Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 76
"Enrollment and Reenrollment"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A
State or federal law(s) implemented by the rulemaking: Iowa Code chapters 249A and 514I and 42 CFR §435 and 42 CFR §457

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

August 26, 2025 2 p.m.	Microsoft Teams Meeting ID: 217 057 970 823 5 Passcode: M3ue7ZD7

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

Victoria L. Daniels
321 East 12th Street
Des Moines, Iowa 50319
Phone: 515.829.6021
Email: compliancerules@hhs.iowa.gov

Purpose and Summary

This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10.

The proposed chapter specifies the process for enrolling and reenrolling in the Iowa Medical Assistance or "Medicaid" program and addresses related matters.

Eligible individuals must be enrolled for the date on which services are provided in order for payment to be made for the services received.

Initial enrollment must be based on an application submitted to the Department (including for hawki benefits), an application from the Federally Facilitated Marketplace (FFM), an express lane eligibility determination, a Supplemental Security Income (SSI) eligibility determination, a transmittal from the federal Social Security Administration for Medicare savings programs, or a presumptive eligibility determination as described in rules 441—76.2(249A) through 441—76.7(249A).

In addition to the elimination of restrictive terms and language duplicative of the Iowa Code or federal regulations, this proposed rulemaking implements changes necessitated by the federal Patient Protection and Affordable Care Act of 2010.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Iowans who want to enroll or reenroll in the Medicaid program will benefit from the guidance in this proposed chapter.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

As of the most recently available data, almost 700,000 individuals are enrolled in medical assistance programs. Each year, the Department receives an average of nearly 225,000 applications for medical assistance, which includes both individual and household submissions. Recent program activity reflects that annually there are approximately 139,000 individuals approved for medical assistance at the time of application. Over the same period, the Department generally completes more than one million eligibility approval actions, including both initial approvals and redeterminations that result in continued or transitioned coverage. Additionally, nearly 122,000 eligibility determinations annually result in ineligibility, encompassing both application denials and terminations of existing coverage.

- **Qualitative description of impact:**

The Department does not expect any adverse impact as a result of the proposed rulemaking.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement this proposed chapter.

- **Anticipated effect on State revenues:**

This rulemaking has no effect on State revenues.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Not applicable.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

This rulemaking is required under Executive Order 10.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 76 and adopt the following **new** chapter in lieu thereof:

CHAPTER 76
ENROLLMENT AND REENROLLMENT

441—76.1(249A) Definitions. The following definitions apply to this chapter in addition to the definitions in rule 441—75.1(249A).

"Act" or *"the Act"* means the federal Social Security Act, and all references herein are as amended to August 1, 2025.

"Authorized representative" means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, the review of eligibility and other ongoing communications with the department.

"Business hours" or *"HHS business hours"* means the hours between 8 a.m. and 4:30 p.m. Central Time, during a weekday (Monday through Friday), excluding public holidays.

"Code of Federal Regulations" or *"CFR"* means the United States Code of Federal Regulations. All references to the CFR herein are as amended to August 1, 2025, unless another effective date is specified.

"Electronic account" means a web-based account established by the department for an applicant or member for communication between the department and the applicant member.

"Electronic case record" means an electronic file that includes all information collected and generated by the department regarding each individual's Medicaid eligibility and enrollment.

"Federally Facilitated Marketplace" or *"FFM"* means the health insurance marketplace established by the United States Secretary of Health and Human Services for states that choose not to set up their own marketplace or that do not get approval for one pursuant to 42 U.S.C. §18041.

"Federally Facilitated Marketplace referral" or *"FFM referral"* means an application submitted at healthcare.gov that requests help paying for health insurance. These applications are screened by the FFM and, if found to be potentially eligible for Iowa Medicaid or hawki, are transmitted via an electronic data file to the department for a final Medicaid/hawki determination.

"Health insurance marketplace" means a health insurance marketplace established pursuant to 42 U.S.C. §18031.

"Medicare savings program" refers to the limited Medicaid coverage groups that provide payment of Medicare premiums, coinsurance, and deductibles for low-income elderly or disabled individuals. Those groups are:

1. Qualified disabled and working people (QDWP) pursuant to 42 U.S.C. §1396a(a)(10)(E)(ii);
2. Qualified Medicare beneficiaries (QMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(i);
3. Specified low-income Medicare beneficiaries (SLMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(iii); and
4. Expanded specified low-income Medicare beneficiaries (ESLMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(iv).

