CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

PREAMBLE

These rules define and structure the department of human services healthy and well kids in Iowa (HAWK-I) program. The purpose of this program is to provide transitional health and dental care coverage to uninsured children who are ineligible for Title XIX (Medicaid) assistance. The program is implemented and administered in compliance with Title XXI of the federal Social Security Act. The rules establish requirements for the third-party administrator responsible for the program administration and for the participating health and dental plans that will be delivering services to the enrollees.

441—86.1(514I) Definitions.

"Applicant" shall mean all parents, spouses, and children under the age of 19 who are counted in the HAWK-I family size and who are listed on the application or renewal form.

"Benchmark benefit package for health care coverage" shall mean any of the following:

1. The standard Blue Cross Blue Shield preferred provider option service benefit plan, described in and offered under 5 U.S.C. Section 8903(1).
2. A health benefits coverage plan that is offered and generally available to state employees in this state.
3. The plan of a health maintenance organization, as defined in 42 U.S.C. Section 300e, with the largest insured commercial, nonmedical assistance enrollment of covered lives in the state.

"Capitation rate" shall mean the fee the department pays monthly to a participating health or dental plan for each enrollee for the provision of covered medical or dental services whether or not the enrollee received services during the month for which the fee is intended.

"Contract" shall mean the contract between the department and the person or entity selected as the third-party administrator or the contract between the department and the participating health or dental plan for the provision of medical or dental services to HAWK-I enrollees for whom the participating health or dental plans assume risk.

"Cost sharing" shall mean the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act and Iowa Code section 514I.10.

"Covered services" shall mean all or a part of those medical and dental services set forth in rule 441—86.14(514I).

"Dentist" shall mean a person who is licensed to practice dentistry.

"Department" shall mean the Iowa department of human services.

"Director" shall mean the director of the Iowa department of human services.

"Earned income" means the earned income of all parents, spouses, and children under the age of 19 who are not students who are living together in accordance with subrule 86.2(3). Income shall be countable earned income when a person produces it as a result of the performance of services. "Earned income" includes:

1. All income in the form of a salary, wages, tips, bonuses, and commissions earned as an employee, and
2. The net profit from self-employment determined by comparing gross income produced from self-employment with the allowable costs of producing the income. The allowable costs of producing self-employment income shall be determined by the costs allowed for income tax purposes. Additionally, the cost of depreciation of capital assets identified for income tax purposes shall be allowed as a cost of doing business for self-employed persons. Losses from a self-employment enterprise may not be used to offset income from any other source.

"Eligible child" shall mean an individual who meets the criteria for participation in the HAWK-I program as set forth in rule 441—86.2(514I).

"Emergency dental condition" shall mean an oral condition that occurs suddenly and creates an urgent need for professional consultation or treatment. Emergency conditions may include hemorrhage, infection, pain, broken teeth, knocked-out teeth, or other trauma.

"Emergency medical condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

"Emergency services" shall mean, with respect to an individual enrolled with a plan, covered inpatient and outpatient services which are furnished by a provider qualified to furnish these services and which are needed to evaluate and stabilize an emergency medical or dental condition.

"Enrollee" shall mean a child who has been determined eligible for the program and who has been enrolled with a participating health plan.

"Family" shall mean all parents, spouses, and children under the age of 19 who are counted in the HAWK-I family size.

"Federal poverty level" shall mean the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

"Good cause" shall mean the family has demonstrated that one or more of the following conditions exist:

1. There was a serious illness or death of the enrollee or a member of the enrollee's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. There was a reason beyond the enrollee's control.
4. There was a failure to receive the third-party administrator's request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

"Gross countable income" means gross income minus exemptions permitted by paragraph 86.2(2)*"b."*

"Gross income" means a combination of the following:

1. Earned income,
2. Unearned income, and
3. Recurring lump-sum income prorated over the time the income is intended to cover.

"HAWK-I board" or *"board"* shall mean the entity that adopts rules, establishes policy, and directs the department regarding the HAWK-I program.

"HAWK-I program" or *"program"* shall mean the healthy and well kids in Iowa program implemented in this chapter to provide health and dental care coverage to eligible children.

"Health insurance coverage" shall mean health insurance coverage as defined in 45 CFR Section 144.103, as amended to October 1, 2008.

"Institution for mental diseases" shall mean a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services as defined at 42 CFR Section 435.1009 as amended November 10, l994.

"Nonmedical public institution" shall mean an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined in 42 CFR Section 435.1009 as amended November 10, l994.

"Participating dental plan" shall mean any entity licensed by the division of insurance of the department of commerce to provide dental insurance in Iowa that has contracted with the department to provide dental insurance coverage to eligible children under this chapter.

"Participating health plan" shall mean any entity licensed by the division of insurance of the department of commerce to provide health insurance in Iowa or an organized delivery system licensed by the director of public health that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

"Physician" shall be defined as provided in Iowa Code subsection 135.1(4).

"Provider" shall mean an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical or dental care or services to an enrollee pursuant to the HAWK-I program.

"Recurring lump-sum income" means earned and unearned lump-sum income that is received on a regular basis. These payments may include, but are not limited to:

1. Annual bonuses.
2. Lottery winnings that are paid out annually.

"Regions" shall mean the six regions of the state as follows:

- Region 1: Lyon, Osceola, Dickinson, Emmet, Sioux, O'Brien, Clay, Palo Alto, Plymouth, Cherokee, Buena Vista, Woodbury, Ida, Sac, Monona, Crawford, and Carroll.
- Region 2: Kossuth, Winnebago, Worth, Mitchell, Howard, Hancock, Cerro Gordo, Floyd, Pocahontas, Humboldt, Wright, Franklin, Calhoun, Webster, Hamilton, Hardin, Greene, Boone, Story, Marshall, and Tama.
- Region 3: Winneshiek, Allamakee, Chickasaw, Fayette, Clayton, Butler, Bremer, Grundy, Black Hawk, Buchanan, Delaware, Dubuque, Jones, Jackson, Cedar, Clinton, and Scott.
- Region 4: Harrison, Shelby, Audubon, Pottawattamie, Cass, Mills, Montgomery, Fremont, and Page.
- Region 5: Guthrie, Dallas, Polk, Jasper, Adair, Madison, Warren, Marion, Adams, Union, Clarke, Lucas, Taylor, Ringgold, Decatur, and Wayne.
- Region 6: Benton, Linn, Poweshiek, Iowa, Johnson, Muscatine, Mahaska, Keokuk, Washington, Louisa, Monroe, Wapello, Jefferson, Henry, Des Moines, Appanoose, Davis, Van Buren, and Lee.

"Self-employed" means that a person satisfies any of the following conditions:

1. The person is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions; or
2. The person establishes the person's own working hours, territory, and methods of work; or
3. The person files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

"Third-party administrator" shall mean the person or entity with which the department contracts to provide administrative services for the HAWK-I program.

"Unearned income" means cash income of all parents, spouses, and children under the age of 19 who are living together in accordance with subrule 86.2(3) that is not gained by labor or service. The available unearned income shall be the amount remaining after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes) and any reasonable income-producing costs. Examples of unearned income include, but are not limited to:

1. Social security benefits, meaning the amount of the entitlement before withholding of a Medicare premium.
2. Child support and alimony payments received for a member of the family.
3. Unemployment compensation.
4. Veterans benefits.

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441—86.2(514I) Eligibility factors. The decision with respect to eligibility shall be based primarily on information furnished by the applicant, the enrollee, or a person acting on behalf of the applicant or enrollee. A child must meet the following eligibility factors to participate in the HAWK-I program.

86.2(1) *Age.* The child shall be under 19 years of age. Eligibility for the program ends the first day of the month following the month of the child's nineteenth birthday.

86.2(2) *Income.*

a. Gross countable income. In determining initial and ongoing eligibility for the HAWK-I program, gross countable income shall not exceed 300 percent of the federal poverty level for a family of the same size.

b. Exempt income. The following shall not be counted toward the income limit when establishing eligibility for the HAWK-I program.

(1) Nonrecurring lump sum income. Nonrecurring lump sum income is income that is not expected to be received more than once. These payments may include, but are not limited to:

1. An inheritance.
2. A one-time bonus.
3. Lump sum lottery winnings.
4. Other one-time payments.

(2) Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

(3) The value of benefits issued in the Food Assistance Program.

