CHAPTER 76
APPLICATION AND INVESTIGATION

[Ch 76, 1973 IDR, renumbered as Ch 911]
[Prior to 7/l/83, Social Services[770] Ch 76]
[Prior to 2/11/87, Human Services[498]]

441—76.1(249A) Application. Each person wishing to do so shall have the opportunity to apply for assistance without delay.

76.1(1) *Application forms.* The applicant shall immediately be given an application form to complete. When the applicant requests that the form be mailed, the department shall send the necessary form in the next outgoing mail.

a. An application for family medical assistance-related Medicaid programs shall be submitted on the Health and Financial Support Application, Form 470-0462 or Form 470-0466 (Spanish); the Health Services Application, Form 470-2927 or Form 470-2927(S); the HAWK-I Application, Comm. 156; or the HAWK-I Electronic Application Summary and Signature Page, Form 470-4016.

b. An application for SSI-related Medicaid shall be submitted on the Health Services Application, Form 470-2927 or Form 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466 (Spanish).

c. A person who is a recipient of supplemental security income (SSI) benefits shall not be required to complete a separate Medicaid application. If the department does not have all information necessary to establish that an SSI recipient meets all Medicaid eligibility requirements, the SSI recipient may be required to complete Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information, and may be required to attend an interview to clarify information on this form.

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

76.1(2) *Place of filing.* An application may be filed over the Internet or in any local office of the department or in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided. The hospital, health center, or facility shall forward the application to the department office responsible for completing the eligibility determination.

a. The Health Services Application, Form 470-2927 or Form 470-2927(S), may also be filed at the office of a qualified provider of presumptive Medicaid eligibility, a WIC office, a maternal health clinic, or a well child clinic. The office or clinic shall forward the application within two working days to the department office responsible for completing the eligibility determination.

b. The HAWK-I Application, Comm. 156, and the HAWK-I Electronic Application Summary and Signature Page, Form 470-4016, shall be filed with the third-party administrator as provided at 441—subrule 86.3(3). If it appears that the family is Medicaid-eligible, the third-party administrator shall forward the application to the department office responsible for determining Medicaid eligibility.

c. Those persons eligible for supplemental security income and those who would be eligible if living outside a medical institution may make application at the social security district office.

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

76.1(3) *Date and method of filing application.* An application is considered filed on the date an identifiable application, Form 470-0462, 470-0466 (Spanish), 470-2927, or 470-2927(S), is received and date-stamped in any place of filing specified in subrule 76.1(2).

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

b. An identifiable application, Form 470-2927 or 470-2927(S), which is filed to apply for FMAP or FMAP-related Medicaid at a WIC office, well child health clinic, maternal health clinic, or the office of a qualified provider for presumptive eligibility, shall be considered filed on the date received and date-stamped in one of these offices.

c. When a HAWK-I Application, Comm. 156, or HAWK-I Electronic Application Summary and Signature Page, Form 470-4016, is filed with the third-party administrator and subsequently referred

to the department for a Medicaid eligibility determination, the date the application is received and date-stamped by the third-party administrator shall be the filing date.

d. A copy of an application received by fax or electronically at one of the places described above shall have the same effect as an original application.

e. An identifiable application is an application containing a legible name, address, and signature.

f. If an authorized representative signed the application on behalf of an applicant, the signature of the applicant or the responsible person must be on the application before the application can be approved. For FMAP and FMAP-related Medicaid, the signature of a parent or stepparent in the home must be on the application before the application can be approved.

76.1(4) *Applicant cooperation.* An applicant must cooperate with the department in the application process, which may include providing information or verification, attending a scheduled face-to-face interview, or signing documents. Failure to cooperate in the application process shall serve as a basis for rejection of an application.

76.1(5) *Application not required.* For family medical assistance-related programs, a new application is not required when an eligible person is added to an existing Medicaid eligible group or when a responsible relative becomes a member of a Medicaid eligible household. This person is considered to be included in the application that established the existing eligible group. However, in these instances the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date of entry or the date of report, whichever is later.

a. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing paternity as described at 441—subrule 75.14(2) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by cooperating in obtaining medical support or establishing paternity.

