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Medicaid

Case Maintenance

Page

Overview **1**

Client Reporting Requirements **1**
- Supplying Information and Verification 1
- Reporting Changes 3
- Interviews Due to Questionable Information 5

Changes In Household Circumstances **6**
- Moving and Returned Mail 7
- Changes Reported From IEVS and Other Automated Sources on Alerts 8
  - IEVS Wage Report 8
  - IEVS Unemployment Compensation Report 8
  - IEVS Bendex and State Data Exchange 9
  - IEVS Earnings and Pension Report (IRS) 9
  - IEVS Internal Revenue Service Report (IRS) 9
- Acting On IEVS Information On a Community Spouse 10
- Acting on Changes Received From Other Sources 10
- Death of a Member 11

Reinstatement **12**
- Grace Period 12

90-Day Reconsideration Period **16**

Automatic Redetermination **17**
- Additional Information for Non-MAGI-Related Redeterminations 18

Additional MAGI-Related Case Maintenance **19**
- Passive Renewal 19
- Review Process 19
- Requirements for a Complete Report 20
- MAGI-Related Eligibility Reviews 21
  - Voter Registration Procedures 21
- Adding a New Member to an Existing MAGI-Related Case 22
  - Acting on a Client's Report of a Future Change 23
  - Establishing the Date of Application and Eligibility 23
  - Determining the Income of People Added 25
- Other Changes In the Household 26
  - Returning Parent Not Eligible for Medicaid 26
  - Person Becomes Ineligible for Medicaid 26
  - Child Goes into Foster Care 27
- Budgeting For Ongoing Eligibility For MAGI-Related Households 28
  - Income Changes Reported on Review Forms from Other Programs 28
  - Acting on Changes 29

Page

Additional Non-MAGI-Related Case Maintenance....35
- Non-MAGI-Related Eligibility Reviews....35
- MEPD Case Maintenance....36
  - MEPD Reviews....36
  - Effect of Nonpayment of Premiums....36
  - Reinstating a Case Canceled for Failure to Pay Premium....38
  - Reopening a Case Canceled for Failure to Pay Premium....38
  - Premium Change for Current or Past System Months....38
  - Decrease a Premium....38
  - Increase a Premium....39
  - Refunds....40
- New Members in Non-MAGI-Related Households....41

Fraud and Overuse of Medicaid Services....42

Overview

This chapter covers policies relating to how to handle changes involving active Medicaid cases.

The first section deals with the client's responsibility to report changes in household circumstances and worker actions based on the information received about changes. Reported changes may result in reinstatement or automatic redetermination, which are topics that follow the discussion on changes.

The next two sections relate to specific MAGI-related and Non-MAGI-related case maintenance issues. Reporting fraud or misuse of Medicaid services by clients or providers comprises the final section of the chapter.

Client Reporting Requirements

Client reporting requirements include:

- Supplying requested information or verification.
- Reporting changes.

NOTE: "Clients" include applicants, members, people who are conditionally eligible, and people whose income or assets are considered in determining eligibility for an applicant or member.

All clients are responsible for reporting changes timely as they occur. However, the specific changes required to be reported and the time frames within which they must be reported may differ depending on whether the member receives Non-MAGI-related or MAGI-related Medicaid.

The following sections explain requirements for:

- Supplying information and verification
- Reporting changes
- Interviews due to questionable information

Supplying Information and Verification

Legal reference: 42 CFR 435.916, 435.952(c)-(d), 441 IAC 75 (Rules in Process) 441 IAC 76 (Rules in Process), 76.8(2)-(3), 86.3(7)(c)

Policy: For MAGI-related Medicaid, the client shall not be required to provide additional verification if attested income meets the Department's standards for 'reasonable compatibility' as defined in 8-A, *Definitions*, and if the Department can verify all other required information through an Electronic Data Source. 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 Electronic Data Source, send a written request for the additional information or verification.

Before terminating or reducing benefits, a request must be sent to members for information that cannot be obtained electronically or is obtained electronically but is not reasonably compatible with information provided by or on behalf of the individual.

For non-MAGI-related Medicaid, the client must supply complete and accurate information needed to establish ongoing eligibility.

Procedure: If you need additional information, give, mail, or fax a written request to the client. Inform the client in writing of the date the information is due and the consequences for failure to supply the information or verification.

The client must supply the information within ten calendar days of the day you give or mail a written request to the client. The ten-day period begins with the day after you issue the written request. When the tenth day falls on a nonworking day or a legal holiday, extend the due date to the next working day for which there is regular mail service.

"Supply" means the Department receives the requested information or verification by the specified date. You can allow additional time when the client is making every effort to obtain the information but is unable to do so in ten days and notifies you about the problem.

See 1-C-Appendix for a list of release forms to use when obtaining information from a third party. Explain the following to the member, in writing:

- When the client must obtain information from a third party, it is the client's responsibility to return the information timely. It is not the responsibility of the third party.
- It is the client's responsibility to follow up with the third party before the due date to make sure the third party will have the information ready to pick up or has mailed the information in time to be received by the Department by the due date.
- The client may ask for more time to get the information to the Department if the third party does not have the information ready or it will not arrive by the due date.

Although it is the client's responsibility to provide information, do not cancel assistance if the client is unable to get the information because of a disability, lack of education, or lack of knowledge. If requested, assist the client in getting information to establish continuing eligibility.

A client who provides a signed release to a specific individual or organization for specific information has met the requirement for supplying requested information or verification. The general release does not meet this requirement unless the client asks for help.

Cancel or deny Medicaid if the client fails to supply the information or refuses to authorize you to obtain it from other sources when the client is unable to obtain the information.

If the client is unable to get information from a spouse who is no longer in the household, do not cancel the case. Contact the client to obtain the best information available. Ask the client about bank accounts, records showing deposits of the spouse's income, information from the divorce proceedings, and tax returns.

Ask the client to provide information that would help to verify what the client is telling you about the spouse who is no longer in the home. Determine eligibility from the information provided. If the member fails to provide the requested information, cancel the case.

Reporting Changes

Legal reference: 42 CFR 435.916(c); 441 IAC 75 (Rules in Process) and 76.15

All clients or someone acting on the client's behalf must report the following and any other changes that affect eligibility:

- Income from all sources.
- Changes in household membership.
- Health insurance premiums or coverage, including Medicare and buy-in.
- A change in mailing or living address. Remember to offer *Voter Registration* forms when a client reports a change of address, either in person or by phone. Ask clients reporting an address change, "If you are not registered to vote where you live now, would you like to apply today to register to vote?" Send the *Voter Registration* form if the client wants to register.
- Receipt of a social security number.
- Filing of an insurance claim against a possible liable third party with the expectation of seeking restitution or payment of medical expenses that resulted from an injury and were paid by Medicaid.
- Retaining an attorney with the expectation of seeking restitution for an injury from a possible liable third party when Medicaid has paid the resulting medical expenses.
- The receipt of a partial or total settlement for payment from a liable third party of medical expenses due to an injury which were paid by Medicaid.
- Alien or citizenship status.

MAGI-related clients must also report the following:

- School attendance.
- Federal income tax filing status on claimed dependents for federal tax purposes.

IHAWP clients must also report:

- Entitlement or enrollment in Medicare Part A or Part B, or both.
- Entry into a nonmedical institution, but not limited to a penal institution.
- Childern under the age of 21 living with the client who lose minimum essential coverage, if the client is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
- The member is confirmed pregnant.

Non-MAGI-related clients (except individuals receiving SSI benefits) must also report:

- Unmet medical bills.
- Resources.
- Recovery from disability.
- 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.
- Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation, or spenddown.
- Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

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.

Individuals receiving Medicaid based on the **receipt of Title IV-E funded foster care or based on an adoption 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.

Individuals receiving **state-only funded Medicaid** are required to report any changes in the following:

- Income from all sources.
- Mailing or living address.
- Receipt of a social security number.
- Health insurance coverage.
- Alien or citizenship status.

Clients may report changes in person, by telephone, by mail, or online using the DHS Services Portal. Give clients form 470-5590, *Ten-Day Report of Change for Medicaid/Hawki* when requested by the client.

Members and people being added to the existing household must report changes within ten calendar days of the day the change occurred. If the last day to report a change is a nonworking day, the person must report the change by the next working day.

Act on changes and complete a redetermination within ten days of when you become aware of a change or when you verified the change, if verification is appropriate, unless using the automatic redetermination policy for information received and verified after the tenth of the month.

If the change is adding someone to the household or results in an application, follow application policies regarding effective dates.

If the change results in cancellation from the current coverage group, follow the automatic redetermination policy on whether the information was received by or after the tenth of the month.

When the client reports changes in health insurance, send form 470-2826, *Insurance Questionnaire*, to the client to fill out and return. When the client reports filing an insurance claim, retaining an attorney, or receipt of a settlement, notify the Iowa Medicaid Enterprise Lien Recovery Unit at 1-888-543-6742.

