Iowa Department of HUMAN SERVICES

Employees' Manual
Title 8, Chapter B

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Medicaid

Application Processing

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Overview

This chapter explains the procedures for processing Medicaid applications. The mechanics of filing and handling applications are covered first, followed by interview and verification procedures. Time lines for processing applications and effective date of eligibility are given in the next sections.

The remaining pages of the chapter address eligibility for the retroactive period, referrals to the Child Support Recovery Unit (CSRU) and to the Healthy and Well Kids in Iowa (***hawk-i***) program, and representation.

Filing a Medicaid Application

Legal reference: 42 CFR 435.403, 435.906, and 435.908; 441 IAC 76.1(2) and (4), 86.3(2); Iowa Code Section 249A.3

All people have the right to apply for Medicaid for themselves or on behalf of another. Give an application to anyone who asks for one regardless of the person's county of residence. If the request is by mail or telephone, send the application in the next outgoing mail.

See 8-F, Express-Lane Eligibility for MAC, for children under age 19 who are eligible without an application under the express-lane eligibility process.

A separate application for Medicaid is not required when a person is also applying for:

- The Family Investment Program (FIP)
- Refugee Cash Assistance
- The Healthy and Well Kids in Iowa (***hawk-i***) program
- State Supplementary Assistance
- Supplemental Security Income (SSI) benefits

NOTE: People applying for FIP or Refugee Cash Assistance must also indicate on the application that they want to apply for Medicaid or notify the worker that they want Medicaid before a decision is made on the application. A person already **receiving** FIP or Refugee Cash Assistance must file a separate application for Medicaid.

An application for SSI benefits is automatically considered an application for Medicaid if SSI is approved. A denied SSI application is not considered a Medicaid application, and the filing date is not protected for Medicaid purposes. See Collecting Eligibility Information from SSI Recipients.

When requested, assist the applicant with completing an application. Applicants can authorize other people to represent them during the application process. Other people can also help the applicant during the application process.

An application may be filed on behalf of a deceased person. Eligibility is based on whether the person would have been eligible had application been made on or before the date of death and whether there are unpaid medical bills. However, eligibility cannot be established any earlier than three months before the month of application.

An application may be filed on behalf of a person temporarily out of the state. This situation usually happens when someone is visiting outside the state and has an accident or sudden illness. Apply all of Iowa's policies regarding application processing and eligibility. See 8-C, Residency, for more information about determining when a client is a resident of Iowa.

Which Application Form to Use

Legal reference: 45 CFR 435.907, 435.909; 441 IAC 76.1(249A)

Determine which of the following application forms to use based on the assistance the applicant is requesting:

Application Form	Who Should Use the Form
Health Services Application, forms 470-2927 and 470-2927(S)	People applying **only** for Medicaid under the following coverage groups: ♦ FMAP-related coverage groups ♦ FMAP-related Medically Needy ♦ Refugee Medical Assistance ♦ Iowa Family Planning Network (IFPN) An aged, blind, or disabled person applying for: ♦ SSI-related Medicaid ♦ SSI-related Medically Needy People applying for: ♦ Medical facility care ♦ A home- and community-based waiver ♦ State Supplementary Assistance Women who need treatment for breast or cervical cancer. A child in foster care or subsidized adoption

Application Form	Who Should Use the Form
Health and Financial Support Application, forms 470-0462 or 470-0462(S)	People applying for FIP or Food Assistance **and** the following Medicaid coverage groups: ♦ FMAP-related coverage groups ♦ FMAP-related Medically Needy ♦ Refugee Medical Assistance ♦ Iowa Family Planning Network (IFPN) ♦ SSI-related coverage group ♦ SSI-related Medically Needy ♦ State Supplementary Assistance
hawk-i *Application* (located in Comm. 156 and Comm. 156(S)) or *Healthy and Well Kids in Iowa* (***hawk-i***) *Electronic Application Summary*, form 470-4016	People applying for the (***hawk-i***) program

Include form 470-2826, *Insurance Questionnaire*, in the application packet for all new applications except for persons approved for SSI. Have the applicant complete the *Insurance Questionnaire* if insurance availability is indicated on the application or you are aware that the applicant has insurance available.

Exceptions:

- People who complete *SSI Medicaid Information*, form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS), do not have to complete the *Insurance Questionnaire*. A person approved for SSI must complete the insurance section of *SSI Medicaid Information* before Medicaid can be approved, unless you already have all the information needed.
- People who have received Medicaid within the last six calendar months do not have to complete the *Insurance Questionnaire* unless there has been a change in medical resources since the person last received assistance. Verify any changes and ask the person to complete the *Insurance Questionnaire*, if necessary.
- Applicants for the IFPN coverage group do not complete the *Insurance Questionnaire*.

See 6-Appendix for instructions about what to do with the *Insurance Questionnaire* and the information provided on the form. See 8-O, Applications, for the applications that may be used for persons applying for IowaCare.

Referrals From the *hawk-i* Program

Legal reference: 441 IAC 86.3(514I)

When a ***hawk-i*** *Application* (located in Comm. 156 and Comm. 156(S)) or *Healthy and Well Kids in Iowa* (***hawk-i***) *Electronic Application Summary* (form 470-4016) is filed with the ***hawk-i*** administrator, the application is screened to determine if the child may qualify for Medicaid.

If it appears that Medicaid eligibility exists, ***hawk-i*** staff will refer the application to income maintenance (IM) workers located at the ***hawk-i*** office for a Medicaid eligibility determination for the children. (A ***hawk-i*** application is considered a Medicaid application for the children only.) The ***hawk-i*** administrator also:

- Notifies the family of the referral.
- Returns any original verification documents.

NOTE: If the IM worker at the ***hawk-i*** office determines that the family has an active case at the local DHS office or a pending application for Medicaid or any other program, the ***hawk-i*** application is referred to that office for the Medicaid eligibility determination.

If the children's application is pending with the IM worker at the ***hawk-i*** office when the parents request Medicaid for themselves, the parents' application date is **initially** set the **same** as the children's application date.

The IM worker at the ***hawk-i*** office documents the contact date and sends the parents form 470-2927 or 470-2927(S), *Health Services Application*, to be completed and returned to the local office.

If the IM worker at the ***hawk-i*** office approves the children for Medicaid and the parents are eligible for Family Medical Assistance Program (FMAP), Child Medical Assistance Program (CMAP), or Mothers and Children (MAC), add the parents to the children's case without a Medicaid application. The effective date for the parents is the same as for the children.

If the IM worker at the ***hawk-i*** office approves the children for Medicaid and the parents are eligible only for Medically Needy, the parents must complete the *Health Services Application.* The Medically Needy application date is the date the local office receives the parents' application.

If the IM worker at the ***hawk-i*** office denies the children's application, the parents' *Health Services Application* is also a reapplication for the children. The date of application is the date the local office receives the *Health Services Application*.

If the parents contact the local office to request Medicaid for themselves while the children's Medicaid application is pending with the IM worker at the ***hawk-i*** office, the date the local office receives the paper application is the application date for adding the parents to the children's eligible group.

If a parent requests Medicaid after the children are approved for Medicaid, the local office IM worker handles the request. All policies regarding application processing for Medicaid apply, including time frames for processing the application and notice and verification requirements.

Who Must Sign the Application

Legal reference: 42 CFR 435.907 and 435.909; 441 IAC 76.1(3)"e" and "f"

To be considered a valid application, an application must have the following:

- A legible name,
- An address, and
- A signature.

Before eligibility can be **approved**, the application form must be signed by:

- The applicant (including a child living independently or a minor applicant for the Iowa Family Planning Network), or
- A responsible person acting on behalf of a minor applicant or an incompetent, physically incapacitated, or deceased applicant, such as:
  - A child's parent or stepparent,
  - A spouse,
  - A guardian or conservator,
  - A friend or relative with knowledge of the applicant's circumstances, or
  - A person or organization that has signed form 470-3356, *Inability to Find a Responsible Person*.

If an authorized representative signs the application on behalf of the applicant, the signature of the applicant or responsible person must be on the application before eligibility can be approved. See Representation.

NOTE: If the applicant is under a guardianship or conservatorship that was established voluntarily, the applicant may sign the application. When a person voluntarily asks the court to appoint a guardian or conservator, the court may do so without making a determination that the person is incompetent.

Applications that are filed electronically, whether signed and faxed or scanned and e-mailed, do not have to be signed again.

Where the Application Must Be Filed

Legal reference: 441 IAC 76.1(1), 76.1(3), 86.3(3)

The application forms listed under Which Application Form to Use may be filed in any of the following locations:

- At a Department office (whether open full time or less than full time).
- At a disproportionate-share hospital, federally qualified health center, mental health institute, state resource center, or other facility where out-stationing activities are provided.
- With the third-party administrator for the ***hawk-i*** program.

Form 470-2927 or 470-2927(S), *Health Services Application*, may also be filed at:

- Offices of a qualified provider of presumptive Medicaid eligibility.
- WIC sites.
- Maternal or child health centers.

If an application should have been filed in another DHS office, send the application to the correct office for processing within two working days of receipt.

