

ALL PROVIDERS

II. MEMBER ELIGIBILITY



**Iowa Department
of Human Services**



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CHAPTER II. MEMBER ELIGIBILITY

A. DEMONSTRATION OF ELIGIBILITY

Most members will demonstrate Medicaid eligibility through form 470-1911, *Medical Assistance Eligibility Card*. See [Medical Assistance Eligibility Card, Form 470-1911](#), for more information.

EXCEPTIONS:

A *Medical Assistance Eligibility Card* will not be issued to women or children whose eligibility has been determined presumptively by a qualified medical assistance provider will instead have form 470-2580 or 470-2580(S), 470-5190 or 470-5190(S), or 470-5191 or 470-5191(S). It is possible that a person has or will have Medicaid coverage, but does not yet have a *Medical Assistance Eligibility Card*. For example:

- ◆ When the Department accepts financial responsibility for a child in foster care, form 470-2747 or 470-2747(S), *Foster Care Provider Medical Letter*, may be issued to the foster care provider for use in obtaining the child's medical care.

This form assures providers that the child will eventually be authorized for Medicaid coverage under the identification number given (usually within 60 days).

Click [here](#) to view an English sample of the form.

Click [here](#) to view a Spanish sample of the form.

- ◆ People who have applied for Medicaid benefits may have form 470-2979, *Proof of Application for Medicaid*. This form verifies that the person has applied for Medicaid benefits, but eligibility has not been determined.

This form is used most often by people who may become eligible for Medically Needy coverage only after spending a certain amount on medical care (a "spenddown"). The person may ask the provider to submit claims to count toward the spenddown. See [Members Under the Medically Needy Program](#) for more information on Medically Needy eligibility and procedures. Click [here](#) to view a sample of the form.



Failure to present a *Medical Assistance Eligibility Card* for inspection does not necessarily mean that a person is ineligible for Medicaid. The provider may verify eligibility through the Iowa Eligibility Verification System (ELVS) or the IME web portal. See [Eligibility Verification](#) for more information on how to verify eligibility.

1. *Medical Assistance Eligibility Card, Form 470-1911*

The *Medical Assistance Eligibility Card* is issued to new Medicaid members at the time of approval. Each member (not each household) receives a wallet-sized plastic card plus two keychain cards. Replacement cards are issued upon the request of the member.

The cards display the member's name, state identification number, and birth date. The back of the card lists IME contact phone numbers for both members and providers. Click [here](#) to view a sample of the card.

Note that possession of the *Medical Assistance Eligibility Card* does not guarantee Medicaid eligibility. Call the Eligibility Verification System (ELVS) or access the IME web portal to verify the member's specific eligibility information. See [Eligibility Verification](#) for more information on how to verify eligibility.

NOTE: Not all mental health services are covered under fee-for-service reimbursement. Preauthorization is necessary for people enrolled in the Iowa Plan. ELVS or the web portal will indicate if the member is enrolled in the Iowa Plan.

2. *Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580*

Possession of a *Presumptive Medicaid Eligibility Notice of Action* (forms 470-2580 or 470-2580(S), 470-5190 or 470-5190(S), or 470-5191 or 470-5191(S)), indicates that a qualified entity has determined that a person is presumptively eligible for Medicaid. This notice explains the results of the eligibility determination.

This decision entitles a person to time-limited Medicaid coverage as described in [Covered Services](#).

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3. Eligibility Verification

All providers of service should request and inspect the member's eligibility card on each occasion of service. The Eligibility Verification System (ELVS) and the IME secure web portal offer providers a fast, convenient method of verifying a member's Medicaid eligibility.

Either call the ELVS line or access the IME secure web portal to verify the following information:

- ◆ If Medicaid, Marketplace Choice or Iowa Wellness Plan eligibility exists for date of service.
- ◆ If the member is eligible for limited benefits such as:
 - Aliens eligible for "emergency medical services." (See [Aliens Receiving Emergency Services](#) for more information.)
 - Members eligible under the Iowa Family Planning Network who are covered for specific family planning services. (See [Members Under the Iowa Family Planning Network](#) for more information.)
 - Members eligible under a presumptive Medicaid program.
 - Members eligible under the qualified Medicare beneficiary (QMB) coverage group and eligible only for the Medicare deductibles and coinsurance. (See [Members Under the Qualified Medicare Beneficiary Program](#) for more information.)
- ◆ If the member is enrolled in managed care, including a health maintenance organization, a prepaid health plan, or the Medicaid patient access to service system.
- ◆ If the member is locked in to specific providers.
- ◆ If the member has third party liability.

Only providers enrolled in Medicaid can obtain this information. Use the Medicaid provider number to access these systems. Click [here](#) to be redirected to the web portal. To get authorization to use the web portal, submit an *Additional Access Request Form for Iowa Medicaid Real-Time Transactions* to EDI Support Services. Click [here](#) to view this form online.



ELVS is an automated response system that uses a touch-tone telephone to report:

- ◆ A member's eligibility status as of specific dates of service.
- ◆ Whether other third-party resources exist.
- ◆ The name of the third-party payers, if known.
- ◆ Medicaid HMO, MediPASS, or Iowa Health and Wellness Plan coverage (and telephone number).
- ◆ Services not covered by the member's managed health care plan.
- ◆ Any lock-in restrictions for the member.
- ◆ The amount of the member's Medically Needy spenddown balance for the certification period (including the date of service), if any.
- ◆ Vision and dental eligibility.

The system can also give the date and amount of a provider's last payment. ELVS can process up to five inquires per call.

ELVS should be accessed:

- ◆ At the time service is provided or requested.
- ◆ When a person presents a *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580 or 470-2580(S).
- ◆ To obtain remaining spenddown amount to be met by a member on Medically Needy.

To use ELVS:

1. Call the ELVS line at (800) 338-7752, or locally in Des Moines at (515) 323-9639.
2. ELVS will greet the caller and ask for a choice of information.
 - ◆ Press **1** to hear the help message.
 - ◆ Press **2** for member eligibility.
 - ◆ Press **3** for provider payment.
 - ◆ If the caller does not have a touch-tone telephone, please hold for further instructions.

When entering data, it is not necessary to wait for message completion. Begin entering data after the first word is spoken for each prompt.



3. ELVS will ask for the national provider identification (NPI) number. Please enter the ten-digit NPI number. If the Medicaid provider number is miskeyed or inactive, re-enter the number or end the call.
4. ELVS will ask for a member identification number. Please enter the first seven digits of the member's Medicaid ID number, followed by the pound sign (#). (ELVS does not use the letter at the end.)

If there is no Medicaid identification number, enter the member's date of birth using eight digits (month, day, and year as MMDDYYYY, e.g., 04232003) followed by the member's social security number (nine digits).

5. Enter the date of service using the eight-digit format (month, day, and year as MMDDYYYY, e.g., 04232003), or press **9** for the current date. ELVS will repeat the date and confirm whether the member is eligible for basic Medicaid services on that date. If the member has other resources available, that information will be disclosed.
6. After the eligibility information is spoken:
 - ◆ Press **1** to repeat eligibility information for this member.
 - ◆ Press **2** to enter a new member's identification number.
 - ◆ Press **3** to enter a new date of service for this member.
 - ◆ Press **4** for provider payment information.
 - ◆ Press **9** to end the call.
 - ◆ Press **0** to be transferred to the IME Provider Services Unit (between the hours of 7:30 a.m. to 4:30 p.m., Monday through Friday).

Due to time lags in transferring information from the eligibility system to the claims system, updated eligibility information may not always appear on ELVS when accessing the system. It takes ELVS two to three days to update.