When a probable change affects eligibility, act on the change if you have all information you need to establish eligibility, and the best information available indicates that the change will actually take place as reported. See 8-A, *Notification*, for timely notice requirements. See Automatic Redetermination.

Establish a claim for any medical assistance that was incorrectly paid when a change affecting eligibility was not reported timely.

Interviews Due to Questionable Information

Legal reference: 42 CFR 435.907(d), 441 IAC 76 (Rules in Process)

Procedure: For MAGI-related Medicaid, an interview shall not be required.

For non-MAGI-related Medicaid, a face-to-face or phone interview may be required at application or review, if needed, to clarify information or resolve discrepancies.

Changes In Household Circumstances

Legal reference: 42 CFR 435.916(d), 441 IAC 76.16 and 76.16(1)

Policy: After assistance has been approved, changes occurring during a month are effective the first day of the next calendar month, provided timely notice can be given. When timely notice is required and cannot be given, the effective date is the first day of the second month following the month the change was reported. For exceptions to this policy, see 8-F, *Transitional Medicaid*.

When a change is reported or comes to the attention of the Department, eligibility shall be redetermined regardless of whether the change was required to be reported.

Procedure: The following sections explain procedures that apply to all Medicaid households for acting on:

- Changes received through IEVS.
- Changes received from other sources.
- The death of a member.

When you become aware of unreported information, the date you receive a signed release for specific information from the member or the date the member otherwise acknowledges the previously unreported information is the date the member reports the change.

Do not cancel or deny anyone's Medicaid due to a failure to supply information about a change in circumstances that does not affect a person's eligibility.

Comment:

> Mrs. R and her three children receive Medicaid under a MAGI-related Medicaid coverage group. The youngest is receiving Medicaid as a newborn child of a Medicaid-eligible mother. Mr. R, the father of all three children, returns home and has earnings.
> The worker requests income verification, but the information is not returned by the due date. The worker cancels the Medicaid for the parents for failure to return requested information. The children remain on Medicaid due to continuous eligibility.

See also Additional MAGI-Related Case Maintenance: Adding a New Member to an Existing MAGI-Related Case and Other Changes in the Household, for additional procedures specific to MAGI-related households.

Moving and Returned Mail

Legal reference: 441 IAC 75.10(249A) and 76.15

Policy: A member must remain an Iowa resident for Medicaid eligibility purposes; however, a move within Iowa is not required to be reported.

Comment: Reporting a change in a mailing or living address within Iowa is always desired and is beneficial to the household in order to continue proper communication with the Department.

Procedure: When mail is returned to the Department, handle the mail according to the following:

- When the Post Office has attached a forwarding address and it is in Iowa:
  - Use this address and update the DHS systems.
  - It is not necessary to contact the member.
  - Send any returned mail to the member at the correct address and keep a copy in the case record.
  - Transfer the case to the correct county, if appropriate.
- When the Post Office has attached a forwarding address and it is out-of-state, contact the member to ensure the member is no longer an Iowa resident.
- When there is no forwarding address (i.e., address unknown, undeliverable), cancel the case because we are unable to find the member using the only address we have on file.
- When there is hand-writing on the returned mail, attempt to contact the member to resolve the issue. If you are unable to contact the member, cancel the case because we are unable to find the member.

Changes Reported From IEVS and Other Automated Sources on Alerts

Legal reference: 42 CFR 435.945, 435.948, 441 IAC 75 (Rules in Process), and 76.14(2)

In addition to changes reported by the household, information that might affect eligibility is also available through alerts that are issued to the worker through the WISE system.

When you receive an alert, act on it as follows:

1. Determine if the client reported the information and if you have already acted on it. If so, notate in WISE and file alert as "no action required".
2. Act on information received from the alert that was not previously reported by the household within 30 days from the date printed on the alert. Check the description of each alert to see whether the information must be verified or is already considered verified.

   If the new information requires verification, contact the household in writing and obtain a specific release of information, if necessary. You may delay action beyond 30 days when a third party causes the delay by not providing requested verification. It may be necessary to reduce or cancel future benefits and to establish a claim.
3. If the income does not affect past, current, or future eligibility, notate in WISE and file alert as "no action required".
4. If the alert information affects eligibility, complete a redetermination and adjust future benefits. Do a claim if necessary.

IEVS Wage Report

Legal reference: 42 CFR 435.945(g), 435.948(a)(1), 441 IAC 75 (Rules in Process)

Use information provided by Iowa Workforce Development on the *Wage Report*, S470X225-A, to determine if the household reported earnings. If the *Wage Report* indicates earnings that were not reported or were underreported, contact the client to verify information. Do not take any case action based solely on data taken from this report.

IEVS Unemployment Compensation Report

Legal reference: 42 CFR 435.945, 435.948, 441 IAC 75 (Rules in Process)

The *Unemployment Compensation Report*, S470X160-A, is a monthly list of all Medicaid cases that contain a household member whose social security number matches with the social security number of a person to whom Iowa Workforce Development (IWD) issued unemployment benefits for the previous month.

Consider benefits received on the second day after IWD mailed the check. The column entitled "Date Received" shows this date. When the second day falls on a Sunday or legal federal holiday, the IEVS system extends the time to the next mail delivery date.

The report lists the amount withheld for child support. Consider this amount verified. This amount is considered income and must be added to the net amount received by the client. However, allow it as an income deduction or diversion if the child for whom the support is intended is not living in the home. See 8-E, *Income*.

The amount listed as withheld for unemployment insurance recoupment is not considered income.

Consider the benefit amounts on this report to be verified income. Act on the unemployment benefit information before the next benefit month.

Allow the household to verify the amount of benefits actually received when the household indicates the amount of unemployment benefits provided through IEVS is wrong. Use the verified amount from the household instead of the amount shown on the printout.

The household must report the discrepancy before the first month affected by the discrepancy or ten days after the date of the *Notice of Decision* (whichever is later) to have medical eligibility redetermined for the first month affected by the discrepancy.

IEVS Bendex and State Data Exchange

Legal reference: 42 CFR 435.948, 441 IAC 9.10(4)"c"

Use the information provided by the Social Security Administration on the Bendex and State Data Exchange to verify social security numbers and Social Security, Black Lung, and SSI benefits. This data is in WISE as lookups and alerts.

IEVS Earnings and Pension Report (IRS)

Legal reference: 42 CFR 435.948, 441 IAC 9.10(4)"c"

Use the information as an indicator of the wages and pensions. Consider the information unverified. This data is in WISE as lookups and alerts.

IEVS Internal Revenue Service Report (IRS)

Legal reference: 42 CFR 435.948(a)(1), 441 IAC 9.10(4)"c"

Use the information as an indication of earned and unearned income. Consider this information unverified. This data is in WISE as lookups and alerts.

Acting On IEVS Information On a Community Spouse

IEVS reports are sent for all people whose names and identifying information have been pended on the ABC system, including a community spouse. Do not delay processing eligibility if the IEVS report is not received within the 30-day-processing period.

If Medicaid is approved for the institutionalized spouse, leave the community spouse pended. You should receive an IEVS report on the community spouse as well as on the applicant.

If the Medicaid case is denied for the institutionalized spouse, or only an attribution is completed, leave both cases pending for Medicaid. Manually issue the *Notice of Attribution*. If the Medicaid case is denied, manually issue a notice denying the Medicaid.

An IEVS report should be issued for all pending cases. If there is no IEVS report within 60 days, close the pended case. There is no match for IEVS. If you believe that an IEVS report will not be forthcoming for either the applicant or the community spouse, document this in the case record.

When you receive the IEVS report, compare the resources that are made known with reported resources. If the attribution needs to be corrected, manually issue a *Notice of Decision* to correct the attributed amounts.

Acting on Changes Received From Other Sources

Legal reference: 42 CFR 435.952(a), 441 IAC 76.14(2)

When you receive a report from sources other than the client indicating that there may be unreported income or resources that may affect eligibility, contact the client to ascertain the facts and then determine the effect on eligibility.

If the subject of the report is an SSI-eligible person, forward the information to the Social Security Administration. Investigate only when the client is an institutionalized spouse with a community spouse.

The client must provide requested verification. See Supplying Information and Verification.

You may also receive notification from the Iowa Medicaid Enterprise that a Medicaid member is eligible for Medicare Part A and B when this is not reflected on the current eligibility file. Verify the coverage with the Social Security Administration or with Bendex.

If an update is needed in the "Medicaid Resource Section" of the eligibility file, complete form 470-0397, *Request for Special Update*, according to the instructions in 6-Appendix.

Death of a Member

Legal reference: 42 CFR 431.213(a), 441 IAC 7.7(2)

Policy: Eligibility for Medicaid ends when the member dies.

Procedures: Verify the date of the member's death using a reliable source, such as a funeral director, hospital, courthouse record, newspaper obituary, or SDX. Send a *Notice of Decision* to the member's family, conservator, or guardian, as appropriate. See also 8-D, *Estate Recovery*.