"Presumptive provider" means an organization approved by the department to conduct and authorize presumptive eligibility determinations as described in subrule 76.7(1).

"Qualified entity" means an individual, under the supervision and authority of a presumptive provider, approved by the department to conduct and authorize presumptive eligibility determinations.

"Responsible person" means an individual recognized by the department pursuant to subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

"SSA" means the federal Social Security Administration.

"Supplemental Security Income" or *"SSI"* is a federally administered program established by Title XVI of the Social Security Act to provide supplemental income to individuals who have attained the age of 65 or are blind or disabled.

"United States Code" or *"U.S.C."* means the general and permanent laws of the United States. All references to U.S.C. herein are as amended to August 1, 2025, unless another effective date is specified.

"WIC" is the Special Supplemental Nutrition Program for Women, Infants, and Children established pursuant to 42 U.S.C. §1786.

441—76.2(249A) Application for medical assistance. This rule describes the process of applying for medical assistance from the department. Applications for Medicaid must be made as provided in this rule.

76.2(1) *Application with the department or qualified entity.*

a. Who can file. An application may be filed by:

(1) The applicant;

(2) An adult in the applicant's household, as described in 42 CFR §435.603(f), or family, as described in 26 CFR §1.36B-1(d), including:

1. A spouse as defined in rule 441—75.1(249A);

2. A parent of an applicant child, as defined in rule 441—75.1(249A), including either parent of an unborn child;

3. A caretaker of an applicant child, when the caretaker meets the requirements of rules 441—75.1(249A) and 441—75.51(249A); or

4. A tax-filer who claims the applicant as a dependent;

(3) An authorized representative described in subrule 76.9(2); or

(4) A responsible person described in subrule 76.9(1).

b. How and where to file.

(1) An application may be filed online on the department's website or www.healthcare.gov; at any local HHS office; or at any HHS outstation at a disproportionate share hospital, federally qualified health center in Iowa, or other facility in Iowa where outstationing activities are provided. Applications may be submitted in person, by mail, by telephone at 1.855.889.7985, or by email or fax to a local HHS office. Addresses, email addresses, and fax numbers of local HHS offices are available on the department's website.

(2) An application may also be filed at the office of a qualified entity pursuant to subrule 76.7(2), a WIC office, a maternal health clinic, or a well-child clinic.

c. Form. Applications for Medicaid, including Medicaid applications for foster care and subsidized adoption, may be submitted on forms prescribed by the department.

d. Minimum application requirements. Initial applications must contain a legible name and address and must be signed under penalty of perjury, pursuant to 42 CFR §435.907(f). At least one person listed in paragraph 76.2(1)*"a"* must sign the application. Electronic (including telephonically recorded) signatures and handwritten signatures (transmitted via any electronic means) are acceptable. An application that does not include a legible name, address, and signature under penalty of perjury will not be considered a valid application and will be rejected without a determination of eligibility.

76.2(2) *Date of filing.*

a. An application is considered filed on the date a valid application is received in any place of filing specified in paragraph 76.2(1)*"b."*

b. Reserved.

c. The date of filing and effective date for applications received by a qualified entity for purposes of a presumptive Medicaid eligibility determination are further described in subrule 76.7(5).

d. The department will honor the application date of any application filed at the FFM that is subsequently transmitted to the department for an eligibility determination as described in rule 441—76.3(249A).

76.2(3) *Decision.* The department will notify the applicant of the eligibility decision pursuant to 441—Chapter 16.

441—76.3(249A) Referrals from the FFM. Upon receipt of an FFM referral indicating that an application has been screened and that the applicant has been found to be potentially eligible for Medicaid or hawki, the department will treat the application as if it had been received directly by the department pursuant to rule 441—76.2(249A).

441—76.4(249A) Express lane eligibility. For purposes of the initial enrollment of a child in medical assistance, the department will use express lane procedures as allowed by 42 U.S.C. §1396a(e)(13) and as described in this rule.

