Overview

The Children's Mental Health Waiver will be a new Home and Community Based Waiver service program that will provide supports to children who meet the requirements of special mental health needs for eligibility. The members are eligible until reaching eighteen years of age. There are no premiums. The general eligibility guidelines follow those for all HCBS waiver coverage groups.

Assumptions

Phase II of this project will be completed after July 1, 2005. Phase II will include the addition of medical aid type 377 to the IABC system. The 377 medical aid type will be used for children that meet the 300% group eligibility requirements for the CMH waiver. This decision is based on research by the IABC team with the following conclusion:

Other IowaCare project work being completed for AID TYPE, we are not able to start work on adding a new Medical Aid Type until that service request has been completed. The analysis so far shows that the Medical Aid Types 642 and 643 can be paired with the Aid Type of 377 without delaying the other project.

Requirements

IABC

1. The following case aid and Med aid types combinations will be used for this coverage group:

Case Aid	Medical Aid
377	372
377	308
377	409
377	640
377	920
377	642
377	643

2. The WAVER code of "H" will be entered on the TD03 screen to differentiate the waiver eligibility from facility eligibility.

3. A new Notice message will be created to cancel a case when the member has reached the age limit of eighteen years old.

4. A new fatal War message and companion transactional WAR will be created to advise the IM when entry of the "H" waiver code is not used with any of the above case/med aid type combinations and the vendor number in the TD05 Vendor field is all zeros.

5. Current WARs of 624 and 622 will be used for entry errors for this group.

6. This group will follow the IABC system rules for the PD waiver. Jill Whitten and John Sour have reviewed these together and have agreed that these are appropriate.

7. The existing Notice messages for denials, approvals and cancellations of HCBS waivers will be used. See #3. above for the one new message.

8. There will be only one person entered per waiver case.

ISIS

1. Lin Christensen has chosen the ISIS workflow design based upon the workflow for the PD waiver.
2. New milestones will be created to alert the SW/SM and IM of the approaching eighteenth birthday. The first will state, "The consumer is age 17. Waiver will end at age 18. Begin planning for transition to adult services." We also want a milestone to the CM/SW at 6 months before the child will turn age 18. It will state, "The consumer will turn 18 in 6 months and will be ineligible for waiver at that time." Finally we want a milestone to the IM at 30 days prior to the 18th birth date. It will state, "The consumer will turn 18 in 30 days and will be ineligible for waiver at that time." When the IM responds OK, then send a final milestone to the CM/SW that says, "The consumer will turn 18 in 30 days and will be ineligible for waiver at that time."
3. This coverage group will be included under the Iowa Plan.

TXIX

1. The TXIX system will accept the Waiver code of "H' with the specified case/medical aid types and translate this type of eligibility for the set of designated services.

2. This CMH waiver group will be covered by the Iowa Plan. The case aid of 377 with Medical aid types of 920, 372, 308, 640, 409, 643 and 643 will use the processing codes of "V", "W" or "X".

Functional Impact

1. The eligibility process will be found in the Employee Manual 8 N.

2. The instructions for IABC system entries will be found in EM 14 B Appendix.

Process Diagram

There isn't a diagram at this time.

References

As of May 18, 2005, the Rules for this coverage group have not been finalized.

Overview

The four MHIs, the UIHC, and Broadlawn's (hospitals) will be submitting claims attributable to the expansion population and, in the case of the MHI's, attributable to the newly Medicaid eligible adults at the MHI's. The hospitals will receive lump-sum monthly payments from the Iowacare appropriation that are attributable to the claims they are submitting. The MMIS must price the claims at Medicaid rates of reimbursement, apply any TPL and co-payments to them, then NOT PAY the claims, but report out what they would have otherwise cost the State. Our Audits and Rate setting contractor has to monitor the dollar value of those claims THAT DIDN'T PAY, then notify Field workers when the value of the submitted claims is equal to the twelve annual lump-sum payments that the hospitals receive, in order for Field workers to STOP TAKING APPLICATIONS for IowaCare until the beginning of a new State fiscal year. This program is capped to the extent of the appropriated funding.

In the past, many of the Medicaid adult clients would have been on the Iowa Plan. However, if they were involuntarily placed in an MHI, then Medicaid coverage was stopped.

The IowaCare population previously did not qualify for Medicaid due to maximum income requirements.

Assumptions

- The individual may qualify for IowaCare or full Medicaid. The services provided by the MHI institutions will be processed for reporting purposes and compared to the allotted amount the facility is receiving.
- A separate indicator will identify if the person is in an MHI.
- LOC is not required because involuntary placement is determined by the Court, and because this is considered an inpatient service, not a Long Term Care service.
- The case and medical aid types will be determined by which program the member is financially eligible for.
- The claims from the MHIs will be submitted as inpatient claims.
- The covered services provided by the Mental Health Institution must be subject to client participation.
- Clients who are in an MHI on July 1 who qualify for the IowaCare eligibility will have the opportunity to pay premiums.

- 95% of the newly eligible members will be Medicaid Adult. (*Not sure if this is true.)*

- The average voluntary length of stay for MHI patients who are on IowaPlan is 5 days. Consumers who are involuntarily placed often stay longer because it takes longer for the court system process to release the member.

Requirements

Eligibility Group	Voluntary	Involuntary
Medicaid Adult	Covered by Iowa Plan - No change	- Change enrollment so not in Iowa Plan. - These cases will have case aid type 377 - Ages 21-64 - Mark eligibility so Medicaid services paid , while MHI claim needs to be processed, NOT paid
Medicaid Adult over 65		
Iowa Care	- Ages 19-64 - Aid Type 60-E - All claims – processed , NOT paid	- Ages 19-64 - Aid Type 60-E - All claims - processed, NOT paid

1. The appropriations to the MHI's from the Iowacare account have to be attributed to various "sources". The sources are 1) regular Medicaid inpatient and outpatient attributions (not payments); 2) expansion population attributions (not payments); 3) disproportionate share hospital attributions (not payments); and possibly 4) graduate medical education attributions (not payments).

2. In order for any of the claims submitted to the MMIS to suspend, but attribute to any of the four categories listed above, these claims will have to be able to be identified. The only way that can happen is through the eligibility identifiers.

Federal Reporting

Functional Impact

1) When a person applies for Medicaid , or change eligibility due to involuntary placement in an MHI, the IM Worker will enter the aid types:

   Case Aid : 377

   Medical Aid:

308	920
642	643
640	377 (for 300% group when available)

   60-E and 60-P

2) The facility provider number (one of the six available for IowaCare) will be entered

3) An indicator will be set to identify this consumer as an MHI resident. It should only be set for Involuntary for the 377 case aid types, but for 60-E it doesn't matter if it's voluntary or involuntary.

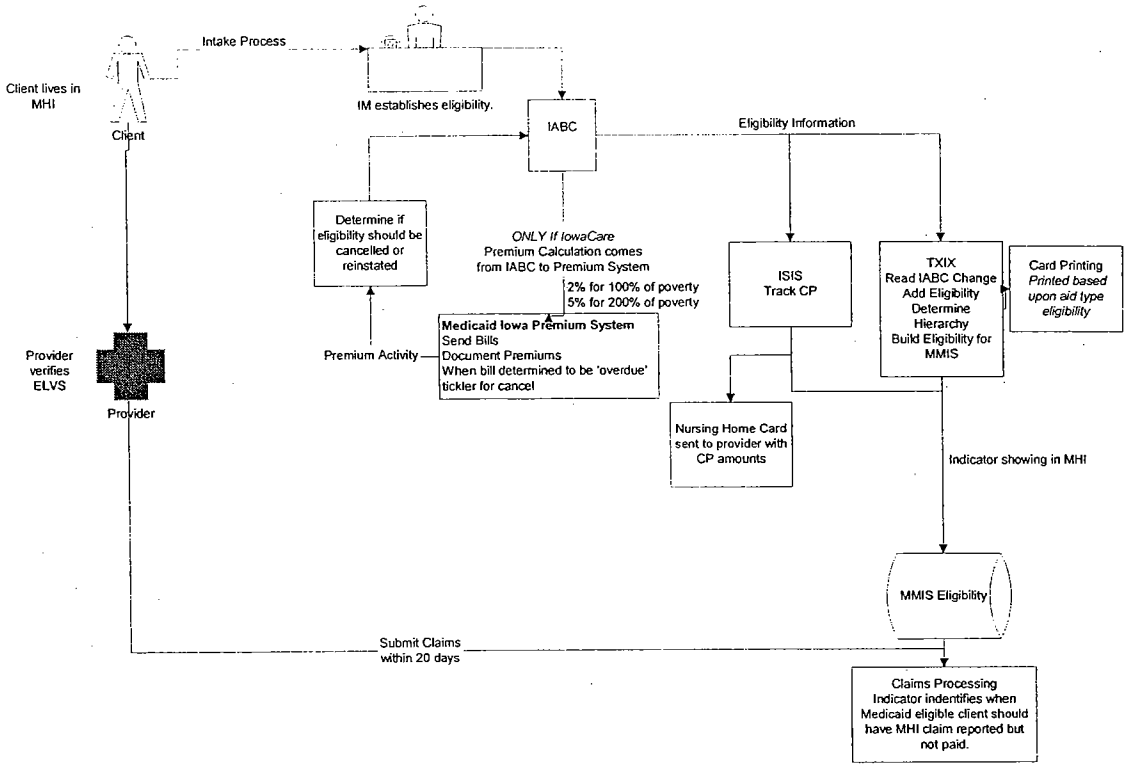
4) ISIS will look for a record with the aid type, new indicator, and facility – and will create a new program request (Type '9' for IowaCare MHI). This program request will not have workflows, it will come in as approved. Changes to the eligibility will be sent to the facility for purposes of CP notification via the Nursing Home Card process. The program request with CP amounts will flow through with the long term care records to MMIS.

