



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

August 23, 2013

GENERAL LETTER NO. 8-O-21

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

SUBJECT: Employees' Manual, Title 8, Chapter O, **IOWACARE**, Contents (pages 1 and 2), revised; and pages 1 through 41, revised.

Summary

Chapter 8-O is revised to:

- ◆ Note that the IowaCare program and the pre-existing chronic condition group will end for all members on December 31, 2013.
- ◆ Change the certification period for all members who were eligible for IowaCare on July 1, 2013, to end on December 31, 2013. This means that some members had their certification extended to December 31, 2013, and other members had their certification period shortened to end on December 31, 2013.
- ◆ Stop all new eligibility for IowaCare members after the eligibility date effective June 1, 2013. Applications received July 1, 2013, or later will not be processed for IowaCare eligibility.
- ◆ Stop issuing form 470-4364, *IowaCare Renewal Application*, to existing members with certification periods ending June 30, 2013. There will be no more renewal processing for members as all certifications will end December 31, 2013.
- ◆ Remove the transportation section as transportation is no longer provided by the University of Iowa Hospitals and Clinics.
- ◆ Remove references to application renewal processing.

Effective Date

July 1, 2013

Material Superseded

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

<u>Page</u>	<u>Date</u>
Contents (page 1)	November 12, 2010
Contents (pages 2 and 3)	February 24, 2012
1	May 27, 2011
2-4	November 12, 2010
5	January 18, 2013
6	February 24, 2012
7	September 14, 2007
8	October 21, 2011
9	March 7, 2008
10	January 18, 2013
11, 12	May 27, 2011
13	November 12, 2010
14	February 24, 2012
15	January 18, 2013
16	March 26, 2010
17	November 12, 2010
18	March 30, 2007
19	September 14, 2007
20	October 21, 2011
21, 22	January 18, 2013
23, 24	February 24, 2012
25	December 7, 2007
26	March 30, 2007
27	January 18, 2013
28	March 15, 2013
29	February 24, 2012
30, 31	November 12, 2010
32, 33	March 30, 2007
34, 35	November 12, 2010
36	March 15, 2013
36a	February 24, 2012
37	May 27, 2011
38-41	March 30, 2007
42	October 21, 2011
43	March 7, 2008
44	February 24, 2012
44a, 44b	October 21, 2011
45	March 7, 2008
46	March 6, 2009
47	January 18, 2013
48	March 15, 2013
49	January 18, 2013
50	February 24, 2012
51, 52	November 12, 2010

53, 54
55-65
66, 67
68-76

January 18, 2013
February 24, 2012
March 15, 2013
February 24, 2012

Additional Information

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

	<u>Page</u>
Overview	1
Legal Basis	2
Definitions	3
Determining IowaCare Eligibility.....	5
Concurrent Eligibles	5
Nonfinancial Eligibility	6
Medical Benefits From Other Sources.....	6
Group Health Insurance.....	6
Cooperation in Obtaining Medical Resources	9
Cooperation With Third-Party Liability Unit	9
Failure to Cooperate With Third-Party Liability Unit.....	11
Good Cause for Failure to Cooperate	11
Medical Assistance Lien.....	11
Residents of Public Nonmedical Institutions	12
Halfway House	13
Inpatient Medical Institutions	14
Quality Control.....	14
Availability of Funds	14
Premiums	14
Premium Amount.....	15
Payment of Assessed Premiums	16
Deducting <i>hawk-i</i> Premiums	19
Premium Exclusion.....	19
Billing and Payment	19
Hardship.....	21
Failure to Pay the Premium	24
Premium Refunds	25
Case Maintenance	25
Reporting Changes.....	26
Acting on Changes	26
Recovery	28
Terminating Eligibility.....	30
Right to Appeal.....	31

	<u>Page</u>
Covered Services	31
Network Providers	32
Obstetric Coverage for Qualifying Pregnant Women	35
Newborn Coverage.....	36
Prescriptions	37
Routine Preventive Medical Examinations	37
Services to Quit Smoking.....	38
Pre-Existing Chronic Condition Group.....	38
Notice of Decision	40
Reporting Requirements	40
Acting on Changes	41
Case File	41

Overview

The IowaCare program ends December 31, 2013. All certification periods beginning effective on or after January 1, 2013, will end December 31, 2013.

This chapter provides information specific to the Medicaid waiver program called "IowaCare." The IowaCare program extends limited Medicaid eligibility to people who are not eligible for assistance under any Medicaid coverage group except the Iowa Family Planning Network. These include:

- ◆ Persons ages 19 through 64 whose countable household income is less than 200% of the federal poverty level.
- ◆ Pregnant women whose gross income is less than 300% of the federal poverty level and whose allowable family medical expenses bring their countable income to below 200% of the federal poverty level ("qualifying" pregnant women).

NOTE: Only a woman whose resources are over the limit for the Mothers and Children (MAC) coverage group will qualify for IowaCare instead of MAC. See 8-F, [MAC Resource Limit](#), for amounts.

- ◆ Newborn children born to qualifying pregnant women who are not eligible for MAC coverage. NOTE: A Medicaid application must be filed to establish that the infant does not qualify for Medicaid.

New enrollment for IowaCare ended with applications received after June 30, 2013, due to an enrollment cap approved by the Centers for Medicare and Medicaid. There will be no new IowaCare members determined eligible with an effective eligibility date after June 2013.

Members who have income over 150% of the federal poverty level for the household size must pay a premium for IowaCare coverage. The premiums are based on a sliding scale. A member must pay for at least four months of premiums. The premium may be waived on a month-by-month basis if a hardship is claimed.

IowaCare provides limited services (chiefly hospital and physician services) from a limited provider network the University of Iowa Hospitals and Clinics, Broadlawns Hospital in Des Moines, and designated federally qualified health centers.

Individuals who were eligible for IowaCare on July 1, 2013, will remain eligible for IowaCare until December 31, 2013, unless eligibility is lost due to:

- ◆ Turning 65,
- ◆ Entitlement to Medicare,
- ◆ Moving out of Iowa,
- ◆ Becoming eligible for a Medicaid coverage group,
- ◆ Enrollment in health insurance coverage,
- ◆ Fails to timely pay a premium, or
- ◆ Other reasons as described in 441 IAC Chapter 92.

Legal Basis

Legislation in 2005 Iowa Acts, Chapter 167, directed the Department to apply for waivers of federal Medicaid requirements to create a new “expansion population” for the Iowa Medicaid program. The Centers for Medicare and Medicaid Services approved the waivers with an effective date of July 1, 2005.

Iowa Code Chapter 249J, “IowaCare,” has been revised by:

- ◆ 2006 Iowa Acts, Chapter 1184, changing provisions for reenrollment, health risk assessment, premium payment, and the IowaCare account.
- ◆ 2007 Iowa Acts, Chapter 218, clarifying premium payment standards.
- ◆ 2008 Iowa Acts, Chapter 1014, clarifying that acceptance of a premium payment doesn’t confer eligibility.
- ◆ 2009 Iowa Acts, Chapter 110, relating to the agreement with the University of Iowa Hospitals and Clinics.
- ◆ 2009 Iowa Acts, Chapter 182, establishing a fund for reimbursement of nonparticipating providers.
- ◆ 2010 Iowa Acts, Chapter 1134, expanding the provider network to include federally qualified health centers.
- ◆ 2010 Iowa Acts, Chapter 1141, updating requirements for health risk assessment, tracking, and reporting and removing references to coverage at state mental health institutes.
- ◆ 2010 Iowa Acts, Chapter 1193, making editorial changes.

All state expenditures under the IowaCare program qualify for matching with federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to section 1115 of the Social Security Act (42 USC §1315). Therefore, IowaCare shall remain in effect only as long as these waivers are in effect.

Definitions

Legal reference: 441 IAC 92.1(249A,249J)

“Applicant” means an individual who has applied for medical assistance under the IowaCare program described in this chapter.

“Department” means the Iowa Department of Human Services.

