76.9(2), or a responsible person recognized pursuant to subrule 76.9(1).

c. How and where to file.

(1) An application may be filed over the Internet at www.dhs.iowa.gov or at www.dhsservices.iowa.gov or at the health insurance marketplace Web site at www.healthcare.gov, by submission to any local office of the department, or by submission to a department outstation at a disproportionate share hospital, federally qualified health center, or other facility where outstationing activities are provided. Applications may be submitted in person, by mail, by telephone at [telephone number], or by e-mail or fax. Addresses, e-mail addresses and fax numbers of local offices of the department are available at www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html.

(2) An application may also be filed at the office of a qualified entity for presumptive Medicaid eligibility determinations, a WIC office, a maternal health clinic, or a well child clinic.

(3) Individuals applying for medical assistance for family planning services under 441—subrule 75.1(41) or 441—Chapter 87 may also apply at any family planning agency as defined in rule 441—87.1(82GA,ch1187).

d. Minimum application requirements. Initial applications must be signed under penalty of perjury. An authorized representative or responsible person recognized pursuant to rule 441—76.9(249A) may sign on an applicant's behalf. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any electronic transmission are acceptable. An application that does not include a signature under penalty of perjury will be rejected without a determination of eligibility.

e. Additional information or verification needed to determine eligibility. The applicant must provide additional information or verification as requested by the department, including information or verification necessary to determine SSI-related Medicaid eligibility, as requested on SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS).

f. Interviews. The applicant, authorized representative, or responsible person may be required to attend a face-to-face or telephone interview to clarify information or to resolve conflicting information. Failure to attend a required interview will result in denial of the application.

76.2(3) Date of filing.

a. An application is considered filed on the date a valid application is received in any place of filing specified in paragraph 76.2(1) “*c*” or 76.2(2) “*c*.” When an application is delivered after business hours, it will be considered received on the next business day.

b. A valid application for Medicaid which is filed at a WIC office, a well child clinic, a maternal health clinic, an outstationed office, or the office of a qualified entity for presumptive Medicaid eligibility determinations shall be considered filed on the date it is received and date-stamped in one of those offices. When the application is received while the office is closed, it will be considered received on the next business day.

441—76.3(249A) Referrals from a health insurance marketplace. Upon receipt of a referral from a health insurance marketplace indicating that an application filed with the health insurance marketplace has been screened and that the applicant has been found to be potentially eligible for Medicaid or HAWK-I, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The applicant is required to cooperate as described in this chapter for applications received directly by the department.

441—76.4(249A) Express lane eligibility. For purposes of the initial enrollment of a child in medical assistance, the department will use express lane procedures as allowed by 42 U.S.C. § 1396a(e)(13) and as described in this rule.

76.4(1) For purposes of initial enrollment, the department shall rely on a determination of the child’s eligibility for food assistance pursuant to 441—Chapter 65 as establishing that a child under the age of 19 meets all eligibility requirements established in 441—subrule 75.1(28) except for citizenship or alienage requirements, unless:

a. The child’s household already includes other persons receiving Medicaid based on the use of the modified adjusted gross income methodology, or

b. The child was previously granted express lane eligibility and the household has not had at least a two-month break in food assistance eligibility since that time, or

c. The household’s income as calculated by the food assistance program exceeds the income limit for the mothers and children coverage group found at 441—subparagraph 75.1(28) “*a*”(1).

76.4(2) To obtain express lane enrollment for a child, the child’s household must request medical assistance for the child on Express Lane Medicaid for Children, Form 470-4851 or Form 470-4851(S). The department shall send Form 470-4851 or Form 470-4851(S) to the household when a child eligible for express lane enrollment is approved for food assistance pursuant to 441—Chapter 65. An adult member of the child’s household or a child receiving food assistance as head of household must sign Form 470-4851 or Form 470-4851(S) and return it to the department within 30 calendar days of issuance.

76.4(3) As a condition of express lane enrollment, the child must meet the citizenship or alienage requirements of rule 441—75.11(249A).

76.4(4) The month of application for express lane enrollment is the month of the child’s food assistance effective date. Express lane eligibility begins on the first day of the month of the child’s food assistance effective date.

76.4(5) Retroactive enrollment is available for any of the three months before the month of the child’s food assistance effective date when the child:

a. Has medical bills for covered services that were received in that period, and

b. Would have been eligible for medical assistance benefits in the month services were received if the application for medical assistance had been made in that month and the eligibility determination was made without regard to food assistance eligibility.