5) The new indicator will pass through to MMIS is a new field defined in the filler area after the MED ID Sysdate on the monthly eligibility file.

6) When the person leaves the MHI – the case will close and will reopen under a different case type / aid type (i.e. if you were 920/920 then 377/920 – they would change back to 920/920)

References

Process Diagram



- Client in MHI
- Must qualify for program - can be Medicaid, IowaCare , or other plan....
- If indicator set, claims are adjudicated and reported, but not paid.

Overview

DSH is an acronym for Disproportionate Share Hospital. It is a federally funded program - that depends upon state matching dollars. HF 841 establishes DSH as a portion of the funds going into the IowaCare account, as are Medicaid expansion, and Federal Indirect Medical Education funds.

There is a group of Iowans who have been on State Papers - receiving services continuing care of a chronic disease, who will not qualify for the IowaCare program. DHS plans to assure these citizens that their care will continue to be provided.

We expect this group to apply for IowaCare (see the process discussed below). If they are not eligible for IowaCare, and they need continuous care for a chronic illness, then we want to identify the person - and put them in a new program. This program does not have any defined benefits. The person will be given a StateID - and that ID should be placed on the letter going back to the consumer telling them they have continuous care. The person will show the letter to the Hospital - so that the hospital can identify the State ID for billing purposes.

There will be NO card (because technically they are not on a program). There will be NO premiums. There should be a review at some point to determine if the financial status has changed and the person qualifies for IowaCare or another Medicaid program in the future (12 months).

This is a 'grand fathered' in group - it should not grow beyond the group of people who held State Papers in June 2005.

Assumptions

While DSH payments have been made in the past, we did not track the details of the claims or the citizens.

The claims will not be paid directly – but will be attributed towards the monthly allocation to the Hospitals.

The will not be a card.

No premiums will be collected. DHS does not have legal authority to charge premiums for this population.

The population will be established once and will not grow beyond that.

The person will apply for IowaCare and will only be placed on the system for DSH if the person does not qualify for another program, and has a need for continuous care for a chronic illness.

The hospital will submit claims to MMIS in the same manner they submit IowaCare and Medicaid claims.

The claims will be priced for Medicaid payments.

The person will receive their StateID on the letter and will show it to the Hospital.

Requirements

1. A new AID type will need to be created to track this population. (777)
2. The Fund Code will be '3' (Adult, State)
3. The person will not be on DSH and another Medicaid program at the same time.
4. The person and AID type will be entered into TXIX via a modification to the TXIX Presumptive Eligibility System and creating pre-authorization records for specific provider(s) & service(s) for this member
5. TXIX will pass the person and AID type to MMIS.
6. MMIS will edit the claim to identify the person's AID type and will process the claim in a manner similar to IowaCare.
7. The MAS BOE codes are used for federal MSIS reporting purposes. These members should not be reported for MSIS, so reporting codes won't be needed.

Federal Reporting

Not applicable.

Functional Impact

The University of Iowa will send out an IowaCare application with a letter that contains a tear out stub to all State Papers clients.

The client must return the survey with the application and apply for IowaCare to qualify for the DSH identification.

The IM worker will check for IowaCare eligibility... and if the client does not qualify, but does need continuous care (as determined by a list of clients provided by the University of Iowa Hospitals) – the IM worker will forward a request that the client be set up for DSH.

The TXIX system will be responsible for sending a notification of continuous care to the client with a copy to the University of Iowa Hospital.

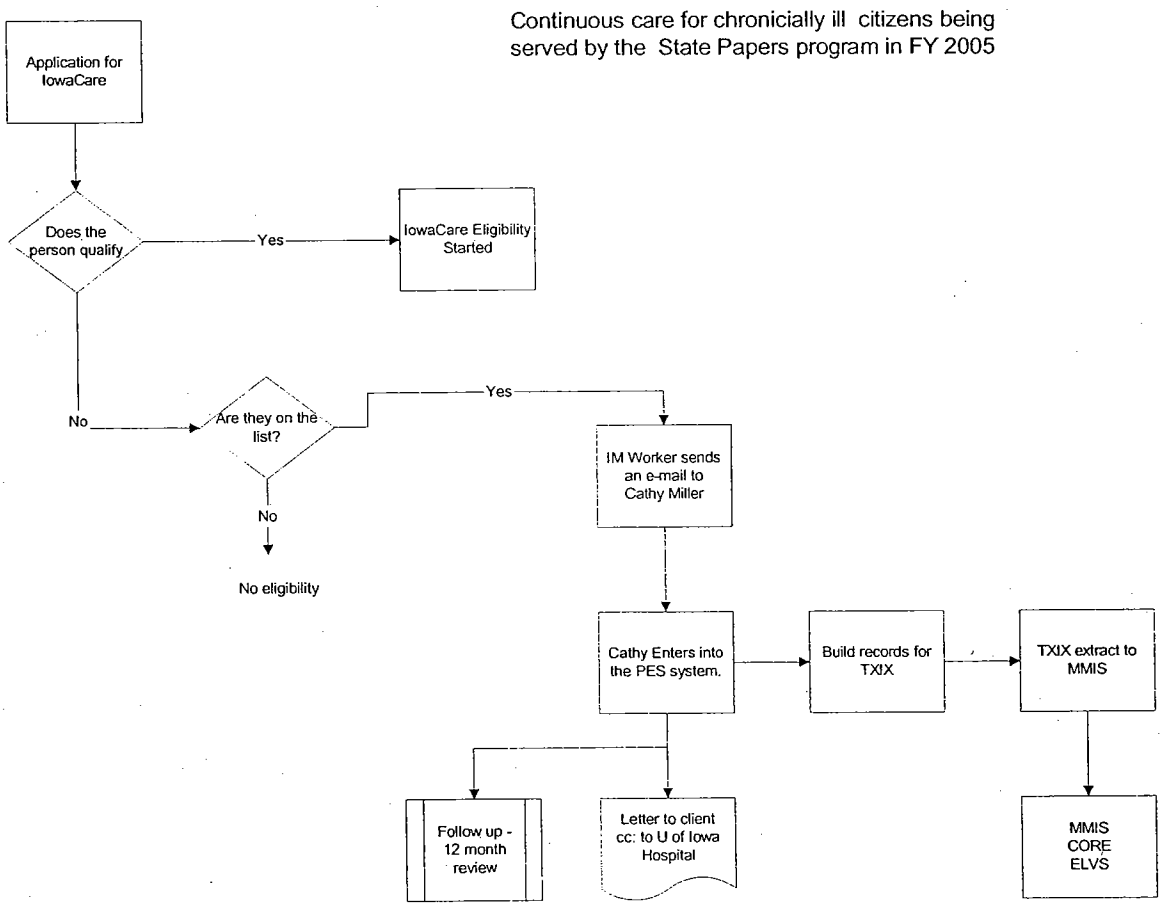
The TXIX system will be responsible for sending timely notice at the end of the year to the client and to the IM worker. (process to be defined in the future by Eligibility)

The hospital will bill for the DSH client – and the claims will be processed similarly to IowaCare.

References

StatePaperContinuingCoverage.doc
PreExistOverview.doc

Process Diagram



Overview

The Family Planning Waiver will be available to woman from 13 through 44 years of age. The medical services will be limited to family planning services. This waiver coverage would be canceled if the member becomes pregnant during the year long certification period.

Assumptions

1. A new Family Planning Waiver (FPW) web application will be built to allow intake from family planning clinics and IM workers. The IM workers will have more options and display more information on their version of the application.
2. The fiscal agent will alert the Family Planning Waiver Application of possible eligibility (group A) for Medicaid recipients.
3. Items listed under Eligibility Determination will be completed in Phase I, unless otherwise noted.
4. The family planning waiver will be kept in the Family Planning Waiver and a case will not be built in IABC for the eligibility.
5. The handicap code does not need to be carried.

Requirements

Eligibility

Family Planning Waiver 90-6	Gross income minus deductions of - 20% of earned income - childcare of up to $200.00 per child for 1 child or $175.00 per child for 2 or more children - Court ordered child support, alimony, or spousal support paid equal/under 200% FPL	No premium

Eligibility Determination

1. Eligibility may be initiated by two separate processes:
   Group A: The person may be a Medicaid recipient at the time the pregnancy ends. This person is eligible for 12 consecutive months of family planning Medicaid. Month one is the month following the month postpartum ends. (Postpartum period is the 60 days following the date the pregnancy ended.) DHS

staff will be recording a person's eligibility for this group.
Group B: Women with countable income at or below 200% of the federal poverty level. Family planning clinics will provide intake functions only for Group B (although DHS could as well).

2. Women eligible under this aid type will not be enrolled in managed care.

3. A woman's eligibility will either be initiated by records from:
   - Medicaid fiscal agent
   - Clinic staff
   - DHS IM worker

4. When the fiscal agent identifies eligibility for the FP waiver, they will send a file that will go to the Family Planning Waiver application: the name, case number and State ID of the person who had a pregnancy end and the MM/DD/YYYY of the pregnancy end date.

5. Eligibility for the family planning coverage is secondary to any eligibility for full Medicaid benefits. IowaCare and Family Planning will run concurrently.

