



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

January 24, 2014

GENERAL LETTER NO. 8-A-58

ISSUED BY: Bureau of Financial, Health and Work Supports
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 8, Chapter A, **ADMINISTRATION**, Contents (page 1), revised; and pages 3, 4, 5, 9, 10, 11, 19, 24, 25, 34, and 36, revised.

Summary

Chapter 8-A is revised to:

- ◆ Remove references to the IowaCare program.
- ◆ Update references for intermediate care facilities for persons with an intellectual disability (ICF/ID).
- ◆ Remove references to the IowaCare medical card.
- ◆ Add the Iowa Health and Wellness Plan under the duties of the Bureau of Adult and Children's Medical Programs.
- ◆ Clarify the procedures for processing requests for information.
- ◆ Reflect policy changes for programs administered by the Iowa Department of Revenue as follows:
 - Increase the income limit for a property tax credit from \$21,335 per year to \$21,697.99 per year.
 - Increase the income limit for a rent reimbursement from \$21,335 per year to \$21,697.99 per year.

Effective Date

Upon receipt.

Material Superseded

This material replaces the following pages from Employees' Manual, Title 8, Chapter A:

<u>Page</u>	<u>Date</u>
Contents (page 1)	October 9, 2009
3	October 9, 2009
4	June 18, 2010
5, 9-11	February 25, 2011
19, 24, 25	October 9, 2009
34, 36	January 4, 2013

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

	<u>Page</u>
Overview	1
Definitions	2
Eligibility	9
Medical Assistance Eligibility Card	9
Eligibility Verification System	10
Benefits	11
Iowa Medicaid Enterprise.....	11
When Members Are Responsible for Payment of Medical Bills	14
Copayments.....	15
Recovery	17
Amount to Recoup	19
Medically Needy Overpayment.....	21
Department Responsibilities	24
Confidentiality	25
Maintenance of Facility Inspection Reports	25
Nondiscrimination	26
Notification	27
When Notice Is Required	27
Timely Notice When Probable Fraud Exists	28
When Timely Notice Is Not Required.....	28
Notice Forms.....	29
Appeals.....	30
Reimbursement After Appeal Decisions.....	31
Bills That Cannot Be Reimbursed	32
Reimbursement Process	33
Property Tax Relief	33
Homestead Property Tax Credit for the Elderly or Disabled	34
Property Tax Suspension	34
Rent Reimbursement	36

“Disabled person” for SSI-related or Social Security Administration purposes, is a person who is unable to engage in substantial gainful activity because of a physical or mental impairment that has lasted or is expected to last for 12 continuous months or result in death. EXCEPTION: The MEPD coverage group does not apply the substantial gainful activity test to determine disability. A disabled person must meet the only physical or mental impairment criteria.

“E-SLMB” means the SSI-related expanded specified low-income Medicare beneficiary coverage group.

“Family Investment Program” (FIP) is the name of Iowa’s Temporary Assistance for Needy Families program. The purpose of FIP is to provide financial and other assistance to needy, dependent children and the parents or relatives with whom they live.

“Family Medical Assistance Program” (FMAP) is the basis of Medicaid eligibility policy for coverage groups for pregnant women, families, and children.

“Federal financial participation” (FFP) is the rate at which the federal government reimburses the state for providing Medicaid services.

“FIP” means the Iowa Family Investment Program.

“FMAP” means the Iowa Family Medical Assistance Program.

“FMAP-related” describes coverage groups whose eligibility criteria are derived in relation to the Family Medical Assistance Program, directed toward children and their parents or caretakers.

“Health maintenance organization” (HMO) means an organization formed by a group of doctors and other medical professionals to provide complete health care to the patients who join it. The HMO provides or arranges for hospitalization, lab or X-ray needs, and most other medical services. HMOs make these services available to the patient for a fixed monthly rate that is paid by Medicaid.

“HMO” means health maintenance organization.

“ICF/MI” means an intermediate care (nursing) facility for people with mental illness.

“ICF/ID” means in intermediate care facility for persons with an intellectual disability.

“IME” means the Iowa Medicaid Enterprise.

“Institutionalized spouse” means a person who lives in a medical institution (or participates in a home- and community-based services waiver) and will remain there for at least 30 consecutive days but whose spouse is not in a medical institution or in a waiver program. “Spouses” include people who are married under state law or common law and people who are separated.

“Intermediate care facility for persons with an intellectual disability” or **“ICF/ID”** means a medical institution used primarily for the diagnosis, treatment, or rehabilitation of people who have an intellectual disability. In a protected residential setting, the facility provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or related services to help each resident function at the resident’s greatest ability.

“Iowa Plan for Behavioral Health” or **“Iowa Plan”** means a statewide Medicaid managed care program that integrates treatment for mental health and substance abuse. All mental health and substance abuse treatment services available through fee-for-service plus an expanded array of community-based services are available to Iowa Plan enrollees.