Responsibility for processing applications for waiver services or institutional care lies with the county indicated on the following chart. **EXCEPTIONS:**

- If the county where the client lives, where the facility is located, or where the client has legal settlement has a less-than-full-time office, the application is processed at the full-time Department office associated with that county.
- If an income maintenance worker is out-stationed at a facility, that worker processes the application, regardless of the applicant's county of residence.

If the applicant is:	The application is processed in:
Requesting waiver services	The county where the applicant will live
In a hospital	The county where the applicant lives
In an intermediate care facility for persons with mental retardation (ICF/MR)	The county of legal settlement
In an ICF/MR and applying for waiver services	The county where the applicant will live
In a nursing facility (including skilled care)	The county where the facility is located
In a residential care facility (RCF)	The county where the facility is located
In an residential care facility for persons with mental retardation (RCF/MR)	The county where the facility is located
In a psychiatric medical institution for children (PMIC)	The county where the facility is located

Applications for Iowa Family Planning Network coverage can also be filed and processed at the following family planning agencies and their satellite clinics:

- Allen Memorial Hospital, Waterloo
- Central Iowa Family Planning, Marshalltown
- Community Opportunities, AKA New Opportunities, Carroll
- Edgerton Women's Health Center, Davenport
- HCCMS Family Health Services, Denison
- Hillcrest Family Services, Dubuque
- Northeast Iowa Community Action, Decorah
- North Iowa Community Action, Marshalltown
- Planned Parenthood of East Central Iowa, Cedar Rapids
- Planned Parenthood of the Heartland, Des Moines
- Planned Parenthood of Southeast Iowa, Burlington
- Southern Iowa Family Planning Clinic, Ottumwa
- St. Luke's Hospital, Cedar Rapids
- Unity Healthcare, Muscatine
- Visiting Nurse Services, Des Moines
- Women's Health Services, Clinton

If a ***hawk-i*** *Application* (Comm. 156) is filed with the local office instead of the ***hawk-i*** administrator, date-stamp the application and send it to the ***hawk-i*** program administrator within two working days of receipt.

Date of Application

Legal reference: 441 IAC 76.1(3) and 86.3(4)

Policy:
An application is considered filed on the date when a form that is listed under Which Application Form to Use and contains a legible name, address, and signature of the client or representative is received at a location defined under Where the Application Must Be Filed.

For SSI recipients, the date the SSI application was filed with the Social Security Administration, as shown on the SDX, is the date of application for Medicaid. See Effective Date for SSI Recipients and 14-E, *SSI STATE DATA EXCHANGE*, for SDX information.

Procedure:
An application left at a closed office will be considered received on the first day that is not a weekend or state holiday following the day that office was last open.

> County A is a less-than-full-time office and open on Monday and Wednesday. The office was last open Wednesday, April 24. When the office re-opens on the following Monday, staff find several applications that have been left under the door. All applications are date-stamped as being received Thursday, April 25.

A faxed or electronic application shall be considered as an original application. A faxed or electronic application is considered filed on the date it is received when it comes in during normal business hours.

If the application comes in after normal business hours (during the evening, weekend, or holiday), the application is considered received on the first day that is not a weekend or state holiday following the day that office was last open.

When a person fills out an incorrect application form, the person must complete the correct form before eligibility can be established. Use the filing date on the incorrect application as the filing date when the correct application is received. Attach the incorrect application to the correct application and file it in the case record. On all applications, use the filing date as the application date.

Withdrawal of Application

Legal reference: 45 CFR 435.913(b)(1), 441 IAC 76.1(6)

Applicants may withdraw the application entirely or for any month covered by the application, if the request is made before the date the application is processed.

EXCEPTION: The Medically Needy coverage group requires that concurrent months be included in the certification period. A Medically Needy applicant may withdraw the application for the month in which the application is filed, if the applicant wants to have the certification period begin the following month.

The request to withdraw the application may be oral or in writing. Document the withdrawal in the case record. Issue an adequate notice of decision if the entire application is withdrawn. If only a month of the application is withdrawn, and a notice of decision will be issued when the remaining application is processed, a separate notice is not necessary.

Procedures for SSI Applicants or Potential SSI Eligibles

Legal reference: 441 IAC 76.1(249A), 76.2(249A)

Persons who would be eligible for Supplemental Security Income (SSI) may apply at the Social Security Administration district office for both SSI and Medicaid. Normally it is to a low-income person's advantage to apply for SSI because of the money payment. However, application for SSI is not a condition of eligibility for Medicaid.

If a person applying for Medicaid at a DHS office has income less than the SSI payment standard for the person's living arrangement, refer the person to the Social Security Administration district office to apply for SSI benefits:

- If the person chooses not to apply with the Social Security Administration, process the application as you would any SSI-related application. See 8-F, SSI-Related Coverage Groups: People Eligible for SSI Benefits But Not Receiving Them.

- If the person has already applied for or intends to apply for SSI or Social Security disability benefits (SSDI) within ten working days of the Medicaid application, see Concurrent Medicaid and Social Security Disability Determinations.

If the Social Security Administration has made an SSI eligibility determination, the information is sent to the Department via the SSI State Data Exchange (SDX) system. Information from the SDX is used to process SSI recipients for Medicaid. Chapter 14-E explains the SDX system and how to use and interpret the fields. See Collecting Eligibility Information from SSI Recipients.

The Social Security Administration may presumptively determine an SSI applicant to be disabled. "Presumptive" disability is indicated by code "P" in the disability field on the SDX. If all other Medicaid eligibility criteria are met, the person is eligible for Medicaid for a maximum of six months. See 8-C, Presumptive Disability.

When more than 60 days have passed since the person filed for SSI, you can send form 470-0363, *Certification of Eligibility of SSI Applicant*, to determine the status of the person's SSI eligibility determination. You may also use this procedure before 60 days have passed if the applicant has an urgent need. Form 470-0363 completed by the Social Security Administration indicating that a person is eligible for SSI may be accepted as verification in place of an SDX.

Collecting Eligibility Information from SSI Recipients

Legal reference: 441 IAC 75.2(249A), 76.1(249A), and 76.1(5)"d"

SSI recipients do not need to fill out a separate application for Medicaid. However, unless the SSI recipient was already receiving Medicaid, you will need additional information to determine Medicaid eligibility. Use *SSI Medicaid Information*, form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS), to:

- Gather information about Medicaid eligibility factors, such as qualifying trusts and other health insurance coverage.
- Gather information to determine retroactive Medicaid eligibility.
- Determine if an SSI recipient in a nursing facility has a community spouse.
- Obtain agreement to assign Medicare Part B claims to the medical provider.
- Issue Comm. 121 or Comm. 121(S), *Important Notice to Property Owners and Renters* (attached to the information form).

- Inform the client that the Department can recover Medicaid payments from those responsible for the cost of the client's medical expenses, such as from third-party insurance or trusts that can be used to pay medical expenses.

  As a condition of Medicaid eligibility the member must assign rights of medical support to the Department, unless good cause exists. See 8-C, Assignment of Medical Support.

See 14-E, *SSI STATE DATA EXCHANGE*, for instructions on how form 470-0364 is generated by the system. If the form is not automatically generated, issue the form within ten days of receipt of the SDX. If the client does not return the *SSI Medicaid Information* form in ten days, issue form 470-3193 or 470-3193(S), *SSI Medicaid Reminder*, if the system does not automatically issued it.

If more information is required after *SSI Medicaid Information* is returned, send a request with a due date and an explanation that Medicaid eligibility cannot be determined until the information is received. If the information is not returned, deny Medicaid eligibility.

If needed, conduct an interview to clarify information received. See Interviews.

To gather information specifically for the month of SSI application (and the intervening months, when SSI was not approved back to the application date), manually issue form 470-0364(M) or 470-0364(MS) and adjust the form as follows:

- On page 1, write the period for which the information is required.
- On page 2, cross out the heading "Retroactive Medical Coverage" and the first sentence under the "Income" heading. Write the months for which information is required in the spaces provided.
- On page 3, write the appropriate months in the spaces provided.

When one *SSI Medicaid Information* form will not cover the month of application and the intervening months, include additional pages for income and resources (pages 2 and 3 of the form) to cover these months.

When you need one *SSI Medicaid Information* form for the retroactive months and another form for the intervening months, issue both forms at the same time. This will make it less confusing for the applicant. Include a letter with the forms that explains why this information is needed. An example of language to use in this situation is as follows:

Dear [name],

You applied with the Social Security Administration for Supplemental Security Income (SSI) on [date]. Your application for SSI was approved effective [date].

An application for SSI is also used as an application for Medicaid. When you get SSI, the Department of Human Services (DHS) needs more information to decide if you can get Medicaid. DHS will decide if you can get Medicaid for the three months before you started getting SSI and for months that you did not get SSI.

We are sending you this form to fill out to get information to decide if you can get Medicaid for months that you did not get SSI. Please fill out the enclosed form(s) and send back to the DHS by _________.

If you have questions, please call [phone number].

