



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

October 21, 2011

GENERAL LETTER NO. 8-O-16

ISSUED BY: Bureau of Financial, Health and Work Supports
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 8, Chapter O, **LOWACARE**, Title page, revised;
and pages 8, 20 through 23, 36, 42, 44a, 44b, 59, 60, 67, and 68,
revised.

Summary

Chapter 8-O is revised to:

- ◆ Add examples of where medical services are provided for pregnant women.
- ◆ Revise procedures for recording dates applications are received.
- ◆ Clarify the certification period for reporting changes.
- ◆ Revise examples regarding self-employment income.
- ◆ Clarify procedures for screening for Medically Needy before IowaCare determination.
- ◆ Remove reference to Agent Orange income because the fund closed September 27, 1997, and no more funds can be disbursed.
- ◆ Clarify dependents included in the household size.

Effective Date

Upon receipt.

Material Superseded

This material replaces the following pages from Employees' Manual, Title 8, Chapter O:

<u>Page</u>	<u>Date</u>
Title page	March 30, 2007
8	March 26, 2010
20	September 14, 2007
21, 22	March 30, 2007
23	November 12, 2010
36	March 25, 2011
42	March 30, 2007
44a, 44b	May 27, 2011
59, 60, 67, 68	November 12, 2010

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

Revised October 21, 2011

Employees' Manual
Title 8
Chapter 0

IOWACARE



Iowa Department
of Human Services

Date of Application

Legal reference: 441 IAC 76.1(249A), 92.3(249A,249J)

An application is considered filed on the date when Comm. 239, *IowaCare Application*, containing a legible name, address, and signature of the applicant or representative is received at a location listed under [Where the Application Must Be Filed](#).

The date the application is received is recorded in the Electronic Case File (ECF). If the application was filed in the incorrect Department office and sent to the appropriate office for processing, the date the application was filed in the first office is still the date of application.

When an application is left at a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that office was last open.

A faxed application shall be considered as an original application. A faxed application is considered filed on the date it is received during normal business hours. If the fax comes in after normal business hours (during the evening, weekend, or holiday), the faxed application is considered received on the first day that is not a weekend or state holiday following the day that office was last open.

Withdrawal of Application

Legal reference: 441 IAC 76.1(249A), 92.3(249A,249J)

An applicant may withdraw the application entirely or for any month covered by the application if the request is made before the application is processed.

The request to withdraw the application may be done orally or in writing. Document the withdrawal in the case record. Issue an adequate notice of decision if the entire application is withdrawn. If only a month of the application is withdrawn, and a notice of decision will be issued when the remaining application is processed, a separate notice is not necessary.

Grace Period Following the Denial of an Application

Legal reference: 441 IAC 92.4(1)"c"

See 8-B, [Grace Period Following the Denial of an Application](#).

Case Action	Scenario 4	Scenario 5	Scenario 6
Action of IM worker	Approves IowaCare application.	Approves IowaCare application.	Approves IowaCare application.
Action of IowaCare member	Has a disabling event and applies for SSD. Reports disability to IM worker.	Has a disabling event and applies for SSD. Does not report disability to IM worker.	Has a disabling event and applies for SSD. Does not report disability to IM worker.
Action of IM worker	Documents that the member reported applying for disability. Waits for disability decision. Premium not paid. Case is canceled.		Premium not paid. Case is canceled.
Social Security approves disability	IM worker uses the 7/1 IowaCare application to determine Medicaid eligibility based on disability. Grants Medicaid eligibility if otherwise eligible.	The member did not report application for disability and must file a new application for Medicaid. IM worker determines Medicaid eligibility based on disability.	The client reports receipt of SSD but must file an application for Medicaid. If eligible for SSI, the person's Medicaid eligibility is based on the SSI determination.
Difference	Reports disability after approval. The cancellation does not have anything to do with the disability. The application is considered to be pending for a disability determination.	Does not report disability, therefore the 7/1 application was not pending for a disability determination.	Does not report disability, therefore the 7/1 application was not pending for a disability determination. If the person receives SSI based on the disability determination, the SSI determination is treated as an application for Medicaid.

Reminder: If the person applies for social security disability and is approved for SSI for the first five months, the SSI determination is treated as an application for Medicaid. Follow the policies in 8-B, [Procedures for SSI Applicant or Potential SSI Eligibles](#), for determining eligibility for a person who is determined eligible for SSI.

