Department of HUMAN SERVICES

Employees' Manual
Title 5, Chapter A

December 5, 2014

INTERIM ASSISTANCE REIMBURSEMENT

Page

Overview

This chapter lays-out the procedures by which county agencies can be reimbursed by the federal government for providing interim assistance to persons who are waiting for SSI benefits.

"Interim assistance" is assistance provided by a county agency to meet the participant's basic needs during the interim period. (See Definitions: Interim period.) Assistance can be either cash or vendor payments. Payment for basic needs must be made using the same payment standards used for other relief recipients served by the agency.

The chapter explains the administrative requirements for participating in the interim assistance program and the process to apply for and receive reimbursement. The last section deals with how county agencies can receive payment for Medicaid-covered services the county has paid.

Legal Basis

Legal reference: 20 CFR 416.1902, 441 IAC 57.1(249), 441 IAC 57.2(249)

Section 1631 of the U.S. Social Security Act as amended provides that under certain conditions the Social Security Administration may reimburse states and their political subdivisions which have furnished interim assistance in cash or in the form of vendor payments.

The 1984 Iowa General Assembly enacted enabling legislation (1984 Iowa Acts, Chapter 1310, Section 9) to permit the Department of Human Services to implement this program. The Department adopted rules for the program at 441 IAC Chapter 57, "Interim Assistance Reimbursement."

Definitions

Legal reference: 441 IAC 57.1(249)

"Basic needs" means:

- Food
- Clothing
- Shelter
- Medical care and services not covered by Medicaid
- Other essentials of daily living

Basic needs do **not** include:

- Medicaid-covered care or services.
- County payment of social service costs associated with services provided during the interim period.

"Benefits" means the Supplemental Security Income (SSI) benefits or any federally administered State Supplementary Assistance payments that are determined by the Social Security Administration to be due to the person when the SSI payment is made.

"County agency" means a county general assistance agency, veteran affairs agency, or central point of coordination under the jurisdiction of the county which furnishes relief in the form of cash or vendor payments to or on behalf of needy persons in accordance with established standards under the provisions of Iowa Code Chapter 252, "Support of the Poor," or Chapter 35B, "County Commissions of Veteran Affairs."

"Initial payment" means the amount of benefits (including any retroactive amounts) that are determined by the Social Security Administration to be due the person when the initial SSI payment is made.

"Interim period" means the period:

- Beginning with the month following the month in which a person files an application for benefits for which the person is found eligible to receive SSI benefits and ending with (and including) the month the person's benefits begin, or
- Beginning with the day a person's benefits are reinstated after a period of suspension or termination, and ending with (and including) the month the person's benefits are resumed.

The interim period includes processing time on the initial application, as well as any of the appeal levels in the Social Security Administration appeal process if the initial application is denied and that denial is appealed. Any assistance provided before the interim period is not reimbursable.

The interim period does not include any periods during which the person is underpaid by the Social Security Administration due to that agency's failure to make a timely modification of the person's SSI benefit or for any other reason. Interim assistance does not apply to retroactive corrective payment to adjust the amount of a recipient's SSI benefit.

The county agency is not entitled to reimbursement for interim assistance paid for the month in which the application for SSI is filed if the applicant is not eligible for that month. (For example, someone filed for SSI in September but did not attain age 65 until October.)

"Posteligibility payment" means the amount of benefits (including any retroactive amounts) that are determined by the Social Security district office to be due the person following a period of suspension or termination.

Administrative Requirements

The Department of Human Services has entered into an agreement with the federal Social Security Administration (SSA) under which the Department coordinates activities of county agencies in administration of interim assistance reimbursement. The Department:

- Acts as liaison with the SSA Regional Office in Kansas City in matters of policy, and
- Assists in resolution of any disputes arising between SSA and county agencies.

A county agency shall:

- Direct to the interim assistance reimbursement (IAR) program manager in the Department's Iowa Medicaid Enterprise (IME) any questions about policy information in this chapter.
- Direct to the SSA district office any questions or problems relating to:
  - Individual authorizations,
  - Retroactive payments,
  - Non-receipt of SSA reports, and
  - Status of individual cases.