Concurrent Medicaid and Social Security Disability Determinations

Legal reference: 42 CFR 435.909 and 435.541, 441 IAC 75.20 (2)"b" and "c"

Policy:
When a person has applied concurrently for both Social Security disability benefits and SSI-related Medicaid, the Department is required to await the outcome of the Social Security Administration disability determination.

If the applicant is eligible only for Medically Needy, see 8-J, SSI-Related Medically Needy.

Procedure:
If an SSI-related applicant has not been determined to be disabled by the Social Security Administration, take the following actions:

1. Ask the applicant to apply for SSI and Social Security disability (SSDI) benefits from the Social Security Administration. The applicant will either:
   - State that an application has already been filed, or
   - Agree to apply for benefits within ten working days of the Medicaid application date.

2. When the applicant has already applied or agrees to apply for SSI and SSDI, complete form 470-2631, *Notice of Pending Medicaid Applications,* and send it to:

   - ♦ The Social Security Administration, and
   - ♦ Disability Determination Services (DDS).

   DDS completes the status of the disability determination on Section II of the form and returns the form to the IM worker within 15 calendar days.

3. If DDS does not have a referral from the Social Security Administration, follow up on the DDS response by contacting the applicant to verify that the benefit application has been filed with the Social Security Administration.

4. If DDS has a pending disability determination for this person:

   - ♦ Make a note in the narrative, and
   - ♦ Make a tickler to check for the completed disability determination on the SDX screen or on the Income and Eligibility System (IEVS).

5. If DDS has already completed the disability determination for Social Security, check the SDX screen.

   - ♦ If the SDX shows SSI was approved, then approve Medicaid if all other eligibility requirements are met.

   - ♦ If the SDX shows SSI was denied due to disability, deny Medicaid as "not disabled."

6. If the SSI was denied due to other eligibility requirements, such as income or resources, contact the Social Security Administration to see if an eligibility decision for SSDI will be made within 30 days.

   - ♦ If so, wait for the Social Security Administration decision on SSDI.
   - ♦ If not, then get a copy of the disability determination from the Social Security Administration and get the income and resource verification from the applicant. Complete the application processing.

7. When a final Social Security disability determination has been made, contact the Social Security Administration to see if the full eligibility determination will be made within ten days.

   - If so, wait for the Social Security Administration decision.
   - If not, get a copy of the Social Security Administration disability decision and determine Medicaid eligibility.

Medicare Savings Program Applications

Legal reference: 441 IAC 76.1(1)"e"

Policy:
When the Social Security Administration (SSA) sends data on an *Application for Extra Help with Medicare Prescription Drug Plan Costs* to the Department, that data is considered an application for the Medicare Savings Programs.

Medicare Savings Programs (MSP) include qualified Medicare beneficiaries (QMB), specified low-income beneficiaries (SLMB), expanded specified low-income beneficiaries (E-SLMB), and qualified disabled working persons (QDWP).

The date that SSA received the Extra Help application is the application filing date for purposes of establishing eligibility for the Medicare Savings Programs. The date the Department receives the data from SSA begins the 30-day processing time to determine eligibility.

The applicant's signature on the Extra Help application from which the data was generated shall be treated as the signature for the MSP application. Income and resource data provided by the SSA shall be considered verified unless the applicant provides different information.

The Department will issue form 470-4846, *Medicare Savings Programs Additional Information Request*, which the applicant must complete and return within ten days to provide the rest of the information needed to establish eligibility.

Comment:
Medicare beneficiaries apply to the SSA for Extra Help. The *Application for Extra Help with Medicare Prescription Drug Plan Costs* tells beneficiaries that:

- They may be able to get help from Medicaid with their Medicare costs under the Medicare Savings Programs; and
- By completing the Extra Help application, they also start the application process for a Medicare Savings Program benefit, unless they check the 'No' box on the application form indicating they do not want to apply for MSP.

Procedure:
SSA sends DHS data on a daily basis for all Iowa Medicare beneficiaries who do not check the 'No' box for the Medicare Savings Program on the Extra Help application. SSA does not forward the data to DHS until it has made a decision on eligibility for Extra Help. The application data is forwarded to DHS regardless of whether Extra Help was approved or denied.

The Automated Benefit Calculation (ABC) system automatically creates a case and pends the MSP application. The case will be assigned to a county based on the mailing address.

When data sent by the SSA indicates the applicant is not a Medicare beneficiary or is over income or over resources for MSP, the ABC system automatically denies the application and generates a *Notice of Decision* sent to the applicant.

For all other cases, ABC generates form 470-4846, *Medicare Savings Programs Additional Information Request*, populated with the data from SSA. (See 6-Appendix for a list of this data.) The form is sent to the applicant at the mailing address the applicant provided to the SSA.

When the applicant returns the form:

1. Determine if the mailing address and living address are the same. If the addresses are different and the living address is:
   - In another county, date-stamp the form and route it to the DHS office responsible for the applicant's county of residence within two working days of the receipt.
   - In another state, deny the application on the basis of the applicant's residency.

2. Determine eligibility for MSP using the policies in Employees' Manual 8-F.
   IMPORTANT:

   - A "V" following the case number printed on page 1 of form 470-4846 indicates that the Department accepts the information that was printed on the form as verified. If the applicant has made changes to the printed income or resource information, verify the change.

   - An "NV" behind the case number indicates that the information on the form is not verified and must be verified.

3. Make ABC system entries to approve or deny the application. If no decision has been entered by the 30th day, the system will automatically send a *Notice of Decision* denying the MSP application for failure to return form 470-4846.

The Medicare Savings Programs (MSPS) screen displays data from the SSA that was used to deny the application. Use this information to support a denial of eligibility for MSP in the event the applicant appeals the denial decision. See 14-B(4), MSPS = LIS-Application History.

1. SSA receives Ms. Z's application for Extra Help on January 15. SSA determines that Ms. Z is eligible for Extra Help on March 1. Ms. Z indicated that she wanted to also apply for the Medicare Savings Program.

   On March 1, SSA sends Ms. Z's data from the Extra Help application to the Department. The Department receives the data on March 1. Ms. Z's application date for MSP is January 15. The Department has 30 days beginning March 1 to determine Ms. Z's eligibility for MSP.

   On March 1, the Department pends Ms. Z's application on the ABC system and sends her form 470-4846, *Medicaid Savings Programs Additional Information Request*. The cover letter tells Ms. Z to return the form by March 11.

   Ms. Z reviews the forms and does not make any changes to the data printed in the form. She returns the form on March 8. The worker determines that Ms. Z is eligible for QMB effective April 1.

2. Same situation as above except that Ms. Z is determined to be eligible for SLMB. Ms. Z's eligibility is effective January 1.

   If Ms. Z indicates that she has medical expenses for the three months before January 1 and she meets the SLMB eligibility requirements before January 1, Ms. Z would need to meet a category of eligibility for the retroactive period as defined in 8-A, Definitions. If she does, Ms. Z could be eligible for SLMB benefits effective October 1.

Interviews

Legal reference: 42 CFR 435.905-435.914; 441 IAC 76.2(1), 76.1(3)

An interview is not required when determining Medicaid eligibility for an FMAP-related or SSI-related applicant or member unless you determine that an interview is necessary to:

- Clarify information on the application,
- Clarify questionable information, or
- Ensure there is a better understanding of programs.

It is important to treat applicants and members equitably and to use the "prudent person concept." See 8-A, Definitions, for "prudent person concept."

An interview shall not be required for the following:

- Children as defined by the Medicaid program
- Applicants for Iowa Family Planning Network (IFPN)
- Applicants for IowaCare

Grant an interview if the applicant, member, or authorized representative requests one.

Procedure:
To require a face-to-face interview or a phone interview, you must request a scheduled time with the applicant or member. When an interview is needed or is requested by an applicant, a member, or an authorized representative, schedule a date, time, place, and method of the interview (in the local office, home visit, or by phone, etc.).

Grant requests to reschedule when you determine that the applicant, member, or authorized representative is making every effort to cooperate with the interview process. Interviews rescheduled at the request of the applicant, member, or authorized representative may be agreed upon verbally and documented without written confirmation.

Failure to attend the interview you requested, including a scheduled phone interview, is cause to deny or cancel the adults on the application.

Contact the applicant or member whenever you need to clarify information in order to determine eligibility.

When you ask a client to come in to the local office for an interview, do not deny or cancel the children if the adult fails to attend the interview. However, if you request information at the same time as you set up an interview and the information is not provided within ten days, you may cancel or deny the entire household for failure to provide requested information.

Comment:

> Ms. W applies for Medicaid for herself and her three-year-old son. The application date is May 4. The worker sends a request for additional information and verification with a due date of May 15 (ten calendar days). The worker determines an interview is necessary on this case to clarify questionable information. An interview is scheduled for May 10 at 10 A.M. in the local office.
>
> Ms. W fails to attend the face-to-face interview. The worker can deny the application for Ms. W, but must leave the application pending for Ms. W's son. Or, the worker may wait to deny Ms. W until the application for her son is processed.