A member with a Medically Needy spenddown obligation who does not have a *Medical Assistance Eligibility Card*, and for whom ELVS indicates ineligibility for Medicaid, may later be determined to be retroactively eligible. ELVS indicates the remaining spenddown to be met.

When the person does not have a *Medical Assistance Eligibility Card*, but there is reason to believe that the person may be eligible on a particular date of service, even though ELVS does not indicate this, contact the Department of Human Services for final verification.



B. GROUPS COVERED BY MEDICAID

1. Aliens Receiving Emergency Services

Medicaid benefits are available to pay for the cost of emergency services for an alien who does not meet Medicaid citizenship or alienage or social security number requirements. To be eligible for Medicaid benefits, such aliens must:

- ◆ Meet financial, categorical, and state-residency requirements, and
- ◆ Have had or currently have an emergency medical condition.

“Emergency medical condition” means a medical condition of sudden onset (including labor and delivery) manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably result in:

- ◆ Placing the member’s health in serious jeopardy.
- ◆ Serious impairment of bodily function.
- ◆ Serious dysfunction of any bodily part or organ.

Any person who might be eligible for Medicaid emergency benefits should be referred to the Department of Human Services for the county in which the person claims residence. See the [Map of DHS Offices](#) for a list of the addresses of Human Services offices.

a. **Verification of Emergency Health Care Services, Form 470-4299**

Since the necessity of emergency medical treatment is a condition of eligibility under this provision, the Department of Human Services will seek verification of the emergency.

Department income maintenance workers use form 470-4299 or 470-4299(S), *Verification of Emergency Health Care Services*, to obtain the date of service and to verify that an emergency service was received from the medical provider. Click [here](#) to view a sample of the English form on line. Click [here](#) to view a sample of the Spanish version online.

Complete the section, “To be completed by the provider.” It is important to provide all the information requested so that the Department can determine whether an emergency service was provided. Return this form to the Department of Human Services. Contact the Department of Human Services with any questions regarding this form.



Following this determination and a determination that all other factors of eligibility are met, the Department will issue a *Medical Assistance Eligibility Card*, form 470-1911, to the member.

The member (or someone acting on the member's behalf) must present this card to the providers of emergency service. The providers may then submit a claim for Medicaid payment in the usual manner.

b. Covered Services

Payment for treatment of an emergency medical condition is limited to:

- ◆ Inpatient or outpatient hospital services.
- ◆ Physician services.
- ◆ Services of an independent diagnostic laboratory or x-ray facility.

To be payable, care must be provided during the three-day period beginning with the date the member presented for treatment of the emergency condition, regardless of the length of time the emergency condition exists.

If the member presents for treatment later during that month for some other emergency condition, three days of treatment for that condition are also payable in that month once the emergency condition has been verified.

If an emergency condition again takes place during a later month, DHS must again determine eligibility and verify the existence of an emergency condition.

2. Children in Foster Care or Subsidized Adoptions or Guardianship

Medicaid covers children in foster care, subsidized adoption, or subsidized guardianship if the Department of Human Services is wholly or partially financially responsible for their support.

Iowa Medicaid covers children who are from another state but residing in Iowa in foster care, subsidized adoption, or subsidized guardianship if:

- ◆ The child receives federal funding under Title IV-E of the Social Security Act, or
- ◆ The state providing an adoption subsidy has entered into a reciprocity agreement with Iowa.



3. Members Related to the Family Medical Assistance Programs

The Medicaid program covers:

- ◆ Low-income children and their parents or needy caretaker relatives who are recipients of the Family Medical Assistance Program (FMAP) for people who would be eligible for the Iowa Family Investment Program as in effect on July 16, 1996.
- ◆ People terminated from FMAP because of increased earnings or increased child support.
- ◆ People under 21 who are ineligible for FMAP because they do not qualify as dependent children.
- ◆ Pregnant women and infants whose income is not more than 300 percent of the federal poverty level.
- ◆ Children aged 1 through 18 whose income is not more than 133 percent of federal poverty level.

4. Members Related to the Supplemental Security Income Program

The Medicaid program covers all beneficiaries of cash assistance under the Supplemental Security Income (SSI) program for low-income people who are aged, blind, or disabled, which is administered by the Social Security Administration. The Medicaid program also covers:

- ◆ Aged, blind, or disabled people who:
 - Are ineligible for SSI because of rules that don't apply to Medicaid, or
 - Would be eligible for SSI if certain conditions were met (e.g., if changes in disability criteria or increases in social security benefits due to cost of living or actuarial changes were not considered).
- ◆ Medicaid for employed people with disabilities (MEPD) who:
 - Are under age 65.
 - Are considered disabled based on SSI medical criteria.
 - Have earned income from employment or self-employment.
 - Have resources under \$12,000 (individual) or \$13,000 (couple).
 - Have net family income of less than 250 percent of the federal poverty level.
 - Pay a premium assessed for each month of eligibility if gross income is over 150 percent of the federal poverty level.



- ◆ Children under age 19 (“kids with special needs” or MKSN) who:
 - Are considered disabled based on SSI disability criteria.
 - Have gross family income at 300 percent of the federal poverty level or less.
 - Are enrolled in a parent’s employer’s group health insurance when the employer pays at least half of the annual cost of premiums.

5. **Members Receiving State Supplementary Assistance**

People who receive State Supplementary Assistance are eligible for Medicaid. State Supplementary Assistance is a state program that makes a cash assistance payment to certain SSI beneficiaries and people that are not eligible for SSI due to income slightly exceeding the SSI standard.

The monthly State Supplementary Assistance payment supplements the person’s income to meet the cost of special needs, including residential care, in-home health-related care, family-life home care, a dependent person, or special needs due to blindness. Certain people eligible for both Medicare and Medicaid receive a small State Supplementary Assistance payment quarterly.

6. **Members Residing in Medical Institutions**

People who reside in a medical institution (a hospital, nursing facility, psychiatric institution, or intermediate care facility for the intellectually disabled) and meet a period of 30 days in a medical institution per 441 IAC 75.1(7)“c” may be eligible for Medicaid.

These people must meet all eligibility requirements for SSI, except that their monthly income may be such that they would be ineligible to receive cash assistance through the SSI program.

There is a special Medicaid income limit in effect for people in medical institutions. To be eligible in terms of income, the person’s monthly income may not exceed 300 percent of the basic SSI benefit. This limit generally increases on January 1 of each year, as increases occur in the basic SSI benefit.



7. Members Under the Iowa Family Planning Network

The Iowa Family Planning Network provides limited Medicaid coverage. It is available to people who are capable of reproducing, who are not pregnant and who:

- ◆ Were Medicaid members at the time their pregnancy ended, or
- ◆ Are over age 12 and under age 55 and have countable income no greater than 300 percent of the federal poverty level.

Eligibility continues for 12 consecutive months beginning with:

- ◆ The month after the postpartum period ends for people who had a pregnancy end while a Medicaid member, or
- ◆ The first month in which eligibility is established for people who have income at or below 300 percent of the federal poverty level.

During the period of eligibility, a woman or man is entitled to limited Medicaid benefits. Covered services are limited to those that are either primary or secondary to family planning services. Payable services are found in Chapter III of the [Iowa Family Planning Network Waiver](#) manual.

8. Members Under the Iowa Wellness Plan

The Iowa Wellness Plan covers individuals aged 19-64:

- ◆ That are not eligible for other Medicaid coverage groups,
- ◆ That are not pregnant,
- ◆ That are not entitled to or enrolled in Medicare,
- ◆ Whose countable income does not exceed 100 percent of the Federal Poverty Level for their household size, and
- ◆ If there are dependent children, the children are covered by essential health benefits.