Screening for Full Medicaid

Legal reference: 441 IAC 92.2(1)"a"(1), 92.4(2)

Screen each *IowaCare Application* and *IowaCare Renewal Application* for other Medicaid eligibility. Persons eligible for other Medicaid coverage groups are not eligible for IowaCare. **There are two exceptions:**

- ◆ Iowa Family Planning Network. A woman eligible for Iowa Family Planning Network may also be concurrently eligible for IowaCare.
- ◆ Medically Needy. A person who is unable to meet the spenddown for the Medically Needy coverage group may choose to receive IowaCare instead of Medically Needy.

A person who is unable to meet the spenddown is not Medicaid-eligible and therefore should be given the option to choose IowaCare. See [Choice of IowaCare or Medically Needy With a Spenddown](#).

Determine that a person aged 19 or 20 is not eligible for other Medicaid coverage groups (e.g., Child Medical Assistance Program (CMAP)) before approving for IowaCare.

If the applicant is eligible under another Medicaid coverage group, the *IowaCare Application* shall be considered an application for that coverage group. If it appears the applicant may qualify for Medicaid but fails to cooperate in providing information necessary to establish eligibility under another Medicaid coverage group, deny the IowaCare application.

1. Mr. A receives SSI. He fails to return the requested information to the Department. He is not eligible for Medicaid until he returns the information. He applies for IowaCare.

The IM worker screens the application for other Medicaid coverage groups. A determination on Medicaid eligibility must be made first because the information on the application indicates that he may be eligible for Medicaid. The worker again requests the information to determine Medicaid eligibility. Mr. A does not return the information. His IowaCare application is denied.

2. Mr. and Mrs. C and their 17-year-old child apply for IowaCare. The IM worker screens the application for Medicaid and requests information to determine Medicaid eligibility. The information is not returned by the due date. The worker denies the IowaCare application because it could not be determined if the family was Medicaid eligible.

Concurrent Eligibles

Legal reference: 441 IAC 92.2(1)"a"(1)

There are situations when a member may become eligible for another Medicaid coverage group while receiving IowaCare. These include:

- ◆ A woman age 19 through 44 receiving Iowa Family Planning Network (IFPN).
- ◆ An IowaCare-eligible woman who becomes eligible for MAC due to pregnancy.
- ◆ A woman who is determined presumptively eligible for Medicaid.
- ◆ An IowaCare member who can now meet the spenddown for Medically Needy.
- ◆ An IowaCare member who is now eligible for another Medicaid coverage group.

When a person has been determined eligible for IowaCare and then is later determined eligible for a Medicaid coverage group that has full Medicaid benefits, the IowaCare eligibility continues with the Medicaid coverage until the IowaCare can be canceled in a timely manner. EXCEPTION: A woman aged 19 through 44 may be eligible for both IowaCare and IFPN.

The SSNI=Medicaid Eligibility File screen will show a blended aid type for these situations. NOTE: The Medicaid Eligibility system cannot allow IowaCare to be an underlying eligibility with Medicaid coverage groups that have limited benefits, such as QMB and SLMB. Persons determined eligible for IowaCare and then later determined eligible for QMB or SLMB in the same month, require special handling. Contact central office.

Choice of IowaCare or Medically Needy With a Spenddown

Legal reference: 441 IAC 92.2(1)"a"(1), 92.4(1)

Policy:

When processing an application, screen for Medicaid eligibility in the Medically Needy group.

1. Check to see if the applicant is eligible under Medically Needy:
 - ◆ Pregnant,
 - ◆ Has children in the household,
 - ◆ Is under 21, or,
 - ◆ Blind or disabled.
2. If the applicant meets one of these eligibility requirements, check with the applicant to find out about the applicant's current and expected medical bills.

3. If the applicant can meet the spenddown amount, the applicant must be approved for Medically Needy. The applicant does not have a choice between IowaCare and Medically Needy with the spenddown because the applicant will be eligible for Medicaid after meeting spenddown.
4. If the applicant **cannot** meet a spenddown with medical expenses that the applicant has or will incur, the applicant should be given a choice of Medically Needy or IowaCare. Document the person's choice in the case file. **Do not** give the applicant a choice if the applicant can meet the spenddown.

An applicant who is approved for Medically Needy with a spenddown cannot request IowaCare for the months of the Medically Needy certification period.