The SSA district office also contacts the county agency directly with any problems.

The following sections address:

- How counties apply for the program
- Certification of authority for the county
- Maintenance and confidentiality of interim assistance records
- Appeal procedures of reimbursement decisions

How to Apply to Participate in the IAR Program

Legal reference: 20 CFR 416.1910, 441 IAC 57.2(249)

A county agency that wishes to participate in the interim assistance reimbursement program should first contact the IAR program manager to indicate a desire to participate.

The county agency must enter into an agreement with the Department. For purpose of the agreement, the administrator of the Iowa Medicaid Enterprise (IME) acts as the designee for the Department's director.

The IAR program manager shall:

- Prepare the agreement with the county agency using form 470-1948, *Interim Assistance Reimbursement Agreement*, for agreements between the state and the county general assistance agency, central point of coordination, or veteran affairs office.
- Send a copy of the agreement to the county agency for signature.

The county agency shall:

- Sign the agreement.
  - The chair of the county board of supervisors must sign the agreement for the county general assistance agency or for the central point of coordination.
  - The chair of the county commission of veteran affairs must sign the agreement for the county commission of veteran affairs.
- Return the original to the administrator of the Iowa Medicaid Enterprise (IME) for signature.

The administrator shall:

- Sign the agreement on behalf of the Department.
- Send one copy of the agreement back to the county agency.
- Keep the other original copy in the Department file for that county.

Certification of Authority

Legal reference: 441 IAC 57.3(249)

The county agency must submit form 470-1947, *Certificate of Authority: Interim Assistance Reimbursement (IAR)*, to:

- The Social Security Administration Regional Office, and
- The IAR program manager.

This form designates officials of the county agency authorized to process interim assistance claims. The Social Security Administration will not process claims when signed by a person whose signature, name, and title are not on file with the SSA Regional Office on form 470-1947.

Form 470-1947 must be submitted:

- Before the county agency receives its first interim assistance reimbursement payment, and
- When any change in authorized officials occurs.

County agencies should report changes of address immediately to the Social Security Administration by writing to:

Social Security Administration
IAR Coordinator
Room 1073, Federal Office Building
601 E. 12th Street
Kansas City, MO 64106

DO NOT OPEN IN THE MAILROOM

In reporting changes of address, always provide the full name of the agency. The county agency should also notify the IAR program manager to update the Department mailing list.

Maintenance and Confidentiality of Records

Legal reference: 441 IAC 57.2(3)

The requirements for maintenance of records and confidentiality are explained in Section VI of form 470-1948, *Interim Assistance Reimbursement Agreement*.

To facilitate operation of the program, the county agency must maintain a log or running record of interim assistance transactions. The log must show:

- The status of any case at a given time with respect to provision of interim assistance,
- Receipt of the reimbursement from the Social Security Administration,
- Payment to the recipient (if due).

See 5-A-Appendix for a sample of form 470-IAR2, *Interim Assistance Reimbursement Summary*. County agencies do not have to use this form, but must maintain a similar running record which contains, at a minimum, the information on the sample form.

Appeals

Legal reference: 20 CFR 416.1920

The county must provide the recipient with the opportunity for a hearing before the county board of supervisors or the county veteran affairs commission on disputes arising from the payment from the Social Security Administration.

Form 470-1949, *Notice of Interim Assistance Payment*, explains that the request for a hearing must be made no later than 30 days following the date on the form. Each county agency must use its usual procedures regarding filing an appeal and conducting a hearing.

Reimbursement Process

Legal reference: 441 IAC 57.2

An applicant for interim assistance must authorize the county agency to receive the applicant's initial payment or initial posteligibility payment of SSI or State Supplementary Assistance for reimbursement of county expenditures. (See **Definitions:** Initial payment and Posteligibility payment.)

Reimbursement to the county agency may occur after ongoing monthly payments begin when the retroactive payment due is deferred pending Social Security Administration reverification of payment accuracy for the retroactive period.

An emergency advance payment or a payment based on presumptive disability or presumptive blindness is not considered to be the initial SSI payment for interim assistance reimbursement purposes. Emergency or presumptive disability or blindness payments are issued directly to the applicant.