6. When the clinic staff perform intake (for Group B), they will record the financial and non-financial information in a web-based system. The web-based system shall calculate and determine eligibility.
7. The Medical status of "I" that <u>will not</u> prohibit FPW eligibility when the notice reason is: 945, "did not cooperate with the Child Support Recovery Unit", or 847 HIPP, or 960 TPL – third party liability. When the client server team receives data from ABC that shows a person with an individual med status of "I" with the notice reason of 945, 847, or 960 - they can approve FPW. All other individuals with a med status of 'I' and a sanction notice reason of anything other than 945, 847, or 960 would be denied. The sanction reason that will continue with ineligibility is 203 (did not cooperate with QC). Donna will write the notice language that should be generated because of cancellation or denial for the 203 sanction.

8.

System Requirements

1. The program would be set up with a review period of 12 months. For Family Planning, at timely notice, the family planning waiver application will automatically cancel the case at end of the month if the NEXT REV is equal to current month. A system-generated review form will be sent at month end of the 11th month of eligibility (1 month prior to end date). *This requirement does not need to be completed until June 2006.*

2. The group discussed individuals eligible for both IowaCare (60-E) and Family Planning (90-6). There will be two cases in all instances where the member may have eligibility under another medical aid type.

3. The FPW application will add eligibility for the clients sent from the fiscal agent with eligibility starting 60 days after the pregnancy end date.

4. When the FPW web system receives the terminated pregnancy file, the system will verify that an active FPW case for the client does not exist. If one does exist, no action will be taken. If one does not exist, FPW will create an FPW case for the client and send an eligibility record via ABC to TXIX.

5. FPW will generate an NOD trigger record and send it to ABC to generate a Notice for the automatically generated cases.

6. New headers will be created for the NOD. Many of the existing reason codes, but some new reasons may also be added.

7. Persons eligible for Family Planning may have QC sanctions applied. Note: individuals sanctioned due to Child Support non-cooperation are eligible for FP Waiver. *Donna Carter needs to rework this statement.*

8. Fund codes will follow these age guidelines:

    - "A" female 18 or older
    - "C" females under the age of eighteen years

9. Exceptions to policy will require manual entry of 3 or 4 by the Client/Server team.

10. 906 coverage group members who will reach the age of 45 years at the next birthday will be automatically canceled with timely notice in the correct month. If the date of birth is the first day of the month, the Family Planning Waiver case will be canceled as of the last day of the preceding month. If the date of birth is any date other than the first of the month, then the Family Planning Waiver case will be canceled as of the last day of that month.

11. The insurance override will be passed to the TXIX system in a new field added to the eligibility record. Y for override, N for no override. This information will be forwarded to the fiscal agent.

12. Notice of Decisions for the clinics will be printed in the clinics. DHS workers will have the option of printing the NOD at a local printer or of having the FPW system generate an NOD trigger record to have the NOD processed through normal ABC batch processing.

13. The FPW medical eligibility record will be included in any daily or month end file to Title XIX system.

14. Designated Family Planning clinic staff will provide intake functions and record data into the FPW web system designed by the client server team. The FPW system shall calculate financial eligibility for those who meet the non-financial criteria. The information will be captured by the FPW system and an FPW case will be created under the new 906-aid type on a case number with a 96 designated FBU. These case records will reside in the FPW system.

15. We have requested a separate process for DHS staff to enter a case via the web-based system. The IMW shall record the individual's state ID, existing ABC case number, and the date pregnancy ended, and minimal other required information into the web-based system. The FPW system will then create an FPW case for the client.

16. The web-based system shall be able to pull the individual's demographic information such as 1) state ID, 2) name, 3) birth, 4) sex, 5) race/ethnicity, and 6) county of residence from the ABC system. It will also pull and display the address for the first active medical ABC case number that the system finds. If no active medical cases exist, it will search for the first active case it can find for that State ID. If no active cases are found, it will just select the first case it finds associated with that State ID. This information will be displayed and the worker can either accept or modify the information.

17. Other actions will be recorded in this system; such as: address changes, review dates, transfers to other clinics. *This will not be part of phase 1 – but will be a later release.*

Title XIX

1. Title XIX sets a FP indicator when the FP Waiver is underlying eligibility for full Medicaid coverage. This indicator is included in the Title XIX record to fiscal agent.

2. TXIX will use addresses from the FPW eligibility record for the MEDID card. They will add individuals from the FPW eligibility – but not override addresses, etc.

3. Medicaid cards will be issued via the TXIX system each month on the violet limited services card. The card will state that the services will be limited to Family Planning services only. A phase 2 request is to send one card per year for the client.

4. Title XIX will pass the insurance override indicator to MMIS along with eligibility.

Fiscal Agent

1. Fiscal agent shall create a record in a file for DHS when:

a. A claim is received for a Medicaid eligible person indicating that a pregnancy end, and
b. No claim has been submitted for sterilization, and
c. FP waiver eligibility does not currently exist.
d. The person is not a 3-day emergency (special processing as 'C' in the indicator).

2. The record shall include the name, case number and State ID of the person who had a pregnancy end and the MM/DD/YYYY of the pregnancy end date

3. Claims shall be paid according to the rules and limitations of the family planning waiver eligibility.

4. If the insurance override is set, MMIS will not process the claim for TPL or try to collect from other entities for the family planning waiver services.

- Aid type 906
- Members eligible in this group will be enrolled in the Iowa Plan.
- The Iowa Plan codes (restricted-svc-ind) that will be used are existing codes VF, VM, WF, WM, XF, and XM.
- When Family Planning coverage is concurrent with the IowaCare 200% or 300% eligibility, the special processing indicator will be passed as "P". The aid type will be 60E, 60H, 60P, or 60T with an active fund code (1,2,3,4,A,C,R).
- The insurance override indicator will be sent in the TPL-HIPP-FLAG field. "Y" is the value that will indicate insurance override for Family Planning. Any other value will indicate no insurance override for Family Planning.

Federal reporting codes are:

AID	Fund	PART A	PART B	PART C	PART D	MAS-BOE
906	1	BEX	BCN	ABD	BBE	45
906	2	BEX	BCN	ABE	BBE	44
906	3	DHF	DEO	ACA	DBA	XX
906	4	DHG	DEO	ACA	DBA	XX
906	A	BEX	BCN	ABD	BBE	45
906	C	BEX	BCN	ABE	BBE	44
906	R	BEX	BCN	ABE	BBE	44

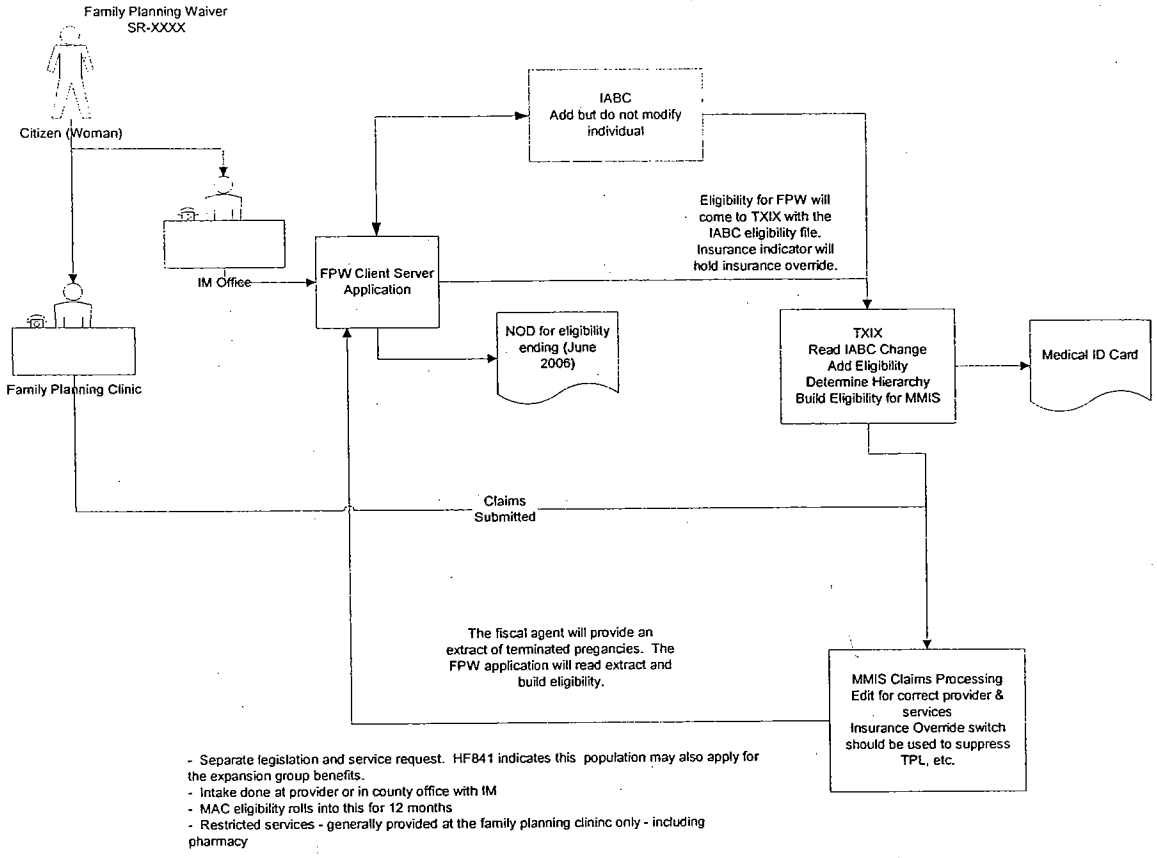
Functional Impact

The eligibility and case maintenance work process for the Income Maintenance Worker will be defined in the Employee Manual. The system entry instructions will be described in EM 14 B Appendix.

Help Desk support will be performed by Donna Carter. A generic e-mail address will be assigned. Any systems issues and security requests will be forwarded to the client server team.