Iowa Plan enrollment is automatic and mandatory and for most enrolled beneficiaries begins with the month of application. The following Medicaid members are excluded from Iowa Plan enrollment:

- ◆ Members eligible as medically needy with a cash spenddown.
- ◆ Members living in the Woodward or Glenwood State Resource Centers.
- ◆ Members with limited Medicaid benefit packages, such as QMB, SLMB, E-SLMB, QDWP, illegal aliens, and presumptive eligibles.

“Local office” means the Department field office in each county, a centralized unit, or a state mental health institute or resource center.

“MAC” means the FMAP-related mothers and children coverage group for certain pregnant women and children under the age of 19.

“Managed care” is a delivery system in which the patient is linked to a primary care physician or provider who monitors, coordinates, and provides medical care. There are currently three different types of managed care initiatives in Iowa: health maintenance organizations, MediPass, and the Iowa Plan.

“Medicaid for Kids with Special Needs” or **“MКСN”** means a medical coverage group for children with disabilities.

“Medical Assistance Advisory Council” or **“MAAC”** means the group that advises the Department about health and medical care services and participates in policy development. The MAAC is composed of representatives from:

- ◆ Provider groups.
- ◆ The General Assembly.
- ◆ The Department of Public Health.
- ◆ Consumers.
- ◆ The public.

(Legal reference: 42 CFR 431.12, 441 IAC 79.7(249A))

“Medical institution” means:

- ◆ Acute care hospitals
- ◆ Psychiatric institutions, including:
 - State mental health institutes (MHIs)
 - Psychiatric hospitals
 - Psychiatric medical institutions for children (PMICs)
- ◆ Long-term care facilities, including:
 - Nursing facilities (NFs)
 - Nursing facilities for people with mental illness (ICF/MI)
 - Hospital-based or non-hospital-based skilled nursing facilities (SNFs)
 - Intermediate care facilities for persons with an intellectual disability (ICF/IDs)

Residential care facilities are **not** medical institutions and are not Medicaid providers.

Eligibility

The Bureau of Financial, Health, and Work Supports in the Department's Division of Adult, Child, and Family Services is responsible for formulating Medicaid eligibility policy and procedure within the framework of state and federal law and regulations. See Chapter 8-F, [COVERAGE GROUPS](#), for more information on ways that people can qualify for Medicaid benefits.

The Department has at least one local office in each county in Iowa. These offices are organized into five geographic service areas and a centralized service area, each led by a service area manager. Income maintenance workers in the Department's service areas determine Medicaid eligibility. However, in certain circumstances, eligibility determination is done by staff of the Social Security Administration or by qualified providers.

Service areas are responsible for maintaining the Medicaid eligibility records for all members. Each member's case is assigned to a particular income maintenance worker, who enters eligibility information into a centralized automated system.

Medical Assistance Eligibility Card

Legal reference: 441 IAC 76.6(249A), 80.5(1), 88.46(5)

The Department issues a *Medical Assistance Eligibility Card*, form 470-1911, to all Medicaid members. The *Medical Assistance Eligibility Card* is issued at time of approval (or when spenddown is met for a medically needy person).

EXCEPTION: Members determined presumptively eligible for Medicaid have form 470-2580 or 470-2580(S), *Presumptive Medicaid Eligibility Notice of Decision*, as evidence of eligibility rather than the *Medical Assistance Eligibility Card*.

The card lists the member's name, state identification number, and date of birth. Replacement cards can be issued upon a member's request.

Only the member named on the card can use the card. Members are responsible for:

- ◆ Notifying the provider of service that they are Medicaid members.
- ◆ Showing the card or providing the health care provider with information needed to verify Medicaid eligibility.

Providers must check ELVS or the web portal to identify existing health insurance coverage and any service restrictions, such as lock-in, HMO, MediPASS, or Iowa Plan. Services are covered only when provided under the Medicaid coverage group under which the member enrolled.

Eligibility Verification System

The Department's Eligibility Verification System (ELVS) and secure web site allow a provider to verify:

- ◆ 24 months of member eligibility.
- ◆ Eligibility for PACE enrollees.
- ◆ Eligibility for qualified Medicare beneficiaries.
- ◆ Conditional eligibility for Medically Needy members.
- ◆ The amount of spenddown balance for Medically Needy.
- ◆ MediPASS patient manager's name and telephone number.
- ◆ HMO or managed care coverage, with the provider's name and phone number.
- ◆ Services not covered by an HMO.
- ◆ Iowa Plan information.
- ◆ Third-party resources.
- ◆ Lock-in restrictions.
- ◆ The date and amount of the provider's last remittance.