(4) The value of the United States Department of Agriculture donated foods (surplus commodities).

(5) 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.

(6) Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

(7) Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

(8) 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.

(9) Interest and dividend income.

(10) Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe.

(11) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program.

(12) 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.

(13) Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

(14) Experimental housing allowance program payments.

(15) The income of a Supplemental Security Income (SSI) recipient.

(16) Income of an ineligible child if the family chooses not to include the child in the eligibility determination in accordance with the provisions of paragraph 86.2(3)*"c."*

(17) Income in kind.

(18) Family support subsidy program payments.

(19) All earned and unearned educational funds of an undergraduate or graduate student or a person in training. However, any additional amount of educational funds received for the person's dependents that are in the eligible group shall be considered as nonexempt income.

(20) Bona fide loans.

(21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

(22) Payment 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.

(23) 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.

(24) Payments received from the Radiation Exposure Compensation Act.

(25) Reimbursements from a third party or from an employer for job-related expenses.

(26) Payments received for providing foster care when the family is operating a licensed foster home.

(27) Any payments received as a result of an urban renewal or low-cost housing project from any governmental agency.

(28) Retroactive corrective payments.

(29) The training allowance issued by the division of vocational rehabilitation, department of education.

(30) Payments from the PROMISE JOBS program.

(31) The training allowance issued by the department for the blind.

(32) Payments from passengers in a car pool.

(33) Compensation in lieu of wages received by a child under the Job Training Partnership Act of 1982.

(34) Any amount for training expenses included in a payment issued under the Job Training Partnership Act of 1982.

(35) Earnings of a child under the age of 19 who is a full-time student as defined at 441—75.54(1)*"b"*(1) and (2).

(36) Incentive payments received from participation in the adolescent pregnancy prevention programs.

(37) Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complementary assistance by federal regulations.

(38) Incentive allowance payments received from the work force investment project, provided the payments are considered complementary assistance by federal regulation.

(39) Honorarium income and all moneys paid to an eligible family in connection with the welfare reform longitudinal study.

(40) Family investment program (FIP) benefits.

(41) Moneys received through pilot self-sufficiency grants or diversion programs.

(42) Income that has ended as of the date of application.

(43) Any income restricted by law or regulation that is paid to a representative payee living outside the home, other than to a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.

(44) A federal or state earned income tax credit, regardless of whether the payment is received with the regular paycheck or as a lump sum with the federal or state income tax refund.

(45) All earnings received by temporary workers from the U.S. Bureau of the Census.

c. Verification of income. Income shall be verified using the best information available. For example, earnings from the 30 days before the date of application may be used to verify earned income if it is representative of the income expected in future months.

(1) Pay stubs, tip records, tax records and employers' statements are acceptable forms of verification of earned income.

(2) Unearned income shall be verified through data matches when possible, award letters, warrant copies, or other acceptable means of verification.

(3) Self-employment income shall be verified using business records or income tax returns from the previous year if they are representative of anticipated earnings. If business records or tax returns from the previous year are not representative of anticipated earnings, an average of the business records or tax returns from the previous two or three years may be used if that average is representative of anticipated earnings.

(4) When a child who has been determined ineligible for Medicaid is referred to the HAWK-I program, the third-party administrator shall use the income amount used by the Medicaid program unless rules in this chapter require the income to be treated differently.

d. Changes in income. Once initial eligibility is established, changes in income during the 12-month enrollment period shall not affect the child's eligibility to participate in the HAWK-I program. However, if income has decreased, the family may request a review of their income to establish whether they are required to continue paying a premium in accordance with rule 441—86.8(514I).

86.2(3) *Family size.* For purposes of establishing initial and ongoing eligibility under the HAWK-I program, the family size shall consist of all persons living together who are children under the age of 19 or who are parents of those children as defined below.

EXCEPTION: Persons who are receiving Supplemental Security Income (SSI) under Title XVI of the Social Security Act or who are voluntarily excluded in accordance with the provisions of paragraph *"c"* below are not considered in determining family size.

a. Children. A child under the age of 19 and any siblings under the age of 19 of whole or half blood or adoptive shall be considered together unless the child is emancipated due to marriage, in which case, the emancipated child is not included in the family size unless the marriage has been annulled. Emancipated children, their spouses, and children who live with parents or siblings of the emancipated child shall be considered as a separate family when establishing eligibility for the HAWK-I program.

b. Parents. Any parent living with the child under the age of 19 shall be included in the family size. This includes the biological parent, stepparent, or adoptive parent of the child and is not dependent upon whether the parents are married to each other. In situations where the parents do not live together but share joint physical custody of the children, the family size shall be based on the household in which the child spends the majority of time. If both parents share physical custody equally, either parent may apply on behalf of the child and the family size shall be based on the household of the applying parent.

c. Persons who may be excluded when determining family size. If including a child in the family size causes siblings to be ineligible, the family may choose not to count the child in the family size. However, this rule shall not apply when the child is receiving Supplemental Security Income (SSI) benefits because SSI recipients are not counted in determining family size for the purposes of HAWK-I eligibility.

d. Temporary absence from the home. The following policies shall be applied to any person who would be counted in the family size in accordance with paragraphs *"a"* and *"b"* who is temporarily absent from the home.

(1) When a person is absent from the home to secure education or training (e.g., the person is attending college), the person shall be included when establishing the size of the family at home and, if otherwise eligible, shall be covered under the program.

(2) When a person is absent from the home to secure medical care, the person shall be included when establishing the size of the family at home and, if otherwise eligible, shall be covered under the program when the reason for the absence is expected to last less than 12 months.

(3) When a person is absent from the home because the person is an inmate in a nonmedical public institution (e.g., a penal institution) in accordance with the provisions of subrule 86.2(9), the person shall be included when establishing the size of the family at home if the absence is expected to be less than three months. However, when the person is a child under the age of 19, coverage under the program shall not be provided pursuant to subrule 86.2(10) until the child returns to the home.

(4) When a child is absent from the home because the child is in foster care, the child shall not be included when establishing the size of the family at home.

(5) When a child is absent from the home for a vacation or a visit to an absent parent, for example, the child shall be included in establishing the size of the family at home and, if otherwise eligible, shall be covered under the program if the absence is expected to be less than three months.

86.2(4) *Uninsured status.* The child must be uninsured.

a. A child who is currently enrolled in an individual or group health plan is not eligible to participate in the HAWK-I program. However, a child who is enrolled in a plan shall not be considered insured for purposes of the HAWK-I program if:

(1) The plan provides coverage only for a specific disease or service (such as a vision, dental, or cancer policy), or

(2) The child does not have reasonable geographic access to care under that plan. "Reasonable geographic access" means that the plan or an option available under the plan does not have service area limitations or, if the plan has service area limitations, the child lives within 30 miles or 30 minutes of a network primary care provider.

b. A child whose health insurance ends in the month of application shall be considered uninsured for purposes of HAWK-I eligibility. However, a one-month waiting period may be imposed pursuant to subrule 86.5(1) for a child who is subject to a monthly premium pursuant to paragraph 86.8(2)*"c."*

c. American Indian and Alaska Native. American Indian and Alaska Native children are eligible for the HAWK-I program on the same basis as other children in the state, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care.

86.2(5) *Ineligibility for Medicaid.* The child shall not be receiving Medicaid or eligible to receive Medicaid if application were made except when the child would be required to meet a spenddown under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

a. A child who would be eligible for Medicaid except for the parent's failure or refusal to cooperate in establishing initial or ongoing eligibility shall not be eligible for coverage under the HAWK-I program.

b. Children who are excluded from the Medicaid household due to the income or resources of the child may participate in the HAWK-I program if otherwise eligible.

86.2(6) *Iowa residency.* The child shall be a resident of the state of Iowa. A resident of Iowa is a person:

a. Who is living in Iowa voluntarily with the intention of making that person's home in Iowa and not for a temporary purpose; or

b. Who, at the time of application, is not receiving assistance from another state and entered Iowa with a job commitment or to seek employment or who is living with parents or guardians who entered Iowa with a job commitment or to seek employment.

