STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
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Medicaid
Administration

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Overview

This chapter provides general administrative information about Iowa's Medicaid program. The Medicaid program is a health care payor: It pays for health care services and long-term care services and supports vulnerable Iowans who are eligible.

The Medicaid program is funded by federal and state governments and is managed by the Iowa Department of Human Services (referred to as "the Department" or "DHS"). The Department's Medical Services Division leads the Iowa Medicaid Enterprise, which administers the Iowa Medicaid Program.

A wide range of medical and health services are available through the Iowa Medicaid program. Services are covered only if they are medically necessary. Medicaid members have free choice of a doctor, dentist, pharmacy, and other providers of services. NOTE: People who are eligible for both Medicaid and Medicare receive prescription drug coverage through Medicare Part D.

A provider that chooses to participate in the Medicaid program must accept the payments that Medicaid makes and make no additional charges to the member for services covered under the program.

Federal policies for the Medicaid program are in the Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Parts 430 through 489. Iowa Code Chapter 249A authorizes Iowa's participation in the program. The policies specific to the Medicaid program are in Iowa Administrative Code (IAC) 441, Chapters 73 through 91.

This chapter describes:

- Department responsibilities for:
  - Setting Medicaid eligibility policies and determining member eligibility,
  - Determining what services are covered and paying claims, and
  - Meeting Medicaid administrative requirements;
- Appeal policies; and
- Information about other programs that provide benefits to Medicaid members.

Definitions

"Aged" means a person who is 65 years of age or older.

"Applicant" means a person who is requesting medical assistance on the person's own behalf, or a person for whom medical assistance is requested, or a person requesting medical assistance on behalf of another person.

"Blind" for Non-MAGI-related or Social Security Administration purposes, means a person must have central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Client" means any of the following:

- A Medicaid applicant,
- A Medicaid member,
- A person who is conditionally eligible for Medicaid, or
- A person whose income or assets are considered in determining eligibility for an applicant or member.

"Client participation" is the amount the client is required to pay for care in an institution.

"CMAP" means the Child Medical Assistance Program and is used only for children under age 21 either placed in licensed foster care for whom non-IV-E foster care maintenance payments are made or with non-IV-E adoption assistance with Iowa or with a state with which Iowa has a reciprocity agreement.

"Common-law marriage" is a legal and valid marriage in Iowa. When a common-law marriage exists, the department views the adults the same as any other married couple. Accept a couple's attestation that a common-law marriage exists unless questionable. See 8-I, Determining if a Common-Law Marriage Exists, for more information.

"Community spouse" means a person who is not in an institution or on a waiver but who is married to a person who is in an institution or is applying for or receiving waiver services or PACE.

"Coverage group" means a group of persons who meet certain common eligibility requirements.

"CSRU" means the Child Support Recovery Unit (the Department's Bureau of Collections, including its field offices).

"Department" means the Iowa Department of Human Services.

"Dependent" means a person who can be claimed by another person as a dependent for federal income tax purposes. (Dependent person for the State Supplementary Assistance Program is defined in 6-B).

"Dependent children" means children who meet the nonfinancial eligibility requirements of the applicable MAGI-related coverage group.

"Disability Determination Services" or **"DDS"** is a state agency in the Division of Vocational Rehabilitation Services of the Iowa Department of Education. The Department has an agreement with DDS to determine disability for State Supplementary Assistance and NonMAGI-related Medicaid.

"Disabled person" for NonMAGI-related or Social Security Administration purposes, is a person who is unable to engage in substantial gainful activity because of a physical or mental impairment that has lasted or is expected to last for 12 continuous months or result in death. EXCEPTION: The MEPD coverage group does not apply the substantial gainful activity test to determine disability. A disabled person must meet only the physical or mental impairment criteria.

"Electronic Data Sources" or **"EDS"** means federal and state data sources with which the department conducts data matches for the purpose of determining eligibility. Federal data sources include Internal Revenue Service (IRS), Social Security Administration (SSA) and Department of Homeland Security. State data sources include IWD Wage and Unemployment Compensation, SSA, IRS, and Public Assistance Reporting Information System (PARIS).

"Eligibility Integrated Application Solution" or **"ELIAS"** is the system used by the Department to determine Medicaid eligibility.

"E-SLMB" means the NonMAGI-related expanded specified low-income Medicare beneficiary coverage group.

"Family Investment Program" or **"FIP"** is the name of Iowa's Temporary Assistance for Needy Families program. The purpose of FIP is to provide financial and other assistance to needy, dependent children and the parents or relatives with whom they live.

"Federal financial participation" (FFP) is the rate at which the federal government reimburses the state for providing Medicaid services.

"Family-related Medically Needy" describes the Medically Needy coverage group whose eligibility criteria are derived in relation to the Family Medical Assistance Program, directed toward pregnant women, children, and their parents or caretakers, except for excess income.

"Intermediate care facility for people with mental illness" or **"ICF/MI"** means an intermediate care (nursing) facility for people with mental illness.

"Iowa Health and Wellness Plan" or **"IHAWP"** means the coverage group directed toward the adult population of individuals ages 19 through 64.

"IME" means the Iowa Medicaid Enterprise.

"Institutionalized spouse" means a married person who lives in a medical institution or nursing facility, or participates in a home- and community-based services waiver (or PACE) and who is likely to remain living in these circumstances for at least 30 consecutive days and whose spouse is not in a medical institution or nursing facility, on a waiver program, or PACE. "Spouses" include people who are married under state law or common law and people who are separated.