Reinstatement

Legal reference: 441 IAC 7.7(249A), 7.7(6), and 76 (Rules in Process)

Policy: Eligibility shall be reinstated without a new application when eligibility can be reestablished:

- Before the effective date of cancellation, or
- After the effective date of cancellation as allowed under Grace Period.

Comment: If you can process the information and make all necessary computer entries before the effective date of cancellation, the case can be reinstated even if the system does not process the information until after the effective date of cancellation.

Procedure: Issue adequate and (if appropriate) timely notice whenever an attempt at reinstatement is made. See 8-A, *Notification*, for notification requirements.

When a notice to cancel is issued and the member resolves the issue but should be canceled for another reason or should be reinstated with higher client participation, send timely and adequate notice of the new action, unless listed under 8-A, *When Timely Notice Is Not Required*.

If the additional timely notice required for a second reason cannot be issued in time to be effective the first day of the immediately following month, reinstate the case with the former client participation amount.

Then, issue the second timely notice to cancel the case or increase client participation effective the first day of the second following month. You cannot increase client participation on a canceled case during the reinstatement process unless you give timely notice.

The fact that you have already issued a *Notice of Decision* or *Notice of Action* to cancel a case does not stop you from manually issuing a second notice when a new reason for cancellation occurs. The member then must resolve both issues before assistance can be reinstated.

Grace Period

Legal reference: 441 IAC 76 (Rules in Process)

Policy: A "grace period" is a specific period of time during which a member has the opportunity to "cure" the reason for cancellation. The grace period is defined as the 14 calendar days immediately following the effective date of cancellation. If the fourteenth day falls on a weekend or state holiday, the fourteenth day is extended to the next business day for which there is regular mail service.

Eligibility on a canceled case shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the effective date of cancellation. Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

If the member is eligible, the effective date of assistance shall be the first day of the month following the month of cancellation. See Effect of Nonpayment of Premiums for MEPD. See 8-A, *Notification*, for notification requirements.

Comment: The grace period does not apply to late payment of premiums or to noncooperation actions. Cancellation reasons for which a grace period may apply include, but are not limited to, failure to provide information necessary to determine eligibility and inability to find the member.

If the case was closed because mail was returned or the Department was unable to find the member, a new application is not required if the household contacts the Department within the 14 days to provide a current Iowa address and eligibility can otherwise be established.

When cancellation is due to no review form and the review form is received during the 14-day grace period, first follow the 14-day grace period policy to determine if the case can be reinstated. If the case cannot be reinstated during the 14-day grace period, process the review as an application under the 90-day reconsideration period. Only send a request for information after the 14-day grace period has expired. If the information is not returned, deny the application.

Procedure: Based on the circumstances of your case, take the appropriate action as follows:

- **No information provided**: When no information is provided by the 14th day after the effective date of cancellaton, no further action is required.
- **Partial information provided**: When some of the information is returned, but there is still information needed to determine eligibility:
  - Attempt to contact the household to let the household know what is needed and that if the information is not received by the end of the grace period, the household will have to reapply. Document the contact. A written request for the previously requested information is not required.
  - If the information is not provided by the end of the grace period, no further action is necessary.
- **Requested information provided and a change has occurred**: If the original requested information is provided, but the household also reports a change for which verification is necessary:
  - Make every effort to verify the information and inform the member that you cannot make an eligibility determination unless the change is verified by the end of the grace period. Document the contact. A written request for the new information is not required.

- If the new information is not verified by the end of the 14-day grace period, send a manual "Remain Canceled" notice (See below for language). This is because the original reason for cancellation has been cured, but you cannot determine eligibility due to a change in circumstances that is required to be verified. Document your decision. (Your Medicaid is still cancelled because you did not give us the information we asked for. We cannot determine if (insert person's name) (is/are) eligible. 441 IAC 74.7, 76.14(2), 76.16 (249A))

- **Unable to verify change within grace period**: When an additional change is reported and it is unlikely the information can be verified by the end of the 14-day grace period, attempt to notify the member to file a new applicaiton. Document the contact.

NOTE: If a generic release is on file, it should be utilized.

1. Ms. B, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice is issued to cancel the case effective May 1 for failure to provide requested information. Ms. B provides two of the items on April 17 and the third item on May 5. There have been no other changes in the household circumstances. Medicaid is reinstated for Ms. B effective May 1.
2. Ms. C, a Medicaid member, fails to provide two pieces of information requested by the Department. A notice to cancel the case is issued effective June 1 for failure to provide requested information. Ms. C provides the two items on July 17. The household is not eligible to be reinstated and no additional notice is issued. Ms. C must reapply.
3. Mr. D, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice to cancel the case is issued effective July 1 for failure to provide requested information. Mr. D provides two of the items on June 21 and the third item on July 10. On July 10, Mr. D also reports that he has changed jobs. The IM worker explains to Mr. D that he has until July 14 to provide verification of the old job ending and the beginning of the new job or he will have to reapply for Medicaid.

   Mr. D does not provide verification of the end of the old job or the beginning of the new job. The household is not eligible to be reinstated. The IM worker issues a "remain canceled" notice to the household, since Mr. D had provided the original requested information but did not provide the new verification. Mr. D will have to reapply.

4. Ms. E, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice to cancel the case is issued effective April 1 for failure to provide requested information. Ms. E provides two of the items on March 21 and the third item on April 5. On April 5, Ms. E also reports that she has changed jobs. The IM worker explains to Ms. E that she has until April 14 to provide verification of the old job ending and the beginning of the new job or she will have to reapply for Medicaid.

   On April 14, Ms. E provides verification of the end of the old job but does not provide verification of the beginning of the new job. An eligibility determination cannot be made. The IM worker issues a "remain canceled" notice to the household since Ms. E had provided the original requested information but did not provide the new verification. Ms. E will have to reapply.

5. Mr. F, a Medicaid member, fails to provide three pieces of information requested by the Department. A notice to cancel the case is issued effective July 1 for failure to provide requested information. Mr. F provides two of the items on June 21 and the third item on July 6. On July 6, Mr. F also reports that he has changed jobs. The IM worker explains to Mr. F that he has until July 14 to provide verification of the old job ending and the beginning of the new job or he will have to reapply for Medicaid.

   Mr. F provides verification of the end of the old job and the beginning of the new job on July 14. The IM worker processes the new information and, if eligible, benefits will be reinstated effective July 1.

6. Ms. G, a Medicaid member, fails to provide all the information requested by the Department within the ten days. A notice of cancellation is issued effective February 1, for failure to provide requested information. On March 10, all the information is returned in order to determine eligibility. The information is entered into the system but Ms. G is not eligible. A "remain canceled" notice is issued to Ms. G.

90-Day Reconsideration Period

Legal reference: 42 CFR 435.916, 441 IAC 76.14 (Rules in Process)

The reconsideration period is the 90-day period following the Medicaid cancellation date due to failure to submit a Medicaid review form or other information needed to determine continued eligibility at the time of review.

Eligibility shall be reconsidered back to the date of cancellation without a new application when the following conditions apply:

- Medicaid was canceled for failure to return a completed Medicaid review form or other information needed to review eligibility, and
- A completed Medicaid review form is received within 90 days following the effective date of cancellation.

If the 90th day falls on a weekend or state holiday, the member shall have until the next business day to provide the review form.

The eligibility effective date shall 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 shall not be granted any earlier than the month in which all eligibility criteria are met.

For the Qualified Medicare Beneficiaries (QMB), the Home- and Community-Based (HCBS) Waiver groups, and the Program for All-Inclusive Care for the Elderly (PACE), apply the 90-day reconsideration period policy, but treat the review form like an application when establishing the eligibility effective date for these specified groups.

Automatic Redetermination

Legal reference: 42 CFR 435.916(f)(1), 435.930(b), 441 IAC 76.17(249A)

Whenever a member no longer meets the eligibility requirements of the current coverage group, an automatic redetermination of eligibility for other Medicaid coverage groups will be made.

EXCEPTION: An automatic redetermination will not be made if the reason the client is ineligible under the current coverage group relates to a condition of eligibility that applies to all coverage groups. Examples include refusal to provide verification and failure to assign a third-party benefit.

For MAGI-related and Non-MAGI-related cases, the redetermination process is built in the ELIAS hierarchy when Eligibility Determination and Benefit Calculation (EDBC) is completed. However, when the person is an SSI recipient, you will first need to gather additional verification of income and resources before the redetermination process can be completed.

If a non-MAGI-related person is no longer disabled, look for eligibility under MAGI-related Medicaid. If a MAGI-related person loses eligibility, check to see if the person is disabled for non-MAGI-related Medicaid. "Disabled for non-MAGI-related Medicaid" means that the person:

- Is currently receiving social security disability payments; or
- Has previously been determined disabled by the Department; or
- Is a child who lost SSI due to reevaluation of disability but who remains eligible for non-MAGI-related Medicaid under the Balanced Budget Act of 1997.