76.4(1) For purposes of initial enrollment, the department will rely on a determination of the child's eligibility for the Supplemental Nutrition Assistance Program (SNAP) pursuant to 441—Chapter 65 as establishing that a child under the age of 19 meets all eligibility requirements established in 441—subrule 75.3(2) except for citizenship or alienage requirements unless:

a. The child's household already includes other persons receiving Medicaid based on the use of the modified adjusted gross income (MAGI) methodology, or

b. The child was previously granted express lane eligibility and the household has not had at least a two-month break in SNAP eligibility since that time.

76.4(2) To obtain express lane enrollment for a child, the child's household must request medical assistance for the child on forms prescribed by the department. The department will send forms to the household when a child eligible for express lane enrollment is approved for SNAP pursuant to 441—Chapter 65. An adult member of the child's household or a child receiving SNAP benefits as head of household must sign the form and return it to the department within 30 calendar days of issuance.

76.4(3) As a condition of express lane enrollment, the child must meet the citizenship or alienage requirements of rule 441—75.11(249A).

76.4(4) The month of application for express lane enrollment is the month of the child's SNAP effective date. Express lane eligibility begins on the first day of the month of the child's SNAP effective date.

76.4(5) After the initial express lane enrollment, all redeterminations of medical assistance eligibility will be made without reliance on any SNAP eligibility determination.

76.4(6) Retroactive enrollment is available pursuant to subrule 76.13(3) for any of the three months before the month of the child's SNAP effective date. The retroactive eligibility determination must be made without regard to SNAP eligibility.

441—76.5(249A) Enrollment through SSI. Upon receipt of a referral from the SSA indicating that an individual has been approved for SSI, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The SSI recipient may be required to provide additional information when necessary to determine Medicaid eligibility. The SSI recipient may be required to attend an interview to clarify information.

441—76.6(249A) Referral for Medicare savings program. Referrals received from the SSA pursuant to 42 U.S.C. §1320b-14(c)(3) when the individual has indicated that the individual wants to apply for the Medicare savings program will be treated by the department as an application for the Medicare savings program and will be processed as if the application were received directly by the department. The date of the individual's application with SSA will be the application date for benefits under the Medicare savings program. When requested to do so, the applicant must complete a Medicare Savings Programs Additional Information Request form to provide additional information needed to determine Medicare savings program eligibility.

441—76.7(249A) Presumptive eligibility. Persons may be temporarily and immediately enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity at a presumptive provider pursuant to this rule.

76.7(1) *Presumptive provider.* A presumptive provider is an organization approved by the department to conduct and authorize presumptive eligibility determinations. A provider organization that seeks to be authorized to make presumptive Medicaid eligibility determinations shall do all of the following:

a. Complete the required self-directed policy and system training.

b. Apply to the department using the Application for Initial/Recertification to Be a Presumptive Provider form.

c. Read the Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations form and agree in writing to its terms.

d. Comply with the requirements outlined in Iowa's Medicaid state plan.

e. Meet the definition of "qualified provider" pursuant to 42 U.S.C. §1396r-1.

f. Meet the definition of "qualified entity" in the following federal regulations for the category of persons covered:

(1) For children under the age of 19, as described in 42 CFR §435.118, the provider must meet the requirements of paragraphs (1) through (10) of the definition of "qualified entity" in 42 CFR §435.1101;

(2) For pregnant women, as described in 42 CFR §435.116, the provider must meet the requirements of 42 U.S.C. §1396r-1(b)(2);

(3) For parents and caretakers, as described in 42 CFR §435.110, the provider must meet the requirements in 42 CFR §435.1103(b);

(4) For persons aged 19 through 64, as described in 42 CFR § 435.119, the provider must meet the requirements in 42 CFR §435.1103(b);

(5) For former foster care children, as described in 42 CFR §435.150, the provider must meet the requirements in 42 CFR §435.1103(b);

(6) For persons needing breast or cervical cancer treatment (BCCT), as described in 42 U.S.C. §1396r-1b(b)(2); and

(7) For all of the categories of persons covered in subparagraph 76.7(1)*"f"*(1) through *"f"*(6), a qualifying hospital must meet the requirements in 42 CFR §435.1110(b).

g. Be recertified annually by doing the following:

(1) Complete the required self-directed policy and system training;

(2) Complete the Application for Initial/Recertification to Be a Presumptive Provider form; and

(3) Re-attest to the terms of the Provider Memorandum of Understanding by signing in writing.

