Iowa Medicaid
IOWA HHS

DATE: <date>

To: Appeals Section, Bureau of Policy Analysis

ATTENTION: Liaison for appeals

FROM: <Preparers Name>, Iowa Medicaid Member Services

APPEAL SUMMARY

CASE NAME: <Members Name>

APPEAL NUMBER: <Appeal number>

ISSUE BEING APPEALED:

Whether the Department correctly determined the appellant did not meet the definition of a Medically Exempt individual based on the results of the Medically Exempt Survey. 441 IAC 74.1(249A, 85GA, SF446), 74.12(3); 42 CFR 440.315(f).

Whether the Department failed to issue adequate or timely notice. 441 IAC 7.7(17.A); 42 CFR 435.919.

DEPARTMENT SUMMARY STATEMENT:

A Medically Exempt Member Survey was completed by <Members Name> (see exhibit B). Based on the information self-reported by <Members Name>, Medically Exempt status was not met. It was determined that <Members Name> is currently enrolled in the best plan to meet <his/her> medical needs. <Members Name> was notified on <date of Medically Exempt Denial letter> (see exhibit A) that <his/her> did not meet the criteria.

441—74.1(249A,85GA,SF446) Definitions.

"Caretaker relative" means a relative listed in 441—subrule 75.55(1).

"Countable income" means "modified adjusted gross income" (MAGI) or "household income," as applicable, determined pursuant to 42 U.S.C. § 1396a(e)(14).

"Department" means the Iowa department of human services.

"Enrollment period" means the 12-month period for which Iowa Health and Wellness plan eligibility is established.

"Essential health benefits" means the essential health benefits defined at 42 U.S.C. § 18022.

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

"Health insurance marketplace" or *"exchange"* means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

"Iowa Health and Wellness Plan" means the medical assistance program set forth in this chapter.

"Iowa wellness plan" means the benefits and services provided to Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Marketplace choice plan" means the benefits and services provided to Iowa Health and

Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level.

"Medical home" means a team approach to providing health care that originates in a primary Care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access and integrate all medical and nonmedical health-related services across all elements of the health care system and the patient's community as needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the following characteristics:

1. A personal provider.

2. A provider-directed team-based medical practice.

3. Whole person orientation.

4. Coordination and integration of care.

5. Quality and safety.

6. Enhanced access to health care.

7. A payment system that appropriately recognizes the added value provided to patients who have a patient-centered medical home.

"Medically exempt individual" means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR § 440.315 as amended on July 15, 2013.

"Member" means an individual who is receiving assistance under the Iowa Health and Wellness Plan described in this chapter.

"Minimum essential coverage" means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code.

"Modified adjusted gross income" means the financial-eligibility methodology prescribed in 42 U.S.C. § 1396a(e)(14).

"Personal provider" means the patient's first point of contact in the health care system with a primary care provider who identifies the patient's health-related needs and, working with a team of health care professionals and providers of medical and nonmedical health-related services, provides for and coordinates appropriate care to address the health-related needs identified.

"Primary care provider" includes but is not limited to any of the following licensed or certified health care professionals who provide primary care:

1. A physician who is a family or general practitioner, a pediatrician, an internist, an obstetrician, or a gynecologist.

2. An advanced registered nurse practitioner.

3. A physician assistant.

4. A chiropractor.

"Primary medical provider" means a personal provider trained to provide first contact and continuous and comprehensive care to a member, chosen by a member or to whom a member is assigned under the Iowa health and wellness plan as the member's primary medical provider.

"Qualified employer-sponsored coverage" shall be defined pursuant to 42 U.S.C. § 1396e-1(b).

"Qualified health plan" shall be defined pursuant to Section 1301 of the Patient Protection And Affordable Care Act, Public Law 111-152.

74.12(3) *Medically exempt individuals.*

An Iowa Health and Wellness Plan member who has been determined by the department to be a medically exempt individual shall be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

a. A member may attest to being a medically exempt individual by submitting a completed Form 470-5194.

b. A provider with a current National Provider Identifier number, an employee of the department of human services, a designee of the department of corrections, a qualified health plan, or a mental health and disability services region established pursuant to Iowa Code sections 331.388 to 331.399 may refer a member for a medically exempt individual determination by submitting a completed Form 470-5196, Medically Exempt Attestation and Referral Form.

c. Upon receipt of Form 470-5194 or 470-5196, the Iowa Medicaid enterprise shall determine whether the member qualifies as a medically exempt individual in accordance with 42 CFR § 440.315 as amended on July 15, 2013.

42 CFR 440.315(f) – Exempt individuals.

(f) The individual is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs must at

least include those individuals described in § 438.50(d)(3) of this chapter, individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

441—7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance.

7.7(1) *Notification.*

a. Whenever the department proposes to cancel or reduce assistance or services or to

revoke a license, certification, approval, registration, or accreditation, it shall give timely and adequate notice of the pending action, except:

(1) When a service is deleted from the state's comprehensive annual service plan in the Social services block grant program at the onset of a new program year, or

(2) As provided in subrule 7.7(2).

b. For the purpose of this subrule, "assistance" includes food assistance, medical assistance,

the family investment program, refugee cash assistance, child care assistance, emergency

assistance, the family planning program, family or community self-sufficiency grant, PROMISE JOBS, state supplementary assistance, healthy and well kids in Iowa (HAWK-I) program, foster care, adoption, aftercare services, or other programs or services provided by the department.

c. The department shall give adequate notice of the approval or denial of assistance or services; the approval or denial of a license, certification, approval, registration, or accreditation; and pending action for a state or federal tax or debtor offset.

d. "Timely" means that the notice is sent at least ten calendar days before the date the action Would become effective. The timely notice period shall begin on the day after the notice is sent.

e. "Adequate" means a written notice that includes:

(1) A statement of what action is being taken,

(2) The effective date of such action,

(3) A clear statement of the specific reasons supporting the intended action,

(4) The corresponding rule reference,

(5) An explanation of the appellant's right to appeal, and

(6) The circumstances under which assistance is continued when an appeal is filed.

42 CFR 425.919 – Timely and adequate notice concerning adverse actions.

(a) The agency must give beneficiaries timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid.

(b) The notice must meet the requirements of subpart E of part 431 of this subchapter.

ATTACHED SUPPORTING DOCUMENTS:

Exhibits A and B

CC: ALJ <Judges name>

<Members Name>