When a person is approved for IowaCare and later has high medical bills that would meet the spenddown, the person may file an application for Medically Needy for months that the person was already receiving IowaCare. Cancel the IowaCare case with timely notice.

1. Mr. and Mrs. A have two children in the MAC coverage group. The parents apply for Medicaid on May 5. The IM worker explains that the spenddown amount would be \$3,000.

Before Medically Needy is approved, the worker asks if Mr. and Mrs. A have medical expenses of \$3,000 or if they expect to have that much in medical bills for the two-month period. Mr. and Mrs. A state that they expect to have only \$500 in medical bills.

Since Mr. and Mrs. A cannot meet the spenddown of \$3,000 for Medically Needy, the worker explains that they could choose IowaCare. They request IowaCare. Before the worker approves IowaCare, the worker sends Mr. and Mrs. A form 470-4194, *IowaCare Premium Agreement*, to sign.

In August, Mrs. A calls the worker to report that Mr. A was hospitalized at the local hospital after an accident. The worker explains that IowaCare will not pay the bill because he is not at the University of Iowa Hospitals and Clinics and that Mr. and Mrs. A could apply for Medically Needy. They apply for Medically Needy on August 15. Medically Needy is approved September 10 and IowaCare is canceled with a timely notice effective October 1.

IowaCare shows as the primary coverage on SSNI for the months of August and September until the spenddown is met for Medically Needy. Once spenddown is met, Medically Needy shows as the primary coverage on SSNI.

Income Policies

Legal reference: 441 IAC 92.2(1)"a"(1), 92.2(1)"b"(1), 92.5(249A,249J)

Eligibility for IowaCare is based on the income of an applicant's or member's household as of the date of decision based on the applicant's or member's declaration of income. To be eligible, the household's income minus allowable deductions shall not exceed 200% of the federal poverty level for the household size, or 300% of the federal poverty level for a qualifying pregnant woman.

Income Limit	IowaCare Household Size						
	1	2	3	4	5	6	7
200%	\$1,815	\$2,452	\$3,089	\$3,725	\$4,362	\$4,999	\$5,365
300%	\$2,723	\$3,678	\$4,633	\$5,588	\$6,543	\$7,498	\$8,453

1. Mr. S files an *IowaCare Application* and states that his monthly gross income from working is \$500. The IM worker determines his eligibility based on the information provided on the application.
2. Mr. J files an *IowaCare Application* on July 6 stating that his monthly gross income from working is \$600. On July 8, Mr. J calls to report that his income has changed and he will receive \$650 monthly income. The IM worker determines eligibility on July 9 using the \$650 income that he reported on July 8.

Household Size

Legal reference: 441 IAC 92.1(249A, 249J), 92.5(1)

The household size includes the applicant or member and spouse and dependent or unborn children of the applicant or member who are living in the same home.

"Dependent child" means the child or stepchild who is under the age of 18 or is 18 years of age and will graduate from high school before reaching the age of 19. Include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return. EXCEPTION: Do not include the following:

- ◆ A spouse or dependent child who receives Supplemental Security Income,
- ◆ A foster child who is not included in the household size, or
- ◆ A child who is ineligible for Medicaid because of nonfinancial reasons or was voluntarily excluded.

- ◆ Experimental housing allowance program payments made under annual contribution contracts entered into before January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
- ◆ The income of a Supplemental Security Income recipient.
- ◆ Payments from the Family Support Subsidy program.
- ◆ Grants obtained and used under conditions that preclude their use for current living costs.
- ◆ All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative, conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents that are in the eligible group shall be counted as nonexempt income.
- ◆ Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.
- ◆ Bona fide loans. Evidence of a bona fide loan may include any of the following:
 - The loan is obtained from an institution or person engaged in the business of making loans.
 - There is a written agreement to repay the money within a specified time.
 - If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
- ◆ The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
- ◆ Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief, and Emergency Assistance Amendments of 1988.

When a third or fifth check is given during the period being used to project income, do not ignore it. Instead, add all check amounts together, divide the total by the number of checks, and multiply that result by four, if the income occurs weekly, or by two, if the income occurs biweekly.

For income from salary, wages, or tips, "earned income" means the total gross amount of income irrespective of the expenses of employment. Applicants who receive earned income from salary, wages, or tips shall declare their household's monthly gross income and are not required to provide verification, unless the information is questionable.

Applicants who are self-employed, including self-employment on an irregular basis and from seasonal earnings, shall self-declare their household's net annual income.