The effective date of cancellation from the current coverage depends upon when you receive information that causes ineligibility.

Information Received:	Time Frames to Complete Automatic Redetermination	Effective Date of Cancellation
By the tenth of the month	Complete the redetermination by the end of month.	First day of the month following the month the information was received. Issue timely notice.
After the tenth of the month	Complete the redetermination no later than the end of the following month.	No earlier than the first day of the first month following the month the information was received, but no later than the second month following the month the information was received. Issue timely notice.

During the redetermination period, provide Medicaid only to people who were receiving Medicaid in the eligible group when eligibility under the initial coverage group ceased. This applies only to situations where the information causing ineligibility was received after the tenth of the month.

When an SSI recipient loses SSI and additional verification is needed, send form 470-3152 or 470-3152(S), *Notice of Cancellation/Redetermination*, and request the verification. Allow the client ten calendar days from the date of notification to return the requested verification.

- If the client returns verification by the due date on the *Notice of Cancellation/ Redetermination*, complete the redetermination and issue a *Notice of Action*.
- If the client does not return verification but has a legitimate reason not to supply verification by the due date, you can grant an extension but the cancellation remains in effect. If verification is received by the second due date, treat it as though it was received timely. Complete the redetermination and issue a *Notice of Action*.
- If the client does not return verification and you have not granted an extension, do not do anything further. Do not send a *Notice of Action*, because the client already received a *Notice of Cancellation/Redetermination*.

If you receive an SDX from the Social Security Administration and the payment status is N01, use the SDX as income verification when completing the automatic redetermination. NOTE: Some people in an N01 payment status may be eligible for the 1619b coverage group. See 8-F, *People Ineligible for SSI (or SSA): Due to Earnings Too High for an SSI Cash Payment (1619b Group)*.

If the client is canceled from SSI for being over resources, status N04, call the Social Security Administration to determine the amount of resources. If resources are within Medicaid limits, document the contact and complete the redetermination process. Use the SDX for resource verification. If resources are **not** within Medicaid limits, contact the client and request verification of resources.

Keep adequate documentation in the case record to show that a redetermination was completed. Document what steps were taken to complete the process and the results of that process.

If a client files a timely appeal and reinstatement of eligibility is required, reinstate to the coverage group under appeal until a final decision is reached.

Additional Information for Non-MAGI-Related Redeterminations

For SSI-related redeterminations, eligibility under a new coverage group is usually apparent. The only time it should be necessary to use the automatic redetermination aid type is when you need additional information to make a redetermination. This affects mainly:

- SSI recipients living in their own homes who lose SSI eligibility due to excess income.
- People in the 300% group who return to their own homes from a medical facility.
- People returning home from a residential care facility.

Additional MAGI-Related Case Maintenance

This section contains information on additional procedures for ongoing maintenance of MAGI-related cases, including:

- Passive renewal
- Review process
- Requirements for a complete report
- Eligibility reviews
- Adding a new member to an existing MAGI-related case
- Other changes in the household
- Budgeting for ongoing eligibility

Passive Renewal

Passive renewal is a system-driven process that intends to speed up the annual renewal process of the state by eliminating more worker-driven actions during the renewal period. The intent is to determine eligibility based on an individual's case information which is verified from data sources and notifies the individual of the outcome without worker interaction.

Not all cases qualify for the passive renewal process. If the case does not qualify, a pre-populated review form is generated and sent to the individual.

When the individual has a successful passive renewal, narrative records are sent to WISE to inform the worker of the outcome. The worker will need to refer to the *Notice of Action* for more information and to see the individuals who are passively reviewed.

Act on any changes that are reported during or after the passive renewal process.

Form 470-5168 or 470-5168(S), *Medicaid/Hawki Review* will be generated to households that did not meet the criteria for passive renewal or households who were not successfully passively renewed.

Passive renewal will not occur for more than three consecutive years. The issuance of a pre-populated review form will begin a new three year period.

Review Process

Legal reference: 42 CFR 435.916, 441 IAC 76.14

A review of eligibility for MAGI-related Medicaid households will be conducted once every 12 months and no more frequently. Except for individuals who are passively renewed, a pre-populated form 470-5168 or 470-5168(S) will be generated and mailed. The client will have at least 30 days from the date the form is mailed to complete necessary information, sign, and return the completed review form.

Requirements for a Complete Report

Legal reference: 441 IAC 75 (Rules in Process)

For a report to be considered complete:

- All questions must be answered.
  - Questions with a "yes or no" response must have either "yes" or "no" marked.
  - If the answer is "yes," all requested information must be completed.
  - The question is considered answered if the member does not answer on the form but sends verification of the information.
- The member must sign the form. See 8-B, *Who Must Sign the Application*.
  - When both parents or a parent and stepparent are in the home, **either** may sign for the household, even if temporarily absent.
  - Forms that are signed and then faxed or sent electronically, such as scanned and e-mailed, do not have to be resigned. A faxed report shall be considered an original report.
- All nonexempt income must be verified. EXCEPTION: Members do not need to verify prorated or annualized income that remains unchanged, as long as you and the member have established a set schedule for verifying the income.

Procedure: Verification of earned income does not always mean that the household has submitted every pay stub. If a pay stub is missing but you can calculate the gross income from the missing pay stub by using the year-to-date figures on the pay stubs submitted, the earned income is verified.

Changes reported on a report form in the sections "Other Changes" and "Expected Changes" do not have to include verification for the report form to be complete. Give the household ten calendar days to provide any needed verification.

Inform self-employed people that income and expense records must be supplied at the time of the annual review. This is a requirement for the report to be considered complete.

Send a request for information to obtain any information that was not provided.

Allow the client ten calendar days to provide any additional records. If the records are still not provided, cancel Medicaid for failure to cooperate in providing information needed to establish eligibility.

If the requested information is returned within 14 calendar days and eligibility is determined, reinstate the case. See Reinstatement earlier in this chapter for more information. Also see Grace Period.

MAGI-Related Eligibility Reviews

Legal reference: 42 CFR 435.916, 441 IAC 76.14(249A)

Policy: Review each MAGI-related case at least every 12 months. Interviews are not required. Children approved for Mothers and Children through express-lane eligibility will not be reviewed for Medicaid eligibility under express-lane procedures.

Procedure: Follow standard Medicaid eligibility review procedures for children approved through express-lane eligibility. See 8-F, *Express-Lane Eligibility For MAC*.

Supply a *Voter Registration* form at the time of review.

Voter Registration Procedures

Legal reference: National Voter Registration Act of 1993, Iowa Code 48A.19, 721 IAC Ch. 23

Policy: The voter registration form and the declination form shall be given to every person who receives an application, recertification, or review form for medical assistance, or who reports an address change.

Procedure: The *Voter Registration* form is given to clients at the time of the annual review.

When a client moves, ask if the client would like to register to vote at the new address. If yes, mail or give the client the *Voter Registration* form. No follow-up is necessary to track the return of the *Voter Registration* form.

When a client returns a completed *Voter Registration* form, keep the declination section and return the voter registration information section to the member. Follow your local procedure for handling the form after completion.

When the member returns an incomplete *Voter Registration* form, contact the member to get a completed form. If the member chooses not to check "yes" or "no," leave the section blank and accept that the member has chosen not to register to vote. If the member chooses not to sign the form, print the member's name and the date where indicated, and initial the form.

If the member requests help with registering to vote, be careful not to influence the member's voter registration options in any way.

See 6-Appendix for office procedures regarding processing the forms.

Adding a New Member to an Existing MAGI-Related Case

Legal reference: 441 IAC 76.12(249A)

A new application is not required to add a person to an **existing** MAGI-related eligible group. This includes:

- New household members.
- Other caretakers.
- Newborn children of Medicaid-eligible mothers.
- Ineligible household members

1. Ms. C's two children are receiving MAC. Ms. C is having some medical problems and has asked that she be added to the Medicaid case. Because there is no decrease in income, a paper application is required to determine eligibility under Medically Needy.
2. Same as Example 1 above, except that Ms. C's income has decreased. She calls her worker to request Medicaid. Due to the decrease in income, Ms. C is determined eligible for MAGI-related Medicaid along with her children. No paper application is necessary, because Ms. C is being added to an existing MAGI-related household. The application date is the date she requested Medicaid.

Because a paper application is not needed to add a person to an existing case, it is especially important to document contacts with the client. Detailed case record documentation is crucial to provide pertinent information that would substantiate your actions in the event of a Quality Control (QC) review or an appeal.

There is a difference between an **inquiry** and a **report** as far as what you do with the information:

- An **inquiry** occurs when the client contacts you to find out about the impact on the client's case if another person should join the household, but the client is not sure if or when the person may actually join.

  In this situation, give the client the necessary information, and remind the client to contact you within ten days of when the change occurs or if possible, a week before the change is expected to occur. Document the client contact and your response in the case record. Do not issue a *Notice of Decision* (NOD).