86.2(7) *Citizenship and alien status.* The child shall be a citizen or lawfully admitted alien. The criteria established under 441—subrule 75.11(2) shall be followed when determining whether a lawfully admitted alien child is eligible to participate in the HAWK-I program.

a. The citizenship or alien status of the parents or other responsible person shall not be considered when determining the eligibility of the child to participate in the program.

b. As a condition of eligibility for HAWK-I:

(1) All applicants shall attest to their citizenship status by signing the application form, which contains a citizenship declaration. EXCEPTION: Applicants applying pursuant to subrule 86.3(6) shall instead complete and sign Form 470-2549, Statement of Citizenship Status.

(2) When a child under the age of 19 is not living independently, the child's parent or other responsible person with whom the child lives shall be responsible for attesting to the child's citizenship or alien status and for providing any required proof of the status.

c. Except as provided in 441—paragraph 75.11(2)*"f,"* applicants or enrollees for whom an attestation of United States citizenship has been made pursuant to paragraph 86.2(7)*"b"* shall present satisfactory documentation of citizenship or nationality as defined in 441—paragraphs 75.11(2)*"d," "e," "g,"* and *"h."*

d. An applicant or enrollee shall have a reasonable period to obtain and provide proof of citizenship and nationality. For the purposes of this requirement, the "reasonable period" begins on the date a written request to obtain and provide proof is issued to an applicant or enrollee and continues to the date the proof is provided or to the ninetieth calendar day from the date the written request was issued.

e. Eligibility for HAWK-I shall be approved for applicants for one reasonable period as described in paragraph 86.2(7)*"d."*

(1) The reasonable period shall begin no earlier than the first day of the month following the month in which a valid application is received and shall continue until the end of the month in which the ninetieth day occurs or until acceptable documentary evidence is provided, whichever is earlier. However, coverage may be canceled before the end of the reasonable period when another eligibility requirement is not met.

(2) For the purposes of HAWK-I eligibility, an applicant who received coverage during a reasonable period as a Medicaid applicant shall not be granted coverage pursuant to this paragraph for a second reasonable period.

f. Failure to provide acceptable documentary evidence by the ninetieth calendar day from the date the written request was issued pursuant to paragraph 86.2(7)*"d"* shall be the basis for cancellation of coverage under HAWK-I for the child.

g. Failure to provide acceptable documentary evidence for a child shall not affect the eligibility of other children in the family for whom acceptable documentary evidence has been provided.

86.2(8) *Dependents of state of Iowa employees.* The child shall not be eligible for the HAWK-I program if the child is eligible for health insurance coverage as a dependent of a state of Iowa employee unless the state contributes only a nominal amount toward the cost of dependent coverage. "Nominal amount" shall mean $10 or less per month.

86.2(9) *Inmates of nonmedical public institutions.* The child shall not be an inmate of a nonmedical public institution as defined at 42 CFR Section 435.1009 as amended November 10, l994.

86.2(10) *Inmates of institutions for mental disease.* At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental disease as defined at 42 CFR Section 435.1009 as amended November 10, l994.

86.2(11) *Preexisting conditions.* The child shall not be denied eligibility based on the presence of a preexisting medical or dental condition.

86.2(12) *Furnishing a social security number.*

a. As a condition of eligibility, a social security number or proof of application for the number if the number has not been issued or is not known must be furnished for a child for whom coverage under HAWK-I is being requested or received.

(1) When proof of application for a social security number has been provided, the number must be reported upon receipt.

(2) The requirement to provide a social security number does not apply if the person refuses to obtain a social security number because of well-established religious objections. The term "well-established religious objections" means that the person is a member of a recognized religious sect or a division of a recognized religious sect and adheres to the tenets or teachings of the sect or division, and for that reason is conscientiously opposed to applying for or using a national identification number.

b. Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of a social security number when the applicant or enrollee is cooperating in providing information necessary for issuance of the number.

c. The mother of a newborn child shall have until the second month following the mother's discharge from the hospital to apply for a social security number for the child.

d. A social security number may be requested for a person in the family for whom coverage under HAWK-I is not being requested or received, but provision of the number shall not be a condition of eligibility for the applicant or enrollee.

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441—86.3(514I) Application process.

86.3(1) *Who may apply.* Each person wishing to do so shall have the opportunity to apply without delay. When the request is made in person, the requester shall immediately be given an application form. When a request is made that the application form be mailed, it shall be sent in the next outgoing mail.

a. Child lives with parents. When the child lives with the child's parents, including stepparents and adoptive parents, the parent shall file the application on behalf of the child unless the parent is unable to do so.

If the parent is unable to act on the child's behalf because the parent is incompetent or physically disabled, another person may file the application on behalf of the child. The responsible person shall be a family member, friend or other person who has knowledge of the family's financial affairs and circumstances and a personal interest in the child's welfare or a legal representative such as a conservator, guardian, executor or someone with power of attorney. The responsible person shall sign the application form and assume the responsibilities of the incompetent or disabled parent in regard to the application process and ongoing eligibility determinations.

b. Child lives with someone other than a parent. When the child lives with someone other than a parent (e.g., another relative, friend, guardian), the person who has assumed responsibility for the care of the child may apply on the child's behalf. This person shall sign the application form and assume

responsibility for providing all information necessary to establish initial and ongoing eligibility for the child.

c. Child lives independently or is married. When a child under the age of 19 lives in an independent living situation or is married, the child may apply on the child's own behalf, in which case, the child shall be responsible for providing all information necessary to establish initial and ongoing eligibility. If the child is married, both the child and the spouse shall sign the application form.

86.3(2) *Application form.* An application for the HAWK-I program shall be submitted on Comm. 156, HAWK-I Application, or on Form 470-4016, HAWK-I Electronic Application Summary and Signature, unless the family applies for the Medicaid program first.

a. When an application has been filed for the Medicaid program in accordance with the provisions of rule 441—76.1(249A) and Medicaid eligibility does not exist in accordance with the provisions of rule 441—75.1(249A), or the family must meet a spenddown in accordance with the provisions of 441—subrule 75.1(35) before the child can attain eligibility, the Medicaid application shall be used to establish eligibility for the HAWK-I program in lieu of the HAWK-I Application, Comm. 156, or Form 470-4016, HAWK-I Electronic Application Summary and Signature.

b. Applications may be obtained by telephoning the toll-free telephone number of the third-party administrator or by accessing the Web site at www.hawk-i.org.

86.3(3) *Place of filing.* An application for the HAWK-I program shall be filed with the third-party administrator responsible for making the eligibility determination. Any local or area office of the department of human services, disproportionate share hospital, federally qualified health center, other facilities in which outstationing activities are provided, school nurse, Head Start, maternal and child health center, WIC office, or other entity may accept the application. However, all applications shall be forwarded to the third-party administrator.

86.3(4) *Application filing date.*

a. Date of filing. The application is considered filed on the date an identifiable application is received by the third-party administrator or the department. An identifiable application is an application containing a legible name, address, and signature.

b. Applications received after business hours. When an application is received after business hours, it will be considered received on the next business day.

c. Medicaid applications referred to the HAWK-I program. When the family has applied for Medicaid first and the department makes a referral to the third-party administrator, the date the Medicaid application was originally filed with the department shall be the filing date.

86.3(5) *Right to withdraw application.* After an application has been filed, the applicant may withdraw the application at any time prior to the eligibility determination. Requests for voluntary withdrawal of the application shall be documented, and the applicant shall be sent a notice of decision confirming the request.

86.3(6) *Application not required.*

a. An application shall not be required when a child becomes ineligible for Medicaid and the local office of the department makes a referral to the HAWK-I program.

(1) A referral to the HAWK-I program pursuant to subrule 86.4(3) or 86.4(4) shall be accepted in lieu of an application.

(2) The original Medicaid application or the last review form that is on file in the local office of the department, whichever is more current, shall suffice to meet the signature requirements.

b. A new application shall not be required when an eligible child is added to an existing HAWK-I eligible group.

c. A new application shall not be required when a child moves between supplemental dental-only coverage as specified in rule 441—86.20(514I) and full medical and dental coverage.