Information Provided

Legal reference: 42 CFR 435.905

When conducting the interview or by other means, explain to the client:

- The programs for which the client may be eligible such as:
  - FMAP-related Medicaid
  - SSI-related Medicaid
  - Medically Needy
  - Home- and community-based service waivers
  - Iowa Care
  - State Supplementary Assistance
  - FIP
  - Food Assistance
- The policies and procedures for the client's coverage group.
- The factors of eligibility that must be verified, including what is needed as verification, and that documents that are the property of the client are returned to the client.
- The penalties for giving false information.
- The client's right to receive a ten-day advance notice of adverse actions and the right to appeal any decisions on Medicaid eligibility.
- The social service programs available. Make referrals when necessary.
- The client's responsibility to:
  - Report changes that occur during the application process within five days of the change. See Processing Standards.
  - Report changes that occur after approval within ten days of the change and report any changes in medical resources. See 8-G, Reporting Changes.
  - Cooperate with the Quality Control and Economic Assistance Fraud Bureaus. See 8-C, Cooperation With Investigations and Quality Control.
  - Apply for and accept other benefits for which the client is eligible. See 8-C, Benefits From Other Sources.
  - Cooperate with the HIPP Unit and the Third-Party Liability Unit and refund third-party payments for services paid by Medicaid. See 8-C, Cooperation with the Health Insurance Premium Payment (HIPP) Unit and Cooperation with the Third-Party Liability Unit.

For Medically Needy applicants with a spenddown who have children, discuss the Healthy and Well Kids in Iowa (***hawk-i***) program. Explain that if it appears they meet the criteria for the ***hawk-i*** program, a referral will be made to the ***hawk-i*** program.

Give or mail to applicants or anyone inquiring about the Medicaid program the following pamphlets that explain coverage, conditions of eligibility, benefits of the program, related services available and client rights and responsibilities:

- Comm. 20, Your Guide to Medicaid
- Comm. 30, Medicaid for the Medically Needy
- Comm. 51, Information Practices
- Comm. 123 and Comm. 123(S), Important Information for You and Your Family Members About the Estate Recovery Program
- Comm. 209, Information About Your Privacy Rights
- Comm. 233 and Comm. 233(S), Rights and Responsibilities
- Comm. 255 and 255(S), Important Information about the HIPP Program
- Comm. 258 and 258(S), Verifying Citizenship and Identity
- 470-0306 or 470-0307(Spanish), Application for Food Assistance. Exceptions: Do not give this application to people living in a medical institution or to children entering foster care unless supervised apartment living is the first foster care placement.

For all applicants under the age of 21, discuss the availability and benefits of the EPSDT "Care for Kids" program. Make sure the client understands the program and the advantages of screening. Give or mail to the applicant Comm. 4, *Care For Kids*. See 8-M, Care for Kids (EPSDT), for more information.

To FMAP-related applicants, also give:

- Comm. 27, Medicaid for Families and Children
- Iowa WIC Program income guidelines

The Department of Public Health revises the WIC flyer annually in March to incorporate updated WIC income guidelines. The revised flyer is effective April 1. Public Health sends a blanket supply of the revised flyer to local offices. Destroy previous versions of the flyer. Get additional supplies of the WIC flyer cost-free by calling 1-800-532-1579.

To applicants who are aged, blind, or disabled, also give:

- Comm. 28, Medicaid for SSI-Related Persons.
- Comm. 60, Medicaid for the Qualified Medicare Beneficiary.
- Comm. 121 and Comm. 121(S), Important Notice to Property Owners and Renters.
- Comm. 180, Medicaid for Employed People with Disabilities.

To applicants who are in a nursing facility, also give Comm. 52, *Medicaid for People in Nursing Homes and Other Care Facilities*. If the applicant has a spouse at home, also give Comm. 72, *Protection of Your Resources and Income*.

Voter Registration Procedures

Legal reference: 721 IAC Chapter 23

The Department is responsible for helping clients complete voter registration forms and for mailing the forms to the county election office. (The actual voter registration occurs at the election office.) Issue voter registration forms:

- With all applications,
- With the *Review/Recertification Eligibility Document (RRED)*, and
- When the client moves within Iowa.

When an interview is held, ask if the client wants to register to vote. If the client wants to register and has not filled out the voter registration form, have the client complete it at the interview. Offer to help the client complete the form. Be careful when helping the client that you do not influence the client's voter registration options in any way.

If you are conducting a phone interview, ask the questions and send the form to the client for signature. No follow-up is necessary after the form has been mailed.

Review the client's rights as listed on the form. If the client chooses not to check "yes" or "no," leave the section blank and consider that the client has chosen not to register to vote. If the client chooses not to sign the form, print the client's name and the date where indicated, and initial the form.

If there isn't an interview, mail the form to the client and document your action.

If the client returns the form, follow your office procedures for handling it. Tear off the voter registration information section and give it to the client. Keep the declination part of the form. See 6-Appendix for a copy of the *Voter Registration* form and for office procedures for handling the form after completion.

Verification

Legal reference: 441 IAC 76.1(4) and 76.2(4)

Applicants must provide requested verification. Notify the applicant in writing what additional information or verification is needed. Provide this notice to the applicant personally, by mail, or by facsimile. Give the applicant ten calendar days to supply the information.

Explain the following to the applicant in writing:

- An applicant who must obtain information from a third party should not leave the information with the expectation that the third party will return it timely.
- The applicant is responsible for following up with the third party to be sure the third party has the information ready to pick up or has mailed the information to the Department in time to be received by the due date.
- The applicant may ask the Department for more time to get the information if the third party does not have the information ready or it will not arrive by the due date.

When the applicant is making every effort to obtain the information from a third party but is unable to do so in ten days and notifies you about the problem, you can allow additional time. Help the applicant to get the needed information, as requested.

An applicant who provides a signed release to a specific individual or organization for specific information has met the requirement for supplying requested information or verification to give you permission to get it. The general release does not meet this requirement unless the applicant asks for help.

Deny the application if the applicant does not provide the requested information by the specified due date and does not authorize the Department to obtain the information within the requested time.

If the applicant is unable to get information from a spouse who is no longer in the household, do not deny the application. Contact the applicant to obtain the best information available. Ask the applicant about bank accounts, records showing deposits of the spouse's income, information from the divorce proceedings, and tax returns.

Ask the applicant to provide information that would help to verify what the applicant is telling you about a spouse who is no longer in the home. From the information provided, determine eligibility. If the applicant fails to provide the requested information, deny the application.

Reporting Changes

Legal reference: 441 IAC 76.2(249A); 76.10(249A)

The applicant shall report any change that occurs during the application process within five working days of the date of the change.

Moving and Returned Mail

Legal reference: 441 IAC 75.10(249A), 75.52(4)

Policy:
A member must remain an Iowa resident for Medicaid eligibility purposes; however, a move within Iowa is not required to be reported.

Procedure:
When mail is returned to the Department, handle the mail as follows:

- When the Post Office has attached a forwarding address and it is in Iowa:
  - Use this address and update the DHS systems.
  - It is not necessary to contact the member.
  - Send any returned mail to the member at the correct address and keep a copy in the case record.
  - Transfer the case to the correct county, if appropriate.

- When the Post Office has attached a forwarding address and it is out-of-state, contact the member to ensure they are no longer an Iowa resident.
- When there is no forwarding address (i.e., address unknown, undeliverable), deny the case for unable to locate using the only address DHS has on file.
- When there is hand-writing on the returned mail, attempt to contact the member to resolve the issue. Deny the case for unable to locate if you are unable to contact the member.

Comment:
Reporting a change in a mailing or living address within Iowa is always desired and is beneficial to the household in order to continue proper communication with the Department.

Processing Standards

Legal reference: 42 CFR 435.911, 441 IAC 76.3(249A)

The following sections explain:

- Processing guidelines that apply to all Medicaid applications.
- Grace period following the denial of an application.
- Guidelines for processing applications for children.
- Processing IowaCare from a Medical application.

Guidelines for All Applications

Process applications on the earliest possible date. Determine eligibility and issue a written notice of decision for FMAP-related and SSI-related Medicaid by making system entries no later than the 30th day following the date of application. For the Medically Needy program, the applicant must receive a written notice approving or denying Medicaid no later than 45 days from the date of application.

If the 30th day or 45th day falls on a weekend or holiday, process the application by making system entries the next working day.

When the application is for SSI-related Medicaid, including SSI-related Medically Needy, and a blindness or disability determination is pending, the time limit is 90 days. See Concurrent Medicaid and Social Security Disability Determinations.

If a person's eligibility is dependent upon a 30-day period of residency in a medical institution, delay the eligibility decision until the 30-day period has been met, unless the person is ineligible due to some other factor.

The time limit for approving or denying a Medicaid application can be waived in unusual circumstances. Examples of unusual circumstances include:

- You and the applicant have made every reasonable effort to get necessary information but have not been able to do so within the time frames.
- Retroactive Medicaid was requested for a person whose proof of citizenship and identity has not yet been provided as described in 8-C, Reasonable Opportunity Period.
- Emergencies, such as fire or flood.
- Other conditions beyond the administrative control of the local office.

You cannot deny an application because of the time period alone. To deny the application, there must be either failure to act on the part of the applicant or a determination of ineligibility.