For self-employment income, "earned income" means the net profit from self-employment. "Net profit" is defined as gross income less the costs of producing the income. Do not deduct depreciation and the cost of capital expenses. Do not offset any self-employment loss from a different source of income. Use the net annual income from self-employment to determine the net monthly income.

Applicants who are temporarily unemployed or who receive earnings on a seasonal basis or on an irregular basis shall self-declare their household's annual income.

Do not use income that ended in the month of application to project household income for the certification period for applicants who do not expect to return to work.

Count all earned income received by anyone included in determining the household size. EXCEPTION: Do not count the earnings of a child who is a full-time student in a secondary school setting.

Anticipated earned lump-sum income is prorated over the period for which it will be received.

1. Mr. K applies for IowaCare October 7. He states on the application that he earns \$1,800 per month and that he gets a \$2,000 bonus in December of each year. To project Mr. K's monthly income: $\$1,800 \times 12 = \$21,600 + \$2,000 = \$23,600 \div 12 = \$1,966.67$.
2. Mr. Z is employed at a farm, on a seasonal basis, from April through October. He reports that his earnings are \$1,000 a month. The IM worker annualizes his income. $\$1,000 \times 7 \text{ months} = \$7,000 \div 12 = \$583.33$ per month.
3. Ms. R is not currently working and will be off work for 8 weeks. She usually grosses \$1,725 per month. To project her monthly income: $\$1,725 \times 10 \text{ months} = \$17,250 \div 12 = \$1,437.50$ per month.
4. Mr. M asks for help in completing his application. He wants to know if he may count the expenses he has for self-employment and the depreciation on his machinery. The IM worker tells him that he may use business expenses except for depreciation.
5. Ms. Y applies for IowaCare on May 1. She reports earned income of \$1,000 a month from working in the school cafeteria. She states the job will end June 1. The IM worker calls Ms. Y and asks if she will be returning to work in August and how much income she made earlier in the year.

Ms. Y states that she will return to work at the end of August and that she averages \$1,000 a month when working. She states that she will not receive a check in August. The worker annualizes Ms. Y's income. $\$1,000 \times 9 \text{ months} = \$9,000 \div 12 = \$750$ per month.
6. Mr. Z applies for IowaCare on June 5. He states on his application that he will receive \$1,550 gross income in June. He will not be returning to work and is unable to look for a new job due to an injury. He will not receive any worker's compensation. The IM worker does not use his terminated income to determine his eligibility or premium amount.

Case Maintenance

The following sections address:

- ◆ [The member's responsibility for reporting changes](#)
- ◆ [Terminating eligibility](#)
- ◆ [Recovery of overpaid benefits](#)
- ◆ [The member's right to appeal an adverse action](#)
- ◆ [Automatic redetermination](#)

Reporting Changes

Legal reference: 441 IAC 7.7(1), 92.10(249A,249J), 92.13(249A,249J)

A member shall report the following changes no later than ten calendar days after the change takes place:

- ◆ The member moves.
- ◆ The member obtains other health insurance coverage.
- ◆ The member enters a nonmedical institution, including but not limited to a jail or other penal institution.

When a change is not timely reported, any incorrect program expenditures shall be subject to recovery. See [Recovery](#).

Acting on Changes

Legal reference: 441 IAC 92.5(6), 92.7(1)"d," 92.7(1)"e," 92.10(2), 92.10(3), 92.13(249A,249J)

After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

- ◆ Timely notice of adverse action is required (ten day notice).
- ◆ The certification period has expired.

A person found to be income-eligible upon application or renewal of eligibility remains income-eligible for the certification period regardless of any change in income or household size.

Do not increase the premium established for a certification period due to an increase in income or a change in household size. Decrease a premium when a member reports a decrease in income or an increase in household size. This change is effective the first of the month following the change report.

1. Ms. J is approved March 1 for IowaCare. On May 5, she reports that she now has health insurance and requests that her IowaCare be canceled.

The IM worker cancels the case effective June 1. Because Ms. J has health insurance and reported the change, the worker zeroes out the premium for June. (Even though June is a mandatory month, Ms. J does not owe for June since she now has health insurance.)

2. Ms. K is approved March 1 for IowaCare. She starts working in April and does not report that she started receiving health insurance in May. Her case is canceled August 1 because she did not pay the May premium. She owes the premiums for May, June, and July.