Training for the clinic staff will be led by Donna Carter.

Process Diagram



- Separate legislation and service request. HF841 indicates this population may also apply for the expansion group benefits.
- Intake done at provider or in county office with IM
- MAC eligibility rolls into this for 12 months
- Restricted services - generally provided at the family planning clininc only - including pharmacy

References

\\DHSIME\IAMEDREFORM\Family Planning\Updated Waiver Application to CMS.doc

Update Process for Premium Calculation

I. When the Hardship indicator is "N", and the member is not a Newborn (individual who is less than one year old), the premium will be calculated as follows:

60E Med Aid Types

1. The gross earned income of individuals with Medical Status of A, B, C, F or I will be used as countable income.
2. There will be a deduction of 20% of the earned income from the total earned income.
3. The gross unearned income of individuals with Medical Status of A, B, C, F or I will be added to the net earned income.
4. The resulting amount will be compared to the amount equal to 100% of the Federal Poverty Level for the household size.
5. The resulting percentage will be used to determine the gross IowaCare premium amount as found on the Eligibility and Benefits Data Table.
6. The gross premium amount will be reduced by the amount of the *hawk-i* premium to determine the final net premium.

60P Med Aid type

1. The gross earned income of individuals with Medical Status of A, B, C, F or I will be used as countable income.
2. There will be a deduction of 20% of the earned income from the gross earned income.
3. The gross unearned income of individuals with Medical Status of A, B, C, F or I will be added to the net earned income to determine the net countable income.
4. The medical expense deduction will be subtracted from the net countable income.
5. The resulting amount will be compared to the amount equal to 100% of the Federal Poverty Level for the household size.
6. The resulting percentage will be used to determine the gross IowaCare premium amount as found on the Eligibility and Benefits Data Table.
7. The gross premium amount will be reduced by the amount of the *hawk-i* premium to determine the final net premium.

II. Hardship

60E Med Aid Types

1. When the Case Master Medical Hardship Indicator is equal to "Y", the premium for each individual on the case will be set to zero.

60P Med Aid type

2. When the Case Master Medical Hardship Indicator is equal to "Y", the premium for each individual on the case will be set to zero.

III. Newborns

60E Med Aid Types

1. The Newborn premium exclusion does not apply.

60P Med Aid type

1. The premium for an eligible individual who is less that one year old will be zero.

HOUSEHOLD INCOME	PREMIUM AMOUNT
10% of FPL	$ 0.00
20% of FPL	$ 1.00
30% of FPL	$ 3.00
40% of FPL	$ 4.00
50% of FPL	$ 6.00
60% of FPL	$ 7.00
70% of FPL	$ 9.00
80% of FPL	$ 11.00
90% of FPL	$ 12.00
100% of FPL	$ 14.00
110% of FPL	$ 39.00
120% of FPL	$ 43.00
130% of FPL	$ 47.00
140% of FPL	$ 51.00
150% of FPL	$ 55.00
160% of FPL	$ 59.00
170% of FPL	$ 63.00
180% of FPL	$ 67.00
190% of FPL	$ 71.00
200% of FPL	$ 75.00

Overview

The IowaCare expansion group will receive a limited set of Medicaid benefits through a limited set of providers. Benefits for this group will also be limited by the total amount of funding available through the fiscal year.

Assumptions

The IM workers will enter the aid types 60-E or 60-P. MMIS will see aid types of 60-E or 60-P.

There will be a time when a member will send in a payment that is less than the full amount.

Hardship declaration on the Billing Statement only applies to premium. Hardships for Pharmacy co-pays are declared to the pharmacist.

Requirements

Eligibility

1. Applicants must meet non-financial and income requirements for IowaCare.
2. The individual is not eligible for the medical assistance program on or after 4/1/05.
3. See the attached Table with Poverty Levels. To determine the poverty level we round up (139.1% becomes 140%, with the exception of 299.9 will round down to 299%).

Program	Eligibility Calc	Premium Calc
IowaCare OB & Newborn 60-P, No age restrictions; 60P with a hardship becomes 60T for TXIX	Test 1: Gross income minus 20% earned income deduction under 300% FPL; Test 2: Gross income minus 20% earned income deduction and Med Expenses deduction equal/under 200% FPL	Premium determined from premium table. Run Premium Calc only if Eligibility Calc results in eligibility. Premium Test 2: countable income used to determine the premium amount and the *hawk- i* deduction off of the total premium. The *hawk-i* premium will be deducted from premiums for both eligible parents.
IowaCare Age19 – 64; 60-E; 60-E with a hardship becomes 60H for TXIX	Gross income minus 20% earned income deduction is equal to or under 200% FPL	Run Premium Calc only if Eligibility Calc results in eligibility. Premium determined from premium table. 20% deduction off of

		the earned income to determine the premium amount and *hawk-i* deduction off of the total premium. The *hawk-i* premium will be deducted from Iowacare premiums for both eligible parents.

Medical systems needs MAS-BOE Codes.

Eligibility Entries

1. Income and deductions would be entered on the BCW2 screens for 60-E and 60-P. Amounts entered will be used to determine percent of FPL and income eligibility. For 2 person eligible cases, the hawk-i deduction should be entered for only one person, but will be used to calculate the premium that will be assessed to bother persons.
2. Resources will be entered on RSCM screens for 60-E and 60-P, but there will be no resource calculations.
3. The individuals associated to the case with a medical status of A, B, C, F, or I will determine HH size. Individuals with medical status of A, B, C, F or I would have BCW2 income counted for eligibility. Considered individuals would be added to the case with an "S" fund code. We will not use the Med Status of "H".
4. Fund codes will follow these age guidelines:
    - 60-E may be "A", "3", or "S" fund codes, with Med Status of A, B, C, or D when the age is 19 years thru 64 years
    - 60-E may be "S" fund code only for Med Status of I or F
    - 60-E may be only "S" fund code when the age is under 19 years
    - 60-P may be "A" or"3" for females of eighteen years or older
    - 60-P may be "S" fund code only for males 19 –64 years
    - 60-P may be "C" or "4" for either males or females under the age of one year
5. The decision was made to include the unborn child(ren) in the HH size. The existing edits will force the entry of the MED LIMIT date for the post partum period. This will cause the cancellation of 60-P postpartum mothers. For 60-E postpartum mothers, the mother will cancel due to the Med LIMIT date, and the IM will need to go in and change the fund code back to "A".
6. If a person is under 19 or over 64 generate an edit error and a fatal WAR if the IM worker attempts to add eligibility for 60-E or 60-P coverage groups.
7. 60E and 60P programs will end after the 12 months certification period. There will not be an auto- redetermination.
8. Food Assistance programs may be on the same case as the IowaCare case, but this will be discouraged through training.

9. The request for one month of retro eligibility will be allowed at the time of application only. Retro means any month prior to the month of application (June 2005 may NOT be a retro month). The retro month will have to be entered on the RETR screen until Phase 2 will allow the entry of the one month code in the TD05 RETRO field.
10. Individuals eligible for both IowaCare (60-E) and Family Planning (90-6) will have separate cases created.
11. For newborns under the 60P group, the eligibility will be limited to the 60-day period following birth (ends on the last day of the month when the 60 days ends).

Hardship

1. Declaring hardship is month-to-month. This information will not be collected by the IM and does not need to be in IABC or **TXIX.** This information will be recorded in the TXIX Eligibility System.

2. The member will declare hardship on the bottom of the premium billing form, and this will cover the amount due on the statement. Hardship requests must be received in the month that the premium is due. Requests for hardship will not be accepted if made after that month.

3. The IowaCare billing statement needs to be modified to accommodate the "hardship" action. This has been completed.

4. The *(or MIPS?)* Premium system will provide a screen to enter the "hardship" indicator - and will program logic to cover these actions.

5. If there is a partial payment (it will not be applied to a month, but it will appear in the credit field *), or if there is a full payment, or if hardship is coded, the billing system will not notify ABC to close a case for nonpayment. * In Phase 2, we will add programming that will allow the partial payment to be applied to the month indicated.

6. If there is no payment received, nor any indicator for hardship, the billing system will tell ABC system to cancel for nonpayment.

7. When making changes to billing statement, the billing system will list each unpaid month on the bill and the member may claim hardship for all unpaid months listed on the statement. (See #2 above)

8. Staff responsible for entering payments will also be entering the hardship indicator via the MIPC screen. In phase 2, this can be redesigned if required.

9. The TXIX System can use the "hardship" aid types for viewing on the SSNI and MIPS screens in the TXIX System (60-H or 60-T); however, the "non-hardship"

aid type would be passed to the Fiscal Agent making this transparent to the CORE System.

10. ~~The Hardship for exemption for the co-pays will not be coded on the MIPS system.~~

11. The system must be able to produce reports to allow management to do trend analysis and monitor the usage of the monthly hardship declaration.

NODs: Eligibility Calcs and Premium Calcs

1. For 60P and 60E aid types, the premium calc only will be shown if case eligible. If the case is denied for over income then an eligibility calc will be displayed on the right side of the notice.
2. These programs may utilize the headers currently in IABC or each notice reason would be all-inclusive (Header and reason info).

IowaCare Card

1. The IowaCare medical card will be issued once per certification period after initial eligibility is approved.
2. This card has a design resembling a health insurance card.
3. If a card needs to be reprinted, the IM worker should request the reprint through IABC.
4. Every time a new mandatory 4-month period begins, a new card should be printed.