An applicant must cooperate with the application process. This may include providing information or verification, attending required interviews or signing documents. Failure to cooperate with the application process shall serve as a basis to deny an application.

Grace Period Following the Denial of an Application

Legal reference: 441 IAC 76.2(4)"d"

Policy:
A "grace period" is a specified period of time during which an applicant has the opportunity to "cure" the reason for the denial of an application. The grace period is defined as the 14 calendar days immediately following the date of denial.

"Day one" of the 14-day grace period is the day following the date printed on the notice of decision. If the 14th day falls on a weekend or a state holiday, the 14th day is extended to the next working day for which there is regular mail service.

A previously denied application shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the date of denial. Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

If the applicant is eligible, the original filing date of the application establishes the effective date of eligibility. The effective date of eligibility is the first day of the month an application was filed or the first day of the month in which all eligibility factors were met, whichever is later.

Comment:
The grace period does not apply to late payment of premiums or noncooperation actions. Denial reasons for which a grace period may apply include, but are not limited to, failure to provide information necessary to determine eligibility and inability to locate the applicant.

If the application was denied because mail was returned or the Department was otherwise unable to locate the applicant, a new application is not required if the household contacts the Department within the 14 days, provides a current Iowa address, and eligibility can otherwise be established.

Procedure:
Based on the circumstances of your case, take the appropriate action as follows:

- **No information provided:** When no information is provided by the 14th day after the date of denial, no further action is required.
- **Partial information provided:** When some of the information is returned, but there is still information needed to determine eligibility:
  - Attempt to contact the household to let the household know what is needed and that if the information is not received so that a decision can be made by the end of the grace period, the household will have to reapply. A written request for the previously requested information is not required.
  - If the information is not provided by the end of the grace period, no further action is necessary.
- **Requested information provided and a change has occurred:** If the original requested information is provided, but the household also reports a change for which verification is necessary:
  - Make every effort to verify the information and inform the applicant that you cannot reconsider the application unless the change is verified by the end of the grace period. If a generic release is on file, use it to obtain the information if possible. A written request for the new information is not required.
  - If the new information is not verified so that an eligibility determination can be made by the end of the 14-day grace period, send a "remain denied" notice. This is because the original reason for denial has been cured, but you cannot process the application due to a change in circumstances that is required to be verified.

- **Unable to verify change within grace period:** When an additional change is reported and it is unlikely the information can be verified and eligibility established by the end of the 14-day grace period, attempt to notify the applicant that to file a new application.

Comment:

1. Mr. A, a Medicaid applicant, fails to provide an employer's statement of earnings that was requested by the Department. The IM worker issues a denial notice on April 1, which is dated April 2. Mr. A provides the employer's statement on April 16. There have been no other changes in the household circumstances. The IM worker reopens Mr. A's application and processes it.

2. Ms. B, a Medicaid applicant, fails to provide an employer's statement of earnings that was requested by the Department. The IM worker issues a denial notice on April 5, which is dated April 6. Ms. B provides the employer's statement on April 21. Since the 14-day grace period has expired, Ms. B must file a new application and the original denial stands.

3. Mr. C, a Medicaid applicant, fails to provide three pieces of information requested by the Department. The IM worker issues a denial notice on May 10, which is dated May 11. Mr. C provides two of the items on May 13.

   The worker attempts to contact Mr. C since not all the items needed to determine eligibility came in. The third item is received on May 25. There have been no other changes in the household circumstances. The IM worker processes the application.

4. Mr. D, a Medicaid applicant, fails to provide three pieces of information requested by the Department. The IM worker issues a denial notice on May 15, which is dated May 16. Mr. D provides two of the items on May 17.

   The worker attempts to contact Mr. D since not all the items needed to determine eligibility came in. The third item is received on May 31. Since the 14-day grace period has expired, the IM worker issues a "remain denied" notice. Mr. D must file a new application.

5. Ms. E, a Medicaid applicant, fails to provide three pieces of information that were requested by the Department. The IM worker issues a denial notice on July 21, which is dated July 22. Ms. E provides two of the items on July 31 and the third item on August 1.

   Also on August 1, Ms. E reports that she has changed jobs. The IM worker explains that in order for the original application to be reconsidered, Ms. E has until August 5 to provide verification of the old job ending and the beginning of the new job. Otherwise, Ms. E will have to reapply.

   Ms. E does not provide verification of the end of the old job or the beginning of the new job. The IM worker issues a "remain denied" notice since Ms. E had provided the original requested information but did not provide the new verification.

6. Mr. F, a Medicaid applicant, fails to provide three pieces of information that were requested by the Department. The IM worker issues a denial notice on August 30, which is dated August 31. Mr. F provides two of the items on September 2 and the third item on September 6.

   Also on September 6, Mr. F reports that he has changed jobs. The IM worker explains that in order for the original application to be reconsidered, Mr. F has until September 14 to provide verification of the old job ending and the beginning of the new job. Otherwise, Mr. F will have to reapply for Medicaid.

   Mr. F provides verification of the old job ending and the beginning of the new job on September 7. The application is processed with the new information and a notice is sent informing Mr. F of the decision.

Processing Applications with Children

Expedite the Medicaid eligibility determination for any child, regardless of any other programs for which the child is applying. Review the application and request any additional information or verification immediately. When adults and children apply together, do not delay the child's eligibility decision because of needed information or a necessary interview that affects only the adult's eligibility. See Interviews.

> Mrs. C and her two children apply for Medicaid on July 2. On July 3, the worker sends an appointment letter scheduling an interview for Mrs. C on July 19 because the worker determines information on the application is questionable. Also, on July 3, the worker sends a request for additional information and verification needed to make an eligibility determination with a due date of July 14.
>
> All requested information and verification is supplied on July 9. The worker processes the application for the children, since their eligibility is not questionable. The household's countable income is within the FMAP income limits for a three-member household. However, since Mrs. C has not yet been approved, the children are approved for Medicaid under CMAP with Mrs. C coded as a considered person on the Automated Benefit Calculation (ABC) system case.
>
> On July 19, Mrs. C attends the interview. The worker then processes the application for Mrs. C. Mrs. C is "added" to the ABC case by changing her entry reason and status code, entering a positive date, and changing her fund code. The worker also changes the ABC case aid type to the FMAP aid type and changes the children's fund codes.

A ***hawk-i*** application that is referred to Medicaid from ***hawk-i*** for a Medicaid eligibility determination is considered an application only for the children.

When it is not clear whether the application is for just the children or for both the adults and the children, contact the applicant for clarification. If attempts to contact the applicant are unsuccessful, presume that the applicant is applying for everyone listed on the application until the applicant can clarify otherwise.

When information is missing or questions on the application have not been answered, try to contact the applicant by phone before sending a written request, so the request can be as complete as possible. The applicant is still responsible to complete the application.

Regardless of whether attempts to contact the applicant by phone are successful, include in the written request the pages of the application that are incomplete and request that they be completed. Be sure to keep a copy of all application pages that you return to the applicant.

Children in the household were approved for Medicaid based on a July 7 application.

In August, the parents call the local office to ask about getting Medicaid for themselves. They indicate they have medical bills in April, May, June, and July and request retroactive medical assistance. The inquiry is considered an application, and the date of the contact is documented in the case record as the date of application.

The worker explains that retroactive benefits go back only three months and only for individuals who meet a category of eligibility for the retroactive period as defined in 8-A, Definitions. The worker explores retroactive Medicaid eligibility for the parents for May, June, and July. The parents are added to the case effective August 1. If retroactive period criteria is met, they may be eligible as of May 1.

Effective Date of Eligibility

Legal reference: 42 CFR 435.914, 441 IAC 76.5(2)

The effective date of eligibility for Medicaid is the first day of the month an application was filed or the first day of the month all eligibility factors were met, whichever is later. EXCEPTION: Eligibility under the qualified Medicare beneficiary coverage group begins the first day of the month after the month of decision.

See 8-F, Express-Lane Eligibility for MAC, for the effective date of eligibility for children under age 19 who are eligible without an application under the express-lane eligibility process.

For **FMAP or FMAP-related** coverage groups, eligibility for Medicaid begins on the first day of the month when eligibility was established any time during the month.

FIP application filed	April 25
Date of decision	May 8
Eligible for FIP grant effective	May 2 (due to the seven-day waiting period)
Effective date of Medicaid eligibility	April 1 if eligibility requirements are met in April

For **SSI-related** coverage groups and State Supplementary Assistance, the applicant must meet all eligibility criteria and be resource-eligible as of the first moment of the first day of the month in order to be eligible for the month.

Effective Date for SSI Recipients

Legal reference: 441 IAC 76.5(249A)

An SSI recipient is eligible for Medicaid as of the first of the month before the month that the person attains SSI eligibility, unless either:

- The person's Iowa residency date is later, or
- There is a Medicaid policy that precludes eligibility, as listed in 8-F, SSI Recipients.

1. Mr. M lives in Nebraska and files an application for SSI in January. In March, Mr. M moves to Iowa. Social Security processes Mr. M's application in March and establishes SSI eligibility effective January 1.