- A **report** occurs when the client (or the client's authorized representative) contacts you with an approximate or specific date that the person is expected to join the household. (See 8-F, *Newborn Children of Medicaid-Eligible Mothers* for information on adding newborns.)

NOTE: A parent returning to the home may not be added to the eligible group if the parent was previously sanctioned and the sanction has not been cured. See Other Changes in the Household for more information.

The following sections give more information on:

- Acting on a client's report of future changes.
- Establishing the date of application and eligibility.
- Determining the income of people added.

Acting on a Client's Report of a Future Change

When a client has reported to you that a new person will be joining the household at some time in the future, the client still has a responsibility to timely report when the person actually joins the household.

Contact the client in writing within one or two days after the person was expected to enter the household. Ask for updated information about the anticipated change and any needed information about the person. The client has ten calendar days to provide the information.

If the client reports that the person will be joining the household **within 30 days** of the report, and you receive the information by the due date you gave the client, process the application to add the person.

If you do **not** receive the information by the due date, cancel the existing MAGI-related case for failure to provide the information and deny the application to add a person to the household. Issue timely notice. Reinstate the case if the information is received before the effective date of cancellation. The date you receive the information is the new date of application to add the person.

If the client reports that the person will **not** be joining the household within 30 days of the report, issue a *Notice of Action* denying the application to add the person. Follow up with the client at the time the person was expected to enter the household, as described above. Remember to document your contacts with the client.

Establishing the Date of Application and Eligibility

Legal reference: 441 IAC 76.12(249A)

The date of application and the effective date of eligibility depend upon the client's situation.

The date of application to add a new person to an existing eligible group is usually the date the household reports the new person in the home. However, circumstances of the client's situation may affect the date of application.

When the household requests to add a new person to the eligible group and that person meets eligibility requirements, the effective date is the first day of the month in which the request is made.

<table>
<tr><th>Person Being Added</th><th>Date of Application</th><th>Effective Date of Eligibility</th></tr>
<tr><td rowspan="2">Household member who is in the home</td><td>Date of report.</td><td>Add the person effective as of the first day of the month in which eligibility is established.</td></tr>
<tr><td colspan="2">1. On May 4, Mrs. A reports that Mr. A, the father of her children, returned home on May 3. The date of application to add Mr. A is May 4. The effective date of eligibility is May 1.
2. On May 5, Ms. B reports that she got married to Mr. C on April 2. Mr. C is not the father of the child.
On May 5, Mrs. C (formerly Ms. B) requests to add Mr. C to her case. The date of application is May 5. The effective date is May 1.</td></tr>
<tr><td rowspan="2">Person who will join the household (anticipated)</td><td>Date of report.</td><td>No earlier than the first day of the month in which the person enters the household or the first day of the month in which entry is reported, whichever is later.</td></tr>
<tr><td colspan="2">Ms. D and her child receive MAGI-related Medicaid. On May 20, she reports that another child will come to live with her within the next couple of weeks. On June 1, she reports that the child actually returned on May 25. The child is added to the eligible group May 1.</td></tr>
<tr><td>Person who lost their Medicaid eligibility because they failed to cooperate</td><td>Date the person indicates willingness to cooperate (e.g., cooperate with Third Party Liability or HIPP).</td><td>No earlier than the first day of the month in which the person indicates willingness to cooperate, which is the month of application. Do not take action to add the person until cooperation has actually occurred.</td></tr>
<tr><td rowspan="2">Person previously sanctioned due to failure to cooperate with CSRU</td><td>Date the person indicates willingness to cooperate.</td><td>No earlier than the first day of the month in which the person indicates willingness to cooperate. Contact CSRU for this date if the client does not contact you directly.

Do not take action to add the person until cooperation has actually occurred per CSRU.</td></tr>
<tr><td colspan="2">Ms. G has not received Medicaid for several months because she failed to cooperate with CSRU. On May 10, she contacts her worker to indicate her willingness to cooperate with CSRU. On June 2, CSRU notifies IM that Ms. G has cooperated. She is approved for Medicaid effective May 1.</td></tr>
</table>

Person Being Added	Date of Application	Effective Date of Eligibility
Person ineligible for failure to provide a social security number or proof of application	Date the number or proof of application is provided.	No earlier than the first day of the month in which the number or proof of application is provided.
	Ms. T and her two children receive MAGI-related Medicaid. A third child is ineligible due to lack of a social security number. On May 5, Ms. T provides proof of application for the child's number. The child is approved for Medicaid effective May 1.	

When the household fails to timely report a new person in the home, the date of application to add the person to the eligible group is still the date of report. In addition, determine the affect of the person's presence on eligibility as of the date the person entered the home.

Determining the Income of People Added

Legal reference: 441 IAC 75 (Rules in Process)

The income of people added to the eligible group is counted prospectively. See Budgeting for Ongoing Eligibility for MAGI-Related Households in this chapter and also 8-E, *MAGI-Related Budgeting Procedures for Determining Financial Eligibility* for more information.

When the person being added was a Medicaid member for the immediately preceding month, obtain a new self-attested income. Do not use the previous self-attested income for months before the person is added to the existing household.

> Mrs. A receives FMAP for herself and two children. They have no income. On May 2, Mr. A, who had been a Medicaid member in another household in April, returns to the home. Mrs. A reports his return on May 5.
>
> Although Mr. A's income was projected at $300 per month in the other household, his new self-attended income is $250 per month. The new self-attested income is expected to continue.
>
> The $250 per month for Mr. A is entered into the system and used when checking electronic date sources.

Other Changes In the Household

The following sections contain more information on what to do when:

- A parent returns but is not added to the eligible group.
- A person on an active case becomes ineligible.
- A child goes into foster care.

Returning Parent Not Eligible for Medicaid

Legal reference: 441 IAC 75 (Rules in Process)

Count the income of a returning parent who is not eligible for Medicaid (e.g., a sanctioned parent or an ineligible adult alien) when determining eligibility unless it is specifically excluded or an allowable expense. Also count the returning parent in the household size. Project income of the returning parent.

See 8-E for *Projecting Future Income*. See Determining the Income of People Added when the returning parent is added to the MAGI-related Medicaid household.

Person Becomes Ineligible for Medicaid

Legal reference: 441 IAC 75 (Rules in Process)

If a Medicaid eligible person is determined to be ineligible for Medicaid, cancel the person's Medicaid effective the first of the following month allowing a 10-day notice.

Household size will be determined according to the tax filing status.

If the person is a parent of a child in the household and the parent continues to reside with the household, the parent continues to be counted in the household size. If the person is not a parent of a child in the household, the person may continue to be counted in the household size, based on tax filing status.

1. Child A leaves the household and is removed effective January 1. Child A's unearned income of $40 per month is not counted when determining eligibility for the remaining members of the household beginning with the month of January.
2. Mr. and Mrs. D receive Medicaid under MAGI-related for themselves and their two children. Mr. D has failed to cooperate with Third Party liability. The worker is notified and Mr. D's Medicaid is canceled effective the first of the next month, allowing a ten-day notice.

   Although Mr. D is sanctioned, the household remains a four-member group and Mr. D's income is used in determining eligibility for Mrs. D and the children.

3. Mr. and Mrs. Q receive Medicaid under MAGI-related for themselves and their two children, Bob, age 12 and Gary, age 17. Gary is not in school and has been employed for quite some time. Mrs. Q reports that Gary lost his job. The worker instructs Gary to apply for Unemployment benefits. Gary refuses to apply.
   Gary's Medicaid is canceled effective the first of the next month, allowing a ten-day notice. The household size remains the same. Any income Gary receives would be counted in determining eligibility for Mr. and Mrs. Q and Bob.

Child Goes into Foster Care

Legal reference: 441 IAC 76 (Rules in Process)

When a child leaves the home to enter foster care, remove the child's needs from the eligible group effective the first day of the following month. System requirements may delay the effective date until the first day of the second month after the month in which the child left the home.

However, if the child returns to the home before the effective date of cancellation, reinstate the child or case without a new application.

When a child leaves the home to enter foster care, but returns to the household in the same month and has not yet been canceled from the case, do not remove the child from the household.

1. Mrs. A receives Medicaid under MAGI-related for herself and one child. The child is placed in foster care July 2. Notice is issued to cancel the child from the case effective August 1, and eligibility for Mrs. A is redetermined under a MAGI-related Medicaid coverage group.

   The worker establishes a foster care Medicaid case for the child with an effective date of August 1. On July 19, the child returns to the home. The foster care case is canceled and the child is reinstated on Mrs. A's case.

2. Mrs. B receives Medicaid under MAGI-related for herself and one child. The child is placed in foster care July 25. Since it is too late to cancel for August, the child is canceled effective September 1. Eligibility for Mrs. B is redetermined under a MAGI-related Medicaid coverage group effective September 1.

   The worker establishes a foster care Medicaid case for the child with an effective date of September 1. The child returns to the home August 4. The foster care case is canceled and the child is reinstated on Mrs. B's case.