76.4(6) After the initial express lane enrollment, all redeterminations of medical assistance eligibility shall be made without reliance on any food assistance eligibility determination.

441—76.5(249A) Enrollment through SSI. Upon receipt of a referral from the Social Security Administration indicating that an individual has been approved for SSI, the department will treat the

referral as an application for medical assistance and will process the application as if received directly by the department. The SSI recipient shall be required to complete SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS), when additional information is necessary to determine Medicaid eligibility. The SSI recipient may be required to attend an interview to clarify information on this form.

441—76.6(249A) Referral for Medicare savings program. Referrals received from the federal Social Security Administration pursuant to 42 U.S.C. 1320b-14(c)(3) when the individual has indicated that the individual wants to apply for the Medicare savings program will be treated by the department as an application for the Medicare savings program and will be processed as if the application were received directly by the department. The date on which the referral is transmitted by the Social Security Administration shall be treated as the date of application. When requested to do so, the applicant must complete Medicare Savings Programs Additional Information Request, Form 470-4846, to provide additional information needed to determine Medicare savings program eligibility.

441—76.7(249A) Presumptive eligibility. Individuals may be temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity pursuant to this rule.

76.7(1) *For eligibility effective prior to January 1, 2014.*

a. Applicants for presumptive eligibility for children will complete Application: Presumptive Health Care Coverage for Children, Form 470-4855 or 470-4855(S).

b. Applicants for presumptive eligibility for pregnant women or for presumptive eligibility for breast and cervical cancer coverage group shall complete Health Services Application, Form 470-2927 or Form 470-2927(S).

76.7(2) *For eligibility effective on or after January 1, 2014.* Applicants for presumptive eligibility will complete Health Services Application, Form 470-2927 or 470-2927(S).

76.7(3) *How and where to file.* Applications for presumptive eligibility are filed at the office of a qualified entity for presumptive Medicaid eligibility determinations.

76.7(4) *Enrollment.* An individual is enrolled on the date that presumptive eligibility is determined by the qualified entity.

76.7(5) *Notice and appeal rights.* Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

76.7(6) *Full medical assistance eligibility determination.* All presumptive eligibility applications shall receive a full determination of eligibility for Medicaid or HAWK-I except for breast and cervical cancer and pregnant women coverage groups.

441—76.8(249A) Applicant responsibilities.

76.8(1) *Accurate information.* Applicants are responsible to give complete and accurate information needed to establish eligibility.

76.8(2) *Time frames for providing information or verification.* Applicants shall have ten calendar days to supply the information or verification requested by the department.

76.8(3) *Extensions.* The applicant may request an extension of a reasonable period of time when the applicant is making every effort but is unable to secure the required information or verification.

76.8(4) *Failure to comply.* An application shall be denied if the applicant does not attend a required interview, if applicable under subrule 76.2(1) or 76.2(2), or if the department does not receive one of the following by the due date:

- a.* The information or verification,
- b.* An authorization to obtain the information or verification, or
- c.* A request for an extension of the due date.

76.8(5) *Grace period.* If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department shall complete the eligibility determination as though the information were received timely.

If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information.

76.8(6) Referrals to the Social Security Administration. When an applicant or member may be eligible for benefits from the Social Security Administration and is directed by the department to apply for such benefits, the applicant or member must make application for such benefits as described in rule 441—75.3(249A).

441—76.9(249A) Responsible persons and authorized representatives.

76.9(1) Responsible person. If an applicant or member is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased, a responsible person may act for the applicant or member. Except as provided in paragraph 76.9(1) "a" below, the responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and has a personal interest in the applicant's or member's welfare. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative as provided for in subrule 76.9(2) to represent the applicant or member. However, the designation of an authorized representative does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

a. When there is no person as described above to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member, any individual or organization may be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes Inability to Find a Responsible Person, Form 470-3356, attesting to the individual's or organization's inability to find a responsible person to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member.

b. The department may require verification of the applicant's or member's incompetence or death and of the responsible person's relationship to the applicant or member.

c. Copies of all departmental correspondence with the applicant or member shall be provided to the recognized responsible person.