Individuals apply for coverage under the Iowa Wellness Plan by visiting the Federal website Healthcare.gov or by completing a DHS application.

- ◆ Click [here](#) to be re-directed to the Healthcare.gov website.
- ◆ Click [here](#) to access the DHS application online.



The Iowa Wellness Plan provides a comprehensive benefit package that ensures coverage for all of the Essential Health Benefits (EHB) as required by the Affordable Care Act (ACA). The EHB and other benefits covered include:

- ◆ Physician services, including primary care.
- ◆ Outpatient services.
- ◆ Emergency room services and emergency transportation (ambulance).
- ◆ Hospitalization.
- ◆ Mental health and substance use disorder services and treatments.
- ◆ Rehabilitative and habilitative services and devices (physical, occupational, and speech therapy, etc.).
- ◆ Lab services, x-rays, imaging (MRI, CT, etc.).
- ◆ Preventive and wellness services.
- ◆ Home- and community-based services for people with chronic mental illness.
- ◆ Prescription drugs.

After enrollment, Iowa Wellness Plan members will have 90 days to select a patient manager from the list of Iowa Wellness Plan-enrolled primary care providers. Until a patient manager has been selected the members are eligible as fee-for-service.

The patient manager provides the member a “medical home.” This provider has the responsibility of:

- ◆ Coordinating and monitoring necessary medical care,
- ◆ Acting as a monitor to assure appropriate utilization of services, and
- ◆ Serving as an advocate for the member who might not otherwise seek appropriate medical care.

The patient manager is also responsible for authorizing all referrals when necessary.



Medically Exempt Individuals

Individuals that likely have the need for coverage of some services beyond what is found in the Iowa Wellness Plan may be identified as “medically exempt.” Exempt individuals will have a choice between the Iowa Wellness Plan and the “regular” Medicaid state plan benefit, which offers more comprehensive coverage.

“Medically exempt” is defined in 42 CFR § 440.315(f) as including individuals with:

- ◆ Disabling mental disorders (including adults with serious mental illness),
- ◆ Chronic substance use disorders,
- ◆ Serious and complex medical conditions,
- ◆ A physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or
- ◆ A disability determination based on Social Security criteria.

9. Members Under the Medically Needy Program

The Medically Needy program provides medical coverage to people who are pregnant, under age 21, caretaker relatives, aged, blind, or disabled, and would qualify for Medicaid programs, other than the Iowa Wellness Plan, except that:

- ◆ They have slightly too much income or resources, or
- ◆ They have higher incomes but have unusually high medical expenses.

The Medically Needy income level is based on family size. Members whose income is equal to or less than the Medically Needy income level are eligible for Medicaid through the Medically Needy program.

Members who meet all eligibility factors for the Medically Needy program except for income are allowed to reduce their excess income through incurred medical expenses. This process is called spenddown.

Members who have a Medically Needy spenddown obligation are “conditionally eligible” for Medicaid until they have verified enough medical expenses to meet their spenddown for that certification period. Information about the status of these members is available through the Eligibility Verification System (ELVS). See [Eligibility Verification](#) for more information.



Eligibility for Medically Needy members is based on a certification period. For people with a spenddown obligation, the certification period is two months. A new application is required before eligibility can be re-established.

Medical Assistance Eligibility Cards are issued for Medically Needy members:

- ◆ Who do not have a spenddown amount, or
- ◆ Who have met their spenddown obligation.

NOTE: Not all mental health services are covered under fee-for-service reimbursement. Preauthorization is necessary for people enrolled in the Iowa Plan. ELVS or the web portal will indicate if the member is enrolled in the Iowa Plan.

Medically Needy members are entitled to receive all services covered by Medicaid except:

- ◆ Care in a nursing facility,
- ◆ Care in an institution for mental disease,
- ◆ Care in an intermediate care facility for the intellectually disabled.

Expenses used to meet spenddown are not payable by Medicaid. See [Medically Needy Conditional Eligibility](#) for information on how this affects billing and payment for services provided.

a. Medically Needy Conditional Eligibility

A member with a spenddown may not have a *Medical Assistance Eligibility Card* when service is requested, but may have met the spenddown, or may later be determined to be eligible retroactively.

Expenses used for spenddown are considered as a deductible and are not paid by Medicaid. Medicaid may cover a service provided before the member receives a *Medical Assistance Eligibility Card* if the service was not used to meet the spenddown obligation.

Expenses used to meet spenddown can include both services that would be covered by Medicaid if spenddown were met and services that would not be covered by Medicaid, such as a service provided before the Medically Needy certification period that remains unpaid at the beginning of the period.



Members who have successfully reduced their excess income through spenddown are notified what bills were used for spenddown and are, therefore, their personal obligation.

When a member has met spenddown, but eligibility has not yet been updated to reflect Medicaid coverage for the certification period, ELVS will report that the remaining spenddown is zero. The time lag between the spenddown reaching zero and the eligibility update showing the member as Medicaid-eligible should be no longer than two days.

b. Submitting Claims for a Person with a Spenddown

Once it is determined through ELVS that a conditionally eligible member has a spenddown balance to meet, submit claims for services for the member or responsible relative to the IME just as if the member were eligible for Medicaid, using claim forms or electronic billing.

If the member has not met spenddown, the IME will apply the claim to the spenddown balance. Claims that are used to meet spenddown will be denied for Medicaid payment. The amount used for spenddown will be listed on the *Remittance Statement*. Claims that are not used to meet spenddown or are only partially used to meet spenddown are automatically resubmitted for Medicaid payment.

In order for expenses to be accurately applied towards spenddown, the provider must bill a member's other insurance or Medicare before submitting the claim to the IME.

Claims will not be forwarded for spenddown processing and must be corrected and resubmitted if:

- ◆ They have missing or incorrect data (invalid procedure, national drug code, diagnosis, date of service, etc.).
- ◆ They post any edits for spenddown (EOB 480), insurance, or invalid data.
- ◆ The member's information is not on the Medically Needy system (EOB 270).



Conditionally eligible members who have “old bills” or other expenses that will not be Medicaid-payable need to have verification of these bills to apply the bills to their spenddown obligation and achieve Medicaid eligibility for current covered expenses. These claims cannot be filed electronically or submitted directly to the IME.

Submit claims for such services to the member’s income maintenance worker in the Department of Human Services. See the [Map of DHS Offices](#) for a list of the addresses of Human Services offices. The worker will attach the necessary documentation to the claim and forward it to the IME for spenddown processing.

c. *Medically Needy Expense Deletion Request, Form 470-3931*

When a prescription is filled and billed to Medicaid for a potentially eligible Medically Needy member, but the member does not pick up the prescription, the pharmacy must complete form 470-3931, *Medically Needy Expense Deletion Request*.

Click [here](#) to view a sample of this form on line. Fax the completed form to the IME as soon as possible to prevent claims for services not used to meet spenddown by the Medically Needy member.

10.Members Under the Qualified Medicare Beneficiary Program

The Medicare Catastrophic Coverage Act of 1988 mandated a coverage group for qualified Medicare beneficiaries (QMB). QMB coverage provides for limited Medicaid payment. Medicaid pays only for Medicare premiums (Part A or B), coinsurance, and deductibles.

To qualify for QMB, a person must:

- ◆ Be entitled to hospital insurance benefits under Part A of Medicare.
- ◆ Be within the income and resource limits specific to QMB.
- ◆ Meet all other Medicaid eligibility requirements.