Premiums

1. Net premium will equal the premium amount less the hawk-i deduction. (The hardship reduction will result in a zero premium amount.)
2. The net premium will be stored on the case master (shown on TD05 Screen). The net premium will reflect the amount that <u>each</u> individual on the case will be required to pay.
3. The net amount will be sent to the MIPS billing system for each eligible individual.
4. Individual Billing Statements will be generated from the Medicaid IowaCare Premium System (MIPS).
5. Paid premiums shall not be refunded due to hardship or the client being found eligible for other Medicaid coverage. 6/24/05 – Lucinda said that premiums will be refunded under the following conditions: a.) the member becomes eligible retroactively for a full Medicaid coverage group or b.) the member paid future months in advance and then requests a refund of payments for future months

6. Unpaid premiums for months of IowaCare eligibility will continue to be considered a debt, when eligibility is retroactively gained for any other Medicaid coverage.
7. Future months paid premium credit on MIPS may be refunded if the individual gains eligibility for other Medicaid coverage.
8. To modify the hardship or premium for prior months, the IM worker can use the MIPC screen.
9. After the Hardship indicator of "Y" is entered, an NOD will be system generated to reflect the reduced premium obligation *(Is this still true?) 6/20/05 Checking with Steve and mike on this. 6/24/05 Steve replied:* At this time, there would be no NOD generated by ABC due to hardship not being stored on ABC now. jw
10. If premiums need to be increased, it would be done through ABCC by SPIRS *(phase 2 because audits won't start for a couple of months.)*

Billing

1. The member is required to pay the monthly premiums for the mandatory period. The mandatory period is defined as the month of the positive action and the next three consecutive months of the certification period.
2. If a retro month is coded, the ABC system will change the Positive action date to be one month earlier prior to sending the premium record to the billing system. ABC will still show the positive action date that was entered by the IM worker.
3. After a mandatory period ends, a new four month mandatory period will begin each time there is a break of eligibility of more than one month past the date of cancellation.
4. Mandatory periods will not overlap.
5. Premium payment statements will be sent as follows:
    a. The first premium payment will be due on the last day of the month following the date the premium record was processed by MIPS. The billing for this premium will include the first and second months of eligibility, and possibly the third month if a retro month is included in eligibility.
    b. The premium for the remaining months of the mandatory period will be due on the last day of the billing month. (The premium for the third month is due on the last day of the third month of eligibility, the premium for the fourth month is due on the last day of the month, etc.)
    c. The premiums for months after the mandatory period will be due on the last day of the month of eligibility. (For example, the fifth month is due on the last day of the fifth month.)
6. If the last day of the month falls on a weekend day or holiday, the premium will be due the first business day of the following month.
7. When the Billing system receives the code for hardship, the 'Y' <u>will override any other information</u> we have regarding the premium. In other words if hardship is granted, but, there is also a premium record

in the billing system that still shows a dollar amount greater than 0 for the premium, client will not be billed, nor required to pay anything for any month hardship is granted. The billing system will 'know' if there is a "Y" for hardship, the premium is $0 for that month.

8. The premiums statements will be generated on the first working day of the month. The premiums statement will state the premium is due by the fifteenth of the billing month, or the first working day after the 15th if the 15th is not a working day.
9. The MIPS will send a friendly payment reminder letter to members who have not paid the required premium(s) after the fifteenth or the first working day after the 15th if the 15th is not a working day.

Case Maintenance

1. If IowaCare and Food Assistanceand/or FIP were on the same case, system coding will be added to stop reviews/recertification dates from aligning between these programs. (This is phase 2)
2. Persons eligible for IowaCare may have sanctions applied.
3. For 60-E cases with two eligible IowaCare members: A WIF will be sent to the IM if one member fails to timely pay premiums, that member will become a considered person on the case and the fund code will be changed to "S". Existing system case actions can be used to accomplish this.
4. After the end of a mandatory period, when a member goes beyond the period of reinstatement (Reinstatement #1 – cases will be re-opened only if the premium is paid during the period between timely notice and the last day of the month) and requests IowaCare coverage again, they must file a new application and begin a new four-month mandatory period.

Cancellation

1. After eligibility is sent to T-19 for the twelfth month, the IowaCare Aid Types (60-E & 60-P) will cancel effective end of twelfth month with no NOD. This process is based on the date in the NEXT REV field on the TD05 screen.
2. 60-E members who will reach the age of 65 years at the next birthday will be automatically canceled with timely notice in the correct month. If the date of birth is the first day of the month, the IowaCare will be canceled as of the last day of the preceding month. If the date of birth is any date other than the first of the month, then the IowaCare will be canceled as of the last day of that month. This is Phase 2.
3. The dates off the MIPS billing file will be used to trigger the cancellation process. MIPS will send a file to IABC with the following for each person:
    - Start Date
    - Last month paid
    - Unpaid Balance

    (This will be a phase 2 – due by the end of August).

Reinstatement

1. . An individual's case may be reopened when eligibility is canceled for non-payment of premium when:
    - The premium owed is paid in the calendar month following the month the payment was due during the period between Timely notice and the last day of the month., or
    - The payment for the mandatory months is paid in full by the last day of the month following the last mandatory month. (see Billing #5.)
2. The use of "C" "C" entries will be required to re-open the case as these entries require the use of a new POS DATE on TD05. The entries of "B "B" will trigger a fatal WAR.
3. The dates off the MIPS billing file will be used to trigger the reinstatement process. (Not due until 8/31/05)

Rules for Retaining Eligibility

1. Single comprehensive medical examination within 90 days (as of 3/1/06)
   (May access Medicaid providers for this exam)
2. Health risk assessment (3/1/06)
3. Personal Improvement Plan (6/1/06)

Fiscal Agent

The claims will be adjudicated and third party liability determined, but these claims will NOT be paid.

Clean claims must be submitted within 20 days of the last date of service.

The new aid type must show eligibility information on REVS, POS, and any other eligibility verification tools.

If a hardship is identified (60-H or 60-T) then the member does not make pay premiums.

Premiums qualify toward spend down when applying for other programs.

A new category of service will be identified for these claims.

Medical Services

Services provided:

- Inpatient hospital procedures
- Outpatient hospital services
- Physician and ARNP services
- Dental Services
- Limited Pharmacy benefits

Provider network

University of Iowa
Broadlawns
State Mental Health Institutions (4)

Federal Reporting

1. IowaCare OB/newborn group – BELOW 300% pov

aid type 60P is non-hardship
aid type 60T is hardship (no premiums)
These members are not enrolled in the Iowa Plan or Medical Managed Care.

Federal reporting codes are: (mas-boe codes are still pending from CMS)

AID	Fund	PART A	PART B	PART C	PART D	MAS-BOE
60P	1	FAB	BCT	ABO	BCB	
60P	2	FAC	BCT	ABO	BCB	
60P	3	DHF	DEO	ACA	DBA	XX
60P	4	DHG	DEO	ACA	DBA	XX
60P	A	FAB	BCT	ABO	BCB	
60P	C	FAC	BCT	ABO	BCB	
60P	R	FAC	BCT	ABO	BCB	
60T	1	FAB	BCT	ABO	BCB	
60T	2	FAC	BCT	ABO	BCB	
60T	3	DHF	DEO	ACA	DBA	XX
60T	4	DHG	DEO	ACA	DBA	XX
60T	A	FAB	BCT	ABO	BCB	
60T	C	FAC	BCT	ABO	BCB	
60T	R	FAC	BCT	ABO	BCB	

2. IowaCare group – equal to or less than 200% pov

aid type 60E is non-hardship
aid type 60H is hardship (no premiums)
These members are not enrolled in the Iowa Plan or Medical Managed Care.

Federal reporting codes are: (mas-boe codes are still pending from CMS)

AID	Fund	PART A	PART B	PART C	PART D	MAS-BOE
60E	1	FAA	BCS	ABN	BCB	
60E	2	FAA	BCS	ABN	BCB	
60E	3	DHF	DEO	ACA	DBA	XX
60E	4	DHF	DEO	ACA	DBA	XX
60E	A	FAA	BCS	ABN	BCB	
60E	C	FAA	BCS	ABN	BCB	
60E	R	FAA	BCS	ABN	BCB	
60H	1	FAA	BCS	ABN	BCB	
60H	2	FAA	BCS	ABN	BCB	
60H	3	DHF	DEO	ACA	DBA	XX
60H	4	DHF	DEO	ACA	DBA	XX
60H	A	FAA	BCS	ABN	BCB	
60H	C	FAA	BCS	ABN	BCB	
60H	R	FAA	BCS	ABN	BCB	

Functional Impact

The eligibility and case maintenance work process for Income Maintenance Workers will be defined in the Employee Manual. The system entries will be described in the EM 14 B Appendix.

Premium payments will be sent to a lock box, and processed at the IME building.