76.9(2) Authorized representative. An individual or organization designated by a competent applicant or member, designated by a responsible person recognized pursuant to subrule 76.9(1), or with other legal authority to do so may act on behalf of the applicant or member in the application process, renewal of eligibility, or for ongoing eligibility.

a. The designation of an authorized representative by an applicant, member, or responsible person must be in writing and must be signed and dated by the applicant or member or the responsible person. The applicant, member, or responsible person may authorize the representative to complete and sign an application on the applicant's behalf, complete and submit a renewal form, receive copies of the applicant's or member's notices and other communications from the department, and act on behalf of the applicant or member in all other matters with the department.

b. Legal documentation of authority to act on behalf of the applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a written authorization by the applicant or member.

c. Designations of authorized representatives, legal documentation of authority to act on behalf of the applicant or member, and modifications or terminations of designations or legal authority may be submitted via the Internet Web site, www.dhsservices.iowa.gov, by mail, by e-mail, by fax, or in person.

d. For purposes of this rule, the department shall accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by fax or other electronic transmission.

e. If the authorization indicates the time period or dates the authorization is to cover, the stated period or dates shall be honored and may include subsequent applications, if necessary, that relate to the time period or dates indicated on the authorization. If the authorization does not indicate the time period or dates it is to cover, the authorization shall be valid for any applications filed within 120 days from

the date the authorization was signed and for all subsequent actions pertaining to the applications filed within the 120-day period.

f. The power to act as an authorized representative based on a designation by an applicant, member, or responsible person is valid until the applicant, member, or responsible person modifies the authorization or notifies the department that the representative is no longer authorized to act on behalf of the applicant or member or until the authorized representative informs the department that the representative no longer is acting in such capacity. Such notice must be in writing and should include the applicant's, member's, responsible person's, or authorized representative's signature as appropriate.

g. Copies of all departmental correspondence shall be provided to the applicant or member and the authorized representative.

76.9(3) *Additional requirements applicable to all authorized representatives and responsible persons.*

a. An authorized representative or responsible person must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or member provided by the department.

b. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible person must sign an agreement that the provider, staff member, or volunteer will adhere to the regulations in Part 431, Subpart F of 42 CFR Chapter IV and at 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

c. The authorized representative or responsible person is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible person represents.

441—76.10(249A) Right to withdraw the application. The applicant may withdraw the application at any time before the eligibility determination has been made. The applicant may request that the application be withdrawn entirely or request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

441—76.11(249A) Choice of electronic notifications. The applicant is responsible to indicate if notices and other communications are to be provided by the department in an electronic format through the individual's electronic account, rather than by regular mail. The applicant may change the selection at any time. Notices and other communications provided through the individual's electronic account are deemed to be received upon the sending of an e-mail to the individual notifying the individual of the notice or other communication.

441—76.12(249A) Application not required.

76.12(1) *Adding a new person.*

a. Adding an eligible person. For members whose eligibility is based on the modified adjusted gross income methodology, a new application is not required when an eligible person is added to an existing Medicaid-eligible group. Such a person is considered to be included in the application that established the existing eligible group. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date of entry or the date of report, whichever is later.

b. Adding a person previously ineligible due to a failure to cooperate. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing paternity as described at 441—subrule 75.14(2) is to be granted Medicaid benefits, the

person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by cooperating in obtaining medical support or establishing paternity.

c. Adding a person previously ineligible due to failure to provide a social security number. In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described at rule 441—75.7(249A) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number.

d. Adding a person who was voluntarily excluded. In those instances where a person who has been voluntarily excluded from the eligible group in accordance with the provisions of rule 441—75.59(249A) is being added to the eligible group, the person shall be added effective the first of the month after the month in which the household requests that the person no longer be excluded.

76.12(2) Reinstatement after cancellation. Eligibility for medical assistance may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the information.

76.12(3) Loss of HAWK-I eligibility. In those instances where a child loses HAWK-I eligibility and has been determined eligible for Medicaid, with no break in coverage, an application for Medicaid is not required.

441—76.13(249A) Initial enrollment.

76.13(1) Enrollment date. Applicants who have been determined to be eligible shall be enrolled by the department in the Medicaid program.

a. First day of the month. The effective date of enrollment is the first day of the first month for which eligibility has been determined, with the following exceptions:

(1) Presumptive eligibility is effective on the date that presumptive eligibility was determined by a qualified entity for presumptive Medicaid eligibility determinations.

(2) Eligibility under the qualified Medicare beneficiary coverage group begins on the first day of the month after the month of decision.

(3) Eligibility for individuals approved for supplemental security income, programs related to supplemental security income, state supplementary assistance, or medical assistance benefits shall be effective on the first day of the month when the individual was resource-eligible as of the first moment of the first day of the month and met all other eligibility criteria at any time during the month.

(4) When a request is made to add a new person to the eligible group, medical assistance shall not be effective before the first of the month in which the request was made.