"Intermediate care facility for persons with an intellectual disability" or **"ICF/ID"** means a medical institution used primarily for the diagnosis, treatment, or rehabilitation of people who have an intellectual disability. In a protected residential setting, the facility provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or related services to help each resident function at the resident's greatest ability.

"Local office" means the county office of the Department of Human Services, or a state mental health institute, or hospital school.

"MAC" means the MAGI-related mothers and children coverage group to pregnant women, infants under age one, and to children who have not reached age 19.

"MAGI" means the modified adjusted gross income.

"MAGI-exempt" describes Medicaid coverage groups for MAGI-related special populations who are exempt from the income test.

"MAGI-related" describes Medicaid coverage groups for pregnant women, children under 19, parents and caretakers, and the adult population (IHAWP).whose eligibility criteria are derived from the MAGI tax-based methodology determination.

"Managed care organization" or **"MCO"** means an organization that provides members with comprehensive health care services, including physical, behavioral, and long term care services and supports. MCOs make these services available to the member for a fixed monthly rate (capitation payment) that is paid by Medicaid.

"Medicaid for Kids with Special Needs" or **"MKSN"** means a medical coverage group for children with disabilities.

"**Medical Assistance Advisory Council"** or **"MAAC"** means the group that advises the Department about health and medical care services and participates in policy development. The MAAC is composed of representatives from:

- Provider groups.
- The General Assembly.
- The Department of Public Health.
- Consumers.
- The public.

Legal reference: 42 CFR 431.12, 441 IAC 79.7(249A))

"Medical institution" means:

- Acute care hospitals
- Psychiatric institutions, including:
    - State mental health institutes (MHIs)
    - Psychiatric hospitals
    - Psychiatric medical institutions for children (PMICs)
- Long-term care facilities, including:
    - Nursing facilities (NFs)
    - Nursing facilities for people with mental illness (ICF/MI)
    - Hospital-based or non-hospital-based skilled nursing facilities (SNFs)
    - Intermediate care facilities for persons with an intellectual disability (ICF/IDs)

Residential care facilities (RCFs) are **not** medical institutions and are not Medicaid providers.

"Medicare savings programs" is a limited Medicaid coverage group assisting low-income people with the payment of Medicare premiums, coinsurance, and deductibles. These groups include QDWP, QMB, SLMB, and E-SLMB.

"Member" means a person who has been determined eligible and has been enrolled to receive Medicaid. Member may be used interchangeably with "recipient".

"MEPD" means the NonMAGI-related coverage group for employed people with disabilities.

"Minimum Essential Coverage" (MEC) means any insurance plan that meets the Affordable Care Act requirement for having health coverage. Examples of plans that qualify include: Marketplace plans; job-based plans; Medicare; and Medicaid & CHIP.

"Modified Adjusted Gross Income" (MAGI) is the tax-based methodology used to determine income eligibility and household size for Medicaid coverage groups for pregnant women, children under 19, parents and caretakers, and the adult population (IHAWP).

"Needy specified relative," means a non-parental specified relative, as listed in 8-C, Specified Relatives, who meets all the eligibility requirements to be included in the family-related Medically Needy eligible group.

"NonMAGI-related" describes Medicaid coverage groups whose eligibility criteria are derived from the Supplemental Security Income (SSI) program for people who are aged, blind, or disabled, except for income and resource limits.

"Nursing facility" or **"NF"** means a medical institution that provides care for people who need nursing care and other services in addition to room and board because of their mental or physical condition.

"PACE" means a program for all-inclusive care for the elderly. A PACE provider receives a monthly capitated payment for enrollees and is responsible for ensuring that enrollees receive any services determined necessary for their health and well-being.

"Parent" means a natural or biological parent, an individual legally recognized as the parent of a child based on the conception, gestation, or birth of the child during a legal marriage, an adoptive parent, or the spouse of another parent (step-parent), unless parental rights have been legally terminated.

"PMIC" means a psychiatric medical institution for children.

"Prudent-person concept" refers to the authority given to the income maintenance workers to review and analyze information given by the client and decide whether the information is sufficient for making an eligibility determination, or if further checking should be done. The "prudent person" must be vigilant, cautious, perceptive, and guided by generally sound judgment.

"QDWP" means the NonMAGI-related coverage group for qualified disabled and working people.

"QMB" means the NonMAGI-related qualified Medicare beneficiary coverage group.

"Reasonable Compatibility" means the standard by which the total attested countable income for each person's household size is compared with the total amount from available Electronic Data Sources used by DHS. In order for attested income to meet the standards for 'reasonable compatibility' it must meet one of three criteria:

- Both the total attested income and the total income from the Electronic Data Sources are above, at, or below the applicable income limit for Medicaid or HAWK-I, or
- The total attested income is within 10% of the total income from Electronic Data Sources, or
- The total attested income exceeds the total income from electronic data sources.

If the attested income meets any of the reasonable compatibility criteria, the income is considered to be verified. "Reasonably compatible" is another term used in place of "reasonable compatibility" and carries the same meaning as "reasonable compatibility".

"RCF" means a residential care facility licensed by the Iowa Department of Inspections and Appeals.

"Recipient" means a person who is receiving assistance, including receiving assistance for another person (also referred to as a "member").

"Recovery" is the process by which an overpayment is collected from the client. Department staff are responsible for establishing the amount of the overpayment and making the referral to the Department of Inspections and Appeals. DIA is responsible for collection actions.