3. Mrs. C receives Medicaid under MAGI-related for herself and one child. The child is placed in foster care July 17. The child is canceled effective August 1. Eligibility for Mrs. C is redetermined under a MAGI-related Medicaid coverage group effective August 1.

   The child returns to the home August 8. An automatic redetermination of eligibility is completed for the child when leaving foster care. The child is reinstated to Mrs. C's case effective September 1.

Budgeting For Ongoing Eligibility For MAGI-Related Households

Legal reference: 441 IAC 75 (Rules in Process)

When a change in income is reported, act on it regardless of whether the change was required to be reported or not. First, determine if the change being reported is indicative of future income.

If the change is not indicative of future income, document in the case that the change was reported but a new projection of income was not completed because the change is not indicative of future income.

If the change is indicative of future income, request a new self-attestation from the client. Accept the client's statement as to whether the change is indicative of future income, unless questionable.

1. Mr. H receives Medicaid for himself and his son under MAGI-related. On November 20, Mr. H reports that he will be working ten additional hours per week in December. He states that the additional hours will only occur in December, due to the holidays, and that he cannot anticipate working any overtime in the future.

   The worker documents the reported change in Mr. H's case file. The worker further documents that the reported change is a one-time change and is not representative of future income. Verification of the change is not requested, and a new projection of income is not completed.

2. Ms. I receives Medicaid for her children under MAC. She does not receive Medicaid for herself. On August 27, Ms. I reports that she began working the evening shift on August 25. The evening shift pays an additional $.50 per hour. Ms. I states that her employer was unclear as to whether this change was temporary or permanent.

   The worker requests verification from the employer, which is received September 3. It indicates that Ms. I will be working the evening shift only until September 15, at which time she will return to her usual shift and her usual hourly rate. The worker documents this in the case file and does not complete a new projection of income, since the change is not representative of future income.

3. Same as Example 2, except that the verification from the employer indicates that Ms. I will be working the evening shift until at least November 1 and perhaps longer. The worker requests a new self-attestation of income based on the increase in Ms. I's hourly rate. The new self-attested income is used beginning with the month of October.

Income Changes Reported on Review Forms from Other Programs

Some MAGI-related Medicaid members may also receive benefits from other programs. The other programs' reporting requirements may affect Medicaid eligibility.

When income reported on a review form differs in the amount that was projected for MAGI-related Medicaid, act on the new amounts as a reported change if it is indicative of future income.

When the change is **only** due to a third or fifth check, do not enter the income for MAGI-related Medicaid. Allow the income used for eligibility the previous month to roll forward.

1. Mr. and Mrs. J apply for Medicaid and SNAP on May 3. They request SNAP for the entire family and Medicaid for just their two children. The application is approved for both programs. Mr. J's earnings are the only income for the family. At application, the projection was $1,500 gross per month.

   At recertification for SNAP, the J family reports that Mr. J now has monthly gross earned income of $1,700. The worker enters the same income into the computer system for both programs.

2. Mrs. K and her two children receive Medicaid under MAGI-related in addition to FIP and SNAP. Mrs. K has earned income of $515 bi-weekly. $1,030 per month is entered into the computer system for all three programs.

   At the next FIP review, Mrs. K reports income of $1,545 due to a third paycheck. Since this income is not a good indicator of future income, the income of $1,030 is allowed to roll forward for MAGI-related Medicaid.

   At the next FIP review, Mrs. K reports an increase in income to $530 bi-weekly. Since this income did not include a third check and is indicative of future income, $1,060 is entered into the computer system for MAGI-related Medicaid.

Acting on Changes

Legal reference: 42 CFR 435.911(b) & (c), 435.916(1) and (2), 435.930, 435.948, 435.952, 441 IAC 76 (Rules in Process), and 75 (Rules in Process)

Act on the change as soon as possible, but no later than ten working days from the date you become aware of the change, unless using the automatic redetermination policy for information received and verified after the 10th of the month.

Complete an automatic redetermination when changes are reported or become known. See Automatic Redetermination. Verification requirements apply before acting on changes. See 8-A, *Notification*, for timely notice requirements.

When a probable change affects eligibility, act on the change if you have all information you need to establish eligibility, and the best information available indicates that the change will actually take place as reported.

<table>
<tr><th>Change Reported</th><th>Effect on Eligibility</th><th>Effective Date</th><th>Do a Recoupment or Adjustment?</th></tr>
<tr><td colspan="4">Timely reporting for members is within ten days after the change occurred.</td></tr>
<tr><td rowspan="2">Timely</td><td>Positive</td><td>The month following the month the change is reported.
Timely notice is not required.</td><td>No, if the Department acted timely.</td></tr>
<tr><td>Negative</td><td>The month following the month change is reported.
Timely notice is required.</td><td>No, if the Department acted timely.</td></tr>
<tr><td colspan="4">Timely reporting for members is within ten days after the change occurred.</td></tr>
<tr><td rowspan="2">Not Timely (or not at all)</td><td>Positive</td><td>The month following the month the change is reported or became known. (Do not adjust benefits back to when the change occurred.)</td><td>No, if the Department acted timely.</td></tr>
<tr><td>Negative</td><td>The month following the month the change occurred, regardless of when the change occurred or became known.</td><td>Yes, if benefits were received incorrectly. Redetermine eligibility beginning with the month following the month of the change..</td></tr>
<tr><td rowspan="2">Not Required to be Reported Until Annual Review</td><td>Positive</td><td>The month following the month the change is reported.</td><td>No, if the Department acted timely.</td></tr>
<tr><td>Negative</td><td>The month following a timely notice.</td><td>No, if the Department acted timely.</td></tr>
</table>

NOTES:

- If the change is adding someone to the eligible group or results in an application, follow application policies regarding effective dates. See 8-B, *Application Processing*.
- If the change results in cancellation from the current coverage group, follow the automatic redetermination policy on whether the information was received by or after the 10th of the month. See Automatic Redetermination.

- If the household would have been eligible under the Medically Needy program, determine the spenddown amount for each certification period. See 8-J, *Income Policies*.
- See 8-A, *When Timely Notice Is Not Required*, for more information on when timely notice is not required.

1. **Positive Change Timely Reported:**

   Mr. and Mrs. X receive Medicaid under MAGI-related for themselves and their children. Mr. X is the only one with income. Mrs. X reports on August 3 that Mr. X has left the home July 25.

   Although the loss of a household member is negative, this change is positive because Mr. X is the only one with income. Since this change was reported timely in August, Mr. X is canceled effective September 1 and his income is no longer used for eligibility purposes. No claim is established for August.

   Had this same change been reported untimely, a claim for Mr. X would have been completed for the month of August and any months thereafter, since the change occurred in July and was not reported timely.

2. **Negative Change Timely Reported:**

   Mr. B receives Medicaid for himself and his children under MAGI-related. On July 23, he timely reports beginning unearned income that will make him and his children only conditionally eligible under Medically Needy (MN) with a spenddown. He provides verification timely on August 5.

   The effect of the change on eligibility is adverse and requires a timely notice. The effective date of the change is September 1. The MN certification period is September/October. No claim is established for August, since the change was reported timely.

   The children remain continuously eligible under MAGI-related Medicaid until the annual review. If the children are no longer eligible at the annual review due to income, they will be considered for Hawki.

3. **Negative Change Timely Reported:**

   Ms. G and her children receive Medicaid under MAGI-related. Ms. G starts a new job and receives her first paycheck on May 23. Ms. G reports the change timely by June 2. The worker requests verification and it is returned timely by June 15.

   The effective date of the change is July 1 if the worker acts on the change by timely notice in June. The effective date of the change is August 1 if the worker acts on the change after timely notice in June but before timely notice in July.

   No claim is established in either situation because the verification was received after August 10.

   If Ms. G and her children go over income for FMAP and are otherwise eligible for transitional Medicaid (TM), TM begins the first of the month after MAGI-related ends.

   The children remain continuously eligible until the annual review. If the children are no longer eligible at the annual review due to income, and TM does not apply, they are considered for Hawki.

4. **Positive Change Not Timely Reported but Required to Be Reported:**

Mr. F's children receive Medicaid under MAGI-related. In June, Mr. F reports that he got a new job the previous December with a new company and had a decrease in income.

Due to this change, Mr. F is eligible for Medicaid under MAGI-related. The effective date of the income change is July 1, since he reported the job in June.

The worker explains to Mr. F that it appears he would now be eligible for Medicaid. Mr. F states he has health insurance and doesn't want Medicaid.

In August, Mr. F calls his worker and requests Medicaid. He says he has medical bills that his health insurance didn't cover for the past six months.

Mr. F's request for Medicaid is treated as an application. The worker explores whether Mr. F is eligible for August and ongoing. Mr. F is not eligible for Medicaid for February through July because this application for Medicaid was in August.

