Medicaid Eligibility

May 2024

IOWA Health and Human Services

How is Eligibility Determined?

Eligibility is determined by the Health and Human Services Income Maintenance team.

Eligibility criteria is both financial and non-financial

Proof required of all eligibility factors **except** residency, household size, and pregnancy. However, if these are questionable, the Department will request verification

Eligibility factors are verified through electronic data sources or additional information requested from the applicant/member

A notice explaining the outcome of the application or redetermination of eligibility is mailed when the determination is complete

Who is eligible?

- Individuals age 65 or older
- People who are disabled
- People who are blind
- Families with dependent children
- Pregnant women
- Children (up to age 21)
- Former foster children (up to age 26)
- Adults aged 19 - 64
- Individuals with breast and/or cervical cancer

Types of Coverage Groups

Modified Adjusted Gross Income (MAGI)

- Coverage groups using modified adjusted gross income (taxed based) methodology

non-MAGI

- Coverage groups using eligibility criteria from the Supplemental Security Income (SSI) program

Additional Eligibility Information

- Can have other health insurance and be eligible for Medicaid
- After eligibility is approved, an enrolled member is assigned with a Managed Care Organization (MCO)
- The date of MCO enrollment is the same as the effective date of eligibility
- Eligibility period is not guaranteed for a full 12-months as any change in circumstances could affect eligibility for Medicaid
- Before Medicaid is canceled or reduced, at least 10 days notice is given prior to the action.

How to Apply

Online

- Visit the Iowa Department of Health and Human Services website and click on “Apply for Services”
- HealthCare.gov

In Person

- At any local HHS office or a federal qualified health center in Iowa

By Mail

- Mail completed application to: Imaging Center 4, PO Box 2027, Cedar Rapids, Iowa 52406

By Phone

- Call 1-855-889-7985 to complete an application over the phone

By Email or Fax

- Send a completed application to the local HHS office via email (imagingcenter4@dhs.state.ia.us) or fax (515-564-4016).

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Application Process

An eligibility determination must be completed within 45 days

Applications are processed through MAGI first

EXCEPTION: specific services requested, over age 65 with no dependents, or Medicare eligible

Processed through non-MAGI if no MAGI eligibility and attestation of being blind or disabled or over age 65

If additional information is needed to complete processing Form 470-5089, *Request for Information* is sent to the applicant

Notice of Action or Notice of Decision is mailed when the determination is complete

Requesting Information

- Additional information is often needed from an applicant
- Form 470-5089, *Request for Information* is sent if additional information is needed from the applicant
- 10 days are allowed to provide requested information
- Requested information can be provided by email, fax, mail, or in person. If the client has an account, requested information may also be submitted through the SSP.
- Not providing requested information may result in denial of an application

Reporting Changes

Members must report changes in circumstances within 10 days, including but not limited to:

ADDRESS CHANGE

RECEIPT OF A SOCIAL SECURITY NUMBER

SOMEONE MOVES INTO OR OUT OF THE HOME

CHANGE IN CITIZENSHIP OR IMMIGRATION STATUS

CHANGE IN TAX FILING STATUS OR CLAIMED DEPENDENTS (MAGI)

INCOME: CHANGE IN INCOME, STARTING OR ENDING A JOB

RESOURCES (NON-MAGI)

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NOTE: Unreported changes may result in an overpayment that the member must repay to the Department

How to Report a Change

Phone
1-877-347-5678

Online
HHS Services Portal

Mail
Imaging Center 1
417 E Kanesville Blvd
Council Bluffs, IA
51503

Fax
1-877-238-0015

Email
IMCSC@dhs.state.ia.us

Redetermination of Medicaid Eligibility

When is eligibility redetermined?

- Once every 12 months, or
- Anytime a change is reported or becomes known to the Department

How is eligibility redetermined?

- Passively through an electronic process, or
- A renewal form is mailed for completion
  - Form 470-5168, *Medicaid/Hawki Review*
  - Form 470-5482, *Medicaid/State Supp Review*
- If a renewal form is mailed the member also has the option to complete their renewal online using the HHS Services Portal

Timeline

- The renewal process begins up to 80 days prior to the end of a member's 12-month eligibility period
- The completed form and verification must be received by the Department prior to the end of a member's 12-month eligibility period
- Member's may have an additional 90 days to provide their renewal form before being required to submit a new application

90-Day Reconsideration for Renewals

- If a review is not returned prior to the end of the household's 12-month certification period, their eligibility will be discontinued
- The household is allowed a 90-day reconsideration period
- 90-day Reconsideration Period
  - The 90-day period following the Medical Assistance cancellation date due to failure to submit a review form or required information needed with the review form.
- If a review form and/or required information is returned during the 90-day reconsideration period, the household's eligibility will be reconsidered back to the date of cancellation without the requirement of a new application (Exception: HCBS Waiver, PACE and QMB.)

Estate Recovery

The Department is required by law to be reimbursed from the estate of a person who has received Medicaid benefits.

Estate Recovery applies to members:

- Age 55 or older, or
- Under age 55, residing in a medical facility, and unlikely to return home

Estate Recovery

How it works

At the time of death, all medical assistance paid by the Department becomes a debt against the member's estate.

If the member has no assets in their estate, there is no recovery.

What is subject to recovery

All medical assistance paid out by the Department is subject to recovery. This includes: fee-for-service claims, capitation fees to MCOs (regardless of how much the actual services cost the MCO), and interest.

Exception: The only exception from recovery is for Medicare cost-sharing and Medicare premiums for lower income populations after January 1, 2010.

Appeals

If you disagree with an eligibility outcome, you may appeal

How to file an appeal

- In person, by telephone, or in writing.
- Complete electronically at: Appeals | Health & Human Services (iowa.gov)
- Send or take form to your county HHS office or mail to:
  - HHS Appeals
    1305 E Walnut St.
    Des Moines, Iowa 50319-0114
- Question? Call your Income Maintenance worker.

After an appeal is filed

- Benefits may continue until the appeal is final
- A hearing notice will be mailed with the date and time a telephone hearing is scheduled

*Appeals for Medicaid must be submitted within 90 calendar days

Important Information

- Check your mail and respond to any requests from HHS.
- If you have questions, about any documents you receive, call your local HHS office.
- Income and Resource information for non-MAGI

QUESTIONS?