"Retroactive period" means the three calendar months immediately preceding the month in which a Medicaid application is filed for:

- A pregnant woman
- An infant (under one year of age)
- A child under 19 years of age
- A resident of a nursing facility licensed under Iowa Code chapter 135C

"Retroactive certification period" is one, two, or three calendar months before the month in which application for Medicaid is filed. Under Medically Needy, the retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately before the month of application.

"SLMB" means the NonMAGI-related specified low-income Medicare beneficiary coverage group.

"SNF" means a nursing facility certified to provide skilled care under the Medicare program.

"Spouse" is a legally married person under state law. This includes common-law and separated spouses.

"State Data Exchange" or **"SDX"** means the system by which the Social Security Administration transmits information related to SSI or federally administered State Supplementary Assistance beneficiary eligibility and benefit amounts to the beneficiary's state of residence. The SDX file is designed to disperse SSI eligibility data from the Department central office to the local office.

"State Supplementary Assistance" or **"SSA"** means a program that provides cash payments for aged, blind, or disabled people who have a certain need that is not met by SSI basic payments. The policies governing this program are based on SSI policies.

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent by ceremonial or common-law marriage. A stepparent is considered a "parent" for the purpose of determining eligibility under a coverage group that is subject to MAGI methodology.

"Supplemental Security Income" or **"SSI"** means federal cash payments issued by the Social Security Administration to aged, blind, or disabled people to bring the person's total income up to a prescribed level based on living arrangement. To qualify for SSI, the person's income and resources must fall within limits established by federal law.

"Supply" means that the Department receives the requested information by the specified due date.

"Third-Party Liability Unit" is a unit at the Iowa Medicaid Enterprise or a unit within the MCO that has responsibility to identify any third-party financial source that would pay medical bills.

"Third-party payments" are payments made by a party other than Medicaid or the client for medical expenses that otherwise would be met through the Medicaid program.

"Waiver services" are medical services provided to people who need at least nursing level of care but who are not living in an institution.

Eligibility

The Department's Iowa Medicaid Enterprise (IME) is responsible for formulating Medicaid eligibility policy and procedure within the framework of state and federal law and regulations. See Chapter 8-F, *Coverage Groups*, for more information on ways that people can qualify for Medicaid benefits.

The Department is organized into five geographic service areas, each led by a service area manager. Income maintenance workers in the Department's service areas determine Medicaid eligibility. However, in certain circumstances, eligibility determination is done by staff of the Social Security Administration or by qualified providers.

Service areas are responsible for maintaining the Medicaid eligibility records for all members. Each member's case is processed by an income maintenance worker, who enters eligibility information into a centralized automated system.

Medical Assistance Eligibility Card

Legal reference: 441 IAC 76.13(2), 441 IAC 80.5(1)

The Department issues a *Medical Assistance Eligibility Card*, form 470-1911, to all Medicaid members. The *Medical Assistance Eligibility Card* is issued at time of approval (or when spenddown is met for a medically needy person).

EXCEPTIONS:

- Members determined presumptively eligible for Medicaid have form 470-2580 or 470-2580(S), *Presumptive Medicaid Eligibility Notice of Action*, as evidence of eligibility rather than the *Medical Assistance Eligibility Card*.
- An individual who is eligible only for limited emergency Medicaid for aliens will be issued a Notice of Action, form 470-0485, 470-0485(S), 470-0485(M), or 470-0485(MS), which will include certification information.

The card lists the member's name, state identification number, and date of birth. Replacement cards can be issued upon a member's request.

Only the member named on the card can use the card. Members are responsible for:

- Notifying the provider of service that they are Medicaid members.
- Showing the card or providing the health care provider with information needed to verify Medicaid eligibility.

Providers must check ELVS or the web portal to identify existing health insurance coverage and any service restrictions, such as lock-in. Services are covered only when provided under the Medicaid coverage group under which the member enrolled.

Eligibility Verification System

The Department's Eligibility Verification System (ELVS) and secure web site allow a provider to verify:

- 24 months of member eligibility.
- Eligibility for PACE enrollees.
- Eligibility for qualified Medicare beneficiaries.
- Conditional eligibility for Medically Needy members.
- The amount of spenddown balance for Medically Needy.
- Managed Care (MCO) coverage
- Third-party resources.
- Lock-in restrictions.
- The date and amount of the provider's last remittance.

The ELVS telephone number for the Des Moines area is **515-323-9639** and for the rest of the state is **1-800-338-7752**. A touch-tone phone is needed, and providers must know:

- Their provider number,
- The date of service, and
- Either the member's state identification number or the member's date of birth and social security number.

To set up access to the secure web site, providers must contact EDISS at **1-800-967-7902**.

Benefits

Members who are not required to be in managed care and are not PACE enrollees have primary responsibility to find and select providers who accept Medicaid. If a member asks you for help in finding a provider, refer the member to https://dhs.iowa.gov/ime/members/find-a-provider.

Coverage of Medicaid services is explained in more detail in 8-M, *Medicaid Services*, and in 8-F, *Coverage Groups*. If the member asks you about coverage of a particular service, refer the member to https://dhs.iowa.gov/ime/members/what-services-are-available.

Iowa Medicaid Enterprise

To learn more about IME and to visit the Contact Directory, go to https://dhs.iowa.gov/ime/about.