The ELVS telephone number for the Des Moines area is **515-323-9639** and for the rest of the state is **1-800-338-7752**. A touch-tone phone is needed, and providers must know:

- ◆ Their provider number,
- ◆ The date of service, and
- ◆ Either the member's state identification number or the member's date of birth and social security number.

To set up access to the secure web site, providers must contact EDISS at 800-967-7902.

Benefits

Members who are not required to be in managed care and are not PACE enrollees have primary responsibility to find and select providers who accept Medicaid. If a member asks you for help in finding a provider, encourage the member to check the yellow pages and call the provider to ask if the provider will accept the member as a patient and will bill Medicaid for the needed service.

Coverage of Medicaid services is explained in more detail in 8-M, [MEDICAID SERVICES](#), and in 8-Appendix, *Medicaid Provider Manuals*. If the member asks you about coverage of a particular service, tell the member to contact the provider of the service. If the provider is unsure about coverage, the provider can call the IME Provider Relations Unit.

Iowa Medicaid Enterprise

The **Division of Medical Services** administers the Iowa Medicaid Program and the Children's Health Initiative Program (CHIP) and coordinates the activities of its bureaus: Long Term Care, Adult and Children's Medical Programs, Operations, Program Integrity, and the contracting teams. Support of the Medical Assistance Advisory Council (MAAC) is also provided.

The Division administers the development of policies about coverage and payment for pharmacy benefits, as well as the Iowa Plan for Behavioral Health and other managed care contracts. All activities associated with national health care reform, as it applies to the Medicaid program, except policy related to expanded eligibility, are also administered out of this Division.

The Division's **Bureau of Long-Term Care** is responsible for policy development about coverage and payment, as well as quality oversight, for the state's nursing facilities (SNF and ICF), intermediate care facilities for persons with intellectual disabilities (ICF-ID), home health agencies, rehabilitative services, and home- and community-based services waiver programs.

The Division's **Bureau of Adult and Children's Medical Programs** is responsible for the development of policies about coverage and payment for all other services. Additionally, this bureau is responsible for policy development, administration and oversight of the Health Insurance Premium Payment (HIPP) program, the Healthy and Well Kids in Iowa (*hawk-i*) program, and the Iowa Health and Wellness Plan and coverage policies.

6. If the household received Medicaid but was ineligible, calculate an overpayment.
7. Complete the Initial Claim Entry on line. EXCEPTION: For overpayments before July 1, 1997, contact central office for assistance.
8. Wait to determine the amount of the Medicaid overpayment for six months after the "To Date" on the claim to allow time for claims to be submitted. (While providers have 12 months to submit a claim, the majority of Medicaid claims are submitted in the six-month period after service is given.) See [Amount to Recoup](#).

Comment:

See [6-G](#) for information about how to establish a claim for an overpayment, repayment options available to members, and types of collection actions.

Members usually repay the Department directly. In the case of overpayment due to incorrect calculation of client participation for a member in a nursing facility, PMIC, ICF/ID, or mental health institute, the member repays the facility. The Department then recovers the funds from the facility through a vendor adjustment. See 8-I, [Client Participation](#).

Amount to Recoup

Policy:

Consider the following when determining the Medicaid claim amount:

When:	Recoup:
The overpayment was a member error, and the member is completely ineligible for Medicaid...	All Medicaid claims paid, including capitation fees.
The overpayment was an agency error...	All Medicaid claims paid except for capitation fees.
The member is ineligible for full Medicaid but would continue to be eligible for under the Iowa Family Planning Network...	All Medicaid claims paid except for family planning services. Include capitation fees.

If the appellant disputes the amount of the overpayment ask if the appellant has any documentation to show that the appellant is obligated to pay or has paid these pharmacy claims.

Mr. Z, who is potentially eligible for Medically Needy for May and June, has a spenddown of \$150. Mr. Z takes his prescription to Pharmacy M on May 15. Pharmacy M submits a claim through the Point of Sale (POS) system and finds out that Mr. M. has not met his spenddown.

Pharmacy M does not give Mr. Z his prescription, since he cannot pay the \$175 cost. The POS system does not know that Mr. Z did not receive the prescription. It sends the claim to MMIS. MMIS submits the claim to the Medically Needy subsystem and Mr. Z meets his spenddown.

Pharmacy M faxes the *Medically Needy Expense Deletion Request* to the Medically Needy Unit at IME. The Medically Needy Unit determines that Mr. Z has met spenddown using the prescription that he did not receive.

The Medically Needy Unit sends the income maintenance worker a letter stating that Mr. Z did not incur the expense for the prescription. The worker checks the Medically Needy subsystem and determines that the \$175 submitted by Pharmacy M on May 15 was used to meet spenddown.

On the first of January, six months after the end of the certification period, the worker obtains information from the Overpayment Recovery Detail system to determine the amount of claims that Medicaid paid for Mr. Z for the months of May and June.