76.7(2) *Qualified entity.*

a. An individual that seeks to be authorized to make presumptive Medicaid eligibility determinations under the supervision and authority of a presumptive provider shall do all of the following:

(1) Complete the required self-directed policy and system training.

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal (MPEP) Access Request.

(3) Read the Provider Memorandum of Understanding and agree in writing to its terms.

(4) Obtain confirmation of acceptance by the department that the individual is determined by the department to be capable of making presumptive Medicaid eligibility determinations.

b. In addition to the requirements in paragraph 76.7(2)*"a,"* a qualified entity for BCCT must also have either:

(1) Been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department; or

(2) A cooperative agreement with the department under the Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program established under Title XV

of the Public Health Service Act as amended to August 1, 2025, to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the care for yourself breast and cervical cancer early detection program.

c. Only employees of the presumptive provider may be given the authority to make presumptive eligibility determinations.

d. Qualified entities are required to be recertified annually by doing the following:

(1) Complete the required self-directed policy and system training;

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal Recertification form; and

(3) Re-attest to the terms of the Provider Memorandum of Understanding in writing.

76.7(3) *How and where to file.* An applicant for presumptive Medicaid shall complete an application with a qualified entity in one of two ways:

a. Provide information in person to the qualified entity that enters the applicant's information into the MPEP system; or

b. Complete a paper application provided by the qualified entity that enters the applicant's information into the MPEP system.

76.7(4) *Signature.* An individual listed in paragraph 76.2(1)*"a"* must sign the completed paper application or a printed version of the completed MPEP application. A copy of the signed application must be maintained by the qualified entity.

76.7(5) *Date of filing and effective date of coverage.*

a. For purposes of determining the application date of filing for an ongoing eligibility determination, a paper application is valid only if it contains the applicant's legible name, address, and signature under penalty of perjury and must be date-stamped on the date it is received by the qualified entity. The date of filing as described in paragraph 76.2(2)*"a"* is used for purposes of determining the effective date of coverage for ongoing eligibility but does not determine the effective date of coverage for presumptive Medicaid.

b. The effective date of coverage for presumptive Medicaid is the date on which a qualified entity completes the presumptive eligibility determination within the MPEP system.

c. The applicant must provide to the qualified entity all information necessary to make a presumptive eligibility determination in the MPEP system.

76.7(6) *Notice and appeal rights.* The qualified entity shall inform the applicant of the eligibility decision as soon as possible but no later than two working days after the date the determination is made by the qualified entity. Timely and adequate notice requirements and appeal rights of the Medicaid program, including those outlined in 42 CFR Part 431, subpart E; Iowa Code chapter 17A; 441—Chapter 7; and 441—Chapter 16, do not apply to determinations of presumptive eligibility under this rule.

76.7(7) *Full medical assistance eligibility determination.* All presumptive eligibility applications will be given the option within the MPEP system to also receive a full determination of eligibility for Medicaid or hawki.

441—76.8(249A) Applicant and member responsibilities.

76.8(1) *Accurate information.* Clients, and those individuals acting on behalf of clients, are responsible for giving complete and accurate information needed to establish eligibility.

76.8(2) *Additional information or verification needed to determine eligibility.* An applicant or member will not be required to provide additional verifications if attested income meets the department's standards for reasonable compatibility and if the department can verify all other required information through an EDS. If attested income does not meet the department's standards for reasonable compatibility or if the department is not able to verify other required information through an EDS, the department will send the applicant or member a written request for the additional information or verification. The applicant or member must provide the additional information or

verification by the requested due date or such application may be denied or Medicaid or hawki benefits may be discontinued.

76.8(3) *Time frames for providing information or verification.* Clients have ten calendar days from the date on the written request by the department to provide additional information or verification requested. If the tenth calendar day falls on a weekend or state holiday, the individual will have until the end of business hours on the next business day to provide the information or verification. The information or verification is considered provided on the date it is received by the department.

76.8(4) *Extensions.* The applicant or member may request an extension for a reasonable period of time when the applicant or member is making every effort but is unable to secure the required information or verification.

76.8(5) *Interviews.* Applicants and members who are being evaluated on the basis of the MAGI methodology will not be required to attend an interview. Applicants and members who are being evaluated on a basis other than the MAGI methodology may be required to attend an interview to clarify information or to resolve conflicting information. The department will not require an in-person interview as part of the application process.