When Members Are Responsible for Payment of Medical Bills

Legal reference: 441 IAC 79.1(13), 441 IAC 79.9(4), 441 IAC 80.4(1), 441 IAC 80.5(1)

The member is responsible for paying for all or part of medical services when:

- Medicaid does not cover the services.
- The member receives services during a period when the member was not eligible for Medicaid.
- The provider does not participate in Medicaid. Members are responsible for making sure their providers accept Medicaid.
- A specified copayment is required.
- The bill is used to meet spenddown for the Medically Needy coverage group.
- The member is enrolled in an MCO and uses a provider who is not on the MCO's list of providers.
- The member fails to notify the provider of the member's Medicaid eligibility during the Medicaid claim-filing period. EXCEPTION: The member is **not** responsible for payment if the length of time for determination of retroactive eligibility prevents a member from timely informing the provider.
- The member is enrolled in the PACE program and uses a non-PACE provider for nonemergency services.

For more information on member responsibilities and copayments, go to:

- If enrolled in an MCO; https://dhs.iowa.gov/iahealthlink/benefits and click on Member Managed Care Program Handbook.
- If fee-for-service (FFS); https://dhs.iowa.gov/ime/members/FFS and click on Your Guide to Medicaid Fee-for-Services (FFS).

Recovery

Legal reference: 42 CFR 435.930(b) and 455.12, Iowa Code Section 249A.53, 441 IAC 75.28(2) and 76 (Rules in Process)

Policy: The Department is responsible for recovering overpayments from a member for all Medicaid funds incorrectly paid to or on behalf of the member. The Department also recovers overpayments from providers. Provider overpayments are processed by the Iowa Medicaid Enterprise (IME).

The Department is also responsible for recovering medical assistance paid on behalf of the member from the estates of deceased Medicaid members. See 8-D, *Estate Recovery*, for information on when estate recovery applies.

Comment: Member errors, agency errors, or administrative errors can result in incorrect expenditures. Examples of situations in which overpayments occur are:

- Services were incorrectly provided because the member was ineligible.
- The member loses an appeal, and assistance was continued pending the decision.

Procedure:

1. Determine the period of time during which the overpayment occurred.
    - When the overpayment is caused by an **agency** error, go back to the month the error was made and redetermine eligibility as it should have been determined from that point forward.

> Mr. A receives his first check from XYZ Inc. on January 23. He reports the new job on January 25. The worker forgets to verify the income from the new job until the case is pulled for the annual review in July. The worker verifies the income at that time.
>
> The process that should have taken place is: The worker would have written a letter to Mr. A requesting verification of the new job and allowed ten days to return the verification. The due date would have been in early February. Once the verification was received, if there was a change in eligibility, it would have been effective March 1, allowing a ten-day notice for any negative action.
>
> If the worker had acted timely on the new job report, eligibility would not have been affected until March 1. Therefore, if an overpayment exists, it would begin effective March 1 because it was an agency error.

- When the overpayment is caused by a **member** error, go back to when the error occurred and redetermine eligibility as if the information was timely reported. If an overpayment exists, it begins the month following the month of the member error. EXCEPTION: When the member does not report the receipt of a lump-sum payment timely, the overpayment begins the month the lump sum was received.

> 1. The worker discovers at the annual review in July that Mr. B began a new job at XYZ Inc. the previous January and didn't report it. Mr. B received his first check from XYZ Inc. on January 13. He did not report this income within ten days of receipt of his first check. If an overpayment exists, it would begin effective February 1.
> 2. Same as Example 1, except Mr. B received the first check on January 23 and did not report the receipt of his first check until March 1. If an overpayment exists, it would begin effective February 1.

2. If the reason for the Medicaid overpayment is because of any type of income for any household member, including "absent parent" in the home or an unreported spouse:
   - Request income information and give them ten days to provide the information.
   - Explain to the member that failure to provide the income information would:
     - Result in the Department not being able to determine eligibility, and
     - Result in a larger overpayment.
3. Send a letter requesting verification. If the member does not provide information, all benefits are subject to recoupment.
4. When income information is provided, determine if family members continue to be Medicaid eligible. Use the information that is now available to determine eligibility and the overpayment.
5. If family members are over income for Medicaid, determine the spenddown amount for Medically Needy for each certification period. This is not a matter of whether the person wants Medically Needy or not, but is a matter of calculating the correct overpayment amount. See Medically Needy Overpayment.
6. If the household received Medicaid but was ineligible, calculate an overpayment.
7. Complete the Initial Claim Entry on line. EXCEPTION: For overpayments before July 1, 1997, contact central office for assistance.
8. Wait to determine the amount of the Medicaid overpayment for six months after the "To Date" on the claim to allow time for claims to be submitted. (While providers have 12 months to submit a claim, the majority of Medicaid claims are submitted in the six-month period after service is given.) See Amount to Recoup.

Comment: See 6-G for information about how to establish a claim for an overpayment, repayment options available to members, and types of collection actions.

Members usually repay the Department directly. In the case of overpayment due to incorrect calculation of client participation for a member in a nursing facility, PMIC, ICF/ID, or mental health institute, the member repays the facility. The Department then recovers the funds from the facility through a vendor adjustment. See 8-I, *Client Participation*.