Ms. K loses her job and applies for IowaCare in September. She does not think she should pay the premium for May and June, since she had other health insurance. It's too late to decrease the premium amount for May and June. Since Ms. K did not timely report the change, the worker does not zero out the premium for July.

3. Ms. L reports to her IM worker that her income increased on November 15. Ms. L did not need to report this change in income. The worker does not act on the change.

4. Ms. M's household size is three when IowaCare eligibility is determined in July. She reports that her husband has moved out of her home. He did not have income at the time of the application. Ms. M did not need to report this change. The worker does not act on the change that would otherwise increase the premium. The premium stays the same.

5. Mr. J returns his *IowaCare Renewal Application* on July 30. He states on his application that his gross earned income is \$1,200 a month. On August 10, the IM worker approves the application. Mr. J's new IowaCare certification period will begin September 1.

On August 15, Mr. J reports that his pay increased. The worker does not act on the change because the *IowaCare Renewal Application* is already approved.

Pregnant women who are not in the “qualifying” 300% group but are eligible for IowaCare (e.g. over resources for MAC) must receive covered services at their medical home or at UIHC.

1. Ms. A, an IowaCare qualifying pregnant woman (aid type 60-P), lives in Boone County. Since she is a qualifying pregnant woman, she may receive obstetric services at any licensed hospital or health care facility that accepts Medicaid. However, if she moves to Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, Ms. A must receive her obstetric services at the UIHC.

2. Ms. C, an IowaCare qualifying pregnant woman (aid type 60-P), lives in Woodbury County. She may receive obstetric services at any licensed hospital or health care facility that accepts Medicaid.

However, since there is a medical home in her geographic area, once her pregnancy ends she must go to the medical home that serves her county of residence to receive services.

3. Ms. B lives in Cedar County and is over resources for MAC. Her income is below 200% of the federal poverty level. She is eligible for IowaCare (aid type 60-E) in her own right and not because she is pregnant. Since her basis of eligibility is not because she is a qualifying pregnant woman, she must receive all her care, including obstetric services at the UIHC.

Obstetric Coverage for Qualifying Pregnant Women

Legal reference: 441 IAC 92.8(3)

Covered IowaCare services for qualifying pregnant women are limited to:

- ◆ Inpatient hospital services when:
 - The primary or secondary diagnosis code is V22 through V24.9, and
 - The diagnosis-related group submitted for payment is 370 to 384.
- ◆ Outpatient hospital services when:
 - The primary or secondary diagnosis code is V22 through V24.9, and
 - The ambulatory patient group submitted for payment is 175, 304, 492, 493, or 494.
- ◆ Services from another Medicaid provider if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

Qualifying pregnant women who live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County must receive these services from the University of Iowa Hospitals and Clinics.

Qualifying pregnant women who live in other counties may receive these services from any provider participating in the Iowa Medicaid program.

Newborn Coverage

Legal reference: 441 IAC 92.8(3)

Covered services under IowaCare for newborn children of mothers who were qualifying pregnant are limited to the following services provided while the newborn is hospitalized for a period not to exceed 60 days from the date of birth:

- ◆ Inpatient hospital services when the diagnosis-related group submitted for payment is between 385 and 391.7.
- ◆ Services from a health care provider other than a hospital, subject to normal Medicaid coverage limitations.

Once the newborn leaves the hospital of birth, the newborn is not eligible for any other medical coverage under IowaCare except for one check-up, if done within 60 days after birth.

Ms. A is eligible for IowaCare as a qualifying pregnant woman. She delivers her baby at a Sioux City hospital in January and reports it to her IM worker. The worker mails an application to Ms. A and requests proof of Ms. A's income in order to determine whether the baby qualifies for a Medicaid coverage group.

The worker determines that the newborn is not eligible for Medicaid because Ms. A's income is now over the MAC income limits. The worker makes the system entries to add the newborn to the IowaCare case and issues a *Notice of Decision*.

The newborn has health complications and remains in the Sioux City hospital for two weeks after birth. At the end of the two weeks, the newborn is transferred to the University of Iowa Hospitals and Clinics.

The newborn was eligible for IowaCare while in the hospital of birth. However, the newborn is not eligible for IowaCare upon transfer to another hospital, including the University of Iowa Hospitals and Clinics.

Prescriptions

Legal reference: 441 IAC 92.8(2)

If the IowaCare member received inpatient care, the member may receive a 30-day supply of "take-home" drugs. The IowaCare member may also receive any drug that is administered in the outpatient clinic.