CHAPTER 92
IOWACARE

PREAMBLE

This chapter defines and structures the IowaCare program administered by the department pursuant to Iowa Code Supplement chapter 249J. It is the department's intent that all state expenditures under the IowaCare program shall qualify for federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. §1315). Therefore, this chapter shall remain in effect only as long as such waivers are effective. Further, this chapter shall be construed to comply with the requirements of Title XIX or with the terms of any applicable waiver of Title XIX requirements. To the extent that these rules may be found to be inconsistent with any applicable requirement of Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—92.1(249A,249J) Definitions.

"Applicant" means an individual who applies for medical assistance under the IowaCare program described in this chapter.

"Clean claim" means a claim that can be adjudicated in the Medicaid claims payment system to result in either a paid or denied status.

"Department" means the Iowa department of human services.

"Dependent child" means the child or stepchild of an applicant or member who is living in the applicant's or member's home and is under the age of 18 or is 18 years of age and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching the age of 19. Correspondence school is not an allowable program of study. "Dependent child" shall also include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.

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

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

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

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

"IowaCare" means the medical assistance program explained in this chapter.

"Medical expansion services" means the services described in Iowa Code Supplement section 249J.6.

"Member" means an individual who is receiving assistance under the IowaCare program described in this chapter.

"Newborn" means an infant born to a woman as defined in paragraph 92.2(1)*"b."*

441—92.2(249A,249J) Eligibility. IowaCare eligibility shall be determined according to the requirements of rules 441—75.2(249A) to 441—75.4(249A), 441—75.7(249A), 441—75.10(249A), and 441—75.12(249A) and the provisions of this rule.

92.2(1) *Persons covered.* Medical assistance under IowaCare shall be available to the following people as provided in this chapter:

a. Persons 19 through 64 years of age who:

(1) Are not eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40) or 75.1(42), including persons unable to meet spenddown under 441—subrule 75.1(35); and

(2) Have countable income at or below 200 percent of the federal poverty level.

b. Pregnant women whose:

(1) Gross countable income is below 300 percent of the federal poverty level; and

(2) Allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below.

c. Newborn children born to women defined in paragraph *"b."*

92.2(2) *Citizenship.* To be eligible for IowaCare benefits, a person must meet the requirements in 441—paragraph 75.11(2)*"a."* A person who claims a qualified alien status shall provide documentation of this status.

92.2(3) *Other disqualification.* A person who has been disqualified from Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

92.2(4) *Group health insurance.* A person who has access to group health insurance is not eligible for IowaCare. An applicant or member shall not be considered to have access to group health insurance if any of the following conditions exist:

a. The applicant or member is not enrolled in the available group health plan and states that:

(1) The coverage is unaffordable; or

(2) Exclusions for preexisting conditions apply; or

(3) The needed services are not services covered by the plan.

b. The applicant or member is enrolled in a group health plan but states that:

(1) Exclusions for preexisting conditions apply; or

(2) The needed services are not covered by the plan; or

(3) The limits of benefits under the plan have been reached; or

(4) The plan includes only catastrophic health care coverage.

92.2(5) *Payment of assessed premiums.* As a condition of eligibility for IowaCare, an applicant or member must pay premiums in accordance with 441—92.7(249A,249J). Premiums incurred and unpaid from a previous certification period must be paid in full before an applicant can establish new eligibility under this chapter.

92.2(6) *Availability of funds.* Eligibility for IowaCare shall not be approved when the department has determined that there are insufficient funds available to pay for additional enrollment, in accordance with 441—92.14(249A,249J).

441—92.3(249A,249J) Application. Medicaid application policies in 441—76.1(249A) and 441—76.8(249A) apply to IowaCare except as follows:

92.3(1) An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) shall also sign Form 470-4194, IowaCare Premium Agreement.

92.3(2) A new application is required for each 12-month certification period.

441—92.4(249A,249J) Application processing. Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

92.4(1) *Verification.* Applicants seeking eligibility under 92.2(1)*"b"* shall provide verification of medical expenses as required under 92.5(5)*"b."* IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

a. The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

b. Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

92.4(2) *Screening for full Medicaid.* The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

92.4(3) *Time limit for decision.* The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

a. One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

b. The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).