76.8(6) *Failure to comply.* An application will be denied or assistance will be discontinued if:

a. The applicant or member does not attend a required interview, pursuant to subrule 76.8(5), or

b. The department does not receive one of the following by the due date indicated on the written request for additional information in accordance with subrules 76.8(2) through 76.8(4):

(1) The information, verification, or a statement that reasonably explains the discrepancy;

(2) An authorization for the department to obtain the information or verification; or

(3) A request for an extension of the due date.

441—76.9(249A) Responsible persons and authorized representatives.

76.9(1) *Responsible person.* If an applicant or member is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased, a responsible person may act for the applicant or member.

a. Except as provided in paragraph 76.9(1)*"d,"* when the applicant or member is incompetent, incapacitated, or deceased, the responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and has a personal interest in the applicant's or member's welfare.

b. Except as provided in paragraph 76.9(1)*"d,"* when the applicant or member is unable to act on the applicant's or member's own behalf solely because the applicant or member is a minor, the responsible person shall be an adult in the child's household or family as described in paragraph 76.2(1)*"a."*

c. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative pursuant to subrule 76.9(2) to represent the applicant or member. However, the designation of an authorized representative does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

d. When there is no person as described in paragraphs 79.6(1)*"a"* through *"c"* to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member, any individual or organization may be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes the required form, attesting to the individual's or organization's inability to find a responsible person to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member.

e. The department may require verification of the applicant's or member's incompetence or death and of the responsible person's relationship to the applicant or member.

f. Copies of all correspondence the department would otherwise provide to the applicant or member will be provided to the recognized responsible person.

76.9(2) *Authorized representative.*

a. An individual or organization designated by a competent applicant or member, or by a responsible person recognized pursuant to subrule 76.9(1), or with other legal authority to do so may act on behalf of the applicant or member in the application process, in the review process, or for ongoing eligibility.

b. The designation of an authorized representative by an applicant, member, or responsible person must be in writing and must be signed and dated by the applicant, member, or responsible person. The applicant, member, or responsible person may authorize the representative to complete and sign an application on the applicant's or member's behalf, complete and submit a review form, receive copies of the applicant's or member's notices and other communications from the department, and act on behalf of the applicant or member in all other matters with the department.

c. Legal documentation of authority to act on behalf of the applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a written authorization by the applicant or member.

d. Designations of authorized representatives, legal documentation of authority to act on behalf of the applicant or member, and modifications or terminations of designations or legal authority may be submitted via the department's website, mail, email, or fax or in person.

e. For purposes of this rule, the department will accept electronic, including telephonically recorded, signatures and handwritten signatures (including when transmitted by fax or other electronic means).

f. If the authorization:

(1) Indicates the time period or dates the authorization is to cover, the stated period or dates will be honored until or unless a rescission is submitted to the department as described in subparagraph 76.9(2)*"f"*(2) and may include subsequent applications, if necessary, that relate to the time period or dates indicated on the authorization.

(2) Does not indicate the time period or dates it is to cover, the authorization will be valid until the applicant, member, or responsible person modifies the authorization and notifies the department that the representative is no longer authorized to act on behalf of the applicant or member or until the authorized representative informs the department that the representative no longer is acting in such capacity. Such notice must be in writing and should include the signature of the applicant, member, responsible person, or authorized representative, as appropriate.

g. Copies of all correspondence will be provided to the applicant or member and the authorized representative.

76.9(3) *Additional requirements applicable to all authorized representatives and responsible persons.*

a. An authorized representative or responsible person must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or member provided by the department.

b. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible person must sign an agreement that the provider, staff member, or volunteer will adhere to the regulations in 42 CFR Part 431, Subpart F; 45 CFR §155.260(f) (relating to confidentiality of information); and 42 CFR §447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

c. The authorized representative or responsible person is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible person represents.

441—76.10(249A) Right to withdraw the application. The applicant may withdraw the application at any time before the eligibility determination has been made. The applicant may request that the application be withdrawn entirely or request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of rule 441—75.8(249A).