(5) When a request is made prior to January 1, 2014, to add to the eligible group a person who previously was excluded, in accordance with the provisions of rule 441—75.59(249A), medical assistance for the person shall be effective no earlier than the first day of the month following the month in which the request was made.

b. Care or services prior to enrollment. No payment shall be made for medical care or services received prior to the effective date of enrollment.

76.13(2) Retroactive enrollment.

a. Except as provided in paragraphs 76.13(2)“*e*” and “*f*,” medical assistance shall be available for all or any of the three months preceding the month in which an application is filed to persons who:

(1) Have medical bills for covered care or services received during the three-month retroactive period; and

(2) Would have been eligible for medical assistance in the month services were received if application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance shall be made available when an application has been made on behalf of a deceased person if the conditions in paragraph 76.13(2)“*a*” are met.

d. Persons enrolled in Medicaid based on receipt of supplemental security income benefits who wish to make application for Medicaid benefits for three months preceding the month of application shall complete SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS).

e. Exceptions to retroactive enrollment. This subrule does not apply to the following individuals:

(1) Individuals whose citizenship or alien status has not been verified even though they are eligible during a 90-day reasonable opportunity period.

(2) Individuals determined eligible only under presumptive Medicaid benefits.

(3) Individuals eligible for Medicaid only under the qualified Medicare beneficiary program.

(4) Individuals eligible only under the home- and community-based waiver services program.

f. Exceptions to length of retroactive enrollment. Individuals eligible for Medicaid only on the basis of eligibility for a state supplementary assistance program are only eligible for retroactive enrollment for the 30 days prior to the date of application. All other provisions of this subrule apply.

76.13(3) Certification for services. The department shall issue a Medical Assistance Eligibility Card, Form 470-1911, to persons who have been determined to be eligible for the benefits provided under the Medicaid program, with the following exceptions:

a. *Presumptive eligibility.* A person who has been determined only presumptively eligible will be issued a Presumptive Medicaid Eligibility Notice of Action, Form 470-2580 or 470-2580(S), that will include certification information.

b. *Emergency Medicaid for aliens.* An individual who is eligible only for limited emergency Medicaid for aliens pursuant to 441—subrule 75.11(4) will be issued a Notice of Action, Form 470-0485 or Form 470-0485(S), that will include certification information.

441—76.14(249A) Reenrollment. Reviews of all conditions of eligibility will occur for the purposes of determining continued enrollment in Medicaid.

76.14(1) Reenrollment frequency.

a. *Eligibility reviews for eligibility prior to January 1, 2014.*

(1) Eligibility reviews shall be made as often as circumstances indicate, but in no instance shall the period of time between reviews exceed 12 months.

(2) Eligibility reviews will be conducted using information contained in and verification supplied with the review form specified in 441—subrule 75.52(3).

(3) When the review form is issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the fifth calendar day of the following month.

(4) When the review form is not issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

b. *Eligibility reviews for eligibility effective on or after January 1, 2014.*

(1) Eligibility reviews for members whose eligibility is based on the modified adjusted gross income methodology, who are eligible for Medicaid related to reciprocity for a subsidized adoption, who are eligible for Medicaid programs that are solely state-funded, who are Medicaid-eligible based upon the receipt of Medicaid related to foster care at the time they aged out of foster care, and who are eligible based on breast or cervical cancer treatment shall be conducted once every 12 months and no more frequently.

(2) Eligibility reviews for other members shall be made as often as circumstances indicate, but in no instance shall the period of time between eligibility reviews exceed 12 months.

76.14(2) Reenrollment process.

a. *Reenrollment process prior to January 1, 2014.*

(1) Within ten working days from the date a written request is issued, the member shall supply, insofar as the member is able, additional information needed to establish continued eligibility.

1. The member shall give written permission for the release of information when the member is unable to furnish information needed to reestablish eligibility.

2. Failure to supply the information or verification requested or refusal to request assistance and authorize the department to secure the requested information from other sources shall serve as a basis for

cancellation of Medicaid. Signing a general authorization for release of information to the department does not meet this responsibility.

(2) Information for the eligibility review shall be submitted on Review/Recertification Eligibility Document (RRED), Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), with the following exceptions:

1. Persons whose eligibility for Medicaid is related to the family medical assistance program shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

2. Persons whose eligibility for Medicaid is related to supplemental security income and who are receiving state supplementary assistance shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

3. Persons whose eligibility for Medicaid is based on foster care, subsidized adoption or subsidized guardianship shall have continued eligibility determined by submission of Foster Care, Adoption and Guardianship Medicaid Review, Form 470-2914 or Form 470-2914(S).