   Even though Mr. M was determined SSI-eligible in March, he is not eligible for Iowa Medicaid in January and February because he was not an Iowa resident. The earliest Mr. E's Iowa Medicaid eligibility can begin is March 1.

2. Ms. E is determined eligible for SSI beginning in May. After receiving an SDX about Ms. E's eligibility, the IM worker sends her form 470-0364 requesting more information. Ms. E returns the form but refuses to answer the questions about the paternity of her 13-year-old son, who is on Medicaid.

   The worker denies Medicaid for Ms. E due to refusal to cooperate in establishing paternity or support for a child under 18.

Beginning with determinations made on or after August 22, 1996, the effective date of approval under the SSI program is the later of:

- The month following the month of application for SSI, or
- The month following the month the client first meets all SSI eligibility factors.

1. Mr. A files for SSI on January 15. Mr. A meets all SSI eligibility criteria for January. SSI payment is approved effective February 1.

2. Mr. B files for SSI on January 15. Mr. B does not meet all SSI eligibility criteria until February (turns 65 in February). The earliest date that SSI payment will begin is March 1 (the month following the month that all SSI eligibility factors are first met).

For the month immediately before the effective date of approval, the Social Security Administration has already determined that the client meets all SSI eligibility factors. (The client does not receive an SSI payment due to SSI's effective date of approval policy.) Thus, for Medicaid purposes, it is not necessary to verify eligibility factors independently for that month.

Determine Medicaid eligibility for that month in the same manner as if the client was an SSI cash recipient. (It is still necessary to determine if the client has a trust or other item listed at 8-F, SSI Recipients.)

1. Mr. A files for SSI on June 15. SSI cash payments are approved effective July 1. In order for SSI payments to begin effective July 1, the Social Security Administration must have determined that Mr. A met all SSI eligibility criteria for the month of June. Thus, it is not necessary to verify information independently for June.

   The IM worker sends form 470-0364 to Mr. A using June 15 as the application date and March, April, and May as retroactive months. Mr. A returns the form indicating he does not have a trust or other item that precludes Medicaid eligibility (listed in 8-F, SSI Recipients). Mr. A is eligible for Medicaid in the month of June and ongoing (and potentially the retroactive months if he meets a category of eligibility for the retroactive period as defined in 8-A, Definitions).

2. Mr. B files for SSI on January 15. SSI cash payments are approved effective March 1. In order for SSI payments to begin effective March 1, the Social Security Administration must have determined that Mr. B met all SSI eligibility criteria for the month of February.

   Mr. B did not meet all eligibility criteria for the month of January (or SSI would have begun February 1). It is not necessary to verify information independently for the month of February. It is necessary to verify information and determine the reason that Mr. B was ineligible for January.

Use the SSI application date as the Medicaid application date. The effective date of eligibility can be no earlier than three months before the date of application for SSI if the individual meets a category of eligibility for the retroactive period as defined in 8-A, Definitions. This date is on the SDX.

When the date of the SSI application is in a different month from the month that SSI eligibility begins, determine if there is Medicaid eligibility for:

- The month of SSI application.
- All months between the date of application and the month of eligibility for SSI.
- The retroactive period.

See Collecting Eligibility Information from SSI Recipients.

Establishing Beginning Months of Eligibility for MEPD

Legal reference: 441 IAC 75.1(39)"b""4", and 75.1(39)"b""6"

Policy:
Medicaid for Employed People with Disabilities (MEPD) applicants may choose to have either MEPD or Medically Needy coverage for months between the date of application and the date that the case is approved on the ABC system.

Comment:
Application processing may be delayed due to waiting for a disability determination decision. This may result in a delay of several months between the date of application and the date the approval is entered in ABC. "Back months" are the months between the date of application and the month when the case is actually approved on ABC.

"Conditional eligibility" for MEPD means the member must pay a premium before getting Medicaid eligibility for a month.

If the member wants to have Medically Needy for some back months, see the procedures in 8-F, Relationship to Medically Needy.

Procedure:
The MEPD Billing System applies premium payments in a specified order. The person who enters the payments in the MEPD system cannot change the order of how the payment will be applied to pay for "back months."

Before entering conditional approval on ABC for back months, it is important to check with the applicant to see if the applicant wants Medicaid for each of the back months. Do **not** give the applicant conditional MEPD eligibility for a month when the applicant does not want MEPD benefits.

Corrections can be made on the MEPC screens after the initial and back months are assessed for MEPD premiums.

Changing Conditionally Approved Months for MEPD	
Situation:	Worker Action:
After conditional eligibility has already been entered in ABC for "back months," the member tells the worker that there are some months for which the member does not want to pay premiums.	Ask the member to sign a statement that lists the "back months" for which the member does not want Medicaid. Do not block months until the signed statement is received.
♦ If the premiums for those months have **not** been paid…	"Block" the months when the member does not MEPD coverage so that payments are not applied to premiums for those months. Enter "B" for the months that need to be blocked on the member's MEPC screen.
♦ If the premiums for those months **have** been paid…	Do **not** block the month, as Medicaid eligibility was already given.
The worker needs to "block" a paid month due to an error in giving conditional eligibility for that month.	"Block" the month by entering "B" for that month on the member's MEPC screen. The system will: ♦ "Back out" the premium payment for the blocked month. ♦ Hold the premium payment as a credit or apply it to another unpaid month. ♦ Issue a WIFS requesting recoupment of the paid Medicaid claim for that month.
A month is blocked in error.	"Unblock" the month on the MEPC by entering a "U" for unblock over the "B" on the month line. Remember, once a month is blocked, the member will not be given Medicaid eligibility for that month until it is unblocked.

Comment:
See 14-B(9), Change to MEPD Premium: Using MEPC.
See 8-F, Relationship to Medically Needy.

Determining Eligibility for the Retroactive Period

Legal reference: 42 CFR 435.914, 441 IAC 76.5(1)

Medicaid benefits may be available for any or all of the three months before the month in which the application is filed. This time is called the "retroactive period." The person must meet a category of eligibility for the retroactive period as defined in 8-A, Definitions. EXCEPTION: The following coverage groups do not have retroactive eligibility:

- Iowa Family Planning Network (IFPN).
- Qualified Medicare Beneficiary (QMB).
- Home- and community-based services waivers.
- Program for all-inclusive care for the elderly (PACE).

For children under age 19 who are eligible without an application under the express-lane eligibility process described at 8-F, Express-Lane Eligibility for MAC, the "retroactive period" is any of the three months before the effective date of the child's express-lane eligibility.

To be eligible for retroactive benefits, an applicant must meet both of these conditions:

- The applicant has paid or unpaid medical bills for Medicaid-covered services received during the retroactive period, **and**
- The applicant would have been eligible for Medicaid benefits in the months services were received, if a valid application had been filed.

An applicant does not need to be eligible in the month of application to be eligible for the retroactive period. If an application is submitted on behalf of a deceased person, determine the deceased person's retroactive eligibility using the same requirements.

When retroactive coverage is requested, evaluate the three months before the month of the current application to see if eligibility exists even if some of those months were denied on a previous application.

1. Ms. A, a pregnant woman, files an application on July 8. She indicates on the application that she wants retroactive benefits. The worker requests in writing that Ms. A provide income verification for the months April through June. Ms. A fails to provide the income information and is denied Medicaid for the retroactive period. The application is approved for ongoing eligibility.

2. Same as Example 1, except that Ms. A is also denied for ongoing benefits due to failure to provide requested information. She reapplies on August 15, and this time cooperates in providing information needed to establish eligibility. She is eligible for the retroactive period of May through July, the three months before the month of the reapplication, and also for ongoing benefits.

Determine eligibility for the retroactive period on a month-by-month basis. This includes using a third or fifth paycheck when calculating monthly income. The coverage group under which the person is eligible in the retroactive period may be different for each month. EXCEPTION: See Retroactive Eligibility for Medically Needy Recipients.

Issue a notice of decision when retroactive eligibility is denied.

When approving an application for retroactive Medicaid only, include the month when eligibility ended on either the *Notice of Decision* approving the retroactive months or on a separate notice. The notice does not need to be timely when assistance is simultaneously approved and ended for retroactive eligibility.

A member who did not know that there were bills in the retroactive period at the time of application can ask to have eligibility for retroactive benefits determined at a later date. The retroactive period is the three months before the month of the most recently **approved and active** Medicaid application. Retroactive eligibility cannot be determined later on an application that was denied or canceled for ongoing benefits.

Also, a person may request retroactive coverage but may fail to provide the information needed to determine eligibility. Even though a notice of decision was issued, the member may request to have eligibility determined again for the same retroactive period if the application was approved for ongoing benefits **and** it remains the most recently approved Medicaid application.

Although a member may request retroactive benefits at any time, payment will not be authorized for services provided 23 months or more before the current month unless extenuating circumstances exist. See 8-M, Submitting Claims, for more information.

Additionally, Medicaid benefits cannot be approved on the ABC system for any month before January 1 of the previous calendar year (e.g., in March 2010, benefits can be authorized only for January 2009 or later). Benefits can be approved for SSI approvals beyond the two years by submitting special updates when the SSI eligibility determination went beyond the two years.