Reports

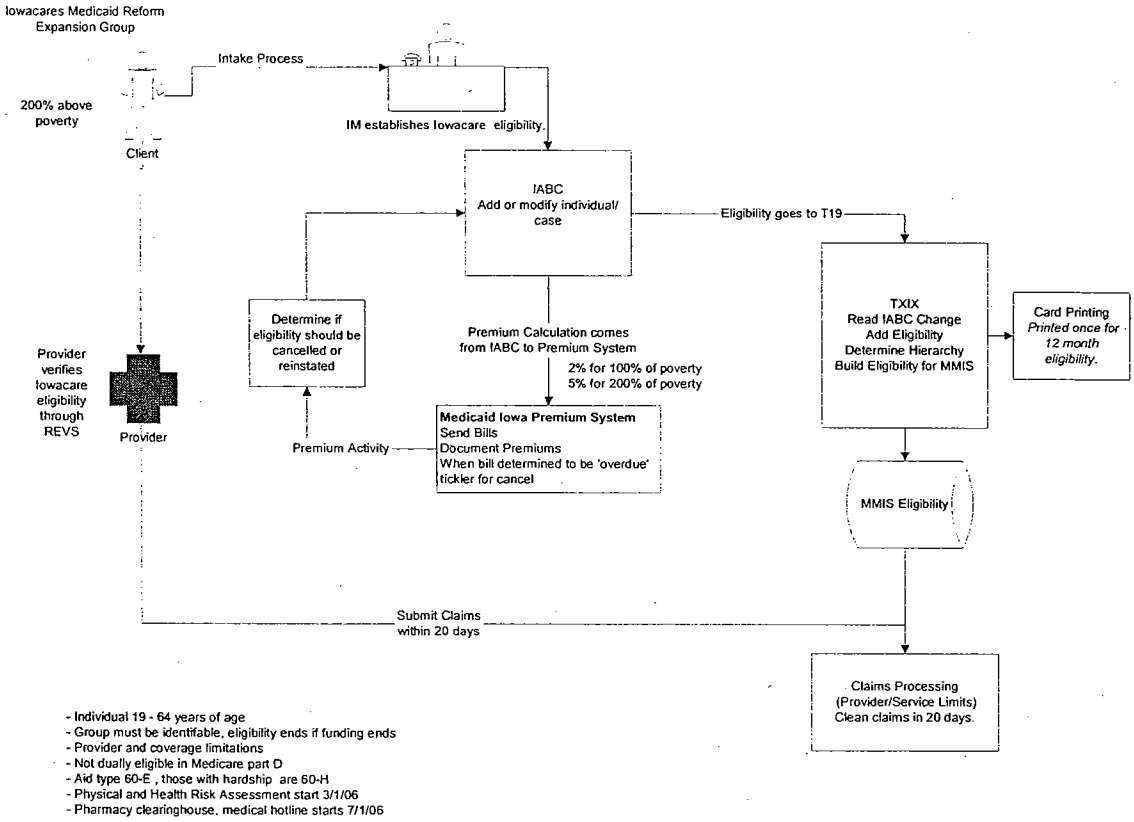
References

Draft 441—91.1(249) through 91.17(3)

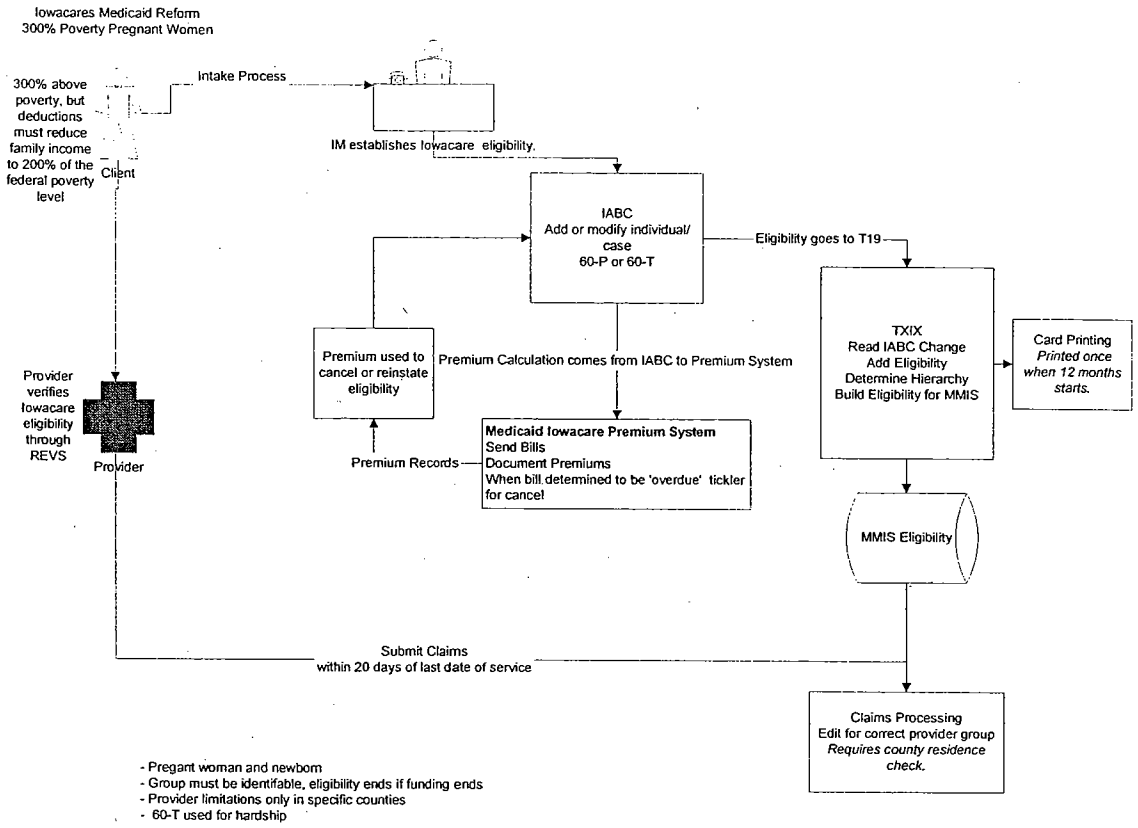
Changes for MMIS-CORE.doc

Iowacare Business Requirements – Premium Calc.doc

Process Diagram



- Individual 19 - 64 years of age
- Group must be identifable, eligibility ends if funding ends
- Provider and coverage limitations
- Not dually eligible in Medicare part D
- Aid type 60-E , those with hardship are 60-H
- Physical and Health Risk Assessment start 3/1/06
- Pharmacy clearinghouse, medical hotline starts 7/1/06


Iowacares Medicaid Reform
300% Poverty Pregnant Women
300% above poverty, but deductions must reduce family income to 200% of the federal poverty level
Client
Intake Process
IM establishes Iowacare eligibility.
IABC
Add or modify individual/ case
60-P or 60-T
Eligibility goes to T19
TXIX
Read IABC Change
Add Eligibility
Determine Hierarchy
Build Eligibility for MMIS
Card Printing
Printed once when 12 months starts.
Premium used to cancel or reinstate eligibility
Premium Calculation comes from IABC to Premium System
Provider verifies Iowacare eligibility through REVS
Provider
Premium Records
Medicaid Iowacare Premium System
Send Bills
Document Premiums
When bill determined to be 'overdue' tickler for cancel
MMIS Eligibility
Submit Claims
within 20 days of last date of service
Claims Processing
Edit for correct provider group
Requires county residence check.
- Pregant woman and newborn
- Group must be identifable, eligibility ends if funding ends
- Provider limitations only in specific counties
- 60-T used for hardship

IowaCare Reporting Requirements

Overview

The IowaCare Medicaid expansion is part of House File 841 approved by the Iowa Legislature in 2005. The group includes adults under 200% of the Federal Poverty Level who are not otherwise covered by insurance for needed medical care.

The objective of the reports is to identify the level of interest in the program, and monitor the program to ensure the demand does not exceed the State and Federal governments ability to provide funding for care.

Assumptions

- The programs of primary interest are the IowaCare group (Adults under 200% of FPL), IowaCare OB/Newborn (Pregnant woman under 300% FPL with medical costs that reduce the level of income to 200% or less) , and Continuous care for chronically ill citizens who were previously on State papers.
- The reports do not cover the Family Planning Waiver
- The reports do not cover the Children's Mental Health waiver.

Requirements

1. Provide Monthly and YTD totals by county for the IowaCare applications.

   Desired Measures:

Column	Source Data
Applications Received	Not Available
Applications Approved	MMIS Eligibility or Title 19 Eligibility Aid Type 60-E or 60-P
Applications Denied	Meeting on Monday 8/1 to determine if information can be captured or interpreted.
Denied OverIncome Chronic Condition Approval	MMIS Eligibility or Title 19 – Aid Type 777
Pending	N/A or Manual
Eligible for a Medicaid Program	N/A or Manual

   - Group by: County, with a grand total at the bottom of the report
   - Order by: County Name
   - Freshness of Data: Eligibility – Minimum weekly
   - Format: Table with a row for each county and data in the columns

IowaCare Reporting Requirements

- Filters:
  Gender
  Age
  Federal Poverty Level (not sure if available yet)

2. Provide Month and YTD counts of distinct recipients on Medicaid

- *Need to determine if we count any eligible – or if there are selected AID types that should be bypassed.*

Desired Measures

Column	Source Data
Count of approved members	MMIS Eligibility or T19 Eligibility

- Group by: County, with a grand total at the bottom of the report
- Order by: County Name
- Freshness of Data: Monthly
- Format: Table with a row for each county and data in the columns ; This would be a good candidate for a bar graph show growth or trends would be visible.
- Filters:
  Gender
  Age (19-29, 30-39, 40-49, 50-59, 60-65)
  Ethnicity

Would it be helpful or interesting to show a combined table of IowaCare and Medicaid – and in addition to showing counts of recipients YTD – show the percentage of the population in the county - for example Polk County as 50% of the IowaCare members and 33% of the total Medicaid members. This would allow a quick comparison so show if the IowaCare population is spread geographically similarly to the overall population of Medicaid.

3. Premium Reporting

Desired Measures:

1) Percentage of people with zero premium (and count)
2) Percentage of people with premiums > than zero who have paid, declared hardship, not responded … for each month of premium due. (Starts August, 2005) (and counts)
3) Total premiums collected
4) YTD total percent of people (and count) who have claimed hardship at least one month.

IowaCare Reporting Requirements

5) YTD total percent of people who have claimed hardship for all months.
6) YTD total percent of people who have never claimed hardship.

Data Source - Premium System .