“Dependent child” means the:

- ◆ Child or stepchild of an applicant or member who is living in the applicant’s or member’s home and is under the age of 18 or is 18 years old and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching age 19. NOTE: Correspondence school is not an allowable program of study.
- ◆ Child or stepchild attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.
- ◆ If the child is a full time student, the parents may claim the child as a dependent up to the age of 24.

“Enrollment period” means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

“Federal poverty level” means the poverty income guidelines revised annually and published in the Federal Register by the U. S. Department of Health and Human Services.

“Group health insurance” means any plan of, or contributed to, by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer’s employees, former employees, or the families of the employees or former employees.

“Initial application” means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

“IowaCare” means the medical assistance program that provides limited Medicaid services by IowaCare network providers to persons who are not otherwise eligible for Medicaid. Exception: Women receiving Medicaid through the Iowa Family Planning Network may receive IowaCare coverage.

“IowaCare network provider” means a provider that participates in the IowaCare program. See [Network Providers](#).

“Mandatory months” means the four consecutive months immediately following the month in which the eligibility decision is made. Mandatory months are applied only at initial application and when there has been a break in coverage.

“Medical expansion services” means the following services:

- ◆ Inpatient and outpatient hospital care
- ◆ Physician and advanced registered nurse practitioner services
- ◆ Certain dental services
- ◆ Certain pharmacy services
- ◆ Pregnancy-related services and newborn care
- ◆ Services to help members quit smoking
- ◆ Transportation to and from the network provider
- ◆ Routine preventive medical examination

“Medical home” means a team approach to providing health care that:

- ◆ Originates in a primary care setting;
- ◆ Fosters a partnership among the patient, the personal provider, other health care professionals, and where appropriate, the patient's family;
- ◆ Utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential;
- ◆ Maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and
- ◆ Has all of the characteristics specified in Iowa Code section 135.158.

“Member” means a person who is receiving assistance under IowaCare or Medicaid.

“Newborn” means an infant born to a qualifying pregnant woman.

“Qualifying pregnant woman” means a pregnant woman whose resources are over MAC resource limits and whose gross income is under 300% of the federal poverty level but whose allowable family medical expenses bring her countable income to below 200% of the federal poverty level.

Determining IowaCare Eligibility

Concurrent Eligibles

Legal reference: 441 IAC 92.2(1)“a”(1)

There are situations when a member may become eligible for another Medicaid coverage group while receiving IowaCare. These include:

- ◆ A woman age 19 through 44 receiving Iowa Family Planning Network (IFPN).
- ◆ An IowaCare-eligible woman who becomes eligible for MAC due to pregnancy.
- ◆ A woman who is determined presumptively eligible for Medicaid.
- ◆ An IowaCare member who can now meet the spenddown for Medically Needy.
- ◆ An IowaCare member who is now eligible for another Medicaid coverage group.

When a person has been determined eligible for IowaCare and then is later determined eligible for a Medicaid coverage group that has full Medicaid benefits, the IowaCare eligibility continues with the Medicaid coverage until the IowaCare can be canceled in a timely manner. EXCEPTION: A woman aged 19 through 44 may be eligible for both IowaCare and IFPN.

The SSNI=Medicaid Eligibility File screen will show a blended aid type for these situations. NOTE: The Medicaid Eligibility system cannot allow IowaCare to be an underlying eligibility with Medicaid coverage groups that have limited benefits, such as QMB and SLMB. Persons determined eligible for IowaCare and then later determined eligible for QMB or SLMB in the same month, require special handling. Contact central office.

Nonfinancial Eligibility

Nonfinancial eligibility factors for IowaCare include:

- ◆ [Acceptance of benefits from other sources](#)
- ◆ [Residence in a public nonmedical institution](#)

Medical Benefits From Other Sources

Legal reference: 441 IAC 75.2(249A), 92.2(249A,249J)

IowaCare applicants and members must apply for and accept any medical resources that are reasonably available to them **without charge**. A medical resource is considered “reasonably available” when it may be obtained by filing a claim or an application. Such medical resources include:

- ◆ Health and accident insurance.
- ◆ Eligibility for care through Veterans Affairs.
- ◆ Specialized health care services.
- ◆ Medicare, including Part A or Part B, or Medicare Advantage Plan.

Deny or cancel IowaCare benefits of the person when an IowaCare applicant or member fails to file a claim or application or to cooperate in the processing of that claim or application without proving good cause. See 8-C, [Cooperation in Obtaining Medical Resources](#).

Group Health Insurance

Legal reference: 441 IAC 92.2(4)

Policy:

A person who is enrolled in employer group health insurance is not eligible for IowaCare. Group health insurance means any plan of an employer or contributed to by an employer to provide health care.

Persons receiving Medicare are not eligible for IowaCare.

Procedure:

When an applicant or member reports enrollment in employer group insurance, the worker must follow up. Send form 470-4542, *IowaCare Insurance Information Request*, and 470-2826 or 470-2826(S), *Insurance Questionnaire*, to the IowaCare applicant or member to complete and return.

IowaCare coverage **may** be approved or continue when the applicant or member is enrolled in a group health plan but states that:

- ◆ Exclusions for pre-existing conditions apply, or
- ◆ The needed services are not covered by the plan, or
- ◆ The limits of benefits under the plan have been reached, or
- ◆ The plan covers only catastrophic health care.

IowaCare coverage may **not** be approved or continue when the applicant or member is enrolled in a group health plan but states only that the coverage is unaffordable. The applicant or member is not eligible for IowaCare while enrolled in a plan that covers all the person's needs. An applicant or member who feels the health coverage is too costly should disenroll from the employer group plan and then apply for IowaCare.

IowaCare coverage **may** be approved or continue when the applicant or member is not enrolled in the available group health plan and states that:

- ◆ The coverage is unaffordable, or
- ◆ Exclusions for pre-existing conditions apply, or
- ◆ The needed services are not services covered by the plan, or
- ◆ The limits of benefits under the plan have been reached, or
- ◆ The plan covers only catastrophic health care.

1. Mrs. C, age 40, applies for IowaCare. She is not enrolled in her employer group health insurance plan, which costs \$150 per month. Mrs. C states that she cannot afford the group health insurance plan. If Mrs. C meets all other eligibility requirements for IowaCare, her application is approved.

2. Mr. D, age 54, applies for IowaCare. His employer offers a group health insurance plan at no cost. He did not enroll in the group health insurance and the open enrollment is past. He states that he needs surgery that would not be covered by the group health insurance.

The IM worker approves IowaCare. At the time of the next open enrollment, Mr. D must enroll in his employer's group health insurance plan. Failure to do so will result in cancellation of IowaCare. If Mr. D still needs services that are not covered by the employer's plan, IowaCare can also continue.

The reason IowaCare is approved is that the needed services are not covered by the plan. Otherwise, IowaCare would have to be denied for failure to enroll in an affordable group health insurance.

3. Mr. E, age 55, applies for IowaCare. He does have health insurance. However, his health plan does not cover his pre-existing condition of heart problems. If Mr. E meets all other eligibility requirements for IowaCare, his application is approved. The IM worker sends Mr. D form 470-4542 to complete.

4. Ms. M, age 40, applies for IowaCare. She checks on the application that she has health insurance. The IM worker sends form 470-4542 to find out: Does the plan exclude pre-existing conditions? Are the needed services not covered by the plan? Has she reached the limit of the benefits under the plan?

Ms. M answers all of the questions "no." The reason she is applying for IowaCare is that she has a high deductible. The worker denies the *IowaCare Application*.

5. Ms. H, age 59, applies for IowaCare. She checks on her application that she has employer group health insurance. Her health insurance has an annual coverage limit of \$10,000.

The IM worker calls and asks if Ms. H has met the annual limit for the year. Ms. H indicates that she has not met the limit yet. The worker explains that the limit must be met before Ms. H can approve IowaCare and suggests Ms. H reapply when the limit is met. The worker denies the application due to insurance.

Cooperation in Obtaining Medical Resources

Legal reference: 441 IAC 75.2(249A), 92.2(249A,249J)

All applicants and members are required to cooperate with certain processes related to obtaining medical resources as a condition of eligibility for IowaCare, unless good cause exists for failure to cooperate. Form 470-2826 or 470-2826(S), *Insurance Questionnaire*, is required for IowaCare when health insurance is reported.