86.3(7) *Information and verification procedure.* The decision with respect to eligibility shall be based primarily on information furnished by the applicant, enrollee, or person acting on behalf of the applicant or enrollee.

a. The third-party administrator shall notify the applicant, enrollee, or person acting on behalf of the applicant or enrollee in writing of additional information or verification that is required to establish eligibility. The third-party administrator shall provide this notice personally, by mail, or by facsimile.

b. Failure to supply the information or verification or refusal to authorize the third-party administrator to secure the information shall serve as a basis for rejection of the application or cancellation of coverage. If the requested information or authorization is received within 14 calendar days of the notice of decision on an application or within 14 calendar days of the effective date of cancellation for enrollees, the information or authorization shall be acted upon as though it had been provided timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant or enrollee shall have until the next business day to provide the information.

c. The applicant, enrollee, or person acting on behalf of the applicant or enrollee shall have ten working days to supply the information or verification requested by the third-party administrator. The third-party administrator may extend the deadline for a reasonable period when the applicant, enrollee, or person acting on behalf of the applicant or enrollee is making every effort but is unable to secure the required information or verification from a third party.

86.3(8) *Time limit for decision.* The third-party administrator shall make a decision regarding the applicant's eligibility to participate in the HAWK-I program within ten working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed within the period for a reason that is beyond the control of the third-party administrator.

a. EXCEPTION: When the application is referred for a Medicaid eligibility determination and Medicaid eligibility is denied, the third-party administrator shall determine HAWK-I eligibility no later than ten working days from the date the administrator receives the notice of Medicaid denial unless additional verification is needed.

b. "Day one" of the ten-day period shall mean the first working day following the date of receipt of a completed application and all necessary information and verification.

86.3(9) *Applicant cooperation.* An applicant must cooperate with the third-party administrator in the application process, which may include providing verification or signing documents. Failure to cooperate with the application process shall serve as basis for a denial of the application.

86.3(10) *Waiting lists.* When the department has established that all of the funds appropriated for this program are obligated, the third-party administrator shall deny all subsequent applications for HAWK-I coverage unless Medicaid eligibility exists.

a. The third-party administrator shall mail a notice of decision. The notice shall state that:

(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or

(2) The person does not meet eligibility requirements. In which case, the applicant shall not be put on a waiting list.

b. Prior to an applicant's being denied or placed on the waiting list, the third-party administrator shall refer the application to the Medicaid program for an eligibility determination. If Medicaid eligibility exists, the department shall approve the child for Medicaid coverage in accordance with 441—86.4(514I).

c. The third-party administrator shall enter applicants on the waiting list on the basis of the date an identifiable application form specified in subrule 86.3(2) is date-stamped by the third-party administrator. An identifiable application is an application containing a legible name, address, and signature.

(1) In the event that more than one application is received on the same day, the third-party administrator shall enter applicants on the waiting list on the basis of the day of the month of the oldest child's birthday, the lowest number being first on the list.

(2) The third-party administrator shall decide any subsequent ties by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, the third-party administrator shall select applicants from the waiting list based on the order in which their names appear on the list and shall notify them of their selection.

e. After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant's continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within 15 working days, the third-party administrator shall delete the applicant's name from the waiting list and shall contact the next applicant on the waiting list.

86.3(11) *Falsification of information.* Rescinded IAB 11/19/08, effective 1/1/09.

86.3(12) *Applications pended due to unavailability of a plan.* When there is no participating health plan in the applicant's county of residence, the application shall be held until a plan is available. The application shall be processed when a plan becomes available and coverage shall be effective the first day of the month the plan becomes available.

[**ARC 8580B**, IAB 3/10/10, effective 3/1/10; **ARC 9083B**, IAB 9/22/10, effective 9/1/10; **ARC 0552C**, IAB 1/9/13, effective 4/1/13]

441—86.4(514I) Coordination with Medicaid.

86.4(1) *HAWK-I applicant appears eligible for Medicaid.* At the time of initial application, if it appears the child may be eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), a referral shall be made by the third-party administrator to the department for a determination of Medicaid eligibility as follows:

a. The original Healthy and Well Kids in Iowa (HAWK-I) Application, Form 470-3526, or Form 470-4016, HAWK-I Electronic Application Summary and Signature Page, and copies of any accompanying information and verification shall be forwarded to the department within 24 hours, or the next working day, whichever is sooner. The third-party administrator shall maintain a copy of all documentation sent to the department and a log to track the disposition of all referrals.

b. The third-party administrator shall notify the family that the referral has been made. The third-party administrator shall return to the family any original verification and information that was submitted with the application and retain a copy in the file record.

c. The referral shall be considered an application for Medicaid in accordance with the provisions of rule 441—76.1(249A). The time limit for processing the referred application begins with the date the Healthy and Well Kids in Iowa (HAWK-I) Application, Form 470-3526, or Form 470-4016, HAWK-I Electronic Application Summary and Signature Page, is date-stamped as being received by the third-party administrator.

86.4(2) *HAWK-I enrollee appears eligible for Medicaid.* At the time of the annual review, if it appears the child may be eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the third-party administrator shall make a referral to the department for a determination of Medicaid eligibility as stated in subrule 86.4(1) above. However, the child shall remain eligible for the HAWK-I program pending the Medicaid eligibility determination unless the 12-month certification period expires first.

86.4(3) *Medicaid applicant not eligible.* If a child is not eligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), or is voluntarily excluded from the Medicaid eligible group under the provisions of 441—75.59(249A) and meets the criteria specified at 86.2(5), the department shall make a referral to the third-party administrator for an eligibility determination under the HAWK-I program as follows:

a. The department worker shall submit an electronic referral to the HAWK-I program or complete Form 470-3563, Referral to HAWK-I, and send the form and a copy of the Medicaid notice of decision to the third-party administrator.

b. The third-party administrator shall date-stamp Form 470-3563 with the date the completed form is received.

c. The third-party administrator shall notify the family of the referral and proceed with an eligibility determination under the HAWK-I program.

d. The period for processing the referral begins with the day on which:

(1) Form 470-3563, Referral to HAWK-I, is date-stamped as received by the third-party administrator; or

(2) The third-party administrator receives the electronic referral file.

86.4(4) *Medicaid member becomes ineligible.* If a child becomes ineligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), or is voluntarily excluded from the Medicaid eligible group under the provisions of rule 441—75.59(249A) and meets the criteria specified at subrule 86.2(5), the department shall make a referral to the third-party administrator for an eligibility determination under the HAWK-I program as follows:

a. The department worker shall submit an electronic referral to the HAWK-I program or complete Form 470-3563, Referral to HAWK-I, and send the form and a copy of the Medicaid notice of decision to the third-party administrator.

b. The third-party administrator shall:

(1) Date-stamp Form 470-3563 with the date the completed form is received;

(2) Notify the family of the referral; and

(3) Proceed with an eligibility determination under the HAWK-I program.

c. The period for processing the referral begins with the day on which:

(1) Form 470-3563, Referral to HAWK-I, is date-stamped as received by the third-party administrator; or

(2) The third-party administrator receives the electronic referral file.

441—86.5(514I) Effective date of coverage.

86.5(1) *Initial application.* Coverage for a child who is determined eligible for the HAWK-I program on the basis of an initial application for either HAWK-I or Medicaid shall be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed, or when a plan becomes available in the applicant's county of residence. However, when the child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost. Also, a one-month waiting period shall be imposed for a child who is subject to a monthly premium pursuant to paragraph 86.8(2)*"c"* when the child's health insurance coverage ended in the month of application. EXCEPTIONS: A waiting period shall not be imposed if any of the following conditions apply:

a. The child is moving from Medicaid to HAWK-I.

b. The child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.

c. The cost of health insurance coverage for the child exceeds 5 percent of the family's gross income. The cost of health insurance for the child shall be the difference between the premium for coverage with and without the child.

d. The health insurance was provided through an individual plan.

e. The child's health insurance coverage was lost due to:

(1) Domestic violence.

(2) Divorce or death of a parent.

(3) An involuntary loss of employment that qualified the parent for dependent coverage, including but not limited to layoff, business closure, reduction in hours, or termination.

(4) A job change to a new employer that does not offer the parent dependent coverage or that requires a waiting period before children can be enrolled in dependent coverage.

(5) Utilization of the maximum lifetime coverage amount.

(6) Expiration of coverage under COBRA.

(7) Discontinuation of dependent coverage by the parent's employer.

(8) A reason beyond the control of the parent, such as a serious illness of the parent, fire, flood, or natural disaster.