The premium system would provide the net premium not the gross premium – so we would not be able to derive Federal Poverty Level information from this

We should also consider a detailed drill down that shows the same results based upon premium amount to reflect if the percentage of hardships go up as the premium amounts go up, or if the higher premium (and theoretically higher FPL – allows the client more ability to pay.)

Group by Month
Data Freshness: Monthly
Format: This information could be presented in a table format – or in a series graphs

1) A pie graph showing the premium amount and percent in relationship to the pie.
2) A stacked bar chart showing the premium amount on the x axis and then stacking – %paid, %hardship, and %unpaid. (YTD)
3) A stacked bar chart showing the month on the bottom and the total premium amount paid each month

Filters:

Gender
Ages

4. Claims paid for IowaCare

Desired Measure:

For each of the providers show Monthly (1st date of service) and YTD dollars in claims paid .

2640029 - Cherokee
2640037 - Independent
2640045 – Mt. Pleasant
2640052 – Clarinda

2260927 – UIH Pharmacy
2600585 – UIH Hospital
2231827 – Ambulance
2084012 - UIH DME / Supplies

2601013 – Broadlawns Hospital
2427476 – Broadlawns Physician Group
2066068 - Broadlawns Dentist

Suggestions:

- It might be helpful to show the dollars spent YTD in relationship to the amount allocated to the institution.... But for this purpose you'd want to break out by aid type so that the DSH dollars reflect separately.
- Allow filters by AID type (60E - IowaCare, 60P – IowaCare OB/Newborn , 777 – DSH)
- Report the total dollars claimed for the 60-P group – regardless of the institution.
- Show the average length of days between last day of service and the claim submission date.

5. Months of Participation for IowaCare (60E)

Desired Measure:

Overall: The 12 month enrollment period, the number of months a person was enrolled.
People with no premium obligation or who claimed hardship , the number of months a person was enrolled.
People with premium obligation or who claimed hardship, the number of months a person was enrolled.
Number of people who have started on the program since July 1 and are still active.
Number of people who started on the program since July 1 but are closed.
- display the data by length of months active, filter by premium vs. no premium.
Reasons for Disenrollment – (Do we have this information?)

For this measure we need to find a way to clarify people who enrolled in July 2005, v.s. someone who enrolled after that – it might be that in July 2006 – we begin a look at people who started in July 2005 – and do rolling statistics, etc. We will likely want to start looking at this prior to July 2006 –

Program Eligibility	Chronic Condition / State Papers 2005	Pharmacy	Pharmacy Funding	DME Coverage	DME Funding
DSH (> 200% poverty)	No	N/A	N/A	N/A	N/A
DSH (> 200% poverty)	Yes	Take Home – Yes	DSH	Yes	DSH
		Ongoing – Yes, only for pre-existing chronic condition	DSH		
IowaCare	No	Take Home – Yes	IowaCare	No	N/A
		Ongoing – No	N/A		
IowaCare	Yes	Take Home - Yes	IowaCare	Yes – only for pre-existing chronic condition	DSH
		Ongoing – Yes, only for pre-existing chronic condition	DSH		

Overview

The IowaCare expansion group will receive a limited set of Medicaid benefits through a limited set of providers. Benefits for this group will also be limited by the total amount of funding available through the fiscal year.

Assumptions

MMIS will translate the 60T and 60H aid types as those that do not require co-pays.

Requirements

Eligibility

1. Applicants must meet non-financial and income requirements for Medicaid.
2. The individual is not eligible for the medical assistance program on or after 4/1/05.

Program	Eligibility Calc	Premium Calc
IowaCare OB & Newborn 60-P, No age restrictions; 60P with a hardship becomes 60T for TXIX	Test 1: Gross income minus 20% earned income deduction under 300% FPL; Test 2: Gross income minus 20% earned income deduction and Med Expenses deduction equal/under 200% FPL	Premium determined from premium table. Run Premium Calc only if Eligibility Calc results in eligibility. Premium Test 2: countable income used to determine the premium amount and the *hawk- i* deduction off of the total premium. The *hawk-i* premium will be deducted from premiums for both eligible parents.
IowaCare Age19 – 64; 60-E; 60-E with a hardship becomes 60H for TXIX	Gross income minus 20% earned income deduction is under 200% FPL	Run Premium Calc only if Eligibility Calc results in eligibility. Premium determined from premium table. 20% deduction off of the earned income to determine the premium amount and *hawk-i* deduction off of the total premium. The *hawk-i* premium will be deducted from Iowacare premiums for both eligible parents.

Eligibility Entries

1. Income and deductions would be entered on the BCW2 screens for 60-E and 60-P. Amounts entered will be used to determine percent of FPL and income eligibility.
2. Resources will be entered on RSCM screens for 60-E and 60-P, but there will be no resource calculations.
3. The individuals associated to the case with a medical status of A, B, C or I will determine HH size. Considered individuals would be added to the case with an "S" fund code.
4. Fund codes will follow these age guidelines:
   - 60-E may be "A" or "3" only fund codes
   - 60-P may be "A" or"3" for females of eighteen years or older
   - 60-P may be "C" or "4" for either males or females under the age of eighteen
5. IM worker would not make any entries in the NEWBORN or UNB fields on the TD03 screen in regard to pregnancy or newborn status. The aid type would be sufficient to determine the status for pregnancy/newborn. Since we do not want to have the unborn child(ren) counted in the household size, the IMs will be trained to refrain from entering this field for 60-P cases and will receive a fatal WAR if the field is entered in error. (The fatal war and companion transactional WAR could be accomplished after July 1, 2005.)
6. 60E and 60P programs will have review periods of 12 months entered on the TD05.
7. Food Assistance programs may be on the same case as the IowaCare case, but this will be discouraged through training.
8. Do not allow retro medical for these aid types. Retro means any month prior to the month of application.
9. Individuals eligible for both IowaCare (60-E) and Family Planning (90-6) will have separate cases created.
10. For newborns under the 60P group, the eligibility will be limited to the 60-day period following birth (ends on the last day of the month when the 60 days ends).

Hardship

1. The IM will determine if the applicant/member meets the criteria to be granted a hardship exception for the payment of premiums and co-pays.
2. The Hardship indicator will be placed adjacent to the MEPD PREM field on the TD05.
3. The Hardship indicator will default to a "N" unless the IM changes it to "Y" to block premiums and co-pays.

4. At the end of the yearlong certification period or when eligibility ends due to non-payment and is not reinstateable the IABC system will change the "Y" to "N".

NODs: Eligibility Calcs and Premium Calcs

1. For 60P and 60E aid types, the premium calc only will be shown if case eligible. If the case is denied for over income then an eligibility calc will be displayed on the right side of the notice.
2. These programs will not utilize the headers currently in IABC. Each notice reason would be all-inclusive (Header and reason info).

IowaCare Card

1. The Iowa Care medical card will be issued once per certification period after initial eligibility is approved.
2. This card has a design resembling a health insurance card.

Premiums

1. The net premium will be stored on the case master (shown on TD05 Screen). The net premium will reflect the amount that each individual on the case will be required to pay.
2. The net amount will be sent to the MIPS billing system for each eligible individual.
3. Individual premiums payment statements will be generated from the Medicaid IowaCare Premium System (MIPS).
4. Paid premiums shall not be refunded due to hardship or the client being found eligible for other Medicaid coverage.
5. Unpaid premiums for months of IowaCare eligibility will continue to be considered a debt, when eligibility is retroactively gained for any other Medicaid coverage.
6. Future months paid premium credit on MIPS may be refunded if the individual gains eligibility for other Medicaid coverage.
7. In situations where the member meets the qualifications for a hardship exception to paying for premiums and co-pays, the IM will enter "Y" on the hardship indicator on the TD05 screen. The premium amount will be replaced with zeros in the TD05 MEPD PREM field.
8. After the Hardship indicator of "Y" is entered, an NOD will be system generated to reflect the reduced premium obligation

Billing

1. The member is required to pay the monthly premiums for the mandatory period. The mandatory period is defined as the month of the positive action and the next three consecutive months of the certification period.

2. After a mandatory period ends, a new four month mandatory period will begin each time there is a break of eligibility of more than one month past the date of cancellation.
3. Mandatory periods will not overlap.
4. Premium payment statements will be sent as follows:
    a. The premium for the first month of eligibility will be due on the last day of the second month of eligibility.
    b. The premium for the second, third and fourth months of the mandatory period will be due on the last day of the billing month. (The premium for the second month is due on the last day of the second month, the premium for the third month is due on the last day of the third month, the premium for the fourth month is due on the last day of the month, etc.)
    c. The premiums for months after the mandatory period will be due on the last day of the month of eligibility. (For example, the fifth month is due on the last day of the fifth month.)
5. If the last day of the month falls on a weekend day or holiday, the premium will be due the first business day of the following month.
6. When the Billing system receives the code for hardship, the 'Y' will override any other information we have regarding the premium. In other words if hardship is granted, but, there is also a premium record in the billing system that still shows a dollar amount greater than 0 for the premium, client will not be billed, nor required to pay anything for any month hardship is granted. The billing system will 'know' if there is a "Y" for hardship, the premium is $0 for that month.
7. The premiums statements will be generated on the first working day of the month. The premiums statement will state the premium is due by the fifteenth of the billing month.
8. The MIPS will send a friendly payment reminder letter to members who have not paid the required premium(s) by the fifteenth.

Case Maintenance

1. If IowaCare and Food Assistance were on the same case, system coding will be added to stop reviews/recertification dates from aligning between these programs.
2. Persons eligible for IowaCare may have QC or HIPP sanctions applied.
3. For 60-E cases with two eligible IowaCare members: A WIF will be sent to the IM if one member fails to timely pay premiums, that member will become a considered person on the case and the fund code will be changed to "S". Existing system case actions can be used to accomplish this.
4. After the end of a mandatory period, when a member goes beyond the period of reinstatement and requests IowaCare coverage again, they must file a new application and begin a new four-month mandatory period.