441—76.11(249A) Choice of electronic notifications. The applicant is responsible to indicate whether notices and other communications are to be provided by the department in an electronic format through the individual's electronic account rather than by regular mail. The applicant may change the selection at any time. Notices and other communications provided through the individual's electronic account are deemed to be received upon the sending of an email to the individual notifying the individual of the notice or other communication.

441—76.12(249A) Application not required.

76.12(1) *Adding a new person.*

a. Adding an eligible person. For members whose eligibility is based on the MAGI methodology, a new application is not required when an eligible person is added to an existing Medicaid household. Such a person is considered to be included in the application that established eligibility for the existing household. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date the person begins to live in the household or the date of report, whichever is later.

b. Adding a person previously ineligible due to a failure to cooperate. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing liability for support as described in 441—subrule 75.14(2) is to be granted Medicaid benefits, the earliest month for which that person may be eligible for coverage is the month that the person takes action(s) to meet the cooperation requirements described in 441—subrule 75.14(1) and as determined by child support services.

c. Adding a person previously ineligible due to failure to provide a social security number. In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described in rule 441—75.9(249A) is to be granted Medicaid benefits, the person will be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number.

76.12(2) *Loss of hawki eligibility.* In those instances where a child loses hawki eligibility and has been determined eligible for Medicaid, with no break in coverage, an application for Medicaid is not required.

76.12(3) *Grace period.*

a. At application. If benefits are denied for failure to provide requested information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department will complete the eligibility determination as though the information were timely received. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the end of business hours on the next business day to provide the information. The grace period does not apply to late payment of premiums or noncooperation actions.

b. At reinstatement after cancellation (including cancellation at the time of reenrollment). Eligibility for Medicaid may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the end of business hours on the next business day to provide the information. The grace period does not apply to late payment of premiums or noncooperation actions.

441—76.13(249A) Initial enrollment.

76.13(1) *Enrollment date.* The department will enroll applicants who have been determined to be eligible in the Medicaid program.

a. First day of the month. The effective date of enrollment is the first day of the month that the application was filed or the first day of the first month for which eligibility has been determined, whichever is later, with the following exceptions:

(1) Presumptive eligibility is effective on the date that presumptive eligibility was determined by a qualified entity for presumptive Medicaid eligibility determinations pursuant to subrule 76.7(5).

(2) Eligibility under the qualified Medicare beneficiary coverage group described in 441—paragraph 75.6(5)*"a"* begins on the first day of the month after the month of decision.

(3) For individuals who are approved for Medicaid and who are eligible for SSI, programs related to SSI, or state supplementary assistance, Medicaid benefits will be effective on the first day of the month for which the individual meets all eligibility requirements, including resource eligibility, as of the first moment of the first day of the month.

(4) The enrollment date for retroactive Medicaid eligibility is determined pursuant to subrule 76.13(3).

b. Care or services prior to enrollment. No payment will be made for medical care or services received prior to the effective date of enrollment.

76.13(2) *Certification for services.* The department will issue a medical assistance eligibility card to persons who have been determined to be eligible for the benefits provided under the Medicaid program, with the following exceptions.

a. Presumptive eligibility. A person who has been determined only presumptively eligible will be issued a Presumptive Medicaid Eligibility Notice of Action form that will include certification information.

b. Emergency Medicaid for noncitizens. An individual who is eligible only for limited emergency Medicaid for noncitizens pursuant to 441—subrule 75.11(4) will be issued a Notice of Action that will include certification information.

76.13(3) *Retroactive enrollment.* Medical assistance will be available for all or any of the three months preceding the month in which an application is filed to persons who meet the requirements described within this subrule.

a. Except as provided in paragraph 76.13(3)*"e,"* retroactive medical assistance will be available for the months a person was pregnant, an infant (under the age of 1), a child under 19 years of age, or a resident of a nursing facility licensed under Iowa Code chapter 135C during any of the three months preceding the month in which an application is filed and who also meets the following conditions:

(1) Has medical bills for covered care or services received during the three-month retroactive period; and

(2) Would have been eligible for medical assistance in the month services were received if the application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance will be made available when an application has been made on behalf of a deceased person if the conditions in paragraph 76.13(3)*"a"* are met.

d. Persons enrolled in Medicaid based on receipt of SSI benefits who wish to apply for Medicaid benefits for the three months preceding the month of application shall complete a form provided by the department.

e. Exceptions to retroactive enrollment. This subrule does not apply to the following persons who are otherwise eligible for retroactive enrollment:

(1) Persons whose citizenship status has not been verified even if they are eligible during a 90-day reasonable opportunity period.