86.5(2) *Referrals from Medicaid.*

a. Cancellation of Medicaid. Coverage for children who are determined eligible for the HAWK-I program on the basis of a referral from Medicaid due to cancellation of Medicaid benefits shall be effective the first day of the month after Medicaid eligibility is lost, regardless of the date of the referral, in order to ensure that there is no break in coverage. However, when such a child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

b. Denial of Medicaid. Coverage for children who are determined eligible for the HAWK-I program on the basis of a referral from Medicaid due to denial of Medicaid benefits shall be effective no earlier than the first day of the month following the month in which the Medicaid application was received in accordance with 441—subrule 76.1(2). However, when such a child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

86.5(3) *Annual renewals.* Coverage for children who are determined eligible for the HAWK-I program on the basis of an annual renewal shall be effective the first day of the month following the month in which the previous enrollment period ended.

86.5(4) *Children added to an existing HAWK-I enrollment period.* Coverage for children who are determined eligible for the HAWK-I program on the basis of a request from the family to add the child to an existing enrollment period shall be effective the first day of the month following the month in which the request was made. However, if the child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost unless the child is subject to a one-month waiting period in accordance with paragraph 86.2(4)*"b."*

[**ARC 8281B**, IAB 11/18/09, effective 12/23/09; **ARC 9083B**, IAB 9/22/10, effective 9/1/10]

441—86.6(514I) Selection of a plan. At the time of initial application, if there is more than one participating health or dental plan available in the child's county of residence, the applicant shall select the health or dental plan in which the applicant wishes to enroll as part of the eligibility process. The enrollee may change plans only at the time of the annual review unless the provisions of subrule 86.7(1) or paragraph 86.6(2)*"a"* apply. The applicant may designate the plan choice verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose but is not required.

86.6(1) *Coverage in another county's health plan.* If a child traditionally travels to another county to receive medical care, the applicant may choose to participate in the health plan available in the county in which the child receives medical care.

86.6(2) *Period of enrollment.* Once enrolled in a health or dental plan, the child shall remain enrolled in the selected health or dental plan for a period of 12 months.

a. Exceptions. A child may be enrolled in a plan for less than 12 months if:

(1) The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child shall be enrolled in the health or dental plan from which the child was originally disenrolled unless the provisions of subrule 86.7(1) apply.

(2) The child is added to an existing enrollment. When a family requests to add an eligible child, the child shall be enrolled for the months remaining in the current enrollment period.

(3) A request to change plans is accepted in accordance with paragraphs 86.6(2)*"b"* and *"c."*

b. Request to change plan. An enrollee may ask to change the health or dental plan:

(1) Within 90 days following the date the initial enrollment was sent to the health or dental plan regardless of the reason for the plan change or whether the original health or dental plan was selected by the applicant or was assigned in accordance with subrule 86.6(3).

(2) At any time for cause. "Cause" as defined in 42 CFR 438.56(d)(2) as amended to May 13, 2010, includes, but is not limited to:

1. The enrollee moves out of the plan's service area.
2. Because of moral or religious objections, the plan does not cover the services the enrollee seeks.

3. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

4. Other reasons including but not limited to poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

c. Response to request.

(1) If the enrollee has not requested to change health or dental plans within 90 days following the date the initial enrollment was sent to the health or dental plan and it is determined that cause does not exist, the request to change plans shall be denied.

(2) All approved changes shall be made prospectively and shall be effective on the first day of the month following the month in which the request was made.

86.6(3) *Failure to select a health or dental plan.* When more than one health or dental plan is available, if the applicant fails to select a health or dental plan within ten working days of the written request to make a selection, the third-party administrator shall select the health or dental plan and notify the family of the enrollment. The third-party administrator shall select the plan on a rotating basis to ensure an equitable distribution between participating health and dental plans.

86.6(4) *Child moves from the service area.* The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating health or dental plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.

86.6(5) *Change at annual review.* If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose. The child shall remain enrolled in the current health or dental plan if the family does not notify the third-party administrator of a new health or dental plan choice by the end of the current 12-month enrollment period.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 9084B**, IAB 9/22/10, effective 9/1/10]

441—86.7(514I) Cancellation. The child's eligibility for the HAWK-I program shall be canceled before the end of the 12-month enrollment period for any of the following:

86.7(1) *Child moves from the service area.* Rescinded IAB 1/13/10, effective 3/1/10.

86.7(2) *Age.* The child shall be canceled from the HAWK-I program as of the first day of the month following the month in which the child attained the age of 19.

86.7(3) *Nonpayment of premiums.* The child shall be canceled from the program as of the first day of the month in which premiums are not paid in accordance with the provisions of subrules 86.8(3), 86.8(4) and 86.8(5).

86.7(4) *Iowa residence abandoned.* The child shall be canceled from the program as of the first day of the month following the month in which the child relocated to another state. Eligibility shall not be canceled when the child is temporarily absent from the state in accordance with the provisions of subrule 86.2(6).

86.7(5) *Eligible for Medicaid.* The child shall be canceled from the program as of the first day of the month following the month in which the third-party administrator is notified of Medicaid eligibility. If there are months during which the child is covered by both the Medicaid and HAWK-I programs, the HAWK-I program shall be the primary payor and Medicaid shall be the payor of last resort.

86.7(6) *Enrolled in other health insurance coverage.* The child shall be canceled from the program as of the first day of the month following the month in which the third-party administrator is notified that the child has other health insurance coverage. If there are months during which the child is covered by both another insurance plan and the HAWK-I program, the other insurance plan shall be the primary payor and HAWK-I shall be the payor of last resort.

86.7(7) *Admission to a nonmedical public institution.* The child shall be canceled from the program as of the first day of the month following the month in which the child enters a nonmedical public institution unless the temporary absence provisions of paragraph 86.2(3)*"d"* apply.

86.7(8) *Admission to an institution for mental disease.* The child shall be canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

86.7(9) *Employment with the state of Iowa.* The child shall be canceled from the HAWK-I program as of the first day of the month in which the child's parent became eligible to participate in a health or dental plan available to state of Iowa employees.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 9083B**, IAB 9/22/10, effective 9/1/10]

441—86.8(514I) Premiums and copayments.

86.8(1) *Income considered.* The countable income considered in determining the premium amount shall be the family's gross countable income minus 20 percent of the family's earned income.

86.8(2) *Premium amount.* Except as specified for supplemental dental-only coverage in subrule 86.20(4), premiums under the HAWK-I program shall be assessed as follows:

a. No premium is charged if:

(1) The eligible child is an American Indian or Alaskan Native; or

(2) The family's countable income is less than 150 percent of the federal poverty level for a family of the same size.

b. If the family's countable income is equal to or exceeds 150 percent of the federal poverty level for a family of the same size but does not exceed 200 percent of the federal poverty level for a family of that size, the premium is $10 per child per month with a $20 monthly maximum per family.

c. If the family's countable income is equal to or exceeds 200 percent of the federal poverty level for a family of the same size, the premium is $20 per child per month with a $40 monthly maximum per family.

86.8(3) *Due date.*

a. Payment upon initial application. "Initial application" means the first program application or a subsequent application that is not a renewal. Upon approval of an initial application, the first month for which a premium is due is the third month following the month of decision. The due date of the first premium shall be the fifth day of the second month following the month of decision.

b. Payment upon renewal. "Renewal" means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

(1) Upon approval of a renewal, the first month for which a premium is due is the first month of the enrollment period. The premium for the first month of the enrollment period shall be due by the fifth day of the month before the month of coverage or the tenth business day following the date of decision, whichever is later.

(2) All premiums due must be paid before the child will be enrolled for coverage. When the premium is received, the third-party administrator shall notify the health and dental plans of the enrollment.

c. Subsequent payments. All subsequent premiums are due by the fifth day of each month for the next month's coverage and must be postmarked no later than the last day of the month before the month of coverage. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

d. Holiday or weekend. When the premium due date falls on a holiday or weekend, the premium shall be due on the first business day following the due date.

86.8(4) *Grace period.* A grace period shall be allowed on any monthly premium not received as prescribed in paragraph 86.8(3)*"c."* The grace period shall be the coverage month for which the premium is due.

a. Failure to submit a premium by the last calendar day of the grace period shall result in disenrollment.

b. If the premium is subsequently received, coverage will be reinstated if the premium was postmarked or otherwise paid:

(1) In the grace period, or

(2) In the 14 calendar days following the grace period.