Cancellation

1. After eligibility is sent to T-19 for the twelfth month, the IowaCare Aid Types (60-E & 60-P) will cancel effective end of twelfth month with no NOD. This process is based on the date in the NEXT REV field on the TD05 screen.
2. 60-E members who will exceed the age of 65 years at the next birthday will be automatically canceled with timely notice in the correct month. If the date of birth is the first day of the month, the IowaCare will be canceled as of the last day of the preceding month. If the date of birth is any date other than the first of the month, then the IowaCare will be canceled as of the last day of that month.
3. The dates off the MIPS billing file could be used to trigger the cancellation process. MIPS will send a file to IABC with the following for each person:
    - Start Date
    - Last month paid
    - Unpaid Balance

Reinstatement

1. An individual's case may be reopened when eligibility is canceled for non-payment of premium when:
    - The premium owed is paid in the calendar month following the month the payment was due, or
    - The payment for the mandatory months is paid in full by the last day of the month following the last mandatory month. (see Billing #5.)
2. The use of "C" "C" entries will be required to re-open the case as these entries require the use of a new POS DATE on TD05. The entries of "B "B" will trigger a fatal WAR.
3. The dates off the MIPS billing file could also be used to trigger the reinstatement process.

Rules for Retaining Eligibility

1. Single comprehensive medical examination within 90 days (as of 3/1/06) (May access Medicaid providers for this exam)
2. Health risk assessment (3/1/06)
3. Personal Improvement Plan (6/1/06)

Medical Services

Services provided:

- Inpatient hospital procedures
- Outpatient hospital services
- Physician and ARNP services

- Dental Services
- Limited Pharmacy benefits
- *List of services for ACS/MMIS?*

Provider network

Who provides?

Federal Reporting

See attached table

Functional Impact

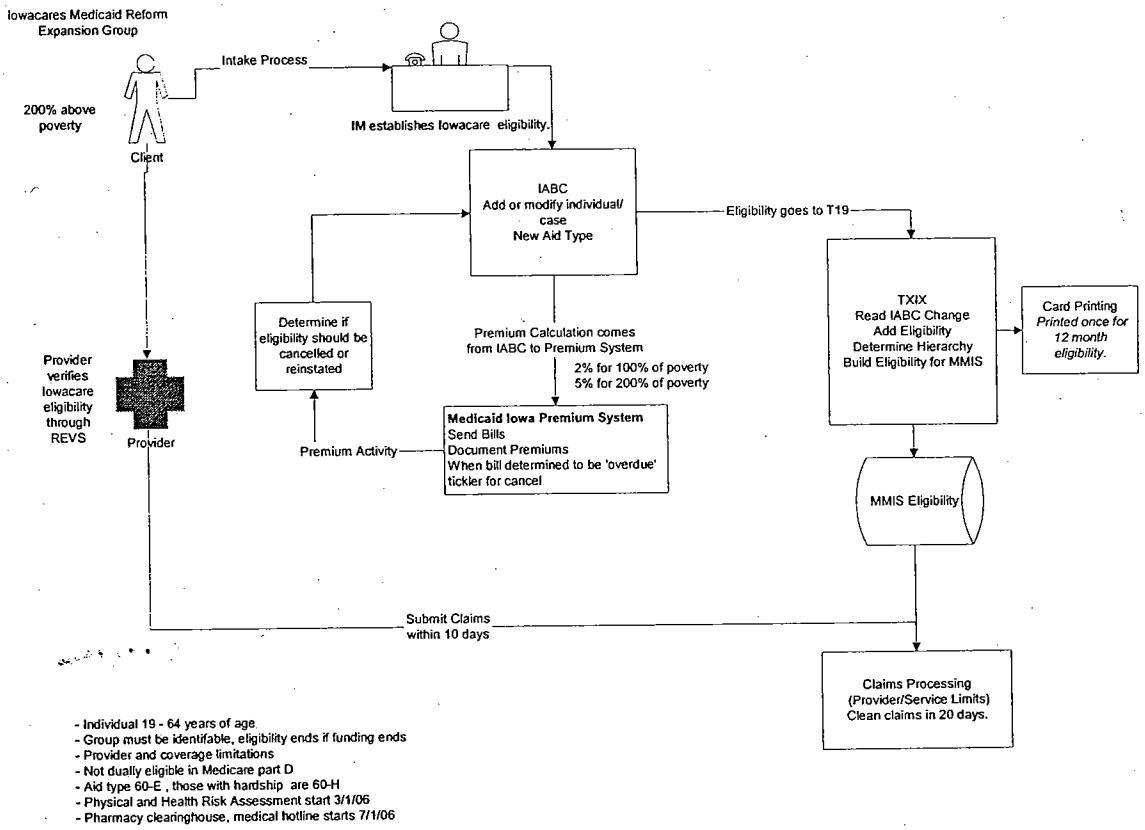
The eligibility and case maintenance work process for Income Maintenance Workers will be defined in the Employee Manual. The system entries will be described in the EM 14 B Appendix.

Reports

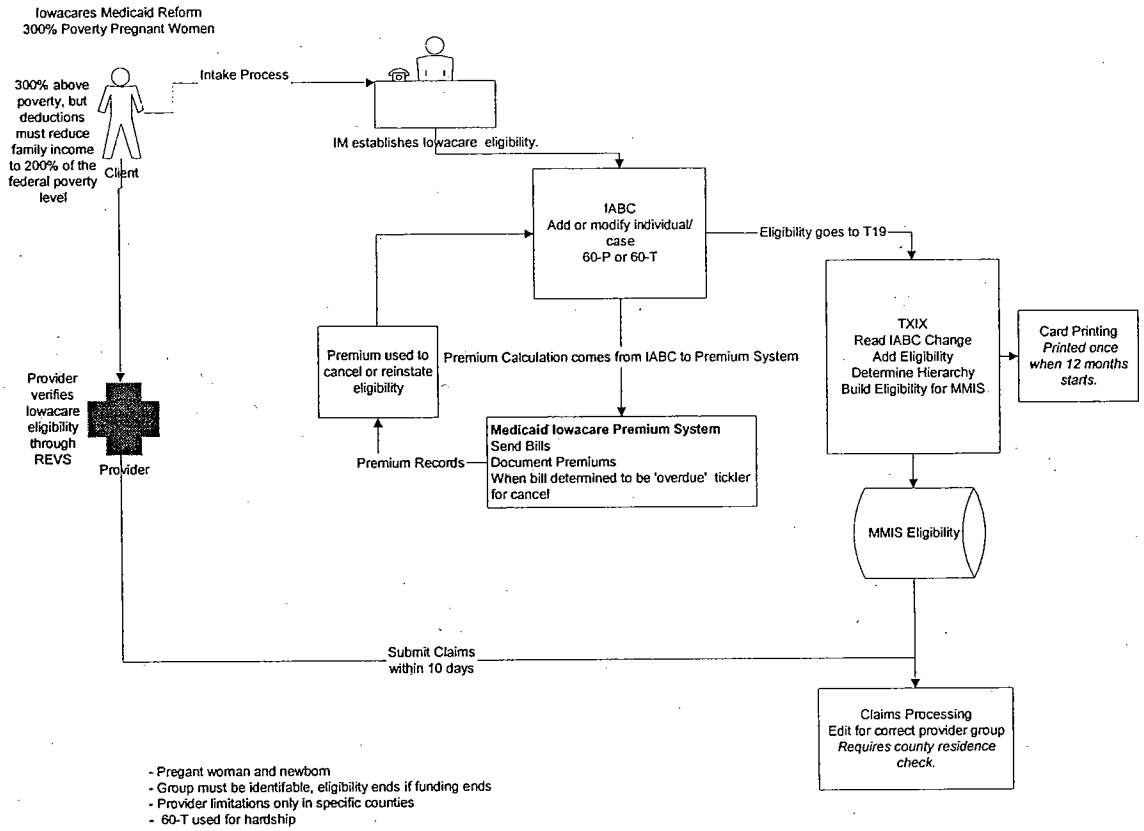
References

Draft 441—91.1(249) through 91.17(3)

Process Diagram



- Individual 19 - 64 years of age
- Group must be identifable, eligibility ends if funding ends
- Provider and coverage limitations
- Not dually eligible in Medicare part D
- Aid type 60-E , those with hardship are 60-H
- Physical and Health Risk Assessment start 3/1/06
- Pharmacy clearinghouse, medical hotline starts 7/1/06


Iowacares Medicaid Reform
300% Poverty Pregnant Women
300% above poverty, but deductions must reduce family income to 200% of the federal poverty level
Client
Intake Process
IM establishes Iowacare eligibility.
IABC
Add or modify individual/ case
60-P or 60-T
Eligibility goes to T19
TXIX
Read IABC Change
Add Eligibility
Determine Hierarchy
Build Eligibility for MMIS
Card Printing
Printed once when 12 months starts.
Premium used to cancel or reinstate eligibility
Premium Calculation comes from IABC to Premium System
Provider verifies Iowacare eligibility through REVS
Provider
Premium Records
Medicaid Iowacare Premium System
Send Bills
Document Premiums
When bill determined to be 'overdue' tickler for cancel
MMIS Eligibility
Submit Claims within 10 days
Claims Processing
Edit for correct provider group
Requires county residence check.
- Pregant woman and newborn
- Group must be identifable, eligibility ends if funding ends
- Provider limitations only in specific counties
- 60-T used for hardship