5. **Negative Change Not Timely Reported but Required to Be Reported:**

Ms. C and her children receive Medicaid under MAGI-related. On September 3, it is discovered that Ms. C failed to timely report beginning earned income. Ms. C received her first paycheck on July 23. Since the change was not reported timely, the effective date of the change is August 1. The worker redetermines Medicaid eligibility for August, September, and ongoing.

If a change in eligibility occurs, a timely notice must be issued. If appropriate, a claim is established for Ms. C.

If eligibility is only under Medically Needy with a spenddown, the certification period is August and September.

The children remain continuously eligible under MAGI-related Medicaid until the annual review. If they are over income for MAGI-related Medicaid at the annual review, they are considered for Hawki.

6. **Required to Be Reported:**

Mr. G and his children are approved for Medicaid under FMAP in November. In December, Mr. G goes from part-time employment to full-time employment at the same company. Mr. G reports this to his worker the following February. The increase in income makes the family over income for FMAP.

The worker acts on the report and the family is eligible for transitional Medicaid (TM) beginning March 1.

It is not a negative action to change coverage from FMAP to TM since they are both full Medicaid programs. Therefore, a ten-day negative action is not sent for FMAP.

7. **Addition of Household Member Reported Timely; Cancellation and Automatic Redetermination; Information Received by 10th of Month:**

Ms. K and her children receive Medicaid under FMAP. On April 20, Mr. K joins the household and the change is timely reported to the Department. Mr. K requests Medicaid and has unearned income. The worker requests necessary information and it is timely provided May 10.

The unearned income makes the family over income for MAGI-related Medicaid. The children are continuously eligible until the annual review when eligibility is examined.

The worker completes an automatic redetermination to MN for the parents in May, effective June 1. An April/May MN certification period is set up for Mr. K and a June/July MN certification period is set up for Mr. And Mrs. K

8. **Addition of Household Member Reported Timely; Cancellation and Automatic Redetermination; Information Received after 10th of Month:**

Mr. Q and his children receive Medicaid under FMAP. On April 20, Mrs. Q joins the household and the change is timely reported to the Department. Mrs. Q requests Medicaid and has unearned income. The worker requests necessary information and it is timely provided May 11.

The unearned income makes the family over income for MAGI-related Medicaid. If time permits, the worker completes an automatic redetermination to MN for the parents in May, effective June 1. However, a redetermination **must** be completed no later than timely notice in June effective July 1. No claim is established in either situation.

The children remain continuously eligible under MAGI-related Medicaid until the annual review. If they are over income for MAGI-related Medicaid at the annual review, they are considered for Hawki.

Alternative Scenario: If the information is not provided by the due date, a Notice of Cancellation is sent canceling Medicaid effective June 1.

If the information is received after timely notice in May, June benefits are reopened and a redetermination would be completed effective July 1. No claim is established.

9. **Addition of Household Member Not Reported Timely; Cancellation and Automatic Redetermination; Information Received after 10th of Month:**

Mr. S and his children receive Medicaid under FMAP. On April 20, Mrs. S joins the household and the change is reported to the Department untimely on June 30. Mrs. S requests Medicaid and has unearned income. The worker requests necessary information and it is timely provided July 19.

The unearned income makes the family over income for MAGI-related Medicaid. An automatic redetermination must be completed no later than August effective September 1 for Mr. and Mrs. S. If appropriate, a claim is established beginning in May for Mr. S.

If eligibility is only under Medically Needy with a spenddown, the certification periods are May/June and July/August.

The children remain continuously eligible under MAGI-related Medicaid until the annual review. If they are over income for MAGI-related Medicaid at the annual review, they are considered for Hawki.

NOTE: If the annual review is due in April, May or June, continuous eligibility may not apply and an overpayment may have occurred on the children.

The effective date of a change that is either reported untimely or not reported at all, is the month following the month in which the change occurred, regardless of when in the month the change occurred and regardless of the effect the change has on eligibility.

> Ms. C and her children receive Medicaid under FMAP. On September 3, it is determined that Ms. C failed to timely report beginning earned income. Ms. C received her first paycheck on July 23. The effective date of the change is August 1. The worker redetermines Medicaid eligibility for August and September and establishes recoupment, if appropriate.

The effective date of a change that was timely reported but was not acted upon depends on when the change occurred, regardless of whether the change was required to be reported or not.

> 1. Mr. and Mrs. D receive Medicaid under MAC for their children. Mr. and Mrs. D do not receive Medicaid. On October 18, Mrs. D timely reports beginning income. In December, it is determined that the worker failed to act on the reported change.
>
>   The worker requests verification, which Mrs. D provides on December 10. Because the change was timely reported after October 10, the effective date of the change is December 1.
>
> 2. Same as Example 1, except that the change was timely reported October 3. Because the change was timely reported on or before October 10, the effective date of the change is November 1.
>
> 3. Ms. E receives Medicaid for herself and her son under FMAP. On May 5, she reports a permanent increase in her hourly rate, which is effective with the paycheck she will receive May 12.
>
>   In September, it is determined that the worker failed to act on the reported change. The worker requests verification, which Ms. E provides on September 22. Even through Ms. E was not required to report the change, because it was reported, it is acted upon like any other reported change. Since the change was reported on or before May 10, the effective date of the change is November 1.

Additional Non-MAGI-Related Case Maintenance

This section contains information for Non-MAGI-related cases on:

- Eligibility review
- MEPD case maintenance
- New members in Non-MAGI-related households

Non-MAGI-Related Eligibility Reviews

Legal reference: 441 IAC 76.14(249A)

Policy: Eligibility shall be reviewed at least once every 12 months for all Non-MAGI-related members **except** when a member receives SSI or only a blind or mandatory State Supplementary Assistance payment

The member shall complete form 470-5482, 470-5482(S), 470-5482(M), or 470-5482(MS), *Medicaid/State Supp Review*, for the annual review.

Procedure: Evaluate the information on the *Medicaid/State Supp Review* to determine if the member remains eligible for Medicaid under the current coverage group. Complete a redetermination when changes are reported that result in the member no longer being eligible under the current coverage group. See Automatic Redetermination.

Comment: An interview is not required as part of the annual eligibility review process, however an individual must attend a face-to-face or telephone interview if requested to do so by the Department. Do not require an interview for cases on which only children receive Medicaid.

MEPD Case Maintenance

Legal reference: 441 IAC 75 (Rules in Process)

MEPD Reviews

Policy: Premiums for Medicaid for employed people with disabilities (MEPD) are established at a fixed monthly rate for a 12-month enrollment period. The MEPD premium may increase or decrease at the time of the eligibility review. However, the premium may increase or decrease during a 12-month enrollment period in specific situations. See Premium Change for Current or Past System Months.

Procedure: The ELIAS system issues a *Medicaid/State Supp Review*, form 470-5482 or 470-5482(S) to the member 60 days prior to the end of the premium period. After the *Medicaid/State Supp Review* is returned, process eligibility in ELIAS and issue the *Notice of Action*.

In order to have the correct premium in the system for billing for the new 12-month enrollment period, the review must be processed and the review entries made in the ELIAS system before timely notice of the twelfth month of the current 12-month enrollment period.

Review entries made by the 15th of the month will be reflected on the next monthly *MEPD Billing Statement.* A revised *MEPD Billing Statement* will be issued when the premium is changed after the 15th but before system cutoff.

Review entries made after cutoff will not update the MEPD billing system and a revised *MEPD Billing Statement* will not be issued until the next regular monthly bill. Premium changes entered in the ELIAS system after cutoff require MEPC entries to revise the premium for the next month.

Effect of Nonpayment of Premiums

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Members who are assessed premiums do not have Medicaid eligibility for a month until a premium payment is applied to that month. Although the due date of a premium payment is generally the 14th of the month for which a premium is assessed, a premium payment may be applied to a month up to three months after the due date.

In other words, to become Medicaid-eligible for a month, the client must pay the premium no later than:

- Three months after the due date of the premium, **or**
- By the premium due date for retroactive months that were initially billed with a due date three months after the month the *MEPD Billing Statement* was issued.

There is no provision to request a hardship waiver for MEPD.

Procedure: When a premium is not received by the due date, a batch will run to discontinue the MEPD case for failure to pay the premium. Standard procedures are as follows:

- When payments are recorded after the due date, an alert is issued to notify the worker to:
  - Reinstate the MEPD case when a payment is received before the effective date of cancellation.
  - Reopen the MEPD case when a payment is received in the month following the month it was due.
  - Leave the MEPD case closed when a payment is received after the month following the month when it was due. The member must file a new application to determine eligibility for MEPD.

1. Mr. B applies for MEPD on January 30. Approval entries are made on March 10 (before system cutoff). Mr. B receives an *MEPD Billing Statement* showing that::

   - The premium for January is due by June 14.
   - The premium for February is due by June 14.
   - The premium for March is due by April 14.

   Mr. B does not pay the March premium by April 14. The system cancels the case with timely notice.

