

191—72.14(249G) Auditing and correcting deficiencies in issuer record keeping.

72.14(1) Within one year of the first date that any policyholder or certificate holder of a particular issuer's policy or certificate has met the criteria for the insured event, and as often as the commissioner of insurance or department of human services deems necessary thereafter, the commissioner of insurance or department of human services shall conduct a systems audit of that company's records. The issuer shall be responsible for advising the department of human services and the division of insurance when this one-year period has begun. The commissioner or department of human services shall promptly inform each issuer of inaccuracies and other potential problems discovered in its systems audits and shall instruct the issuer of the methods necessary to correct any problems in the issuer's methods of operation.

72.14(2) The department of human services shall periodically reconcile a sample of individual applications to Medicaid of persons who have submitted documentation for qualification for asset protection with the reports submitted by issuers. The department of human services shall have the final decision concerning sample sizes and other auditing methods. The department of human services shall promptly advise issuers of any problems discovered and shall instruct the issuer of the methods necessary to correct any problems in the issuer's method of operation. The department of human services shall also notify the issuer of any obligations described in this subrule to hold clients harmless.

72.14(3) The department of human services may enter into voluntary arrangements with issuers of qualified long-term care insurance policies and certificates under which the department of human services would issue binding determinations as to whether or not services qualify for asset protection. Policyholders or certificate holders may submit requests for information and advice through their issuer or case management agency. When the following procedures are followed in all material respects, the written determinations of the department of human services concerning whether services qualify for asset protection shall be binding upon the department of human services in all subsequent actions, and the department of human services shall not make any assertion contradicting these determinations in any action arising in this subrule:

a. All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the department of human services in writing. These requests may include, but are not limited to, requests for determinations in the following areas:

- (1) Whether the insured event has occurred and has been adequately documented.
- (2) Whether a care plan is required.
- (3) Whether a revision of a care plan is required.
- (4) Whether a service or services are in accord with the care plan.
- (5) Whether a service is of such a nature as to qualify for asset protection.
- (6) Whether the applicable amount is the amount paid by the issuer or the amount charged for the service.

b. The department of human services or one of its other authorized individuals may require issuers and case management agencies submitting requests for determination to provide all records and other information necessary for making a determination. The records and other information may include, but are not limited to, the following:

- (1) Assessments.
- (2) Care plans.
- (3) Invoices for services rendered.

The party providing the records and other information shall be responsible for their accuracy. If any records or other information is later determined to be materially inaccurate, the determination based on the inaccurate information shall be void and not be binding on the department of human services or any other person or entity in subsequent actions. In the case of a policyholder or certificate holder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of 72.14(6) and 72.14(7) will apply in the same manner as for any other policyholder or certificate holder.

c. The department of human services or its authorized individual shall render a determination on each request in writing. Each determination of the department of human services or its other authorized individual shall state the reason for the determination, including the following:

- (1) Relevant facts.
- (2) Documentation of facts.
- (3) Statutes.
- (4) Regulations.
- (5) Policies.

d. A copy of all determinations of the department of human services or its authorized individual shall be kept on file at the department of human services, together with the related records and information. The original of the determination shall be sent to the issuer or the case management agency who originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or certificate holder or the policyholder's or certificate holder's authorized producer.

72.14(4) When an audit or other review by the department of human services or the division of insurance reveals deficiencies in the record-keeping procedures of an issuer, the department of human services or the division of insurance will notify the issuer of the deficiencies and establish a reasonable deadline for correction. If an issuer fails to correct deficiencies discovered by the department of human services within a reasonable period of time, the department of human services will notify the division of insurance of the deficiencies. If an issuer fails to correct deficiencies discovered by the division of insurance within a reasonable period of time, the division will notify the department of human services of the deficiencies.

72.14(5) The commissioner of insurance shall reserve the right to remove qualification status of long-term care insurance policies and certificates when deemed necessary. If the division of insurance removes qualification status from a long-term care insurance policy or certificate, a policyholder or certificate holder who purchased a policy or certificate while the policy or certificate was qualified will retain the right to asset protection. A policyholder or certificate holder who purchases a policy or certificate after the removal of qualification status will have no right to asset protection.

72.14(6) If an issuer prepares a service summary which is used in a Medicaid application for a policyholder or certificate holder and the client is found eligible for Medicaid, and the policyholder or certificate holder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the issuer's service summary or documentation of services, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's errors after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(7) If the department of human services determines that an issuer's records pertaining to a policyholder or certificate holder who has received Medicaid benefits are in such condition that the department of human services cannot determine whether the policyholder or certificate holder qualifies for asset protection, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's error; after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(8) The commissioner of insurance and the department of human services shall consult on all audits and examinations that may be required to determine compliance with this rule.

72.14(9) Compliance with 72.14(6) and 72.14(7) is a requirement for a policy or certificate to retain qualification.