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

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

76.1(6) *Right to withdraw the application.* After an application has been filed, the applicant may withdraw the application at any time before the eligibility determination. The applicant may request that the application be withdrawn entirely or may, before the date the application is processed, request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of 441—subrule 75.1(35). Requests for voluntary withdrawal of the application shall be documented in the case record and a Notice of Decision, Form 470-0485, 470-0486, 470-0486(S), or 470-0490, shall be sent to the applicant confirming the request.

76.1(7) *Responsible persons and authorized representatives.*

a. Responsible person. If the applicant or member is unable to act on the applicant's or member's behalf because the applicant or member is incompetent, physically incapacitated, or deceased, a responsible person may act responsibly for the applicant or member. The responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and a personal interest in the applicant's or member's welfare or a legal representative such as a conservator, guardian, executor or someone with power of attorney. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative as provided for in paragraph 76.1(7)*"b"* to represent the incompetent, physically incapacitated, or deceased applicant's or member's position and responsibilities during the application process or for ongoing eligibility. This authorization does not relieve the responsible person from

assuming the incompetent, physically incapacitated, or deceased applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

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

(2) The department may require verification of incompetence or death and the person's relationship to the applicant or member or the legal representative status.

(3) Copies of all department correspondence that would normally be provided to the applicant or member shall be provided to the responsible person and the representative if one has been authorized by the responsible person.

b. Authorized representative. A competent applicant or member or a responsible person as described in paragraph 76.1(7)*"a"* may authorize any individual or organization to represent the applicant or member in the application process or for ongoing eligibility.

(1) The authorization must be in writing, and signed and dated by the applicant or member or a responsible person before the department shall recognize the authorized representative.

(2) If the authorization indicates the time period or dates of medical services it is to cover, this stated period or dates of medical services shall be honored and may include subsequent applications, if necessary, that relate to the time period or dates of medical services indicated on the authorization. If the authorization does not indicate the time period or dates of medical services it is to cover, the authorization shall be valid for any applications filed within 120 days from the date the authorization was signed and all subsequent actions pertaining to the applications filed within the 120-day period.

(3) Anytime an applicant or member or a responsible person notifies the department in writing that the applicant or member or a responsible person no longer wants an authorized representative to act on the applicant's or member's behalf, the department shall no longer recognize that person or organization as the applicant's or member's representative.

(4) Designation of an authorized representative does not relieve a competent applicant or member or a responsible person as defined in 76.1(7)*"a"* of the primary responsibility to cooperate with the department in the determination of initial and ongoing eligibility, which may include providing information or verification, attending a scheduled face-to-face interview, or signing documents on which the authorized representative's signature would be inadequate.

(5) Copies of all departmental correspondence shall be provided to the client and the representative if one has been authorized by the applicant or member.

[**ARC 7544B**, IAB 2/11/09, effective 1/14/09]

441—76.2(249A) Information and verification procedure. The decision with respect to eligibility shall be based primarily on information furnished by the applicant or member. The department shall notify the applicant or member in writing of additional information or verification that is required to establish eligibility. This notice shall be provided to the applicant or member personally, or by mail or facsimile. Applicants for whom eligibility is determined in whole or in part by the Social Security Administration (SSA) shall make application to the SSA within five working days of referral by the department. If, by the due date, the department does not receive the information or verification, an authorization to obtain the information or verification, or a request for an extension of the due date, the application shall be denied or assistance canceled. Five working days shall be allowed for the applicant or member to supply and the department to receive the information or verification requested. The department may extend the deadline for a reasonable period of time when the applicant or member is making every effort but is unable to secure the required information or verification from a third party.

76.2(1) *Interviews.*

a. In processing applications for Medicaid for adults, the department may require a face-to-face or telephone interview upon written notice to the applicant. An interview is not required as a condition of eligibility for children.

b. For SSI-related Medicaid for adults, the department may require a face-to-face or telephone interview at the time of review.

c. The department shall notify the applicant in writing of the date, time and method of an interview. This notice shall be provided to the applicant personally or by mail or facsimile. Interviews that are rescheduled at the request of the applicant or authorized representative may be agreed upon verbally; a written confirmation is not required.

d. Failure of the applicant or member to attend a scheduled interview shall serve as a basis for rejection of an application or cancellation of assistance for adults. Failure of the applicant or member to attend an interview shall not serve as a basis for rejection of an application or cancellation of assistance for children.