   Mr. B pays all three premiums on June 10. After the payments are posted in June, the worker receives an alert saying that the payments were received. Medicaid eligibility is granted for January, February, and March because:

   - March premium was paid within three months of the billing month, and
   - January and February premiums were paid before the due date of June 14.

   It is too late to reopen the case for ongoing benefits because the March payment was received later than the month following the month it was due. Mr. B must reapply if he wants to get MEPD again.

2. Mr. Z applies for MEPD on January 5 and is approved on January 28 (after system cutoff). His first *MEPD Billing Statement* shows:

   - The premium for January is due by February 14.
   - The premium for February is due by February 14.

   Mr. Z doesn't pay the premiums by February 14. The system cancels the case with timely notice.

   Due to the MEPD reopening policy, the worker waits to complete the automatic redetermination to Medically Needy until the end of the month following the month the payment was to cover.

   Mr. Z pays both premiums on March 27. An alert is issued to the worker stating that the premiums have been paid. Mr. Z is eligible for Medicaid in January and February because the premium payments were received during the three-month period to accept payments. The MEPD case is reopened because the premium payments were applied before the last day of the month following the month they were due.

Reinstating a Case Canceled for Failure to Pay Premium

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Reinstatement is allowed when an MEPD case was canceled because a premium payment was not received by the 14th of the month it was intended to cover.

Reopening a Case Canceled for Failure to Pay Premium

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Reopening an MEPD case is allowed when the case was canceled because a premium payment was not received by the end of the month it was due. To qualify for a reopening, payment must be received by the last day of the month following the month it is to cover.

NOTE: Using the CREATE STMT entry on the MEPD STMT screen issues an *MEPD Billing Statement* that is up to date with payments and premiums assessed. The REPRINT (client or worker) a statement selection sends a duplicate copy of an *MEPD Billing Statement.* The REPRINT selection allows the choice of the statement by the date it had been issued.

Premium Change for Current or Past System Months

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Monthly MEPD premiums can be reduced for the remainder of a 12-month enrollment period due to a change in income that results in a lower premium.

Premiums should not be increased during the 12-month enrollment period due to an increase in income. Premiums may be increased only when an error has been made in the calculation and the case is being corrected. The error may be due to:

- The member underreporting the income.
- Incorrect income entries in the system, or
- How income was determined.

Decrease a Premium

Procedure: Reduce MEPD premiums effective the month following the month the lower income is reported. Send a *Notice of Action* with the new premium amount and the month the decrease is effective.

To decrease a premium that has **already been paid** for the **current** or a **past month:**

1. Make entries in the MEPC screen to decrease the premium amount. See 14-B(9), *Using MEPC*.
2. The MEPC changes will update overnight to the MEPD system, which will calculate the difference between the original, paid premium and the new, lower premium to show a credit.

3. The balance of overpaid premiums will be:
   - Applied to unpaid months, or
   - Held as a credit to be applied to future assessed premiums.

To decrease a premium for the **next calendar month:**

1. Income entries made in ELIAS before system cutoff will update the MEPD billing system. A new *MEPD Billing Statement* will be issued with the revised premium amount.
2. Income entries made in ELIAS after system cutoff will not update the MEPD billing system. A revised *MEPD Billing Statement* will not be issued until the next regular monthly bill. Changes entered in ELIAS after system cutoff require MEPC entries

> 1 An *MEPD Billing Statement* for a $110 premium is issued to Mrs. B on March 16. On March 23, Mrs. B reports on the *MedicalState Supp Review* form that her earned income has decreased.
>
> On March 30, the worker makes MEPD review entries in ELIAS with the lower earned income and the unearned income. The lower income causes her premium to decrease to $80. Since the entries are made **after** March system cutoff, the MEPD billing system does **not** automatically update and issue a revised *MEPD Billing Statement* for April.
>
> On March 31, the worker makes MEPC entries to change the premium amount for April to $80. After the premium amount updates to $80 in the MEPD billing system, a revised *MEPD Billing Statement* for $80 is issued for April.
>
> 2. An *MEPD Billing Statement* for a $53 premium is issued on March 16 to Mr. K. On March 18, Mr. K reports that he is searching for a new job and sends form 470-4856, *MEPD Intent to Return to Work*, showing he lost his job on March 10.
>
> On March 19, the worker enters zero earned income and unearned income in ELIAS, which decreases Mr. K's premium to $29 for April. Since the change is entered before March system cutoff, the MEPD billing system is updated with the lower premium and a revised *MEPD Billing Statement* for April is automatically issued with a $29 premium.

<u>Increase a Premium</u>

Procedure: When an MEPD premium needs to be increased for past months, contact the member to report that the premium was incorrect and give the member the choice of either:

- Having the premium corrected to a higher amount for past months, or
- Referring the underpayment to collections.

When the member agrees to pay the higher premiums without timely notice:

1. Ask the member for a signed and dated statement giving permission to increase the premium for past months without timely notice.
2. Send a manually issued *Notice of Action* stating the corrected premium amount and the months involved.

3. Make entries in the MEPC screen to increase the premium for current or past months. See 14-B(9), *Change to MEPD Premium*. ELIAS will update ongoing months.
4. The billing system will issue a revised *MEPD Billing Statement* for the months corrected.

Refunds

Legal reference: 441 IAC 75 (Rules in Process)

Policy: When the member has paid in more than is owed, refunds are automatically issued if there are funds in the MEPD premium account and:

- The premium has been reduced to zero for two consecutive months, or
- There have been two consecutive months of inactivity on the MEPD case.

The Department will also issue a refund upon the member's request.

Procedure: To request a refund on behalf of an MEPD member, send an e-mail to DHS, SPIRS Help Desk. Include the member's name, state identification number, the amount to be refunded, and the reason for the refund. Do not tell the member to call IME Member Services, as IME staff cannot request MEPD premium refunds.

New Members in Non-MAGI-Related Households

Legal reference: 441 IAC 76.1

For Non-MAGI-related Medicaid purposes, the "household" concept and "adding a new member to a household" do not apply in the same way as for MAGI-related cases. Rather, except for eligible married couples, non-MAGI-related cases are based on an individual's eligibility.

Non-MAGI-related Medicaid eligibility for unmarried persons is determined individually rather than as a "household." Therefore, a new member may not be added to an unmarried person's Non-MAGI-related Medicaid case. **NOTE:** A newborn child of a Non-MAGI-related Medicaid-eligible mother may be eligible on the newborn's own case under the coverage group in which the mother received Medicaid at the time of birth.

Non-MAGI-related eligibility for married couples in which both spouses are aged, blind, or disabled is determined together (as a couple) when both spouses are receiving or have applied for Non-MAGI-related Medicaid. When two Non-MAGI-related members marry, determine their ongoing eligibility as a couple in the month following the month of marriage.

When a Non-MAGI-related Medicaid member marries a person who is aged, blind, or disabled but is not receiving Medicaid, the spouse must file an application to begin receiving Non-MAGI-related Medicaid.

When a Non-MAGI-related member is living with a spouse who turns 65 or becomes blind or disabled, the spouse must file an application to begin receiving Non-MAGI-related Medicaid.

Treat an aged, blind, or disabled spouse who has not applied for Medicaid as an ineligible spouse when determining the member's ongoing Medicaid eligibility (i.e., apply income deeming policies).

When a Non-MAGI-related member marries and the spouse is not Medicaid-eligible, determine the effect on the Medicaid member for the next month. If the new spouse applies for Medicaid when the other spouse is already eligible, determine their eligibility as a couple and, when they are eligible, grant Medicaid for the month of application to the spouse who has applied. Then, put the couple together the next month.

When parents or stepparents are also in the home, treat them as considered persons.

Fraud and Overuse of Medicaid Services

Legal reference: 441 IAC 79.2

If you become aware of a situation where it appears that Medicaid services are being overused or excessive or inappropriate Medicaid services are being provided, email the details to FWAReports@dhs.state.ia.us.

If you become aware of any situation that indicates potential fraud by a medical provider, report the circumstances to the IME Program Integrity Unit at 1-877-446-3787 or in Des Moines at 515-256-4615. Examples of such situations include:

- Billing for services, supplies, or equipment that were not rendered to or used for members.
- Billing for supplies or equipment that is clearly unsuitable for the member's needs or so lacking in quality or sufficiency for the purpose as to be virtually worthless.
- Flagrant and persistent overutilization of medical or paramedical services with little or no regard for results, the member's ailment, conditions, medical needs, or the doctor's orders.
- Claiming of costs for noncovered or nonchargeable services, supplies, or equipment disguised as covered items.
- Material misrepresentations of dates and descriptions of services rendered or of the identity of the member or the person who rendered the services.
- Duplicate billing that appears to be deliberate, e.g., billing twice for the same services.
- Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the Medicaid program using various devices to siphon off or conceal illegal payments.
- Charging to the Medicaid program by subterfuge costs that were not incurred or that were attributable to nonprogram activities, other enterprises, or personal expenses.