Cancel IowaCare benefits to a member who fails to cooperate in determining the availability of medical resources.

This section covers procedures for:

- ◆ [Cooperation with the Third-Party Liability Unit](#)
- ◆ [Failure to cooperate with the Third-Party Liability Unit](#)
- ◆ [Good cause for failure to cooperate](#)

Cooperation With Third-Party Liability Unit

Legal reference: 42 CFR 441.20, 441 75.2(249A), 75.4(3), 92.2(249A,249J)

The Third-Party Liability Unit is part of the Iowa Medicaid Enterprise (IME) Revenue Collection Unit. The Third-Party Liability Unit's primary purpose is to identify and collect monies from any available medical resource that can pay all or part of a member's medical expense. Third-party resources include:

- ◆ Medicare
- ◆ Insurance policies
 - Private health insurance
 - Group health insurance
 - Liability insurance
 - Family health insurance carried by an absent parent
- ◆ Railroad Retirement benefits
- ◆ Worker's compensation
- ◆ Veteran's Affairs
- ◆ Tri Care
- ◆ Liability lawsuits (tort action)
- ◆ Orders for restitution as a result of a criminal conviction

A member or a person acting on the member's behalf must cooperate with the Third-Party Liability Unit by providing information and verification about any medical or third-party resources.

EXCEPTION: A woman eligible under the IFPN can claim good cause for not cooperating with the Third-Party Liability Unit due to confidentiality if she is fearful of the consequences of a parent or spouse discovering that she is receiving family planning services.

If you become aware that a member has been involved in an accident and there may be a potential third-party payer, report this to the IME Lien Recovery Unit, P.O. Box 36446, Des Moines, IA 50315. Collect and report all necessary information, including:

- ◆ The name of the insurance company.
- ◆ The policy number.
- ◆ The type of insurance.
- ◆ The name and address of any attorneys involved.

Members must cooperate by:

- ◆ Filing a claim or an application when the resource is reasonably available.
- ◆ Assisting in the processing of the claim or application. A member is not required to initiate a legal suit or file criminal charges.
- ◆ Refunding to the Department any settlement or payment received that is intended to cover medical expenses that would otherwise be paid by Medicaid.
- ◆ Completing and returning form 470-0398, *Priority Leads Letter*, sent by the IME Revenue Collections Unit when requested, and giving complete and accurate information about any accident-related injuries.

Failure to Cooperate With Third-Party Liability Unit

Legal reference: 441 IAC 75.4(249A), 92.2(249A,249J)

When a person fails to cooperate with the Third-Party Liability Unit, a sanction must be applied. EXCEPTIONS: See [Good Cause for Failure to Cooperate](#). A person under sanction counts in the household size as a considered person.

Good Cause for Failure to Cooperate

Legal reference: 441 IAC 75.2(1), 92.2(249A,249J)

The Third-Party Liability Unit or the IM worker may be responsible for determining if good cause for failure to cooperate exists. Good cause for failure to cooperate with the Third-Party Liability Unit or the IM worker exists when the person or family has one or more of the following situations:

- ◆ There was a serious illness or death of a member of the person's family.
- ◆ There was a person or a family emergency or household disaster, such as a fire, flood, or tornado.
- ◆ The person verifies good cause reasons beyond their control.
- ◆ The person did not receive the request for information for a reason that was not the person's fault. Failure to provide a forwarding address does not qualify.

Medical Assistance Lien

Legal reference: 441 IAC 75.4(249A), 92.2(249A,249J)

The Department has the legal right to file a lien to recover IowaCare payments made on behalf of any member if another (third) party is determined to have liability. "Third parties" include:

- ◆ Private health insurance
- ◆ Auto medical insurance
- ◆ Casualty insurance
- ◆ Worker's compensation insurance
- ◆ Tort liability cases

Tort liability exists when a member sues a third party and it is determined that injuries sustained were caused by the negligence of a third party.

When the Department makes IowaCare payments on behalf of a member, the IME Revenue Collections Unit files a lien for all monetary claims that the member may have against third parties, to the extent of IowaCare payments.

For a lien to be effective, the Revenue Collections Unit must file a notice with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility is established. These notices serve as formal notice to the third party of the Department's interest and right to be reimbursed for the member's medical expenses.

Possible liable third parties should be informed of the Department's interest at the earliest possible date, no later than ten days from the time that the Revenue Collections Unit becomes aware of the involvement of the third party.

Residents of Public Nonmedical Institutions

Legal reference: 441 IAC 441 75.12(249A), 92.2(249A,249J)

A person is not eligible for IowaCare while the person is an inmate of a public institution.

A "public institution" is one that is the responsibility of a government unit or over which a governmental unit exercises administrative control. Public institutions include, but are not limited to, publicly operated jails, penal institutions, work release centers, and wholly tax-supported care facilities such as county residential care facilities.

EXCEPTION: A publicly operated community residence that serves fewer than 16 residents is not considered a public institution. For example, a county-owned and operated residential care facility that has fewer than 16 beds may be a publicly operated community residence. To be considered a “publicly operated community residence,” the facility:

- ◆ Must provide some services beyond food and shelter, such as social services, help with personal living activities, or training in social and life skills.
- ◆ Must not be a jail, prison, or other holding facility for people who have been arrested or detained pending charges.
- ◆ Must not be located on the grounds of, or immediately adjacent to any large institution or multiple-purpose complex.

Ms. G, a member of an IowaCare eligible group, enters the county jail on September 5. She is expected to return home December 16. Her IowaCare is canceled effective October 1.

Halfway House

Legal reference: 42 CFR 435.1009, 441 IAC 75.12(249A), 92.2(249A,249J)

Some people in halfway houses (also known as community residential facilities) are serving a prison sentence or have been placed on a work release program. Other people in halfway houses are on probation or parole and are ordered to live in a halfway house as a condition of the probation or parole.

To determine eligibility, you must verify whether the person living in a halfway house is serving a sentence, is on a work release program, or is on probation or parole.

People placed on probation or parole who are living in a halfway house are not considered inmates and can be eligible for IowaCare as long as they meet the other eligibility criteria.

People serving a prison sentence and those who have been placed on a work release program are considered inmates of a penal institution and are not IowaCare eligible unless they are an inpatient of a medical institution. The inmate is eligible only for the period that the person is an inpatient of a medical institution.

Inpatient Medical Institutions

Legal reference: 42 CFR 435.1009, 441 IAC 75.12(249A), 92.2(249A,249J)

An inmate of a penal institution who is admitted as an inpatient of a medical institution (hospital, nursing facility, PMIC) that is not on the grounds of the penal institution and is not owned or operated by the penal institution may be eligible for IowaCare. The person must meet the other eligibility criteria before IowaCare can be approved. The inmate is eligible only for the period that the person is an inpatient of a medical institution.

Quality Control

Legal reference: 441 IAC 76.8(249A), 92.3(249A,249J)

Quality Control pulls a random sampling of cases to review eligibility. IowaCare members must cooperate with Quality Control. Failure to cooperate with Quality Control results in a sanction.

Availability of Funds

Legal reference: 441 IAC 92.2(6)

The Department has notified the IM workers that IowaCare is no longer available for new members after June 2013. If a member is canceled and the person reapplies, the application will be denied.

Do not approve IowaCare eligibility after the eligibility effective date of June 1, 2013.

Premiums

Legal reference: 441 IAC 92.7(249A, 249J), 92.7(5)

With the exception of newborns, IowaCare members are assessed a monthly premium based on a sliding scale based on their income. Payment of the premium is a condition of eligibility unless a hardship exemption is requested.

People who have identified themselves with race or ethnicity of "Indian" are excluded from being assessed IowaCare premiums.

Premium Amount

Legal reference: 441 IAC 92.7(249A,249J), 92.7(1)

The ABC system determines the monthly premium amount for a 12-month certification period beginning with the first month of eligibility. The premium is based on projected monthly income for the 12-month certification period.