76.2(2) *Choice of coverage groups.* An applicant who meets the eligibility requirements of more than one coverage group shall be given the choice of coverage group under which eligibility shall be determined.

76.2(3) *Conditional benefits granted previous to October 1, 1993.* When the client is receiving Medicaid under the conditional benefit policy of the SSI program pursuant to subrule 75.13(2), the client shall be required to describe the efforts that are made to sell the property on Form 470-2908, Description of Efforts to Sell Property, as requested by the department. The department shall request that the form be completed no more often than specified. For personal property being sold Form 470-2908 shall be completed no more often than every 30 days during the conditional benefit period. For real property being sold Form 470-2908 shall be completed beginning 35 days after conditional benefits are granted and no more often than every 60 days thereafter for nine months. If eligibility continues and the real property is not sold, the form shall be completed no more often than every 90 days.

76.2(4) *Monthly reporting.* Rescinded IAB 10/4/00, effective 10/1/00.

76.2(5) *Reporting of changes.* The applicant shall report any change as defined at 441—paragraph 75.52(4)*"c"* which occurs during the application process within five working days of the change. Changes that occur after approval for benefits shall be reported in accordance with paragraph 75.52(4)*"c."*

441—76.3(249A) Time limit for decision. Applications shall be investigated by the county department of human services. A determination of approval, conditional eligibility, or denial shall be made as soon as possible, but no later than 30 days following the date of filing the application unless one or more of the following conditions exist.

76.3(1) The application is being processed for eligibility under the medically needy coverage group as defined in 441—subrule 75.1(35). Applicants for medically needy shall receive a written notice of approval, conditional eligibility, or denial as soon as possible, but no later than 45 days from the date the application was filed.

76.3(2) An application on the client's behalf for supplemental security income benefits is pending.

76.3(3) The application is pending due to completion of the requirement in 441—subrule 75.1(7).

76.3(4) The application is pending due to nonreceipt of information which is beyond the control of the applicant or department. It is the responsibility of the applicant to provide information to the department timely or to ask for an extension of time before the due date when additional time is needed to secure the information or verification.

76.3(5) The application is pending due to the disability determination process performed through the department.

76.3(6) Unusual circumstances exist which prevent a decision from being made within the specified time limit. Unusual circumstances include those situations where the department and the applicant have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit has expired or because of emergency situations such as fire, flood, or other conditions beyond the administrative control of the department.

441—76.4(249A) Notification of decision. The applicant or member will be notified in writing of the decision of the department regarding the applicant's or member's eligibility for Medicaid. If the applicant or member has been determined to be ineligible an explanation of the reason will be provided.

76.4(1) The member shall be given a timely and adequate written notice as provided in 441—subrule 7.7(1) when any decision or action is being taken by the department which adversely affects Medicaid eligibility or the amount of benefits.

76.4(2) Timely notice may be dispensed with but adequate notice shall be sent, no later than the effective date of action, when one or more of the conditions in 441—subrule 7.7(2) are met.

76.4(3) A written notice of decision shall be issued to the applicant the next working day following a determination of eligibility, conditional eligibility or ineligibility.

441—76.5(249A) Effective date.

76.5(1) *Three-month retroactive eligibility.*

a. Medical assistance benefits shall be available for all or any of the three months preceding the month in which the application is filed to persons who meet both of the following conditions:

(1) Have medical bills for covered services which were received during the three-month retroactive period.

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

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

c. Retroactive medical assistance benefits shall be made available when an application has been made on behalf of a deceased person if the conditions in paragraph *"a"* are met.

d. Persons receiving only supplemental security income benefits who wish to make application for Medicaid benefits for three months preceding the month of application shall complete Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information.

e. Rescinded IAB 10/8/97, effective 12/1/97.

76.5(2) *First day of month.*

a. For persons approved for the family medical assistance-related programs, medical assistance benefits shall be effective on the first day of a month when eligibility was established anytime during the month.

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

c. When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first of the month in which the request was made.

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

76.5(3) *Care prior to approval.* No payment shall be made for medical care received prior to the effective date of approval.

441—76.6(249A) Certification for services. The department of human services shall issue a Medical Assistance Eligibility Card, Form 470-1911, to persons who have been determined to be eligible for the benefits provided under the Medicaid program unless one of the following situations exists:

76.6(1) *Pregnant woman.* The eligible person is a pregnant woman determined presumptively eligible in accordance with 441—subrule 75.1(30). These persons shall be issued a Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), by the provider.