The following sections explain:

- Obtaining the applicant's authorization for withholding benefits for reimbursement
- How reimbursement payments are made
- Notification by the Social Security Administration

Obtaining the Applicant's Authorization

Legal reference: 20 CFR 416.1904, 20 CFR 416.1906, 20 CFR 416.1908, 441 IAC 57.2(2)

The county agency must obtain written authorization from the person for the Social Security Administration to withhold the person's initial payment or initial posteligibility payment and make these payments payable to the county agency.

The agency must obtain the authorization on form 470-1950, *Authorization for Reimbursement of Interim Assistance Initial Claim or Posteligibility Case*.

Applicants use these forms to indicate the intent to apply for SSI benefits. The Social Security Administration designates the county agencies to accept these forms, which protect the person's filing date for SSI benefits. The county agency must mail the original copy of these forms to the district office of the Social Security Administration serving that county within 30 calendar days.

For interim assistance reimbursement purposes, each eligible member of a couple is treated as an individual. Each one must sign an authorization. The Social Security Administration issues separate reimbursement checks for each person.

If a county agency sends an authorization to the Social Security Administration district office for a person who does not have a claim pending for SSI, the district office treats the authorization as a lead. Authorization in this case serves as a written statement of intent to file an application for SSI benefits. This statement establishes and protects the effective date of application.

The Social Security Administration does not process interim assistance authorizations if the applicant previously authorized reimbursement to another agency, based on the same application, and the prior authorization has not been withdrawn. In this event, the Social Security Administration returns the authorization to the second agency.

If the person's claim for SSI benefits is denied, that is the final determination. If the decision is reversed on appeal, the appeal decision then becomes the final determination.

If the person files a new application rather than an appeal, a new authorization is required for the county agency to be reimbursed. If the new application is approved, the county agency's reimbursement is only for assistance granted from the month of the new application.

Effective Date of Application

The effective date of protective filing is the date the Social Security Administration district office receives the signed authorization. If it later develops that the person does not wish to file for SSI, the Social Security Administration returns the authorization to the county agency.

When an Authorization Can Be Withdrawn

When a person signs an authorization, the person cannot withdraw or cancel it unless both the person and the county agency agree in writing to withdraw the authorization. The Social Security Administration district office refers anyone requesting withdrawal to the county agency.

If the person and the county agency mutually agree to withdrawal of the authorization, the county agency sends a copy of the signed agreement, together with a letter of transmittal to the Social Security Administration district office.

How Payments Are Made

Legal reference: PL 104-193

The Social Security Administration provides for interim assistance reimbursement to county agencies by direct deposit to the agency's bank account.

Public Law 104-193 requires past due benefits be paid in installments when past-due benefits exceed 12 times the federal benefit rate plus any state supplement. Therefore, the Social Security Administration will not send the past-due benefits to the county agency.

The Social Security Administration prorates the first month's SSI payment based on the actual day of the month all eligibility requirements are met. Likewise, the county agency may be reimbursed for the period beginning with the day that the person filed an application for SSI benefits and was found eligible. This could result in proration of interim assistance paid in the first month of SSI eligibility.

After the county agency receives reimbursement, the Social Security Administration will issue any residual amount to the client. However, if the remainder still exceeds 12 times the federal benefit rate, the Social Security Administration will issue the remainder to the client in installments.

NOTE: The county agency shall return any interim assistance funds incorrectly received to the Social Security Administration district office serving that agency.

Regardless of how interim assistance is provided to the county agency, the county agency must provide each person with a written explanation on the form 470-1949, *Notice of Interim Assistance Payment*. The notice shows:

- The amount of the Social Security Administration's payment to the county agency.
- The amount the county agency retained for reimbursement.

The fact that a warrant or voucher was written for specified goods or services and in a specified amount is considered a commitment of county funds as of the date of the warrant or voucher. If the date falls within the interim period, this amount may be claimed as interim assistance reimbursement without waiting for the provider to submit a claim.

However, the county agency may not claim reimbursement if the recipient decides not to cash the warrant or voucher.