Income eligibility for QMB exists if the household’s income does not exceed 100 percent of the federal poverty level. Net countable income is determined using Supplemental Security Income (SSI) income policies.



The 2015 QMB resource limits are the same as the resource limits for full premium subsidy under the Extra Help for Medicare Part D Drug Plan: \$7,280 for an individual and \$10,930 for a couple. SSI resource policies apply when determining countable resources.

A member can be concurrently eligible for QMB and Medically Needy. Members who are conditionally eligible for Medically Needy and are eligible for QMB are entitled only to services covered under QMB until spenddown is met. Once spenddown is met, they are then entitled to Medicaid benefits payable under Medically Needy.

Eligibility for QMB becomes effective the first day of the month following the month of decision. Each person eligible for QMB is issued a *Medical Assistance Eligibility Card*, form 470-1911.

11. Services to Members Under Waiver and Grant Programs

a. Home- and Community-Based Services Waivers

Home- and community-based services (HCBS) waivers provide a variety of services in a member's home that are not available through regular Medicaid. Services provided under the waivers are not available to other Medicaid members.

The total costs of these services and regular Medicaid cannot exceed the total cost of care and services provided in a medical institution. There are currently seven HCBS waivers, targeting the following groups:

- ◆ *AIDS/HIV* provides services for people with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection who would otherwise require care in a medical institution.
- ◆ *Brain Injury (BI)* provides services for people with a specific brain injury diagnosis to allow them to live in the community.
- ◆ *Child Mental Health (CMH)* provides services for children with a serious mental, behavioral, or emotional disorder.
- ◆ *Elderly* provides services to elderly Iowa residents so they can stay in the home instead of entering a nursing facility.



- ◆ *Health and Disability (HD)* provides services to blind or disabled people who otherwise would need care in a nursing facility, skilled nursing facility, or an intermediate care facility for the intellectually disabled.
- ◆ *Intellectual Disabilities (ID)* provides services to people with a primary diagnosis of intellectual disability who would otherwise require care in a medical institution.
- ◆ *Physical Disabilities (PD)* provides services for people with a physical disability.

b. Program for All-Inclusive Care for the Elderly (PACE)

PACE allows enrolled Medicaid members to stay healthy and live in the community as long as possible. PACE is a seamless way of providing “managed” long-term care to Medicaid members.

PACE is similar to the Medicaid home- and community-based service (HCBS) waiver programs in that members must live in the community and must meet the nursing facility level of care in order to qualify.

PACE eligibility differs from HCBS waiver programs because Medicaid members who are enrolled in PACE continue to be eligible for PACE services if they become a resident of a medical institution.

The PACE provider receives a monthly capitation payment for each PACE enrollee, and in turn, is responsible for ensuring that enrollees receive any services determined necessary for their health and well-being.

c. Money Follows the Person (MFP) Grant Services

MFP grant services provide an opportunity for people to move out of intermediate care facilities for people with an intellectual disability (ICF/ID) and into their own homes in the community of their choice. As of 2014, MFP grant funds are also available to individuals with an intellectual disability and brain injury living in nursing facilities.



Grant funds provide funding for the transition services and enhanced supports needed for the first year after a person transitions into the community. MFP assistance is available to people who:

- ◆ Have a diagnosis of intellectual disability or brain injury,
- ◆ Have lived in an ICF/ID for at least 90 days,
- ◆ Have expressed an interest in moving from a nursing facility or ICF/ID into the community, and
- ◆ Need home- and community-based services (HCBS) in order to successfully reside in a community-based setting.

The MFP Program helps participants locate a place to live and arrange for medical, rehabilitative, home health, and other services in the community, as needed. MFP participants are covered by the program for 365 days, after which time, an HBCS waiver will provide ongoing services.

The MFP grant provides enhanced funding for services intended to support a successful transition and to help support participants in community living. The assistance of a transition specialist (TS) in coordinating transition planning, implementation, and follow-up in securing essential services is included.

12. People Who Need Treatment for Breast or Cervical Cancer

Medicaid is available to people who:

- ◆ Are under the age of 65, and
- ◆ Have been screened and diagnosed:
 - Through the Breast and Cervical Cancer Early Detection Program (BCCEDP), or
 - By any provider or entity and BCCEDP has elected to include screening activities by that provider or entity.
- ◆ This screening includes breast or cervical cancer screenings or related diagnostic services provided or funded by family planning or centers, community health centers, or nonprofit organizations, and the screenings or services are provided to individuals who meet the eligibility requirements established by the BCCEDP, and



- ◆ Have been found to need treatment for either breast or cervical cancer (including a pre-cancerous condition), and
- ◆ Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act, and
- ◆ Are not eligible under another mandatory Medicaid coverage group.

Eligibility continues until the person is:

- ◆ No longer receiving treatment for breast or cervical cancer,
- ◆ No longer under the age of 65, or
- ◆ Covered by creditable health coverage or Medicare.

During the period of eligibility, a person is entitled to full Medicaid coverage. Covered services are not limited to treatment of breast or cervical cancer.

C. PRESUMPTIVE ELIGIBILITY OVERVIEW

Legal reference: 42 USC § 1396a(a)(47)(b), 1396r-1, 1a, 1b;
42 CFR 435.1100-1103, 435.1110, 457.355;
Iowa Code 249A.3(1)(i), 249A.3(2)(a)(b)(2);
441 IAC 7.5(2)“a”(6); 75.1(30), (40), (44);
76.1(249A), 76.7(249A)

The goal of the presumptive eligibility process is to offer immediate health care coverage to individuals likely to be Medicaid eligible, before there has been an ongoing Medicaid determination.

Individuals can enroll in presumptive eligibility for a limited time before ongoing Medicaid applications are filed and processed, based on a determination of likely Medicaid eligibility from an approved provider. Based only on an individual's statements regarding household income and circumstances, a presumptive provider can “presume” that a patient will be eligible for Medicaid.

Presumptive providers can grant temporary Medicaid coverage to these individuals to pay for the cost of certain types of care during the presumptive period.



1. Presumptive Provider Categories

A presumptive provider is any organization that has been approved by the Department to conduct and authorize presumptive eligibility determinations.

The term “presumptive provider” applies to:

- ◆ A provider who has been designated a “qualified Medicaid provider” pursuant to 42 USC § 1396r-1 and 441 IAC 75.1(30)“a” related to presumptive eligibility for pregnant women;
- ◆ A provider who has been designated a “qualified Medicaid provider” pursuant to 42 USC § 1396r-1b and 441 IAC 75.1(40)“c”(1) for presumptive eligibility under the Breast and Cervical Cancer Treatment (BCCT) program;
- ◆ A provider who has been designated a “qualified entity” pursuant to 42 USC § 1396r-1a, 42 CFR § 435.1101 and 441 IAC 75.1(44)“a” related to presumptive eligibility for children; or
- ◆ A provider who has been designated a “qualified hospital” pursuant to 42 USC § 1396a(a)(47)(b), 42 CFR §435.1110, and 441 IAC 76.1(249A) related to presumptive eligibility determinations made by hospitals.

Presumptive providers are prohibited from performing presumptive eligibility determinations for Department programs for which they have not been designated by the Department as a presumptive provider for that program.

Pursuant to 42 CFR 435.1102(b)(2)(vi), only employees of the presumptive provider may be given the authority to make presumptive eligibility determinations. A presumptive provider may not delegate the authority to determine presumptive eligibility to another entity, subcontractor, or agent.