4. Individuals whose eligibility is for the medically needy coverage group shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

5. Members eligible for family planning services only shall complete Family Planning Medicaid Review, Form 470-4071. The member must submit the completed review form before the end of the eligibility period to any location specified in subparagraph 76.2(2)“c”(3).

(3) For SSI-related Medicaid for adults, the department may request a face-to-face or telephone interview. Failure of the member to attend a scheduled interview shall serve as a basis for cancellation of assistance for adults. Failure of the member to attend an interview shall not serve as a basis for cancellation of assistance for children.

(4) If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all questions answered and is signed, dated and accompanied by verification as required in 441—paragraphs 75.57(1)“f” and 75.57(2)“l.”

(5) Reinstatement. When medical assistance has been canceled for failure to return a completed review form, assistance may be reinstated without a new application if the department receives the completed form within 14 calendar days of the effective date of cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the information. EXCEPTION: Members eligible for family planning services only who fail to submit Family Planning Medicaid Review, Form 470-4071, before the end of the eligibility period must reapply as directed in rule 441—76.2(249A).

b. Reenrollment process effective on or after January 1, 2014.

(1) Reenrollment shall be based on information contained in the member’s electronic case record or other more current information available through electronic data matches. The member will be notified of the determination of continued eligibility and the basis of the determination on Notice of Action, Form 470-0485 or Form 470-0485(S). If any information contained in Form 470-0485 or Form 470-0485(S) is inaccurate, the member must sign and return the notice with accurate information within 30 days of the date on the notice.

(2) When eligibility cannot be determined based on information in the electronic case record and data matches, the member will be provided with a prepopulated renewal form, MAGI Medicaid Renewal, Form 470-5168 or Form 470-5168(S), and will have 30 days from the date of the renewal form to sign and return the form with necessary information, with the following exceptions:

1. Members eligible for family planning services only shall complete Family Planning Medicaid Review, Form 470-4071.

2. Members whose eligibility for Medicaid is not based on the modified adjusted gross income methodology shall complete and return Medicaid Review, Form 470-3118 or 470-3118(S), when requested to do so by the department. Members whose eligibility has been determined on the basis of age, blindness or disability must sign and return the notice within 30 days of the date on the notice and provide verification of income and resources before a determination of continued eligibility can be made.

(3) Enrollment will end when information or documentation necessary to complete the determination of continued eligibility is not returned within 30 days, with the exception that members eligible for family planning services only who fail to submit the completed Family Planning Medicaid Review, Form 470-4071, before the end of the eligibility period must reapply as directed in rule 441—76.2(249A). The department shall notify the member on Notice of Action, Form 470-0485 or Form 470-0485(S).

(4) Reconsideration period. When medical assistance has been canceled for failure to return a completed prepopulated renewal form or other information necessary to determine continued eligibility, enrollment may be reinstated without a new application if the department receives the completed form within the three calendar months following the effective date of cancellation. Enrollment for up to three months of retroactive benefits is available when the conditions of subrule 76.13(2) are met.

(5) An individual whose eligibility is not based on the modified adjusted gross income methodology must attend a face-to-face or telephone interview if requested to do so by the department.

441—76.15(249A) Report of changes. As a condition of enrollment and continued enrollment for medical assistance, applicants and members shall report changes in circumstances as required in this rule.

76.15(1) Report of changes for eligibility prior to January 1, 2014.

a. In coverage groups for which Medicaid eligibility is determined using the family medical assistance program (FMAP) income and resource policies, members shall report changes as follows:

(1) At the annual review or upon the addition of an individual to the eligible group, members shall report any change in the following:

1. Income from all sources, including any change in care expenses.
2. Resources.
3. Members of the household.
4. School attendance.
5. A stepparent's recovery from an incapacity.
6. Mailing or living address.
7. Payment of child support.
8. Receipt of a social security number.
9. Payment for child support, alimony, or dependents as defined in 441—paragraph 75.57(8) "b."
10. Health insurance premiums or coverage.

(2) Applicants and members shall report any change in the following within ten calendar days of the change:

1. Members of the household.
2. Mailing or living address.
3. Sources of income.
4. Health insurance premiums or coverage.