On October 1, 2010, a change was implemented in the IowaCare premium scale for new applications and renewals:

- ◆ One premium scale is used for individuals who are the only IowaCare member in the household, and
- ◆ A second scale is used for a combined premium for multiple IowaCare members in the same household. (Members in the same household may not request to have separate premiums. The combined premium is less than twice the premium for one member.)

The monthly premium amount is based on the household's net countable monthly income as a percentage of the federal poverty level (FPL). If the household's income is at or below 150% of the poverty level, members are not assessed a premium. The system calculates the premium amount based on the lowest income level in each 10% increment of poverty level as follows:

Premium Chart Effective April 1, 2013			
One IowaCare member with income at or below the FPL of:	Member's premium amount is:	Two or more members with income at or below the FPL of:	Members' combined premium amount is:
150% = \$1,437	No cost	150% = \$1,939	No cost
160% = \$1,532	\$52	160% = \$2,068	\$70
170% = \$1,628	\$56	170% = \$2,198	\$74
180% = \$1,724	\$59	180% = \$2,327	\$79
190% = \$1,820	\$62	190% = \$2,456	\$83
200% = \$1,915	\$66	200% = \$2,585	\$87

If a correction needs to be made to increase the premium, see 14-B(4), [MIPC=IowaCare Premium Change](#).

Payment of Assessed Premiums

Legal reference: 441 IAC 92.2(5), 92.7(249A, 249J)

Premiums are assessed beginning the month after the system month in which the decision is made on the application. At a minimum, a member is responsible for paying the premium for four months. These are referred to as the “mandatory months.” The mandatory months include the first month following the system month of decision and the following three months.

The member is responsible for paying the premium for:

- ◆ The four mandatory months, regardless of continued enrollment, and
- ◆ Each month of continued enrollment after the mandatory months.

The member will not be billed for the system month of decision or any months before the system month of decision, including the retroactive month.

If there is a break in enrollment of one or more months, a new four-month period of mandatory premiums is assessed, beginning with the month following the system month of decision on the new application.

Effective October 1, 2010, a person is **not** required to pay all past-due IowaCare premiums before the person can become eligible for IowaCare again. In other words, a person may reapply and become eligible for IowaCare even when the person has unpaid IowaCare premiums.

When there is more than one IowaCare member in a household, all of them must be on the same IowaCare case. When there are multiple members on one case, only one combined IowaCare premium is assessed for all the members on the case. If the combined premium is not paid, all members in the household will be canceled from IowaCare.

1. Mr. B is approved for IowaCare on March 15 (March system month). When Mr. B signed the *IowaCare Application*, he agreed to pay a premium for the mandatory four months (April, May, June and July). His countable income is above 190% but below 200% of the federal poverty level. He is responsible for a monthly premium for each month of the mandatory period.
2. Mr. B is approved for IowaCare on March 29 (April system month). When Mr. B signed the *IowaCare Application*, he agreed to pay a premium for the mandatory four months (May, June, July and August). His countable income is above 190% but below 200% of the federal poverty level. He is responsible for a monthly premium for each month of the mandatory period.
3. Mr. G's IowaCare enrollment period is approved November 15 for November 2010 through October 2011. Mr. G paid his IowaCare premium for the four mandatory months (December, January, February, and March). He requests cancellation at the end of the fourth mandatory month (March).

At the end of April 2011, Mr. G files an *IowaCare Application* and is approved effective April 1. Since there was no break in assistance, the new enrollment period does not have four mandatory months of premium payment.

4. Mr. M's IowaCare enrollment period is approved November 15 for November 2010 through October 2011. Mr. M paid his IowaCare premium for the four mandatory months. He requests cancellation at the end of the fourth mandatory month (March).

In June 2011, Mr. M files an *IowaCare Application* and is approved in June for IowaCare. Since there is a break in assistance, there will be four mandatory months of premiums. Mr. M's four mandatory months begin in July.

5. Mr. J's four mandatory months are January, February, March, and April. On March 1, he requests cancellation of his IowaCare.

The IM worker explains that Mr. J will still owe the premium for the month of April or, if he is unable to pay for the month of April, he may declare a hardship by signing the statement on the *IowaCare Billing Statement*.

Waive the mandatory four months of premium when:

- ◆ A person turns age 65. Premiums are due through the month before the 65th birthday. Reduce any remaining mandatory months to zero premiums.
- ◆ A person becomes eligible under any Medicaid coverage group except IFPN. The MIPS will not send a bill for any month for which the member has other Medicaid coverage.
- ◆ A person has access to group health insurance (see [Definitions: Group health insurance](#)). The member must timely report having group health insurance. Reduce any remaining mandatory months to zero premiums.
- ◆ A person dies. Premiums are due through the month of death. Reduce the premium to zero for any month after the month of death if the case has not been canceled.

1. Mr. J is approved for IowaCare in December. His four mandatory months are January, February, March, and April. Mr. J dies in February. The family reports his death to the Department. The IM worker enters the date of death on ABC. MIPS will zero out the premiums for March and April.

2. Mr. K is approved for IowaCare in December. His four mandatory months are January, February, March, and April. Mr. K paid January and February premiums. Mr. K died in February. The family reported his death to the Department in June. The case was already canceled on May 31 due to nonpayment. The IM worker zeroed out the premiums for March, April, and May on the MIPC=IowaCare Premium Change screen.

3. Mr. A is approved for IowaCare in December. His four mandatory months are January, February, March, and April. On March 1, Mr. A reports that he will have affordable health insurance that covers everything beginning April 1. The IM worker cancels the case effective April 1 and zeroes out the premium for the month of April.

4. Mr. E applies for SSI in January 2007. He is approved for IowaCare in April 2007. His four mandatory months are May, June, July, and August.

Mr. E is approved for SSI in July 2007 with an effective date of January 2007. He is determined Medicaid-eligible beginning January 2007. The IM worker cancels IowaCare effective August 1 and requests refunds for months in which a premium was paid. If Mr. E had a premium, MIPS will not send a billing statement for August due to full Medicaid eligibility.

Deducting *hawk-i* Premiums

Legal reference: 441 IAC 92.7(1)“c”

Deduct the cost of premiums paid for **hawk-i** from the premium assessed. **hawk-i** premiums are: \$10, \$20, or \$15 (for dental only). The amount of the **hawk-i** premium is entered in the ABC system. The ABC system determines the amount of the premium to be assessed.

Ms. G applies for IowaCare. She states her monthly gross earned income is \$1,800 and that she pays a \$10 **hawk-i** premium for her son. The IM worker accepts Ms. G's statement for income and the amount of the **hawk-i** premium.

The worker enters the amount of **hawk-i** premium on the BCW2 screen in the DEDUCT 5 field. The system determines the premium amount by deducting the **hawk-i** premium.

Premium Exclusion

When the IowaCare case has a considered person who has an assessed premium for Medicaid for Employed People with Disabilities (MEPD), the ABC system premium calculation will automatically exclude the IowaCare member from being assessed an IowaCare premium.

The exclusion from paying premiums to both programs will ensure that the family will not pay more than 5% of the total monthly household income for cost sharing.

Billing and Payment

Legal reference: 441 IAC 92.7(2)

The Department mails form 470-4164, *IowaCare Premium Billing Statement*, on the first working day of the month to notify members of the premium. Effective October 1, 2010, *IowaCare Premium Notice Reminders* will not be sent.

The IowaCare member returns the portion of the billing statement with the payment or the signed hardship statement in the prepaid and preaddressed envelope provided by the Department. The address on the envelope is: Iowa Medicaid Enterprise IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

If an IowaCare member comes to a Department office to pay the premium, give the member a preaddressed envelope to mail the premium payment. If the member does not have the billing statement, tell the member to include the member's state identification number (SID) on the payment.

If an IowaCare member asks questions about the posting of premium payments, do not tell the member to contact the IME Member Services Unit. Member Services **does not process** the payments. Instead, contact the DHS, SPIRS Help Desk for assistance.

Local offices should maintain a supply of the IowaCare envelopes, 470-4196, to give to members who misplace the envelopes included with the billing statement. Order envelopes for IowaCare premium payments from the Supply Unit, Level A, in central office by e-mailing: Supply@dhs.state.ia.us.

