441—76.11(249A) Automatic redetermination. Whenever a Medicaid recipient 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 recipient 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 county office 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 county office 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 recipients 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.