441—92.5(249A,249J) Determining income eligibility. The department shall determine the income of an applicant's household as of the date of decision. To be eligible, the household's income minus allowable deductions shall not exceed 200 percent of the federal poverty level for the household size.

92.5(1) *Household size.* The household size shall include the applicant and the applicant's dependent or unborn children and spouse living in the same home, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act. A person who is absent from the home shall not be included in the household size, unless the absence is temporary.

a. An applicant's spouse shall not be considered absent from the home when:

(1) The spouse's absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.

(2) The spouse is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

b. The conditions described in 441—paragraph 75.53(4)*"b"* shall be applied to determine whether a person's absence is temporary.

92.5(2) *Self-declaration of income.* Applicants shall self-declare the household's future unearned and earned income based on their best estimate.

a. Applicants who receive income on a regular basis shall declare their household's monthly income as described at 92.5(3) and 92.5(4).

b. Applicants who are self-employed, receive their income on an irregular basis, or are not currently employed shall declare their household's anticipated yearly income as described in 92.5(3) and 92.5(4).

92.5(3) *Earned income.* All earned income as defined in this subrule that is received by a person included in the household size shall be counted except for the earnings of a child who is a full-time student as defined in 441—subparagraphs 75.54(1)*"b"*(1), (2), and (3). Earned income shall include income in the form of a salary, wages, tips, or profit from self-employment.

a. For income from salary, wages, or tips, earned income shall mean the total gross amount of income irrespective of the expenses of employment.

b. For self-employment income, earned income shall mean the net profit from self-employment, defined as gross income less the costs of producing the income.

c. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining the net profit counted as earned income from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member verifies expenses in excess of 40 percent of the total gross income received, the net profit counted as earned income shall be determined in the same manner as specified at paragraph 92.5(3)*"b."*

92.5(4) *Unearned income.* Unearned income of all household members shall be counted unless exempted as income by:

a. 441—subrule 75.57(6), paragraph *"b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m," "p," "q," "r," "t," "u," "v," "w," "x," "y," "z,"* or *"aa"*; or

b. 441—subrule 75.57(7), paragraph *"a," "b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m,"* or *"q."*

92.5(5) *Deductions.* The department shall determine a household's countable income by deducting the following from the household's self-declared income:

a. Twenty percent of the household's self-declared earned income.

b. For women applying under 92.2(1)*"b,"* medical expenses incurred for a person included in the household size that are unpaid and not subject to payment by a third party. Verification of the unpaid expenses must be provided in order to receive the deduction. The medical expenses that can be deducted are:

(1) Health insurance premiums, deductibles, or coinsurance charges; and

(2) Medical and dental expenses.

92.5(6) *Disregard of changes.* A person found to be income-eligible upon application or recertification of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

92.5(7) *Unearned nonrecurring lump-sum income.* All unearned nonrecurring lump-sum income shall be disregarded.

92.5(8) *Earned lump-sum income.* Anticipated earned lump-sum income shall be prorated over the period for which the income is received.

441—92.6(249A,249J) Effective date. The department shall issue Form 470-4164, IowaCare Medical Card, to persons enrolled in the IowaCare program.

92.6(1) *Certification period.* IowaCare eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The certification period shall continue for 12 consecutive months or, for women and newborns eligible under 92.2(1)*"b"* or *"c,"* until 60 days after the birth of the child.

92.6(2) *Retroactive eligibility.* IowaCare benefits shall also be available for the month preceding the month in which the application is filed if during that preceding month:

a. The applicant received Medicaid expansion services from a provider within the Medicaid expansion network; and

b. The applicant would have been eligible for IowaCare if application had been made.

92.6(3) *Care provided before eligibility.* No payment shall be made for medical care received before the effective date of eligibility.