Amount to Recoup

Policy: Consider the following when determining the Medicaid claim amount:

When:	**Recoup:**
The overpayment was a member error, and the member is completely ineligible for Medicaid…	All Medicaid claims paid, including capitation fees.
The overpayment was an agency error…	All Medicaid claims paid **except** for capitation fees.
The member is ineligible for full Medicaid but continues to be eligible for Qualified Medicare Beneficiary (QMB)…	All Medicaid claims, including capitation fees. **Do not** include Medicare Part A or Part B premiums, Medicare deductibles, Medicare copayments or co-insurance.
The member is ineligible for full Medicaid but continues to be eligible for Specified Low-Income Medicare Beneficiary (SLMB)…	All Medicaid claims, including capitation fees. **Do not** include Medicare Part B premiums.
The member is ineligible for HCBS waiver services but continues to be eligible for Medicaid…	Claims paid for HCBS waiver services only.
The member is ineligible for nursing facility services but continues to be eligible for Medicaid…	Claims paid for nursing facility services only.
The member is not eligible for full Medicaid, but would be eligible for Medically Needy with a spenddown…	Medicaid claims paid up to the spenddown amount, plus claims paid for any waiver or any nursing facility services. If the member continues to: ▪ Be eligible for QMB **do not** include Medicare Part A or Part B premiums, Medicare deductibles, Medicare co-payments or co-insurance. ▪ Be eligible for SLMB **do not** include Medicare Part B premiums. See Medically Needy Overpayment for more information.
The member is ineligible because the member is an inmate in a public institution…	All Medicaid claims paid including capitation fee. **Do not** include inpatient hospital services that are provided at a nonpenal institution.
The member is eligible for Medicaid but not eligible for residential care facility assistance…	Claims paid for State Supplementary Assistance only.

Medically Needy Overpayment

Policy: When income information is provided, the amount of the overpayment shall not exceed the amount of the Medically Needy spenddown. When income information is not provided, the spenddown amounts for Medically Needy cannot be determined and the full amount of Medicaid claims paid must be recouped.

Procedure:

1. When the Medicaid overpayment is because the person is over the resource limit for Medicaid, determine if the person's resources are within the resource limits for other coverage groups, i.e., the Medicare Savings Programs, Medically Needy, MEPD.
2. Give the member the opportunity to provide the income information and explain that the overpayment will not exceed the spenddown amounts. If the member appeals and has not been provided this opportunity, the Department may lose the appeal and the ability to collect on the overpayment.
3. When income is provided, determine the amount of the Medically Needy spenddown for each certification period of the overpayment.
   - Use only a three-month certification period for retroactive months.
   - A one-month certification period may be used for overpayments when there is not a second month in the certification period for the overpayment or there is only one month in the retroactive period.

1. Ms. A, a pregnant woman, applies April 1. The Medicaid application is approved with three months of retroactive eligibility. It is later determined that Ms. A was over income for the months of January through June. Ms. A does provide income verification.

   Spenddown amounts are determined for the following certification periods:

   - January, February, and March (retroactive months)
   - April and May
   - June

2. Mrs. B has an overpayment for the months of November through March. There are no retroactive months. This is one Medicaid claim with three certification periods.

   Spenddown amounts are determined for the following certification periods:

   - November/December Spenddown of: $ 1,782.88
   - January/February Spenddown of: $ 1,782.88
   - March Spenddown of: $ 891.44

   Medicaid paid the following medical expenses for Mrs. B:

   - November/December $ 5,000
   - January/February $ 400
   - March $ 1,000

Certification Period	Spenddown	Medicaid Paid	Overpayment
November/December	$ 1,782.88	$ 5,000	$ 1782.88
January/February	$ 1782.88	$ 400	$ 400.00
March	$ 891.44	$ 1,000	$ 891.44

Total amount of overpayment = $3074.32 ($1782.88 +$400 + $891.44)

NOTE: When calculating an overpayment that will include a Medically Needy spenddown, **do not** update the Medically Needy spenddown amounts on the Automated Benefit Calculation (ABC) system or in the Medicaid Management Information: Medically Needy (MMIS MN) subsystem.

4. When a member appeals an overpayment because a prescription was used to meet spenddown, but the member did not receive the prescription, include the following statement on the appeal summary:

"When a pharmacy submits claims for payment for prescriptions to Iowa Medicaid Enterprise (IME), the claim will be denied if the person is not eligible for Medicaid. If the person is conditionally eligible for Medically Needy with a spenddown at that time, the Medically Needy subsystem applies the denied claim to the spenddown for that certification period.

"The system assumes that the service was received when Medicaid claims are submitted. When the person is not eligible for Medicaid, the pharmacy may not give the prescription to the person if the person cannot pay for it. When this happens, the amount of the claim is incorrectly applied towards meeting the spenddown for Medically Needy.

"There are also situations where the pharmacy fills a prescription that is not picked up. Again, the claim has been used to meet the spenddown when the person has not received the service.

"In either situation, when the pharmacy is aware that Medically Needy is involved, the pharmacy submits a deletion form to IME to remove the claim from being used to meet spenddown.

"If the spenddown has not been met, the claim is deleted. If spenddown has already been met, then the person has become Medicaid-eligible without having incurred all of the medical expenses used to establish eligibility and may have an overpayment.

"The amount of the claims for prescriptions that were not received was used to meet spenddown. Since the person did not receive the drugs, the person was not obligated to pay medical expenses that were used to meet spenddown. As a result, the person was made Medicaid eligible and received services for which the person was not eligible."

If the appellant disputes the amount of the overpayment, ask if the appellant has any documentation to show that the appellant is obligated to pay or has paid these pharmacy claims.