(2) Persons determined eligible only under presumptive Medicaid benefits.

(3) Persons eligible for Medicaid only under the qualified Medicare beneficiary program.

(4) Persons eligible only under the home- and community-based waiver services program.

441—76.14(249A) Reenrollment. The department will review all conditions of eligibility for the purpose of determining continued enrollment in Medicaid pursuant to 441—Chapter 75.

76.14(1) *Reenrollment frequency.*

a. The department will conduct eligibility reviews for members whose eligibility is based on the MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided by rule 441—76.15(249A) and paragraph 76.14(1)*"b."*

b. The department will conduct eligibility reviews for the following coverage groups as circumstances indicate but no more frequently than once every 12 months:

(1) Transitional Medicaid as described in 441—subrule 75.3(6).

(2) Medicaid for former foster care youth (EMIYA) as described in 441—subrule 75.3(12).

(3) Postpartum Medicaid as described in 441—subrule 75.3(4).

c. The department will conduct eligibility reviews for members whose eligibility is based on non-MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided in rule 441—76.15(249A) and paragraph 76.14(1)*"b."*

76.14(2) *Reenrollment process.*

a. Reenrollment procedure. Reenrollment will be based on reliable information contained in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS. If the department is able to renew eligibility based on such information, the department must notify the individual of the eligibility determination and the basis of that determination. If any information in that notification form is inaccurate, the member must inform the department through any of the modes permitted for submission of an application under paragraph 76.2(1)*"b"* within 30 days.

b. Members whose eligibility for Medicaid is based on the MAGI methodology. If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

c. Members whose eligibility for Medicaid is in non-MAGI related coverage groups. If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

d. Failure to reenroll. Enrollment will end when information or documentation necessary to complete the determination of continued eligibility pursuant to subrules 76.8(2) through 76.8(4) is not returned before the end of the enrollment period. The department will notify the member of the disenrollment pursuant to 441—Chapter 16. Individuals whose eligibility ends must reapply unless the individual satisfies the requirements of subrule 76.12(3) or paragraph 76.14(2)*"e."*

e. Reconsideration period.

(1) For all coverage groups, except those specified in subparagraph 76.14(2)*"e"*(2), the department will reconsider the eligibility of an individual who is terminated for failure to submit the applicable review form as described in paragraph 76.14(2)*"b"* or *"c"* or for failure to provide necessary information in a timely manner and without requiring an application if the individual subsequently submits a review form within 90 days after the effective date of termination. The department will also reconsider eligibility as described in this subparagraph if the member provides an application form. If the ninetieth calendar day falls on a weekend or state holiday, the member shall have until the end of business hours on the next business day to provide the review form. The eligibility effective date will go back to the first day of the first month of ineligibility only if all other

eligibility criteria are met for that month. Eligibility for subsequent months within the reconsideration period can still be determined even if the applicant remains ineligible for the initial reconsideration month(s), but eligibility will not be granted any earlier than the month in which all eligibility criteria are met.

(2) For qualified Medicare beneficiaries (QMB), the provisions in subparagraph 76.14(2)*"e"*(1) apply, except that the review form as described at lettered paragraph 76.14(2)*"b"* or *"c"* will be acted upon and treated like an application and the eligibility effective date will be determined pursuant to subparagraph 76.13(1)*"a"*(2).

f. Interview required. An individual whose eligibility is not based on the MAGI methodology may be required to attend an interview to clarify information or to resolve conflicting information. The department will not require an in-person interview as part of the process.

441—76.15(249A) Report of changes. As a continuing condition of enrollment for Medicaid, applicants and current members shall report changes in circumstances as required in this rule.

76.15(1) A change in circumstance that may affect the eligibility of applicants and members must be reported within ten days of the date the change occurred. Changes required to be reported are described in this subrule.

a. In coverage groups for which Medicaid eligibility is determined using the MAGI methodology, any change in the following must be reported:

(1) Income from all sources.
(2) Members of the household.
(3) School attendance.
(4) Mailing or living address.
(5) Receipt of a social security number.
(6) Health insurance premiums or coverage.
(7) Alien or citizenship status.
(8) Federal income tax filing status or claimed dependents for federal tax purposes.

b. In coverage groups for which Medicaid eligibility is not determined using the MAGI methodology, any change in the following must be reported.

EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

(1) Income from all sources.
(2) Resources.
(3) Members of the household.
(4) Recovery from disability.
(5) Mailing or living address.
(6) Health insurance premiums or coverage.
(7) Medicare premiums or coverage.
(8) Receipt of social security number.
(9) Gross income of the community spouse or of the dependent children, parents, or siblings of the institutionalized or community spouse who are living with a community spouse when a diversion is made to the community spouse or family, as those terms are defined in rule 441—75.1(249A).
(10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation, or spenddown.
(11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report changes in their health insurance coverage and changes in their living or mailing address.

d. Individuals receiving Medicaid based on the receipt of Title IV-E-funded foster care, based on an adoption assistance agreement, or based on a guardianship assistance agreement are required to

report changes in health insurance coverage, when their living or mailing address changes, upon receipt of a social security number, and upon termination of the adoption assistance agreement.

e. Individuals receiving state-only funded Medicaid are required to report any change in the following:

(1) Income from all sources.
(2) Mailing or living address.
(3) Receipt of a social security number.
(4) Health insurance coverage.
(5) Alien or citizenship status.

76.15(2) Failure to report. When a change is not reported as required by this rule, any Medicaid expenditures for care or services provided when the member was not eligible will be considered overpayments and subject to recovery from the member.

441—76.16(249A) Action on information received. When a change in circumstance is reported, or when a change in a member's circumstances otherwise comes to the attention of the department, its effect on eligibility will be evaluated and eligibility will be redetermined regardless of whether the report of change was required by rule 441—76.15(249A). When the department has information about an anticipated change in a member's circumstances that may affect eligibility, eligibility will be redetermined at the appropriate time based on such change.

76.16(1) After assistance has been approved, except as provided in subrules 76.16(2) and 76.16(3) or as otherwise stated in 441—Chapter 75 or this chapter, action based on a change reported during a month will be effective the first day of the next calendar month unless timely notice of adverse action is required as specified in rule 441—16.2(17A).

76.16(2) When a request is made to add a new person to the Medicaid household and that person meets the eligibility requirements, assistance will be acted upon pursuant to rule 441—76.12(249A).

76.16(3) When the reported change causes a change in coverage from a Medicare Savings Program coverage group described in 441—subrule 75.6(5) to coverage under Medicaid for employed people with disabilities (MEPD) as described in 441—subrule 75.6(6), the reported change will be effective the first day of the calendar month that the change was reported.

76.16(4) When the change creates ineligibility, eligibility under the current coverage group will be canceled and an automatic redetermination of eligibility will be completed in accordance with rule 441—76.17(249A).

441—76.17(249A) Timeliness requirements for conducting automatic redeterminations of eligibility. Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, the department will automatically redetermine eligibility for other Medicaid coverage groups unless the reason for ineligibility is due to not meeting the requirements in rule 441—76.8(249A). If the reason for ineligibility under the initial coverage group pertained to a condition of eligibility that applies to all coverage groups, no further redetermination will be required. When the redetermination is completed, the member will be notified of the decision in writing. The redetermination process will be completed as follows:

76.17(1) *Information received by the tenth of the month.* If information that creates ineligibility under the current coverage group is received by the department by the tenth of the month, the redetermination process will be completed by the end of that month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group will be the first day of the month following the month in which the information is received, pursuant to rule 441—76.16(249A).

76.17(2) *Information received after the tenth of the month.* If information that creates ineligibility under the current coverage group is received by the department after the tenth of the month, the redetermination process will be completed by the end of the following month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage

group will be no earlier than the first day of the first month following the month in which the information is received, pursuant to rule 441—76.16(249A), but no later than the second month following the month in which the information is received.

76.17(3) *Change in federal law.* If a change in federal law affects the eligibility of large numbers of Medicaid members and the United States Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR §435.1003, the redetermination process will be completed within the extended time limit and the effective date of cancellation for the current coverage group will be no later than the first day of the month following the month in which the extended time limit expires.

These rules are intended to implement Iowa Code chapter 249A.