Do not give an IowaCare billing envelope for MEPD bills or vice versa. The payments have separate processing procedures by different entities within the Department. When payments are mailed to the wrong address, eligibility for the member is delayed.

The premium is considered late if the payment is not postmarked by the due date. The IowaCare case is not canceled until the end of the month in which the 60-day grace period ends. See [Failure to Pay the Premium](#).

The premium is due the last calendar day of the month it is to cover. If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend. The envelope must be postmarked no later than the first working day following the holiday or weekend.

Ms. Y applies for IowaCare on February 15. Her application is approved on February 18. The effective date of the coverage is February 1. Premiums are due as follows:

- ◆ No premiums are due in February.
- ◆ The premium for March (the first month following the system month of decision) is due by April 30. If the premium is not paid before June timely notice, the case will be canceled.
- ◆ The April premium must be received by the due date of April 30. If the premium is paid before June timely notice, the case will not be canceled.

- ◆ The May premium must be received by the due date of May 31. If the premium is paid before July timely notice, the case will not be canceled.

NOTE: Hardship will be accepted if the billing statement is received no later than five days after the due date on the billing statement.

EXCEPTION: When the case is approved after system cutoff, premiums for the first two months covered in the initial billing are due the last calendar day of the second initial billing month.

Ms. W applies for IowaCare on December 29. Her application is approved on January 15. The effective date of the coverage is December 1. Ms. W's premiums are due as follows:

- ◆ No premiums are due in December.
- ◆ No premiums are due in January.
- ◆ The premium for February (the first month following the system month of decision) is due by February 28. If the premium is paid before April timely notice, the case will not be canceled.
- ◆ The March premium is due by March 31. If the premium is paid before May timely notice, the case will not be canceled.

The Department applies premium payments received to the oldest unpaid month in the current certification period and then forward. When premiums for all months in the current certification period have been paid, the Department holds any excess and applies it to any months for which eligibility is subsequently established.

Hardship

Legal reference: 441 IAC 92.7(3)

A member who submits a written statement indicating that payment of the monthly premium will be a financial hardship is exempted from premium payment for that month.

To claim hardship, the member may use form 470-4165, *IowaCare Billing Statement*, or write and sign a personal statement. The member must submit a separate statement for each month in which hardship is claimed.

If the statement is not received within five days of the premium due date, the member is obligated to pay the premium. There is no grace period for claiming hardship.

A partial payment received by the premium due date will be considered a request for a hardship exemption if the member also signs the hardship statement. If the hardship statement is signed, an exemption shall be granted for the balance of the premium owed for that month.

Partial payments received without a signed request for hardship are treated as a credit to the member's IowaCare account or used to pay the balance on a month owed.

1. Mr. T is single and applies for IowaCare on April 30. He is approved for IowaCare May 2. The four mandatory months are June, July, August, and September. When Mr. T finds out his premium amount, he says it will be tough to pay. The IM worker explains he can claim a hardship on his premium billing statement and that he must do this monthly.

Mr. T receives the billing statement for June with a due date of June 30. He signs a statement that he would have a hardship paying the premium for June. The envelope is received June 30. Personnel at the IME enter hardship for the month of June.

In July, a billing statement is sent to Mr. T with a due date of July 31. He sends in \$25 as a partial payment and signs the hardship statement on the billing statement. This is received by the due date on the billing statement. The Department applies the partial payment to the month of July and grants Mr. T a hardship for the remaining amount of the premium.

In August, another billing statement is sent to Mr. T. He doesn't sign and return the statement that he has a hardship by August 31. He is now required to pay the August premium.

In September, the fourth mandatory billing statement is sent to Mr. T with a due date of September 30. He signs a statement that it would be a hardship paying the premium for September. Personnel at the IME enter hardship for the month of September.

Mr. T has not paid the premium due August 31. He receives a notice of cancellation effective November 1. If he pays the premium and it is received before October 31, his IowaCare case will be reopened.

2. Mr. A receives a *Notice of Decision* stating the amount of his premium. Mr. A calls his IM worker on May 18 and explains that he does not have enough money to pay his May premium, but that he could pay \$20.

The worker tells him to send the check for \$20 and to sign the hardship statement at the bottom of the *IowaCare Billing Statement*. The worker also tells him that the hardship claim must be received no later than May 31. The worker explains that the \$20 will be applied to the month of May and Mr. A will be exempted from paying the remainder of the May premium.

The worker explains that for the future months, Mr. A has three options:

- ◆ To pay the premium in full, or
- ◆ To make a partial payment (the amount that he can afford to pay) and sign the hardship statement stating he is unable to pay, or
- ◆ To sign the hardship statement indicating that he is unable to pay the entire premium due to hardship.

3. The premium is \$54 and the balance owed is \$54. The member pays \$25 and signs the *IowaCare Billing Statement* claiming hardship. The statement is received by the due date. \$25 is applied to the month and MIPS zeroes out the remainder of the amount. The balance is zero.

4. The premium is \$54 and the balance owed is \$54. The member pays \$25 and does not sign the *IowaCare Billing Statement* claiming hardship. MIPS applies the \$25 as a credit. The balance owed is \$29.

The member may still claim hardship for the remainder of the month by sending in a signed written statement that is received by the due date.

5. The premium is \$54 and the balance owed is \$108 (current month and previous month). The member pays \$54 and signs the *IowaCare Billing Statement* claiming hardship. The statement is received by the due date. MIPS applies the \$54 credit to the previous month and hardship is granted for the current month. The balance owed is zero.

6. The premium is \$54 and the balance owed is \$108 (current month and previous month). The member pays \$25 and signs the *IowaCare Billing Statement* claiming hardship. The statement is received by the due date. MIPS applies the \$25 partial payment as a credit to the previous month and hardship is granted for the current month. MIPS will show \$54 owed. The actual balance owed is \$29 (\$54 owed - \$25 credit).

7. The premium is \$54 and the balance owed is \$54. The member pays \$54 and signs the *IowaCare Billing Statement* claiming hardship. The statement is received by the due date. MIPS applies the \$54 to the month. MIPS does not allow hardship for the month as the member made full payment for the month. The balance owed is zero.
8. The premium is \$54 and the balance owed is \$54. The member pays \$74 and signs the *IowaCare Billing Statement* claiming hardship. The statement is received by the due date. MIPS applies \$54 to the month and applies a \$20 credit. MIPS does not allow hardship for the month as the member made full payment for the month. The balance shows a \$20 credit.

Failure to Pay the Premium

Legal reference: 441 IAC 92.7(4)

Effective October 1, 2010, a 60-day grace period beyond the due date is allowed for payment of the IowaCare premium before IowaCare will be canceled. If the member fails to pay the premium by timely notice in the month in which the 60th day falls, the IowaCare case will be automatically canceled by the ABC system.

If the premium payment is received by the last day of the month of cancellation, a WIFS message will be issued to the worker as notification of the premium payment. If all other eligibility factors are still met, the IowaCare case will be reopened. Otherwise, do not reopen IowaCare without a new application.

1. Mr. B does not pay his premium payment by the due date of April 30. If his payment is received and entered in MIPS before June timely notice day, a cancellation notice will not be sent. Otherwise, the system will send a *Notice of Cancellation* at timely notice in June effective July 1.

If Mr. B's April premium payment is received after June timely notice day but is postmarked by June 30, the IM worker will reopen his case.
2. Mr. and Mrs. J are canceled from IowaCare January 1, 2011, for nonpayment of their combined premium. They owe the combined premium for the months of October, November, and December. They file an application for IowaCare on May 15, 2011. They do not have to pay old premiums before they can get IowaCare again.

Premium Refunds

Legal reference: 441 IAC 92.7(5)

Send requests for IowaCare premium refunds to the SPIRS Help Desk. Request a refund of payments credited for any month after the effective date of cancellation when coverage is canceled due to one of the following circumstances:

- ◆ The member paid premiums in advance and later requests cancellation for future months.
- ◆ An error is made in calculating the premium and the member now has a credit.
- ◆ The member has access to group health insurance (see [Definitions: Group health insurance](#)).
- ◆ The member is determined to be eligible for full Medicaid for months that the member was on IowaCare.
- ◆ The member reaches age 65.
- ◆ The member dies.
- ◆ The member no longer meets program requirements and the four mandatory months have been met.