Verification Requirements

When determining retroactive eligibility, accept a client's statement that the client has paid or unpaid medical bills (unless questionable). See 8-F, Continuous Eligibility for Pregnant and Postpartum Women, for requirements when establishing continuous eligibility for pregnant women at the time of application.

Clearly document in the case record how eligibility or ineligibility for each month was established. Information to be documented includes:

- Verification of income and resources.
- Household composition for each month.
- Beginning date of disability, if applicable.

Retroactive Eligibility for Medically Needy Recipients

Legal reference: 441 IAC 75.25(249A)

A Medically Needy certification period is considered as one unit. Even though the period may include one or more months, determine eligibility for the entire certification period only. The retroactive period for Medically Needy is a one-month, two-month, or three-month period, depending on which month the client first incurred a medical expense. See 8-J.

1. Ms. S, a pregnant woman, applies for Medically Needy on March 5. The certification period is March and April. Ms. S claims to have unpaid bills for December and January, which are within the three-month retroactive period.

   The worker requests income and resource information for all three months of the retroactive period (December - February). If income or resource verification is not provided for December through February, eligibility for the retroactive period cannot be determined.

2. Ms. B, a pregnant woman, applies for Medically Needy on April 15. The certification period will be April and May. She states that there are no unpaid medical bills for the retroactive period (January - March). In June, Ms. B reports that there is an unpaid medical bill for January.

   The worker establishes eligibility for the three-month retroactive period. Income from all three months is used in computing spenddown. Spenddown for the retroactive period is $100. The unpaid bill is $500. The amount in excess of the spenddown ($400) is Medicaid-payable in the retroactive period.

Retroactive Eligibility for SSI Recipients

Legal reference: 441 IAC 76.5(1)

For an SSI recipient to be eligible for retroactive benefits, they must meet a category of eligibility during the retroactive period as defined in 8-A, Definitions. In addition:

- The person must have been eligible for Medicaid benefits in the months services were received (if an application had been filed), and
- The person must have paid or unpaid medical bills for Medicaid-covered services received during the retroactive period. The SDX shows unpaid medical claims in the UNPAID RETRO field.

A person who is presumptively disabled (disability code P on the SDX) is not entitled to retroactive benefits until a final determination has been made that the person is eligible for disability.

Send form 470-0364, 470-0364(S), 470-0364(S), or 470-0364(MS), *SSI Medicaid Information*, to collect information about the retroactive months. See Collecting Eligibility Information from SSI Recipients. Examine retroactive eligibility for an SSI recipient as you would any other applicant. During the retroactive period, the person must have been either:

- At least 65 years of age, or
- Under 18 years of age, or
- Blind, or
- Disabled, and
- Meet a category of eligibility for the retroactive period as defined in 8-A, Definitions.

Accept the member's statement regarding the date of onset of blindness or disability, unless there is evidence to the contrary.

Referrals to CSRU

Legal reference: 441 IAC 75.14(249A)

Policy:
The Child Support Recovery Unit (CSRU) seeks cash medical support as well as financial support for people in the Medicaid eligible group.

Determine if a referral is needed at these times:

- Application,
- When an infant enters newborn status,
- When a child other than a newborn is added to the household,
- End of the postpartum period **only** if redetermining the mother to FIP, and
- Eligibility review **when** cash medical support is reported.

Refer the absent parent (including an adoptive parent) to CSRU when:

- There is an active CSRU case;
- The applicant requests CSRU services;
- The applicant or member receives cash medical support;
- The application is for a child in foster care; or
- The applicant is also applying for FIP.

Do not make a referral to CSRU:

- When the applicant does not want CSRU services and CSRU does not have an active case on the absent parent.
- When both parents are in the home, even when paternity has not been established.
- When the same absent parent was previously referred for a FIP-only case. However, link the existing ICAR case to the Medicaid case. Update information in the comment section.
- If the applicant or member has proven that good cause exists.
- On a parent whose parental rights have been terminated by the court.
- On the parents of an underage parent who is a payee.
- When a child in subsidized adoption is placed in foster care and no child support order currently exists.
- When eligibility is established under the Iowa Family Planning Network.

- When a parent's absence is solely because of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service.

  NOTE: A parent whose absence is solely because of the performance of active duty in the uniformed services of the United States is considered to be absent for purposes of determining Medicaid eligibility. (See 8-C, Absence.) However, a parent who is absent for this reason is not referred to CSRU.

See 8-C, Cooperation With Support Recovery.

Comment:

1. Ms. D applies only for Medicaid for herself and her daughter, Lisa. Lisa's father is not in the home. Ms. D says on the application that:

   - CSRU is not helping her,
   - She does not want a referral to CSRU, and
   - There is no court order for cash medical support.

   The IM worker checks ICAR and finds there is not an active child support case in the ICAR system. The IM worker processes the application and does **not** complete a referral to CSRU.

2. Mr. W applies only for Medicaid for himself and his two children. He says on the application that:

   - CSRU is not helping him,
   - He does not want to pursue child support, and
   - The absent parent **is court-ordered** to pay cash medical support.

   The IM worker explains to Mr. W that a referral will be made to CSRU because of the cash medical support order; that he is required to cooperate with CSRU to receive Medicaid for himself; and that if he does not cooperate, he will not receive Medicaid for himself.

3. Ms. C applies only for Medicaid for herself and her three children. A child support referral was completed last year when Ms. C received medical assistance for her family. Ms. C says on the application that:

   ♦ CSRU is not helping her,
   ♦ She does not want to pursue child support, and
   ♦ There is no court order for cash medical support.

   The IM worker explains to Ms. C that she may contact CSRU to request cancellation of her child support case. If the child support case is:

   ♦ Closed by CSRU before the date of decision on the Medicaid application, the worker will not make a referral to CSRU.

   ♦ Is still active on the date of decision, the worker will make a referral to CSRU.

4. Mr. Q applies for FIP/FMAP and Food Assistance for himself and his children. His children's mother is absent from the home. Mr. Q says on the application that:

   ♦ He does not want to cooperate in obtaining medical support,
   ♦ CSRU is not helping him, and
   ♦ There is no court order for cash medical support.

   The worker tells Mr. Q that as a condition of eligibility for FIP he must cooperate with CSRU in obtaining financial support or the household will be subject to sanction of cash benefits. The worker completes a CSRU referral and it will be "active" for both FIP and Medicaid programs.

   If Mr. Q later fails to cooperate with CSRU, then CSRU will notify the worker to apply the appropriate sanctions to the FIP, FMAP, and Food Assistance benefits.

5. Ms. L files a new application for FMAP. There is an existing FIP sanction that was imposed last year. The children's father is absent from the home. Ms. L says on the new application that:

   ♦ She does not want to cooperate in obtaining medical support,
   ♦ CSRU is not helping her, and
   ♦ There is no court order for cash medical support.

   The worker explains to Ms. L that she must contact CSRU to resolve the noncooperation which caused the sanction and to request cancellation of her current child support case. The worker requests that Ms. L contact CSRU within 10 days and report back to the worker:

   ♦ The date she contacted CSRU,
   ♦ To whom she spoke, and
   ♦ What actions must be taken to cooperate before the sanction can be lifted.

> Ms. L reports the name and date of her contact and that she must complete the paternity questionnaire and return it to CSRU by the due date to lift the sanction.
>
> On the day after the due date, the worker checks the ICAR system and notes the child support case is still active. The worker then contacts CSRU to obtain the status of the child support case. The child support worker informs the IM worker that Ms. L did not return the paternity questionnaire.
>
> The worker approves the FMAP application for the children only. Ms. L is denied Medicaid because she did not cooperate with child support recovery.

Referral Procedures

Procedures:
If the household has more than one absent parent and there is no active CSRU case, the applicant can determine which absent parents are to be referred, if any.

For foster care cases, link both parents. If the ICAR referrals have not been made, complete the referral.

If a mother claims more than one alleged father for a child and wants a CSRU referral, enter a referral on the **same** ICAR case for each alleged father. If the mother claims that her children have different but unknown fathers, establish a **separate** ICAR case for each child to reflect that child's alleged fathers.

> The fathers of both child A and child B are unknown. The mother states that child A and child B have different fathers, but that child B's father could have been one of two people. One ICAR case must be set up for child A's father, and another ICAR case for child B's alleged fathers.

If a mother wants a CSRU referral and claims that the father of the child is someone other than the man to whom she was married when the child was conceived or born (the legal father), make a referral on the legal father, but identify the biological father in the "Comment" section of REFER2.

When Medicaid is approved following a break in assistance, link the Medicaid case to the ICAR case established previously on the same absent parent upon the request of the applicant or when the CSRU case is currently active. Update information in the comment section of REFER2 as needed.

If a parent later **leaves** the home and the custodial parent wants CSRU services for this absent parent, refer the absent parent via entries on REFER. If the children later receive Medicaid on a nonparental case, notify CSRU of the change in caretakers by making entries on the system. When establishing the nonparental case, refer both absent parents if the nonparental caretaker wants CSRU services.