Mr. Z, who is potentially eligible for Medically Needy for May and June, has a spenddown of $150. Mr. Z takes his prescription to Pharmacy M on May 15. Pharmacy M submits a claim through the Point of Sale (POS) system and finds out that Mr. M. has not met his spenddown.

Pharmacy M does not give Mr. Z his prescription, since he cannot pay the $175 cost. The POS system does not know that Mr. Z did not receive the prescription. It sends the claim to MMIS. MMIS submits the claim to the Medically Needy subsystem and Mr. Z meets his spenddown.

Pharmacy M faxes the *Medically Needy Expense Deletion Request* to the Medically Needy Unit at IME. The Medically Needy Unit determines that Mr. Z has met spenddown using the prescription that he did not receive.

The Medically Needy Unit sends the income maintenance worker a letter stating that Mr. Z did not incur the expense for the prescription. The worker checks the Medically Needy subsystem and determines that the $175 submitted by Pharmacy M on May 15 was used to meet spenddown.

On the first of January, six months after the end of the certification period, the worker obtains information from the Overpayment Recovery Detail system to determine the amount of claims that Medicaid paid for Mr. Z for the months of May and June.

Medicaid paid $2,595.55 in claims for Mr. Z. Since Mr. Z did not incur $150 in medical expenses and therefore, did not meet his spenddown, an overpayment for $150 is completed.

Department Responsibilities

The Department has general administrative responsibilities for:

- Maintaining confidentiality of Medicaid-related information
- Maintaining facility inspection reports
- Preventing discrimination by staff or vendors
- Providing notification of Department actions that meets legal requirements.

Confidentiality

Legal reference: 42 CFR 431.300-431.306, 45 CFR 160.102 and 164.504, Iowa Code Section 22.7(2) and 217.30, 441 IAC 9.1 through 9.15(3)

Federal Medicaid regulations require that the Department release information about a Medicaid applicant or member **only** for purposes directly connected with the administration of the Medicaid program unless specifically authorized by the applicant or member.

As a health plan, Medicaid is subject to the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) and corresponding federal regulations on the standards the Department must meet to protect the privacy of protected health information. Health care providers are also subject to HIPAA standards.

Requests for information are made using:

- Form 470-3951 or 470-3951(S), *Authorization to Obtain or Release Health Care Information*, when the request is for a third party/service, such as a law firm.
- Form 470-3952, *Request for Access to Health Information*, when a client requests their own Personal Health Information (PHI).

When either form is received at a DHS office, the worker must send it on to the DHS Security and Privacy Office to be reviewed. Legitimate requests for information will then be gathered from the Data Warehouse and provided to the requester via a File Transfer Protocol (FTP).

See 1-C, *Confidentiality and Records* for additional information on the policies and responsibilities regarding confidentiality of protected health information.

Maintenance of Facility Inspection Reports

Legal reference: 42 CFR 431.115

Department offices must make publicly available survey information from the Department of Inspections and Appeals for:

- Hospitals.
- Nursing facilities.
- Intermediate care facilities for persons with an intellectual disability.
- Home health agencies.
- Independent laboratories.

The following forms regarding facilities must be available for public inspection through web site access at the local offices:

- Form HCFA-2567L, *Statement of Deficiencies*.
- Form HCFA-2567B, Post-Certification Revisit Report.

These forms contain information about facility deficiencies noted by the Department of Inspections and Appeals (DIA) and the facility's plan to correct the deficiencies. The local office is responsible for:

- Making a computer available for the public to view the reports on the DIA web site.
- Giving the public the DIA's web site address, www.dia.iowa.gov,and these instructions:
    - Choose the "Health Facilities Division" option.
    - Click on the link under "Health Facilities Division's web site by clicking here."
    - Select the "Entity Search" option.

If the person reviewing the DIA reports has questions about any deficiencies contained in the reports, refer the person to the DIA, rather than trying to answer the questions yourself. If the person wants a complete copy of the survey, request a copy from DIA.

Nondiscrimination

Legal reference: Title VI of the Civil Rights Act of 1964, as amended; 42 CFR 430.2(b), Iowa Code Section 216.2(13)(b) and 216.7, Iowa Civil Rights Act of 1965, as amended; Iowa Executive Order #15, dated April 2, 1973

Department staff and vendors supplying goods or services to members for which the Department makes direct payment may not discriminate based on:

- Age
- Color
- Creed
- Mental disability
- National Origin
- Physical disability
- Political belief
- Race
- Religion
- Sex

Notification

Legal reference: 42 CFR 435.912, 42 CFR 435.917, Iowa Code Section 249A.4, 441 IAC 7.7(1) and 76.16(1)

Give members adequate notice of any action taken that affects the member's eligibility. See When Notice Is Required. **Every** notice the Department issues must be "adequate." Some notices must also be timely.

Adequate notice can be given no later than the date benefits would have been received. **"Adequate notice"** means a written notice of decision sent to the member that specifies:

- The action taken and the reasons for it.
- The effective date.
- The Employees' Manual chapter number and subheading describing the policy basis for the action.
- The rule or law reference, when the notice of decision relates to a negative action.
- The client's right to request a fair hearing.
- How assistance may be continued when a hearing is requested (if applicable).

"Timely notice" means a written notice given at least ten calendar days before the effective date of adverse action, except in cases of probable fraud (which require notice of five calendar days). The **timely notice period** extends from the day after a notice is issued to the effective date of action. A timely notice period must be at least ten calendar days.