86.8(5) *Method of premium payment.* Premiums may be submitted in the form of cash, personal checks, electronic funds transfers (EFT), or other methods established by the third-party administrator.

86.8(6) *Failure to pay premium.* Failure to pay the premium in accordance with subrules 86.8(3) and 86.8(5) shall result in cancellation from the program unless the grace period provisions of subrule 86.8(4) apply. Once a child is canceled from the program due to nonpayment of premiums, the family must reapply for coverage.

86.8(7) *Copayment.* There shall be a $25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition.

EXCEPTION: A copayment shall not be imposed when family income is less than 150 percent of the federal poverty level for a family of the same size or when the child is an eligible American Indian or Alaskan Native.

86.8(8) *Unpaid premiums.* Before the child can regain coverage under the program, unpaid premiums owed for coverage received in accordance with subrule 86.8(4) within the past 24 months must be paid in full.

a. Failure to pay the unpaid premiums shall result in denial of the application. EXCEPTION: The unpaid premium obligation shall be reduced to zero if upon reapplication a premium would not be assessed because the household's income is less than 150 percent of the federal poverty level.

b. If no reapplication is filed within 24 months of failing to pay a premium, the debt shall be expunged and shall no longer be owed.

[**ARC 7770B**, IAB 5/20/09, effective 7/1/09; **ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 9083B**, IAB 9/22/10, effective 9/1/10]

441—86.9(514I) Annual reviews of eligibility. All eligibility factors shall be reviewed at least every 12 months to establish ongoing eligibility for the program. "Month one" shall be the first month in which coverage is provided.

86.9(1) *Review form.* The third-party administrator shall send the family Form 470-3526, Healthy and Well Kids in Iowa (HAWK-I) Application, on which the answers, except for income, have been completed based on the information on file. The family shall review the completed information for accuracy and fill in the income section of the form. The family shall be required to provide verification of current income and sign and date the form attesting to its accuracy as part of the review process.

86.9(2) *Failure to provide information.* The child shall not be enrolled for the next 12-month period if the family fails to provide information and verification of income or otherwise fails to cooperate in the annual review process. If the completed review form and any information necessary to establish continued eligibility are received within 14 calendar days of the end of an enrollment period, the review form and information shall be acted upon as though they had been received timely. If the fourteenth calendar day falls on a weekend or state holiday, the enrollee shall have until the next business day to provide the review form and any information necessary to establish continued eligibility.

86.9(3) *Change in plan.* Rescinded IAB 1/13/10, effective 3/1/10.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 8580B**, IAB 3/10/10, effective 3/1/10]

441—86.10(514I) Reporting changes. Changes that may affect eligibility shall be reported timely to the third-party administrator. "Timely" shall mean no later than ten working days after the change occurred. "Day one" of the ten-day period shall mean the first working day following the date of the change. The parent, guardian, or other adult responsible for the child shall report the change. If the child is emancipated, married, or otherwise in an independent living situation, the child shall be responsible for reporting the change.

86.10(1) *Pregnancy.* The pregnancy of a child shall be reported when the pregnancy is diagnosed.

86.10(2) *Entry to a nonmedical public institution.* The entry of a child into a nonmedical public institution, such as a penal institution, shall be reported following entry to the institution.

86.10(3) *Iowa residence is abandoned.* The abandonment of Iowa residence shall be reported following the move from the state.

86.10(4) *Other insurance coverage.* Enrollment of the child in other health insurance coverage shall be reported.

86.10(5) *Employment with the state of Iowa.* The employment of the child's parent with the state of Iowa shall be reported.

86.10(6) *Decrease in income.* If the family reports a decrease in income, the third-party administrator shall ascertain whether the change affects the premium obligation of the family. If the change is such that the family is no longer required to pay a premium in accordance with the provisions of rule 441—86.8(514I), premiums will no longer be charged beginning with the month following the month of the report of the change.

86.10(7) *Failure to report changes.* Rescinded IAB 11/19/08, effective 1/1/09.

86.10(8) *Information reported by a third party.* Information reported by a third party shall not be acted upon until the information is verified in accordance with subrule 86.3(7).

86.10(9) *Cooperation.* The provisions of subrule 86.3(7) shall apply when a request for information or verification is made due to a change. In addition, failure of the enrollee or of the person acting on behalf of the enrollee to provide requested information or verification that may affect eligibility for the program shall result in cancellation and recoupment of all payments made by the department on behalf of the enrollee during the period in question.

86.10(10) *Effective date of change in eligibility.*

a. When a change in circumstances has a positive effect on eligibility, the change in eligibility shall be effective no earlier than the month following the month in which the change in circumstances was reported, regardless of when the change was reported.

b. When a change in circumstances has an adverse effect on eligibility, the change in eligibility shall be effective no earlier than the month following the issuance of a timely notification, in accordance with the provisions of rule 441—86.11(514I). When the change in circumstances was not reported timely, as defined in this rule, benefits shall be recouped beginning with the month following the month in which the change occurred.

c. When an anticipated change in circumstances is reported before the change occurs, no action shall be taken until the change actually occurs and is verified in accordance with the provisions of subrule 86.3(7).

441—86.11(514I) Notice requirements. The applicant shall be provided an adequate written notice of the decision of the third-party administrator regarding the applicant's eligibility for the HAWK-I program. The enrollee shall be notified in writing of any decision that adversely affects the enrollee's eligibility or the amount of benefits. The notice shall be timely and adequate as provided in 441—subrule 7.7(1).

441—86.12(514I) Appeals and fair hearings. If the applicant or enrollee disputes a decision by the third-party administrator to reduce, cancel or deny participation in the HAWK-I program, the applicant or enrollee may appeal the decision in accordance with 441—Chapter 7.

441—86.13(514I) Third-party administrator. The third-party administrator shall have the following responsibilities:

86.13(1) *Determination of eligibility.* The third-party administrator shall determine eligibility in accordance with the provisions of rule 441—86.2(514I).

86.13(2) *Dissemination of application forms and information.* The third-party administrator shall disseminate the following:

a. Rescinded IAB 10/17/01, effective 12/1/01.

b. Outreach materials, application forms, or other materials developed and produced by the department to any organization or individual making a request for the materials. If the request is

for quantities exceeding ten, the third-party administrator shall forward the request to Iowa prison industries for dissemination.

c. Participating health and dental plan information.

d. Other materials as specified by the department.

86.13(3) *Toll-free dedicated customer services line.* The third-party administrator shall maintain a toll-free multilingual dedicated customer service line in accordance with the requirements of the department.

86.13(4) *HAWK-I program web site.* The third-party administrator shall work in cooperation with the department to maintain a web site providing information about the HAWK-I program.

86.13(5) *Application process.* The third-party administrator shall process applications in accordance with the provisions of rule 441—86.3(514I).

a. Processing applications and mailing of approvals and denials shall be completed within ten working days of receipt of the application and all necessary information and verification unless the application cannot be processed within this period for a reason beyond the control of the third-party administrator.

b. Original verification information shall be returned to the applicant or enrollee upon completion of review.

86.13(6) *Tracking of applications.* The third-party administrator shall track and maintain applications. This includes, but is not limited to, the following procedures:

a. Date-stamping all applications with the date of receipt.

b. Screening applications for completeness and requesting in writing any additional information or verification necessary to establish eligibility. All information or verification of information attained shall be logged.

c. Entering all applications received into the data system with an identifier status of pending, approved, or denied.

d. Referring applications to the county office of the department, when appropriate, and receiving application referrals from the department.

e. Rescinded IAB 7/9/03, effective 7/1/03.

f. Notifying the health and dental plans when the number of enrollees who speak the same non-English language equals or exceeds 10 percent of the number of enrollees in the health or dental plan.

86.13(7) *Effective date of coverage.* The third-party administrator shall establish effective date of coverage in accordance with the provisions of rule 441—86.5(514I).

86.13(8) *Selection of health or dental plan.* The third-party administrator shall provide participating health and dental plan information to families of eligible children by telephone or mail and, if necessary, offer unbiased assistance in the selection of a health or dental plan in accordance with the provisions of rule 441—86.6(514I).