(3) Members described at 441—subrule 75.1(35) shall also report any change in income from any source and any change in care expenses within ten calendar days of the change.

b. In coverage groups for which Medicaid eligibility is determined using income and resource policies related to the supplemental security income (SSI) program, members shall report any change in the following to the department within ten calendar days of the change. EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

- (1) Income from all sources.
- (2) Resources.
- (3) Members of the household.
- (4) Recovery from disability.
- (5) Mailing or living address.
- (6) Health insurance premiums or coverage.
- (7) Medicare premiums or coverage.

(8) Receipt of social security number.

(9) Gross income of the community spouse or of the dependent children, parents or siblings of the institutionalized or community spouse living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)

(10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.

(11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report when health insurance coverage begins, or when their living or mailing address changes, within ten calendar days.

76.15(2) *Report of changes for eligibility on or after January 1, 2014.* A change in circumstance that may affect the eligibility of applicants and members must be reported within ten days of the date the change occurred. Changes required to be reported are described in this subrule.

a. In coverage groups for which Medicaid eligibility is determined using the modified adjusted gross income methodology, any change in the following must be reported:

- (1) Income from all sources.
- (2) Members of the household.
- (3) School attendance.
- (4) Mailing or living address.
- (5) Receipt of a social security number.
- (6) Health insurance premiums or coverage.
- (7) Alien or citizenship status.

b. In coverage groups for which Medicaid eligibility is not determined using the modified adjusted gross income methodology, any change in the following must be reported. EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

- (1) Income from all sources.
- (2) Resources.
- (3) Members of the household.
- (4) Recovery from disability.
- (5) Mailing or living address.
- (6) Health insurance premiums or coverage.
- (7) Medicare premiums or coverage.
- (8) Receipt of social security number.

(9) Gross income of the community spouse or of the dependent children, parents, or siblings of the institutionalized or community spouse who are living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)

(10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.

(11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report changes in their health insurance coverage and changes in their living or mailing address.

d. Individuals receiving Medicaid based on the receipt of Title IV-E-funded foster care or based on an adoption assistance agreement are required to report changes in health insurance coverage, when their living or mailing address changes, receipt of a social security number, and termination of the adoption assistance agreement.

e. Individuals receiving state-only funded Medicaid are required to report any change in the following:

- (1) Income from all sources.
- (2) Mailing or living address.
- (3) Receipt of a social security number.

- (4) Health insurance coverage.
- (5) Alien or citizenship status.

76.15(3) Failure to report. When a change is not reported as required by this rule, any Medicaid expenditures for care or services provided when the member was not eligible shall be considered an overpayment and subject to recovery from the member.

441—76.16(249A) Action on information received. When a change in circumstance is reported, or when a change in a member's circumstances otherwise comes to the attention of the department, its effect on eligibility shall be evaluated and eligibility shall be redetermined regardless of whether the report of change was required by rule 441—76.15(249A). When the department has information about an anticipated change in a member's circumstances that may affect eligibility, eligibility will be redetermined at the appropriate time based on such change.

76.16(1) After assistance has been approved, except as provided in subrule 76.13(1), action based on a change reported during a month shall be effective the first day of the next calendar month unless timely notice of adverse action is required as specified in 441—subrule 7.7(1).

76.16(2) When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first day of the month in which the request was made unless otherwise specified at rule 441—76.12(249A).

76.16(3) When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.17(249A).

441—76.17(249A) Automatic redetermination of eligibility. Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, an automatic redetermination of eligibility for other Medicaid coverage groups shall be made. If the reason for ineligibility under the initial coverage group pertained to a condition of eligibility which applies to all coverage groups, such as failure to cooperate, no further redetermination shall be required. When the redetermination is completed, the member shall be notified of the decision in writing. The redetermination process shall be completed as follows:

76.17(1) Information received by the tenth of the month. If information that creates ineligibility under the current coverage group is received in the department by the tenth of the month, the redetermination process shall be completed by the end of that month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group shall be the first day of the month following the month in which the information is received.

76.17(2) Information received after the tenth of the month. If information that creates ineligibility under the current coverage group is received in the department after the tenth of the month, the redetermination process shall be completed by the end of the following month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group shall be the first day of the second month following the month in which the information is received.

76.17(3) Change in federal law. If a change in federal law affects the eligibility of large numbers of Medicaid members and the Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR § 435.1003 as amended to January 13, 1997, the redetermination process shall be completed within the extended time limit and the effective date of cancellation for the current coverage group shall be no later than the first day of the month following the month in which the extended time limit expires.

These rules are intended to implement Iowa Code sections 249.3, 249.4, 249A.3, and 249A.4.