The county agency may claim interim assistance reimbursement only for assistance paid **to or in behalf of** the SSI-eligible person. If any of the vouchers or orders issued include the needs of any other family members, the county agency must determine what fractional part was for the SSI-eligible person and claim reimbursement only on that part. For example, if a grocery order is issued for a family of three, the SSI-eligible person's share is one-third.

Payment for Medicaid-covered services for an interim assistance participant cannot be deducted from an interim assistance payment, even if Medicaid will not be billed for the cost of the medical services. See SSI-Related Medicaid Reimbursement, Not IAR for policies and procedures a county agency can use to recover expenditures for Medicaid-covered services for interim assistance participants.

If the county pays for medical service that Medicaid would not cover, this payment can be deducted from the interim assistance payment. (Examples include multiple vitamins and over-the-counter drugs.)

If a Recipient Dies or Cannot Be Located

If a recipient dies or disappears before receiving the SSI benefit, the county agency retains the right to receive benefits due for the retroactive period.

Social Security Administration Notification

Legal reference: SSA POMs Manual

The Social Security Administration uses the following language in a notice sent directly to the recipient when the retroactive check is issued to the county agency:

> "We are sending your first Supplemental Security Income (SSI) check of $_____ to your county agency. You agreed in writing to have your first SSI check sent to that agency because they paid you for _____.
>
> If the county agency paid you less than $_____ for that _____, they will pay you the difference shortly. If you do not receive the difference within two weeks from the date you receive this letter, please contact that agency."

The county agency will receive a *Notice of Interim Assistance Reimbursement* on every case where the person has signed an interim assistance authorization which the Social Security Administration has processed before final determination on SSI eligibility.

When an applicant is entitled to past-due benefits that exceed 12 times the federal benefit rate, the Social Security Administration sends an email message when the person's award or reinstatement is processed. This message:

- Indicates the disposition of the person's SSI application (i.e., denial or award).
- Contains a monthly breakdown of the SSI payments for the retroactive period.
- Provides the county with a way to account on an individual-case basis for the disposition of interim assistance reimbursement funds received.

The county agency should receive this message concurrently with or within a few days of receipt of the initial retroactive check. In any case where the agency does not receive the form within six days of receipt of the SSI payment, report this to the Social Security Administration district office.

The Social Security Administration regional office in Kansas City will contact the county agency directly with any questions relating to the county agency's completion of the form 470-1949, *Notice of Interim Assistance Payment*.

SSI-Related Medicaid Reimbursement, Not IAR

County agencies can receive reimbursement for Medicaid-covered services provided to a client once the client becomes eligible for SSI-related Medicaid.

NOTE: This is a completely separate process from the SSI interim assistance reimbursement program discussed earlier in this chapter. The only relation between the two programs is the disability determination process and the eligibility dates. See also 8-A, *Reimbursement After Appeal Decisions*.

The following sections address:

- Reimbursement after appeal decisions (for bills in the appeal period)
- Agency reimbursements from providers (for all bills in eligible period)
- Assignment of Medicaid claims (for all bills in eligible period)

Reimbursement After Appeal Decisions

Legal reference: 441 IAC 75 (Rules in Process)

County agencies can receive direct reimbursement for certain paid medical bills. When an appeal decision by the Department or the Social Security Administration on an eligibility issue favors a client, county agencies are entitled to reimbursement if:

- The medical bills were for services covered by Medicaid. The Iowa Medicaid Enterprise (IME) determines whether the medical bills are covered by Medicaid and the Medicaid rate.
- The medical bills were actually paid in the appeal period (the time between the date of denial of the initial application and the issuance date on the *Notice of Decision* or *Notice of Action* that approves Medicaid).
- The medical bills were for services incurred in the period now determined to have been denied in error. The period of eligibility can be as early as the first of the third month before the month of application. The ending date is the date on the *Notice of Decision* or *Notice of Action* that approves Medicaid eligibility.

This policy does not apply to appeals resulting from cancellation of ongoing cases. It applies only to denied applications.