When Notice Is Required

Legal reference: 42 CFR 431.213, 435.912, and 435.917, 441 IAC 7.7(17A), 7.7(1), 7.7(6), and 76.16.(1)

Issue an adequate notice whenever you take action on a case:

- An application is approved, rejected, or withdrawn.
- Medicaid is canceled. This includes cancellation due to termination of SSI payments or termination of foster care or subsidized adoption payments.
- Medicaid is reinstated or reinstatement is denied. See 8-G, *Reinstatement*.
- A change in a member's circumstances affects eligibility, including increase, reduction, suspension, or cancellation of benefits.

The notice must also be **timely** to take adverse action on a case, such as when Medicaid is canceled, suspended, or reduced, except as noted under When Timely Notice Is Not Required.

Send a *Notice of Decision* or a *Notice of Action* for an application only when a final decision of eligibility has been made. When determining eligibility under more than one coverage group, you do not need to send a *Notice of Decision* or a *Notice of Action* for each coverage group considered.

When a member resolves the original reason for a cancelation but should be canceled for a new reason, timely and adequate notice of the new action must be sent unless the new reason does not require timely notice.

Timely Notice When Probable Fraud Exists

Legal reference: 42 CFR 431.214, 441 IAC 7.7(3)

When the Department receives information that indicates Medicaid should be discontinued, suspended, terminated, or reduced because of probable fraud, timely notice is required.

Verify any information received about probable fraud. Obtain your supervisor's approval before taking any action. Document the basis for your action in the case record.

Timely notice in cases involving probable fraud must be issued at least **five** calendar days before an action becomes effective. Specify that an appeal must be filed within five days rather than ten days, as stated on the back of the *Notice of Decision* or *Notice of Action*. Count the day after the notice is mailed as day one.

Send this notice by certified mail, return receipt requested.

When Timely Notice Is Not Required

Legal reference: 42 CFR 431.213 and 431.231(d), 441 IAC 7.7(2)

Notice must be adequate but does not need to be timely when:

- The member dies, and the death is verified by a relative, newspaper obituary, nursing home, or hospital.
- The member gives you a clear, written, signed statement that the member no longer wants Medicaid.
- The member gives you a signed statement containing information that results in the end or reduction Medicaid benefits. The statement must indicate the member understands the consequences of supplying the information.
- The member is admitted or committed to an institution where the member does not qualify for Medicaid payments.
- You do not know the location of the member, and the post office has returned the member's Medicaid card with no known forwarding address.
- The member has been approved for Medicaid in another state.
- The member's physician prescribes a change in the level of medical care.
- The member was previously notified that Medicaid benefits would be granted for a specified period, and the period has ended.
- Assistance is simultaneously approved and terminated for a past period, such as the retroactive period.

Notice Forms

Information for more than one action can be on the same notice. When notice is generated by the ABC system, form 470-0485 or 470-0485(S), *Notice of Decision*, is issued.

Use form 470-0486 or 470-0486(S), *Notice of Decision*, when manually issuing notice for Medically Needy denials or cancelations, Refugee Assistance, and other ABC programs when appropriate.

Use form 470-0490, *Notice of Decision: Medical Assistance or State Supplementary Assistance*, when manually issuing notice for SSI-related coverage groups or State Supplementary Assistance.

Use form 470-2330, *Notice of Decision for Medically Needy*, when manually issuing notice for Medically Needy. Attach a copy of form 470-2341, *Medically Needy Spenddown Computation* to the *Notice of Decision for Medically Needy*.

When notice is generated by the ELIAS system, form 470-0485, *Notice of Action*, is issued.

Use form 470-0485(M) or 470-0485 (MS) when manually issuing notice for cases in ELIAS.

Appeals

Legal reference: 42 CFR 431.200, 431.220, 441 IAC 7.5(17A)

The client has a right to appeal any decision and to request an appeal hearing. No one may limit or interfere with this right. Examples of adverse actions in which a hearing may be granted include:

- The denial of medical assistance.
- The delay in acting on the client's application with reasonable promptness.
- The suspension, reduction, or termination of medical assistance.
- The decision regarding attribution of resources.

See 1-E, *Appeals and Hearings*, for a complete explanation of the Department's appeal process, including worker and client responsibilities, time limits, and appeal decisions.

If a person gains eligibility after an appeal decision, providers can submit claims for covered services that have **not** been paid to the IME. If the date the service was rendered is more than 365 days before eligibility was established, the provider must attach to the original claim form a statement from the IM worker that:

- Indicates the date on which the Department was notified of the eligibility determination and
- Lists the retroactive months.

Prepare the statement and explain to the client what instructions to give to providers in this situation. Providers must submit claims within 365 days after the eligibility determination.

The following sections address:

- When paid bills can be reimbursed after the appeal decision.
- Bills that cannot be reimbursed.
- The reimbursement process.

Reimbursement After Appeal Decisions

Legal reference: 441 IAC 75 (Rules in Process)

Members and 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 the member, members and county relief agencies are entitled to reimbursements if all of the following conditions apply:

- The medical bills were for services covered by Medicaid. The Iowa Medicaid Enterprise (IME) determines whether the medical bills are covered 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 of 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	SSI application is filed.
6-16-09	SSI application is denied.
7-5-09	Request for reconsideration is filed (part of Social Security appeal process).
8-15-09	SSI is denied after reconsideration.
9-10-09	Request for hearing is filed.
12-4-09	SSI is approved due to hearing. Eligibility is granted back to date of SSI approval, 2-1-09.
3-4-10	Department *Notice of Decision* or *Notice of Action* approving Medicaid is issued. Medicaid is approved back to 10-1-08, as there are unpaid medical bills for services received in each of the three retroactive months, and all Medicaid eligibility criteria were met in those months including all retroactive period criteria as defined in 8-A, Definitions. (If there were no unpaid bills in those months or retroactive period criteria was not met, eligibility would begin 1-1-09.)