The amount of the refund shall be offset by any outstanding premiums owed in the current certification period. Refunds are automatically issued when the member has a credit and:

- ◆ There have been two consecutive months of inactivity on the IowaCare case; or
- ◆ The premium has been reduced to zero for two consecutive months.

Case Maintenance

The following sections address:

- ◆ [The member's responsibility for reporting changes](#)
- ◆ [Terminating eligibility](#)
- ◆ [Recovery of overpaid benefits](#)
- ◆ [The member's right to appeal an adverse action](#)

Reporting Changes

Legal reference: 441 IAC 7.7(1), 92.10(249A,249J), 92.13(249A,249J)

A member shall report the following changes no later than ten calendar days after the change takes place:

- ◆ The member moves.
- ◆ The member obtains other health insurance coverage.
- ◆ The member enters a nonmedical institution, including but not limited to a jail or other penal institution.

When a change is not timely reported, any incorrect program expenditures shall be subject to recovery. See [Recovery](#).

Acting on Changes

Legal reference: 441 IAC 92.5(6), 92.7(1)"d," 92.7(1)"e," 92.10(2), 92.10(3), 92.13(249A,249J)

After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

- ◆ Timely notice of adverse action is required (ten day notice).
- ◆ The certification period has expired.

A person found to be income-eligible upon application or renewal of eligibility remains income-eligible for the certification period regardless of any change in income or household size.

Do not increase the premium established for a certification period due to an increase in income or a change in household size. Decrease a premium when a member reports a decrease in income or an increase in household size. This change is effective the first of the month following the change report.

1. Ms. J is approved March 1 for IowaCare. On May 5, she reports that she now has health insurance and requests that her IowaCare be canceled.

The IM worker cancels the case effective June 1. Because Ms. J has health insurance and reported the change, the worker zeroes out the premium for June on the MIPC screen. (Even though June is a mandatory month, Ms. J does not owe for June since she now has health insurance.)

2. Ms. K is approved March 1 for IowaCare. She starts working in April and does not report that she started receiving health insurance in May. Her case is canceled August 1 because she did not pay the May premium. She owes the premiums for May, June, and July.

Ms. K loses her job and applies for IowaCare in September. She does not think she should pay the premium for May and June, since she had other health insurance. It's too late to decrease the premium amount for May and June. Since Ms. K did not timely report the change, the worker does not zero out the premium for July. Ms. K must pay the premiums for May, June, and July.

3. Ms. L reports to her IM worker that her income increased on November 15. Ms. L did not need to report this change in income. The worker does not act on the change.

4. Ms. M's household size is three when IowaCare eligibility is determined in July. She reports that her husband has moved out of her home. He did not have income at the time of the application. Ms. M did not need to report this change. The worker does not act on the change that would otherwise increase the premium. The premium stays the same.

5. Mr. J returns his *IowaCare Renewal Application* on July 30. He states on his application that his gross earned income is \$1,200 a month. On August 10, the IM worker approves the application. Mr. J's new IowaCare certification period will begin September 1.

On August 15, Mr. J reports that his pay increased. The worker does not act on the change because the *IowaCare Renewal Application* is already approved.

6. Mr. N reports on May 15 that his income has decreased. The IM worker enters the new monthly income into the ABC system. The change is effective June 1. The premium amount is decreased for June.
7. Mr. S reports on May 29 that his income has decreased. The IM worker enters the new monthly income into the ABC system. The change is effective June 1. The IM worker has to access the MIPC screen to reduce the premium for June because the change was entered after May system month end.
8. Ms. G reports that her husband has returned home. The IM worker changes the household size on the ABC system from two to three, effective the following month. The premium amount is decreased. Since the premium cannot be increased due to income increasing for the household, the worker does not ask about Mr. G's income.

9. Mr. Z, age 61, is approved for IowaCare effective February 1. He has earned income that is used to determine his premium. Mrs. Z, age 61, is a considered person on the IowaCare case.

In July, the Zs want Mrs. Z to receive IowaCare. They also report that Mr. Z's earned income has decreased and that both Mr. Z and his wife will start receiving Social Security income in August.

The IM worker changes Mrs. Z to an active person on the case and decreases the earned income amount. They will have a new combined premium amount. The worker does not use the Social Security income until the Z's submit the *IowaCare Renewal Application* in January.

Recalculate the member's eligibility when it is discovered that:

- ◆ A member's premium was miscalculated, or
- ◆ A member misrepresented household circumstances.

If the member remains eligible, reassess the premium for future months. Give the member the opportunity to claim hardship for an increased premium only when the Department miscalculated the premium.

Recovery

Legal reference: 441 IAC 76.12(249A), 92.10(2), 92.13(249A,249J)

Policy:

The Department recovers all IowaCare funds incorrectly expended on behalf of the member. This includes medical services received in error and past due premiums. See 8-A, [Recovery](#).

The Department shall recover IowaCare funds expended on behalf of a member from the member's estate. See 8-D, [Estate Recovery](#).

Any funds that a provider recovers from third parties, including Medicare, shall be submitted to the Iowa Medicaid Enterprise, and an adjustment shall be made to a previously submitted claim.

Procedure:

For medical services, establish an overpayment claim for months that IowaCare was received incorrectly via referral in the Overpayment Recovery System (OPR). When establishing an overpayment for past months, determine if the overpayment was an agency error or a member error.

For IowaCare premiums, if it is established that the member should have paid a premium or the premium should have been a higher amount:

- ◆ Allow the member the opportunity to claim hardship for the past months if the overpayment was an agency error.
- ◆ Do not allow the member to claim hardship for the past months if the overpayment is due to the member misrepresenting household circumstances.

Contact the SPIRS Help Desk for help with hardships that should be given for past months.

Comment:

Workers are not involved with referring the collection of overdue IowaCare premiums. Overdue premiums are those that have not been paid:

- ◆ Within the 60-day grace period for the first overdue premium, or
- ◆ By the due date for multiple overdue premiums.

MIPS will automatically send data on overdue premiums to OPR for collections. The MIPS SUMM screen shows referred premiums with a code of "R" in the REF ST (referred status) field (last column to the right of the screen).

Once a past-due payment goes to OPR for collection, the client must pay as instructed by the Department of Inspections and Appeals (DIA), not to the IowaCare billing system. If a payment is made to the IowaCare billing system, it will **not** be applied to premiums that have already been referred to DIA.

If the client questions why the overdue premium is owed, the IM worker will explain the reason.

Clients will need to contact DIA about payment plans. The telephone number is on form 470-2891, *Notice of Medical Assistance Overpayment*.

1. Mr. Y declares that his gross income is less than 200% of the federal poverty level. He is approved for IowaCare July 1. Quality Control reviews his case in November and finds that his gross income was 250% of the federal poverty level for the month of July. Mr. Y was not eligible for IowaCare.

The IM worker cancels the case and does a recoupment for the months that Mr. Y was on IowaCare.

2. Same Example 1, except Quality Control finds that in October Mr. Y's income dropped below 200% of the federal poverty level. The IM worker does not cancel the case, but does do a recoupment for the months of July, August, and September.

Terminating Eligibility

Legal reference: 441 IAC 92.12(249A,249J)

IowaCare eligibility ends when one or more of the following occur:

- ◆ The certification period ends.
- ◆ The member begins receiving Medicaid with full or partial benefits, except IFPN. (A person eligible for the IFPN may also be eligible for IowaCare.)
- ◆ The member does not pay premiums or request hardship timely.
- ◆ The member no longer meets the nonfinancial eligibility requirements for IowaCare. See [Nonfinancial Eligibility](#).
- ◆ The member has been determined ineligible due to member misrepresentation or agency error.
- ◆ The member requests cancellation.
- ◆ The member moves out of state.
- ◆ The member dies.