1-6-09	Application for SSI filed.
6-16-09	Application denied.
7-5-09	Request for reconsideration filed (part of Social Security appeal process).
8-15-09	Denial after reconsideration.
9-10-09	Request for hearing filed.
12-4-09	SSI approved due to hearing. Eligibility granted back to date of SSI approval (2-1-09).
3-4-10	Medicaid approved on a Department *Notice of Decision* or *Notice of Action* issued 3-4-10. As there were unpaid medical bills for services received in each of the three retroactive months and all Medicaid eligibility criteria were met in those months, Medicaid is approved back to 10-1-08. (If there were no unpaid bills in those months, eligibility would begin 1-1-09.)

The "appeal period" is the time between June 16, 2009 (the date the initial SSI application was denied) and March 4, 2010 (the date Medicaid was approved).

Period of Eligibility

Retroactive Period	Application Period		Appeal Period		Approval Date	
10-1-08 to 12-31-08	Application date: 1-6-09	Denial date: 6-16-09	6-17-09	3-3-10	3-4-10	
Any Medicaid-covered services received in and paid for in this period cannot be reimbursed.			Any Medicaid-covered services received and paid for in this period can be reimbursed.		The medical provider must submit bills for unpaid medical services received on or after this date to the Iowa Medicaid Enterprise for payment.	
Any Medicaid-covered services received in this period but…			paid in the appeal period can be reimbursed.			

There is no retroactive limit on bills that can be reimbursed under this policy, as long as the requirements listed above are met.

Bills That Cannot Be Reimbursed

Legal reference: 441 IAC 75 (Rules in Process)

Medical bills cannot be reimbursed if a person or agency paid the bill and the member does not have to repay the money. Examples include when:

- The member receives insurance payments.
- A provider refunds the member and bills Medicaid.
- The member receives a legal settlement that designates funds for medical bills.

Medical bills that county agencies pay for a member cannot be reimbursed if:

- The member is repaying the county.
- The provider refunds the agency and bills Medicaid.
- The medical bills are for prescription drugs covered by Medicare Part D. When a person is eligible for both Medicaid and Medicare, Medicare Part D, implemented January 1, 2006, pays for most prescription drugs.

Reimbursement Process

Members and county agencies use form 470-2224, *Verification of Paid Medical Bills*, to file a claim.

When the form is returned to the IM worker with necessary documentation, the IM worker completes Section II of the form, according to instructions in 6-Appendix and submits the form with original signatures to the IAR coordinator at the Iowa Medicaid Enterprise (IME) within 60 days.

Payment is issued from the Iowa Medicaid Enterprise. When the county agency paid the provider, reimbursement is made directly to the agency. When the member (or someone acting on the member's behalf) paid the provider directly, reimbursement is made directly to the member.

A Medically Needy member can choose whether to receive the reimbursement or to allow the bills to be applied to spenddown. However, reimbursement is not made unless the spenddown has been met. Explain the options to Medically Needy members.

Agency Reimbursement From Providers

A county agency can request a provider to reimburse the agency and bill Medicaid for Medicaid-covered services when a member has recently been approved for SSI-related Medicaid. NOTE: A provider is not required to honor this request.

When a county agency asks a provider to reimburse the agency and bill Medicaid for services, the county agency must provide billing documentation that the provider may need.

- If a bill is less than a year old, instruct the provider to bill Medicaid in the normal fashion.
- If the bill is more than one year old, the claim should be submitted to Iowa Medicaid Enterprise (IME), Exception Processing, 611 5th Avenue, Des Moines, Iowa 50309. Attach a written statement from the DHS worker that lists:
  - The months the member is eligible and
  - The date the Department approved Medicaid.

Assignment of Medicaid Claims

County assistance agencies can receive Medicaid payment for medical services when the county has paid a Medicaid-enrolled medical provider for medical services provided to an interim assistance participant. The following sections give more information on:

- Requirements for assigning Medicaid payments to a county agency
- Identification of the bills that can be recovered through assignment

Requirements for Assignment

Legal reference: 441 IAC 80.6(249A), 441 IAC 80.6(2)

To receive payment for Medicaid services, the county agency enters into a signed agreement with the medical provider that transfers the provider's claim for Medicaid payment for the services to the county agency.