86.13(9) *Enrollment.* The third-party administrator shall notify participating health and dental plans of enrollments.

86.13(10) *Disenrollments.* The third-party administrator shall disenroll an enrollee when the enrollee's eligibility for the HAWK-I program is canceled in accordance with the provisions of rule 441—86.7(514I). The third-party administrator shall notify the participating health and dental plans when an enrollee is disenrolled.

86.13(11) *Annual reviews of eligibility.* The third-party administrator shall annually review eligibility in accordance with the provisions of rules 441—86.2(514I) and 441—86.9(514I).

86.13(12) *Acting on reported changes.* The third-party administrator shall ensure that all changes reported by the HAWK-I enrollee in accordance with rule 441—86.10(514I) are acted upon no later than ten working days from the date the change is reported.

86.13(13) *Premiums.* The third-party administrator shall:

a. Calculate premiums in accordance with the provisions of rule 441—86.8(514I).

b. Collect HAWK-I premium payments. The funds shall be deposited into an interest-bearing account maintained by the department for periodic transmission of the funds and any accrued interest to the HAWK-I trust fund in accordance with state accounting procedures.

c. Track the status of the enrollee premium payments and provide the data to the department.

d. Mail a reminder notice to the family if the premium is not received by the due date.

86.13(14) *Notices to families.* The third-party administrator shall develop and provide timely and adequate approval, denial, and cancellation notices to families that clearly explain the action being taken in regard to an application or an existing enrollment. Denial and cancellation notices shall clearly explain the appeal rights of the applicant or enrollee. All notices shall be available in English and Spanish.

86.13(15) *Records.* The third-party administrator shall at a minimum maintain the following records:

a. All records required by the department and the department of inspections and appeals.

b. Records which identify transactions with or on behalf of each enrollee by social security number or other unique identifier.

c. Application, case and financial records.

d. All other records as required by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

86.13(16) *Confidentiality.* The third-party administrator shall protect and maintain the confidentiality of HAWK-I applicants and enrollees in accordance with 441—Chapter 9.

86.13(17) *Reports to the department.* The third-party administrator shall submit reports as required by the department.

86.13(18) *Systems.* The third-party administrator shall maintain data files that are compatible with the department's and the health plans' data files and shall make the system accessible to department staff.
[**ARC 8478B**, IAB 1/13/10, effective 3/1/10]

441—86.14(514I) Covered services. The benefits provided under the HAWK-I program shall meet a benchmark, benchmark equivalent, or benefit plan that complies with Title XXI of the federal Social Security Act.

86.14(1) *Required medical services.* The participating health plan shall cover at a minimum the following medically necessary services:

a. Inpatient hospital services (including medical, surgical, intensive care unit, mental health, and substance abuse services).

b. Physician services (including surgical and medical, and including office visits, newborn care, well-baby and well-child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits).

c. Outpatient hospital services (including emergency room, surgery, lab, and x-ray services and other services).

d. Ambulance services.

e. Physical therapy.

f. Nursing care services (including skilled nursing facility services).

g. Speech therapy.

h. Durable medical equipment.

i. Home health care.

j. Hospice services.

k. Prescription drugs.

l. Rescinded IAB 1/13/10, effective 3/1/10.

m. Hearing services.

n. Vision services (including corrective lenses).

86.14(2) *Abortion.* Payment for abortion shall only be made under the following circumstances:

a. The physician certifies that the pregnant enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the enrollee in danger of death unless an abortion is performed.

b. The pregnancy was the result of an act of rape or incest.

86.14(3) *Required dental services.* Participating dental plans shall cover at a minimum the following necessary dental services:

a. Diagnostic and preventive services.

b. Routine and restorative services.

c. Endodontic services.

d. Periodontal services.

e. Cast restorations.

f. Prosthetics.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10]

441—86.15(514I) Participating health and dental plans.

86.15(1) *Licensure.* The participating health or dental plan must:

a. Be licensed by the division of insurance of the department of commerce to provide health or dental care coverage in Iowa; or

b. Be an organized delivery system licensed by the director of public health to provide health or dental care coverage.

86.15(2) *Services.* The participating health or dental plan shall provide coverage for the services specified in rule 441—86.14(514I) to all children determined eligible by the third-party administrator.

a. The participating health or dental plan shall make services it provides to HAWK-I enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the health or dental plan.

b. Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.

c. If a participating health or dental plan does not provide statewide coverage, the health or dental plan shall participate in every county within the region in which the health or dental plan has contracted to provide services in which it is licensed and in which a provider network has been established. Regions are specified in rule 441—86.1(514I).

86.15(3) *Premium tax.* Premiums paid to participating health and dental plans by the third-party administrator are exempt from premium tax.

86.15(4) *Provider network.* The participating health or dental plan shall establish a network of providers. Providers contracting with the participating health or dental plan shall comply with HAWK-I requirements, which shall include collecting copayments, if applicable.

86.15(5) *Identification cards.* Identification cards shall be issued by the participating health or dental plan to the enrollees for use in securing covered services.

86.15(6) *Marketing.*

a. Participating health and dental plans may not distribute directly or through an agent or independent contractor any marketing materials.

b. All marketing materials require prior approval from the department.

c. At a minimum, participating health and dental plans must provide the following material in writing or electronically:

(1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the HAWK-I enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

(2) All health and dental plan literature and brochures shall be available in English and any other language when enrollment in the health or dental plan by enrollees who speak the same non-English

language equals or exceeds 10 percent of all enrollees in the health or dental plan and shall be made available to the third-party administrator for distribution.

d. All health and dental plan literature and brochures shall be approved by the department.

e. The participating health and dental plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

f. The participating health or dental plan may make marketing presentations at the discretion of the department.

86.15(7) *Appeal process.* The participating health or dental plan shall have a written procedure by which enrollees may appeal issues concerning the health or dental care services provided through providers contracted with the health or dental plan and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of the appeal to the enrollee.

c. Establishes time frames which ensure that appeals be resolved within 60 days, except for appeals which involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.

d. Ensures the participation of persons with authority to take corrective action.

e. Ensures that the decision be made by a physician, dentist, or clinical peer not previously involved in the case.

f. Ensures the confidentiality of the enrollee.

g. Ensures issuance of a written decision to the enrollee for each appeal which shall contain an adequate explanation of the action taken and the reason for the decision.

h. Maintains a log of the appeals which is made available to the department at its request.

i. Ensures that the participating health or dental plan's written appeal procedures be provided to each newly covered enrollee.

j. Requires that the participating health or dental plan make quarterly reports to the department summarizing appeals and resolutions.

86.15(8) *Appeals to the department.* Rescinded IAB 1/13/99, effective 1/1/99.

86.15(9) *Records and reports.* The participating health and dental plans shall maintain records and reports as follows:

a. The health or dental plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the health or dental plan or subcontractor of the health or dental plan, as appropriate, must maintain a medical or dental records system that:

(1) Identifies each medical or dental record by HAWK-I enrollee identification number.

(2) Maintains a complete medical or dental record for each enrollee.

(3) Provides a specific medical or dental record on demand.

(4) Meets state and federal reporting requirements applicable to the HAWK-I program.

(5) Maintains the confidentiality of medical or dental records information and releases the information only in accordance with established policy below:

1. All medical and dental records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, other practitioners, or facilities that are providing services to enrollees under a subcontract with the health or dental plan. This provision also applies to specialty providers who are retained by the health or dental plan to provide services which are infrequently used, which provide a support system service to the operation of the health or dental plan, or which are of an unusual nature. This provision is also intended to waive the need for written consent for department staff and the third-party administrator assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the health or dental plan itself, and other subcontractors which require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, or facilities providing emergency care pursuant to paragraph 86.15(2)*"b."*

4. Written consent is required for the transmission of the medical or dental records information of a former enrollee to any physician or dentist not connected with the health or dental plan.

5. The extent of medical or dental records information to be released in each instance shall be based upon a test of medical or dental necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

6. Medical and dental records maintained by subcontractors shall meet the requirements of this rule.

EXCEPTION: Written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

b. Each health or dental plan shall provide at a minimum reports and plan information to the third-party administrator as follows:

(1) A list of providers of services under the plan.

(2) Encounter data on a monthly basis as required by the department.