Mrs. G is approved for IowaCare in May. In July, her two minor children return to her home. Mrs. G files an application for Medicaid for the children. Although the children are approved for Medicaid, Mrs. G does not provide HIPP information and is sanctioned. Her IowaCare is canceled until she cooperates.

Right to Appeal

Legal reference: 441 IAC 7.5(217), 92.15(249A,249J); 42 CFR 431.200, 431.220

The applicant or member has the right to request an appeal hearing on any decision. No one may limit or interfere with this right. Examples of adverse actions in which a hearing may be granted include:

- ◆ The denial or cancellation of IowaCare.
- ◆ The delay in acting on the member's application with reasonable promptness.
- ◆ The premium amount.

Applicants or members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program.

See 1-E, [APPEALS AND HEARINGS](#), for a complete explanation of the Department's appeal process, including IM worker and applicant or member responsibilities, time limits, and appeal decisions.

Covered Services

Legal reference: 441 IAC 92.8(249A,249J)

IowaCare payment will be made only for covered services provided by IowaCare network providers except as noted below. IowaCare services are limited to the following services as covered by Iowa Medicaid:

- ◆ Inpatient and outpatient hospital care, including any needed drugs that are part of inpatient or outpatient hospital treatment or care.
- ◆ Physician and advanced registered nurse practitioner services.
- ◆ Services to help members quit smoking.
- ◆ Certain dental services. IowaCare providers **may** choose to provide limited dental services at their own cost.
- ◆ Certain pharmacy services. IowaCare providers **may** choose to provide prescription drug services, with member copayments determined by the IowaCare provider.

Conditions for services include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

No payment will be made for any service provided elsewhere or by another provider. Medical services not covered by IowaCare are the responsibility of the IowaCare member to pay. EXCEPTIONS:

- ◆ Payments will be made for routine preventive medical examinations by an IowaCare network provider or any physician, advanced registered nurse practitioner, or physician assistant who participates in Medicaid if the member is not assigned to a medical home.
- ◆ For IowaCare members who are eligible only due to meeting the qualified pregnant women requirements. The covered services consist only of pregnancy-related services and newborn care. Certain pregnant women may obtain covered services from any provider or general hospital that participates in Iowa Medicaid.

Network Providers

Legal reference: 441 IAC 92.8(249A,249J)

Policy:

It is the Legislature's intent that IowaCare members will have a medical home for primary care and ongoing medical services. In 2010, legislation directed the Department to expand the IowaCare provider network services using federally qualified health centers (FQHCs). The purpose of this expansion is to provide IowaCare members with better access to primary care services.

The "medical home" have been assigned to all IowaCare members effective January 1, 2012. The medical homes are assigned by county residency.

- ◆ All Care Health Center in Council Bluffs is the medical home for IowaCare members who live in the following counties:

Adair	Fremont	Montgomery	Taylor
Adams	Guthrie	Page	
Audubon	Harrison	Pottawattamie	
Cass	Mills	Shelby	

- ◆ Broadlawns Medical Center (BMC) in Des Moines is the medical home for IowaCare members who live in the following counties:

Appanoose	Greene	Marion	Union
Boone	Jasper	Monroe	Warren
Clarke	Lucas	Polk	Wayne
Dallas	Madison	Ringgold	
Decatur	Mahaska	Story	

- ◆ Community Health Center in Fort Dodge is the medical home for IowaCare members who live in the following counties:

Calhoun	Humboldt	Pocahontas	Wright
Hamilton	Kossuth	Webster	

- ◆ Crescent Community Health Center in Dubuque is the medical home for IowaCare members who live in the following counties:

Allamakee	Clayton	Dubuque	Howard
Chickasaw	Delaware	Fayette	Winneshiek

- ◆ People's Community Health Clinic in Waterloo is the medical home for IowaCare members who live in the following counties:

Black Hawk	Bremer	Buchanan	Butler
------------	--------	----------	--------

- ◆ People's Community Health Clinic at the Clarksville site with the University of Iowa Hospital and Clinics as their hospital for IowaCare members who live in the following counties:

Floyd	Mitchell
-------	----------

- ◆ Primary Health Care in Marshalltown is the medical home for IowaCare members who live in the following counties:

Cerro Gordo	Hancock	Marshall	Winnebago
Franklin	Hardin	Tama	Worth
Grundy			

- ◆ Siouxland Community Health Center in Sioux City is the medical home for IowaCare members who live in the following counties:

Buena Vista	Dickinson	O'Brien	Sioux
Carroll	Emmet	Osceola	Woodbury
Cherokee	Ida	Palo Alto	
Clay	Lyon	Plymouth	
Crawford	Monona	Sac	

- ◆ The University of Iowa Primary Care Clinics are the medical home for IowaCare members who live in the following counties:

Benton	Iowa	Lee	Van Buren
Cedar	Jackson	Linn	Wapello
Clinton	Jefferson	Louisa	Washington
Davis	Johnson	Muscatine	
Des Moines	Jones	Poweshiek	
Henry	Keokuk	Scott	

IowaCare members who have been assigned to a medical home must use that provider for their primary care and ongoing medical services.

All IowaCare members must obtain care at their assigned medical home except for qualifying pregnant women in the 300% group (aid type 60-P) who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County. Members may obtain pregnancy-related services from any provider or general hospital that participates in Iowa Medicaid.

Members who are assigned to the following medical homes must receive hospital care at Broadlawns Medical Center in Des Moines for routine hospital care:

- ◆ Broadlawns Medical Center
- ◆ Community Health Center of Fort Dodge
- ◆ Siouxland Community Health Center
- ◆ Council Bluffs Community Health Center
- ◆ Primary Health Care in Marshalltown

All other IowaCare members will go to the University of Iowa for hospital care.

If specialty care is needed, the assigned medical home will refer members to the University of Iowa Hospitals and Clinics.

Pregnant women who are not in the "qualifying" 300% group but are eligible for IowaCare (e.g. over resources for MAC) must receive covered services at their medical home or at UIHC.

1. Ms. A, an IowaCare qualifying pregnant woman (aid type 60-P), lives in Boone County. Since she is a qualifying pregnant woman, she may receive obstetric services at any licensed hospital or health care facility that accepts Medicaid. However, if she moves to Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, Ms. A must receive her obstetric services at the UIHC.
2. Ms. C, an IowaCare qualifying pregnant woman (aid type 60-P), lives in Woodbury County. She may receive obstetric services at any licensed hospital or health care facility that accepts Medicaid.

However, since there is a medical home in her geographic area, once her pregnancy ends she must go to the medical home that serves her county of residence to receive services.
3. Ms. B lives in Cedar County and is over resources for MAC. Her income is below 200% of the federal poverty level. She is eligible for IowaCare (aid type 60-E) in her own right and not because she is pregnant. Since her basis of eligibility is not because she is a qualifying pregnant woman, she must receive all her care, including obstetric services at the UIHC.

Obstetric Coverage for Qualifying Pregnant Women

Legal reference: 441 IAC 92.8(3)

Covered IowaCare services for qualifying pregnant women are limited to:

- ◆ Inpatient hospital services when:
 - The primary or secondary diagnosis code is V22 through V24.9, and
 - The diagnosis-related group submitted for payment is 370 to 384.
- ◆ Outpatient hospital services when:
 - The primary or secondary diagnosis code is V22 through V24.9, and
 - The ambulatory patient group submitted for payment is 175, 304, 492, 493, or 494.
- ◆ Services from another Medicaid provider if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

Qualifying pregnant women who live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County must receive these services from the University of Iowa Hospitals and Clinics.

Qualifying pregnant women who live in other counties may receive these services from any provider participating in the Iowa Medicaid program.

Newborn Coverage

Legal reference: 441 IAC 92.8(3)

Covered services under IowaCare for newborn children of mothers who were qualifying pregnant are limited to the following services provided while the newborn is hospitalized for a period not to exceed 60 days from the date of birth:

- ◆ Inpatient hospital services when the diagnosis-related group submitted for payment is between 385 and 391.7.
- ◆ Services from a health care provider other than a hospital, subject to normal Medicaid coverage limitations.

Once the newborn leaves the hospital of birth, the newborn is not eligible for any other medical coverage under IowaCare except for one check-up, if done within 60 days after birth.