If a CSRU referral has been made and then an absent parent **returns** to the home and eligibility continues, continue to link the case. Enter in the "Comment" section of REFER2 that the absent parent has returned to the home and that Medicaid eligibility continues. Do not make a new referral, but change the code in the ABC deprivation field to reflect the change.

Make a new referral whenever a new absent parent is determined on a Medicaid case that was previously referred for a different absent parent.

Pregnant Women

Legal reference: 441 IAC 75.14(6) and (7)

Policy:
As a condition of her eligibility, the woman must agree to cooperate in establishing paternity and obtaining support for the children for whom she receives Medicaid (except for pregnant women under MAC). However, a woman will be referred only as listed under Referrals to CSRU.

Procedure:
Do not make a referral regarding the father of the unborn child until the 60-day postpartum period has ended. Then refer only if the mother requests a CSRU referral or is otherwise required.

(See also 8-C, Cooperation With Support Recovery, and 8-F, Mothers and Children (MAC) Program.)

1. Ms. A is pregnant and lives alone. She applies for Medicaid. No CSRU referral is made and no information is requested regarding the father of the unborn child. The worker does not make a referral until the 60-day postpartum period has ended, and then only if Ms. A requests CSRU services.

2. Ms. B is pregnant and lives with her two children. She applies for Medicaid for herself and the children. Eligibility is examined under the FMAP coverage group.

   The worker makes the referral to CSRU only if Ms. B wants CSRU services or if CSRU already has an active ICAR case. When the 60-day postpartum period ends, the worker refers the newborn if a referral was made on the other children of this absent parent.

3. Same as Example 2, except that Ms. B changes her mind and does not cooperate with CSRU after approval. Medicaid for Ms. B under the FMAP coverage group is canceled.

   Ms. B is placed in the MAC coverage group because cooperation with CSRU is not an eligibility factor for pregnant women under MAC. Ms. B's children are placed in the CMAP coverage group. Ms. B is coded as a considered person on the children's CMAP case, and the children are coded as considered people on Ms. B's MAC case.

4. Ms. C is pregnant and lives with a male friend. She applies for Medicaid. Eligibility is examined under the MAC coverage group. Ms. C is required to provide enough information about her male friend in order for the worker to determine if policy requires the male friend to be considered the legal father.

   If the friend is not considered the legal father, no additional information is required regarding the father of the unborn child until the 60-day postpartum period has ended.

5. Ms. D is pregnant and receives Medicaid under the MAC coverage group for herself and her daughter. Ms. D wishes to have CSRU establish paternity and support for her daughter. The worker makes the referral to CSRU for the daughter.

6. Same as Example 5. The referral is made to CSRU. However, Ms. D changes her mind and does not cooperate with CSRU. Her Medicaid is not canceled, because she receives Medicaid under MAC as a pregnant woman, and is, therefore, exempt from the cooperation requirement.

System Entries When the Custodial Parent is Pregnant

If the custodial parent is pregnant and establishing eligibility under the MAC coverage group at the time the referral is made, enter in the "comments" field of the REFER2 screen "CP is pregnant/exempt from cooperating for child already born. Due date MM/YY."

If the custodial parent is a pregnant woman establishing eligibility under a coverage group other than MAC at the time the referral is made, enter in the "comments" field of the REFER2 screen "CP is pregnant/not exempt. Due date MM/YY."

If the custodial parent becomes pregnant after the referral is made, make the appropriate entry in the "comments" field of the REFER2 screen when Medicaid eligibility for the custodial parent is established or changed based on the pregnancy. If eligibility remains unchanged, make the comment on the REFER2 screen when an entry is made in the UNB field on TD03.

Referrals to the *hawk-i* Program

Legal reference: 441 IAC 86.4(514I)

Policy:
Refer an applicant child to the ***hawk-i*** program when the child:

- Is only conditionally eligible for Medically Needy with a spenddown, or
- Has been voluntarily excluded from the Medicaid eligible group due the child's income or resources.

Do not refer a child to the ***hawk-i*** program if the child:

- Is age 19 or older, or
- Does not meet Medicaid's alien requirements (they are the same for ***hawk-i***), or
- Is ineligible for Medicaid due to noncooperation (failure to provide income verification, etc.).
- Has eligibility established under the Iowa Family Planning Network coverage group.

Procedure:
Make a ***hawk-i*** referral within one working day of the determination that the child is ineligible for Medicaid, must meet a spenddown, or has been voluntarily excluded. See instructions for making the entries via the HREF screen in ABC in 14-C, Making an Automated ***hawk-i*** Referral. Do not complete entries for the referral until other ABC transactions are successfully updated.

Make referrals even if the child is insured. The ***hawk-i*** program staff will work with the family to coordinate the dropping of the child's health insurance and the ***hawk-i*** approval to provide seamless coverage.

hawk-i referrals made via the HREF screen must be made no later than the end of the system month following the month of the NEGATIVE DATE on TD05. Otherwise, the referral must be made using the manual process.

To make a manual referral, fax form 470-3565, *Referral to the **hawk-i** Program*, and a copy of the notice of decision showing the income calculation establishing Medicaid ineligibility to 515-457-7701 or 877-457-7701, or send them to:

The ***hawk-i*** Program
PO Box 71336
Des Moines, IA 50325-9958

Representation

Legal reference: 441 IAC 76.1(7)

A Medicaid applicant or member may need or want to be represented by another person or organization.

- When a client is incompetent, physically incapacitated, or deceased, a "responsible person" is allowed to act on the client's behalf.
- A competent person may name an "authorized representative" to participate in pursuing Medicaid eligibility.

The policies and procedures for these two types of representation are discussed in this section.

Responsible Person

Legal reference: 441 IAC 76.1(7)"a"

When a client is unable to act on the client's own behalf because the client is incompetent, physically incapacitated, or deceased, another person may act responsibly for the client. The responsible person must be:

- A family member, friend, or other person who has knowledge of the client's financial affairs and circumstances, and a personal interest in the client's welfare, or
- A legal representative, such as a conservator, guardian, executor, or someone with power of attorney.

A responsible person assumes the client's position and responsibilities during the application process or for ongoing eligibility.

A responsible person may designate an authorized representative to represent the incompetent, physically incapacitated, or deceased client. (See Authorized Representative.) However, this does not relieve the responsible person from assuming the client's position and responsibilities during the application process or for ongoing eligibility.

Provide copies of all correspondence and documents that you would normally provide to the applicant or member to the responsible person and to the representative, if the responsible person has authorized one.

When there is no person as described above to act as a responsible person, any individual or organization can act as the responsible person if the individual or organization:

- Conducts a diligent search for someone who meets the criteria for a responsible person but cannot locate such a person, and
- Completes form 470-3356, *Inability to Find a Responsible Person*.

Authorized Representative

Legal reference: 441 IAC 76.1(7)"b"

Policy:
A competent applicant or member or a responsible person (see Responsible Person) may authorize any individual or organization to represent the applicant or member in the application process or for ongoing eligibility. See Authorization to Represent for authorization requirements.

Authorized representatives may participate in the application process or in the ongoing eligibility process. Authorized representatives are allowed to:

- File applications.
- Check on the progress of an application or ongoing eligibility.
- Request reschedules of interviews or extensions for providing documentation or verification.

Appointment of an authorized representative does not relieve a competent applicant or member or a responsible person of the primary responsibility to cooperate with the application process or for establishing ongoing eligibility. The applicant, member, or responsible person is still required to:

- Attend interviews, when requested.
- Sign documents.
- Supply information or verifications.
- Meet all other requirements necessary to determine eligibility.

Procedure:
When an applicant, member, or responsible person has named an authorized representative, send the authorized representative copies of all correspondence sent to the applicant or member that will affect eligibility.

When a competent applicant names an authorized representative, send all correspondence to the applicant and copies of all correspondence that pertains to the eligibility determination to the authorized representative.

For incompetent, physically incapacitated, or deceased applicants, send correspondence to the responsible person and copies to the authorized representative.

For members under Medicaid for Employed People with Disabilities (MEPD), also provide a copy of each *MEPD Billing Statement*, form 470-3902, to the authorized representative.

Make entries on the member's MEPD STMT screen to generate a copy of the *MEPD Billing Statement*. See 14-C, STMT = MEPD Billing Statement Screen, (REPRINT (WRKR) field) for entry instructions. After the entries are updated, the worker will receive the duplicate bill and send it to the authorized representative.

Authorization to Represent

Legal reference: 441 IAC 76.1(7)"b"

An authorization to represent is a written document or statement signed and dated by the competent applicant or member or by a responsible person that identifies the individual or organization that will act as the person's authorized representative.

If the authorization identifies the period or the dates of medical services it is to cover, the authorization is valid for the initial application and any additional application filed by the representative or applicant for the stated period or dates of medical services, as well as appeals relating to the application.

If the authorization does not indicate the period or dates of medical services it is to cover, the authorization is valid for any applications filed within 120 days from the date the authorization was signed and all subsequent action pertaining to any applications filed within the 120-day period.

If an applicant, member, or responsible person notifies the Department in writing that the client or responsible person no longer wants an authorized representative to act on the person's behalf, the Department will no longer recognize that individual or organization as the authorized representative.