2. Application to Become a Presumptive Provider Organization

A “**presumptive provider (PP)**” is an organization, approved by the Department, to conduct and authorize PE determinations. The presumptive provider must meet the requirements outlined in the *Application for Certification to Become a Qualified Entity (QE)*. A presumptive provider organization that seeks to be authorized to make presumptive Medicaid eligibility determinations shall apply to DHS on form 470-5200, *Application for Certification to Become a Qualified Entity (QE)*. Click [here](#) to view the form online.

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Send the completed application form and supporting documents (if applicable) to:

Iowa Medicaid Enterprise
 Attn: Provider Enrollment
 PO Box 36450
 Des Moines, IA 50315

Or Fax: (515) 725-1155 Attn: Provider Enrollment

For questions about applying to be a presumptive provider, contact the IME Provider Enrollment Unit at (800) 338-7909 (option 2), or locally (Des Moines) at (515) 256-4609 (option 2) or by e-mail at imeproviderservices@dhs.state.ia.us.

After receiving form 470-5200, the Department determines if the applicant organization meets the criteria to become a presumptive provider. An email sent to the presumptive provider organization contains the required steps for each individual who will be making presumptive eligibility determinations. This email contains required self-directed training, form 470-2582, *Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations*, and form 470-5201, *Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form*.

Click [here](#) to view the *Memorandum of Understanding (MOU) with a Provider for PE Determination*, form 470-2582.

Click [here](#) to view the *Qualified Entity (QE) Medicaid Presumptive Eligibility Portal (MPEP) Access Request Form*, form 470-5201.

3. Application to Become an Individual Qualified Entity

Once the presumptive provider organization has entered into the Memorandum of Understanding and the individual qualified entities (QEs) identified by the presumptive provider organization have completed the necessary requirements, the Department will authorize each individual QE's access to the presumptive eligibility system called Medicaid Presumptive Eligibility Portal (MPEP).



A qualified entity (QE) is an individual, under the supervision and authority of a presumptive provider (PP), who is authorized to determine presumptive eligibility (PE). Only employees of the presumptive provider may be given the authority to make presumptive eligibility determinations. Each individual QE must complete a web-based training module and be certified by the Department before they can begin to make eligibility determinations.

Each QE authorized to make presumptive eligibility determinations will have a unique identifier to access MPEP and cannot share that access authorization with others. Data entries made by the QE are used to determine presumptive eligibility electronically.

Individual QEs who make presumptive eligibility determinations are required to be recertified annually. Each QE within a presumptive provider organization will be notified by email 60 days in advance of the certification expiration date of the requirement to recertify. To be recertified, the QE must complete the self-directed training and re-attest to the *Memorandum of Understanding*.

4. Completing the Application for Health Coverage and Help Paying Costs

The choice of whether and when to apply for presumptive Medicaid belongs to the individual. Providers cannot refuse services based on an individual's decision whether to apply for PE.

Applications for presumptive Medicaid can be completed either by:

- ◆ The QE entering the applicant's information directly online into MPEP at the same time the information is being provided in-person by the applicant, or
- ◆ The QE collecting a paper application from the applicant and later entering the applicant's information into MPEP.

If using the paper application option, the applicant shall complete both the *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S), and the *Addendum to Application for Presumptive Eligibility*, form 470-5192 or 470-5192(S).

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Click [here](#) to view the English version of form 470-5170.

Click [here](#) to view the Spanish version of form 470-5170(S).

Click [here](#) to view the English version of form 470-5192.

Click [here](#) to view the Spanish version of form 470-5192(S.)

Regardless of which method is used to apply, the completed application must be signed by one of the following:

- ◆ The applicant,
- ◆ An adult in the applicant's household or family,
- ◆ An authorized representative, or
- ◆ Someone acting responsibly for an incompetent or physically incapacitated person or for a minor child.

An "X" or a thumbprint may be accepted as a signature if necessary.

If the application is being entered directly online in MPEP, the QE must complete and submit the application in MPEP on that day.

When application entries cannot be completed in MPEP until a later date, a paper application must be completed in order to protect the application filing date. The QE is required to date-stamp a paper application with the date it is received from the applicant.

For purposes of protecting an application date, a paper application is valid and must be date-stamped on the date it is submitted to the QE with only the applicant's legible name, address, and signature. If necessary, the applicant may then answer the other necessary questions on the application after it has been submitted to and date-stamped by the QE.

All necessary information must be obtained from the applicant before the application can be completed and a presumptive eligibility determination is made in MPEP.

The QE must explain to applicants that coverage under the presumptive Medicaid coverage groups of Pregnant Women and the Iowa Health and Wellness Plan do not provide full Medicaid coverage.

The QE must explain to all applicants that coverage under the presumptive program is time limited.



The QE must also explain to applicants that the presumptive eligibility determination is not a formal Medicaid eligibility decision by DHS. With the exception of the presumptive Medicaid coverage groups of Pregnant Women and BCCT, application for ongoing Medicaid is required and occurs automatically when an individual applies for presumptive Medicaid. A presumptive applicant can also apply for presumptive or ongoing Medicaid for anyone else in the household as entered on the application.

The MPEP system automatically transfers the information from the presumptive application to DHS for processing for ongoing Medicaid. Because MPEP will transmit the application electronically, do not send a paper copy of the application to DHS.

Applicants for the presumptive Medicaid coverage groups of Pregnant Women and BCCT are not required to apply for an ongoing Medicaid determination. Applicants for the Pregnant Women or BCCT presumptive coverage groups may choose to apply only for presumptive Medicaid, or to also apply for ongoing Medicaid on the presumptive application. Encourage the pregnant woman or the BCCT applicant to also apply for ongoing Medicaid during the presumptive period if the applicant wants ongoing Medicaid. This will allow Medicaid benefits to begin in a timely manner if the applicant meets eligibility requirements.

The choice to apply for ongoing Medicaid is indicated by the pregnant woman or BCCT applicant answering "yes" to the question, "Do you want to apply for ongoing Medicaid?" on the *Addendum to Application for Presumptive Eligibility* or in MPEP. If the pregnant woman or BCCT applicant does not want to apply for ongoing Medicaid, answering "no" to the question, "Do you want to apply for ongoing Medicaid?" on MPEP ensures the application will be considered only for presumptive Medicaid.

NOTE: The pregnant woman or BCCT applicant may choose whether or not to apply for ongoing Medicaid regardless of whether the application for presumptive is approved or denied. If the pregnant woman or BCCT applicant does choose to apply for ongoing Medicaid with DHS at the same time the applicant applies for presumptive eligibility, the date the presumptive provider received the presumptive application is the date of application the Department uses for purposes of determining the effective date of ongoing Medicaid eligibility.



EXCEPTION: For the purposes of determining the date of application for ongoing Medicaid, an application received by a presumptive provider on a weekend or state holiday shall be deemed to be received on the next business day.

In some situations the pregnant woman or BCCT applicant may not want to apply for ongoing Medicaid at all, or may want to file a separate Medicaid application at a later date. Explain to the pregnant woman or BCCT applicant that:

- ◆ If the pregnant woman or BCCT applicant applies for ongoing Medicaid and DHS denies that application for any reason, presumptive Medicaid will end on the day the ongoing Medicaid application is denied. A pregnant woman cannot be determined presumptively eligible again during the same pregnancy. A BCCT applicant cannot be determined presumptively eligible again during the same 12 month period unless a new cancer diagnosis and treatment period occurs.
- ◆ If the pregnant woman or BCCT applicant applies only for presumptive Medicaid initially, the pregnant woman or BCCT applicant can still file an application for ongoing Medicaid or for limited Medicaid for emergency services at a later date. See [Aliens Receiving Emergency Services](#) for more information on emergency services.