(3) Other information as directed by the department.

c. Each health or dental plan shall at a minimum provide reports and health or dental plan information to the department as follows:

(1) Information regarding the plan's appeal process.

(2) A plan for a health improvement program.

(3) Periodic financial, utilization and statistical reports as required by the department.

(4) Time-specific reports which define activity for child health care, appeals and other designated activities which may, at the department's discretion, vary among plans, depending on the services covered or other differences.

(5) Other information as directed by the department.

86.15(10) *Systems.* The participating health or dental plan shall maintain data files that are compatible with the department's and third-party administrator's systems.

86.15(11) *Payment to the participating health or dental plan.*

a. In consideration for all services rendered by a health or dental plan, the health or dental plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical or dental care and services provided to the enrollees.

b. The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

c. The capitation rate does not include any amounts for the recoupment of losses suffered by the health or dental plan for risks assumed under the current or any previous contract. The health or dental plan accepts the rate as payment in full for the contracted services. Any savings realized by the health or dental plan due to lower utilization from a less frequent incidence of health or dental problems among the enrolled population shall be wholly retained by the health or dental plan.

d. If an enrollee has third-party coverage or a responsible party other than the HAWK-I program available for purposes of payment for medical or dental expenses, it is the right and responsibility of the health or dental plan to investigate these third-party resources and attempt to obtain payment. The health or dental plan shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

86.15(12) *Quality assurance.* The health or dental plan shall have in effect an internal quality assurance system.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10]

441—86.16(514I) Clinical advisory committee. Members of the clinical advisory committee established in accordance with the provisions of 441—paragraph 1.10(2)*"c"* shall be appointed to three-year terms. Members may be appointed for more than one term. No more than one-third of the membership of the committee shall rotate off the committee in any given calendar year.

441—86.17(514I) Use of donations to the HAWK-I program. If an individual or other entity makes a monetary donation to the HAWK-I program, the department shall deposit the donation into the HAWK-I trust fund. The department shall track all donations separately and shall not commingle the donations with other moneys in the trust fund. The department shall report the receipt of all donations to the HAWK-I board.

86.17(1) If the donor specifically identifies the purpose of the donation, regardless of the amount, the donation shall be used as specified by the donor as long as the identified purpose is permissible under state and federal law.

86.17(2) If the donation is less than $5,000 and the donor does not specifically identify how it is to be used, the department shall use the moneys in the following order:

a. For the direct benefit of enrollees (e.g., premium payments).

b. For outreach activities.

c. For other purposes as determined by the HAWK-I board.

86.17(3) If the donation is more than $5,000 and the donor does not specify how the funds are to be used, the HAWK-I board shall determine how the funds are to be used.

441—86.18(505) Health insurance data match program. All carriers, as defined in Iowa Code section 514C.13, shall enter into an agreement with the department to provide data necessary to allow the department to comply with the mandate of Iowa Code section 505.25. Each carrier shall either:

1. Enter into and maintain an agreement with the department on Form 470-4435, HAWK-I Data Use Agreement; or
2. Provide proof of an existing agreement with the department or the department's designee.

441—86.19(514I) Recovery.

86.19(1) *Definitions.*

"Administrative error" means an action of the department or the HAWK-I third-party administrator that results in incorrect payment of benefits, including premiums paid to a health or dental plan, due to one or more of the following circumstances:

1. Misfiled or lost form or document.
2. Error in typing or copying.
3. Computer input error.
4. Mathematical error.
5. Failure to determine eligibility correctly when all essential information was available to the HAWK-I third-party administrator.
6. Failure to request essential verification necessary to make an accurate eligibility determination.
7. Failure to make timely revision in eligibility following a change in policy requiring application of the policy change as of a specific date.
8. Failure to issue timely notice to cancel benefits that results in benefits continuing in error.
9. Failure of the department to provide correct information to the HAWK-I third-party administrator regarding a child's Medicaid eligibility.

"Client error" means any action or inaction of the enrollee or the enrollee's representative that results in incorrect payment of benefits, including premiums paid to a health or dental plan, because at least one of the following occurred:

1. The enrollee or the enrollee's representative failed to disclose information or gave a false or misleading statement, oral or written, regarding income or another eligibility factor; or
2. The enrollee or the enrollee's representative failed to timely report a change as defined in rule 441—86.10(514I).

86.19(2) *Amount subject to recovery from the enrollee or representative.* The department may recover from the enrollee or the enrollee's representative the amount of premiums incorrectly paid to a health or dental plan on behalf of the enrollee due to client error, minus any premium payments made by the enrollee, in accordance with 441—Chapter 11.

a. Premiums incorrectly paid to a health or dental plan on behalf of an enrollee due to an administrative error are not subject to recovery from the enrollee.

b. Payments made by a health or dental plan to a provider of medical or dental services are not subject to recovery from the enrollee regardless of the cause of the error.

86.19(3) *Notification.* The enrollee shall be promptly notified when it is determined that funds were incorrectly paid due to a client error. Notification shall include:

a. The name of the person for whom funds were incorrectly paid;

b. The period during which the funds were incorrectly paid;

c. The amount subject to recovery; and

d. The reason for the incorrect payment.

86.19(4) *Recovery.*

a. Recovery shall be made:

(1) From the enrollee when the enrollee completed the application and had responsibility for reporting changes, or

(2) From the enrollee's representative (i.e., the parent, guardian, or other responsible person acting on behalf of an enrollee who is under the age of 19) when the representative completed the application and had responsibility for reporting changes.

b. The enrollee or representative shall repay to the department the funds incorrectly expended on behalf of the enrollee.

c. Recovery may come from income, income tax refunds, lottery winnings, or other resources of the enrollee or representative.

86.19(5) *Appeals.* The enrollee shall have the right to appeal a decision to recover benefits under the provisions of 441—Chapter 7.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 8839B**, IAB 6/16/10, effective 8/1/10; **ARC 0552C**, IAB 1/9/13, effective 4/1/13]

441—86.20(514I) Supplemental dental-only coverage.

86.20(1) *Definition.*

"Supplemental dental-only coverage" means dental care coverage provided to a child who meets the eligibility requirements for the HAWK-I program except that the child is covered by health insurance through an individual or group health plan.

86.20(2) *Eligibility.* Unless otherwise specified, eligibility for supplemental dental-only coverage shall be determined in accordance with the provisions of rules 441—86.1(514I) through 441—86.12(514I), 441—86.18(514I), and 441—86.19(514I).

86.20(3) *Premiums.* Premiums for participation in the supplemental dental-only plan are assessed as follows:

a. No premium is charged to families who meet the provisions of paragraph 86.8(2)*"a."*

b. If the family's gross countable income is equal to or exceeds 150 percent of the federal poverty level but does not exceed 200 percent of the federal poverty level for a family of the same size, the premium is $5 per child per month with a $10 monthly maximum per family.

c. If the family's gross countable income exceeds 200 percent of the federal poverty level but does not exceed 250 percent of the federal poverty level for a family of the same size, the premium is $10 per child per month with a $15 monthly maximum per family.

d. If the family's gross countable income exceeds 250 percent of the federal poverty level but does not exceed 300 percent of the federal poverty level for a family of the same size, the premium is $15 per child per month with a $20 monthly maximum per family.

e. If the family includes uninsured children who are eligible for both medical and dental coverage under HAWK-I and insured children who are eligible only for dental coverage, the premium shall be assessed as follows:

(1) The total premium shall be no more than the amount that the family would pay if all the children were eligible for both medical and dental coverage.

(2) If the family has one child eligible for both medical and dental coverage and one child eligible for dental coverage only, the premium shall be the total of the health and dental premium for one child and the dental premium for one child.

(3) If the family has two or more children eligible for both medical and dental coverage, no additional premium shall be assessed for dental-only coverage for the children who do not qualify for medical coverage under HAWK-I because they are covered by health insurance.

f. The provisions of subrules 86.8(3) to 86.8(6) and 86.8(8) apply to premiums specified in this subrule.

86.20(4) *Waiting lists.* Before the provisions of subrule 86.3(10) are implemented, all children enrolled in supplemental dental-only coverage shall be disenrolled from the program.

[**ARC 8478B**, IAB 1/13/10, effective 3/1/10; **ARC 9083B**, IAB 9/22/10, effective 9/1/10]

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