Ms. A is eligible for IowaCare as a qualifying pregnant woman. She delivers her baby at a Sioux City hospital in January and reports it to her IM worker. The worker mails an application to Ms. A and requests proof of Ms. A's income in order to determine whether the baby qualifies for a Medicaid coverage group.

The worker determines that the newborn is not eligible for Medicaid because Ms. A's income is now over the MAC income limits. The worker makes the system entries to add the newborn to the IowaCare case and issues a *Notice of Decision*.

The newborn has health complications and remains in the Sioux City hospital for two weeks after birth. At the end of the two weeks, the newborn is transferred to the University of Iowa Hospitals and Clinics.

The newborn was eligible for IowaCare while in the hospital of birth. However, the newborn is not eligible for IowaCare upon transfer to another hospital, including the University of Iowa Hospitals and Clinics.

Prescriptions

Legal reference: 441 IAC 92.8(2)

If the IowaCare member received inpatient care, the member may receive a 30-day supply of “take-home” drugs. The IowaCare member may also receive any drug that is administered in the outpatient clinic.

Take-home prescriptions when a member is released from the hospital may vary depending on the member’s needs and the hospital policy. The Department does not make that determination. UIHC may provide a ten-day supply of carryover take-home drugs for IowaCare members.

If the member was on state papers in state fiscal year 2005 (July 2004 – June 2005) and received drugs for an ongoing chronic condition, the member will continue to receive the prescription only for the chronic condition.

Routine Preventive Medical Examinations

Legal reference: 441 IAC 92.8(4)

A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury. A routine preventive medical examination is the annual physical or checkup. Basic laboratory work associated with the medical examination may also be paid.

If during the routine examination, the provider identifies a specific health issue or concern for the IowaCare member, then the member needs to be referred to the IowaCare provider for follow-up. A member who has a health concern needs to make an appointment with the IowaCare network provider. The routine preventive examination is not used for treatment or diagnosis for specific illness, symptom, complaint, or injury.

Services to Quit Smoking

The IowaCare program covers medication to help members quit smoking. IowaCare members who smoke may go to their IowaCare doctor to get a prescription to help them quit smoking at no cost to the members. After initially seeing the IowaCare provider, the member may have the prescription filled at any pharmacy that accepts Medicaid payment.

After getting the prescription from the IowaCare network provider, the member must use QITLINE IOWA services in order to keep getting the prescription to help the member quit smoking. QITLINE IOWA is free to IowaCare members who have contacted their IowaCare doctor.

IowaCare provides up to 12 weeks of prescriptions and counseling covered during any one-year period.

Pre-Existing Chronic Condition Group

Policy:

The pre-existing chronic condition group will end December 31, 2013.

To be eligible for the pre-existing chronic condition group, a person must:

- ◆ Have applied for IowaCare or Medicaid and indicate the existence of a chronic health condition in state fiscal year 2006 (July 1, 2005 through June 30, 2006), and
- ◆ Have received state papers in state fiscal year 2005 (July 1, 2004 through June 30, 2005), and
- ◆ Have been treated for an eligible chronic medical condition at the University of Iowa Hospitals and Clinics (UIHC), and
- ◆ Have received verification from the UIHC that the person was treated for an eligible chronic medical condition, and
- ◆ Be denied for IowaCare. (People eligible for IowaCare may receive treatment for their chronic medical condition at the UIHC).

No new cases for the pre-existing chronic condition will be approved after July 1, 2006.

A person can be eligible for the pre-existing chronic condition group and also:

- ◆ Be eligible for qualified Medicare beneficiary (QMB) coverage;
- ◆ Be eligible for specified low-income Medicare beneficiary (SLMB) coverage;
- ◆ Be eligible for Iowa family planning network (IFPN); or
- ◆ Have group health insurance (see [Definitions: Group health insurance](#)).

A person who is eligible for the pre-existing chronic care condition group **cannot** be eligible for:

- ◆ Medicaid for employed people with disabilities (MEPD), with or without a premium
- ◆ Expanded specified low-income Medicare beneficiary (E-SLMB)
- ◆ Qualified disabled and working people (QDWP)
- ◆ Medically Needy without a spenddown
- ◆ Any other Medicaid coverage group with full benefits

If the person is eligible for Medically Needy with a spenddown and the person regularly meets the spenddown, the person is not eligible for the pre-existing chronic condition program. If the person indicates that the medical expenses the person has or would incur would not be enough to meet spenddown, the person may choose between the pre-existing chronic condition program and Medically Needy.

For the pre-existing chronic condition group there is no:

- ◆ Age limit
- ◆ Income limit (must be over 200% of federal poverty level)
- ◆ Premium to pay
- ◆ Interview

The pre-existing chronic medical condition coverage group covers only medical services related to the chronic medical condition the person was treated for under the state papers program in state fiscal year 2005. New medical conditions will not be covered.

The difference between someone who has a pre-existing chronic medical condition who is eligible for IowaCare and a person who is eligible only for the pre-existing chronic condition coverage group is that members will receive different services.

- ◆ The person eligible for IowaCare will receive all services allowed under IowaCare including the pre-existing condition. People eligible for IowaCare who have a pre-existing chronic condition will be required to pay a premium unless they claim a hardship on the billing statement.
- ◆ The person eligible for the pre-existing group will receive services only for the pre-existing condition.

Medical cards are not issued to persons eligible for the pre-existing chronic condition group. Members will receive a letter stating they are eligible and for how long they are eligible. There is no retroactive coverage.

The person's state identification number will be on the Eligibility Verification System (ELVS). SSNI will show the aid type as 77-7. The aid type 77-7 is not entered on ABC.

Notice of Decision

Do not send a *Notice of Decision* for the pre-existing chronic condition coverage. Those who are eligible will receive a letter issued by the presumptive system to verify that they are eligible for this coverage and for how long. They will take the letter with them to the UIHC. The Department will already have sent a denial for the IowaCare program and the person may appeal that *Notice of Decision*.

If a person is not eligible, the IM worker may, as a courtesy, send a memo explaining that although the person may have received state papers in SFY '05 (July 1, 2004 through June 30, 2005), the person is not eligible for the pre-existing chronic condition coverage because the person does not meet the criteria for receiving chronic (ongoing) care.

Reporting Requirements

Persons in the pre-existing chronic condition group are not required to report the following changes and workers **do not** act on these reports:

- ◆ Household size, or
- ◆ Income.

The person must report within ten days if:

- ◆ The person is no longer an Iowa resident.
- ◆ The person obtains health insurance coverage that will cover treatment for their pre-existing condition.
- ◆ The person enters a nonmedical institution, including a penal institution.

Acting on Changes

The presumptive system will close the case on December 31, 2013. No *Notice of Decision* is required since the persons were told in the eligibility letter issued in June 2013 that they were eligible until December 31, 2013.

Send the appropriate application to persons whose income decreases or who become age 65. When the person becomes age 65, determine if the person would now be eligible for a full Medicaid coverage group or a Medicare savings program.

Report changes to the Quality Assurance Unit by phone at 1-800-373-6306 or in Des Moines, 281-8253, or by e-mail of the following:

- ◆ Address changes
- ◆ Worker number changes
- ◆ County changes
- ◆ Closing the case
- ◆ Death of the person

Quality Assurance will forward the information to IME staff, who will update the system. Information on closing will be passed to IME staff, who will enter the information into the Presumptive System. Information will show on the Medical Eligibility SSNI screen.

To view the Presumptive System:

- ◆ Clear your screen and type in PRSM and press the ENTER key.
- ◆ Put an "X" in "Display Episodes" field and press the ENTER key.
- ◆ Type in the person's state identification number and press the ENTER key.
- ◆ The "type" column will have a "C" entered for this group.

Case File

Keep a copy of the following:

- ◆ Application.
- ◆ Tear-off sheet (when provided) or documentation that the person had state papers in state fiscal year 2005.
- ◆ Notification from UIHC about the chronic condition.
- ◆ Letter stating that the person is eligible to receive medical services for a chronic condition.
- ◆ All information and documentation showing how eligibility was determined.