Provide the pregnant woman or BCCT applicant with information that allows the individual to make a fully informed decision about when to apply and for which programs to apply, considering the details of pregnant woman or BCCT applicant's own situation and the limited nature of the presumptive Medicaid program.

A pregnant woman contacts a QE to apply for Medicaid.

During the presumptive application process, the QE tells the woman that she may choose to apply for only presumptive Medicaid, apply for both presumptive and ongoing Medicaid at the same time, or apply for presumptive Medicaid now and apply for regular Medicaid at a later date. The QE also explains the possible outcomes of each option.



1. The pregnant woman states that she wants to apply for ongoing Medicaid at the same time as presumptive Medicaid. She understands that if she applies for ongoing Medicaid and DHS denies that application for any reason, presumptive Medicaid will end on the day the ongoing Medicaid application is denied.

When the QE completes entries on MPEP to process the presumptive application, the question, "Do you want to apply for ongoing Medicaid?" is answered "yes."

2. The pregnant woman wants to apply only for presumptive Medicaid at this time. She understands she may file an application for ongoing Medicaid at a later date. When the QE completes entries on MPEP to process the presumptive application, the question, "Do you want to apply for ongoing Medicaid?" is answered "no."

In some situations, it may also be beneficial for an individual who has applied for presumptive to withdraw the application for the current month and begin her presumptive period on the first day of the next month. A new application is not necessary in this situation. If this occurs, document this in the case file.

NOTE: Because the MPEP system will begin eligibility with the date of application, enter the application received date on MPEP as the first day of the next month.

1. An individual files an application with the QE on March 29 but indicates not wanting presumptive eligibility to begin until April 1. Although the application is date-stamped as received on March 29, the provider documents that the person withdrew the application for March.

On MPEP, the "application date" is entered as April 1. **NOTE:** The Medicaid application date transmitted to DHS via MPEP, if applicable, will also be April 1.

2. A person files an application with the QE on April 30. The provider explains that presumptive Medicaid may continue only up to May 31 in this situation, and asks if the applicant would like to withdraw the application for April and make her application effective May 1.

The applicant does not want to withdraw the application for April. The QE processes the presumptive eligibility beginning with April 30 by entering this as the "application date" on MPEP.

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5. Calculating Household Size and Income

Legal reference: USC 42 1396a(a)(14); 42 CFR 435.603;
441 IAC 75.70 and 75.71

Because of the Affordable Care Act, eligibility for all income-based Medicaid programs uses tax-based rules for income and household composition. Modified Adjusted Gross Income (MAGI) is a tax-based methodology for how income is counted. MAGI generally includes all taxable earned and unearned income unless exempted by the Affordable Care Act.

a. MAGI-Medicaid Household Composition and Size

The household composition and size for each presumptive applicant is determined individually. Each applicant's household is constructed based on whether the applicant is a:

- ◆ Tax filer,
- ◆ Tax dependent, or
- ◆ Non-filer (neither a tax filer nor a tax dependent).

The applicant must provide information on the application about everyone living in the household, or in their tax household, if applicable. The family cannot exclude certain family members in order to attain eligibility for other members. (**NOTE:** The requirement to provide information about all household members does not mean that everyone in the household must apply for presumptive or ongoing Medicaid.)

The household size for an applicant or member whose MAGI-based Medicaid household includes a pregnant woman is determined by counting the pregnant woman plus the number of children she is expected to deliver.

b. Treatment of Income under MAGI

Eligibility for Medicaid is calculated using a household's Modified Adjusted Gross Income (MAGI).

The current month's expected income is used to determine presumptive Medicaid eligibility. When income is changing (e.g., either starting, stopping, or fluctuating), the QE should discuss the details of the situation on a case-by-case basis to assist the applicant in providing a reasonable estimate of monthly income.



The application and MPEP capture the information about income and certain allowable expenses that are needed for a calculation of the household's countable MAGI-based income.

The QE enters the taxable income and applicable expenses of each household member on MPEP. MPEP determines the countable amount for each applicant's MAGI-based household size and provides the eligibility decision.

6. Steps in Making a Presumptive Eligibility Decision

Qualified entities complete the following steps when determining presumptive eligibility:

1. Date-stamp the application with the date it is received by a presumptive provider organization or by an individual qualified entity. For purposes of protecting an application date, a paper application is valid and must be date-stamped on the date it is submitted with only the applicant's legible name, address, and signature.
2. Clarify information on the application, if necessary. However, PE Medicaid is based only on the applicant's self-attested situation. This means eligibility is based on the answers the person provides on the application and to the QE in the course of assisting during the application process. Verification cannot be requested or required for PE Medicaid.
3. Except in the case of an applicant for the presumptive coverage groups of Pregnant Women or BCCT, the QE informs the applicant that the application will automatically be sent on Medicaid Presumptive Eligibility Portal (MPEP) to the Department for an ongoing Medicaid eligibility determination.

An application for the presumptive coverage groups of Pregnant Women or BCCT can be sent on MPEP for an ongoing Medicaid determination if the applicant so chooses. During the formal Medicaid eligibility determination, the Department will verify income, citizenship, alien status, identity, and other information as necessary.



4. The QE enters information from the application into the presumptive eligibility system through the MPEP. The system entries should be made as soon as possible and within three working days of the date the application was received. Presumptive eligibility coverage cannot begin until the information is entered and the applicant is approved in MPEP.
5. The QE gives the *Presumptive Medicaid Eligibility Notice of Action* (form 470-2580 or 470-2580(S), 470-5190 or 470-5190(S), or 470-5191 or 470-5191(S)) to the applicant. This notice explains the results of the eligibility determination. The notice should be provided as soon as possible but always within two working days after the determination is made.

NOTE: If you discover after MPEP entries have been made and a *Notice of Action* has been created that you have made an error (e.g., wrong social security number, misspelled name, woman is not pregnant, etc.), ask the DHS Contact Center for instructions on how to resolve the error. Do not reenter the application in MPEP unless instructed to do so by DHS.

6. Maintain documentation to support the presumptive eligibility decision for a period of five years for audit purposes. This may include, but is not limited to:
 - ◆ The application and addendum,
 - ◆ Clarification of any information provided by the applicant,
 - ◆ Proof of screening under BCCEDP (BCCT only), and
 - ◆ A copy of the *Notice of Action*.

NOTE: Do not send photocopies of the application, *Notice of Action*, or any other paperwork to DHS unless instructed to do so by the DHS Contact Center. Any information needed will be provided to DHS electronically based on the system entries made on MPEP.

7. Appeal Rights

Legal reference: 441 IAC 7.5(2)"a"(6)

An applicant denied presumptive Medicaid is entitled to appeal that decision. However, an appeal hearing will not be granted for a presumptive Medicaid determination. Appeal hearings are granted only with formal or ongoing Medicaid eligibility determinations made by the Department.



An individual applies for presumptive eligibility at the office of a QE on August 3. The individual also applies for ongoing Medicaid at the same time the individual applied for presumptive eligibility.

The QE enters the applicant's taxable income in MPEP. MPEP determines that the applicant's income exceeds the applicable limit for the applicant's household size and denies presumptive eligibility. If the applicant requests an appeal on the presumptive eligibility determination, the appeal request will be denied.

However, if DHS also denies the ongoing Medicaid application, the applicant may be granted an appeal based on that decision.