76.6(2) *IowaCare.* A person who is enrolled in the IowaCare program shall be issued an IowaCare Medical Card, Form 470-4164.

76.6(3) *Breast and cervical cancer.* The eligible person is one who has been determined presumptively eligible for treatment of breast or cervical cancer or a precancerous condition in accordance with 441—paragraph 75.1(40)*"c."* These persons shall be issued a Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), by the provider.

441—76.7(249A) Reinvestigation. Reinvestigation shall be made as often as circumstances indicate but in no instance shall the period of time between reinvestigations exceed 12 months.

76.7(1) The member shall supply, insofar as the member is able, additional information needed to establish eligibility within five working days from the date a written request is issued. The member shall give written permission for the release of information when the member is unable to furnish information needed to establish eligibility. Failure to supply the information or refusal to authorize the department to secure information from other sources shall serve as a basis for cancellation of Medicaid.

76.7(2) Eligibility criteria for persons whose eligibility for Medicaid is related to the family medical assistance program shall be reviewed according to policies found in rule 441—75.52(249A).

76.7(3) Persons whose eligibility for Medicaid is related to supplemental security income shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the reinvestigation process when requested to do so by the department.

76.7(4) The review for foster children or children in subsidized adoption shall be completed on Form 470-2914, Foster Care and Subsidized Adoption Medicaid Review, according to the time schedule of the family medical assistance program or supplemental security income program for disabled children, as applicable.

76.7(5) Women eligible for family planning services only shall complete Form 470-4071, Family Planning Medicaid Review, as part of the reinvestigation process. Form 470-4071 shall be issued at least 30 days before the end of the eligibility period. The woman must submit the completed review form before the end of the eligibility period to any location specified in paragraph 76.1(2)*"d."* Women who fail to submit Form 470-4071 before the end of the eligibility period must reapply as directed in rule 441—76.1(249A).

441—76.8(249A) Investigation by quality control or the department of inspections and appeals. The client shall cooperate with the department when the client's case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to do so shall serve as a basis for cancellation of assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once a person's eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

441—76.9(249A) Member lock-in. In order to promote high quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions, recipients that utilize medical assistance services or items at a frequency or in an amount which is considered to be overuse of services as defined in subrule 76.9(7) may be restricted (locked-in) to receive services from a designated provider(s).

76.9(1) A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

76.9(2) Provider selection. The member may select the provider(s) from which services will be received. The designated providers will be identified on the department's eligibility verification system (ELVS). Only prescriptions written or approved by the designated primary physician(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 76.9(3).

76.9(3) Payment will be made to provider(s) other than the designated (lock-in) provider(s) in the following instances:

a. Emergency care is required and the designated provider is not available. Emergency care is defined as care necessary to sustain life or prevent a condition which could cause physical disability.

b. The designated provider requires consultation with another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

c. The designated provider refers the recipient to another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 76.9(5).

76.9(4) When the recipient fails to choose a provider(s) within 30 days of the request, the division of medical services will select the provider(s) based on previously utilized provider(s) and reasonable access for the recipient.

76.9(5) Recipients may change designated provider(s) when a change is warranted, such as when the recipient has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the recipient shall make the determination when the recipient has demonstrated that a change is warranted. Recipients may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

76.9(6) When lock-in is imposed on a recipient, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

76.9(7) Overuse of services is defined as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient.

a. Determination of overuse of service shall be based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System. The system employs an exception reporting technique to identify the recipients most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average.

b. In addition to referrals from the Surveillance and Utilization Review Subsystem described in paragraph *"a,"* referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects that utilization of Medicaid recipient outpatient visits to physicians, advanced registered nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceeds 24 visits in any 12-month period. This utilization review shall not apply to Medicaid recipients who are enrolled in the MediPASS program or a health maintenance organization, or who are children under 21 years of age or residents of a nursing facility. For the purposes of this paragraph, the term "physician" does not include a psychiatrist.

c. An investigation process of Medicaid recipients determined in paragraphs *"a"* or *"b"* to be subject to a review of overutilization shall be conducted to determine if actual overutilization exists by verifying that the information reported by the computer system is valid and is also unusual based on professional medical judgment. Medical judgments shall be made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or consultants for the department. These medical judgments shall be made by the health professionals on the basis of the body of knowledge each has acquired which meets the standards necessary for licensure or certification under the Iowa licensing statutes for the particular health discipline.

