441—76.7(249A) Presumptive eligibility. Persons may be temporarily and immediately enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity at a presumptive provider pursuant to this rule.

76.7(1) *Presumptive provider.* A presumptive provider is an organization approved by the department to conduct and authorize presumptive eligibility determinations. A provider organization that seeks to be authorized to make presumptive Medicaid eligibility determinations shall do all of the following:

a. Complete the required self-directed policy and system training.

b. Apply to the department using the Application for Initial/Recertification to Be a Presumptive Provider form.

c. Read the Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations form and agree in writing to its terms.

d. Comply with the requirements outlined in Iowa's Medicaid state plan.

e. Meet the definition of "qualified provider" pursuant to 42 U.S.C. §1396r-1.

f. Meet the definition of "qualified entity" in the following federal regulations for the category of persons covered:

(1) For children under the age of 19, as described in 42 CFR §435.118, the provider must meet the requirements of paragraphs (1) through (10) of the definition of "qualified entity" in 42 CFR §435.1101;

(2) For pregnant women, as described in 42 CFR §435.116, the provider must meet the requirements of 42 U.S.C. §1396r-1(b)(2);

(3) For parents and caretakers, as described in 42 CFR §435.110, the provider must meet the requirements in 42 CFR §435.1103(b);

(4) For persons aged 19 through 64, as described in 42 CFR § 435.119, the provider must meet the requirements in 42 CFR §435.1103(b);

(5) For former foster care children, as described in 42 CFR §435.150, the provider must meet the requirements in 42 CFR §435.1103(b);

(6) For persons needing breast or cervical cancer treatment (BCCT), as described in 42 U.S.C. §1396r-1b(b)(2); and

(7) For all of the categories of persons covered in subparagraphs 76.7(1)*"f"*(1) through *"f"*(6), a qualifying hospital must meet the requirements in 42 CFR §435.1110(b).

g. Be recertified annually by doing the following:

(1) Complete the required self-directed policy and system training;

(2) Complete the Application for Initial/Recertification to Be a Presumptive Provider form; and

(3) Re-attest to the terms of the Provider Memorandum of Understanding by signing in writing.

76.7(2) *Qualified entity.*

a. An individual that seeks to be authorized to make presumptive Medicaid eligibility determinations under the supervision and authority of a presumptive provider shall do all of the following:

(1) Complete the required self-directed policy and system training.

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal (MPEP) Access Request.

(3) Read the Provider Memorandum of Understanding and agree in writing to its terms.

(4) Obtain confirmation of acceptance by the department that the individual is determined by the department to be capable of making presumptive Medicaid eligibility determinations.

b. In addition to the requirements in paragraph 76.7(2)*"a,"* a qualified entity for BCCT must also have either:

(1) Been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department; or

(2) A cooperative agreement with the department under the Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act as amended to August 1, 2025, to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the care for yourself breast and cervical cancer early detection program.

c. Only employees of the presumptive provider may be given the authority to make presumptive eligibility determinations.

d. Qualified entities are required to be recertified annually by doing the following:

(1) Complete the required self-directed policy and system training;

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal Recertification form; and

(3) Re-attest to the terms of the Provider Memorandum of Understanding in writing.

76.7(3) *How and where to file.* An applicant for presumptive Medicaid shall complete an application with a qualified entity in one of two ways:

a. Provide information in person to the qualified entity that enters the applicant's information into the MPEP system; or

b. Complete a paper application provided by the qualified entity that enters the applicant's information into the MPEP system.

76.7(4) *Signature.* An individual listed in paragraph 76.2(1)*"a"* must sign the completed paper application or a printed version of the completed MPEP application. A copy of the signed application must be maintained by the qualified entity.

76.7(5) *Date of filing and effective date of coverage.*

a. For purposes of determining the application date of filing for an ongoing eligibility determination, a paper application is valid only if it contains the applicant's legible name, address, and signature under penalty of perjury and must be date-stamped on the date it is received by the qualified entity. The date of filing as described in paragraph 76.2(2)*"a"* is used for purposes of determining the effective date of coverage for ongoing eligibility but does not determine the effective date of coverage for presumptive Medicaid.

b. The effective date of coverage for presumptive Medicaid is the date on which a qualified entity completes the presumptive eligibility determination within the MPEP system.

c. The applicant must provide to the qualified entity all information necessary to make a presumptive eligibility determination in the MPEP system.

76.7(6) *Notice and appeal rights.* The qualified entity shall inform the applicant of the eligibility decision as soon as possible but no later than two working days after the date the determination is made by the qualified entity. Timely and adequate notice requirements and appeal rights of the Medicaid program, including those outlined in 42 CFR Part 431, subpart E; Iowa Code chapter 17A; 441—Chapter 7; and 441—Chapter 16, do not apply to determinations of presumptive eligibility under this rule.

76.7(7) *Full medical assistance eligibility determination.* All presumptive eligibility applications will be given the option within the MPEP system to also receive a full determination of eligibility for Medicaid or hawki.

[**ARC 9702C**, IAB 11/12/25, effective 1/1/26]