441—92.7(249A,249J) Financial participation. In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1)*"c,"* shall be assessed a sliding-scale monthly premium. No premium shall be assessed at the time of initial application for months of eligibility before and including the month of decision, including the retroactive month. A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

92.7(1) *Premium amount.* The monthly premium amount shall be established for a 12-month period beginning with the first month of eligibility, based on projected monthly income for the 12-month period.

a. The monthly premium amount is based on the household's countable monthly income as a percentage of the federal poverty level for a household of that size. Effective April 1, 2009, premium amounts based on this percentage are as follows:

When the household's income is at or below:	Each member's premium amount is:
100% of federal poverty level	$ 0
110% of federal poverty level	$45
120% of federal poverty level	$49
130% of federal poverty level	$54
140% of federal poverty level	$58
150% of federal poverty level	$63
160% of federal poverty level	$67
170% of federal poverty level	$72
180% of federal poverty level	$76
190% of federal poverty level	$81
200% of federal poverty level	$85

b. The listed premium amount is calculated based on the lowest income level in each 10 percent increment for a one-person household. Households with income at or below 100 percent of the poverty level are not subject to a premium. Premiums for households with income over 100 percent of the poverty level are 5 percent of the applicable income level. The department will update these amounts annually on April 1 using the latest federal poverty level guidelines.

c. The cost of premiums paid for HAWK-I shall be deducted from the premium assessed according to this subrule.

d. The monthly premium established for a 12-month certification period shall not be increased due to an increase in income or a change in household size.

e. The premium may be reduced prospectively during the 12-month certification period if the member declares a reduction in projected average monthly income or an increase in household size or is granted a hardship exemption.

92.7(2) *Billing and payment.* Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

a. Method of payment. Members shall submit premium payments to the following address: Iowa Medicaid Enterprise, IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

b. Due date. When the department notifies the member of the amount of the premiums, the member shall pay any premiums due as follows:

(1) The premium for each month is due the last calendar day of the month the premium is to cover. EXCEPTION: The premiums for the months covered in the initial billing are due the last calendar day of the following month.

(2) If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend.

c. Application of payment. The department shall apply premium payments received to the oldest unpaid month forward. When premiums for all months have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

92.7(3) *Hardship exemption.* A member who submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph *"c."* If the statement is not postmarked by the premium due date, the member shall be obligated to pay the premium.

a. A partial payment submitted with a written statement indicating that full payment of the monthly premium will be a financial hardship that is postmarked or received on or before the end of the month for which the premium is due shall be considered a request for a hardship exemption. The exemption shall be granted for the balance owed for that month.

b. If the postmark is illegible, the date that the hardship declaration is initially received by the department or the department's designee shall be considered the date of the request.

c. A member shall not be exempted from premium payment for a month in which the member misrepresented the household's circumstances.

92.7(4) *Failure to pay premium.* If the member fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective the last day of the next calendar month. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

92.7(5) *Refund of premium.* When a member's IowaCare coverage is canceled due to a circumstance listed in paragraph *"a,"* premiums paid for any period after the cancellation date shall be refunded.

a. The premium obligation is reduced to zero when a member's IowaCare coverage is canceled because the member:

(1) Is determined eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40);

(2) Has access to group health insurance coverage as defined in subrule 92.2(4);

(3) Reaches age 65;

(4) Dies; or

(5) No longer meets program requirements after the four mandatory premium months.

b. The amount of the refund shall be offset by any outstanding premiums owed.

c. Any excess premium received for an individual not receiving IowaCare benefits shall be refunded after two calendar months unless an application or reapplication is pending or upon the individual's request.

d. Any excess premium received for an IowaCare member shall be refunded after two calendar months of a zero premium or upon the member's request.

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441—92.8(249A,249J) Benefits. Under IowaCare, payment will be made only for services and providers as specified in this rule. No payment will be made for any service provided elsewhere or by another provider.

92.8(1) *Provider network.* Except as provided in subrules 92.8(3) through 92.8(5), IowaCare members shall have medical assistance only for services provided to the member by:

a. The University of Iowa Hospitals and Clinics; or

b. Broadlawns Medical Center in Des Moines; or

c. A state mental health institute, exclusive of the units providing substance abuse treatment, services to gero-psychiatric patients, or treatment for sexually violent predators; or

d. Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel pursuant to 441—subrule 78.1(13).