Medicaid paid \$2,595.55 in claims for Mr. Z. Since Mr. Z did not incur \$150 in medical expenses and therefore, did not meet his spenddown, an overpayment for \$150 is completed.

Department Responsibilities

The Department has general administrative responsibilities for:

- ◆ [Maintaining confidentiality of Medicaid-related information](#)
- ◆ [Maintaining facility inspection reports](#)
- ◆ [Preventing discrimination by staff or vendors](#)
- ◆ [Providing notification of Department actions that meets legal requirements.](#)

Confidentiality

Legal reference: 441 IAC 9.1(17A, 22), 9.2(17A, 22), 9.3(17A, 22), 9.10(8);
42 CFR 431.301 through 431.306

Federal Medicaid regulations require that the Department release information about a Medicaid applicant or member **only** for purposes directly connected with the administration of the Medicaid program unless specifically authorized by the applicant or member.

As a health plan, Medicaid is subject to the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) and corresponding federal regulations on the standards the Department must meet to protect the privacy of protected health information. Health care providers are also subject to HIPAA standards.

Requests for information are made using:

- ◆ Form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, when the request is for a third party/service, such as a law firm.
- ◆ Form 470-3952, *Request for Access to Health Information*, when a client requests their own Personal Health Information (PHI).

When either form is received at a DHS office, the worker must send it on to the DHS Security and Privacy Office to be reviewed. Legitimate requests for information will then be gathered from the Data Warehouse and provided to the requester via a File Transfer Protocol (FTP).

See 1-C, [CONFIDENTIALITY AND RECORDS](#), for additional information on the policies and responsibilities regarding confidentiality of protected health information.

Maintenance of Facility Inspection Reports

Legal reference: 42 CFR 431.115

Department offices must make publicly available survey information from the Department of Inspections and Appeals for:

- ◆ Hospitals.
- ◆ Nursing facilities.
- ◆ Intermediate care facilities for the mentally retarded.
- ◆ Home health agencies.
- ◆ Independent laboratories.

Because the Department serves the population that qualifies for tax suspension and other low-income people who might qualify for a property tax credit or rent reimbursement, the Department is required to:

- ◆ Inform members who might qualify about the program.
- ◆ Provide verification to members who own property and who receive the benefits that qualify them for automatic tax suspension.
- ◆ Verify continued eligibility for tax suspension annually for the county board of supervisors.

Homestead property tax credit and rent reimbursement are explained in Comm. 121 or Comm. 121(S), *Important Notice to Property Owners and Renters*. Give this pamphlet to elderly and disabled applicants. Document this in the case record.

Homestead Property Tax Credit for the Elderly or Disabled

Legal reference: Iowa Code Sections 425.16 - 425.40

Certain elderly and disabled residents are entitled to a tax credit of up to \$1,000.00 of their tax liability on their homestead property. To qualify in 2013, household income must be less than \$21,697.99 per year, and the person must be:

- ◆ 65 years of age or older on December 31, 2013, or
- ◆ Totally disabled as of December 31 of the previous year.

Property owners must file for the tax credit with the county treasurer in the county where their homestead is located. The amount of the credit depends upon the household's income.

Property Tax Suspension

Legal reference: Iowa Code Section 427.9

A person may be eligible for suspension of property taxes when the person:

- ◆ Receives Supplemental Security Income (SSI), or
- ◆ Receives State Supplementary Assistance (SSA), including the supplement for Medicare and Medicaid eligibles, or
- ◆ Lives in a health care facility and the Department is paying for part of the care.

The county board of supervisors shall annually supply to the local Department office a list of names and social security numbers of people receiving tax suspension due to:

- ◆ Eligibility for State Supplementary Assistance or SSI, or
- ◆ Residing in a health care facility with the Department paying for part of the care.

Upon receipt of the list, indicate if the identified people continue to receive benefits that qualify them for tax suspension and return the list to the board of supervisors. No release of information is required to respond to this list.

Rent Reimbursement

Legal reference: Iowa Code Sections 425.16 through 425.40

People who pay rent in buildings that are not tax-exempt may receive reimbursement of up to \$1,000 of the gross rent paid each year.

To qualify for rent reimbursement in 2013, household income must be less than \$21,697.99 per year. Also, the person must be:

- ◆ 65 years of age or older as of December 31, 2013, or
- ◆ Totally disabled as of December 31 of the previous year.

People who live in a health care facility, such as a nursing facility or residential care facility, are considered renters for purposes of this reimbursement. A percentage of the Medicaid payment to a nursing facility or the State Supplementary Assistance payment to a residential care facility may be counted as payment for rent, and therefore is counted for this program.

The Iowa Department of Revenue administers the program. Rent reimbursement forms are available through the offices of the county treasurer and through some agencies that serve the aged or disabled population.