8. Covered Services

Legal reference: 441 IAC 79.9(3)-(4)

Providers shall supply all the same services to Medicaid-eligible individuals served by the provider as are offered to other clients of the provider. Individuals must be informed before the service is provided that the individual will be responsible for the bill if a non-covered service is provided.

With the exceptions discussed below for the presumptive Medicaid coverage groups of Pregnant Women and the Iowa Health and Wellness Plan, presumptive Medicaid provides full Medicaid benefits during the presumptive period. "Full Medicaid benefits" means that all Medicaid-covered services received from an Iowa Medicaid provider can be submitted to Iowa Medicaid for processing.

NOTE: Individuals approved under the BCCT presumptive coverage group are eligible to receive all Medicaid-covered services during the presumptive eligibility period. Their coverage is not limited only to services related to cancer treatment.

Covered services under the presumptive for Pregnant Women Medicaid coverage group are limited to ambulatory prenatal care services during the presumptive period. "Ambulatory prenatal care" means all Medicaid-covered services except inpatient hospital or institutional care and charges associated with delivery of the baby (including miscarriage or termination of a pregnancy).



If a woman approved under presumptive for Pregnant Women chooses to apply for ongoing Medicaid and is approved by DHS, claims for inpatient services and services associated with a delivery or miscarriage can be submitted to Iowa Medicaid for reimbursement consideration for Medicaid-covered services from an Iowa Medicaid provider.

Covered services under the Iowa Health and Wellness Plan presumptive Medicaid coverage group are limited to those benefits included under the Wellness Plan.

9. Period of Eligibility

The effective date of presumptive eligibility is the date a valid application for an eligible applicant was received by a presumptive provider organization or by an individual qualified entity (QE). Eligibility cannot be determined until a QE completes and submits the application into MPEP.

1. A QE working in a remote location without computer access receives an application for presumptive eligibility on September 30. The QE makes entries into MPEP on October 1 using the "application date" of September 30. The applicant is presumptively eligible. Presumptive eligibility begins on September 30.
2. An individual needing emergency surgery files a valid application with their name, address, and signature with a hospital QE before midnight on March 12. The QE obtains the rest of the applicant's necessary information and submits the application on MPEP on March 14 using the "application date" of March 12. The applicant is presumptively eligible. Presumptive eligibility begins on March 12.

A *Medical Assistance Eligibility Card* will not be issued to presumptively eligible applicants. Instead, the QE issues a *Presumptive Medicaid Eligibility Notice of Action* (form 470-2580 or 470-2580(S), 470-5190 or 470-5190(S), or 470-5191 or 470-5191(S)), to inform the applicant of the decision on the application.

The individual should present the *Presumptive Medicaid Eligibility Notice of Action* to show medical providers that the individual is presumptively eligible for benefits. Only Medicaid-covered services from medical providers who accept Iowa Medicaid may be covered.



Unlike regular Medicaid eligibility, which is granted on a monthly basis, presumptive eligibility may be terminated on any given day, without notice, once it is determined that the applicant is not presumptively eligible. Providers should confirm eligibility through the Eligibility Verification System (ELVS) each time services are requested. There is also no retroactive coverage under the presumptive Medicaid program.

If a presumptive applicant files an application for ongoing Medicaid coverage either before or during the presumptive period, presumptive eligibility coverage continues until a decision is made on the ongoing Medicaid application. The presumptive eligibility period ends on the day DHS enters a decision on the computer system to either approve or deny the Medicaid application.

An application for presumptive eligibility is received and approved on October 6. The application is automatically forwarded to DHS. DHS makes a decision on the ongoing Medicaid application on November 3. Presumptive eligibility ends November 3.

EXCEPTION: For children whose ongoing Medicaid is approved under the *hawk-i* coverage group, ongoing Medicaid coverage cannot begin until the first of the following month. The presumptive eligibility period ends the last day of the month before *hawk-i* coverage begins.

An application for presumptive eligibility for a child is received and approved on October 6. The application is automatically forwarded to DHS. DHS approves Medicaid under the *hawk-i* coverage group on October 18. Presumptive eligibility ends October 31.

If a Medicaid application has not been filed by the last day of the month following the month of the presumptive eligibility determination, presumptive eligibility ends on the last day of that month.

Presumptive eligibility will also end on the last day of the month following the month of the presumptive eligibility determination if an application for ongoing Medicaid is withdrawn, or if the application for ongoing Medicaid is not pended on the DHS' computer system by the last day of the month following the month of the presumptive eligibility determination.



An application for presumptive eligibility is received and approved on October 6. The ongoing Medicaid application is automatically sent to DHS. Before an eligibility determination is made, the applicant contacts DHS and withdraws the ongoing Medicaid application. Presumptive eligibility continues until November 30.

NOTE: A person may be determined presumptively eligible only once per pregnancy or once during a 12 month period (BCCT has an exception for a new cancer diagnosis). If a person wants Medicaid after presumptive eligibility ends, the person must apply and be determined eligible for ongoing Medicaid by DHS. The application may not be determined presumptively eligible again within a 12 month period (or during the same pregnancy for a pregnant woman).

No certificate of creditable coverage is issued for a presumptive eligibility period.

1. Ms. B is determined presumptively eligible as a pregnant woman on May 2. She does not apply for ongoing Medicaid at the time she applies for presumptive Medicaid. Instead, she files an ongoing Medicaid application on June 30, and DHS pends the application the same day. Ms. B's presumptive eligibility continues until DHS makes an eligibility determination on her Medicaid application.
2. Same as Example 1, except Ms. B's application for ongoing Medicaid is either not filed with or not pended by DHS until July 1. Ms. B's presumptive eligibility ends on June 30.
3. Child C is determined presumptively eligible on June 6 and applies for ongoing Medicaid at the same time the Child C applied for presumptive Medicaid. On June 20, DHS determines that Child C is not eligible and Child C's Medicaid application is denied. Child C's presumptive eligibility ends June 20.
4. Mr. D applies for ongoing Medicaid at the same time he applies for presumptive eligibility. He is determined presumptively eligible on July 29. By August 31, DHS has not been able to make an eligibility determination on his Medicaid application. If his application was pended at DHS, Mr. D's presumptive eligibility extends beyond August 31 and continues until DHS makes an eligibility determination.



D. ELIGIBILITY CATEGORIES AND REQUIREMENTS OVERVIEW

There are six types of Presumptive Eligibility (PE) programs:

- ◆ Children
- ◆ Pregnant women
- ◆ Breast and Cervical Cancer Treatment (BCCT)
- ◆ Iowa Health and Wellness Plan (IHAWP)
- ◆ Expanded Medicaid for Independent Young Adults (EMIYA)
- ◆ Parents and caretakers

NOTE: Hospitals are the only entities that may process all six types of PE programs.

Presumptive eligibility for all applicants is based on all the criteria discussed in this section. **NOTE:** Additional requirements specific to an eligibility category are covered later in the sections specific to each category.

All eligibility factors used in the presumptive eligibility determination are based on the applicant's self-attested circumstances. Proof of income or any other eligibility factor cannot be requested or required.

Presumptive Medicaid is available to individuals who are Iowa residents.

With exceptions for the presumptive categories of Pregnant Women and BCCT, an individual may only have presumptive eligibility once in a 12 month period. The Pregnant Women category limits presumptive eligibility to once per pregnancy. The BCCT category limits presumptive eligibility to once per 12 months but allows an exception for an individual who has a new cancer diagnosis and treatment period. MPEP data matches are used to determine if an individual had previous presumptive episodes in the applicable time period.