92.8(2) *Covered services.* Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78, 441—79.9(249A), and 441—Chapter 85, Division I. All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

92.8(3) *Obstetric and newborn coverage.* IowaCare members who qualify under 92.2(1)*"b"* or *"c"* are also eligible for the services specified in paragraph *"a"* or *"b"* from the providers specified in paragraph *"c"* or *"d."*

a. Covered services for pregnant women shall be limited to:

(1) Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.

(2) Obstetrical services provided in an outpatient hospital setting when the primary or secondary diagnosis code is V22 through V24.9.

(3) Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

b. Newborns will be eligible while hospitalized and for a period not to exceed 60 days from the date of birth.

(1) Inpatient hospital services shall be payable when the diagnosis-related group (DRG) submitted for payment is between 385 and 391.7.

(2) Services provided by a health care provider other than a hospital shall be covered as provided in subrule 92.8(2).

c. For persons who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, the services listed in this subrule are covered only when provided by the University of Iowa Hospitals and Clinics.

d. Persons who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the services listed in this subrule from any provider that participates in Iowa Medicaid.

92.8(4) *Routine preventive medical examinations.* A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1)*"b"* or *"c"* are eligible to receive routine preventive medical examinations from:

(1) Any provider specified under subrule 92.8(1), or

(2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center. Physician assistants are able to render covered services as auxiliary personnel pursuant to 441—subrule 78.1(13).

b. A provider that bills IowaCare for a routine preventive medical examination shall use diagnosis code V70 and evaluation and management CPT code 99202, 99203, 99204, 99212, 99213, or 99214, as appropriate to the level of service provided. Basic laboratory work may also be billed in association with the medical examination, as appropriate and necessary.

92.8(5) *Drugs for smoking cessation.* IowaCare members may obtain outpatient prescription drugs for smoking cessation that are related to another appropriately billed IowaCare service from any pharmacy participating in the Iowa Medicaid program.

441—92.9(249A,249J) Claims. Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

441—92.10(249A,249J) Reporting changes.

92.10(1) *Reporting requirements.* A member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member obtains other health insurance coverage.

92.10(2) *Untimely report.* When a change is not timely reported, any incorrect program expenditures shall be subject to recovery in accordance with 441—92.13(249A,249J).

92.10(3) *Effective date of change.* After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

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

b. The certification has expired.

441—92.11(249A,249J) Reapplication. A new application is required when a member's 12-month certification period has expired or a member is seeking to regain eligibility after cancellation.

92.11(1) *Reapplication at least three days before end of certification period.* When a member submits an application before the last three working days of the member's current certification period, the department shall approve or deny the application by the last working day of the current certification period unless a condition described at 92.4(3)*"a"* or *"b"* applies.

92.11(2) *Reapplication within three days of end of certification period or later.* When a member submits an application during the last three working days of the member's current certification period or after the certification period ends, the department shall approve or deny the application as described at 92.4(3).

441—92.12(249A,249J) Terminating eligibility. IowaCare eligibility shall end when any of the following occur:

1. The certification period ends.
2. The member begins receiving medical assistance in a coverage group under 441—subrules 75.1(1) through 75.1(40).
3. The member does not pay premiums as required by 441—92.7(249A,249J).
4. The member no longer meets the nonfinancial eligibility requirements under 441—92.2(249A,249J).
5. The member is found to have been ineligible at the time the eligibility determination was made due to member misrepresentation or member or agency error.
6. The member dies.

441—92.13(249A,249J) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with 441—76.12(249A).

92.13(1) The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with 441—76.12(249A).

92.13(2) Any funds recovered from third parties, including Medicare, by a provider other than a state mental health institute shall be submitted to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

441—92.14(249A,249J) Discontinuance of the program. IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expected to be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited to a reduced scope of services until funding is received for the next fiscal year.

92.14(1) *Suspension of enrollment.* To ensure equitable treatment, applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year. "First-come, first-served" status is determined by the date the application is approved for eligibility and entered into the computer system.

92.14(2) *Enrollment for limited services.* Eligibility or payment for services received cannot be approved beyond the amount of funds available. Because funds are limited, applications may be approved for a reduced scope of services.

441—92.15(249A,249J) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. However, households will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program pursuant to 441—92.14(249A,249J).

These rules are intended to implement Iowa Code chapter 249J.

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