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

PERIOD OF ELIGIBILITY

Retro-active Period	**Application Period**		**Appeal Period**		**Approval Date**
	Application date:	Denial date:			
10-1-08 12-31-08	1-6-09	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 in 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 IME for payment.
Any Medicaid-covered services received in this period but…			paid in the appeal period can be reimbursed.		

There is no retroactive time limit on bills that can be reimbursed, as long as these requirements 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 of this type of situation are when:

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

Medical bills for the member that are paid by county relief agencies cannot be reimbursed if:

- The member is repaying the county.
- The provider refunds the agency and bills Medicaid.

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 interim assistance reimbursement coordinator at the Iowa Medicaid Enterprise (IME) within 60 days.

Payment is issued from 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 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.

Property Tax Relief

Legal reference: Iowa Code Chapters 425 and 427

Iowa law provides certain low-income residents with:

- Relief on tax payments for real property through tax suspension and property tax credit.
- Rent reimbursement.

It is to a member's advantage to file for both a tax suspension and a tax credit. A tax suspension means the taxes do not have to be paid until the property is transferred. A tax credit reduces or eliminates the amount of tax to be paid when the property is transferred.

Because the Department serves the population that qualifies for tax suspension and other low-income people who might qualify for a property tax credit or rent reimbursement, the Department is required to:

- Inform members who might qualify about the program.
- Provide verification to members who own property and who receive the benefits that qualify them for automatic tax suspension.
- Verify continued eligibility for tax suspension annually for the county board of supervisors.

Homestead property tax credit and rent reimbursement are explained in Comm. 121 or Comm. 121(S), *Important Notice to Property Owners and Renters*. Give this pamphlet to elderly and disabled applicants. Document this in the case record.

Homestead Property Tax Credit for the Elderly or Disabled

Legal reference: Iowa Code Sections 425.16 - 425.40

Certain elderly and disabled residents are entitled to a tax credit of up to $1,000.00 of their tax liability on their homestead property. To qualify in 2023, household income must be less than $25,328.00 per year, and the person must be:

- 65 years of age or older on December 31, 2022, or
- Totally disabled as of December 31 of the previous year.

Property owners must file for the tax credit with the county treasurer in the county where their homestead is located. The amount of the credit depends upon the household's income.

Property Tax Suspension

Legal reference: Iowa Code Section 427.9

A person may be eligible for suspension of property taxes when the person:

- Receives Supplemental Security Income (SSI), or
- Receives State Supplementary Assistance (SSA), including the supplement for Medicare and Medicaid eligibles, or
- Lives in a health care facility and the Department is paying for part of the care.

Taxes may be suspended if the person owns or is purchasing real property. The person may be either the sole owner or a joint owner of the property. The property does not have to be homestead property.

Tax suspension is automatic once the board of supervisors for the county in which the property is located receives verification that the person is eligible. Taxes on real property are suspended, without penalty, until the property is transferred to someone else.

Eligibility for tax suspension ends when eligibility for SSI or SSA or residence in a health facility ends. Taxes that were suspended while the person was on assistance do not become due until the property is sold or transferred.

The Department is responsible for providing verification to members who may be eligible for property tax suspension. When a person is approved for Medicaid due to SSI eligibility, SSA eligibility, or Medicaid payment for care in a health care facility, the system automatically issues a *Notice of Decision or Notice of Action* with the following statement:

> You get SSI or State Supplementary Assistance or you live in a facility in which the Department of Human Services is paying some or all of the cost. You may not have to pay property taxes at this time. Take this notice to your county Board of Supervisors to discuss having your property taxes delayed.

This notice can serve as verification of eligibility for tax suspension. However, you must provide written verification if the member requests it. Suggested language is as follows:

> _____ (is a recipient of [Supplemental Security Income] [State Supplementary Assistance] is living in a health care facility and the Iowa Department of Human Services is paying part or all of the cost of care.) Therefore, this person appears to qualify for property tax suspension.
>
> (Worker signature, title, and date)

The county board of supervisors shall annually supply to the local Department office a list of names and social security numbers of people receiving tax suspension due to:

- Eligibility for State Supplementary Assistance or SSI, or
- Residing in a health care facility with the Department paying for part of the care.

Upon receipt of the list, indicate if the identified people continue to receive benefits that qualify them for tax suspension and return the list to the board of supervisors. No release of information is required to respond to this list.

Rent Reimbursement

Legal reference: Iowa Code Sections 425.16 through 425.40

People who pay rent in buildings that are not tax-exempt may receive reimbursement of up to $1,000 of the gross rent paid each year.

To qualify for rent reimbursement in 2023, household income must be less than $25,328.00 or less per year. Also, the person must be:

- 65 years of age or older as of December 31, 2022, or
- Totally disabled as of December 31 of the previous year.

People who live in a health care facility, such as a nursing facility or residential care facility, are considered renters for purposes of this reimbursement. A percentage of the Medicaid payment to a nursing facility or the State Supplementary Assistance payment to a residential care facility may be counted as payment for rent, and therefore is counted for this program.

The Department administers the program. Participants may apply online at the Department's website beginning January 3, 2023