441—76.10(249A) Client responsibilities.

76.10(1) In coverage groups for which Medicaid eligibility is determined using income and resource policies related to the supplemental security income (SSI) program, clients shall timely report any changes in the following circumstances to the department. EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless they have a trust or are applying for or receiving home- and community-based waiver services.

a. Income from all sources.

b. Resources.

c. Membership of the household.

d. Recovery from disability.

e. Mailing or living address.

f. Health insurance premiums or coverage.

g. Medicare premiums or coverage.

h. Receipt of social security number.

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

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

k. Residence in a medical institution for other than respite care for more than 15 days for home and community-based recipients.

76.10(2) In coverage groups for which Medicaid eligibility is determined using the family medical assistance program (FMAP) income and resource policies, clients shall report changes in accordance with 441—paragraphs 75.52(4)*"c"* through *"e."* After assistance has been approved, changes occurring during the month are effective the first day of the next calendar month, provided the notification requirements at rule 441—76.4(249A) can be met.

76.10(3) A report shall be considered timely when received by the department:

a. Within ten days from the date the change is known to the member or authorized representative; or

b. Within five days from the date the change is known to the applicant or authorized representative.

76.10(4) When a change is not timely reported, any incorrect program expenditures shall be subject to recovery from the client.

76.10(5) Effective date of change. When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first day of the month in which the request was made unless otherwise specified at rule 441—76.5(249A). After assistance has been approved, changes reported during the month shall be effective the first day of the next calendar month, unless:

a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1).

b. The certification has expired for persons receiving assistance under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

c. Rescinded IAB 10/31/01, effective 1/1/02.

441—76.11(249A) Automatic redetermination. Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, an automatic redetermination of eligibility for other Medicaid coverage groups shall be made. If the reason for ineligibility under the initial coverage group pertained to a condition of eligibility which applies to all coverage groups, such as failure to cooperate, no further redetermination shall be required. When the redetermination is completed, the member shall be notified of the decision in writing. The redetermination process shall be completed as follows:

76.11(1) *Information received by the tenth of the month.* If information that creates ineligibility under the current coverage group is received in the department by the tenth of the month, the redetermination process shall be completed by the end of that month unless the provisions of subrule 76.11(3) apply. The effective date of cancellation for the current coverage group shall be the first day of the month following the month the information is received.

76.11(2) *Information received after the tenth of the month.* If information that creates ineligibility under the current coverage group is received in the department after the tenth of the month, the redetermination process shall be completed by the end of the following month unless the provisions of subrule 76.11(3) apply. The effective date of cancellation for the current coverage group shall be the first day of the second month following the month the information is received.

76.11(3) *Change in federal law.* If a change in federal law affects the eligibility of large numbers of Medicaid members and the Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR Sec. 435.1003 as amended to January 13, 1997,

the redetermination process shall be completed within the extended time limit and the effective date of cancellation for the current coverage group shall be no later than the first day of the month following the month in which the extended time limit expires.

76.11(4) *Referral for HAWK-I program.* When the only coverage group under which a child will qualify for Medicaid is the medically needy program with a spenddown as provided in 441—subrule 75.1(35), a referral to the Hawk-I program shall be made in accordance with 441—subrule 86.4(4) as part of the automatic redetermination process when it appears the child is otherwise eligible.

441—76.12(249A) Recovery.

76.12(1) *Definitions.*

"Administrative overpayment" means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

"Agency error" means medical assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

"Client" means a current or former Medicaid member.

"Client error" means medical assistance incorrectly paid to or for the client because the client or client's representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client's income, resources, or other eligibility and benefit factors. It also means assistance incorrectly paid to or for the client because of failure by the client or client's representative to timely report as defined in rule 441—76.10(249A).

"Department" means the department of human services.

76.12(2) *Amount subject to recovery.* The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client. The incorrect expenditures may result from client or agency error, or administrative overpayment.

76.12(3) *Notification.* All clients shall be promptly notified when it is determined that assistance was incorrectly expended. Notification shall include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery; and the reason for the incorrect expenditure.