The PE application can be submitted without a social security number (SSN). Lack of a SSN has no impact on PE eligibility. However, QEs may encourage PE applicants to provide their SSNs to ensure proper identification. In addition, providing a SSN speeds up processing of the ongoing Medicaid application and allows DHS to verify more information through data matches, thus reducing information that must be requested from the applicant.



With the exceptions of the presumptive categories of Pregnant Women and BCCT, an individual must be either a U.S. citizen or have an eligible immigration status to be eligible for presumptive Medicaid.

These individuals never have eligible immigration status:

- ◆ Nonqualified aliens lawfully admitted to the U.S. only for a specific temporary reason (e.g., visitor for work or vacation, exchange student, temporary worker).
- ◆ Undocumented aliens in the U.S. without papers or status documentation.

These individuals always have eligible immigration status:

- ◆ Children under 21 lawfully present in the U.S.
- ◆ Asylees
- ◆ Refugees
- ◆ Cuban and Haitian entrants
- ◆ Conditional entrant granted before 1980
- ◆ Victims of trafficking and the victim's spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
- ◆ People granted withholding of deportation
- ◆ Members of a federally recognized Indian tribe or American Indian born in Canada

Alien adults age 21 and over in these categories only have eligible immigration status once they have held a qualified status for five years:

- ◆ Lawful Permanent Residents (LPR/Green Card Holder)
- ◆ Battered non-citizens, spouses, children, or parents
- ◆ Paroled into the U.S. for at least one year



1. Presumptive Eligibility for Children

Legal reference: 42 USC 1396a(a)(A)(10)(i)(III), 1396a(e)(14), 1396r-1a, 1397bb;
42 CFR 435.118, 435.229, 435.603, 435.1101-1102, 457.310-320;
441 IAC 75.1(44), 75.70(240A), 75.71(249A), 86.2(2)

In addition to the general eligibility requirements, presumptive eligibility for children is based on the following criteria. The child must:

- ◆ Be under the age of 19. A child whose 19th birthday falls on the first of the month is no longer considered a child for the month of that birthday. A child whose 19th birthday falls on any other day of the month is considered a child for the month of the birthday.

A child who turns 19 on October 1 is considered a child through the month of September, but not in October. A child who turns 19 anytime from October 2 through 31 is considered a child through the month of October.

- ◆ Have countable household income that does not exceed 302 percent (children 1-18) or 375 percent (infants under age 1) of the federal poverty level based on the size of the household.

2. Presumptive Eligibility for Pregnant Women

Legal reference: 42 USC 1396a(a)(10)(i)(III), 1396a(e)(14), 1396r-1;
42 CFR 435.116, 435.603, 435.1103(a);
441 IAC 75.1(30), 75.70(249A) and 75.71(249A)

In addition to the general eligibility requirements, presumptive eligibility for a pregnant woman is based on the following criteria. The woman must:

- ◆ Have countable household income that does not exceed 375 percent of the federal poverty level for the household size.
- ◆ Be pregnant.

NOTE: The Department will end the presumptive eligibility period immediately upon being notified a woman is not actually pregnant. This sometimes occurs when a woman is approved for presumptive Medicaid based on symptoms of pregnancy or a pregnancy test result that is later determined to be a false positive.

There are no citizenship or immigration requirements for presumptive eligibility under the Pregnant Women coverage group.



3. Presumptive Eligibility for Individuals Who Need Treatment for Breast or Cervical Cancer

Legal reference: 42 USC 1396a(aa), 1396r-1b;
42 CFR 435.1103(c)(1);
441 IAC 75.1(40)“c”

In addition to the general eligibility requirements, presumptive eligibility under the breast and cervical cancer treatment (BCCT) coverage group is based on the following criteria. The individual must:

- ◆ Be under age 65.
- ◆ Have been screened and diagnosed:
 - Through the Breast and Cervical Cancer Early Detection Program (BCCEDP), or
 - By any provider or entity and BCCEDP has elected to include screening activities by that provider or entity.

This screening includes breast or cervical cancer screenings or related diagnostic services provided or funded by family planning or centers, community health centers, or nonprofit organizations, and the screenings or services are provided to individuals who meet the eligibility requirements established by the BCCEDP.

- ◆ Need treatment for a cancerous or pre-cancerous condition of the breast or cervix.
- ◆ Not have creditable health insurance coverage.

There are no income, resource, or citizenship or immigration requirements for presumptive eligibility under BCCT.

4. Presumptive Eligibility for Iowa Health and Wellness Plan

Legal reference: 42 USC 1396a(e)(14), 42 CFR 435.119, 435.1103, 435.1110, 440.315(f), Iowa Code 249A.4, 249N;
441 IAC Chapter 74; 441 IAC 75.70 (249A)

In addition to the general eligibility requirements, presumptive eligibility under the Iowa Health and Wellness Plan (IHAWP) coverage group is based on the following criteria. The individual must:

- ◆ Be at least age 19 and under age 65.
- ◆ Not be pregnant.



- ◆ Not be eligible for or enrolled in Medicare under Part A or Part B.
- ◆ Not be eligible for any other Medicaid coverage group, other than Medically Needy.
- ◆ Have or be applying for minimum essential coverage for any dependent children living in their household for whom the individual has parental control.
- ◆ Have income that does not exceed 133 percent of the federal poverty level based on the size of the household.

5. Expanded Medicaid for Independent Young Adults

Legal reference: USC 42 1396a(a)(10)(A)(i)(IX);
42 CFR 435.150, 1103, 435.1110;
Iowa Code 249A.3(1)(w);
441 IAC 75.1(45)

In addition to the general eligibility requirements, presumptive eligibility under the Expanded Medicaid for Independent Young Adults (EMIYA) coverage group is based on the following criteria. The individual must:

- ◆ Be at least age 18 and under age 26.
- ◆ Have been in a foster care placement under the responsibility of Iowa when the youth turned age 18 (or otherwise aged out of foster care).
- ◆ Have been receiving federally funded Medicaid through Iowa when the youth turned age 18 (or otherwise aged out of foster care).
- ◆ Not be eligible for Medicaid under another coverage group other than EMIYA, Iowa Health and Wellness Plan, or Medically Needy.

There are no income limits for presumptive eligibility under EMIYA.

Youth who were in foster care and receiving Medicaid from a state other than Iowa when reaching age 18 do not qualify for coverage under the presumptive EMIYA coverage group.

Youth who are under age 26 and who aged out of foster care before January 1, 2014, are eligible for presumptive EMIYA if the other eligibility requirements are met.



6. Presumptive Eligibility for Parents and Caretakers

Legal reference: 42 CFR 435.110, 435.1110;
441 IAC 75.70(249A) and 75.71(249A)

In addition to the general eligibility requirements, presumptive eligibility under the parents and caretakers coverage group is based on the following criteria. The individual must:

- ◆ Meet the applicable income limits for the household size.
- ◆ Have “parental control” of a dependent child under the age of 18 (or age 18 and still in high school) living in their household.

Parents automatically have parental control of their own dependent child.

Other adults are caretakers with “parental control” of a dependent child when they have assumed the role and responsibilities of a parent due to the absence or incapacity of a parent.

Spouses of parents and spouses of caretakers are also eligible to claim parental control.

MPEP will calculate eligibility under the parents and caretakers coverage group using the following income limits:

Household Size	Monthly Income Limit
1	\$447
2	\$716
3	\$872
4	\$1,033
5	\$1,177
6	\$1,330

Household Size	Monthly Income Limit
7	\$1,481
8	\$1,633
9	\$1,784
10	\$1,950
Over 10	Add \$178 for each additional person