The provider must have a Medicaid provider agreement and the services must be covered by Medicaid. The county agency must have paid the medical provider for the medical services.

The county agency must also have a Medicaid provider number to receive payment. To obtain a provider number, submit a request to the IME Provider Services Unit that includes:

- Name and address of the county agency as it is to be printed on the warrant issued for payment of the claim.
- The county agency's federal tax identification (ID) number.
- A statement that reads: "I certify the information provided is true and accurate. By signing this I attest that Medicaid claims submitted by this agency will be for persons determined eligible for Medicaid for the date of service."
- Signature of the county agency director.
- Date of signature.

Send the request to Iowa Medicaid Enterprise, Provider Correspondence, PO Box 36450, Des Moines Iowa 50315. Incomplete submissions will be returned.

The medical provider must complete an acceptable Medicaid claim for the services.

If Medicaid is approved, submit the Medicaid claim for payment. Attach a copy of the *Notice of Decision* or *Notice of Action* sent to the member that approved the member for Medicaid. Do not submit claims before Medicaid approval.

Enter your assigned provider number on the Medicaid claim in the space provided for this number. Make sure this is the county agency's provider number, not the number of the medical provider.

The following statement must be on each claim submitted for payment to attest that the person is Medicaid-eligible for the time period of the claim: **"***The client named on this claim is Medicaid-eligible for the date of service on this claim.***"** The county agency staff person will sign and date the statement.

Submit Medicaid claims for payment to the Iowa Medicaid Enterprise. Payment to the county agency will be based on the established Medicaid rates at the time services were provided.

Payments That Can Be Recovered Through Assignment

For interim assistance reimbursement participants, all bills paid by the county for Medicaid-covered services provided on or after July 1, 1994, in the interim period for people found Medicaid-eligible can be recovered through assignment.

This includes all periods determined to be eligible periods as a result of interim assistance reimbursement participant's SSI approval, up to the date the Department of Human Services issues the decision to approve Medicaid. Example:

<table>
<tr><th colspan="2">Application Period</th><th colspan="2">Appeal Period</th><th>Date of DHS Notice Approving Medicaid</th></tr>
<tr><td colspan="2">7-6-06 to 11-16-06</td><td colspan="2">11-17-06 to 8-9-07</td><td>8-10-07</td></tr>
<tr><td>Initial application date</td><td>Application denial date</td><td>12-30-06
Date appeal is filed</td><td>7-3-07
Date appeal decision reversed denial back to date of application</td><td></td></tr>
<tr><td colspan="4">The county agency can submit to Medicaid for payment any Medicaid-covered services received in this period, if the agency entered into an assignment agreement with the medical provider and the agency has obtained a Medicaid provider number.</td><td>The medical provider must submit bills for medical services received on or after this date to the IME for payment.</td></tr>
</table>

For non-interim assistance reimbursement participants who attained initial eligibility through appeal, certain bills for Medicaid-covered services can be paid through assignment. The bills must:

- Be for services on or after July 1, 1994, rendered during the period determined to be an eligible period through the appeal process.
- Have been paid between the date of initial denial and the date Medicaid was approved by the Department of Human Services.

<table>
<tr><th>Retroactive Period</th><th>Application Period</th><th>Appeal Period</th><th>Date of DHS Notice Approving Medicaid</th></tr>
<tr><td>4-1-06 to 6-30-06</td><td>7-6-06 to 11-16-06
Initial application date — Application denial date</td><td>11-17-06 to 8-9-07
12-30-06 Date appeal is filed — 7-3-07 Date appeal decision reverses denial (back to date of application)</td><td>8-10-07</td></tr>
<tr><td colspan="2">Any Medicaid-covered services received in and paid for in this period cannot be paid through assignment.</td><td>Any Medicaid-covered services received and paid for in the appeal period may be paid through assignment.</td><td rowspan="2">The medical provider must submit bills for medical services on or after this date to IME for payment.</td></tr>
<tr><td colspan="2">Any Medicaid covered services received in this period.....</td><td>but paid in the appeal period can be paid through assignment.</td></tr>
</table>