76.12(4) *Source of recovery.* Recovery shall be made from the client or from parents of children under age 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

76.12(5) *Repayment.* The repayment of incorrectly expended Medicaid funds shall be made to the department.

However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for the mentally retarded, or mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

76.12(6) *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

76.12(7) *Estate recovery.* Medical assistance is subject to recovery from the estate of a Medicaid member, the estate of the member's surviving spouse, or the estate of the member's surviving child as provided in this subrule. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.5(2)*"d."* The classification of the debt is defined at Iowa Code section 633.425(7).

a. Definition of estate. For the purpose of this subrule, the "estate" of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

b. Debt due for member 55 years of age or older. Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994.

c. Debt due for member under the age of 55 in a medical institution.

(1) Receipt of medical assistance creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1,1994, when the member:

1. Is under the age of 55; and

2. Is a resident of a nursing facility, an intermediate care facility for the mentally retarded, or a mental health institute; and

3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member's behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department shall presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due shall be established. The department shall notify the member of the presumption and the establishment of a debt due.

d. Request for a determination of ability to return home. Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member's behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due shall be established until the department has made a decision on the member's ability to return home. If the determination is that there is or was no ability to return home, a debt due shall be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

e. Determination of ability to return home. When the member or someone acting on the member's behalf requests that the department determine if the member can or could have returned home, the determination shall be made by the Iowa Medicaid enterprise (IME) medical services unit.

(1) The IME medical services unit cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The IME medical services unit will notify the member or the member's representative and the department of the determination.

(2) If the determination is that the member can or could return home, the IME medical services unit shall establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member's representative asks for a reconsideration of the decision.

The IME medical services unit will notify the member or the member's representative and the department of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

f. Debt collection.

(1) A nursing facility participating in the medical assistance program shall notify the IME revenue collection unit upon the death of a member residing in the facility by submitting Form 470-4331, Estate Recovery Program Nursing Home Referral.

(2) Upon receipt of Form 470-4331 or a report of a member's death through other means, the IME revenue collection unit will use Form 470-4339, Medical Assistance Debt Response, to request a statement of the member's assets from the member's personal representative. The representative shall sign and return Form 470-4339 indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist. EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened, because probate procedures provide for an inventory, an accounting, and a final report of the estate.

g. Waiving the collection of the debt.

(1) The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed $10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, "income" and "resources" shall be defined as under the family medical assistance program.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 633.425.

(3) The department shall determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

h. Amount waived. If collection of all or part of a debt is waived pursuant to paragraph *"g,"* to the extent that the person received the member's estate, the amount waived shall be a debt due from the following:

(1) The estate of the member's surviving spouse, upon the death of the spouse.

(2) The estate of the member's surviving child who is blind or has a disability, upon the death of the child.

(3) A surviving child who was under 21 years of age at the time of the member's death, when the child reaches the age of 21.

(4) The estate of a surviving child who was under 21 years of age at the time of the member's death, if the child dies before reaching the age of 21.

(5) The hardship waiver recipient, when the hardship no longer exists.

(6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

i. Impact of asset disregard on debt due. The estate of a member who is eligible for medical assistance under 441—subrule 75.5(5) shall not be subject to a claim for medical assistance paid on the member's behalf up to the amount of the assets disregarded by asset disregard. Medical assistance paid

on behalf of the member before these conditions shall be recovered from the estate, regardless of the member's having purchased precertified or approved insurance.

j. Interest on debt. Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid member, the surviving spouse, or the surviving child, or upon the child's reaching the age of 21.

k. Reimbursement to county. If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code Supplement chapter 633C, the department shall reimburse the county on a proportionate basis.

441—76.13(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance state plan to determine (1) during what period the individual or the individual's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406), service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

76.13(1) *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. The agreement shall prescribe the manner in which information shall be provided to the department of human services and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department to match covered persons and identify third-party payers for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

76.13(2) *Agreement form.*

a. An agreement with the department shall be in substantially the same form as Form 470-4415, Agreement for Use of Data.

b. An agreement with the department's designee shall be in a form approved by the designee, which shall include privacy protections equivalent to those provided in Form 470-4415, Agreement for Use of Data.

76.13(3) *Confidentiality of data.* The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164.

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